CHAIRPERSON: Senator Mary Daugherty Abrams

SENATORS: Cohen, Lesser, Moore Somers

REPRESENTATIVES: Steinberg, Young, Petit Arnone, Betts, Borer, Candelora, Carpino, Comey, Cook, Demicco, Genga, Hennessy, Kennedy, Klarides-Ditria, McCarty, Moore, Petit, Ryan, Scanlon, Terczyk Zupkus

SENATOR ABRAMS (13TH): Good morning everyone. We’re gonna try to get started. On behalf of myself, I’m Senator Mary Daughtery Abrams from 13th District, on behalf of myself and my Co-Chair Representative Jonathan Steinberg we welcome you to the Public Hearing for Public Health today. Just one housekeeping item in the interest of safety I would ask that you note the location of and access to the exits in this hearing room. The two doors through which you entered the room 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. 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 from the Capital 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 announcement 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 all for being here. Our first hour will be for Legislators, agencies and municipalities. And before we begin, any comments from my Chair?

REP. STEINBERG (136TH): Why yes, Public Health Committee meeting here today, just a couple ground rules because there are a lot of people here to testify on a lot of Bills and we want to afford everybody the opportunity to provide their testimony in a peaceful, nonconfrontational manner. So just setting some ground rules going in is that we do not applaud or boo or indicate any emotional response to anybody’s testimony so everybody can feel that they are not being intimidated in any fashion. Secondly I want to make clear, and maybe needed to be repeated as we go along today, that we are going to ask you to confine your remarks to the Bills that are actually before us today, not Bills that you think might be before us or Amendments you think might be before us. We will give you a measure of latitude to talk about the subject area but we’d like not to detour off into what-ifs and subjects that are not before this Committee today with any of the Bills before us. So we will be understanding, we will provide some latitude but on occasion you may find me desiring to interrupt and saying, “Can we get back to the matter at hand.” So we can move with those rules, I’m good. Representative Betts.

REP. BETTS (78TH): Just a quick question, Mr. Chairman. Are we taking this Bills up in the order they are listed on the Agenda, just for the public to know?
SENATOR ABRAMS (13TH): Yes, we are.

REP. STEINBERG (136TH): That is a good point, for people whose Bills that we’re testifying on are somewhat later, we encourage you to make sure you seek nourishment on occasion. You may walk around a little bit, get circulation back. It’s gonna be a long day for all of us, so think about your health as we go forward, the least we can do on this Committee. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments before we begin? Testimony is timed so we will let you know when your time is up. Our first speaker will be the Deputy Commissioner of DDS, Peter Mason. Welcome.

DEPUTY COMM MASON: Good morning Senator Abrams, Representative Steinberg and Petit and good morning to the Public Health Committee. My name is Peter Mason and I’m the Deputy Commissioner of the Department of Developmental Services. Thank you for the opportunity to provide remarks on a few of the Bills on today’s agenda. Before I begin I would like to note that Commissioner Scheff is unable to be here today due to a family commitment but he would like me to ask that I extend to you an invitation to engage with him on any of the related questions that you may have on the Bills we discuss today. I would also like to mention that today is the Intellectual Disability Caucus Hearing Day. This event is taking place in Room 2C and provides an important platform for individuals with intellectual disabilities, parents and their families to tell their stories. I look forward to joining the event after this hearing.
SB-372 AN ACT CONCERNING THE PROVISION OF RESOURCES TO GUARDIANS OF ADULT CHILDREN WITH INTELLECTUAL DISABILITY. This bill would require the State to pay guardians providing care to adult children with intellectual disabilities the same stipend as those providing care under the Connecticut Home Care Program for Elderly. The Connecticut Home Care Program for Elders is a Medicaid Waiver program administered through the Department of Social Services that assists eligible older adults at risk of nursing home placement to continue to live in the community. Under this waiver family members except the spouses and legally liable relatives which includes guardians, maybe reimbursed by Adult Family Living Services at a per diem rate. These service include hands-on care such as bathing, dressing, and independent family living assistance such as meal prep and laundry.

DDS is the operating agency for three Home and Community Based Services Medicaid Waivers including the Individual and Family Support Waiver, the Comprehensive Support Waiver and the Employment and Day Supports Waiver. Under these waivers certain services can be provided by a qualified family member or relative and reimbursed through the appropriately identified waiver rates. However, similar to the Home Care Program for Elder Waivers, services under each of the DDS waivers cannot be provided by or reimbursed to a legally liable relative, including a guardian. This means that any stipend paid to a guardian for services provided, would not be eligible for federal reimbursement and therefore would need to be wholly funded with state appropriations. Without the ability to identify those additional state appropriations to fund such
expenses, the department is unable to support this proposal.

SB-393, AN ACT CONCERNING THE DEPARTMENT OF DEVELOPMENTAL SERVICES' LEVEL OF NEED ASSESSMENT. This proposed bill would require DDS to update our level of need assessment tool to include the most recent medical information, policies and terminology regarding behavioral health. Once an individual is determined eligible for DDS services, case managers use a standardized assessment tool to assess each individual’s level of need for DDS funding and services. This web-based assessment tool evaluates an individual’s need in key areas including, but not limited to health and medical; personal care; daily activities; behavior; safety; comprehension and understanding, communication; community activities; and unpaid caregiver support. Utilizing a scoring algorithm, the individual’s completed LON assessment is then given an overall score ranging from 0 to 8 (8 being the highest level of need).

Both the LON score and the information collected in the assessment is used to develop a comprehensive Individual Plan that identifies areas where the individual needs assistance to actualize his or her personal goals and that addresses any potential risks that could affect the individual’s health and safety. This collaborative effort requires the individual, the individual’s family, the DDS case manager, appropriate clinicians and other members of the individual’s Planning and Support Team to engage directly to determine what funding and services are needed. Each plan is person-centered and created specifically for the individual based on the LON assessment and is reviewed and updated annually.
It is important for the department to stress that although the LON assessment is the primary tool for determining the needs of an individual eligible for DDS supports, there are further opportunities for individuals and their families to request additional funding and supports to assist with meeting needs that may not be measured by the LON’s assessment. In addition, a LON review can be requested at any time to reflect an individual’s changing needs.

The current LON assessment tool has provided the department with the ability to determine an individual’s need for funding and supports in an equitable and consistent manner for the persons that the department serves for the purposes of allocating DDS resources.

The department is open to discussing ways to improve the assessment tool and would be happy to engage with stakeholders on suggested changes and enhancements. In fact, over the years, improvements and changes to the LON have been implemented after stakeholder input identified areas of the LON that could be improved. However, in this difficult fiscal climate, the department would be unable to support any changes to the LON assessment tool that would incur cost.

And lastly, SB-367, AN ACT ESTABLISHING A TASK FORCE ON THE NEEDS OF PERSONS WITH INTELLECTUAL DISABILITY offers a simple Amendment to Special Act 18-2 by extending the reporting test deadline to the taskforce on the needs of persons with an intellectual disability from January 1, 2019 to January 1, 2020. As this task force was never convened, the department has no concerns with
extending the reporting deadline to allow time for establishment of the taskforce.

Thank you again for the opportunity to testify on SB-367, 372 and 393. Written testimony that provides additional details on each of these Bills has been submitted to the Committee. I would be happy to answer any questions that you may have.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions, comments? Representative Petit.

REP. PETIT (22ND): Thank you Madam Chair. Thank you for your testimony. On 372 is there a way for family members to not have guardianship or conservatorship and still be able to be reimbursed by the Federal Government or just being a family member makes them automatically ineligible for federal reimbursement?

DEPUTY COMM MASON: A family member can. They can’t be the person who is legally responsible for them. So we do have other family members that could do it, it’s the person who is legally responsible.

REP. PETIT (22ND): That’s how I understood it, so if they had a different legal relationship, they potentially could be reimbursed through the Federal Government.

DEPUTY COMM MASON: Could be reimbursed, yes, through our Medicaid Waivers that is correct.

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

SENATOR ABRAMS (13TH): Any other questions or comments? Representative Arnone.
REP. ARNONE (58TH): Hello, on 372 do you have any estimates of what that would cost to implement that Bill?

DEPUTY COMM MASON: No, we can go back and take a look and determine what the financial implications would be.

REP. ARNONE (58TH): Okay and on 393 which you were talking about the LON, the reporting that we’re doing now and you feel that that reporting is sufficient to keep everything updated cause in that reporting you’re actually using parents, friends, information from close relatives so you’re gathering all that medical information ahead of time and there is really no need for actually what would be a new job on your job description is that correct? I know, you’re busy enough now. Thank you.

DEPUTY COMM MASON: (Laughter) Yep.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. Thanks for being here today. Next we have Representative Allie-Brennan. Welcome, thank you for being here.

REP. ALLIE-BRENNAN (2ND): Thank you so much to the entire Committee for having this Hearing today. I am here to testify in support of HB-6540. I am going to yield by time to Shawn Lang who is the Deputy Executive Director for AIDS Connecticut. Thank you.

SHAWN LANG: Thank you, I appreciate that. To the Committee, Senator Abrams, Representative Steinberg I am Shawn Lang and as mentioned I’m the Deputy Director of AIDS Connecticut, a statewide AIDS organization and I am here to testify in support of
House Bill 6540 – AN ACT CONCERNING THE PREVENTION OF HIV.

As many of you know, I’ve been an AIDS activist since the early 80s helping to start the Middlesex County AIDS Buddy Network in Middletown. That Network grew out of a conversation with the first friend of mine who came out to me as HIV+. He, and others, at that time felt isolated as there were no services for people with HIV anywhere in Middletown and we were all volunteer run, created a group to provide support and companionship to people with HIV/AIDS. I watched far too many of my friends die from complications of AIDS during those days because there were no really or adequate interventions available and prevention primarily consisted of condom distribution. The primary population that was hardest hit at that time were gay and bisexual men.

In CT, the population hardest hit by the epidemic in the early years were people who inject drugs. To address that population we passed legislation in 1991 to provide syringe services programs and since then, we’ve completely reversed the tide of HIV infections among that group. In 2002, people who inject drugs accounted for 40 percent of new HIV infections, and in 2017, it was just percent.

In stark contrast, gay and bisexual men or as the CDC defines them – men who have sex with men accounted for 19 percent of new infection in 2002, but in 2017 they accounted for nearly 50 percent and 12 percent of those men are 29 years of age and under, and 43 percent are Black and Latino.

Today, we have medications which, for many, make HIV a chronic manageable disease. In the realm of
prevention, we have a robust toolbox full of interventions, evidence-based interventions which include education, outreach, syringe services, HIV counseling and testing, and targeted prevention strategies.

And, we have PrEP, which stands for pre-exposure prophylaxis. It’s a one a day pill that provides up to 99 percent reduction of HIV transmission for people who take the medication as directed. It also requires patients to see their provider every three months for medical care, sexually transmitted disease testing, and counseling.

This is a game changer for preventing HIV particularly for young, Black and Latino men who have sex with men. The proposed language simply clarifies providers’ ability to prescribe this medication to prevent a potentially deadly disease.

So urge you to support House Bill 6540 and I’m happy to answer any questions.

SENATOR ABRAMS (13TH): Thank you very much. Is there any questions or comments from the Committee? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you for that testimony. We certainly have come a long way from the early 80s I would agree. Can you tell me Shawn your understanding of specifically of Truvada, what the FDA, what the package insert currently allows in terms of dosing – prescribing in terms of ages?

SHAWN LANG: If you allow me, I would like to ask Dr. Kristen Wagner to answer that. She’s really the health expert on this?
REP. PETIT (22ND): Sure, thank you.

SENATOR ABRAMS (13TH): Please give us your name for the record, thank you.

DR. KRISTEN WAGNER: Certainly, Dr. Kristen Wagner. So Truvada was initially approved and packaged for the treatment of HIV in 2012, it was FDA approved as a pill for prevention for those who 18 years and older and that in May of 2018 that indication was extended to adolescents and so in the package insert it would include both indications for treatment of HIV and prevention of minors and adults.

REP. PETIT (22ND): And is there a specific FDA definition for adolescents?

DR. KRISTEN WAGNER: It’s a weight-based definition so it is 37.5 kg or 70 pounds.

REP. PETIT (22ND): Has there been any, I guess I assume there’s been no difference, but I assume there’s no differences in terms of treating people greater than 18 versus adolescents in terms of side-effects and the positive effects in terms of preventing HIV?

DR. KRISTEN WAGNER: So there was, in order for the FDA to extend its approval to minors, there was the specific study that looked at individuals who were of that weight and specifically looking at both safety and efficacy of Truvada in 15 years and older.

REP. PETIT (22ND): Thank you, are any of the three of you aware of other states that have proceeded in this fashion to try to decrease the transmission of HIV?
DR. KRISTEN WAGNER: So there are 13 states which have amended their legislation for adolescent access to reproductive and sexual health care and in those three states which include New York, California they have specifically added HIV prevention and access to preexposure prophylaxis, so we would be joining those states in protecting our youth.

REP. PETIT (22ND): And the Bill is currently written basically as nonspecific to increase access, can you comment on the issue of parental permission in terms of the younger kids that access this medication?

DR. KRISTEN WAGNER: So we are amending existing legislation that allows minors to access a range of reproductive and sexual health services that include contraception, STD diagnosis and treatment and even the treatment of HIV without parental consent. When that legislation was written and passed PrEP was not available it was just a concept and so we are simply adding a various effective HIV prevention tool to existing legislation.

REP. PETIT (22ND): Thank you for that. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative Betts.

REP. BETTS (78TH): Thank you, Madam Chair and thank you for your testimony. I was taking a look at the cost of Truvada and I believe it’s listed as around $1,600 dollars and in order to get access to this under your proposal where is the financing coming from that you’re trying to increase the access for these folks to be able to get it?

SHAWN LANG: [Clears throat] Excuse me, you know, insurance would cover the cost, there would be co-
pays and as we all know it depends on what insurance you have and what your co-pay is going to be. There is also patient assistance programs through the company that makes Truvada. So there’s, you know, some options there for people. And you know, the reality is in both preventing HIV – HIV has a lifetime cost of up to, you know, $800,000 dollars for care so even though this is an expensive medication it’s less costly to prevent HIV than it is to treat it.

REP. BETTS (78TH): That’s an excellent point, it’s more humane too but I’m just trying to understand from the State’s point of view, the exposure financially not only if we were to fund this, or partly fund this, how much would it be then to be able to make sure we sustain the funding as opposed to it going back and forth and the relationship between that and the insurance companies. So as part of this proposal are you seeking funding from the State or just clarify for me, when you say increase access, who would be, you have access to it, who would be paying for this?

SHAWN LANG: Insurance. We’re not seeking any funding from the State to pay for this so depending on what type of insurance someone has or if they’re uninsured, hopefully through going through the health clinics they would get them connected to insurance or get them connected to the patient assistance programs.

REP. PETIT (22ND): Okay, thank you so much. Thank you.

DR. KRISTEN WAGNER: And if I could just add to that, the use of PrEP is apotheotic use. It’s during the period where an individual is at higher risk of
becoming HIV infected. What happens then if, in the alternative, if someone acquires HIV then they are going to require treatment for the duration of their lives and when we’re talking about young people that is going to be decades. So in the terms of actual financial cost, we think that it is considerably different.

SENATOR ABRAMS (13TH): Thank you, any other questions or comments?

REP. STEINBERG (136TH): I just want to go back and touch on a comment you made earlier. I just to be clear as to what’s currently in Statute right now. You made mention of there’s an opportunity for treatment for HIV without parental consent, can you just be as explicit as possible about what the statute does call for at this time?

DR. KRISTEN WAGNER: So there are two relevant Acts. I’m sorry, there are two relevant Sections that refer to testing and treatment of minors. We are specifically looking at an Amendment to Section 19A-592 which currently allows for testing, HIV testing and if necessary the treatment of an HIV infected individual or minor without parental consent. We are adding to that, we are recommending adding to that, the additional ability of physicians, nurses to prescribe PrEP for the prevention of HIV, specifically to prevention.

REP. STEINBERG (136TH): Thank you.

SENATOR ABRAMS (13TH): Thank you. Representative Petit.

REP. PETIT (22ND): Thank you again. I would ask you to give everyone on the Committee some CME cause I’ve had questions from folks saying so this is
preexposure so you give one pill, two pills, five pills what is the typical approach in clinical practice in terms of how many bills are handed out or is it vary widely based on the individuals, the individual case?

DR. KRISTEN WAGNER: So this is a hot and evolving area in terms of what constitutes preexposure prophylaxis. The current recommendation is that anyone at risk would take a daily medication. Again we are looking at, the scientific community is looking at dosing before sex, after sex, looking at injectable forms to improve adherence but it is currently prescribed as a daily pill.

REP. PETIT (22ND): So currently, so there is one anticipated sexual encounter you still are prescribing the pill for 30 days even if there is only one encounter in the middle of the month but looking at shorter regimens to see if the regiment can be shortened and still keep you protected?

DR. KRISTEN WAGNER: That’s right. They’re looking at options for dosing around the particular sexual event but the reality is, particularly I think among youth and young adults that sex is very highly unanticipated and we want to be sure that our youth are protected no matter what circumstances they’re in.

SENATOR ABRAMS (13TH): Representative Borer.

REP. BORER (115TH): Hello, thank you for testifying. So with this Bill like a few other Bills that we have regarding minors getting service without parental consent the question has come up about the minor being aware of their medical history or the person administering the vaccine or the treatment
may not be aware of the minor’s medical history. Who would be administering this, would it be a PCP, how would, you know?

DR. KRISTEN WAGNER: So as with any medication this would be provided by a professional physician, physician's assistant, APRN with knowledge of the individual’s medical history. There would also be a very close follow up but I just want to be very clear we’re talking about a medication Truvada which is a drug and is not a vaccine. It does not induce an immune response. It has no properties of a vaccine. So it’s giving a medication as one would any medication by a responsible clinician.

REP. BORER (115TH): A clinician that would have access to that minor’s full medical history?

DR. KRISTEN WAGNER: That’s correct and would follow that minor. This isn’t a one-time administration of a medication. There is actually very close follow-up every three months with repeat HIV testing, STD testing and that’s actually one of the benefits, it engages young people in health care where the clinician will actually learn more and make sure this is going -- is being effective and safe for that individual.

REP. BORER (115TH): Okay, that’s helpful.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. I apologize, I’m coming in late so I just want to try to understand to be clear. So I have a 15-year-old daughter, so they go to the pediatrician and can you just explain to me kind of what, they go in, they talk to my daughter and then they decide to give her
this medicine, can you explain it to me I guess what you’re trying to do.

DR. KRISTEN WAGNER: Sure. So an adolescent is seen by their clinician and it’s part of that encounter, we hope, that the clinician is obtaining a good sexual history, really knows what that 15-year-old sexual orientation is, activity is, history of sexually transmitted infections and on that basis the two of them, in partnership, the patient and the clinician see a need for HIV prevention and at that point the clinician prescribes this pill Truvada to protect your 15-year-old. In the same way is that they may, let’s say, you know, you need to be on birth control, I’m going to prescribe oral contraceptives or we diagnosed with chlamydia and I am going to treat you with an antibiotic. These are all currently available, sexual health services that any 15-year-old in Connecticut can currently access and we just want to insure that the newest, most effective way to prevent HIV infection is adding to existing legislation.

REP. ZUPKUS (89TH): So being new on this Committee for the first time, I can only speak for my pediatrician because that is where we go obviously, and they will not see my daughter unless, because of her age unless a parent is there or a guardian. So is that, what’s the law?

DR. KRISTEN WAGNER: So the American Academy of Pediatric recommends that at age 13 the physician, the clinician along with the adolescent. And one of the objectives of that is to be able to have an honest conversation with the teen about information that the teen may not be comfortable with their parents knowing and that could be information about
sexual activity, sexual orientation, gender identity. That is what the American Academy of Pediatric recommends.

REP. ZUPKUS (89TH): So I can be in the waiting room, they’re talking to my daughter and they can prescribe this to my child and I would never know anything about it, because that’s what you’re looking for right without parental consent. So under 18 or whatever they can just prescribe this to my daughter?

DR. KRISTEN WAGNER: They can. They can currently but I guess what I want to also emphasize is that I think a clinician, I would, encourage a conversation with parents and how would you talk to your parents about this, why would you be reluctant to. That would be a detailed conversation. But if at the end of the day, that 15-year-old is going to be a risk of getting HIV and they are not willing to have the conversation until their parents, they just cannot do it but then I want to protect them from HIV.

REP. ZUPKUS (89TH): And I don’t, this is my last comment, I am not sure HIPPA applies to kids under 18, I’m not sure what that piece of the law is, but I would hope that the physician would say I’m out in the waiting room, your daughter is 15 and I prescribed this to her, but that’s just my own, I’m a big believer is parental consent. Thank you.

REP. STEINBERG (136TH): Representative McCarty.

REP. MC CARTY (38TH): Thank you Mr. Chair and welcome today and thank you for your testimony. Just very briefly, the Truvada that you mentioned, has there ever been any evidence of any adverse effect from the medicine and then secondly the
second question would relate to settings, are there any settings aside from speaking with the clinician for instance there are other settings where medicines are delivered to children so I’m just wondering in the school-based health center I was thinking in those areas so that allowed in any other setting?

DR. KRISTEN WAGNER: With respect to safety there are sporadic cases of Truvada having an effect on kidneys and kidney injury and therefor the protocol for providing this medication is that you see the individual on a three-month basis in addition to repeating HIV testing you also check kidney function. In my experience of providing it, I have not encountered that side-effect but it is one that we monitor closely. In terms of other settings, you know, I think ideally this is provided by the individual’s primary care physician but as you mentioned some minors receive their care from school based-health centers and so it could be applicable to that.

REP. MC CARTY (38TH): Thank you for that clarification.

REP. STEINBERG (136TH): Are there any other questions? If not, thank you for your testimony today. Next up we have Representative Currey.

REP. CURREY (11TH): Good morning Chairs, Ranking Members and Members of the Public Health Committee. I appreciate you hearing House Bill 6540 Concerning the Prevention of HIV and before I yield my time to Sam Smith here, just a quick snapshot of Connecticut’s HIV stats. According to the 2017 data, there were 281 people newly diagnosed with HIV in Connecticut. This is an increase of 4 percent from
269 cases reported in 2016 and compared to the overall decrease we’ve seen throughout the Northeast of 14 percent. The speaker before us gave you a few stats with regards to the particular populations that are most at risk and I just want to take the opportunity to thank Commissioner Pino and former Governor Malloy for their efforts in launching the Getting to Zero Campaign and we hope that Governor Lamott and his team will join us and be just as supportive in these efforts to provide real options for all Connecticut residents both young and old, gay and straight, black, white, brown so we don’t have to hear stories like the one Sam Smith is goin to share with you now. Sam.

SAM SMITH: Thank you for that introduction. Distinguished members of the Public Health Committee, my name is Sam Smith, I’m a citizen of New Haven and I am here urge you to favorably report H.B. No. 6540, AN ACT CONCERNING THE PREVENTION OF HIV. I strongly support adding preventive and prophylaxis treatments to the permitted treatment of minors for human immunodeficiency virus infection in Conn. Gen. Stat. § 19a–592.

I am testifying here today because I believe this Bill could have helped me avoid having to live life with HIV. I am here so that this Bill and its potential isn’t an abstraction to you. It may be too late to help me but it’s not too late to help all the young people in Connecticut now and in the future.

I was diagnosed with HIV in May of 2016 during Get Yourself Tested Day at Wilbur Cross High School in New Haven. It was over a month or so before graduation and I was excited to be starting school
down in Miami and thought, “What’s the worst that could happen?” Two weeks later I was officially diagnosed with HIV.

At the time, my parents did not know I was sexually active with men, and I had absolutely no intention of telling them. Like many people in the gay community, I had known about PrEP, but as a minor I was not able to consent to preventative or prophylaxis treatments. And I felt that keeping my personal life a secret was more important than my own health, so I did not seek out a prescription for PrEP. What I don’t need to tell you about PrEP, I’m sure you’ll hear testimony from experts on how effective it is, how dramatic an impact it is having on HIV transmission rates, you know that.

I am here to tell you that I wish this Bill would have passed three years ago. If I had known about — if I had been able to protect my health while protecting my privacy I would have. That would have been clearly the no-brainer decision but that is not what the current law allowed. The present statute that allows treatment for individuals with HIV requires closeted individuals to choose between their privacy and their personal health if they choose to seek a prescription for PrEP. I chose my privacy, as many others in my community do. Had the law allowed me to protect myself from a lifelong infection as life threatening as HIV while also allowing to protect my privacy, I would have easily taken that option and my entire life would now be different and drastically safer.

I am a 20-year-old gay man living with HIV. The proposed change to section 19a-592 would help ensure that youth in Connecticut can consent to
preventative and prophylaxis treatments before they, like me, are diagnosed with HIV. In my opinion this Bill is a no brainer. Teenagers have sex and so do adults. The main difference is that under the current state of the Law, teenagers do not have access to the same protections as adults do. I am here to tell you that they should. This change is such an easy one to make and I urge the Committee to support the amendment to Conn. Gen. Stat. § 19a-592 by voting favorably on H.B. 6540. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony today. Thank you Representative Currey for shining a spotlight on this. I want to thank you for coming forward and telling your personal story with regard to this difficult issue. Just to reprise, how old were you when you were diagnosed?

SAM SMITH: I had just turned 18. So my birthday is in April and I have this card May 2016, late May.

REP. STEINBERG (136TH): Could you describe the explanation that was given to you by the practitioner with regard to both the disease and what the PrEP program offered you as a way of dealing with this problem?

SAM SMITH: So I wasn’t really introduced to PrEP by a physician, that’s mostly the whole issue, but at Wilbur Cross there was a rapid test done and I was found positive for antibodies so they referred me to Dr. Kirsten Wagner at the Fairhaven Health Clinic and there they run like the more intensive tests then I got that back a week or so later and she kinda sat me down with a therapist and they explained the next steps and how I could kind of get to a safer health level.
REP. STEINBERG (136TH): Were you as an 18-year-old able to understand all the things that she was telling you?

SAM SMITH: Yeah, definitely. I believe that she explained it very well and it was all inclusive in terms of my physical and mental health.

REP. STEINBERG (136TH): And I am going to ask you to speculate for a moment. Let’s say you were only 15 or 16 and you were posed with the same issues do you think you would be in a position to make a good informed choice with regard to avail yourself with this medication?

SAM SMITH: In terms of getting myself prescribed the PrEP? Definitely, yeah. I had done research about it, obviously like I’d seen movies and TV shows that mention HIV and had, I’m a premedical student at the University of Miami and so I have always been interested in public health and medications so it was such a big issue in the back of my mind knowing that I was gay and knowing that it was such a pressing issue in our community and so I heard about PrEP but I was too scared to bring it up to my PCP or my parents.

REP. STEINBERG (136TH): Thank you, yes Representative.

REP. CURREY (11TH): And I think that’s the issue on hand here is that we have certain segments of our population who are definitely have a higher risk of contracting HIV and, you know, speaking for myself and for Sam also is that, you know, when you are a young gay person it is not easy to have that conversation with your parent or your guardian. I mean I didn’t come out until I was 20 years old and
so that was a number of years in which I could have been putting myself at risk and had I been able to access some of this preventative medicine it would have prevented, you know, folks from contracting HIV because they were able to have that conversation with their doctor and not worry about the stigma they were going to feel from their parents. Kids are being thrown out of their houses on the regular for coming out to their parents in some of these populations. So if we can at least take a step forward to provide that proactive measure to not put another person in a situation that Sam is in currently then we should be stepping up and doing that for the residents and the young people especially in the State of Connecticut. You know, I know I’m preaching to the choir when I say an ounce of prevention is worth a pound of cure but we can be the choir and we can start singin so let’s start singing.


REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony today. So I have one question for you and I think you may have touched on or answered it. So you hadn’t come out to your parents yet when you were sexually active.

SAM SMITH: No I hadn’t.

REP. KLARIDES-DITRIA (105TH): So there was no one you felt that you could discuss any of this with, any other family members?

SAM SMITH: My mom and sister are here with me, back here. I talked to my sister about it but I expressly told her I do not feel comfortable talking to my
parents about it, even if were to say that I was like exploring my sexuality I definitely would not share any sexual experience with them or any potential sexual experience with them. We definitely that would not be in the conversation.

REP. KLARIDES-DITRIA (105TH): But this was available to you back then and you would have sought this out?

SAM SMITH: Yes, yes definitely.

REP. KLARIDES-DITRIA (105TH): Very good. I applaud you for coming here today and thank you Representative Currey. Thank you again. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you. Any other questions or comments? Representative Cook.

REP. COOK (65TH): Thank you, Mr. Chairman. Thank you very much for sharing your story and Representative Currey for bringing the important issue to our table for thought. I am a mother of four and always hope that we have the conversations with our children but we also know that our children sometimes feel exactly like how you feel, that how do I have a conversation about something that might embarrass em or not make my parents proud of me and I’m sorry that you had to make a decision that you had to make. But I would say that as you move forward they have much to be proud of and thank you for leading the charge and making it so very important to spend time with us to explain to us the impacts and to insure that we can see if from a younger person’s point-of-view not necessarily from an adult’s point-of-view, so thank you. Thank you, Mr. Chairman.
SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for being here today. Next we have Representative Zawistowski. Good morning.

REP. ZAWISTOWSKI (61ST): Good morning. Good morning Co-Chairs Abrams and Steinberg, Ranking Members Somers and Petit and Members of the Committee. Thank you for the opportunity to testify here today. I have with me Melissa Sullivan from Suffield who is here to testify on SB-94 and SB-858.

MELISSA SULLIVAN: Good morning, thank you for hearing my testimony on both of these very important Bills today and we’re geared up for a long day and I just wanted to kinda share with you my story of my child and why I oppose both of these Bills.

Both of these Bills would allow our children access to first a flu shot without my consent and second an HPV or Gardasil vaccine without my consent. This is very concerning to me because I have a vaccine injured child. At two-months old he had a severe reaction to one of his vaccines and at a year he had a second reaction to the flu shot. If my son were given the flu shot today he would be dead. He would die. The fact that my son could go into CVS as written right now with SB-94 and get a flu shot without consent because someone might offer him a $25.00-dollar Starbucks gift card and because he’s a special needs child that might be lost on him. So this is very concerning as a parent that this State would decide that my child can do this without my knowledge or my consent.

HPV is also a very concerning vaccine as well. We’ve had a tremendous amount of injuries because of it and what you really need to know is that
vaccinating a child without my knowledge or consent is actually against the federal law which clearly states that as a parent I am supposed to get this vaccine information statement, usually two pages long, it’s not the package insert which you get from every other drug in existence because of all this information on it, very, very different. But the federal law says that parents must be given this prior to a vaccine and as such if you are going to vaccinate my child without it, you are going to be breaking federal law so I am wondering if the State is okay with that because I believe that would leave the State open to liability if you decide to pass a law that goes against the federal law. That is concerning to me as a resident here in Connecticut.

So I stand opposed to these Bills and really am hoping to you know, talk more about this type of legislation moving forward. We are blanketly making laws here in Connecticut that cover every child. As a parent who is actively involved in the well-being and care of my child I really want to be part of equation and I honestly don’t appreciate this State taking away that right. It makes me very uncomfortable. If my special needs child gets a vaccine without my knowledge or consent there could be a real problem and no parent should ever be put in that position. The law does also say, the federal law, does state that you are also supposed to give me the vaccine information statement because if something does happen and there is an adverse reaction to a vaccine I need to be able to get my child medical treatment and if I don’t know something has happened I can’t get my child treatment so that is very concerning as well.

SENATOR ABRAMS (13TH): Thank you, the bell went off.
MELISSA SULLIVAN: I thought so, that was long [Laughter]

SENATOR ABRAMS (13TH): Are there any questions or comments? Yes, Representative Hennessy.

REP. HENNESSY (127TH): Thank you Madam Chair. Thank you Melissa for your testimony. How many people have been hurt by Gardasil in Connecticut?

MELISSA SULLIVAN: We have had in just Connecticut luckily, thank God, no deaths from Gardasil but nationwide we have had 460 deaths just alone from Gardasil. In Connecticut we’ve had 193 emergency room visits, 13 of those which were life-threatening, 36 which were listed as serious and 14 on children that have been disabled in Connecticut from the HPV Gardasil vaccine.

REP. HENNESSY (127TH): Thank you and you are referring to the HPV vaccine talking about injuries, what injuries - do you have any?

MELISSA SULLIVAN: Yeah, so I mean there’s recorded to date over 60,000 injuries from Gardasil, it’s actually the largest ever reported and that number is probably relatively low. We know that through VAERS our Vaccine Adverse Event Reporting System, because it is a self-report statistically they say only about one to ten percent of the injuries are actually reported so 60,000 and if that is only, even if it is only ten percent you can imagine the amount of injuries that have not been recorded and they are not recorded because parents and doctors alike don’t know that this system even exists.

REP. HENNESSY (127TH): Thank you. Thank you for your testimony. Thank you Madam Chair.
SENATOR ABRAMS (13TH): Representative Steinberg.

REP. STEINBERG (136TH): Thank you, Madam Chair. Thank you for your testimony today. Let me start by saying how sorry we are that your child went through an adverse reaction because we all know there are individual differences and even though we are attempting to address the greater public health good of having the vaccination we recognize on occasion as with any drug and with any chemical there are individual difference. What was the conversation you had with your physician after your child had the adverse reaction?

MELISSA SULLIVAN: The conversation was that, you know, we clearly knew that the flu shot had done damage to him, that he actually had brain swelling or encephalopathy which caused irreparable damage. He is right now a ninth-grader operating at about a sixth-grade reading level with a huge deficit for reading and language but is doing amazingly well. We certainly one of the lucky families, I believe and my pediatrician believed at the time that if we continued to vaccinate him we would not have been so lucky. So this reaction was a wakeup call after kind of ignoring a vaccine reaction at two months, if I had done my research after that first reaction, you know this is back in 2004, so there isn’t the Facebook, let’s just say there isn’t Facebook so we didn’t have this information at our fingertips like we do today. So, I mean it was clear we needed to stop vaccinating this child and that the flu shot had put him over the top and, you know, the pediatrician agreed with that. However when I started to stop vaccinating across the board she did have a problem with that because I have another child who’s 17 and she is, you know, she didn’t have
a reaction that we could see that we were worried about and so my pediatrician wanted to continue to vaccinate her. That plays into what you are saying Representative Steinberg that every kid is different and so where there is a risk with any type of pharmaceutical product and I’m gonna just go off course a little bit here, I understand 6540 and Truvada I appreciate what was just said about that medication however, a condom does the trick as well. So, you know, I don’t want my child to get any medication without my knowledge. I am a historian with my children’s medical records. I know what goes in, I know what comes out and as such I should always be part of the equation making these medical decisions for my child. I’ve talked with several of you and while I appreciate we’re looking to protect at risk kids, I do. As a mom, you know, I get it but my child is at risk. My child is at risk.

REP. STEINBERG (136TH): So let’s get to that for a moment. Your pediatrician lived this experience you had with your child with you. You had obviously a very heart-to-heart conversation about that and yet the pediatrician, the medical practitioner so recommended vaccines. Do you think you can explain why that was so important?

MELISSA SULLIVAN: Yes, so obviously and I’m sure many of you feel the same way. My pediatrician was concerned about public health and protecting what we call the herd meaning that we all need to get vaccinated so that we don’t spread things like the measles illness. I did my research and I took to heart what she was saying because I had always trusted her blindly in fact. So blindly that I didn’t do my research until my child was injured and not just once but the second time. It took me twice
to figure this out and in fact how I figured it out was my son immediately qualified for Birth to Three Services in our State and they came out and they said, “Listen just look at vaccines. We’re seeing an explosion of this and you need to do some research.” And so I started that process and then I went back to my pediatrician and I said, Listen I get the herd immunity, I get it. I understand why we vaccinate our children but in Connecticut we have 98.2 percent of our children vaccinated. There is no herd crisis. I did this in Children’s and Senator Abrams can attest to this, I panned the room that day when we were talking about a different Bill and I asked for everyone around, as an adult, who has had a measles, mumps and rubella shot, by raising your hands please tell me who has had the measles, mumps and rubella shot. Okay, not too many but that there was some but that goes to my point. We are part of the herd, measles is not just spread in a school. Measles is spread everywhere. As adults were are unvaccinated. The population in Connecticut was over three million people, is that about what I just heard, okay 3.6. The herd is the 98.2 is our children so we have some 70 percent of our population that is unvaccinated so the herd doesn’t actually apply. And while I understand, your perspective that we have to protect everyone, when you’re looking at adults that are walking around unvaccinated we are not posing a risk. Can we catch the measles, yes?

REP. STEINBERG (136TH): I appreciate your point of view. I think you could use that argument in more than one direction.

MELISSA SULLIVAN: I agree, you can.
REP. STEINBERG (136TH): I am wondering if the parents in the Pacific Northwest that has experienced the measles outbreak would agree with the reasoning which is one reason why this seems such a pertinent issue at this point in time. So yeah, I see your point. It’s a slippery slope, we let a lot of people not get vaccinated and we put the rest of the population at risk, where is that appropriate point and that is part of what the conversation is today.

MELISSA SULLIVAN: Absolutely and I appreciate that point of view, I’m not discounting that to be very clear. But I would tell you that the measles is a very benign illness Out West or in Connecticut wherever we have it. No one is dying from it. We all grew-up with it, many of us had it which gave us life-immunity to it which means that’s better than anything you can find in a vial because it’s a real true immunity to the illness.

REP. STEINBERG (136TH): This is where I’m going to disagree with you. My understanding of measles it is not a benign illness and that it can result in fatalities and it is our lack of our collective memory in this generation of what life was like before we had vaccines. We had devastating diseases like polio. They may give us a false sense of security as well so there are things to balance it. Thank you.

MELISSA SULLIVAN: I understand your point Representative, thank you.

SENATOR ABRAMS (13TH): Thank you. Any other? Representative Candelora.
REP. CANDELA (86TH): Thank you, Madam Chair. Thank you for your testimony. I think a lot of my questions were answered but one of the things I want to ask you about with this Bill, the one I’m speaking to is the prophylaxis Bill specifically, essentially what we are setting up, and I want to accent this cause you talk about history, but we’re creating a mechanism for children to basically seek medical care, not necessarily from their own doctor but any institution or licensed provider and there is a cloak of confidentiality under this section.

The current Law, the reason it’s written that way obviously it is dealing with somebody who has acquired an STD and I think there is a public policy that if a minor acquires an STD you want them to seek treatment on their own without fear of, you know, their parents finding out. In this type of situation we are dealing with sort of preventative treatments which is also noncommunicable disease a lot of times. If we’re speaking specifically to your point to HPV and I’m just wondering if, you know, does your son not to get into confidentiality issues here.

MELISSA SULLIVAN: I’m here, it’s okay.

REP. CANDELA (86TH): Is there a history so your child’s medical record is traced so that people know if you brought them to a health care provider that he shouldn’t be receiving vaccines.

MELISSA SULLIVAN: Yeah, I don’t think we have that technology at this point. If he were to, so let’s talk about this. Let’s talk about we have over 100 school clinics here in Connecticut and as this SB-58 is written right now, it does say a state facility which would include in my mind at least these
clinics and so if you live in a town where they have a school clinic and the school nurse -- right now what happens is if they want to give a vaccine to a student in this clinic, a note goes home to mom and dad, it’s a permission slip you know. We have to sign them for everything but we don’t have to sign it in our school clinics with this law and that’s the scary part. So, you know, the slip goes home and mom says yes or mom says no and sends it back to school and nothing happens to that child. This would allow our schools to vaccinate our children without that slip coming home. Now here’s the problem with that, because that school nurse may not know what I’ve done because of when we accept medical records from parents which isn’t every year in Connecticut, it’s in kindergarten, it’s in seventh grade and if you have your way with the meningococcal bill which we will talk about in a couple of weeks, it will be, you know for that too. So how this works is if I decided I wanted a Gardasil shot for my daughter and I took her or my son and took her to the pediatrician and I got that, now this is a series of shots depending on the child’s age, it could be two or it could be three. So it depends on the child’s age and I have an HPV expert who is going to testify after me who can really dig into this with you guys, she knows everything. But based on their age they get two or three shots. Now I could be in that series with my child, I have not relayed that to the school nurse, they call her down or him and they give her an HPV vaccine and now she’s gotten a double dose. That is horrific with this vaccine. I mean you get two doses of this one we’re lookin at a huge problem. So yeah, I mean it doesn’t make sense because there isn’t the technology right now that says okay, CIGNA is my healthcare provider and CIGNA
has disseminating information and I don’t think this should happen by the way so we’re not goin there, but I don’t think CIGNA should, you know, be disseminating my confidential records for my children or even myself to anyone. You know, I mean I suppose you could argue with the flu shot that you know CIGNA is going to potentially, if my child were to go into CVS because she could win an I-Pad and get a flu shot vaccine and be entered into a drawing or get a $25.00 dollar Starbuck’s gift card I suppose CIGNA could, if she gives them insurance information, they could deny that flu shot based on having received one in the doctor’s office, but I’m not positive that technology exists and it certainly doesn’t exist with school nurses.

REP. CANDELORA (86TH): I appreciate that because it is one of my concerns even with the flu vaccine, I recently had a parent who was paralyzed. She had Guillain-Barre Syndrome, was not supposed to be getting vaccines and the pharmacies don’t have her medical records and you know now she has been hospitalized. So that’s one of flip-side concern and I appreciate that answer cause obviously your son has the medical record he carries with him but if we’re gonna be doing this at school-based health centers and creating a cloak of confidentiality those important records aren’t traveling with him.

MELISSA SULLIVAN: They are not traveling with him and I would say, you know, when we’re talking about special needs children and there are a ton of them, they do not know their medical records. My son may not be able to tell you I shouldn’t get a flu shot and my son is very impressionable and if a school nurse said you need this, he would take it because he is a rule follower and we have taught him to be
respectful and, you know, he would say the school nurse told me to. I’ve heard, you know, from legislators in this building that their granddaughters, their grandsons went into a pediatric office, mom sat in the waiting room and like we were talking about earlier and, you know, mom didn’t know said child came out with a band-aid on their arm and mom says, “What’s that” and they gave me the HPV vaccine. That is illegal. We can’t do that. That is not appropriate. I don’t care if mom was sitting in the waiting room, that is not consent. This is consent, this, and only this. It is not great consent. I would rather have this consent but at least it’s something and that is what the federal law dictates because you have remember, some of you may notice, some of you may not in 1986 our government gave release of liability to every manufacturer of a vaccine that simply means that God forbid if your child ends up in a wheelchair or permanently damaged like mine, or God forbid get killed you can’t sue a sole. You’re out of luck, you’re gonna go to what we call a kangaroo court and you are going to sue the federal government and if your child dies you are gonna get $250,000 dollars. I’m going to tell you that sometimes, well I’m gonna tell you that over the 15 years that my son has been alive and we didn’t go through this court cause I didn’t know but we were part of an Omnibus Hearing we spent well over $250,000 dollars trying to get this kid well. It’s been a nightmare. He’s a special education student, not only did I have to fight the medical community but I had to fight my school district, it’s horrific. No parent should be put in this position if they know what happens to their child. I’m sorry.
REP. CANDELORA (86TH): Thank you I appreciate you sharing this story. Thank you.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Representative McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair and I will be very quick. I just would like to thank you for coming in and giving your testimony and your very heartfelt perspective and for all the work that you’ve done. Thank you very much. This is more a comment than really a question but I would like to thank you for bringing the forms and pointing them out to us but also for pointing out, I’m still struggling with, I don’t understand how a child that is special needs or with an IEP could possibly give consent so, it might, but there will be a number of children that may not understand what they are giving consent to. So I would just like to thank you and if you wanted to comment about that.

MELISSA SULLIVAN: Yeah, I agree. I mean how does a child give consent when they don’t know really what it is and I should tell you that per the CDC even if this child, even if we were to give this child the vaccine information statement, which again is supposed to be given to me, but even if we were to give this to them, this is written at a tenth grade level per the CDC, right there on their website so they absolutely could not comprehend this. And, you know, it’s funny because I read this last night for the HPV vaccine because I don’t vaccinate my children this wasn’t something that I’d ever read because I haven’t been given one of these in many years. Sorry, I’m flipping through my many papers here, I’m not locating it but for the HPV, this is for the flu shot, but for the HPV vaccine this
clearly states that you shouldn’t get the HPV vaccine if you are allergic to any of the ingredients. Huh, the ingredients aren’t on here. [Laughter] How would I know that. How would my kid know it?

REP. MC CARTY (38TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for being here.

MELISSA SULLIVAN: Thank you for hearing my testimony.

REP. STEINBERG (136TH): We have now gone past the first hour which we exclusively deal with elected officials. Just two things before we move on, and we are going to start moving to the public and alternate. Somebody who is very passionate about this did distribute to this Committee a number of books that deal with one of the vaccine Bills before us today. They are available to Committee members at the Clerk’s desk. Obviously you are not expected to read this now, there will not be a quiz but it is available to you I should just make you aware of that. We’ve also decided that we would poll the Committee there are apparently four people here with very young children and we thought it might be better to prioritize them as we rotate back and forth if all the Committee members are amenable we will start the public portion with one of four from that group. Everybody okay with that? So Sheila Diamond. Sheila, we’ll come back to ya, how’s that? [Laughter] Multitasking would be a lot to ask for in this case. That’s all right Sheila we can come back to ya, don’t worry [Laughter continues] Trust us, we can come back to you. Dawn Jolley? We’ll keep
workin here. Is that Dow K? Okay, please. You’re definitely not nursing so that’s.

DOW KOWALCZYK: Hello.

SENATOR ABRAMS (13TH): Can you tell us your full name please?

DOW KOWALCZYK: Yes, my first name Dow, like Dow-Jones and last name Kowalczyk. I grew up in West Hartford. I now live in Richfield. Here’s the simple -- I don’t have my timer on. I’m not prepared. I took off work today because for a number of weeks, this was never on my radar. Just was never on my radar. Something came up in the newsfeed, I went huh and in my spare time I’ve been poking around just a little bit, I don’t have much time and the stuff I’m finding is this emoji, poof. I can’t believe what I’m finding and I’ve just been, you know a few minutes here, and a few minutes there for a few weeks. This is very disturbing to me what’s happening. Let’s see if I can just spew it.

REP. HENNESSY (127TH): I don’t mean to interrupt but I’m trying to understand the Bill you’re talking about.

DOW KOWALCZYK: Yeah, the Bill has to do with mandates for vaccine. I am speaking to three Bills apparently and believe me I don’t have all the details. This was like a last-minute thing. This is my daughter Kaylee. If anything like this gets mandated and I’m told I have to give her something, I will move out of Connecticut. I will move out of state. Devastating to my family, to my kids in school and I never thought I would have said this two weeks ago, three weeks ago but once you read just a little bit about what’s going on, you
wouldn’t be able to do it either. In good conscience I now am simply someone who has so many questions that don’t add-up that I just couldn’t hand her over and say yeah doc, stick her and then again, and again and again. When I was a kid I got six shots. Next generation got 25. Now with the baby there are apparently hundreds more in the works. The pharmaceutical companies have more people lobbying in Washington that in the Senate and House combined. They are spending billions of dollars. If these things were so safe, if there was really a crisis wouldn’t the product, this fantastic products that are tested beautifully which they are not, and properly which they’re not, there wouldn’t be any problem You wouldn’t need to be spending billions of dollars to do this. I know I’m probably up with my time. I did a tiny bit of poking around on the CDC Website as you may know when they talk about these things they figure maybe one percent of cases are reported, injury and death. That’s sometimes 30,000 for one vaccine in a year. You do the math. I can’t do that to my daughter. It’s too much of a risk.

SENATOR ABRAMS (13TH): Thank you are there any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. Just comment, thank you very much for taking the time to come here to testify. Public Hearing we need to hear from the public. There is kind of an echo chamber quite often in which the so-called experts, you know, give out their information and you know, maybe it’s not in the public’s best interest all the time.

DOW KOWALCZYK: May I respond to you?
REP. HENNESSY (127TH): Please do.

DOW KOWALCZYK: There is just one thing I thought of so, this is hypothetical. Let’s say, pick a number, in the United States, maybe 100,000 total children or people are injured to some degree of severity, some as you know completely devastating and some deaths every year. If you want to mandate vaccines because it is so important for the general public health to do so, wouldn’t you have to have maybe 200,000 people having devastating things happen because of all these things we’re vaccinating against which would be in the news, it would be a total national crisis. I don’t hear anything about that. Measles, give me a break. Itchy for a week. So how does this work? If there’s these in the CDC website, I haven’t dug it up, it is hard to find but it’s there though, so many people injured and the number of many thousands of people being killed by vaccines and it’s reported and verified so if we’re going to mandate this, show me where if we don’t what this crisis is. This is two percent or one percent, we don’t want to do this are creating, I don’t understand the math. It makes absolutely no sense to me. Who’s heard in this room, anything in the last three or six months about really serious outbreak of disease, deadly disease that is devastating this State, that state, this community, anyone? Okay. But look at all these people, yeah. I promise you people, you spend just a half and hour here and there poking around on the web and just asking questions and keeping an open mind, I was someone who never cared, vaccinate my kids fine. Two weeks, a couple of hours, un-huh, never gonna happen. And as you can see this is an emotional thing. The State has no business doing this. This
is my business, my doctor, my decision with my daughter and my teenagers how can you take that agency away. How can the State? I assume they know enough to tell me I have to do that. I just can’t and I’m sorry I’m a lifelong resident here, I’ll leave the State. Doesn’t make any sense to me. Billions of dollars of lobbying. Oh, four billion dollars paid out for vaccine injury and death by the pharmaceutical companies since 1986. Correct me if I’m wrong, $37 million so far this year, $73 million. Wait a minute if you’re saying that vaccines don’t cause absolute gigantic numbers of injuries that are being paid out, that is just the ones paid out. How about the ones that aren’t paid out? The number just go up and up. People are being injured and killed. I’m paying for that because the pharmaceutical companies back whenever got immunity, immunity because oh, we’re getting sued too much. I’ll tell you, if I was in your shoes now, Republican or Democrat that immunity thing, when you’re talking about injecting every citizen of the nation, with poisons and toxins and heavy metals and Representative Steinberg you mentioned to the last speaker a slippery slope, for my side, I see one too and it’s starting with stuff like this. This has nothing to do with a political party. This is just common sense. The State starts to intervene in personal medical decisions between me and my children, my doctor can’t even advise me what to do and say don’t do it because your child is likely to get hurt because of certain preexisting things in children that predispose them to being injured. My doctor can’t say it’s not a good idea for this child but for that one, where does that put me. Where does that put me?
SENATOR ABRAMS (13TH): Representative Hennessy did you have any other questions.

REP. HENNESSY (127TH): Thank you your voice has been heard. Thank you for your time.

SENATOR ABRAMS (13TH): Representative Dauphinais.

REP. DAUPHINAIS (44TH): Good morning esteemed members of the Public Health Committee. Thank you for having us this morning. I am here with Eileen Iorio to testify against SB-858 AN ACT CONCERNING THE PROPHYLACTIC TREATMENT OF MINORS FOR SEXUALLY TRANSMITTED DISEASES. Eileen Iorio is a researcher and a coauthor of the book “HPV Vaccine on Trial.” I know that you mentioned some other books there and I recommend that you all look at this as well and before I yield time to her to speak I just want to mention that the comment made earlier was over four billion dollars has been paid, not by the pharmaceutical companies, by the federal government in vaccine injuries. We the taxpayers are the ones that are paying for vaccine injuries. I just wanted to make that comment and I will yield the rest of my time here to Eileen.

EILEEN IOIRO: Thank you Anne. Esteemed Chairs and Members of the Public Health Committee thank you. The Bill concerns the term.

SENATOR ABRAMS (13TH): I’m sorry, I don’t mean to cut you off but could you state your name again.

EILEEN IOIRO: Oh, I’m sorry. Eileen Iorio. The Bill uses the term prophylactic treatment. In medicine, the term “prophylactic” essentially refers to a vaccine. My testimony today is based on the assumption, unless explicitly corrected by the Committee here, that this Bill is written to include
the HPV vaccine which is approved for children as young as nine and any other vaccine indicated in the prevention of sexually transmitted infections or diseases in the future.

It must be stipulated that the vaccine is clearly not a treatment as it is given to healthy children free of disease. The term “prophylactic treatment” used in the Bill is both misleading and a contradiction in terms. It is the legislative equivalent of trying to put a square peg into a round hole. Current Connecticut health law only permits doctors to TREAT minors for sexually transmitted diseases without parental consent. Even that is egregious but we understand the reasons for that. The law was not designed for such broad medical interventions on minors such as a vaccine for an STI without parental consent. Indeed, as regards the HPV vaccine or vaccines in general, it contravenes Federal Law to do so.

The law is the National Childhood Vaccine Injury Act which talks about given blanket product immunity to vaccine manufactures, the fund is funded by taxpayers, by a tax on every vaccine and explicitly states that parents must receive information and give consent both prior to the vaccine and receive information on all vaccines afterwards. The HPV vaccine is the most reactive vaccine out of them all and there have been 134 cases of death and injury which has settled or been decided in vaccine court. That means that essentially there are risk that children can’t really understand.

The other thing which is not as pleasant to talk about should this become law it opens up the unpleasant issue of minors who are abused or
trafficked being force into getting vaccinations as a preventative measure. This adds another level of control abusers have over children in the terms of receiving preventative, it’s predatory in nature. It could be predatory in nature. The State should be seen to act on behalf of children and preventing any further abuse of children in this regard.

I understand that the intention of this Bill may include other drugs.

SENATOR ABRAMS (13TH): I am going to have to ask you to sum up.

EILEEN IOIRO: Thank you, I’ll sum up. I understand this may include other drugs for sexually transmitted diseases but this vaccine is for children as young as nine. I am here today to ask that this Bill not proceed out of Committee on the basis of the ill-defined terms, overreach of government which unduly places parental rights and puts children at risk for harm. Thank you very much.

SENATOR ABRAMS (13TH): Thank you, any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. What are some of the most commonly reported issues and what types of reactions or injuries have been compensated by the Government Vaccine Court?

EILEEN IOIRO: Thank you Representative. Yes, I’ve mentioned 134 cases have been adjudicated or settled by the Vaccine Injury Compensation Fund. Overall there have been over 60,000 reports of injury. But of these 134 cases which eventually made it through lengthy court hearings, in Federal Compensation Hearings, 134 cases included death in a number of
cases. It also included Guillain-Barre Syndrome, demyelinating illnesses such as MS, chronic fatigue syndrome, head trauma due to syncope. Syncope is fainting without warning, it is a neurological condition and chronic. The table injury which is the limited number of injuries you’re allowed to sue the Federal Government for is quite limited and very restrictive. But we do know that over 60,000 cases that doctors and manufactures have reported are not fully investigated but they are also underreported. It is a very, very understated number.

REP. HENNESSY (127TH): Thank you. Thank you for your testimony.

EILEEN IOIRO: Representative if I may add, we have a young girl here if you look to your right who has been injured by the HPV vaccine, her name is Linny and her mom hopes to testify later and she has been paralyzed after the vaccine. We thank her for coming today. My apologies.

REP. HENNESSY (127TH): Thank you for the testimony. Thank you for availing the Committee with these books I am going to be looking through it and thank you Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. I wonder if you could just give us a little more insight to the deaths because when I looked at the data that is easily available to us through VAERS and the Vaccine Safety Data line, when they start out say VAERS got 117 reports of death after Gardasil, some are not confirmed, some were found to be other causes such as homicide, suicide, accident, etc. So the numbers
that get thrown out, there is 40 deaths, or 60 deaths or 100 deaths, most of them are not attributable to the vaccine they are attributable to other causes and the issue with syncope, I’m not an expert in this area, but the syncope was associated with quadrivalent Gardasil vaccine and now the 9-valent vaccine they not seeing the syncope that was seen with the quadrivalent vaccine. And you know, simple fainting was seen with almost all vaccines depending on the person’s situation. So I’m just wondering if you could give us a little more information on where the data on the deaths are because I’m not finding the number of deaths that people are testifying about.

EILEEN IOIRO: Sure, okay so the VAERS System yes that can be lacking in information. Not all reports are validated because they are not investigated. There have been 454 deaths, I think now, and again as much as some of the deaths may not be attributable they may just be reported by the public. It is also a system that is underreported to the tune of, because so few doctors report, the public isn’t aware a combination of that anywhere between one and ten percent is reported. So, you know, as far as some of those that may not be, we could also say on the other side that there could be 4,000 deaths, we just don’t know. But there have been cases in vaccine compensation, the Vaccine Compensation Program that have been settled for death so the one case that was actually decided this year, sorry in 2018, Tarsell vs. HHS. In that case Chris Tarsal died alone in her dorm room at college in Bard, New York. Bard College, New York and in her case, her mother fought for eight years to get resolution in her case and the Special Master found
that Gardasil did cause her death. Because it’s a no-fault compensation court or Federal Program that was as far as they could take it that it more likely than not caused her death was the highest burden of proof that the mother had to prove. It took eight years with Appeals. There is another case settled in the case of Jessica Erickson in Upstate New York, her case was also settled for $200,000 dollars. The Tarsell case was $250,000 and that’s the maximum. Another case is currently being settled the case of Joel Gomez, a young boy who died on a football field the day after he received his second dose. His family has been compensated. There is another case, there are two or three more cases which actually is in the book, oh, actually you can see here. So this is actually Chris Tarsell and that is her headstone, a beautiful young girl. This is Colson Barrett who, he succumbed after his HPV shot I believe it was his second within two weeks he was quadriplegic eventually he regained some function but he took his own life after five years of being in a state of permanent, of having to carry around his respiratory permanently on his body. This is Joel Gomez I spoke of earlier, beautiful young boy who died on the sports field. This young girl, oh this is Maddie, she took her own life due to the ongoing chronic illness that she suffered from her vaccine injury.

REP. PETIT (22ND): Maybe you can give me some insight, I’m not as familiar with the legal process. Are people who are, sue the government, go to the Vaccine Fund do they automatically have to be in the Vaccine Adverse Advanced Reporting System or the Vaccine Safety Data Link or are they excluded from that or if a finding is found for the person for the
vaccine with, is it then placed in one of those data bases?

EILEEN IOIRO: No the VAERS data base is a passive reporting system anyone can report to, there is no connection with the Compensation Program. The Compensation Program is adjudicated by the Department of Justice, the lawyers for the Government are from the Department of Justice so is the Special Master and it’s worth nothing that the HPV vaccine does earn the CDC or NIHA royalty so it is a government vaccine and they have a certain interest in keeping this vaccine on the market and in as plentiful supply as possible and they are the ones adjudicating on each case that goes through the Federal Program. That’s an injustice and that’s something that, you know, you have to deal with and it started off in 1986 as a good idea. It had good intentions to create a system whereby families could be compensated promptly without adversarial legal processes but now has very much become a necessary environment for parents where the onus of proof is on them for something they can’t prove. This is a new vaccine, it’s poorly understood, it has high amounts of aluminum adjuvants and Novo adjuvant by MERCK which has never been independently tested. This vaccine has never been shown to prevent cancer so as much the Bill here talks about prophylactic prevention we don’t quite know yet what it is preventing. You know, as I said, that’s a contradiction in terms anyway. HPV is an infection which clears in over 90 percent of people. It is not HIV. I understand the Bill wishes to address that but this Bill should not make it out of Committee due to the language and the provision that the vaccine could be given to children as young as
nine who cannot consent to such a complex medical arrangement as a two-shot series of a vaccine which carries risk of death.

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

SENATOR ABRAMS (13TH): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you for your testimony today. My question is of these deaths that you’ve reported, are any of them due to an allergic reaction to the ingredients?

EILEEN IOIRO: To our knowledge none have been due to anaphylaxis is that what you mean? Anaphylaxis is quite rare, one ingredient in the vaccine has been associated with anaphylaxis which is polysorbate 80. That has also been associated with infertility. But as you mentioned ingredients another one of the ingredients is actually banned to consume but it is allowed in a vaccine, that is borax and that has also been banned in Europe and associated with infertility. So I think anaphylaxis is not as much of a concern as the long-term chronic health outcome that has been associated. The vaccine, you know, doesn’t become immunogenic for two weeks which means the antibodies don’t develop for two weeks and that is when we see most of the injuries occur. So once the immune system has responded and is gearing up the response that is when we see most of the reports and incidentally in the clinical trials children were, or young women were only observed for two weeks and after two weeks no reaction recorded after that was being associated with the vaccine which we talk about in this book.
The clinical trials were flawed because of that reason. It’s just too soon to tell.


SENATOR ABRAMS (13TH): Representative Candelora.

REP. CANDELORA (86TH): Thank you, Madam Chair. Thank you for your testimony. I had two questions. In speaking of the language of prophylactic and treatment as you had pointed out, the prophylactic piece seems to suggest that vaccine was treatment I guess seems to suggest you would be performing some kind of procedure on somebody who has already acquired the disease. I think, I guess my question is the natural conclusion is that this is bringing in the HPV vaccine and making it readily available, do you see any other types of vaccines or treatments that might get pulled into this?

EILEEN IOIRO: When I first read it immediately I thought of the vaccine because of the word prophylactic. It could encompass any sexually transmitted disease or infection vaccine in the future such as gonorrhea or chlamydia which are in process. My concern for this one is that the FDA approved this vaccine for children as young as nine and that is the concern. Without parental consent at any age is concerning but I think, and I thank Representative Zupkus earlier for talking about the importance of parental consent. I think any drug or any vaccine is of concern to parents and I understand there are conditions where children may be intimidated and wish to advocate for their own rights and access to medication but because this vaccine is essentially given to nine to twelve-year old’s is wholly inappropriate place to put the word prophylactic into an otherwise Bill intended for as
we hear is supposed to be for a different purpose. So unless that’s critically clear, I don’t see how this could be amenable to the Committee.

REP. CANDELORA (86TH): And so also in your research, I remember when the HPV vaccine came out it was targeted towards, you know, young girls like 16, 17, 18-year-olds individuals that, women that would becoming sexually active and then there was the transition to giving it to boys as well and now what I’m seeing is recommending younger and younger ages regardless of whether you are sexually active. And I guess my question is why do you think that is occurring as well and if somebody is going to receive the HPV do you know what the standard age recommendation really should be or would be?

EILEEN IOIRO: Well the CDC and the FDA recommend it for 11 to 12-year-olds and that is to coincide also with them entering middle school, it is a captive age where they go to the doctor for DTap or something else and the other reason is because giving it to younger children means that it is, it works better they say. Now works better also means that it is more immunogenic in younger children which means that they create antibodies, more antibodies to the virus and I am not a doctor I should say that but from my research and what we’re told by the CDC and FDA and the manufacturer what comes with a highly immunogenic vaccine comes more reactions. And like I said, this vaccine has the highest reactions out of all vaccines combined, all five of the vaccines combined except for the flu shot. Because we talk about the Federal Law, the Vaccine Injury Compensation Fund or Program was set-up for childhood vaccines, the National Childhood Vaccine Injury Act of 1986 so it was initially only
to support cases for childhood vaccines. It is now expanded to adults who receive or have access to the same types of vaccines the children, so now we have the flu vaccine taking over the HPV vaccine but outside of the adults reporting or taking cases affording injury, the HPV vaccine is the highest of all reported injuries combined since 2006. I’m sorry did I answer your other question?

REP. CANDELORA (86TH): You did, I appreciate that.

SENATOR ABRAMS (13TH): Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman and thank you for your testimony. I have a question, it is a hard question to ask because we’re talking about children and we are talking about lives but as you cite deaths that could be or potentially associated with a vaccine, obviously underage deaths have had autopsies, correct? Or do we know in all of these cases and are there any underlying other undiagnosed medical issues that could have been a factor in this situation?

EILEEN IOIRO: I have not read all the autopsies. I haven’t read any of them but from the case information that you see in Vaccine Courts I know that in the case of Chris Tarsel she died of heart failure and because she was an athlete she had many tachy-cardiograms, the doctor might correct me, EEGs before the vaccine actually on an annual basis and she had no preexisting conditions that would indicate she would die from a heart attack. The same with Joel Gomez. There has been, to my knowledge, no underlying condition that would mean these girls are susceptible, it is actually something that advocates such as ourselves push for and that study the case we want the CDC to study these children and
to study these cases and figure out why some girls react and some boys react and others don’t. So to your question I think it is very much a case where research is not being done and I think it should be and we wait for that to happen because 60,000 reported reactions and I think it is 8,000 of those were serious which meant hospitalization and the 400 deaths of course. You know that is something we advocate for is more research into why someone reacts.

REP. COOK (65TH): Some coming, as you heard me say, earlier, I am the mother of four. Three of my four children have heart conditions. None of those heart conditions were picked up by an EKG, so and they are all athletes. The only way those heart conditions were picked up were by an echocardiogram.

EILEEN IOIRO: Which is what Chris Tarsel had.

REP. COOK (65TH): So and then some of those heart conditions may have never been picked up unless, like my brother-in-law passed away because he had an undiagnosed mitral valve disease and [Cross-talking] so what I’m saying is I don’t want to battle the issue but I want thorough facts and I am not saying that you are not trying to do that so please don’t take offense to what I’m saying, but I am also looking at the whole conversation. As I look at an article from Forbes Magazine about how there were 100 deaths that were supposed to be attributed to Gardasil that were proven not to be or what have you, so our job here is to protect all in the best way that we can. I understand what you are saying about research and needs to investigate. I given two of my, both of my daughters have had the vaccine. One is a nurse and she, and I went to her
and said would you give it to your sister and she said absolutely. So I struggle with all of this so I hope that you understand that we’re not saying that we’re not taking these conversations lightly.

EILEEN IOIRO: Oh no and I appreciate that.

REP. COOK (65TH): I also have been asked to state very clearly that the meds for HIV that have been spoken about are not vaccines so I hope that we move forward with that and we stop that conversation. I’m not saying that you did [Cross talking. Medications are not vaccinations and we need to insure that we do not associate the two for the sake of the future conversation. So thank you.

EILEEN IOIRO: And I just wanted to add to that, you know, heart condition is not a contraindication to getting the vaccine, that is not what I was saying. I was saying they died from heart failure and they did not have a previous diagnosis and I know that you said it doesn’t always get picked-up but to our knowledge that is not it. But under this Bill the issue here is the Health Law does not cover preventative treatment like a vaccine and the way it is written with prophylactic treatment seems to be pushing the vaccine into this law where it is not supposed to be unlawful because Federal Law allows for parents to have full access to information. It is actually Federal Law that a doctor must record all details of the vaccination and give the parent access. That is also in the Law, the parent has to have access to that information and the reason and it is also written into the Law, and I have it here, I have a link to it here in my testimony that the onus is on the parents to monitor the child afterwards to mitigate more serious reactions, it’s
in the Law. So if you were going to remove parental rights or parental monitoring of their children after vaccines as young as nine and I understand to your point that this is not, you know, the drug for HIV, well I think that is very unclear right now. HPV and HIV are very, very different. HPV is pretty much a benign infection in most people and a very tiny percentage go on to develop cervical cancer, less than one-half of a percent and it must be a persistent infection, untreated of the same strain. This is not something that is a trivial disease that ends up as cancer automatically, this isn’t the case. So I think a distinction in the risk must also be made. It isn’t a case where you get exposed to HPV and then you get cancer, that is a fallacy of the marketing that we’ve been exposed to. Very often children and this speaks to courting children almost is that the marketing that has been put out by the company, by medical organizations is that you should get the vaccine or you’ll get cancer and we also see that doctors are told to tell the patients, tell the parents that this is, don’t talk about the sexually transmitted of this talk about this as a cancer vaccine. That’s what doctors are told to tell their patients by the AAP. So we’re left with a case of nine-year-olds to twelve-year-olds being influenced heavily by the messaging which is very simple, get the vaccine or you’ll get cancer. How do you combat that with a professional who is telling you that? So parents should be absolutely in the driving seat in terms of risk. So what increases your risk factor is smoking, having children in your teens, poverty, poor nutrition, actually being HIV is also a risk factor. So there are so many other things that play into developing cancer that to put a prophylactic into this Bill and
removing parental consent would be a great mistake and I think as Melissa pointed out, this is Federal Law that a parent should get access. That’s what we’re really talking about, not about the risks of the vaccine. We’re not really here to talk about that. It’s to talk about how Federal Law is there to protect parents and the vaccinée because all other liability, the vaccine manufacturers do not have liability for this procedure. In other cases such as a drug, if you have a reaction to this HIV drug you can sue the manufacturer. You can’t do that with a vaccine, so putting prophylactic treatment which doesn’t make sense, but putting prophylactic in here will allow for this vaccine is very clear and I don’t believe this should be considered by the Committee under that pretense. Thank you.

SENATOR ABRAMS (13TH): I’m wondering if you have a medical degree and do you have a medical degree?

EILEEN IOIRO: No, as I said earlier I am not a doctor.

SENATOR ABRAMS (13TH): And I am wondering what degrees you might hold particular to any expertise in this area.

EILEEN IOIRO: I hold a Business Degree. I am one of the researches on the book. This book is not a medical book, it doesn’t give medical advice.

SENATOR ABRAMS (13TH): I don’t mean about the book. I’m just talking about you personally. So you have, I’m sorry. Is there anything else, I didn’t mean to cut you off?

EILEEN IOIRO: No, no, no that’s fine. I have a Business Degree.
SENATOR ABRAMS (13TH): Thank you very much. Any other questions or comments? Thank you very much. We will go back to Sheila Diamond if you are available now. And she is testifying on Bill 94.

SHEILA DIAMOND: Good morning. I would just like to clarify that I want to touch on 858 and 94. My name is Sheila Diamond. I have been a resident of Connecticut for 16 years. I live in Hartford County with my husband and our two young daughters; my degree is in nursing, I hold the BSN.

I strongly oppose proposed bill SB-858. I am quite concerned that this committee would consider taking my parental rights away and recklessly endangering my daughters’ health as we’ve seen. Allowing physicians or a facility to permit prophylactic treatment of minors for sexually transmitted diseases for infections without the consent of a parent or guardian is an abhorrent overreach of the State.

It is quite clear that $9.5 million dollars recently spent by the State for the purchase of Human Papillomavirus vaccines correlates with the expansion of HPV for all children 11 and 12 years of age according to Mick Bolduc, Vaccine Coordinator-Connecticut Vaccine Program.

I wanted to mention a few points about HPV from the CDC in case you weren’t aware.

1.) HPV is the most common sexually transmitted infection in the US. An estimated 79 million persons are infected, and an estimated 14 million new HPV infections occur annually. Over 120 HPV types have been classified into low and high-risk categories.
Although the incidence of infection is high, most infections resolve without treatment.

2.) Infection with a high-risk HPV type is considered necessary for the development of cervical cancer, but by itself it is not sufficient to cause cancer because the vast majority of women with an HPV infection do not develop cancer.

3.) A small proportion of infected persons become persistently infected and that is the most important risk factor for the development of cervical cancer. If it is left undetected years or decades later it can progress to cervical cancer.

4.) The gold standard continues to be PAP screening on a regular basis.

Basically to put this into perspective, my daughters have a 0.0002 percent chance of developing cervical cancer if they contract HPV that’s the 12,595 cases out of 79 million infected. So if you think about that 0.0002 percent chance of developing cervical cancer IF they contract it and even less of death.

As a parent, as mother I shouldn’t feel like I can’t protect my children and I feel based on the research I’ve done as a nurse, and other credible sources, that this is one vaccine that should never be given to children mandatorily. So I would ask that you take that into consideration.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. So you had mentioned that the State had bought vaccines.
SHEILA DIAMOND: Yes, it was in the budget for 2017-2018.

REP. HENNESSY (127TH): So, I’m sorry, so we bought.

SHEILA DIAMOND: $9.5 million dollars.

REP. HENNESSY (127TH): $9.5 million dollars for the HPV vaccine.

SHEILA DIAMOND: That is my understanding, yes.

REP. HENNESSY (127TH): That’s sitting in some facility waiting to be utilized. Okay, thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony and for bringing your beautiful daughter. Next is Representative Pavalock-D’Amato.

REP. PAVALOCK-D'AMATO (77TH): Good morning. My name is Cara Pavalock-D’Amato and I am here with my constituent Mr. Brian Festa. So we are here today to vie against Senate Bill 858 so I am going to hand it over to him. Thank you very much.

BRIAN FESTA: Thank you members of the Public Health Committee for allowing me the opportunity to speak today and Representative Pavalock-D’Amato as well. I am before you today to address an urgent public health crisis: the usurpation of medical rights from parents by the medical profession. This is a crisis sweeping across the nation, and it has crept its way into Connecticut. Sadly, some among you apparently see no problem with allowing a minor child to make important, potentially life-altering medical decisions without parent consent.
Make no mistake; this is medical tyranny. Our State decided long ago that a minor cannot give consent to engage in sexual activity below the age of 16. The reason for this is obvious: minors below that age cannot properly comprehend and appreciate the potential life-altering ramifications of engaging in sexual activity, and therefore are not capable of providing informed consent. And so it goes with medical treatments such as the prophylactic HPV vaccine known by the brand name Gardasil. I will not spend much time addressing the potential dangers of Gardasil, for they are well documented, and have been addressed by many other speakers today and am sure will be after me as well. But rest assured, they are real and not as rare as those in the medical establishment would have you believe. To allow medical professionals to inject a substance into a minor child, a substance which has the real potential to cause serious side effects, including permanent disability and death without parental consent is unconscionable and reprehensible. No medical treatment should ever be administered to a patient without informed consent, and there can be no informed consent for a minor without parental consent.

And there are more problems still. And I am going to speak now from my experience as an attorney. I am an attorney who practices Civil Rights Law. Even if we could be assured that there were no real threat of serious adverse reactions from the HPV vaccine (an assurance which not even the CDC is willing to provide), this bill presents significant legal problems. There are parents who have sincerely held religious objections to vaccination. Parents have legal guardianship and custody over their children,
and with that comes the right to decide the religious affiliation of their minor children. Bear in mind that this bill does not restrict the term “minor” to any particular age threshold. So even those assert that children should have, you know, at some point, at some age should have religious autonomy, a position by the way has been consistently upheld by the Courts that they should have religious autonomy over the right of their parents could not argue that this could extend and say to a five-year-old or a six-year-old at most, that would be pretty much ridiculous and I think most of us would agree. So I urge you to oppose Senate Bill 858. One last thing I would like to say is, it’s been brought up a couple of times, this is just for HIV prevention this Bill wouldn’t address, you know, vaccines or HPV but again it is not worded that way and the way I read it, again from a legal perspective, is that the proposed draft does not restrict it to any particular one course of prophylactic treatment so that is a concern.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Thank you for being here today. Dawn Jolly.

DAWN JOLLY: My name is Dawn Jolly, I am a resident of Richfield, Connecticut. I am also a United States Navy Veteran who signs-up during 9/11 to risk my life to fight for the freedoms but I am here to fight for again today and I am absolutely blown-away by the amount of Bills that have been introduced this Legislative Session that are restricting my rights as a parent to take care of my children in the way that I see fit. I assure I’m educated. I’m a wonderful mother. I have excellent relationships with my children, they are open with me and while I
understand there are children here that don’t feel comfortable talking to their parents I should not be punished because I have done what I need to do as a parent, to have these types of relationships with me that they are happy to speak with me about, such intimate matters as sex, and drugs, and drinking things that teens face and why should I have to feel as though I can’t exercise my rights as a parent because there may be a small subset of the population that is in a different circumstance.

So I don’t know what kind of viewpoints you take into consideration as you make these decisions but there is really no one-size-fits-all approach to this. You can’t encompass such different viewpoints with one Bill and especially when it is so vaguely written. How does it speak to any one clear intent and purpose, it doesn’t, it just doesn’t? Nowhere in these Bills does it state the parental consent is required and parents should be able to choose any and all medical treatments for their children and as Brian just mentioned previously at what age is parental consent not required. At what age is a child able to make a decision for themselves? Is my two-yea-old able to, or my 13-year-old, or my 15-year-old who is not here today. At what age is it permissible for children to make medical decisions themselves?

The HIV [Inaudible-01:57:29]drug PrEP I am just going to have just one quick statement about that. There was a doctor who spoke previously to that point, from my research, and I am not a medical doctor but I am someone who has done tons of research on this topic I do not see that it is indicated for use in all minors. It has only been studied for males ages 15-17. So what about all
female minor children? I’ll try to wrap it up here in a moment.

I just want to talk on two other things one is that the Country of Japan has banned the HPV vaccine from its recommendations due to all the adverse reactions. So if an entire country has decided not to include this in their recommended vaccines, there is a reason for that and we should be looking to them as countries usually look to us and we should be looking to them to see why is that the case rather than attempting to mandate it or give it to children without parental consent.

And one last point, that the flu shot, I do not believe it should be given by a pharmacist because pharmacists do not know the medical history of a child. So if they are not privy to that information how do they know that child should be getting that flu shot. How do they know that the child has not already received their flu shot for that year? There is no system in place that currently tracks all of these things so my 13-year-old could walk into CVA to grab some makeup and get her flu shot and then be persuaded to do the same thing 10 minutes later if she walked right down the block into Walgreens. They are offering financial incentives to people to get their flu which is included in my testimony and I really believe that is a conflict of interest.

SENATOR ABRAMS (13TH): Thank you, I am going to have to stop you there. Any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. I just would like to comment on your disclosure that you are a Veteran, a Navy Veteran, 9/11. You rose
to your Country’s defense and you are doing that now. I’d just like to complement you on your courage for serving for your Country and also for.

DAWN JOLLY: By the way, I’m sorry to interrupt you I was 17 and I had to have my parental consent to sign up for the military because I was risking my life. [Laughter]

REP. HENNESSY (127TH): You showed courage bringing your children here due to the intervention of Chair’s, we’ve brought you forward so that you won’t subject your kids for an entire day of sitting, awaiting to testify and I really thank the chair for that.

DAWN JOLLY: I greatly appreciate that as well.

REP. HENNESSY (127TH): An I just want to thank you and thank you for your courage and thank you for your service.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. I am just gonna make a comment and it’s a broad comment, but I do thank you for your service. My daughter is in the Navy and signed up at 17 and we had to sign for her too. So thank you and that is a very odd feeling for a mom to do that so. I guess my comment in general is, I mean, I agree with you. In this session we are looking at Bills to raise the age for smoking to, you know, 21 because smoking is bad for your health. There is a Bill about adoption where people want to be able to find their medical records yet with this Bill we wouldn’t even know as parents, so you know, everything just kind of contradicts itself here. I just wanted to say thank you for
coming, your children are beautiful. Thank you for serving our Country.

SENATOR ABRAMS (13TH): Representative Candelora.

REP. CANDELORA (86TH): I thank you as well. One of the comments you made that really, it does strike accord, it is about parental consent and not necessarily about the procedure and I am glad that you speak to that point because ultimately the way I see this is what probably is gonna happen is that the person administering the treatments are the ones actually making the decisions not really a 10,11 or 12-year-old. And in looking at this Bill as well, you know, to me I find the drafting a little bit frustrating and offensive because we’re adding in a prophylactic treatment and leaving the rest of the language in the Bill. What is interesting is again the treatment becomes confidential so you as a parent are not allowed to find out if your child is a school with a school health center, what kind of treatments they’ve been giving if they chose not to tell you about it and then if that treatment, for instance HPV, happens to be given to your child who is under the age of 12, strangely then the Bill requires a mandatory reporting to DCS and now you’re putting through a State system because your child was treated with an HPV vaccine. However, the premise if it was an actual STD obviously they would have been abused. So we’re going down a very slippery slope and I think it is important to hear from parents like you to push back because it is just critical. Thank you for your service to this Country.

DAWN JOLLY: I agree and I thank you for that. And just one comment to that, my daughter and I have a
very open relationship as I mentioned previously. My children tell me all sorts of things and I won’t go into details [Laughter] but my child also can stay up until twelve o’clock on a homework assignment and then completely forget to turn it in the next day and one of my other children has an IEP so as Melissa had mentioned earlier how are these children able to make informed decisions, they are not even presented with all the information they need to make an informed decision and they are not yet capable to do so. So thank you for that.

REP. CANDELORA (86TH): I appreciate that and I just stepped out, my daughter sprained her finger in school so the nurse called me to let me know and under this Bill we’re saying you don’t have any right to know, it’s crazy. Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony and thank you for your service. Senator Logan.

SENATOR LOGAN (17TH): Good afternoon Senator Abrams and Representative Steinberg and all the Distinguished Members of the Public Health Committee. It is a pleasure to be here before you. I am here to testify regarding House Bill 5902, AN ACT CONCERNING NATUROPATHIC MEDICINE. This is a Bill that came before us last session as well that I championed.

It has to do with naturopathic doctors and their ability to have -- prescribe certain medicines. Currently they have no prescriptive authority. This is a profession where we actually train these naturopathic doctors, right here in Connecticut. We have a program at the University of Bridgeport and what’s happening is that many of these naturopathic
physicians that we are training are, many finding themselves leaving the State of Connecticut because of this limitation. So I brought with me, here with me, an expert Dr. Lindsey Wells who is a Naturopathic Physician practicing out of Wilton, Connecticut. I concede my time to her.

DR. LINDSEY WELLS: Hi, Senator Abrams, Representative Steinberg and Members of the Public Health Committee.

My name is Dr. Lindsey Wells. I am a Naturopathic Physician that practices in Connecticut. I graduated from the University of Bridgeport with my Doctorate in Naturopathic Medicine in 2016 and this program is the one East of Chicago.

With that being said, now that my practice is in Wilton I do practice with a medical doctor. She is an integrative pediatrician. We both essentially treat children mainly with special needs and other neurodevelopmental disorders and other chronic illnesses and as a result based off our approach we do have a very long wait list coming from all over the state and country and from that a lot of times when pharmaceutical medications are necessary we are unable to bring new patients into the practice and we have to refer them out to other integrative doctors, usually out of the state. Not only is this a loss of revenue to our practice but also a loss of revenue to the State. In addition to that, if I do have an established patient and they come in with an acute illness say Strep throat and they need an antibiotic, I am going to have to refer them out to their local pediatrician or even to a walk-in and with the patients that I work with who are mainly
special needs on the spectrum, this can be extremely disruptive to their care.

Okay, so with that being said it just essentially reminds me of why a lot of my class left the State of Connecticut to go and practice elsewhere because with the same exact training they are then to have full prescriptive authority while I do not. So we are asking for very limited prescriptive rights and I think that would be better for the care of my patients as well as the whole entire community that seeks treatment from Naturopathic physicians. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair, good job. Thank you for your testimony today. I have a question for you. If this Bill was to become Law would there be additional training that Naturopaths would have to go through to then get their prescriptive authority?

DR. LINDSEY WELLS: Yes, of course. So not every single Naturopathic doctor would be granted the prescription rights, its only the ones that move forward. We do have a course setup with the University of Massachusetts that would require additional training for Naturopathic doctors in Connecticut so it’s a full pharmacology course and then on top of that, we would have to take a State Board Exam, and of course have to pass that, and then from there every single year we would have increased continuing education credits, 15 at least that have to deal specifically with pharmacology.
REP. KLARIDES-DITRIA (105TH): And that course you’re referring to, are there any other disciplines right now that use that course in the curriculum?

DR. LINDSEY WELLS: For my, for Naturopathic doctors?

REP. KLARIDES-DITRIA (105TH): For anything.

DR. LINDSEY WELLS: No, because other states that allow Naturopathic doctors to prescribe, it is already built on to our course from our Doctorate training. So they don’t need additional course after they graduate. I could essentially move to Vermont, take the state exam and start prescribing tomorrow. So Vermont, California, Oregon, Arizona, Washington State all of these with some extra have full prescription authority, even some minor surgery.

REP. KLARIDES-DITRIA (105TH): Full, you said full?

DR. LINDSEY WELLS: Yeah, they do. They are very robust. [Cross-talking]. We are looking for a very limited prescriptive authority that essentially would be based off a formulary that we would work with the Department of Public Health in order to bring that up. So essentially things like an antibiotic would be really fantastic, so just very small.

REP. KLARIDES-DITRIA (105TH): Certain unscheduled drugs then?

DR. LINDSEY WELLS: Yes, of course.

REP. KLARIDES-DITRIA (105TH): Thank you. Thank you for your testimony. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Zupkus.
REP. ZUPKUS (89TH): Thank you Madam Chair. Thank you for coming today. I go between my primary care physician and a Naturopathic doctor, my whole family does and I take what I want from both, you know, so I appreciate your work and my niece just became a Naturopathic doctor in Connecticut, had to move to California to practice. She and her husband and they are now expecting their first child so they have left our State and she just saved a man’s life. She was just feeling him and he had an aneurysm that was fixin to burst and she actually saved his life there. So I appreciate the great work that you do and I find it interesting that even on top of what you’re wanting to do is that my youngest has gone to her primary care physician and they have told/suggested that we think about Ritalin which would be paid for where I took her to the Naturopathic doctor just on Friday and got fish oil and vitamins and we had to pay for. So I find that very frustrating. But thank you.

DR. LINDSEY WELLS: And with that also being said, that since we have no drug authority at all, if we had somebody that comes in on pharmaceutical medication like if you chose to go through with the Ritalin and yet we were able to manage it with fish oil and magnesium and what not, I wouldn’t even be able to change, recommend a change in the dosage of the Ritalin meanwhile take them off Ritalin. I would then have to refer them back to their prescribing physician.

SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you and thank you for your testimony. You know, we heard this Bill last session and I believe and my former Co-Chair
can correct me if I am remembering this incorrectly that the Naturopath went through Scope of Practice with the Commissioner and there was a very limited formulary that was provided. It had some vitamins, etc. on there but that Public Health when they did their scope review they did not feel that the curriculum was consistent among all Naturopaths that held the ND and they were not comfortable in providing prescription authority because Naturopathic medicine is considered complementary medicine and I remember there was Vermont, California a few states allowed for full prescription authority but most did not, most were very restrictive. So my question is if we’ve already gone the Scope of Practice with the Department of Public Health it puts us as a Public Health Committee in an unusual position to be having to go, we would usurping their authority to expand your scope without their cognizance or their you know agreement as to, you know, what should happen and one of the things we had spoken about last year was to try to get the Naturopathic Physicians together with the Department of Public Health and figure out how to make it work because I think we’re almost at a détente with the Commissioner of Public Health saying, you know, this is how we feel, this is what we’re willing to give you but that doesn’t seem to be what you want. That is kind of where we are. I’m hesitant to go against the scope of practice because we rely on that so heavily and there is all different specialties that are at that table when things are evaluated but I just wanted to kind of let you know what we’ve been through before. I am sure that you’re aware of it and just to provide the landscape of what we’ve been through last session and again this session.
DR. LINDSEY WELLS: Thank you for your efforts with all that but the scope of practice it wasn’t updated for over 90 years in regards to Naturopathic physicians so we’re able to make a little bit of leeway with that but we would still like to try to get at the same rights or scope of practice that some of our neighboring states have such as Vermont.

SENATOR SOMERS (18TH): I think it was also offered to the Naturopathic physicians that they might be willing to do something but it would be in a supervisory position so you would have to work with a physician who would, you know, I guess an MD versus and ND that would supervise or signoff on your prescriptions and that wasn’t something that was also acceptable.

DR. LINDSEY WELLS: I think mainly from us being able to collaborate, in my case, it would work out great, I work with an MD but that is not the case for all NDs in the state that they are able to graduate and essentially open up their own practices afterwards if they don’t have to be under supervision so it might make it a little bit of a burden, not a burden, but more of a barrier to be able to get those.

SENATOR SOMERS (18TH): Okay, I think that was something that was also offered too. I want people to understand that it is not as if public health has not looked at this before and has gone through scope of practice and has tried to have conversations about what they feel is acceptable and what is perhaps not acceptable for them so I just wanted to make sure everybody knew that. Thank you.

SENATOR LOGAN (17TH): I just want to point out as well that, you know, this is not something that
we’re asking Connecticut to be cutting-edge, first time, give this a whirl here. This is something that’s happening in several states, in other states they’re giving full prescriptive – full prescriptive authority. We’re not seeking that here and in some cases docs are able to actually do some minor surgical procedures so we are far, far from there. We are looking at this from a very, very conservative standpoint here and we think that this is something that the state supports in terms of one of our major institutions of higher education has an entire program and dedicated to it and they’re trying to hold that program together and hold it on. They are training folks. They’re leavin the State of Connecticut, going to other states and prospering, treating patients. Physicians like Dr. Wells are treating patients here now even though they are very hamstrung and again we’re asking for very limited prescriptive authority. I think this would be a way for us to show the leadership that we are and the State that we are in terms of moving this very important, I think, Bill forward and really, you know, helping one of our own, a group of our own here really do the work they’ve been trained to do, right here in the State of Connecticut with the full powers and training that they’ve been afforded from again, right here in Connecticut. Thank you.

SENATOR ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): The formulary itself is a document specifically stating what, I see some like Hawaii has a very extensive one and everything that you can prescribe or use in category is listed on this document. Can you speak a little bit about how that all becomes?
DR. LINDSEY WELLS: Yes. So we do, there has been a lot of work done extensively on coming up with a formulary and there will be other people to testify later on who have done most of that work but essentially it was just used as a guideline to then be able to give the Public Health Department and just see if they would agree with them and then it’d be an open conversation regarding that. But it’s mainly limited to maybe what a primary care physician would be able to prescribe so things like antibiotics, antifungal whatnot but it was listed out very explicitly there but Rick Liva in particular will be here, he’s the one who really spent a lot of time on that along with the Connecticut Naturopathic Association.

REP. ARNONE (58TH): So you would submit a written document [Cross-talking] approval. Thank you.

DR. LINDSEY WELLS: Oh, of course yes.

SENATOR ABRAMS (13TH): Representative McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair and I just wanted to welcome Senator Logan to let you know we miss you here in Public Health and to welcome you Lindsey. So this has been going on for a while and I agree, we’re going to have a real shortage of physicians going forward in Connecticut. We’re going to be talking about that a little bit later so I think -- my question was so you worked in a specialized field in Naturopathic right with neurodevelopmental disorders.

DR. LINDSEY WELLS: Yes.

REP. MC CARTY (38TH): So, I’m just curious do you think that all Naturopaths, so if we change, the prescriptive authority, but would some be more
likely to use the prescriptive authority than others? Would there be a percentage of?

DR. LINDSEY WELLS: I wouldn’t be able to give you the exact percentage but it would be up to the Naturopathic doctor if they want the prescriptive authority or not because they will then have to pursue the course, take the State exam and also follow through yearly on the continuing education credits. So I wouldn’t be able to say how many would actually go through that.

REP. MC CARTY (38TH): But in your particular field it would be useful in where you are?

DR. LINDSEY WELLS: Yes, very much so. So that’s why I’m here essentially for those families that I spend a lot of time treating their children with special needs mainly autism. I see a lot of autoimmune disorders and the special needs population and there are times where they come to me instead of going into a walk-in clinic or their pedestrian because they have something like Strep throat and I need to be able to prescribe an antibiotic for them because what I’m doing is just referring them out again and it can be very detrimental from the sense that they don’t want to go to someplace that doesn’t know their child’s care or can be very disruptive to them so it makes a huge difference for my family which is why I’m here.

REP. MC CARTY (38TH): Thank you very much.

SENATOR ABRAMS (13TH): Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. First I would like to say Hi to Senator Logan, it was wonderful working with you on Veterans’ Committee those years and thank you for your leadership in
this Bill. This Bill has been before the Legislature a number of years. We’ve been fighting. I know the Bridgeport delegation is very much in support of this and helping the University of Bridgeport School of Naturopathic Medicine and to move forward to be competitive. It is the only Naturopathic school in the Northeast and unfortunately the enrollment is falling because of this issue. So one of the things that I’ve heard that is critical of this Bill is Naturopaths don’t deal with prescriptive drugs, it is against their, you know, their practice so why would we be granting them this formulary if in fact, well they don’t do that kind of thing. It just seems to be kind of a spurious red-herring that is thrown out and I’d like to hear a Naturopath’s response to that.

DR. LINDSEY WELLS: Sure. So as a Naturopathic Doctor my goal is always to provide the best, most effective care to my patients. So there are many times when a pharmaceutical medication is necessary but it not always going to be the first go-to, right. We have a lot of other tools that we can use whether that being nutrition, herbal medicine, nutraceuticals, vitamins, supplements and whatnot. But there are acute illnesses that it is necessary for a pharmaceutical medication so it is not always going to be our first go-to but it would be nice to be able to use it in the cases where it’s necessary.

REP. HENNESSY (127TH): Thank you. I’d just like to mention that, you know, the Naturopaths are trying to be competitive to, to provide the best health care for their patients. You know, unfortunately there is an allopathic reality in which they are kind of controlling the know your of medicine. We have the most expensive medical system in the
country and unfortunately the outcomes are among the least in developed countries. So I’m hoping that as populations become more educated as to their health care to increase their health and not have to wind up with severe illness that we in the Legislature can support them to be able to make these practices without having to jump through hurdles. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Representative Genga.

REP. GENGA (10TH): Thank you, Madam Chair. Good afternoon, welcome Senator Logan. Doctor you mentioned that these Naturopaths are leaving Connecticut to go other places where they can prescribe. How many other states are there?

DR. LINDSEY WELLS: How many other states are there that prescribe?

REP. GENGA (10TH): Yes.

DR. LINDSEY WELLS: I’m not sure on the exact number but I could get that information and I think over probably at least nine of them.

REP. GENGA (10TH): Okay. Are all of their prescriptive authorities the same or is there different levels?

DR. LINDSEY WELLS: There’s different levels. Every single state has essentially probably their own formulary and that’s gonna differ.

REP. GENGA (10TH): I would like to read you some prepared testimony we’re gonna hear from the Connecticut Medical Society and ask you to respond to this.
“Naturopathy has long been considered by many state legislatures and the public as a natural path practice of health care. To grant the right to prescribe any form of drug to the Naturopath is not only dangerous but confusing to the public.”

DR. LINDSEY WELLS: Okay, so you know, we are trained. We have it in our curriculum that we do have pharmacology training. It is happening in other states where we prescribe and have somewhat robust prescriptive authority at least in comparison to Connecticut with great outcomes actually. And there have been very little malpractice suits against Naturopathic doctors who have prescriptive authority. So, I think it is interesting that they would say dangerous when it is happening in other states with very great success rates so I don’t know if there is any information on where there are dangerous suits for that.

REP. GENGA (10TH): We’ll find out when they come later [Laughter]. I thought that was pretty profound. And I would also say as well that you look at any profession and most professional organizations they are trying to hold on to their turf, you know, and as far as having prescriptive authority if you’re a physician here in Connecticut you would rather have the exclusive right to be able to do that so to have the Naturopath have a limited prescriptive authority some doctors would see that as a threat but this is not a threat to them it is a matter of public safety, improving public safety, helping families like the ones that Dr. Wells is helping as well and it’s more complimentary than actually being some sort of a threat or limiting the expertise and the authority of those practicing doctors here in Connecticut. But my take on that
would be it’s more of a turf war thing related to prescriptive medicine.

SENATOR LOGAN (17TH): I was also looking at there could be different levels of prescriptive authority which the Department of Public Health could decide which would be beneficial to the public.

DR. LINDSEY WELLS: That is what we’re asking for.

REP. GENGA (10TH): Thank you.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair and thank you for that testimony. I’m looking at the 2-year-old, 2/17/2017 Scope of Practice review and page 12, the first part of the summary says; “Some on the Committee felt that the didactic component of refresher course would be helpful by the collaborative relationship with an experienced provider be critical should prescribing rights be granted. The physicians and APRN representatives on the Committee stress that real learning about prescribing occurs through residency or collaborative relationship and cannot be filled through didactic education alone.”

Can you tell me in your training what nondidactic training you got in terms of prescribing medications?

DR. LINDSEY WELLS: In prescribing medications in my training? So we had pharmacology classes then we had to go through all our clinic rotation so with that and the University of Bridgeport and any other type of Naturopathic school you essentially, when you approach a case, you will then have to talk it over with your mentors on what pharmaceuticals you
would use and also interaction with other medications as well as herbals or supplements and all of that. My personal training is I work with an MD so I work very closely with her and with that being said I have a lot of experience with the prescriptions that we use mainly for our population.

REP. PETIT (22ND): I appreciate that but I meant in terms of training while you were still in school versus when you are out in practice, what is required at, you know, UB or other places what is required in terms of real time clinical training while you’re still in school.

DR. LINDSEY WELLS: I don’t know the exact number but Marsha Pine-Gruber who is the Dean of the University of Bridgeport she knows all that information and with the exact hours in comparison to all the other schools and comparison to MD schools and she will happily provide you that information later on today.

REP. PETIT (22ND): Thank you and I would say for those interested I think what is in this report from 2017 summarizes what Senator Sommers said earlier and it says in the final paragraph from page 12 of the report from 2/17/3027, “Should the Committee decide to raise the Bill related to prescribing authority for Naturopaths the Department of Public Health respectfully requests the opportunity to work with the Public Health Committee, organizations representative Scope of Practice Review Committee expresses interest in being involved should Legislature decide to proceed with considering prescribing rights for Naturopaths.” So it seems like they would like that to occur before we proceed with a formal Bill. Thank you, Madam Chair.
SENATOR ABRAMS (13TH): Thank you, any other questions or comments? Thank you very much. Ann Henry. Welcome.

ANN HENRY: Sorry, I’ve never done this before, please bear with me. Good Afternoon, my name is Ann Henry and this is my daughter, Linny. We are here to speak to you today because we are vehemently opposed to the proposed Bills SB94, SB858 and HB7199.

As a parent it is our job to provide the best opportunity for our children the highest quality of life and to lead them on a path to become happy and healthy adults. All three of my children went to routine doctor’s appointments and were given scheduled vaccinations as they grew-up.

In 2010 my daughter’s pediatrician informed me that my daughter must get the HPV vaccine. My daughter was not sexually active but he insisted that she have it. As someone who trusted his medical advice because I always followed what my doctor told me to, I had my daughter get the first round of Gardasil. Had I know what repercussions were, how my daughter’s life would change and how my life would change and my family’s life would change I would never have agreed to this. I will carry the guilt of having my daughter have this vaccine to my grave. So if I can’t have it, and I’m kinda old then I can’t imagine how a young child can go to a pharmacist and ask for a flu shot or any other kind of shot that may have some kind of a side-effect that could do serious damage to them. I’m not mature enough to make this decision and I’m 59, so I can’t imagine a 10-year-old or a 12-year-old going in
saying I want a flu shot, I want to go get an I-Pod. It blows my mind.

Linny had everything. She was bright and happy and her entire life ahead of her. She wanted to have a career as a Social Worker to “help teen’s in crisis.” She played guitar in a band with her brother. And she was on her school softball and swimming teams. She taught religious education, was on the Board of Milford’s Promise (a volunteer group for the City.)

The day of the HPV vaccine, Linny started having terrible head pains that never stopped. She started losing her balance and the falls became more frequent. My daughter had a stroke at the age of 20. She lost the ability to speak, breathe and my family watched as she gradually lost the ability to walk. She developed hyperacusis and right now Linny is wearing very strong, I’m sorry, earplugs under her headphones which are there to muffle the noise. She will go unconscious if noises are too loud, if the bird chirps at too high a pitch, truck blasts its horn, etc. She now needs jaw thrusts which my sons have also learned to do for her as she will choke to death on her saliva if she loses consciousness which any loud noises will do to her.

Neurological problems got so much worse after the second round of the HPV vaccine. She also has developed gastroparesis, acid reflux and violent hiccups causing her to be in constant pain. Linny and I traveled to so many doctors such as the campus at Yale, UConn, Massachusetts General and Cleveland Clinic. Doctors from all over the country who have stated the second round of Gardasil is the cause of what happened to Linny. We still make the long
extensive trips to Cleveland Clinic for her appointments and she travels weekly to two specialists in New York for their help. She has physical therapy and occupational therapy two days a week. All she does is try to get her life back.

To pass these bills is creating a situation that is unavoidably dangerous and parents should be aware of ANY medication given to their child. The HPV vaccine should never be mandated, please look at my beautiful courageous daughter and think of all the things she will never have, the pain and frustration she feels as she longs for all the things we take for granted. When it’s time to vote, think of her and vote against SB-95, SB-858 and HB-7199. Would you want your vote to cause another child to go through this, another family to go through this? Her brothers have been told that they should appreciate Holiday’s. We were told one Thanksgiving she probably would not be here for Christmas and we had to live through that. Another thing she was told, we were told was put her in a nursing home, let her die with dignity, don’t do the jaw thrust. My family didn’t do that. She has two incredibly wonderful brothers who both took time off from college for a year to help with her. They took off from work, their social lives just caved and she adores them. Her father works very hard and yet there is never money. I’m sorry, can I please finish, there isn’t money left ever. We’ve lost our house over this because of this lovely vaccine. I don’t want to ever see another family wonder if their child is going to die because of this. I was at a restaurant for my husband’s birthday the other day and the waitress said, “We’ve been trying to get you” and I said why and they said their mother,
“Needs to talk to you, her child just had the same reaction as yours.” Please do not let these Bills go through. Please defeat them. If they make it so eventually the HPV, these vaccines, I can’t go into a drug store and buy it. If I can’t deal with this, if my family can’t deal -- well we are dealing with it, if we can’t, how do you expect a 15-year-old to get this infection, the parents know nothing about it and could die that afternoon. The kid could die later.

SENATOR ABRAMS (13TH): Thank you so much for being here. Any questions or comments from the Committee? Senator Sommers.

SENATOR SOMERS (18TH): Yes, thank you for sharing your testimony today and I’m sorry for everything you and your family have been through especially your daughter. I can’t imagine that as a mom what you’ve been through, so my heart goes out to you. I do have a question concerning the first time you had the initial dose of the vaccine, your daughter experienced symptoms and then upon the second round did you after, you know, what happened did you report that to the FDA, did you report it to a doctor?

ANN HENRY: May I please explain one thing about the two times that she had the vaccine? She had the first one and she started having neurological symptoms. We were told, as I said, we’ve gone through many hospitals, we were told it could be MS, it could be Cushing’s Disease, it could be mitochondrial disease. There were so many things and they were all terminal, 99 percent of them were terminal is what they said. We went through so much sad things. She had bone marrows takes repeatedly.
She has been through so much. I did not want her to have the second vaccine. I absolutely refused. The doctor who is a pediatrician near where we live locked the door and said you are not leaving until she has it. This is not related. I was kept in his office for an hour. He took my phone out before we went in. My daughter passed out at one point, was on the floor, and he left her there. I had to lift my daughter and he just said you’re not leaving until you sign. I finally signed cause I didn’t have a choice because she was unconscious, my daughter now has Pots syndrome among other things and this doctor had his own agenda. He said, “You know, I don’t even make that much when I do this for you.” Okay, you’re telling me how much you’re gonna charge to make my daughter get worse. Immediately that night, you could see major things happening neurologically and it just kept getting worse and the Pots got worse and she had the stroke. My daughter will never have the things she should have. My daughter was offered, when she was in high school, a full ride to UV for softball. Full ride. That’s pretty cool. My daughter when it was time for that couldn’t get off the couch. She was there, all she could move were her eyes. The vaccine is poison. I have been a parent who has had their child vaccinated all along but when I head about SB94 this morning, it was, “Oh my God”, if I can’t do this, a kid is gonna go in, a parent will have no knowledge until their child is dead or in the hospital. If we counted up how many millions have been spend in keeping my daughter alive, and I know we have good insurance, however we still have co-pays, we still the gas to the different appointments, driving to Cleveland has been hard. Linny can’t fly because it’s too much for her and we
actually did try it once and she was unconscious more than conscious on the flight and I kept doing the jaw thrusts.

SENATOR SOMERS (18TH): I’m just going to have some very specific questions for you if you can answer them cause we have a lot of people signed up to testify today. Based on what you just said, I’m hoping you made a complaint about that clinical with the Department of Public Health, is there a record of that that you might have made a complaint?

ANN HENRY: I did not make a complaint because I had no where else to take her. I didn’t know what to do and eventually he said, you know you’re giving me too hard a time on this, she’s getting sicker, I don’t know how to help her, find somebody else. The gentleman we found after the doctor, it was Dr. Casablanca in Trumbull, I’m sorry, it was Shelton, and he says, “I’ll tell you right now unless a parent makes me, I’ll never give this vaccine again.”

SENATOR SOMERS (18TH): Thank you very much for your testimony.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you for being here and thank you Linny for being here also. Representative Kupchick, can’t read the writing, sorry.

REP. KUPCHICK (132ND): Thank you Madam Chair, Representative Steinberg. I am here about HB 6364 that Senator Wong and I both introduced and just to quickly and then I’m going to turn it over to our Chief Canine Sargent from the Fairfield Police Department Hector Arrizari who leads our three
canines in Fairfield to share a story about something that happened with one of our canines.

The purpose of this Legislation is to allow our EMS workers to be able to treat a canine dog if it is hurt doing a situation that happens while they are on duty. So right now our canine officers can treat their own animal, they have the ability to do that, but if they are along at the scene and something happens to the animal they can’t leave the scene. So if they are in pursuit of a suspect, they can’t leave the scene to take their animal to the veterinarian or treat the animal. So this would allow this extra layer of protection for canines in our State and I also was contacted by the Department of Corrections who said they would like to have their animals also included in this if we could move forward. I know that the Department of Health had some issues with it and I’m sure there is a possibility to work together to try to fix that language so that we could try to make a compromise but I would like to turn it over to Sgt. Arrizari to just share some of his comments.

SGT. ARRIZARI: Good afternoon Ladies and Gentlemen, thank you for having me here. I appreciate this opportunity to testify on behalf of the canines, the police canines in the State of Connecticut. I’m the proud Canine Supervisor from the Fairfield Police Department. I oversee a three canine unit team. We have three canines assigned to our department. Last year I was assigned Canine Jake who is by far the best dog in the State, I’m not biased or anything, [Laughter] but we were doing a training exercise in Southport, Connecticut and what we were doing is we were training for tracking. As you know we use these dogs for many, many different purposes
narcotics, tracking good and bad people, more good than bad fortunately in Fairfield but that is because we have great leaders there. With that being said Canine Jake was doing a tracking exercise. I know what that means, I’ll make a short.

SENATOR ABRAMS (13TH): Yep, it means your time is up, but take a moment to summarize as you would.

SGT. ARRIZARI: Absolutely, so Canine Jake was doing a tracking exercise and we out on an icy terrane in Southport and he severed a major artery in his right leg. I noticed a huge amount of blood spurting out of his leg and I picked Jake up, ran to the police car with him, bandaged him up as best as I could and he was young at the time, so of course he was more interested in what I was doing to his leg than the actual pain he was probably suffering from. So I had to take Jake, throw him in the back of my police car and loop the leash through the cage and hold it taught to the back of the cage as I am driving, lights and sirens from Fairfield to Norwalk Vet Hospital. How I made it through that drive, I mean, you know, we drive under high stress conditions numerous times a day but I’m freaking out a little bit about my dog and him bleeding to death in the backseat of my police car as I’m trying to get to this emergency hospital as quickly and as safely as I could. Had I had some assistance from a paramedic or an ambulance where I could have placed Jake in the back of an ambulance, taking care of his wounds while we were driving, you know, we probably got there a lot a safer than I did. And I just hope that this Bill passes because if anything, just the transport fact alone would be a tremendous asset to Law Enforcement Canines. Luckily Jake recovered from his wound and he is out there working now, or
waitin for me, then we’re gonna go to work. But, you know, we just need some sort of assistance out there in the field. As you know with the fentanyl crisis that’s going on, our dogs if they sniff that narcotic they are in for a world of hurt. We all carry Narcan, same Narcan we use on humans, we carry it in our pockets in the event our dogs become ill from inhaling or ingesting that awful drug so any assistance we could get from the medical community would be greatly appreciated.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Thank you for your service and thank you also for honoring the canines that do such great service for our community. It’s appreciated. Senator.

SENATOR HWANG (28TH): If I may just simply sum it up for ya, I think first and foremost we are addressing our canine law enforcement partners to treat them with the same degree of attention and afford the protection that they deserve. That being said, I think what’s also important is the fact that perhaps not even legislatively for us to be able to look at perhaps the scope of responsibilities for EMS because what Officer Arrizai just mentioned is the fact that right now the law prohibits our EMS to be able to transport law enforcement canines in their vehicles to get treatment and perhaps this is an opportunity to explore a scope of change that doesn’t require significant changes in our cost as well as our ability to provide these important things. But ultimately I think it is an important conduit for us to make that transition. Canines are law enforcement officials and we should treat them as such because they have become such an integral part of being able to help us stay safe in our
communities. So I appreciate the opportunity to be able to present this Bill and I welcome some conversations, any questions from the Committee. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you, the three of you for your testimony. I think it is very important to take care of our canine companions and officers that put their lives on the line every day and thank you for your service and thank you for your canine service. My question, if this Law was to pass and canines were able to go on the ambulance, would the handle have to go with them or is this something they could transfer on their own?

SGT. ARRIZARI: I would like to say that the handler would want to be with that canine because the canine is gonna be probably be going through some trauma and some shock and he is going to feel most comfortable with the handler itself. So the handler would accompany the dog on the ambulance.

REP. KLARIDES-DITRIA (105TH): And then just another question with either liability of the ambulance or just the training of the paramedics and/or EMS to handle the canine?

SGT. ARRIZARI: I really can’t comment on the liability side of it, all I’m looking for is just that transportation to get us safely to a vet hospital.

REP. KLARIDES-DITRIA (105TH): Okay, thanks.
REP. KUPCHICK (132ND): Just a follow up to that, other states do this now, there is I think five states. There is no state that does dual so there is no one state that allows transport and treatment but I think we could work with the Department of Public Health on some compromise cause they’re talking about different levels of certification for EMTs and that potentially not all EMTs are allowed to provide intravenous which I think is something I think we can discuss cause it’s the same as a human and I think anyone does need that level of care, if you potentially need intravenous treatment in an ambulance on the way to either a veterinarian or a hospital I am assuming most EMTs would have someone at least on the ambulance that can perform that. So that is some of the things that the Department of Public Health Commissioner is talking about but I was hoping we could at least work with the Commissioner on some language that would at least allow the transport.

REP. KLARIDES-DITRIA (105TH): Do you know how many states offer transfer only right now?

REP. KUPCHICK (132ND): I believe its five.

REP. KLARIDES-DITRIA (105TH): Anybody near us?

REP. KUPCHICK (132ND): I’ll check into that and I can get back to you.

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

SENATOR HWANG (28TH): And ultimately I think its important to include the EMS in this dialogue as a significant shareholder in this conversation but I think the key is really this is a common-sense
approach to insure the law enforcement officials are protected, K9 or human.

SENATOR ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): So, I did read several of the other state’s laws, I think New York was one. So this is also a priority list human to dog, I think this needs to be written into any law that goes forward cause we could obviously tie-up an ambulance in a critical situation. There need to be some kind of protocol for them to follow. So that’s written in just about all the other bills and some of the basic first aid was also a training issue that I think that can be overcome also for the most part especially when it’s tourniquet, just keeping, you know, the dog comfortable and safe for the transportation. So I think a little more conversation hopefully we could add to those states. Thank you.

SENATOR ABRAMS (13TH): Representative Genga.

REP. GENGA (10TH): Thank you for your testimony and you make an excellent point here about canines. March 13th is Canine Veterans’ Day. It will be celebrated and this will be the second celebration since Governor Malloy allowed this celebration. The military at one time thought about canines as just property and didn’t treat them proper like Vietnam, you know, hundreds of dogs were left there. But now they’re considered as part of the military and I think you’re asking for the same thing. But because of a situation that’s happened in my town you’re not saying the paramedics cannot administer to the canines are you? Does the law prohibit that?
SENATOR HWANG (28TH): I think at current, it is not within their scope of duties nor is it within their scope right now to even transport the said animal and I think that is an important part as the testimony provided by the officer here. He literally had to put himself at risk to insure that his partner, you know, you talk to officer that have a canine partner, these are partners in law enforcement and when the good Representative mentioned would you go in the car, you sensed there was no hesitation what so ever. You’re there for your partner, you depend and you trust for your partner to protect you and that’s what we’re talking about here is that during the course of law enforcement should a canine get injured they should be afforded all the resources to insure that they are safe because they are doing it in the conduct of public safety.

REP. GENGIA (10TH): I agree but I was trying to ask you because we had a situation is East Hartford. We have canines and a canine was sent in after a criminal, knifed the canine and the paramedics did provide service. I don’t know how it was transported. I doubt that it was transported by an ambulance it was probably transported by the police because they are going to follow what their best instincts are just like you did. There is no question about these kinds. I just wanted to get to the law and do we need, not only to transport because you say that is definitely not allowed, but the administration because there is no question the dogs are a part of the police force. I was out with the police and I saw ‘em in action dealing with criminals and it’s pretty reassuring.
SENATOR HWANG (28TH): I think if you talk to law enforcement and you talk to EMS and all our terrific first responders their first instinct is to appreciate that they come to the aid of any of their fellow first responders. And I think in the case you saw right then and there they weren’t waiting for legislation they were doing what was right but we raised the concern if it is not codified in legislation it opens up a liability as well as a scope of duty and we want to respect that and I will left Office Arrizari speak because the relationship is dynamic that he has with Jake. It is very special and it is important for us to understand that we have to make the pivot. Canine is a law enforcement official doin the job to protect the men and women of our Committee.

REP. GENGA (10TH): I agree with you, no question about it.

SGT. ARRIZARI: Jake lives with me, so 24/7 we’re together. We work anywhere from eight to sixteen hours a day together. He depends solely on me for feeding and training and so forth so he has become a part of my life that I’m not willing to live without. So absolutely we are dedicated to providing as much care as we can to our canine and it this Bill passed can help further that or create that conversation to move forward then I would appreciate it.

REP. GENGA (10TH): Yeah, I agree with you. Thank you.

SENATOR ABRAMS (13TH): Representative Comey.

REP. COMEY (102ND): Thank you. So you mentioned in the legislation it says that you wanted to be able
to carry and administer opioid antagonist. Is there any other medication that would be helpful in, you know, that would be something that you would want to administer?

SGT. ARRIZARI: Right, I believe what Representative Kupchick was talking about was the Narcan and being administered to the canine by EMS. Us as canine officers, as I said before, we all carry Narcan on us and we would, in a heartbeat, administer that same Narcan to the dog as we would to a human being and to try to save his life. As far as any other treatment, I think just basic first aid and in my personal experience, just bandaging and tourniquets is what I needed at that time. If there was something as tragic as a dog being stabbed, then anything that would help just treat and prevent any further damage until we could get that dog to a hospital would be quite beneficial. But outside of that I don’t see anything else.

REP. COMEY (102ND): Thank you.

SENATOR HWANG (28TH): If I may add, it is important to get that scope of change because I can share a little brief story at the indulgence of the Chair. It was four and a half-years ago that the opioid epidemic and the use of Narcan was brought to the forefront and at that moment four and a half-years ago only paramedics could carry Narcan and in working with them, the Commissioner of Public Health, I explored the fact that it’d be important to allow all of our first responders that are first at the scene from police, to fire to be able to carry as part of the repertoire of tools to lifesaving and not wait for a paramedic that could only carry it and what we did was in working through
Public Health, through the various governing boards and training we were able to get within six months a change of scope that allowed for first responders to now carry Narcan. What has resulted in that is the fact that many, many lives are saved from their ability to carry Narcan so I think it’s not just simply law making but also to perhaps reevaluate a change of scope in duties that would allow us to protect and save our canine law officers.

REP. COMEY (102ND): Thank you Senator, I was just actually going to ask you. I mean I’d love to know how you did that with the Department of Public Health because there are other Scope of Practice issues as far as lifesaving medications that would be great for police officers to carry and for other emergency responders to be able to carry such as epinephrine so I would be interested in talking with you about how you did that. Thank you.

SENATOR HWANG (28TH): Absolutely and it was a great credit to the Commissioner of Public Health at that moment but also the first responders that offer insight in the practicalities of implementing the change of scope we talked about and we had paramedics offer support because ultimately we were all at the same common goal and that was to save lives. So absolutely I would be happy to share that with you and again I would ask for your support of this Bill as we move it along because again I sound like a broken record but I believe our canine law enforcement staff deserves every bit of support that we would give to humans as well and I know there has been some controversies related to that, but if you understood the scope and the important work that they do, and you would never question it. So thank you.
SENATOR ABRAMS (13TH): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you for the second time Madam Chair. I just want to let you know I ended up, I did just speak to two of my EMS paramedics in my town and they both send the balloons of course, they would be supporting this and then I contacted our K9 office and he said the same thing, this is something that needs, they need to go through and are very supportive and hopefully it will pass. So thank you again for everything.

REP. KUPCHICK (132ND): And that you for checking into that. I think that we just need to work with the Committee the Department of Public Health and try to come up with some plan to get this moving.

SENATOR ABRAMS (13TH): Representative McCarty.

REP. MCCARTY (38TH): Very briefly, welcome it’s good to see you here today at Public Health and thank all the canine officers and the dogs that do this tremendous work that we really need to have done, but mine is how many of the dogs really would perhaps, when they’re out searching, how many are exposed and the overdose frequency, it there a high frequency with the canine?

SGT. ARRIZARI: I wouldn’t say there is a high frequency. I would say but the threat is there so what I’m looking to do is just more of a preventative approach and trying to have that option there so if one of our dogs did ingest some sort of narcotic or did receive some sort of injury we can get that treatment as soon as possible. As far as numbers are concerned, I am only able to determine how many canines are killed in the line-of-duty and
I know it ranges anywhere from 20 to 40 for the past three years and that is all different types of injuries that caused those deaths.

REP. MC CARTY (38TH): And I ask the question only to look at the logistics. If we’re looking for the transportation I think the previous question is how frequent, would there be enough ambulances for all of those kinds and so some more thought but looking at the Scope of Practice is a good beginning there so thank you very much for being here today.

SENATOR ABRAMS (13TH): Thank you very much and again I would like to thank you for your service and for your care of these canine servants for public servants and also for being willing to work with us on this Bill. So I appreciate it. Julianna Jolly. Welcome.

JULIANNA JOLLY: Hello. Good afternoon members of the Public Health Committee. Thank you for the opportunity to speak today. My name is Julianna Jolly and I am an eight grader in Richfield, Connecticut and I am here to oppose the Senate Bills 94 and 858. The thought that any child would really like want to go into any store and really get a vaccine that like their parent doesn’t know about or just anything like that is kinda insane to me because, me, I would not like to go to any place and get a vaccine without my mom being there with me or at least my mom not even knowing about it. And I don’t really think any parent would want their child to go get a vaccine that they don’t know about. God forbid anything happens or goes wrong. And just a few months ago I was supposed to go on a school fieldtrip but they wouldn’t allow me to go because I didn’t have the proper medical forms and I have an
allergy that requires me to carry an EpiPen even though my mother has submitted documentation from the doctors about this allergy they did not take it. We live in a world where kids should feel open to going to their parents about all of this stuff and feeling safe but since the government is telling us to go behind their backs just to get something that they don’t even know about.

So the forms that my mother gave to both the high school and the middle school were not even taken in to anything and were not even considered to the potential liability and somehow it’s okay to provide medical treatment that carries extreme risks such as disability and death. I don’t understand and it doesn’t make any sense to me. So in conclusion, both of these Bills are dangerous and I ask to please not like move them out of this Committee.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Are there any questions or comments? Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Thank you for coming today. It is always nice to hear from younger people, we always hear from our moms and dads and it’s nice to hear from your point of view and I appreciate that. I hope that my daughter will keep the open communication that you have with your mom. But thank you for coming today, I know it takes a lot of courage to come up here to do that so thank you.

SENATOR ABRAMS (13TH): Thank you, anything else. Thank you very much for being here.

JULIANNA JOLLY: Thank you, have a nice day.

REP. GILCHREST (18TH): Good afternoon, Senator Abrams and Members of the Public Health Committee. Thanks for having me this morning. I am State Representative Jillian Gilchrest and I am happy to turn it over to Rebecca Ruitto who is a West Hartford resident, Licensed Marriage and Family Therapist as well as the Chair of the Connecticut Association of Marriage and Family Therapy.

REBECCA RUITTO: Good afternoon Chairwoman Abrams and Honorable Members of the Public Health Committee. Thank you for allowing me to speak today and thank you Representative Gilchrest for your support. My name is Rebecca Ruitto and I work and reside in West Hartford, Connecticut and I am also the Chair of the Association for Marriage and Family Therapy in Connecticut. I am here in support of HB-7132. I have been practicing for approximately 6 years with children and families in both outpatient and school-based settings.

Currently Connecticut has four MFT Graduate Programs producing 100 to 120 new professionals yearly. Of those few of these students can have a big impact for our citizens struggling with mental health issues. MFT training is unique in that it is 100 percent clinical. Before an MFT can become licensed they must graduate from an accredited MFT Program, pass the professional exam, complete 1,000 practice hours serving clients and obtain 100 hours of supervision. These clinical hours are required to be face-to-face and this process took me about two years to complete.
In response to BPH testimony they indicated that supervision would be difficult that providing a supervisor first is still just to keep those MFTs in training on the right path and to account for their process status. The current gap in licensure often leaves a graduate unable to apply for open positions posing employment and financial difficulties for new professionals, poor continuity of care for clients. Despite their clinical knowledge and capabilities MFTs in training do not meet requirements for many posted open positions due to not having a tiered license.

Throughout my clinical experience I found a clear need for additional mental health professionals in Connecticut. Clients either struggle to be seen as often as needed or I have had to place someone on a wait list even after they’ve already contacted other multiple providers unable to accept them.

There are 28 other states who have implemented a tiered licensing structure for MFTs and this has been identified by the America Association for Marriage and Family Therapy (AAMFT) as a best practice across the country. Connecticut has continued to be ahead of most states in identifying and implementing best practices in the MFT field. An associate license for MFTs in Connecticut will allow Connecticut to remain a state that other states strive to emulate.

HB 7132 will remove barriers for MFTs working towards licensure including the number of mental health professionals living, working and treating patients in Connecticut as well as providing accountability for MFTs and ensure that their
requirements for licensure are completed in a timely manner.

Thank you for your time and your consideration. I can discuss questions.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments? Thank you very much for being here today. Rico Dence. I apologize if I’m not saying your last name correctly. Rico? Okay, okay.

RICO DENCE: My name is Rico Dence and it is great to see some of you again. I used to work as an Assistant Clerk here at the Capital and I actually ran for office. In 2014 I was diagnosed with chronic myeloid leukemia so it made me aware of other people dealing with cancer. When I was in sophomore year in high school a friend of mine named John Collier passed away from leukemia and a Youth Pastor at that same time, Mike Reed he told me how he received a bone marrow transplant.

I am testifying in favor of Bill 5547 and Representative Ritter had introduced. I asked him to introduce the Legislation. I have been traveling the U.S. for the past two and one-half years living out of the car. I don’t even have a home right now. I am purposely doing this and making an awareness for this Legislation and I am working on a couple other Legislations.

Why this is needed, only two percent. I forgot to go back. Youth Pastor Mike Reed, in 1976 he received a bone marrow transplant and had been able to live until last year. So for 42 years he had life because someone had donated a bone marrow transplant. Paul, the Clerk of the Veterans’ Committee he has actually
donated twice so you guys could even learn about the procedure a little bit more from Paul. I actually found out yesterday when I was in Starbucks. I happened to see him and we talked and he’s like, “That’s cool.” Why this is needed only two percent of Americans are registered bone marrow donors and less than half, I’m sorry. Less than two percent of Americans are registered bone marrow donors, at any give time 7,500 people are looking for a bone marrow transplant and less than half ever find a match. People with leukemia, lymphoma, aplastic anemia can benefit from this, Sickle cell disease and other rare blood diseases.

It is interesting when I was in Idaho just two weeks ago, when Senator Lee Hyde went to introduce the legislation and was looking for the drafter, the drafter was actually outside and she saw it and said this Bill is needed because my daughter might need a bone marrow transplant. A week later it passed out of Committee and passed on the Senate floor unanimously. There is not fiscal cost to this. There is no cost to the doctor. No cost to the potential donor. I do recommend a little change on the title just to make it a requirement versus recommendation just so that the Medical Association doesn’t backlash and say no, we don’t want this. So any questions?

SENATOR ABRAMS (13TH): thank you very much for your testimony and I hope you’re well. Are there any questions or comments? Thank you very much.

RICO DENCE: Does everyone know what a bone marrow, how the bone marrow transplant works?

SENATOR ABRAMS (13TH): Yep, I believe so.
RICO DENCE: I hope you would cosponsor it, the legislation, all of you. [Laughter] And just on a side note about the HPV vaccination.

SENATOR ABRAMS (13TH): I have to stop you there, I’m sorry cause your time is up. Thank you so much.

RICO DENCE: Thirty-five percent of [Cross talking]. So thank you.

SENATOR ABRAMS (13TH): Thank you so much. Is Senator Fasano here? Okay then we’ll move along. Elaine Nord. Welcome.

ELAINE NORD: Am I on? Hello, my name is Elaine Nord. I’m from Westport, Connecticut. I did submit some written testimony which is in the record. In the interest of time, I am going to summarize some of my remarks.

This Bill, Number 6522, is about the value of early detection. Put simply, teach the symptoms, improve the screening. I have some of the classic symptoms of Neuroendocrine tumors and my colonoscopy done years before by diagnosis, if they had had this proposed change, my tumor would have been detected much sooner. Instead I was diagnosed with Stage IV Endocrine cancer in 2012, much too late. After years of feeling really crummy with the basic classic symptoms of facial flushing, acid reflux and much difficulty swallowing at times and many tests with no results. A simple ultrasound located my tumors in the small intestine near the ileum and on my liver.

The proposed better screening would have detected that tumor much earlier. Teach the symptoms and improve the screening. With experts in Neuroendocrine tumors at Memorial Sloan Kettering in
New York City, I endured multiple surgeries for the past seven years with most procedures aimed at controlling the tumors in my liver. This disease is incurable. Because it took so long to figure out I have chronic cancer. I am the face of a Chronic Cancer Survivor.

Let’s talk about what my life is like and what the cost of chronic cancer is to our community. I worry all of the time. I worry about the spread of my disease. I worry about my tests. I worry about planning appointments around my life. I worry about planning my life around bathroom trips and I worry about my family and friends worrying about me. Let’s talk about the cost every year. I get a monthly injection to control the serotonin that comes from my tumors and can damage my heart and caused diabetes. That injection costs $10,000 dollars a month. Multiple that times 12, it’s pretty easy, $120,000 dollars a year. Add in six-month CT scans and lots of blood work and that adds up to another $20,000 dollars or a total of $140,000 dollars just for maintenance for me to survive. This is ordinary cost, add any liver embolization or any other procedures and the price goes up a lot. I figure I’m up over $1 million dollars so far and that doesn’t include any of the old diagnostic tests including that colonoscopy that didn’t find my tumor. Teach the symptoms and improve the screening. In a world of high health care costs, earlier detection of Neuroendocrine tumors would save heartache and dollars.

Don’t get me wrong, I’m happy to be alive and I live each day as if its my last. I’m thankful for the support of my family and friends who have lifted me up continuously and I am grateful for the experts
who treat me. I am in control of my life again because of those around me. Please pass this Bill. Teach the symptoms to the medical community and improve the screening. It could have helped me and may help you. Thank you very much for your time.

SENATOR ABRAMS (13TH): Thank you so much for being here today. I really appreciate it that you would take the time to try to make things better for others. Any questions or comments? Thank you very much.

ELAINE NORD: Thank you.

SENATOR ABRAMS (13TH): Mariead Painter. Resign your name, I think,

MARIEAD PANITER: Good afternoon Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. My name is Mariead Painter and I am a State Long-Term Care Ombudsman. I am here to testify before you today on Proposed Bill 375 AN ACT CONCERNING NURSING HOME STAFFING LEVELS. The Ombudsman Program is in support of resident and involved parties having accurate information regarding staffing patterns in all nursing homes.

I wanted to take this opportunity to let you know that there is currently staffing pattern availability through CMS. In late 2017, CMS began to collect the data and then began reporting on it in 2018. This reporting is a public use file on the CMS website. In my written testimony I included the website. It is called the PBJ, the Payroll-Based Journal staffing data system. And through this, this is a system in which each nursing home must submit their staffing by payroll. It has been broken down by the type of staff that is in the
building at that time, on that date so that you can
distinguish whether the nurse was an administrative
nurse, or an on the floor nurse and it does go all
the way down to the CNAs. It is not instantaneous,
you can get it on a quarterly basis. We’ve talked
to CMS about it but you can go back and look by date
and request that information. If there is an
accident or an incident and you’re looking to see
how many staff were in the building on a certain
date, that is accessible at this time. These
categories are broken down by facility and every
facility in Connecticut is listed by the quarter. So
I just wanted to make sure you have that
information, that it is accessible to you and I am
available for questions. Do you have any?

SENATOR ABRAMS (13TH): Thank you very much.
Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman and
thank you for all that you do in your commitment to
insuring that people that are in homes have the
right amount of care and are advocated
appropriately. As you’re talking about this, for
the sake of this conversation, Registry or
information that we have on staffing levels, how
often is that reviewed by the Department of Public
Health at a random basis or is it only reviewed if
there is an issue that arises?

MARIEAD PANITER: They would have access to this
just like anyone else. I am not sure how often they
look at it. I know that they look at it on surveys,
so there is a licensure survey when they are in the
building and they look at staffing on the survey.
The Department of Public Health can probably give
you that information on how often they look at the
PBJ and what relationship they do that.

REP. COOK (65TH): And is there any possibility that
information is not 100 percent accurate and
subjective by the people that are inputting the
information?

MARIEAD PANITER: It’s their payment record. So it
is by which staff members have been paid on what
date to do what job. So it would be difficult unless
they were paying someone and they weren’t really
there and that is the reason they went that method.
I would say if anything it is underreporting how
many hours at this point. There are some buildings
if you look to this first quarter that it was
reported it looks like there wasn’t staff in the
building and I think CMS was having some difficulty
in pulling that data initially and they did report
that but they are saying that now they are in the
fourth quarter of reporting and that the data is
more reliable, it is more up-to-date so anything it
would show less numbers potentially than more.

REP. COOK (65TH): Thank you. Thank you, Madam
Chairman.

SENATOR ABRAMS (13TH): Any other questions?
Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. So how
many sources do you think there are in terms of this
information that the facilities themselves clearly
have the data, the Department of Health has it, CMS
for Medicare/Medicaid track it as well, is there
anybody else that tracks the data?

MARIEAD PANITER: Not to my knowledge. We refer to
the CMS data. We are able, if we are in a building,
able to look at the daily reported data that the nursing home provides but then we would refer to if there was an accident or incident and we were looking at a specific date we would refer back to this data.

REP. PETIT (22ND): And I assume unfortunately the one piece of information you don’t have is the level of the acuity so staffing may see a spike for a couple of weeks if the acuity goes up on a unit or a facility and then fall way off so there could be wide swings. Is there anyway to, other than talking to the facility themselves to know what the acuity was based on what the staffing was?

MARIEAD PANITER: Well this staffing when they are looking at the percentage and the ratio, so its done by a ratio and how it’s calculated. It’s tied to the minimum data set and the MVS is done quarterly or on change of condition on admission and then that is compared to the reported number of staff by position in the building and that is how they come up with the percentages so that really is just a relationship of person-to-person but it doesn’t account for acuity and we’re always very concerned about individual acuity and acuity on a certain unit or in a certain building related to the number of individuals providing care that it needs that individual acuity.

REP. PETIT (22ND): And this Bill, as far as you know, would apply to all skilled nursing facilities having people from all the way from long-term stable chronic care to people who are acute right out of the hospital to people who are acute rehab after a knee or hip going out in a week or two, there is no differentiation between the type of patient they’re
dealing with, they’re saying nursing homes in general as opposed to dividing them up into different tracks of data?

MARIEAD PANITER: The way I read the Bill, the way it’s written is to require adequate reporting. So what is adequate reporting? Is it on the number, is it according to acuity? The reporting criteria in Connecticut is by hours per day to residents which we would love to have that increased as well but this only reports that and we want to make sure that you knew there was a mechanism through the Federal Government already to do that.

REP. PETIT (22ND): So maybe I should turn that around. So what would you recommend that if the Bill goes forward that it account for that would make sense? What would be the most useful dataset for you to look at in terms of numbers, acuity, etc.?

MARIEAD PANITER: We really promote person center planning so that an individual is assessed. We look at their individualized need and then the building staff to that individual’s need. It is hard to say it would be a fluid number. There are several Bills regarding staffing so it is a very important issue. It has come up a lot this session and we want to make sure that for us, yes, we are trying to increase the minimum numbers in a nursing home at any given time, however beyond that we feel it is really important that the acuity is looked at through the minimum dataset, through the personal care conference where you’re looking at what an individual feels their needs are and their wants and that they’re staffing to those, also for the reduction of falls and other incidents.
SENATOR ABRAMS (13TH): Any other questions? Representative McCarty?

REP. MC CARTY (38TH): Thank you, Madam Chair. Good afternoon, good to see you Mariead. So I am just trying to understand this a little better. Say a resident or a family member wanted to check the actual staffing levels at a nursing home could they actually access this information?

MARIEAD PANITER: Yes, it became public about a year ago and I've included the site. People are welcome to go on to either Medicare Compare or Nursing Home Compare or to this site and look it up. It does breakdown by state and then by nursing home. Again I would caution if you see a zero there are actually staff in buildings, some of the buildings in the first couple of quarters had trouble reporting and pulling it in but it is getting more accurate as it moves forward.

REP. MC CARTY (38TH): So how would they actually build that, they would have to type in what PBJ or would they go to the Medicare site or how -- what would they?

MARIEAD PANITER: You could go to the CMS site. There is the data.cms.gov site or you can Google the payroll-based journal and the link to the site comes up.

REP. MC CARTY (38TH): So there were a couple of avenues they could use. Thank you very much.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you for being here today. Appreciate your testimony. Greta Stifel.
GRETA STIFEL: Excuse me, I just have to setup a few things it can eat into my time. This is for visual impact. Thank you Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. My name is Greta Stifel and I am here to talk about Public Health Bill No. 6522 continuing medical education requirements for physicians for gastrointestinal, certain rare cancers, inflammatory breast disease and a few other things. You have the Bill and you have my testimony.

I am going to try to condense this as much as I can because I have a lot to get out here. This is the second time I am up at bat with this Bill. Speaker of the House Aresimowicz is my constituent and he actually has supported this Bill last year and he has done it again and I was hoping he was going to be here to sit next to me, but apparently he can’t be. In here, in front of you are close to 3,000 pages of my medical records. These are just some of my pills I have to take everyday for the rest of my life because I have a rare neuroendocrine cancer called carcinoid cancer. However it is not that rare. It hides. It gestates for a period of five to ten years and by the time it is found by doctors it’s metastasized to other organs and is full-blown Stage IV. My friend Elaine who testified prior is one of the patients.

I am a patient advocate known throughout the country for this cancer, neuroendocrine cancers, but am also a very outspoken advocate for the rare disease community as well because as a biproduct of my cancer I got two rare disease with it. The Public Health Bill that I have before you is to create an awareness platform for the medical community at
large so that they are informed, aware and educated with continuing medical education requirements every two years for rare cancers including neuroendocrine cancers, neuroendocrine tumors, gastrointestinal cancers, gastric and colon cancer and by the way neuroendocrine cancer is a scary cancer because kids can get it, adults, older people anybody. It hides anywhere it wants to go it will go, eyes, ears, your mouth. Usually it goes to the GI tract where about 70 percent of all tumors are found. But this is a very scary cancer. More and more people are getting it and in another two to three years this will not be a rare cancer it will be a mainstream one.

I have gone through, and this is my important takeaway, because of a medical professional, a top gastroenterologist in the Hartford Health Care System misdiagnosed me for a number of years and then when I demanded a colonoscopy she missed my tumor. It was sitting right there. Four months later I bowel obstructed and blew-up and cancer was everywhere and now I have the worst quality of life. There is no cure for this cancer. There is no remission for it and it is a huge, huge cost. Cancer is expensive but rare cancer is even more expensive. I am appalled and the lack of education and awareness for not only this cancer but other ones and the amount of people that get misdiagnosed not only with my cancer but with others is astronomical. It is 90 percent of cases are misdiagnosed. So this is why I brought this Public Health Bill to the forefront. It is Preventative Medicine 101. It is a no-brainer. It has to be passed because this is a wake-up call not only to the medical community at large but affiliations and so on and so forth. This is a cost to the State of Connecticut because I will
tell you what, $1.8 million dollars is what my insurance has been billed to-date in three years.

SENATOR ABRAMS (13TH): I’m sorry, I’m going to have to cut you off there. Are there any questions or comments? Thank you so much for being here and I hope that you are well.

GRETA STIFEL: I’m not going to be well that’s the point. This could have been avoided. This could have been avoided by having the doctors be educated and armed with the information that they need and that’s why the CME is required. It’s a no-brainer. No cost. This is expensive to the State because were Medicaid bound. I mean that’s what will happen. This one box of pills $16,000 dollars a month. Insurance doesn’t cover it. It’s Afinitor. It’s a biosimilar.

SENATOR ABRAMS (13TH): In any case, thank you. Representative McCarty.

REP. MC CARTY (38TH): Thank you Madam Chair. I just want to take the opportunity to thank you and I see you went to a lot of effort to come up here and testify so you believe in this. What are you actually looking, it’s my understanding and I could be wrong but you’re looking for continuing medical education and training of doctors so they could look to these rare type of cancers in screening and is that possible?

GRETA STIFEL: Yes it is. Better screenings and being aware of the uncommon is very important because what they train them in medical school is to look for the common but you need to have the ability to take the blinders off and think beyond the common because it could be uncommon and there are more
uncommon diseases, rare diseases and rare cancers that are coming out and, you know, it’s a huge burden for the State of Connecticut because most of the rare disease community and rare cancer patients go bankrupt. They can’t afford it. It’s insane and they go on Medicaid so, you know, do you want that to happen? I don’t think so that’s why this Bill is Preventative Medicine 101. It’s going to the core. It’s a critical mass awareness educational platform. It’s simple, its every two years. There is not a big cost to the State to even push this through the CME, it’s something that’s needed. I have medical testimony that they received through electronic means and hundreds of patients that supplied testimony. I live and breathe this cancer. I have had, and I’m just going to tell you this straight up. I have had seven major surgeries, 479 blood vials drawn from me in less than three years. I have been in the hospital 9 times in a month and a half at Yale from GI obstructions because the cancer kept on coming back. I go through literal hell. I am living hell. And you know what, I don’t want anybody to suffer. I want to save lives. This is to save lives. It is to extend peoples lives, it is to increase the quality of life. The quality of life sucks as a cancer patient, it really truly does but on a rare cancer patient’s level another dynamic because we don’t have specialists that treat this cancer by the way in Connecticut. Yale is now just starting. I just started on a major radiotherapy program and Dr. Saltz is there from Connecticut Medical Health, who couldn’t come today but, you know they have this radiotherapy that just got approved about six months ago. The point is and this is the takeaway, this is a huge amount of pain and suffering that at patient goes through when it
didn’t have to be that way. My doctor was a top gastroenterologist. She missed it and I had all these symptoms. I had the fog, she missed it and she just discounted it. Oh, you’re going through menopause, you have cecum thickening, you have diverticulitis, you have ulcerative colitis, you have this. All this was commonplace diagnoses. She didn’t think, hello, it could be neuroendocrine cancer. And let me tell you something neuroendocrine cancer, you don’t want this cancer. It’s hideous, it goes everywhere. It doesn’t stop. It’s gonna take my life and I implore you to pass this bill because it will save lives. It will give a better quality of life. If caught early people can live with this cancer for 10, 20, 30 years. I’m not gonna be so lucky. So I urge you to pass this Bill, it is needed. It’s time. I the patient, as a patient advocate I’m known throughout the country now. I have a big voice. I just testified for Rosa Deloria on Friday on biosimilars. That drug I just pulled out of that bag, $16,000 dollars which is Afinitor that is a biosimilar and the NAFTA treaty is trying to, you know, get that where the drug companies like Novartis can have 10-15 years as a lock-on, well you know what that’s going to do to me, [Laughs] and a lot of other patients, it’s just unfair and one thing, this is my last time that I am going to physically get up to pound the pavement for this Bill because I am not going to make it. I’m getting sicker [Crying], I cannot have anymore surgeries, they are going to put feeding tubs into me next, half my body has been altered and taken from me, my insides. I live and breathe a horrible life and I don’t want anybody to live one-tenth of what I’ve gone through. I have gone through 106 body scans, 106 in three years. That insane. I
have, I am hooked up to radiotherapy where they blast me with radiation and it gets me so sick you have no idea what the side-effects are but they’re horrible. I almost passed out here waiting since ten o’clock this morning and I’m glad that I was called but I hope that I made an impact for the Public Health Committee to get this Bill passed, please. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Appreciate your advocacy. Senator Looney.

SENATOR LOONEY (11TH): Good afternoon, Senator Abrams and Representative Steinberg, Senator Somers, Representative Petit and members of the Public Health Committee. I am Martin Looney, State Senator from the 11th District representing parts of New Haven, Hamden and North Haven and thank you for the opportunity to testify today on Senate Bill 375, AN ACT CONCERNING NURSING HOME STAFFING LEVELS. The Senate Democratic Caucus proposed this concept as part of our 2019 agenda and I am very pleased that the Committee is hearing this important legislation.

The Bill would require that nursing homes disclose the actual number of direct care staff providing care to residents, and make this information accessible to patient families, in an accurate and understandable manner.

Currently, the Centers for Medicare & Medicaid Services require the posting of staffing levels on its Nursing Home Compare Website. However, consumers are often unaware that this website exists, and those who do can find it difficult to navigate. Furthermore, the data featured on the website can include nurses performing administrative functions and not direct patient care. Data on the ratio of
actual direct care workers to residents is not readily available and I think an important point was raised earlier by Representative Petit is his questioning about adequate reporting also needs to document levels of acuity at different times in different facilities to make sure the comparisons are in fact accurate.

The other issue, of course, regarding the direct patient care is that in many facilities there are nurses who are in administrative positions very often RNs are doing administrative work not often in direct patient contact while LPNs and CNAs are doing most of the direct patient care but often in some of the statistics the RNs are counted in the direct care count even though they are not in fact providing direct hands-on care to patients so it would give, I think, a misleading impression about the number of staff who are involved in direct care unless those numbers are carefully separated.

The bill would make staffing levels obvious for any consumer who enters a facility. Such information is critical to consumers in being able to appropriately evaluate a nursing home and the care that can be expected to be given to a grandparent or spouse who maybe frail and needing that care. There is a growing body of evidence that demonstrates a link between adequate nurse staffing and better patient outcomes. When nursing homes are short of staff, nurses and aides scramble to deliver meals, ferry bedbound residents to the bathroom and answer calls for pain medication. Essential medical tasks such as repositioning a patient to avert bedsores can be overlooked when workers are overburdened, sometimes leading to avoidable hospitalizations if preventive care were taken.
Only accurate, transparent reporting of actual direct care nurse staff levels can assure residents that their vulnerable family members are receiving the appropriate amount of care. Patients should not have to experience a negative outcome for their family to realize they are being inadequately cared for. For instance one of the things that is done routinely in Massachusetts as a best practice, I’m not sure to the extent it is done here, is that patient care staff lists on a board, on a message board, chalkboard, in the room, the other room numbers that that caregiver is attending to at that time on that shift so family members will know where to look for the caregiver who is supposed to be providing care in that room in case something arises while the family member is there and it also makes it easier for them to keep in touch with that caregiver who may be actually be providing services in several other rooms at the same time and at least this way the family member will get acclimated to the facility and know, well maybe that person is not here in the room right now but should I need one, I can find her in rooms 10, 11 or 12. So there are lots of things that could be done to provide greater accountability to families in their efforts to consciously have a degree of oversight on the facilities where their loved ones are being kept in frail health.

Thank you to the Members of this Committee for raising this important Bill and again my commendations to this Committee for all the valuable work in the public interest that you’ve done over the years.

SENATOR ABRAMS (13TH): Thank you, Senator Looney. Are there any questions or comments?
REP. ARNONE (58TH): Just one comment, so my own personal experience with nursing homes is there is a hardworking group and they are always spread thin and it surprises me that there is no accounting at this time. So, you know, I really think this is, I have constituents that call all the time, you know, how do we know what kind of care we can chose. We have a nursing home in my town also and people are concerned about what the ratios are and they can’t find that information so I think this is a great idea.

SENATOR LOONEY (11TH): Thank you, Representative. Also another issue that comes up sometimes is that we hear anecdotal evidence from families that staffing levels are uneven throughout the week. Sometimes there is a shortage of staff on weekends and the staff on weekends are spread more thinly that staff during the week so it’s more difficult sometimes to schedule staff to be there on weekends. But the patient’s needs are the same whether it is a Saturday or Tuesday and so that also I think needs to be monitored.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Representative Betts.

REP. BETTS (78TH): Thank you and thank you very much Senator Looney for this. I’ve certainly visited relatives where this has occurred as well. But one of the thoughts that came across my mind when we did come across nursing shortage or staff shortages really was a budget issue. Would you concur with that and if you do, what role do your think the State can do to alleviate that problem?

SENATOR LOONEY (11TH): Well I think that’s why I support and to mandate reasonable staffing levels
and obviously facilities can try to make their facility more profitable if they try to get by on staffing that doesn’t meet minimal standards but my concern is that we have a baseline that every facility is supposed to meet seven days a week rather than having those spikes at different times as Representative Petit mentioned earlier. I think the accounting and the oversight and the adequate reporting also needs to document the levels of acuity as well.

REP. BETTS (78TH): So, and I agree with you. We are all in agreement with that. I’m still a little unclear if, I’m not sure that all nursing homes fall under the category of necessarily making a profit but, you know, if you owned a nursing home or were managing it are budgets not an issue for a lot of these places, is that a factor in terms of how many people they can?

SENATOR LOONEY (11TH): I don’t think so. I don’t think you could use budget as an excuse for lack of adequate care.

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

SENATOR ABRAMS (13TH): Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Thank you, Senator. I believe that you and I have a couple of similar pieces of Legislation out there this year and the one you were just speaking of was exactly that, the staffing Bill which is heard in another Committee so that would help Representative Betts questions in regards to that. But I do want to just touch base on something that you said earlier and it was something I was trying to get to on a prior question that I had about qualification
of the data. And I think that you said it very well about which staffing member was doing which job and what category they fall under, under how you report. Could you go a little bit further into that by any chance if you have any more information?

SENATOR LOONEY (11TH): Yes, we have some information has been cited, reported to us that there are times when administrative personnel who are in fact nurses, get added into the category of staff on duty providing care when they are not, in fact, actually providing care, direct patient care at the time. They are on duty at the time, supervising caregivers but they are not themselves providing care but by adding those numbers in, it may appear that the staff to patient ratio is better than it actually is.

REP. COOK (65TH): Thank you for that clarification. Thank you, Madam Chairman.

SENATOR ABRAMS (13TH): Any other questions or comments? Representative Klarides-Ditria.

REP. Klarides-DITRIA (105TH): Thank you, Madam Chair. Thank you, Senator Looney for your testimony. Just to clarify, this Bill 375 that’s just to do adequate reporting, correct?

SENATOR LOONEY (11TH): Yes, just require adequate reporting of the number of nursing home staff and making sure that the reporting is detailed enough to provide the vital information that’s needed.

REP. Klarides-DITRIA (105TH): Okay and it’s another Bill that Representative Cook mentioned is for mandating the correct amount of personnel, the appropriate amount of personnel?
SENATOR LOONEY (11TH): I’m not sure, I believe that what the Representative’s Bill has.

REP. Klarides-Ditria (105TH): Right, thank you very much.

SENATOR LOONEY (11TH): I would support her Bill as well.

REP. Klarides-Ditria (105TH): Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you, Senator Looney. Lauralyn Lewis. Welcome.

LAURALYN LEWIS: Good afternoon, Senator Abrams and all Members of the Public Health Committee. It’s a little bit of an irony following Senator Looney that I find myself sitting in this chair because the Bill before you, I’m in support of 367, you’ve got my testimony. Those of you that were here last year passed it out of Committee and we greatly appreciate it. This is a much-needed taskforce Bill that is going to look at two segments of the ID population, those with complex behavioral issues and those that are aging with more complex issues such as Alzheimer’s.

I’m sorry, my son just left. I would have liked to have had him here cause I walked into the room today and I heard somebody talking about cancer. My son has Down’s syndrome. He is 27 years old and he is a cancer survivor. And the Down’s population has a greater propensity for Alzheimer’s. His grandmother currently has Alzheimer’s and we have no plan in Connecticut for this population and it is desperately needed. We need to have the conversation. I don’t need to convince you,
obviously you were all onboard with it last year so I am asking you once again, come through for us and please pass it out of Committee. We greatly appreciate it. Thank you.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Are there any questions or comments? Thank you for being here. Representative Rojas.

REP. ROJAS (9TH): Thank you, Madam Chair. I am going to reserve my time for Mr. Morales Sanchez to provide you testimony but here in support of HB-6540 AN ACT CONCERNING THE PREVENTION OF HIV and will turn it over to Mr. Morales Sanchez.

JESUS MORALES SANCHEZ: All right, good morning. Well good afternoon at this point. I thank you very much. Well I am here in support and I have provided written testimony so I’m just gonna emphasize some of my remarks. I am here to provide testimony in support of the ACT CONCERNING THE PREVENTION OF HIV. I’m an advocate usually for immigrant rights and human rights. So we have an organization called Unidad Latina en Acción but I’m also a community member and I’m a really proud gay man who is taking preexposure prophylaxis also known as PrEP everyday as a preventative measure to minimize the risk of HIV infection.

I’m not gonna bore you, you have a more detailed story of my fears of growing up. I do want to emphasize that it was not an easy experience. I came to the United States 2010, barely knowing English. I had to adapt to a new culture. In the middle of all of that I had to struggle with my own sexual identity which made me really vulnerable to people that in retrospect abused and took advantage of my vulnerability. During that time of my life I did
engage in sexual relationships with men without the adequate protection.

I can only consider myself fortunate to know that out of those encounters nothing bad happened to me as now I realize how much risk I put, not only myself but also future sexual partners. As to this preventative treatment, it can save lives. All this vulnerability, all these people taking advantage of me as a teenager could have really affected my life. Had I been with the wrong partner I would not be right now, or I would be here in a completely capacity. And it’s not like I could like access to have access to all these different preventative measures. First of all back then it was not available really was not yet available to the public and had it been I did not count with the support of my family and my parents. I grew up in a Catholic Mexican household, very conservative. Sex is still a taboo topic, it is not something that is discussed very freely. When I came out it became a very toxic unsafe environment so now I really couldn’t go to my parents and say, hey I want to engage into sexual activity and be protected, be responsible about it. And I wasn’t. Again it is only because of God or because of some luck, some divine gesture that I am here as a healthy young man advocating for you throughout the State to be able to access the adequate treatment to prevent them from a lifechanging event.

I am right now, as of a couple of months ago, I was diagnosed with type I diabetes. It is a chronic disease that will require me to be on insulin and other treatment for the rest of my life. I see in the diabetic community a lot of people complaining and honestly heartbroken because they cannot access
the adequate medication. They know that it is something that are going to need for life and every so often I do see in the news people who have passed away because they couldn’t access insulin. They start rationing it and eventually they go into diabetic ketoacidosis because of their lack of ability to obtain that treatment. We live in a society unfortunately where access to medication especially for chronic illness is not easily available. What makes this thing that a teenager would be able to access treatment when they cannot even access the preventing measure. Why should we wait until they need the treatment when we can prevent it? We know that in recent years the communities that are mostly impacted are men, especially queer men, LGBTQ men from black and brown communities. Preexposure prophylaxis has around 92 percent success rate and it can be a safety net. It can be something, it’s also something that can be used along with all other prevention methods to just insure that the life of a child, the life of a youth, of a young person or the life of anyone who is especially vulnerable the same way that I was when I was 16 is not changed forever in a negative manner.

So, I am asking you, I am urging you to really come through with this proposal. Allow teenagers to be prescribed preexposure prophylaxis as it can be a safety net, it change the lives of so many people that are already at risk and if we save one life because of this, if we are able to get one youth the treatment or the prevention that is needed to protect them from a lifelong sentence, but it is no longer that sentence but still a burden as cost for treatment is still very costly. It will be a
success, it will be worth it. So, thank you very much. As I said the rest of my testimony is written so thank you very much.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Are there any questions or comments from the Committee? Yes, Representative.

REP. ARNONE (58TH): Yeah, I have a comment. You spoke about the abuse, the toxic atmosphere cultural religious part growing up and having to deal with this and coming out. We heard a lot of testimony today about parenting and not everybody is always open parent and can accept these and this is what worries me the most with your case. Its suicide rates that come out of this because of the embarrassment and the problem with school and peers and if could just speak a little more on that to us what your life is life as a youth trying not to come out for fear of abuse, for fear of retribution. Thank you.

JESUS MORALES SANCHEZ: Yes, of course. Like I said my household is very Catholic, very culturally speaking it is very close minded to sexuality. Coming out was something that I fought every single step of the way. I was conflicted from a very early age. I tried to repress it, I tried to deny it for a very longtime. Ultimately and in two will actually be the sixth-year anniversary of me coming out, it was done in the most chaotic scenario that one can imagine. It was in the middle of an argument, it started basically the break-up of my family. Immediately after I came out I was cut-off financially. I was verbally abused. In the later months my relationship with my father specifically deteriorated. At one point he and I starting an
argument that escalated into physical violence. I ended up running away from my house without shoes, with a bloody shirt. Somehow I had managed to keep my phone in my pocket and I was able to call one of my best friends from high school and asked him to pick me up a few blocks away from there and asking him if I could crash at this place for the night because I was so unsafe. This talks to a much larger issue that we are not going to be fixing today or this year or probably within my lifetime which is the acceptance of the LGBQT community in our society. We know that there is a lot of issues. These issues have followed me through my adulthood. I managed to get into college. I was a chemical engineering major. During that time I was still in conflict with my family. My father ended up cutting off economically my mom and my brother as well at that time. Left me spiraling out of control and ended up falling into a really great depression. I became suicidal and made me drop out of college.

So yep, if, I don’t know if that answers your question but there are a lot of really abusive households. There is a great deal of lack of support and that just leads to how people like me and youth like me end up becoming vulnerable and throughout all these years obviously I was vulnerable and I made myself vulnerable and I fell for a lot of people that took advantage of that who for one moment made me feel like I was special, like I was someone worth, you know, that life was worth living and ultimately ended up being just something. Ended up turning into a situation that could have put me at much greater risk. Whether it was simply engaging in unhealthy habits, you know, started abusing alcohol or, you know, having unprotected sexual
intercourse. It all could have ended my life. Fortunately as of now things are a little bit better. My family, what’s left of my family which is my mom and my brother, we are dealing with the situation. We are able to survive and go on and I was able to like find a good support group with my community the same community with which I do advocacy for the immigrant community with which I try to do advocacy for youth and for queer community but it took a lot of time and I know that a lot of people are as lucky as I am. A lot of people have that same support system and in the same way you heard before me a classmate of mine, someone that I know from my early days in high school and his sister so we know that not everyone is as lucky as I am and I don’t think this should be something to be left up to luck this should be something that, you know, protects youth everywhere without relying on that fortune, on that divine intervention per se.

SENATOR ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Thank you and thank you for sharing your personal story and I can only imagine in listening in how really hard that had to have gone through and the breakup of the family and I am sure there are a lot of other unintended consequences to that. But you’ve been here, I think, for awhile and you’ve heard as we know there are usually two sides to a story. You’ve heard the sides you heard earlier on about the parent. I wonder if you could imagine yourself being married and maybe adopting kids, now you’ve become a parent, become a lot more protective. You know you’re really vested in your kids and you’re very protective. Do you think you would feel the same way if you were in that circumstance now, would you feel the same way
if you were told that your kids could receive medical treatment without your knowledge or approval would that bother your or would that -- how would you feel if circumstance were like that for somebody who you loved and felt responsible for?

JESUS MORALES SANCHEZ: With all due respect, I think that feelings trump safety and survival and we’re talking about. I understand the frustration that some parents might feel or even will go through if their kids cannot trust them for something this big. But let’s take into consideration that this is not necessarily something that will effect kids that have that support system at home. This is something that will impact greatly those that do not have that support system, that don’t have those relationships with their parents and while I can see that being disheartening or slightly uncomfortable or quite uncomfortable for parents to think that their kids can access medical treatment without their consent I believe that the wellbeing of the children, the youth and the people that will have to go through this will have to endure the consequences of their actions for the rest of their lives should take priority. We’re talkin about youth, we’re talking about kids that can easily find themselves in a situation where not only is there immediate safety at risk but their health for the rest of their lives and if it takes taking a visit to a doctor and requesting access to a pill that may be the safety net that will protect them from a lifelong chronic illness, a very costly chronic illness, that still may be a death sentence if they don’t have all the adequate resources for the rest of their life I think that takes a lot of priority and I guess I cannot, it’s unfair to me to really give testimony
answers how would a parent feel because, again that is not my field of expertise. I’m not a parent so far and so I can only imagine that but I think that from I can only speak from the perspective of a kid which is I want to make sure that kids can do the responsible thing, look after their health and understand that actions have consequences and that there is support and that there is access to -- for them to do the right thing and the responsible thing which is try to protect themselves in which ever way they are capable of and the State should support that.

REP. BETTS (78TH): Thank you, appreciate that. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you, are there any other questions or comments? Thank you very much for your testimony.

JESUS MORALES SANCHEZ: All right, thank you very much.

SENATOR ABRAMS (13TH): Dawn, I think its. Dawn I can’t read this name, will somebody? [Off mike voice]. Thank you, I could not read your handwriting, appreciate it.

DAWN ODOUR: Thank you, Madam Chair. Good afternoon Honorable Member of the Public Health Committee. My name is Dawn Odour and I live in East Haven with my 26, soon to be 26-year-old some who has intellectual disability and several other diagnoses. He is severely, severely, profoundly intellectually disabled. He has Cerebral Palsy, Spina Bifida, a neurogenic bladder, neurogenic bowel. I cath him every four hours. He lives at home. I also do cecostomy irrigation in order to flush his colon
every evening and I am here to talk to you about Senate Bill 372.

I’ve submitted written testimony and I have also submitted an addendum that I want to, where I want to summarize what I am talking about here.

I adopted my son when he was five weeks of age from Kenya, East Africa where I was service as a missionary. My son is now 26 years old. He is a quadriplegic. Like I said he lives at home. We have some in-home support from DDS. I am his guardian. I am his only parent and my family has not been very accepting of him so there is no backup plan if you will. He has been placed in four different group homes, two were private, two were public. In each case he was injured. His left femur was broken in two places. He had doctor’s orders for clean, intermittent catherization every four hours in another group home, they waited 48 hours allowing urine to backflow into his ureters and into his kidneys and he had a hydronephrosis. Poor management of infection also caused him an E.coli infection for four months while actually on an antibiotic. How that happened, I don’t know but each time I had to bring him home. I’ve been employed, I have had to leave work. We live on Social Security and my monthly income is $1600 dollars a month.

SENATOR ABRAMS (13TH): I’m sorry, ma’am that was the time, can you sum up for us please?

DAWN ODOUR: Therefore I am requesting that you seriously consider supporting Senate Bill 372 which is akin to the Connecticut Home Care Plan for the Elderly which pays children of elderly parents a stipend that is tax-free to care for their elderly
family member in their home. I appreciate your attention. I welcome your questions.

SENATOR ABRAMS (13TH): Are there any questions or comments? Thank you for your testimony.

SAWN ODOUR: You’re quite welcome, Madam Chair.


BELA BARROS: Good afternoon Mr. Chairman, Senator Abrams and Members of the Committee. My name is Bella Barrows and I reside in the town of Orange. I am the parent of a child with an intellectual disability, an intractable epilepsy. I am here today to testify in support of Bill also number 372 AN ACT CONCERNING THE PROVISION OF RESOURCES TO GUARDIANS OF ADULT CHILDREN WITH INTELLECTUAL DISABILITY.

My son Alex is 12 years old and has a very severe form of epilepsy that resembles Lenox Gestaut Syndrome. The syndrome is resistant to existing seizure medicines. He has an average of ABOUT 10-15 drop seizures day. This makes it very difficult to function and attend school on a regular basis. The seizure drops have caused many injuries and require continues supervision for safety.

The constant seizures have also provoked behavioral challenges and other medical complexities. We spend countless weeks admitted to hospitals out of state during the year to resolve appalling side effects from new medications and trial therapies. I am extremely concerned over his deteriorating health and the lack of supports I am receiving from the school system and other agencies.
All of his needs have demanded that I permanently resign from my position as a special education teacher and become his primary care giver. Additionally, I am also caring for my 80-year-old parents who reside with me and for whom I have been unsuccessful in obtaining supports from the Connecticut Adult Family Caregiver Program that has stopped new applicants at the moment.

As you can see, the challenges my family and I are facing are extreme and I am here today to speak for my son and other children with disabilities and medical complexities. These children need extensive care provided by their parents and guardians.

While I recognize that in its present form, this bill does not address children under 18, I feel it is imperative that this legislative body understand the financial burden of families like my own that are unemployed due to their child’s medical instability and that this burden is not isolated to the 18 and over age group. I would encourage this committee to expand this bill to include the age group under 18 that have intellectual disabilities and extensive medical complexities.

I thank you very much and I encourage you to support this legislation.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from the Committee? Thank you very much for your testimony.

BELLA BARROS: Thank you for your time.

SENATOR ABRAMS (13TH): Sabina Wozniak.
SABINA WOZNIAK: Hi, I’m Sabina Wozniak and I will be reading, sorry, [crying] my mom’s testimony. So like I said it’s my mom’s.

I am the mother of three children, all who were born happy and healthy. I am here today to testify on behalf of my youngest child, Adam, who is currently 25 years old. He was born a happy and healthy baby, in the 95th percentile. At his two-month check-up, doctors described him to be progressing as if he was already six to seven months old; needless to say, he was a remarkable baby who was advancing so quickly. I wonder if I could attribute this to the love of his two older siblings that they showed him and their constant interest in him, helping him grow and develop and continue to do so.

On September 25th, one day shy of turning three months old, a regular day for us as a family, we decided to take a walk in our neighborhood. It was myself and my three children; Adam was in a baby stroller, while my husband was outside fixing the car. We made it three houses down from ours to stop to talk to a neighbor, where my two oldest children played on the lawn with the dog and I stayed next to the curb behind the baby stroller. As a car passed us, I thought nothing of it except that had I been still walking with my children, we all would have been hit. What happened next changed our lives forever. The man driving the car circled back around the block and drove directly into Adam and myself.

When his vehicle struck the baby stroller head on, Adam was thrown from his baby stroller and the side rear view mirror broke off on my hip, causing me to spin and lose consciousness for a brief period of
time. By an act of God, having been thrown from the baby stroller played a part in saving Adam’s life because had he been strapped in completely, he would have been run over and killed. Adam and I were both transported to the local hospital, from where he was then LifeStarred to Hartford Hospital. He was in the NICU for 19 days, where he was induced into a medical coma for some of those days due to brain swelling. He remained in the hospital for 3 months, during which doctors performed brain surgery and continued to monitor Adam. When he was transitioned from the NICU to intensive care unit, doctors described him as a miracle because rarely has any one has survived this type of accident, let alone an infant.

Not only did this accident affect myself and Adam physically, it has had a psychological impact on all of our family, as my two oldest children (ages 4 and 7) witnessed this event no more than 3 feet away. Adam today is 25 years old, with the functioning of barely a six-month old infant. He cannot walk, talk, see, or care for himself in any capacity and has severe seizures. We do everything for him. He is paralyzed on his left side, which has stunted his growth on his left arm and leg. But he continues to amaze us at what progress he has been able to make. We love him and cherish every moment we have with him. His smile can put a smile on any one’s face. If I continue for another moment?

SENATOR ABRAMS (13TH): Yes, but I do need you to sum-up if you would please?

SABINA WOZNIAK: Absolutely. So due to the accident I was unable to work due to my own injuries and the intensive care needed for Adam. I did not work for
six months and when I had to return to work, I had to go from full-time to part-time which included a significant pay-cut to minimum wage. I chose to do this because I needed to be available for the care for Adam and my family.

Had something like SB-372 been available to my family, I would have been able to utilize this service and provide basic needs to my family. During these times, a family should not have to focus on meeting basic needs, but rather focusing on the recuperation of all family members to process the trauma. I did the best I could as a mother who experienced this life trauma and continue to do the best I can.

Adam lives at home full time with myself, my husband, and my oldest son, where he continues to thrive and live a happy lifestyle. This Bill would benefit our family beyond belief along with the additional assistances that the State currently provides.

SENATOR ABRAMS (13TH): Thank you very much. Thank you for being here with your mom and I’m sorry for what you went through. Are there any questions or comments from the Committee? Representative McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair and thank you very for your testimony, I’m so sorry. But I think the trouble and I’m trying to understand the Bill in front of us, it is my understanding and we heard from the DDS Commissioner that if this were to, and I think it’s worthwhile, we have to work on it, but there might be something with the Bill that would not allow the Medicaid, under the Medicaid waiver if you’re a legally liable person for the
individual so I think there are things that we have to look at. But I certainly understand all the work that you do and just want you to know that we are very appreciative.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you so much for your time today. Walt Golamb, I can’t read the writing, I’m sorry. Is Walt here? No, okay. Richard Rothstein.

RICHARD ROTHSTEIN: I promise to [Indiscernible-04:18:11].

SENATOR ABRAMS (13TH): Well thank you for saying that so people know it’s the handwriting and not me although it really is both. Excuse me, Sir would you please turn on your microphone? Thank you.

RICHARD ROTHSTEIN: Okay, My name is Richard Rothstein. I am speaking on behalf of CT-DDS Families First with regard to SB-393 AN ACT CONCERNING THE DEPARTMENT OF SUPPLEMENTAL SERVICES’ LEVEL OF NEED ASSESSMENT.

The level of need assessment is, consists really of two parts. One is an extensive questionnaire that spells out in various parts of an individual’s life, safety, medical, behavior, etc. and then it is processed to an algorithm to come up with a score. We have heard over the years many issues, personally myself with my son who is 36 years-old and with others and we think there are number of things that need to be addressed by the department and in order to improve we are suggesting that something be done in terms of legislation. Currently individuals are not well-informed about what the law even means. They are not given guidance on how to fill out the
questionnaire, it always should be filled out as part of a team with the case manager, the providers and any specialists that are involved in the person’s case. We know that this doesn’t always happen and steps should be taken to improve the training of case manager and provide more consistency and written directions for families before answering these questions.

The LON is currently filled out in paper form and then the DDS case manager takes it back to the office and then inputs it even though it’s a web-based model. We think that consideration should be given to completing it in the field. That would be consistent with Governor Lamont’s IT [Inaudible-04:20:52]. The version of LON now being used is Version 1.1 and shows a date of 07/08. This and other information that we are aware of suggests that this was the date of the latest revision and it was only revised the one time since it was put into place in the mid 2000’s.

SENATOR ABRAMS (13TH): I am going to have to ask you to wrap-up if you would.

RICHARD ROTHSTEIN: Okay, we would like to see revisions of the LON instrument and in the procedures so that the world out there changes medically, behaviorally and technologically that the LON can become more meaningful and give a more consistent result for families.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from the Committee? Thank you very much, sir. Claudia Gruss. Welcome.

DR. CLAUDIA GRUSS: Thank you. Senator Abrams, members of the Public Health Committee I am Dr.
Claudia Gruss. I’m President of the Connecticut State Medical Society. On behalf of the physicians and physicians in training please accept this testimony in support of Senate Bill 96 AN ACT ESTABLISHING A WORKING GROUP TO ENHANCE PHYSICIAN RECRUITMENT IN THE STATE. And we certainly appreciate that the acknowledgement with this proposed Bill of the difficulties we face in recruiting and retaining physicians in Connecticut.

We have provided in our written testimony data that shows the economic impact that demonstrates that physician have outsized impact on the state economy. Just briefly including 50,000 direct jobs are supported by physicians and more than twice that when you add in indirect jobs and it is actually approximately 9.4 percent of the Gross State Product is directly related to physicians.

Yet while physicians are significant contributors to economic activity we face some worrisome statistics. Nearly 1/3 of Connecticut physicians are 60 years old or older and as one of those physicians I hear more of my colleagues considering retirement. We talk about nationwide, projections are for shortage of 90,000 physicians by the 2025 and we will need to compete for those doctors to keep them and bring them into this state rather than going elsewhere. And it’s a lovely State, but we have to make it conducive for doctors to stay here and come here.

Only about 1,892, 15 percent of physicians in Connecticut are under 40 years-old. And Connecticut is well below the median by state when it comes to physicians who graduate from medical schools, staying in the state and also more telling to me is we’re well-below the state median of physicians.
retained after they do their Graduate Medical Education in the state. Only 35 percent which is a rank of about 45th when you go state-by-state comparisons.

There was an article where this can make a difference in the quality of care of our patients. Actually a study just came out last week that was published in JAMA for people who are interested showed an association in a primary care physician supply with population mortality in the United States and it showed that the greater the primary care physician supply in a given area was associated with lower mortality of the patients that they cared for.

So we know there are difficulties in recruiting and retaining people in the state. It’s not due to just one specific factor but obviously this task force can go along way in helping determine what we can do to keep and bring physicians into the state and I mentioned a number of things and I’ll wrap up, but a number of things are in our written testimony that we think are problematic or can be improved in retaining physicians and encouraging them to come to the State including things like loan forgiveness programs but I’ll let you take a look and read that yourselves.

SENATOR LESSER (9TH): Thank you Doctor for your testimony. My question was sorta going to be along those lines are there specific steps that other states have taken that you think would be likely to be recommend by this task force?

DR. CLAUDIA GRUSS: Well, there are a number of states that I outlined. I mean one thing is incentives on physicians because if they start
working in the state they are going to stay here and I looked into the, how much it costs to go to medical school over the weekend and it was frightening. I mean true, for UConn its about the tuition alone is about $34,000 dollars a year but for people who are out-of-state it was $67,000 dollars a year and at Yale it was $57,000 dollars a year and again this is just tuition costs. So if we can work for their loan forgives programs and other programs that have been worked in other states that we could bring to Connecticut which I think would be a big thing. We have a medical liability issues that Connecticut is not conducive to encouraging people to stay in the state and unfortunately they need to be addressed, it is a lot less expensive for a doctor to go to Texas, if you like Texas. Also Certificate of Need issues limit what physicians can do in their offices compared to if they went to another state that is another problem. Also there are taxes. I know that we are talking a lot about taxes these days but there are provider taxes and taxes on ambulatory services in areas where actually it’s cheaper to provide medical care, less expensive, but they are being taxed as opposed to going to a more expensive facility.

So I think establishing a work group would be very helpful in determining that. And the other issue that really ties into this, really is issues in regard to physician employment contracts which is Senate Bill 377 which also has an impact that I would be happy to just make a couple of comments on if there is time.

SENATOR LESSER (9TH): Any questions from the Committee? Yes, Representative Petit.
REP. PETIT (22ND): Thank you, Mr. Chair. I wonder if Dr. Gruss could comment further on their Certificate of Need. Does CSMS feel that CON issues are inhibiting physicians from coming to Connecticut to practice?

DR. CLAUDIA GRUSS: Yeah, I think that they are and I think that we think that they are. There are certain situations where certainly hospitals do supply certain services at an increased cost where physicians can supply those services at a lesser cost in their offices but certain issues such as procedures, surgical centers, imaging issues in regards to limited CT scans and MRIs preclude those physician offices from providing those services.

REP. PETIT (22ND): I’m wondering if you would be able to comment on who you think determines the makeup of the task force, who would be most valuable in terms of recruiting folks.

DR. CLAUDIA GRUSS: Well I think it needs to be a wide group of people. I think certainly we have to include primary care physicians on the task force. We have to include young physicians on the task force, but also subspecialists. I mean we have a chance of -- we have to be able to retain our subspecialists as well so we’re talking also privately practice physicians who are in private practice as well as employed physicians because each of those groups have very different needs in regards to who should be, what Connecticut can do to retain those people. We also should include Fellows, and medical students and residents on that Committee, at least representation for them because they are the ones who are making the decision as to whether they
REP. PETIT (22ND): I agree completely with that last bit and finally, final question, you mentioned a little bit employment contracts. Do you think folks are sometimes when it gets down to one or two choices they’re making a decision based on the current statues in terms of noncompete clauses in this State or do you think that is not related to people making a decision whether they practice here or not?

DR. CLAUDIA GRUSS: Yeah and also it is not a matter of whether the practice comes to this state but also whether they stay in the state. Obviously there has been a big scene change in the way that medicine is delivered in this state. I mean for 30 years, three decades I was self-employed as part of either with a very small group of physicians or a partner in a larger group. I am now an employed physician of a hospital system in the past five years myself I had to change in order to survive, in order to stay in the state. But there are issues involved with that because there are large health care systems, when I receive a contract it’s basically a take-it or leave-it contract. I think that Senate Bill, the public act that was passed, Public Act 1695 that limited noncompete convivence to certain areas were a great step but I can tell you that it is not the whole picture and that I think it should be strengthened because I just lost a colleague, a gastroenterologist who had been in the Norwalk Community for again, approximately 25 years who has now left. He is in his early 60s but he has left to go to Florida and it was a tremendous loss to the community but he felt under the circumstances that
he could not stay especially due to the change in his contract and his noncompete clause. I think that unfortunately we have a very uneven playing field when it comes to physicians, especially employed physicians of large groups where they’re given contracts and I know that the Public Act 1695 did say that if the employer makes a bonified offer to renew the contract on the same or similar terms and conditions then the noncompete covenant remains in effect. But who interprets same or similar terms and conditions and I think that the physician, that the wording needs to be strengthened at a minimum in that if there are, if contracts are offered that do not have similar terms and conditions then the physician should have more flexibility to be able to stay in the community and continue to provide care to the patients that he really cares about. Right now that would have to be litigated in court and that could be a long, drawn-out process that physicians probably just leave the community. So I think there is real problems with Public Act 1695 in the way that things have changed in the community. I understand large employers, small employers they have put in a significant investment into bringing physicians and keeping physicians in the state but I think that the physicians also need certain protections as well.

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

SENATOR LESSER (9TH): Thank you, Representative. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair and Representative Petit asked my question about who would sit on the task force. I hear all the time what you’re saying about people leaving and hard to
do business here in our State and I think it’s not just physicians I think it is across the board in a lot of industries. I will say we used to have a Representative that a count of all the task force and it was like 15,500 and something and I have worked on putting task force together for very important issues and what I find when we put these, if they ever get put together, these task forces that we take what they have to say and try to make it better and I find that’s a struggle here so I would encourage that if this Bill moves along that we get very specific. That the people whoever we can get assigned and get them working because we’ve had to in other Committees that I’ve sat on, put together task force and had to change their deadline year, after year, after year because people weren’t assigned to the task force, they couldn’t get started until everybody was on the task force so I would just encourage if this moves forward that we put something in there to say if two people are assigned get em movin and get em going with their suggestions. That’s all.

DR. CLAUDIA GRUSS: That’s a great suggestion.

SENATOR LESSER (9TH): Thank you, Representative. Any other questions or comments from the Committee. If not, thank you for your testimony. Next up we have Dr. Scott Walters.

DR. SCOTT WALTERS: Good afternoon to Members of the Public Health Committee. Thank you for the opportunity to speak this afternoon and thank you to our prior speaker from CSMS who I think provided some really, a lot of the data that I was gonna provide in terms of the statistics on physicians in
I just wanted to offer my perspective. My name is Scott Walters, I am a Board Certified ophthalmologist and retina specialist. I practice in Hartford, Farmington and Cromwell, Connecticut. I am a relative newcomer to the state. I started practice here about 14 months ago after 15-1/2 years of training all over the country, Stanford, UPenn, Duke, the Bascom Palmer Eye Institute in Miami, and I really I landed an awesome job here. I’m very happy to be practicing in this State. I was joined by two other exceptional ophthalmologists who came to practice in Central Connecticut at the same time as me after graduating Fellowship. I’ve gone on to build a busy clinical practice. I’ve taken on over 1,000 new patients. I’ve performed over 400 retinal surgeries last year. I became a Board member of the Connecticut Society of Eye Physicians, a volunteer faculty member at UConn, an investor and a medical advisory board member in a surgery center, a leadership role in the Department of Ophthalmology at Hartford Hospital so if business is booming and the opportunities are here for may career advancement why is it that I’m only one of the three who is still left in Connecticut practicing ophthalmology?

You know, two of these excellent ophthalmologists left the state and I would love to find out why. I had dinner with one of them a couple of weeks ago and kind of picked his brain on this and I think that we need to be a little bit more systematic and figure out what it is about the practice environment here that is such a deterrent to young physicians who chose to come here and maybe a deterrent to ones
who never even consider coming here despite the abundance of opportunities with our retiring, you know, 30 percent of the physician workforce over age 60. My practice is dominated by, you know, were seven physicians, I’m in my 30s, one in their 40s, one in their 50’s and the remained over 60 including three over 65. So, you know, we’re gonna face a crisis if we can’t recruit people to come here and all the guys over 65 are buying homes in Florida and getting ready to do six months and one day down there.

So that’s all I have to say but I think the task force is a great idea and I hope you’ll support it.

SENATOR LESSER (9TH): Don’t go anywhere. Thank you, Doctor for your testimony. It hits a little close to home because one of my best friends from high school, the ophthalmology, I’ve been trying to get him to come to Connecticut and trying to figure out why he won’t come. Why did you come?

DR. SCOTT WALTERS: Well I just found a great group here and, you know, I wanted to work hard. I wanted to build a practice quickly and I think in some ways the lack of young people in this practice environment, you know, makes it attractive to people like myself who want to build their practice quickly and get very busy. You know sometimes that’s not possible in every specialty and not possible in every practice environment. So that was a real, you know, draw for me, but you know, I think there are deterrents certainly the tax environment is hard for people with high student debt and other factors that were elaborated on by the prior speaker.

SENATOR LESSER (9TH): But that wasn’t a deterrent for you because you found a practice?
DR. SCOTT WALTERS: Yeah, I mean I’m in a fortunate situation. My parents paid my way through medical school. I did not carry debt. I assumed debt for my husband and thankfully I’m able to pay that off for him, but you know, it’s a tough job market and I know that he couldn’t have refinanced his loans with his income in this state and so a lot of people are struggling, you know, to pay off their loans and they really consider carefully where they can afford to live.

SENATOR LESSER (9TH): Thank you. Questions from members of the Committee? Representative Petit.

REP. PETIT (22ND): Sort of following up on Senator Lessor’s question, so if you didn’t find a group that had a great group of practitioners that were going to afford this huge job opportunity, so you mentioned taxes and loan repayment would Certificate of Need, noncompete contracts, some of the other issues impact your other issues where other states were more attractive in that regard?

DR. SCOTT WALTERS: Well I think so and particularly for the two folks who left another group in the area. I think both of them were dissatisfied with some of the group dynamics but had, you know, wide noncompete clauses that would have precluded them from seeking employment, you know, elsewhere or have to pay hefty penalties in order to stay in the state and continue practicing and continue seeing, you know, the patients that they had developed relationships with while they were here. So I think that, you know, that certainly both of them left the state. One of them went to Atlanta and I’m not sure where the other one is in practice now but I think
that the noncompete kind of force a lot of young physicians to just cast a much broader net.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the Committee? Just out of curiosity did you look at Texas as a place that you were looking to practice?

DR. SCOTT WALTERS: I did look at an offer in Austin, Texas. Personally, you know, the politics of Texas did not appeal to me more broadly but certainly there were some practices all over the country.

SENATOR LESSER (9TH): Texas has done a lot in the area of liability reform, is that something that was attractive to you as you were considering offers?

DR. SCOTT WALTERS: Yeah, I think that’s a great point. Certainly the medical malpractice liability, you know, the insurance is more expensive here in the State of Connecticut and we have an aggressive, you know, malpractice lobby which I think has tried to find ways of attaching to doctors personal assets which really makes, you know, more challenging for us to build a livelihood here.

SENATOR LESSER (9TH): Thank you for your testimony today. I believe moving on to House Bill 7133 unless Dr. Walter, are you coming back to testify on another Bill, is that your intention?

DR. SCOTT WALTERS: Hello again, well I won’t reintroduce myself [Laughter]. So I am here on behalf of Professional Colleagues in ophthalmology as well as dermatology, urology and ENT and we are a large group of over 1,000 physicians. We see over a million patient visits per year in the State of Connecticut and we are in strong support of Senate Bill 377 AN ACT PROHIBITING THE USE OF NONCOMPETE
CLAUSES IN PHYSICIAN EMPLOYMENT CONTRACTS. So you guys know what noncompetes are. I won’t go into that. But I would like to outline two reasons why we, a diverse group of physicians feel that you our Legislators should prohibit the use of physician noncompete clauses in our state.

So as always I think the first and most important reason is to do what’s best for our patients. The doctor-patient relationship is at the heart of medicine and when a patient and a physician come together to address a medical problem that therapeutic alliance should continue how so ever long it takes to care for the patient. And I think we can all agree that a patient shouldn’t be restricted from choosing a physician simply because the physician changes their employment. So likewise, a physician who leaves a practice where he or she has cultivated these relationships with their patients should be entitled to continue the care of those patients in the future, without restrictions on depending who their employer is.

So the other point is that Connecticut as we were talking about earlier currently faces this problem attracting new physicians and we think that this is one of the, the noncompetes are one of the factors that maybe leading some physicians to not come here in the first place or to leave and, you know, if you look across the board, more than half of new physicians who enter the workforce will change jobs within the first year or two of practice. So that is a lot of people who are affected by these noncompetes and certainly could be a factor in terms of why many of them don’t end up staying here long-term.
So other issues are, you know, there is a lot of growing dissatisfaction with hospital and managed care organized based employment. A lot of young physicians take these contracts and realize that within a year or so that it is just not the right practice environment for them and they want to go to a private practice group and may be precluded from doing so because the hospitals have these very restrictive covenants that they can’t really negotiate when they are straight out of training and they are accepting a boilerplate contract that’s the same for every employee in the organization.

So, in summary, I think noncompete clause is hurting not only physicians who are trying to practice here but also conflict with patient choice in terms of doctor-patient relationships and continuity of patient care. I’ll end my testimony there.

SENATOR LESSER (9TH): Thank you, Doctor. Questions from the Committee? If not, thank you for your testimony. We will be moving on to House Bill 7133. First up is Joelen Gates, followed by Kala Goldfarb. Good afternoon.

JOELEN GATES: Good afternoon. Good afternoon Members of the Public Health Committee. My name is Joelen Gates and I am an attorney for Connecticut Legal Services, in Willimantic. CLS helps low-income households by providing legal advice and services in civil legal matters. We support Raised Bill No. 7133 as a means of protecting the health of Connecticut children, including the children of low-income households, against the permanent and unnecessary human and economic damage caused by childhood lead poisoning. Based on data from 2016, the Department of Public Health identified 2,000 children in
Connecticut who had lead poisoning, a completely preventable disease.

This Bill calls for intervention to identify and eliminate sources of lead poisoning at a blood lead level of 5 micrograms per deciliter, down from the 20 micrograms per deciliter requirement in current law (or two tests, within three months, of 15 micrograms per deciliter). From the perspective of a human cost-benefit analysis, it is both possible and necessary to prevent early and ongoing exposure leading to permanent, irreversible damage, than to maintain the status quo of too little too late under current state law.

The Bill would also bring Connecticut into alignment with the other New England States and the Federal Department of Health and Human Services Center for Disease Control, the CDC, which already considers a child poisoned at lower levels than current Connecticut law. Additionally the U.S. Department of HUD implemented a rule in 2017 that requires a housing provider to test the home for lead exposure when a child under age six has an elevated blood level of 5 micrograms per deciliter. I want to add a note her too that the City of New Haven already has lowered, has an ordnance for the city to require intervention at the level of 5 micrograms per deciliter and the City of Bridgeport also has lowered its level to 10 micrograms per deciliter. So already in the State of Connecticut we have areas and agencies that are acknowledging that 5 is the appropriate level at this time.

While lead exposure from peeling and chipping paint in aged housing stock is by no means the only potential exposure of children to lead, low-income
children are particularly vulnerable to lead poisoning in Connecticut because they live in older homes. The housing stock in Connecticut is statistically older than most of the rest of the country with over 70 percent build before 1978, the year that lead paint was removed from the market. In the largest Connecticut cities where many of our low-income children live, over 80 percent of the housing stock was built prior to 1978.

I guess the bottom line here is that this is preventable disease and we have other New England States that have already lowered their blood levels and they think Connecticut should pass this Bill. We urge passage of this Bill to bring us more in line with the other New England States and with the medical background and history on this and so, thank you very much.

SENATOR LESSER (9TH): Thank you very much. Thank you for your testimony. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman. Mrs. Gates you mentioned New Haven and Bridgeport, do you have any feedback yet as to what the impact in New Haven and Bridgeport has been lowering to 5 and 10 respectively in terms of increased costs for their inspectors and testing and the like and positive results on the other side?

JOELEN GATES: I don’t personally have that information however I did want to mention, I guess it was earlier testimony from the Department of Public Health that lowering it down to 5 micrograms per deciliter would increase the number of inspections to 1,200 per year but we don’t think that took into account that New Haven which already has 5 micrograms and Bridgeport at 10 are already
doing that work so we don’t think the numbers that the Department of Public Health gave earlier would be inline with those because those two larger cities are already doing those inspections, but I don’t know the cost at this point for those two cities.

REP. PETIT (22ND): And you don’t know of any positive affects yet is it still too early, these are just changed recently? Cause I don’t think anyone presented it when we discussed the Bill in Connecticut earlier.

JOELEN GATES: I don’t know but I think there maybe testimony later from another person from New Haven that will be able to answer that for you.

SENATOR LESSER (9TH): Thank you, Representative. Other questions from members of the Committee? I have just a quick one. My understanding is that the State of Connecticut currently has a Healthy Homes Initiative that we are funding in collaboration with HUD in 15 communities across the State. Is there any reason you can identify why lead exposure is only a problem in 15 communities or is it a statewide condition?

JOLENE GATES: I have to say, I’m sorry, I have a hearing impairment, I wear hearing aids and I am having trouble understanding your question. I’m sorry.

SENATOR LESSER (9TH): I would be happy to repeat myself. The Healthy Homes Initiative funded by the State and also by the Department of Housing and Urban Development currently I think provides funding to 15 communities to address lead poisoning issues in those communities. Is this a statewide issue or is it contained largely to 15 communities?
JOLENE GATES: I believe it is a statewide issue wherever there is older housing, they just picked those areas as being the towns with the highest maybe numbers of older housing. I know in the town where I work, Windham was just added to that list but whereas the very first town I worked in, North Grosvenor Dale, Connecticut my very first case 34 or 35 years ago was at an apartment house in North Grosvenor Dale where all the children were poisoned by lead so this has been going on for a longtime.

SENATOR LESSER (9TH): Thank you and I share your concerns. Thank you very much. Other questions from members of the Committee? If not, thank you very much for your testimony. Next up we have Kayla Goldfarb followed by Karen Siegel. Kayla is not here. Could we have Karen Siegel?

KAREN SIEGEL: Good afternoon Esteemed Members of the Public Health Committee. My name is Karen Siegel and I am testifying today on behalf of Connecticut Voices for Children, a research-based child advocacy organization working to ensure that all Connecticut children have an equitable opportunity to achieve their full potential.

H.B. 7133 would bring Connecticut in line with surrounding states as you just heard, so we know that this is a feasible proposal. By intervening as soon as lead poisoning is confirmed, the state can ensure that parents who lack the resources to address this exposure are able to do so before additional poisoning occurs or other children are exposed. The results of lead poisoning in youth are permanent and can include learning disabilities, behavioral problems, and even death.
Connecticut’s children continue to face high exposure to lead again as lead paint was outlawed in 1978, but at least 71 percent of Connecticut homes were built before 1980. In 2016, 2,000 children under age 6 had blood lead levels that the CDC considers to be lead poisoning.

Further lead poisoning effects certain communities more than others. In Connecticut black children were twice as likely as white children and Hispanic children were one and a half times as likely as non-Hispanic children to be poisoned in 2016. These disparities are just one legacy of housing discrimination, redlining, and other forms of structural racism that segregated our state’s children and families of color in urban areas with more multi-family and older housing units. It is imperative that we do what we can so the state can mitigate the impact of that injustice.

Connecticut does adhere to the CDC threshold for lead poisoning in its surveillance reports and also uses lead poisoning as an automatic trigger for early intervention and those are both good first steps but unfortunately, that trigger does not occur until a child has tested as having more than five times the threshold for lead poisoning. In the case of early intervention there is a similar threshold for an environmental investigation of the cause of the poisoning. So this means that poisoned children may continue to be exposed to lead even after a blood test shows they have lead poisoning if their families are unable to identify or address the source of that poisoning.

No family should be in the position of knowing their child has lead poisoning and being unable to
stop that exposure and seek early intervention to mitigate its impact. This Bill would ensure that families have access to the support they need to raise their children in a safe home and mitigate the impact of exposure to lead. Thank you.

SENATOR LESSER (9TH): Thank you. Questions, other questions from members of the Committee? If not, thank you very much for coming up this afternoon. Following Karen we will hear from Bill Powers. Bill are you here?

BILL POWERS: Greetings, my name is Bill Powers and I’m from Windham Willimantic, Connecticut. I am here to speak in favor of HB 7133.

One of the initiatives of the Windham Taskforce for the Prevention of Child Abuse and Neglect, a group of volunteers in Eastern Connecticut, is to increase public awareness of problems, issues, concerns, and needs related to lead poisoning. I am here today on their behalf while serving as a member of this group’s leadership team. I have a particular perspective on lead poisoning due my education and experience. My graduate degrees include clinical/community psychology, special education, and health care management - as well as a graduate level certificate in Advanced Clinical Practice with Children and Adolescents. As a certified teacher in Connecticut in the disciplines of health, special education, and social studies and a Licensed Professional Counselor I have personally witnessed cognitive and behavioral difficulties experienced by children with a history of exposure to lead.

Our group is concerned about the increased numbers of children in Windham with blood tests that are positive for lead at levels exceeding 5 micrograms
per deciliter. Also of concern, by the way this is the bad news, also of concern are children testing positive with levels lower than 5 micrograms per deciliter. Tracking mechanisms are inadequate for this group and we need interventions and some interventions are not performed or even required for that group. As a result of research, we now know there is no lead level in the blood that is good for children. Levels below 5 micrograms per deciliter have been shown to be problematic in recent research. This is especially the case for cognitive and behavioral disabilities.

Now prevention is the most cost-effective means for addressing our lead poisoning problems. Lead is a very toxic neurotoxin and for young brains damage can be permanent and it is preventable. So I am hoping when you think about this you’ll consider that kids with levels of 2, 3 and 4 up to 4.9 are also at significant risk for behavioral and cognitive disabilities. The research is out on that now, there is a good deal to support that and that is something that we need to be concerned about for your children. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony and for your patient this afternoon. You’ve done a lot of research on this and obviously you are also attune to the fact that we can move it down to 5 micrograms we will hopefully catch a lot more of this.

BILL POWERS: That’s good news to do that.

REP. STEINBERG (136TH): I’m glad that you agree. Good, thank you very much. Any other questions or comments? If not, that concludes our testimony on 7133. We now move on, you’ve all been waiting.
Senate Bill 94. First up is Sandy Carbanari. Dr. Carbanari.

DR. CARBANARI: Hi, I am Sandra Carbonari, a primary care pediatrician and the Medical Director of the Connecticut Chapter of the American Academy of Pediatrics. I am testifying on behalf of our nearly 1,000 pediatrician members against SB 94.

We do not think it is appropriate for pharmacists to administer flu vaccine to anyone under the age of 18. This season there are 10 different vaccines in 17 different presentations with a variety of age indications, specific precautions and contraindications. There are two different delivery systems, and one is needle (not jet injector) and intranasal, again with different contraindications and precautions. Determining the appropriate vaccine for a pediatric age patient is not simple and requires accurate information about the medical history and the current health. Documentation of the date and type of vaccine and the date must get into the child’s medical record in their Medical Home and that is very important, the Medical Home as you probably know is the linchpin of Connecticut’s State Innovation Model to improve health outcomes while containing costs.

If the goal is to expand access and reduce costs of immunizing children, pharmacies must be required to accept Medicaid patients. The Connecticut Vaccine Program requires that providers of vaccine for children which includes those on HUSKY get the vaccine through the Connecticut Vaccine Program. These must be kept separately from purchased vaccine and there is extensive regulations and record keeping that is required. As pediatricians can
attest, this program has actually increased our cost of immunizing children. We are concerned that this increased cost would lead to flu vaccine being available only to non-Medicaid adolescents who self-pay or are covered by commercial insurance. Also, it is not clear that the DPH vaccine program, with its current staffing, could handle a large increase in the number of providers in the CVP Program.

Often it is the need for a vaccine that gets parents to seek medical care. Children with asthma are a priority to get the vaccine. Getting it outside the medical home misses an important chance to assess their asthma control and update the individualized treatment plan. The great advantage to adolescents getting flu vaccine in the medical home is the opportunity to engage them in preventive, well care. In this age group, there are other vaccines that they should be getting. We do assessment of their physical health along with mental health and oral health and many other kinds of things that we do for kids. A pharmacist would accomplish none of this during vaccination. Also kids faint after they get their flu vaccine.

REP. STEINBERG (136TH): You don’t have to be a kid to faint after you get a shot. [Laughter] You raise some very good points. Let’s start with the general issue of access to the vaccine. You’ve already seen the trend obviously where we’ve had from year-to-year some challenges making sure there is adequate vaccine available and could you comment a little further about the experience you’d have in the pediatric practice for having sufficient access and why you believe expanding the pharmacists ability to administer the vaccine would cause problems there?
DR. CARBANARI: Well there are two different streams of vaccine to the pediatric practice. One is for all kids under five and then the other stream is either if you’re in the Vaccine for Children Program or not. So there generally hasn’t been a lot of difficulty accessing it through commercial carriers. Sometimes there has been difficulty with the Vaccine for Children Fund but there really is no option. I mean any problem that a pediatric practice would have, any provider whether it is at the pharmacy or whatever would have the same problem.

REP. STEINBERG (136TH): So just to be clear are you suggesting that by expanding those who have the ability to administer that would cause greater strain on the ability for the general public?

DR. CARBANARI: Greater strain on the availability? I really don’t know enough about.

REP. STEINBERG (136TH): Just responding to what I think you said that perhaps you didn’t say that actually. I thought you said that if the pharmacist is the one distributing the vaccine there might not be enough in the practice setting.

DR. CARBANARI: No, no. No what I said is that usually if you’re getting, if a practice is purchasing vaccine there isn’t a difficulty. The difficulty is getting the vaccine to the VFC Program.

REP. STEINBERG (136TH): I see. So the other thing I would like to follow up on was your comments about making sure that you’re aware of the patient’s history. So just to summarize our current electronic medical record systems has not yet got to the point were the pharmacist would be able to
access that information nor would it necessarily be appropriate for the pharmacist to access it.

DR. CARBANARI: It wouldn’t be. All the doctors in the audience are laughing. No, there is no way that would be possible in the foreseeable future.

REP. STEINBERG (136TH): To that point the ability to anticipate any dental issues, know the patient’s history, know their current vaccination history would not be something that the pharmacist would ever be able to access and therefore they would not be as well equipped with information as the practitioner would be before administering any such vaccine?

DR. CARBANARI: That’s correct. Other questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chair. Thank you Doctor for your testimony. So what is your organization’s position on Thiomersal in these vaccines, mercury?

DR. CARBANARI: Well there is none in all vaccines for the very young children. There are some trace amounts in some vaccines that are for only older people and it is not any kind of a risk to older people. We haven’t had it in vaccines in many years.

REP. HENNESSY (127TH): Okay, thank you. Thank you, Mr. Chair.

REP. STEINBERG (136TH): [Off mike chatter] Let’s just let the person testifying speak please. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. I just wanted to say Hi, it’s so nice to see you Dr. Carbanari and I appreciate all of your wisdom and
knowledge and you’re so knowledgeable on all this so thank you for sharing it with us. It’s always great to see you.

REP. STEINBERG (136TH): Other questions or comments? If not thank you for your testimony. Next up is Ben Davis.

BEN DAVIS: Good afternoon Senator Abrams, Representative Steinberg, Senator Lesser, Representative Young, Senator Somers, Representative Petit and members of the Public Health Committee. My name is Ben Davis, and I am a pharmacist at Walgreens. I am here to request your support for SB 94: AN ACT ALLOWING PHARMACISTS TO ADMINISTER THE INFLUENZA VACCINE TO CHILDREN TWELVE YEARS OF AGE AND OLDER.

SB 94 would expand pharmacists’ immunization capabilities for the influenza vaccine to minors 12 years and older. Currently, Connecticut pharmacists can only administer immunizations to anyone 18 years of age and older, and this has limited patient access. SB 94 will remove the 18-year age restriction, thereby improving access to affordable, safe and preventable health care for the patients of our state.

Adolescents as a group are an oft-forgotten about age group with respect to vaccinations, as much of the focus is on pediatric and elderly immunization rates. Allowing pharmacists, one of the most accessible groups of healthcare providers, to vaccinate adolescents would increase coverage rates, which benefits both them and the public as a whole. Walgreens and other Connecticut pharmacies have been administering flu vaccine to adults over the age of 18 for more than 10 years, resulting in much higher
overall immunization rates for that population. I am confident the same effect would occur in the adolescent population.

The unique access pharmacies offer to the public, including extended hours of operation and weekend availability, coupled with being a trusted health care professional, places pharmacies in an ideal position to have a major impact on reducing vaccine-preventable illnesses. Currently, every state allows pharmacists to administer vaccinations. Pharmacists are safely providing immunizations to children and adolescents as young as age of two in New York, nine in Massachusetts, Pennsylvania and Rhode Island, and age 12 in New Jersey.

With recent outbreaks of measles and other vaccine-preventable diseases, anything that can be done to improve immunization rates across the board would benefit the public as a whole. Furthermore, numerous physicians have stressed that they believe collaboration between physicians and pharmacists is key to increasing vaccination rates in Connecticut. Using pharmacists as immunizers is a convenient and easy way to boost rates, especially for the flu vaccine. According to the CDC, the flu broke records for deaths and illnesses in 2017-2018 season, 180 children in the United States that were old enough to receive a vaccination died from the flu this past season. Ninety percent of those children were not vaccinated.

I urge you to vote in favor of SB 94. I thank you for your consideration and welcome any questions you may have.

REP. STEINBERG (136TH): Thank you for your testimony. You probably heard the question that took
place with the previous person who testified, how do you respond to the concern expressed that the pharmacist will not 1) be in a position to access the history of the patient involved and may not be aware of some of the potential issues in admiration of the vaccine?

BEN DAVIS: So I do think there is valid concern. We would love for access to the medical record to be able to establish that ourselves. I would say the same hesitation holds true for adults as well. We don’t have full access so we do full screenings on these patients to clarify and try to weed out those ones that may have a medical history of something that precludes them safely receiving it from a pharmacy and not a medical office so I think adopting this same type of practice would hold true for adolescents as well.

REP. STEINBERG (136TH): Well I have to make an admission, I go to your competition. I go to CVS [Laughter]. I’m always open to new opportunities. My experience there is it is a very busy pharmacy. There is consistently a line, not only to pick-up prescriptions but for consultations and for placing orders. There’s really not a lot of room and those pharmacists are working as hard as they can, the phone is always ringin, it’s just a happening place. I’m trying to visualize how you would incorporate the kind of oversight that seems prudent for administering vaccines, particularly watching for the fainting patient or checking 10-minutes, 15-minutes later to make sure they’re okay give the hurly-burley that describes so many pharmacies in our state.
BEN DAVIS: Again a valid concern I don’t think I can refute everything you’re saying. We are doing already with 18 and over with a host of adult vaccines not only flu, pneumonia but all the other ones on the ACIP approved recommendation list. So you’re talkin about increasing the numbers that we are goin to be administering and I think that is a fair concern and I think that is something that individual pharmacies would have to account into their labor model to account for that. It’s probably the best I can say, so I agree with you, it’s increased workload and I think that would have to be factored in to when we are staffing properly to make sure it’s being taken care of properly.

REP. STEINBERG (136TH): Would you oppose the idea of imposing perhaps some different kinds of oversight or restrictions on administration in the pharmacy setting to make sure that those kind of protections as you describe are available in that setting.

BEN DAVIS: Not necessarily as long as it could be accounted for. I think the other thing that I will want to point out doesn’t necessarily answer your question per se but I do want to mention, is I think some of the testimony against this Bill is going to do with parent, parental consent, parent concern and I would be fully onboard with a parent, parental consent at that age. I think that would be fully appropriate especially in the pharmacy setting. We wouldn’t want to bypass that. But to go back to your question, am I opposed to that? No, I guess we would see what it looks like so next year we can accommodate that in our setting.

REP. STEINBERG (136TH): Thank you. Representative Klarides-Ditria followed by Representative Zupkus.
REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony today. So as far as I see in this Bill when I just look through it quickly, if you are under 18 there is currently no parental consent for the flu vaccine?

BEN DAVIS: No we just can’t administer in the pharmacy. So if you are under 18.

REP. KLARIDES-DITRIA (105TH): In the pharmacy setting.

BEN DAVIS: Correct, only because there is no option. Parental consent or not you cannot get an immunization under the age of 18 in a Connecticut pharmacy.

REP. KLARIDES-DITRIA (105TH): If this passed and under 18 can now get a flu vaccine in the pharmacy by the pharmacist.

BEN DAVIS: Yes, so this would open up to ages 12 to 17.

REP. KLARIDES-DITRIA (105TH): With parental consent?

BEN DAVIS: So I don’t know the wording of the Bill to see if that is in there or not. Whether it is or isn’t I would support that being in there. That’s my comment on that.

REP. KLARIDES-DITRIA (105TH): I can’t support this without parental consent for under 18 getting.

BEN DAVIS: I think that makes perfect sense.

REP. KLARIDES-DITRIA (105TH): Thank you so much for your testimony.
REP. STEINBERG (136TH): Representative Zupkus. Oh, you were just playing traffic cop. Okay, all right. Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chair. So on our Bill website it says, “The purpose of this Bill is to reduce the cost and expand access to the admiration of the influenza vaccine for minors.” So how would this reduce cost?

BEN DAVIS: I don’t know if I can answer that. I don’t know about that. I think that the access, I can speak to. I think that would be a little more of a logical play to see the access with the number of pharmacies extended hours versus the typical traditional physician’s office or group practice. I can’t speak for costs, I don’t know the answer to that.

REP. HENNESSY (127TH): It just seems like that is a major driver at least on the website for this Bill. The other question I have is I have heard anecdotally that there are people with shoulder injuries, this vaccine is injected in the shoulder?

BEN DAVIS: Yes traditionally, yep.

REP. HENNESSY (127TH): So I’ve heard that there is problems where people are having to go get treatment for shoulder injury have you heard anything?

BEN DAVIS: So I haven’t personally experienced that. Any sort of injection carries any sort of risk and certainly a needle penetrating into a muscle, things are goin to happen and that’s gonna happen anywhere. I will say in pharmacies where we’re doing adult immunizations we recommend the patient stay in the store for at least 15 minutes to observe and make sure there is no immediate acute
issues that we can help them take care of but I would characterize what you’re describing as much more anecdotal and much, much more rare than most patients handle this very, very well, low grade fever, light sore arm if that and usually by the next day they feel fine.

REP. HENNESSY (127TH): Thank you for your testimony. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Other questions or comments? If not thank you for your testimony. Next up we have Meredith Nielson.

MEREDITH NIELSON: Good afternoon. So I am Meredith Nielson. I’m from Cheshire. Distinguished members of the Public Health Committee, thank you for hearing my testimony. I have submitted written testimony in opposition to both SB 858 and SB 94.

I can’t possibly do justice to the points that I made for both Bills in three minutes. So I certainly do hope that you read what I wrote. I dedicated quite a bit of time and effort to be sure they were well thought out and researched. I also provided you with links to the resources for the fact I laid out.

A long time ago my husband and I decided to live on one income so that I could be present and home for our children. He also travels nearly every week for his job so it imperative that I’m available for their daily needs and busy schedules. I have neglected my entire family for the last month because I have been busy dealing with all the proposed legislations that would undermine our rights as parents, our ability to live according to our religious creed and our ability to keep our
children safe from the reaches from the pharmaceutical industry. And here I am sitting here today wondering if I’ll make it home on time to pick my daughter up from her activity after school.

More and more I worry that my children will be subjected to medical bullying whether at the hands of a physician who thinks they should have an HPV vaccine, or a school nurse or a pharmacist offering them a gift card if they get a flu shot. My written testimony goes into detail about the risks of these procedures. I am well aware that no one will be held accountable for any fallout whether that be physical harm such as paralysis, infertility, cervical issues, anxiety, shoulder injury from improper administration because kids do have different anatomy than an adult, cancer, MS, etc. etc. or emotional harm from the trauma of having been bullied into accepting an unknown, unnecessary and dangerous medical intervention. It will be me who is left to pick up the pieces. I am brought to tears when I picture my beautiful, sweet and innocent 11-year-old daughter having an unwelcome conversation [Crying] about unprotected sex and cervical cancer with a near stranger and being pressured to accept a medical intervention without her mother present.

I am equally horrified by the thought of my 14-year-old son who believe it or not is very open with what he discusses with us, having the same conversation and feeling that he should accept a medical procedure in an attempt to be independent and make grownup decisions. I am very well aware of the children and teenagers who have either died or become completely incapable of participating in the activities they once loved due to vaccine injuries.
when their parents thought they were doing what was right. Everything having to do with vaccinations is fast tracked and there is a nationwide push to give more and more and a rush to have everyone who is not a doctor administer this to them and an assault on the parental rights by taking choices away from the parents. May I just finish summarizing? Thank you.

It is my job to do what is best for my children, the State has no business interfering with that and no right to play God telling my family what we should or must allow to be injected into our kids and what we’re not allowed to decide for them. That’s fascism and if you can’t see that, you’re not paying close enough attention. I urge you to please standup for what’s right, remember who it is you represent and vote no to both 858 and SB 94. Thank you.

REP. STEINBERG (136TH): Any questions or comments? If not, thank you for your testimony. I’m sorry, that’s it. Maria Smith please.

MARIA SMITH: May I ask a procedural question before you start my time? When we, several of us called in to ask about testimony on Bills, we were told that we could only have three minutes total to address any Bills that were before this Committee today and I do see that you have allowed a variation to that and I’m just expressing my frustration with that.

REP. STEINBERG (136TH): I understand your frustration. We do try to be as evenhanded and equitable as possible and give everybody roughly three minutes until I find a point in which to interrupt somebody when they are trying to finish a thought. It is our goal though to give everybody
roughly the same three minutes and I understand your frustrations.

MARIA SMITH: Mr. Chairman what I was referring to was someone that was up here twice on two different Bills, I was told we could not do that.

REP. STEINBERG (136TH): Well I think the answer is actually you might have to wait to get up the second time.

MARIA SMITH: That is not what I was told and that is what I’m bringing to your attention. I’m not trying to be difficult I’m just sharing that with you because I specifically asked when I called in for procedural information.

REP. STEINBERG (136TH): I apologize on behalf of all of us if there was any confusion as to the rules that are obtained in this Committee for many, many years. Why don’t we continue with your testimony?

MARIA SMITH: Thank you, Senator. My name is Maria Smith. Thank you Co-Chari Steinberg and Committee members for hearing my testimony. I am kind of going off script here, I did want to mention something as a point of clarification. Thiomersal is in the multidose vaccine that is used, I believe, by HUSKY. So the State is actually using a multidose vaccine for children that are under state insurance, that should be a concern. That is one point that I wanted to clarify.

I am speaking today in opposition to Senate Bill 94 and Senate Bill 858. My concerns revolve around parental knowledge and consent. Parents are the gatekeepers of their children’s health care and we are, we have information that is not always current
in the system. We know their allergies, we know their sensitivities to food items. We know their genetic makeup, if they have contraindicating genetics that they need to be concerned about. So to allow our children who are not always versed on those things to be making decisions for themselves regarding getting a vaccination is totally inappropriate and it could lead to a duplicate treatment in many cases. If your child goes to your pediatrician and gets his HPV vaccine there along with his other vaccinations and is unaware of that, and then is going to school where there is a clinic and is offered another one, he wouldn’t know or she would not know to decline that and you would end up with a double dosing of a very dangerous vaccine.

I would like to speak on the Senate Bill 94 which allows pharmacists to administer vaccines to children under 12, under 18 to age 12. As I reviewed this actual section of the General Statutes Section 12-633 clearly states that the vaccine can only be given by a pharmacist pursuant to the order of a licensed health care provider. That is in the Statute and when you go to the general information that defines who a healthcare provider is, it is someone who can give a prescription. So that tells me that someone should not even eligible to get a vaccination at a pharmacy without a prescription. That is in your legislation. So I am trying to find out where the discrepancy is and why that is even happening. And it certainly shouldn’t be happening for children for many of the reasons which are already stated here.

REP. STEINBERG (136TH): Thank you for your testimony. Let me start by saying that I did talk to our Clerk who said that the person you referred to
earlier had signed up themselves and someone else signed them up for the other one so that is why there was dislocation. That is something that is not typically done and I can understand how you feel disadvantaged by someone taking advantage of this situation in that manner.

With regard to your comments, I certainly share your frustration in the difficulty involved in having a nonpractitioner be involved with the vaccine process and I agree with your point that often times it is the parent that is most aware of the specific risks and challenges their particular child has though I would argue it is probably in your interest to have as much of that information in the medical record as possible for the benefit of all practitioners who might be dealing with your patient. So I hope I didn’t hear you say that you were withholding critical allergic information.

MARIA SMITH: No, if I could respond to that, to my point the ability to get a vaccination for a flu shot at a pharmacy does not allow the pharmacist access to the medical records so even if you’ve provided it, it is not there.

REP. STEINBERG (136TH): I agree with you on that point. I just thought I heard you say that you were aware of information that might not be in the medical record and I was encouraging you to make sure for the benefit of your practitioner that as much of that information is given.

MARIA SMITH: Oh, of course, of course. But as I said because these clinics or places that might be able to provide an HPV vaccine for example, they don’t have medical records so they wouldn’t know if
your child had already received a vaccination or not.

REP. STEINBERG (136TH): You raise a good point and that was sort of the frustrations that we all have with the lack of connectivity within the healthcare system with the healthcare information we’re still working to accomplish and that’s why we still have a long ways to go on that exactly to your point. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. Would you just quickly explain, you made a comment about kids on HUSKY and I just wanted to hear what you said.

MARIA SMITH: I would love to clarify that. It is my understanding that children on HUSKY or state insurance when they go to get a vaccination are given a vaccination from a multidose vial. Those vaccinations contain Thiomersal.

REP. ZUPKUS (89TH): So they get a different vaccination?

MARIA SMITH: That is my understanding.

REP. ZUPKUS (89TH): Could you tell me where you heard that or got that. I would like to look into that because that means this children are getting different vaccinations than what my child would get.

MARIA SMITH: Someone else here might be able to speak to that. Melissa could you help me with that? Would that be okay if someone could answer that for me, I don’t have the specifics in front of me. I know it to be true. We’ve actually put a Bill forth to stop that.

REP. STEINBERG (136TH): I’m sorry, we can’t accept testimony cause you won’t be in the record that’s
the real problem. What I would suggest we are eager to get that information to all the members of the Committee and if you can follow it up subsequently with that information that would be helpful.

MARIA SMITH: What I can speak to you on is the regulations of the Connecticut State Agencies which actually speaks specifically to this SB 94 because it defines that requires an order by a doctor, an APRN or someone who has the ability to give an order for a prescription and that is not happening with adults. So to think that we would allow our children to also obtain services there is reprehensible to me.

REP. ZUPKUS (89TH): Thank you. I will look for that information.

MARIA SMITH: It is in my testimony, there are links in my written testimony.

REP. ZUPKUS (89TH): Thank you.

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

REP. HENNESSY (127TH): Thank you, Mr. Chair. So I was just told by a previous witness that there is no mercury, no Thiomersal in these vaccines and you are saying they are. So there seems to be a difference [Cross-talking].

MARIA SMITH: The multidose vials of the flu shot have Thiomersal in them and they are used because they’re cheaper but the Thiomersal is a preservative that is in the multidose vial.

REP. HENNESSY (127TH): Okay, thank you. Through you, Mr. Chair.
REP. STEINBERG (136TH): Yes, Senator Sommers.

SENATOR SOMERS (18TH): Yes, thank you for your testimony. I just wanted to clarify one thing. About eight or nine years ago pharmacists were allowed under Statute to administer vaccines, flu vaccines and they did go through Scope and it was is considered a standing order protocol which means there is a standing order for them to be able to deliver the flu vaccine. So I just wanted to make sure that was clear for the record.

REP. STEINBERG (136TH): That is a very good point, thank you for that. Any other questions or comments? If not, thank you for your testimony. Next up is Maria Smith.

MARIA SMITH: That was me. [Laughter].

REP. STEINBERG (136TH): I apologize. Next up Tina Rudy, excuse me. So Johanna Jolly. And I image Dawn Jolly as well. We had Dow K, he testified earlier, is he still around? No. Jennifer Saines it looks like.

JENNIFER SAINES: Hello, my name is Jennifer Saines. I reside in Middletown, Connecticut. Good afternoon, members of the Public Health Committee. I am here to oppose the Senate Bill 94 and Senate Bill 858. I also oppose allowing pharmacists to administer flu shots to children partly, or mainly I would say the flu shot in itself is shown to be highly ineffective, nearly laughably so, and actually has negative efficacy over time. It is also one of the most likely to cause severe adverse events along with the Gardasil vaccine.

You’re welcome to reference the VAERS data on that and I would recommend reading Peter Doshi [Phonetic]
in the British Medical Journal regarding the efficacy and safety of the flu vaccine.

In addition the minor is not capable of weighing the risk/benefit profile of the flu vaccination especially in the environment of a pharmacy and with the pharmacist who maybe unaware of the risks of the vaccine. The pharmacist may not have even read the vaccine insert for example or know if the child has recently been ill or is on medication.

From personal experience I know how important it is, it is absolutely critical to read the vaccine insert carefully. Sadly the medical profession does not supply us with the vaccine insert before we subject our children to vaccines. My own daughter’s injury could have been avoided if I had had access to the vaccine insert as it was clear from my family’s medical history and the indications on the insert that it was contraindicated for her. The vaccine manufactures themselves have put the inserts out for all to consider. It is not a classified document. The vaccine information sheet that is given to parents is not the same and the vaccine insert.

Regarding Senate Bill 858, I personally know three young women who have been seriously damaged by the HPV vaccine and I will conclude by saying that Luke Montagnier, MD and Nobel Prize Winner for the discovery of the HIV virus has called this vaccination, this vaccine, that is HPV vaccine a crime. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. Are there questions or comments? Senator Somers.
SENATOR SOMERS (18TH): Yes, again I think it is important and I thank you for your testimony and I just wanted to go back and talk about the pharmacists are trained. They have to take a CDC Course, they are certified through the Academy of Pharmacy. They are trained on how to give flu vaccines, nothing is done without parental consent. You have to sign a parental consent form in this Bill, 94 would require parental consent. Adults have to sign a consent form to get the flu vaccine and I just also want to share that there is many other states, and I can provide a list that allow pharmacists to administer vaccines, in some cases there is no age limit at all. The average age is about 11, so again none of this is done without parental consent. I want to make sure that’s clear because we’ve had a lot of people speak to that and that’s not the intent here at all.

JENNIFER SAINES: So, it not written in the Bill as of yet or it will be written into the Bill?

SENATOR SOMERS (18TH): No when you look at the Statue right now, right now in order for a pharmacist to give a flu vaccine to an adult, the adult has to sign a consent form. So the idea here is to, and I know I’ve had people try to get, this is regardless of what your feelings are as far as the flu vaccine, but a parent would like to get a flu vaccine for their child and let’s say the pediatrician’s office is out of them. You can go to Walgreens’ or a pharmacy, they sign a consent form and the pharmacist would then administer the flu vaccine. That is the intent of this Bill. And I know the other Bill talks about, you know, prophylactically being able to have children be, or minors be able to have access to vaccines and other
things but that is not the intent of this Bill at all. I just want to make sure that is clarified.

JENNIFER SAINES: And the intent of the prophylactic is that?

SENATOR SOMERS (18TH): That is not my Bill.

JENNIFER SAINES: That does not require parental consent.

SENATOR SOMERS (18TH): That’s the way that Bill is written. I’m just talking about 94.

JENNIFER SAINES: Okay, thank you.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you very much for your testimony. Next up, let’s see, would be Jennifer Kozek, is that correct?

JENNIFRE KOZEK: Hello House Committee. Thank you so much for having me speak today. I am here to oppose House Bill 94 and House Bill 858. I too was told I that was to only speak once so I am going to talk very fast. I am here because my words, first of all, going back to the whole pharmacy thing, I am not in favor of a pharmacist giving a vaccination. Both my children are allergic to eggs for example and they would have absolutely no idea that that’s in the vaccine. You know, I’ve gotten flu shots at pharmacies, they don’t tell you what’s in the vaccine. They just tell you here, you can get a little redness and soreness, so I’m not for that.

But I’m a parent of two vaccine injured children who both have immune encephalitis and cognitive issue and I am pleading for you to adamantly oppose Senate Bill 858 and any Amendments that would erode my First Amendment Rights and erode religious vaccine
exemption. Since spending tens of thousands of dollars to help restore my children’s health without the help of functional medicine practitioners and naturopathic physicians who I owe my life, I have learned that my children have an MTHFR and other genetic mutations which prevent them from clearing toxins effectively. More and more we’re learning about epigenetics and how it is not so much our genetics but it is actually how toxins and environmental toxins including vaccinations could be interfering with our genetic code and for that I am testifying.

I am not an antivaccine but I am for informed choice. I will no longer allow by beautiful children to get a vaccine because they have suffered as result. If either of my children get another vaccine it could mean that they will die. I was completely gaslighted by every doctor. My son for example his first reaction to a vaccine was in the NICU when he received a Hepatitis B vaccine for sexually transmitted disease that I had no idea, had nothing to do. I don’t have Hep B, my husband doesn’t have Hep B. There was absolutely no reason to be given an STD vaccine in a NICU at an hour old, in my little tiny four-pound baby. He crashed, they called me in. When I suggested it could be the vaccine they said that, oh no this isn’t a vaccine, you know, he’s a preemie. The reason he was in the NICU for eight weeks was because he had an underdeveloped digestive system. At that moment I had no idea that meant an undeveloped immune system. How people are allowed to get away with this in this country is absolutely unbelievable. The State should stop interfering with my children’s medical care and this Bill serves no State interest and
especially my son getting HPV vaccine when he doesn’t even have a cervix.

There are many very bad ingredients in these vaccines and I hope you all do read my testimony which is a lot longer which includes a whole list of side-effects and also please read the documents that I send you which was Robert Kennedy, Jr. which was the “I Can” Statement. The U.S. Department of Health and Human Services has admitted that in direct violation of Federal Law it had failed to provide any single safety study report to Congress for 30 years. This is egregious. There are so many conflicts of interest in the entire county that it is time in Connecticut we stand up. Thank you.

REP. STEINBERG (136TH): In your testimony I think you did pack quite a bit into three minutes [Cross-talking - Laughter]. We will read your full testimony at greater leisure as you put a lot of work into it obviously. Are there questions of comments? If none, thank you for testimony and your patience in waiting so long. Next up we have I think it’s Shannon Gamache.

SHANNON GAMACHE: Dear Public Health Committee, Regarding Bill AN ACT CONCERNING THE PROPHYLACTIC TREATMENT OF MINORS FOR SEXUALLY TRANSMITTED DISEASES.

I OPPOSE this bill. This Bill seeks to further separate children from parents and place them under the thumb of the State.

This Bill seems to be part of another Bill to install health centers IN schools and also another Bill to mandate the HPV vaccine for school attendance. How convenient.
This Bill would allow children to receive intimate exams and medication without parental notification or permission, this is unacceptable. Parents have a right to know if their child has been exposed to known risk. Parents have a right to truly Informed Consent in making these decisions for their children.

Minors who by your assumption, are already engaging in risky behaviors do not need to be presented with another risky behavior receiving a medication or vaccination without knowing all of the possible short-and-long term risks of which their parent will be responsible. If a child is injured by a vaccine temporarily, or medication, or permanently, that parent is now responsible emotionally, physically, lawfully, and monetarily, possibly forever.

This bill is not specific, the only prophylactic medications on the market at this time are the HEPATITIS B vaccine, the HPV vaccine, and Truvada for HIV prevention.

This opens the door and automatically approves ANY medication or vaccination that claims it can prevent a sexually transmitted disease in children.

The HPV and HEP B vaccines fall under a 1986 law indemnifying Pharmaceutical companies from any liability from vaccine injury OR death. Vaccine injury or death is not rare. There have been hundreds of deaths from these vaccines and hundreds of thousands of reported injuries. According to a Harvard study, only one to ten percent of vaccine injuries are ever reported, that means 90-99 percent of vaccine injuries or deaths are not reported. I was injured by the Hepatitis B vaccine when I worked
at Day Kimball Hospital and was told I had to get this vaccine or be fired.

You currently have another Bill that is coming up before you to make this not mandatory for health care providers not to receive vaccine. By the second shot in the three-shot series, I was suffering from daily fevers and a rash on my face for two years while I went from doctor to doctor looking for answers. I never received a diagnosis and 15 years later I still have an autoimmune condition that is still undiagnosed. No one told me I could suffer a reaction such as this, no one told me where or who to report it to, I did not know that VARS existed. In fact no one would accept it was from the Hep B vaccine. My son, three years after this was injured from a vaccine as well. These parents will have no idea why their child may be suffering from strange symptoms all of a sudden if we allow the state to medicate them.

In the last 5 years in Connecticut, there have been an average of 280 cases per year of diagnosed HIV over the age of 20, I could find no data on diagnoses of HIV in the age group of under 20 anywhere. Yet this bill opens the market to possibly hundreds of thousands of children equating to possibly millions of dollars of revenue for Pharmaceutical companies with poor efficacy and unknown safety. Truvada claims that their efficacy rates are 70-92 percent in preventing HIV but that is only of trial participants in which the drug was "used as directed", the efficacy rate overall in the trials is 42-75 percent because many participants do not follow the recommendation of daily medication administration which needs to start within 72 hours of a known exposure. Not only that but it takes
three weeks for maximum efficacy to be met and you have to receive a Hepatitis B test and an HIV negative test prior to that 72 hours. I don’t know any adolescent that would have a known exposure and then be able to immediately make a doctor’s appointment within 72 hours, give their blood and get back those results for Hep B and HIV by 72 hours. That is preposterous. Many participants do not follow recommendations for daily medication, medication administration and initial and quarterly blood testing for HIV and Hep B status is also required to stay on this medication. African American men above the age of 25 are the highest risk group for HIV yet that is not the demographic of risk being suggested here today. There have no long-term safety studies or efficacy studies in adolescents for this drug. [Cross talking] Separation of parental authority and State authority needs to be clear. You cannot inject anything or medicate our children without our permission. Thank you.

REP. STEINBERG (136TH): Thank you and again you also packed a lot. It’s very handy at this moment. The one thing I think definitely requires pointing out is that you’re right compliance is a big issue we have particularly with daily regimens for drugs. I would hope that anybody who feels at risk for contracting HIV would be highly motivated to stick with the compliance regimen but it is a problem we have with a lot of different drugs.

SHANNON GAMACHE: Within 72 hours they would have to seek out this regimen.

REP. STEINBERG (136TH): Well we know that it may not be the appropriate protocol physicians often start
on antibiotics if they think they might have Lyme disease in advance of getting the test back.

SHANNON GAMACHE: Well the medication is contraindicate for those who actually have HIV and you will become drug resistant to HIV, you can’t treat it later if they are HIV positive which is why they have to be tested before and prior and then start it very quickly otherwise it has efficacy.

REP. STEINBERG (136TH): Well it may not be the ideal system but it’s what we’ve got right now and you raised very good points. Are there comments or questions? If not, thank you for your testimony. Next is Isabelle Menozzi.

As we watch the health decline of so many people around us, the reality of our health is that the United States is sicker than ever. The U.S. spends more than any other country on healthcare yet has more chronic health issues than any other country. Half of all adults in the U.S. have a chronic illness, and nearly half will eventually die of cancer. Alzheimer rates and other neurodegenerative disorders are skyrocketing. What is going on? States have allowed the influence of corporations to poison this planet and its inhabitants. Just as Monsanto knew that their product RoundUp causes cancer and failed to disclose it, heads of pharmaceutical and health agencies who are responsible for vaccine safety such as WHO, HHS, CDC, FDA, NIH and HRSA knew that vaccines had not been properly tested, ever. We all know that the pharmaceutical industry spends enormous amounts of money on lobbying. More Than 100 Bills Proposed in 30 States To Expand, Restrict or Eliminate Fundamental Human and Constitutional rights all in
Hi everyone. Thank you for listening to me.

Distinguished committee members, I want to thank you for this opportunity to address two Bills today SB 94 and 858. I am a parent, a Certified Health Coach and a health freedom advocate. I care deeply about the health and wellness of my community and beyond. I frequently educate and empower people to lead healthier lives by creating a nontoxic environment. For the past 10 years though my focus has been to research extensively nutritional and environmental science. Through this work I discovered the deep complexities of the pharmaceutical and giant chemical manufacturers. And I would just like to add that I am not a medical expert but it is not my lack of medical degree that inhibits me to make decisions, medical decisions on my family. I can read, I can even read scientific studies. I learned how to do so, so I am qualified to make decisions for my family.

I oppose this Bills because of legislative creep, many things you have already heard today I don’t have to repeat. I just wanted to make these points.

So as we watch the health decline of so many people around us, the reality of our health is that the United States is sicker than ever. The U.S. spends more than any other country on healthcare yet it has more chronic health issues than any other country. Half of the adults in the U.S. have a chronic illness, and nearly half will eventually die of cancer. Alzheimer rates and other neurodegenerative
disorders are skyrocketing. What is going on? States have allowed the influence of corporations to poison this planet and its inhabitants. Just as Monsanto knew that their product RoundUp caused cancer and failed to disclose it, heads of pharmaceutical and health agencies who you trust, who are responsible for vaccine safety such as the World Health Organization, HHS, CDC, FDA, NIH and HRSA knew that vaccines had not been properly tested, ever. This is all linked to my testimony. Across the country more than 100 Bills proposed in 30 States to expand, restrict or eliminate Fundamental Human and Constitutional rights all in the name of Big Pharma and laws supporting these giant companies start right here, in State Houses. Please allow me to be blunt here, but we have a giant corporation takeover in this country, and in this world and we demand a separation of Pharma and State.

I just wanted to summarize since the bell rang is that I known that we all want the best for our children but we need to start doing that by having good science and a clean regulatory process and we do not have this now. Will the Constitution state protect our First Freedoms, be on the right side of history, do not be complicit with crimes against humanity and please say no to all vaccine mandates and separate Pharma and State? Thank you.

REP. STEINBERG (136TH): Thank you. I will say that speaking just for myself we’re not doing this to help the Pharma companies, I can assure you of that.

ISABELLE MENOZZI: I know that indirectly you probably think you’re not but as these mandates are passing you are because it’s just selling more and
more vaccine. All of this is to sell more and more vaccines. There is no evil outbreak. This is all a media propaganda.

REP. STEINBERG (136TH): Are you suggesting that what is going on in the American Pacific Northwest is fraudulent?

ISABELLE MENOZZI: I am, yes Sir. I am. I am telling you that the media, Pharma pays 70 percent of the advertisement to media. That means that they own media and they also own Congress.

REP. STEINBERG (136TH): I’m sorry, I’ll have to disagree with you on that. Anybody else have questions or comments? Thank you very much. Matt, it looks like Paterna, not here. Looks like Ann Rainer Henry. Okay thank you. We’re gonna move on. We still have more on this, 94. Next is Jennifer Schafer.

JENNIFER SHAFER: Thank you Members of the Committee for allowing me to testify today. I am testifying on two Bills on the SB 94 and I’ll start with that one. Vaccines are a medical procedure and should be done my medical professionals only whether they are trained pharmacists or not. They are medical procedures and there is a presentation called SIRVA typically includes rapid onset of severe long-lasting shoulder pain following vaccination in the deltoid muscles, I hope I pronounced that correctly, resultant limited range of motion and absence of infection. Data from the Vaccine Adverse Reporting System suggested SIRVA is being reported with increasing frequency. A pharmacist is not a doctor. CVS, Walgreens or any drug store is not a place to have a medical procedure. If there is a bad reaction there are no medical professionals to help.
Children are more at risk for injury from improper administration of the vaccine. This Bill will not help lower costs and will cause more harm that good.

And as for 858 again vaccines are medical procedures that come with clear risk. When children are given the HPV vaccine they are told to wait 15 minutes in case of syncope. According to the American Family Physician a peer review journal, syncope is an abrupt and transient loss of consciousness caused by cerebral hypoperfusion. Syncope is classified as a neuro mediated cardiac and orthostatic hypotension and tonic clonic is on the vaccine insert for HPV. The tonic clonic which is a seizure activity, syncope with tonic clonic is there. Vaccines are indemnified from lawsuit due to injury since the passage of the 1986 Vaccine Injury Act. It is alarming that any state would mandate vaccines or give vaccines without parental consent while consumers are left in the dark and forced to take a risk. What if my child were given this vaccine without my consent and passed out, how is that helpful to my child? The vaccine is only effective for four strains of HPV and only two strains are linked to their potential to cause cancer. It’s not even been proven that this vaccine can prevent cancer. Are you guys paying attention to me? [Snicker] I’m sorry. I got, I just got. I don’t know, I thought we were in a hearing. [Bell sounds] If I may summarize please? The Gardasil insert warns that there could be anaphylactic shock due to allergies from the vaccine components.

I am also a produce of a radio show and I’ll end with this. Recently I had a family on my show with a son, and I am going to say his name aloud. He passed away, his name was Christopher E. Bunch. He
was vaccinated for the HPV vaccine and died three weeks later. His family is currently pursuing whatever legal action they can take, which they can’t really take legal action. They can pursue a petition in the Federal Government via the Vaccine Court. That young man died three weeks after the HPV shot. Parents need to know if their children are going to be given a potentially life-threatening medical procedure. It should not ever be done behind their back and it should never be mandated. It always should be with informed consent. Thank you for the opportunity to testify.

REP. STEINBERG (136TH): Thank you for your testimony. Any comments or questions? If not thank you. Next up is Sheila Dognin goin to testify again? No, okay. Gina Consiglio.

GINA CONSIGLIO: Hello, my name is Gina Consiglio from Madison, Connecticut. I don’t have any cool credentials. I was a literature major and opera singer but I did drama. I’m a chicken pox survivor, [Laughter] I’m an HPV survivor thanks to a college jaunt through France and I’m sure I survived the flu but I haven’t had it. [Knocks on wood]. But I know I’d kick it’s but without a flu vaccine. I’m here to oppose SB 858 and SB 94.

SB 858 the Statute Amendment is a huge violation of parental rights. This Bill would clearly encompass the controversial Gardasil vaccine as it would easily fall under prophylactic as we’ve heard. This is a huge crime against parents and their children for a child to be able to get such a risky medical procedure without their parents ever knowing. It is completely unconstitutional, unfair and insane.

Right now Merck is being sued for fraud by one of
our heroes, Robert Kennedy, Jr. It is Jennifer Robi
t Merck and Kaiser Permanente in Los Angeles
Superior Court. The findings, what they are finding
as we prochoice vaccine advocates have know for
years are very disturbing and hopefully will reach
the greater public which as we’ve mentioned is not
reaching because pharma owns the media outlets. So
what they’re finding is that Merck through it’s
reckless over reaching with Gardasil, it’s a public
health flim-flam currently emerging as the most
dangerous vaccine in history. This case has brought
the nation’s leading trial lawyers back to the
brawl. They are discovering in court that Merck’s
clinical trials were purposely deceptive, their
science completely flawed and the marketing of their
product shameful. I urge you to read up on the
current trial. I put the link in my testimony.

The right of the parent to direct upbringing of a
child is firmly supported in Supreme Court history.
What else, I listed a lot of court cases about
parental rights. I find these two Bills relate to
each other in that vein that they are both trying to
further erode the parent/child relationship. This
isn’t unique to Connecticut it is happening all over
the country. There is 129 Bills out in the nation
right now each being regurgitated, the same titles,
the same purposes, its an agenda and as a parent I
won’t buy into it.

REP. STEINBERG (136TH): Thank you for your
testimony. We’re glad you recovered from chicken pox
[Laughter]. Any other questions or comments? Yes,
Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Mr. Chair. I just
want to commend you on your commitment providing us
with exhaustive testimony that I know I’m going to become more familiar with. This is just a wall of information and it is pertinent for now in this session that we do this due diligence but I just want to commend you and the rest of the mothers here for, you know, protecting your kids.

GINA CONSIGLIO: Thank you.

REP. STEINBERG (136TH): Thank you, Representative. Any other questions or comments? If not, thank you for your testimony. Next is Denise Lucitan [phonetic]. Nancy Bean. Moving along, Catherine Kramer. Anna, I’m having problems reading this, Moresky or something close to that? Okay, and then Pazit Edelman.

PAZIT EDELMAN: Hi, thank you for listening to me. My name is Pazit Edelman and I am from Windom and I want to address three Bills. First of all to get it out of the way, I am for Bill 5902. I think that naturopath and holistic doctors are wonderful and most of the time my experience they have more experience than my medical doctors as far as interactions cause they know, they have to deal with older people that have come to them with medical prescriptions that they already take. So I would like you to approve that.

Now, the major things that I would like to testify about are Bill 94 and 858. I submitted my testimony for 858 electronically and it has a lot of links that have information from the CDC, information from other reliable peer reviewed lab reports and I hope that you will read it and click on the links.

I will summarize what I did there, what I wrote but first of all I want to get out of the way what I
Dear Members of the Public Health Committee:

In the quest for convenience, pharmacies in the United States sell drugs on every street corner and in every supermarket. Americans consume more drugs than any other population in the world. Indoctrination in pill polling begins from birth. As children grow older, TV, radio and online advertising cements this message. Statistics show this medical error constitutes the third leading cause of deaths in the United States killing 250,000 people yearly. That is according to Johns Hopkin University, research was then there. According to the CDC they say 150,000 die every year. For me that’s enough but the debates are in between 150,000 to 400,000 of people getting killed, die from medical errors and that does not include vaccines.

The United States Supreme Court has determined that vaccines are unavoidably unsafe. Allowing a vaccination by pharmacy with little or no knowledge of medical history compounds this hazard. Children cannot provide informed consent and it’s dangerous.

As far as the 858 I would like just to summarize and point out a few links that I left there. There is a link, there was a debate here on Thiomersal or not? I enclose a sheet from the CDC with all the ingredients of all the vaccines that are now on the schedule and they have at least a four in them. The multidose does have Thiomersal. Now the other ingredients aluminum, formaldehyde, polysorbate 80 that are in the HPV. If you had put them in a drink and gave it to someone to drink, you would have been arrested for poisoning somebody yet it is okay for
some reason people think it is okay to ingest it to the body.

REP. STEINBERG (136TH): Can you summarize please?

PAZIT EDELMAN: So the thing that I would like you to check in my written testimony that I submitted would be some videos with testimonies in Ireland in the Legislators Office that 130 girls were sick. And some other experts in the world.

REP. STEINBERG (136TH): We will take a look at your links. Thank you for providing them. Yes, Senator Somers.

SENATOR SOMERS (18TH): Yes, I’ve heard repeatedly you say that as far as Bill 94 that children could not provide informed consent. And again, I want to make it clear that this Bill, the parent has to give consent for the trained pharmacist to be able to administer the flu vaccine and may of these pharmacies actually do have clinics within them and they are trained specifically to look for adverse reactions and the pharmacists do send a note to the primary care doctor or the physician that patient X has come in and receive the flu vaccine. And just put it in perspective the CDC reports and you can look it up. In 2018 we lost 80,000 people, they were killed or died from complications from the flu. So I just want to make sure that everybody is clear on that. We’ve heard a lot of information and things said about kids, you know, giving consent. Under 94 when you go to the pharmacy if you want your child to be vaccinated it’s the parent’s decision, they have to sign a consent form and everything is tracked and the information is transmitted to the pediatrician or primary care physician and these
pharmacists are trained. I just want to make sure that’s clear. Thank you.

PAZIT EDELMAN: May I answer on something about it? It’s not the fact that necessarily that kids are going to be giving themselves, giving the consent by themselves, it’s the whole environment that this issue creates that, you know, it’s like you go to the supermarket or you go to a store, oh by the way let’s get a drug, let’s get a vaccine, it’s out there and the risks are very serious and the benefit was proven in mainstream media which conceals information because 70 percent of their advertisements come from pharmaceutical companies so they have no interest to protect us, the public. Our children, us the parents who have to deal with it. They have nothing, that’s not what they want to do. That’s their business, they want to get revenue and 70 percent of the advertisement in the media are from the pharmaceutical industry and no channel would like to touch the area of vaccine, no channel would like to address that because they know that the next day all these pharmaceutical companies are going to withdraw their advertisements in their channel. In my testimony you can see severe whistleblowers that came forward to the CDC and even one of these states, Doctor, the pathologist Finley that found out that they tested Gardasil vials from several countries and all of them were found contaminated with HPV, the disease strain 11 and strain 18.

SENATOR SOMERS (18TH): I’m sorry, if I can interrupt you. I’m talking about Bill 94 which has to do with flu vaccines that was the question, not Gardasil, not HPV. Thank you for your testimony.
PAZIT EDELMAN: They are intertwined because each one of them has different toxins. Think before your inject kids with formaldehyde and aluminum. Aluminum causes Alzheimer, everybody knows that. Everybody knows that it causes dementia and Alzheimer, yet why do we give it to the elderly people, why. To cause them more dementia and Alzheimer?

REP. STEINBERG (136TH): Well thank you for your testimony today. We very much appreciate it. Any other questions or comments? Thank you again. We are gonna move on to House Bill 5902 starting with Dr. David Boisoneau, is that correct?

DR. DAVID BOISONEAU: That’s fine, thank you. Good afternoon, Distinguished Members of the Public Health Committee. My name is David Boisoneau. I am a Board Certified Ear, Nose and Throat doctor practicing in Waterford, Connecticut. I am here representing thousands of physician members and physicians in training for multiple subspecialties in the State of Connecticut. We would like to oppose HB 5902.

Some of you certainly recall our testimony presented in six of the last nine years opposing similar bills for naturopaths seeking prescriptive authority. Yet we are again to address another effort for prescriptive authority. We have submitted information for your consideration regarding the striking contrast of training and experience between physicians and naturopaths. We will discuss that in a moment but we would also like to point out the dangerous precedent this Bill would set. If passed, this Bill could create a mechanism by which professionals could circumvent the time honored and
trusted public hearing and legislative process and the legislature’s own Scope Review Process.

When the previous request by naturopaths for prescriptive authority were reviewed through the Scope Review process, many hours were spent reviewing the education, training and clinical hours in naturopathic training. Each time this has been considered, the Committees have reached the same conclusion, it was not in the public interest to allow naturopaths prescriptive authority. This process has happened three times and each time the same conclusion.

Further this bill requires the DPH to create an administrator process and structure for evaluator reviewing and determining appropriate prescriptive authority. Creating a formulary of this nature is not a simple task and there currently is no process or precedent for doing this. This will require new expertise, personnel and likely funding. There are many healthcare professional who have completed a rigorous and didactive practical training to achieve prescriptive authority. There is no substitute for the hundreds of didactive lectures in pharmacology and thousands of hours in clinical rotation the students complete just to receive their diplomas, but this only lays the foundation. Post Graduate training on the nuances in clinical pharmacology and internships, residencies, Fellowships all under the eye of watchful experienced prescribers and caregivers insures that this knowledge becomes part of our DNA. Other approaches that consist of limited hours or even weekend courses simply cannot insure the safety of our patients. Even just last year the naturopaths suggested additional training be required for them to be allowed for them to
allowed to prescribe medications. However there is nothing in this current Bill that addresses this additional training.

In conclusion, this Bill is wrong in both it’s intent and proposed execution. A collaborative approach would be far more useful and would best utilize the strength of all healthcare professionals. In fact, this is already occurring in Connecticut. There are several examples of naturopaths and MDs working together in integrated practices helping patients with alternative treatments for difficult problems such as chronic pain. We want to continue to work alongside our naturopath colleagues to insure the ongoing health and safety of our residents. Thank you.

SENATOR ABRAMS (13TH): Thank you Dr. Boisoneau. Are there any comments or questions? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. So, Doctor, you referred to the training that doctors get and this is kind of like a Catch-22 kind of thing because pharmaceutical companies underwrite the medical schools.

DR. DAVID BOISONEAU: Okay if you say so. I don’t know that for a fact, thank you.

REP. HENNESSY (127TH): Well it seems to me that they do and.

DR. DAVID BOISONEAU: Do you have evidence on this? I am unaware of this.

REP. HENNESSY (127TH): I’ll try to find it for you and the Committee. But the medical allopathic model that we have, I think it has been mentioned in other
Bills isn’t doing a great job in serving the population of the United States in that it is the most expensive medical program in the country and its performance isn’t that great, so naturopaths dare to support the body, the patient and there’s room. That’s the point I’m makin. There is room for naturopaths to move in and I would just ask that, you know, the allopathic edifice that kind of controls everything would work with us, work with naturopaths to allow them to practice with their full training ability.

DR. DAVID BOISONEAU: There are several examples of naturopaths and MDs working together in integrated practices especially in this state. It’s occurring and can it occur more, absolutely. Does it go on the backs of prescribing medications, I can’t support that as it stands now? At the very least we need to discuss perhaps with doctors, naturopaths and pharmacists, bring everybody to the table to decide to figure out what’s best for the care of the patients in the State. This Bill as written is very limited, it doesn’t say much. It just says there should be a formulary that naturopaths can access, it doesn’t say who can contribute to that information. It doesn’t say who’s going to be at the table, a seat at the table. That all needs to be clarified.

REP. HENNESSY (127TH): I believe that it would be the Commissioner Department of Public Health in conjunction with this commission that we put together a couple of years ago. So this Bill has been before us a number of years and each year what we’re trying to do is come up with something that we can agree on.
DR. DAVID BOISONEAU: Like a Scope Review process cause that occurred multiple times and all three times the multidisciplinary scope review process has come to this similar conclusion that it is not in the best interest of the citizens of the State of Connecticut. That is the current processes we have in place. I don’t disagree with you, maybe more needs to be done but what has been done the processes that are in place now have played out.

REP. HENNESSY (127TH): Okay, well thank you for your testimony. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions. Representative Demicco.

REP. DEMICCO (21ST): Thank you, Madam Chair. Thank you for coming to testify. Just to pick up on Representative Hennessy and your discussion so can you foresee any possible limited formulary that could allow us to make some progress here because it has been several years that we have been going back and forth on this. Is a limited formulary something that’s possible?

DR. DAVID BOISONEAU: What’s possible is a discussion about what even a limited formulary would be. So my answer is I don’t know because we haven’t discussed that yet in the State of Connecticut, we just haven’t.

REP. DEMICCO (21ST): So the Scope Review that has been gone through, you said a couple of times now right, the formulary was not discussed?

DR. DAVID BOISONEAU: A specific formulary with specific drugs was not discussed to the best of my knowledge, to the best of my knowledge.
REP. DEMICCO (21ST): Okay, thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Other questions. Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you for your testimony. I would like to ask you as an MD can you talk to the clinical training that you received as far as pharmacology versus what a naturopathy would get in clinical training?

DR. DAVID BOISONEAU: Yeah, from what I understand which actually came out in the Scope of Process was very glaring disparity between the amount of hours that a physician, MD or OD has to put in to understand, learn about drugs and their potential effects and interactions on patient versus what the naturopath generalized curriculum is. There is a huge disparity in hours. It’s not difficult for a scientifically minded person to understand, read a book and understand what a drug can do. It’s a completely different thing to apply that into real life situations where you’re dealing with various medical problems and multiple medications on people. It takes hours, weeks, years to learn that and it’s ongoing and its continuous.

SENATOR SOMERS (18TH): Yes, as far as the Scope Review process, I would agree with you we have gone through it three times and the Department of Public Health, the commissioner in particular felt very strongly about the fact that there was a large disparity in the hours that are, you know, received or taught in the two different professions and I believe that there was some conversation, if I’m remembering correctly that the commissioner who would have entertained giving access to certain
vitrins that could be prescribed but that was not
with the naturopath really wanted and we had
suggested that they go and talk with the
commissioner of Public Health, they could sit down
and come up with a formulary that then we could
actually speak to but that has not happened as of
yet. We did speak to some folks that were
naturopaths that were here. We asked about the
supervisory collaborative with supervision like we
have with PAs. Can you speak to PA training on
pharmacology versus a naturopathic doctor?

DR. DAVID BOISONEAU: That’s a good question because
I’m not 100 percent familiar with what the PA level,
you know, what’s in their curriculum. My guess, and
it’s probably similar to the medical and naturopath.
We have the same basic exposure, maybe less hours
and naturopath and PA versus medical. The
difference is the boots on the ground training and
the real life use potentially harmful drugs that’s
the difference.

SENATOR SOMERS (18TH): Right and I just want to
point out that PAs have, their curriculum is very
much like a medical doctor’s and they are still
under supervisory role. They have to have their
prescriptions signed-off by a doctor even with a
validation agreement. So I thank you for coming, I
thank you for your comments and I probably will have
another question but I’ll let somebody else go.

SENATOR ABRAMS (13TH): I have a couple of
questions. I am wondering, I know that other states
do allow prescriptive abilities for naturopaths, can
you tell me what might be the difference why some
states would allow that and we are not?
DR. DAVID BOISONEAU: I would like to know myself. I don’t know the differences in other states specific legislation or what drugs. IS it a full access to a full pharmacopeia? Is it limited to certain things as Senator Somers says vitamins, etc.? I don’t know.

SENATOR ABRAMS (13TH): And I think you kind of already answered this so I don’t mean to belabor it but I’m so curious about the fact that a formulary has never been really like laid out and discussed to see if there could be some kind of compromises between naturopaths and physicians or the DPH where ever the situation lies. Do you have any other comments about that, why that hasn’t occurred?

DR. DAVID BOISONEAU: No.

SENATOR ABRAMS (13TH): Okay, thank you. Any other questions or comments. Senator Sommers did you have something else?

SENATOR SOMERS (18TH): A formulary was discussed in the last Scope Review but it was not what the naturopaths wanted and as far as I remember it and the commissioner was going to allow them to have access to certain vitamins they could prescribe but they wanted access to antibiotics and other things.

DR. DAVID BOISONEAU: Yeah, that’s what I’ve heard that antibiotics, antifungals.

SENATOR SOMERS (18TH): We’ve heard this term and maybe you could explain it, we’ve heard that naturopathic medicine is considered complimentary medicine. Could you explain that?

DR. DAVID BOISONEAU: I consider it integrative medicine. They said complementary? Yeah, I can
explain that in a real-world example. I have a very good working relationship with a local naturopath in my area and we actually, I just spoke with her regarding a particular patient last week. We’ve complimented each other on treating a particular patient and she understands that I can take care of surgical problems and antibiotics and treat infections and she’s helped me change nutritional patterns in certain patients of mine and helped manage supplements to improve the outcome. So I think I like that term complementary care. I’m a non-opioid prescribed and I’ve been relying actually on magnesium and other types of natural supplements to help my patients out during postsurgical pain and I think that is a very complementary role between naturopath and MDs and its good for the patient.

SENATOR SOMERS (18TH): So the other thing that we heard, I knew there was a question I wanted to get out there was that if somebody was seeing a naturopathic physician and then it comes to the point where somebody comes in with Strep throat that they would have to then, you know, send them to a physician MD to get the prescription and that seems to be one of the issues that has come up frequently that the patient would then be required to have another doctor’s appointment but if you had a naturopath working in your office and you were complementing each other you could certainly cover for each other without, can you do that without having to have another appointment or how does that work, can you walk through?

DR. DAVID BOISONEAU: You know, I don’t know how it would work because I don’t have that in my practice and I know there’s a couple of examples here and there in the state and there are some double degree
practitioners in the state that are both naturopaths and MDs at the same time. There was one that worked down in our area in Mystic for a while was an emergency room physician and studied naturopathy and so he could do the Strep test, prescribe the antibiotics. The thing is any kind of medication prescribed, even supposedly benign antibiotic for an obvious Strep throat can have a myriad of interactions with other medications that the patient is on. It might not be Strep throat to begin with, I mean that’s a whole other topic, that’s another rabbit hole we can dive down if we wanted to but it’s a lot more nuance than just saying here’s the list of antibiotics that I want to be able to prescribe to patients for infections. I think that can lead to misdiagnosis and mistreatment. It happens with medical doctors, you know, after many many years of training.

SENATOR SOMERS (18TH): One last question for you. Right now if naturopathic doctors were given a formulary of, and I’m not sure you can answer this but, prescription rights would their malpractice change because right now they don’t have an ability to write prescriptions therefore they don’t have an ability to cause and adverse reaction or do you think their liability or their medical malpractice would increase because they would now be adding this large prescriptive right authority?

DR. DAVID BOISONEAU: That’s interesting that you should say that because it sounds like a planted question but it wasn’t. I actually discussed this with a med mal plaintiff attorney who I know in my area and discussed this with her. I asked her how often does she review medication errors by doctors and she says it’s infrequent but does come across
her desk a few times, every few months. And I asked about expanding prescriptive authority and she feels that would potentially increase liability for those practitioners. So, you know, I didn’t go in any deeper than that with her but I thought that’s another, whole other pathway that I think naturopaths should consider if they are looking to have the ability to prescribe potentially harmful medications.

SENATOR SOMERS (18TH): Thank you for your testimony.

SENATOR ABRAMS (13TH): Thank you. Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Thank you for your testimony. This has been a number amount of years that we’ve had this conversation. It’s ironic that we have a University in the State of Connecticut that trains naturopaths but we don’t allow them to practice here which I think is kind of counterproductive when we try to keep people in the State of Connecticut.

DR. DAVID BOISONEAU: Can you clarify they can’t practice naturopathy in the State of Connecticut?

REP. COOK (65TH): Well I think the Scope of which they’ve learned we limit what they can practice. But neither here nor there. The State of Vermont had just expanded their ability for naturopaths to practice. Have you given any time to looking at their Scope of Practice in the State of Vermont at this time?

DR. DAVID BOISONEAU: NO, but I would be happy to.
REP. COOK (65TH): So as I’m looking for it, and I was glad that the good Senator was talking because I was trying to look at this a quick as I can, and they do allow a special license for endorsement for prescription medication but it gives a limit on what you can do and how you can do it. You have to have a specific certification to be able to do it and there’s a couple of other different things in there. I guess my question is if there is a way that we can come up with a happy medium, we have talked about Scope numerous times, we have talked about prescriptive authority numerous time. We did have a list in front of this Committee several years ago about what was or was not what people could agree to or not agree to. I’ve never had a naturopath sit in the chair you are sitting in and say to me that they want to prescribe opioids or other things. I’ve never had one. I’m just trying to figure out a way that we can finally put this conversation to rest and is it going to continuously be an opposition from the medical field to the naturopath or is there an ability to meet in the middle?

DR. DAVID BOISONEAU: There is always an ability to meet to a certain extent.

REP. COOK (65TH): But on whose parameters, like that would be the question.

DR. DAVID BOISONEAU: This is an open-ended question. I guess you have to get all the players together and again, maybe, that the Scope of Review is different, that whole process was different. Right now in the Bill as written it simply says as for formulary so we can’t support that. That’s open-ended and asks for formulary. The Bill on the table is
unacceptable in the House of Medicine in the State of Connecticut as written.

REP. COOK (65TH): And I respect that as it is a very broad, open-ended piece of legislation and I totally understand that. So if I was to say to you we should be able to give naturopaths the ability to prescribe certain vitamins and other things that maybe you can’t get over the counter, things that have to be in a very high dose for example Vitamin D that some people need in 55,00 mg of that if you will, iron and what have you so would there be that conversation that doctors would be willing to say, all right lets have that conversation and take away. Look at the end of the day we have an opioid crisis and I don’t see naturopaths prescribing those and you just said you are not a physician that prescribes opioids. How do we get there? Because we need to have some type of a prescriptive authority. If I go to a naturopath and I show signs of Strep throat can that naturopath, you know, do the test on my throat and send it to the lab to get it tested or do I have to now go refer to my physician of traditional medicine if you will and have them do the test as well and then I have to be billed twice, one that is not covered by my insurance and then one that is. That’s a lot of questions.

DR. DAVID BOISONEAU: You’re saying is that currently what happens. I agree that currently is what happens.

REP. COOK (65TH): So how do we eliminate some of that, because we just got to listen to a whole bunch of parents that said they want to be able to have the ability to say no to vaccines but now we’re saying you cannot have the ability to go to a doctor
to have a choice on how you want to have your medication or treating you. How do we get there?

DR. DAVID BOISONEAU: Good question.

REP. COOK (65TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you Dr. Boisoneau. Dr. Marcia Prenguber. Welcome.

DR. MARCIA PRENGUBER: Thank you to the Members of the Public Health Committee and the Co-Chairs for hearing my testimony. My name is Marcia Prenguber, so well done. I’m an Osteopathic Physician and Director of the School of Naturopathic Medicine at the University of Bridgeport. I previously served as the Director of Integrative Care in a cancer center hospital in the Indiana University Health System.

My role currently at UB is to lead the doctoral training program for future naturopathic physicians. Students undergo 4 years of intense didactic and clinical work, which includes 72 hours of basic training in designated pharmacology courses, not all that different from the 90 hours in medical school, in addition to many more hours of training in the various courses such as cardiology, gastroenterology, rheumatology, oncology, and so forth. Students develop an understanding of the indications, mechanisms of action, the side effects, as well as the interactions with other pharmaceuticals, botanical medicines, nutritionals and supplements through 300 additional hours of training in these therapies. This didactic education is put into practice in their clinical experiences.
As a former President of the U.S. Department of Education-recognized programmatic accrediting body for naturopathic medical programs across the United States and Canada I participated in the evaluation of the naturopathic schools all over North America and can verify that the program at the University of Bridgeport offers the same level of pharmaceutical training as the other naturopathic schools, including those programs in states in which NDs have safely used their prescriptive authority.

UB has the only accredited naturopathic program on the east coast, but enrollment is declining in the past few years, largely related to the limited scope of practice in the State of Connecticut. We are losing students to other states. And I’ll share just this past week, I was on an accrediting review of a school, a naturopathic school in Arizona. As part of the review process, I asked the students why they chose that school. The first student that answered that said, I came here, from here, [taps on podium] and went Arizona from here because they have an increased Scope of Practice. I just heard this this past week from students there at the school in Arizona. So we are losing them.

Too many perspective students to the UB program and our own grads leave the state to relocate to other states in which they can practice to the full extent of their training which includes that use of prescription medications. We need to enroll more students and keep our graduates here, in Connecticut. With a scope of practice that includes prescriptive authority, we will be able to do that, effectively contributing to the health care needs of the people in Connecticut.
Graduates must complete a competency.

SENATOR ABRAMS (13TH): I’m sorry, I’m going to have to ask you to sum up. Thank you.

DR. MARCIA PRENGUBER: Just to say that our students take the same level or training and have to pass the same exams as students who practice in other states. Our students graduate and then move elsewhere and practice safely using prescriptive authority.

SENATOR ABRAMS (13TH): Thank you very much. Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Thank you very much for your testimony and I think you might be part of my question and answer segment. So as you were sitting here and I’d asked the previous speaker about prescriptive authority. If you were to get a wish list of prescriptions that you would like to be able to prescribe in the State of Connecticut what would that be?

DR. MARCIA PRENGUBER: That is a very long answer that would take. We would look for a formulary that would include various categories and I will defer to my colleague Dr. Liva I think is speaking to that who is also and naturopathic physician and a pharmacist who can probably better address what we’re looking at as a formulary opportunity.

REP. COOK (65TH): And have you been in front of this Committee before testifying on this?

DR. MARCIA PRENGUBER: Yes, many times. I moved here in 2014 and within three weeks I was here testifying and every year since.

REP. COOK (65TH): And in those testimonies have we not discussed formulary options in the past?
DR. MARCIA PRENGUBER: We have, we’ve discussed a wide variety of options in terms of specific drugs, exclusionary formularies. Obviously not using those are inappropriate that we are not trained to do so there’s been many, many different ways we’ve looked at it in the past.

REP. COOK (65TH): Thank you very much. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. Hi Marsha, how are you?

DR. MARCIA PRENGUBER: Good, how are you.

REP. HENNESSY (127TH): Good. So you know as a member of the Bridgeport Delegation we’ve been fighting for this Bill for as long as it has been up here and we continue to support it. Not only is it to provide increased opportunities for healthcare for the citizens of Connecticut but it’s a good economic development proposal for the State to keep people from leaving the State and also to keep the University of Bridgeport Naturopathic School of Medicine and thriving with increased enrollment. Do you have, how is enrollment these days?

DR. MARCIA PRENGUBER: In the Naturopathic Program we have dropped 50 percent in the last couple of years because of this issue.

REP. HENNESSY (127TH): Okay, so that’s of course very sad. I had spoken to a previous doctor testifying against it and he was expressing concerns about the lack of ability for naturopaths to have the adequate training that medical doctors have and I kind of pointed out that naturopaths can go into
medical school because it’s completely different mindset of allopathic that pretty much run by the pharmaceutical companies, can you comment on that at all?

DR. MARCIA PRENGUBER: Well I would say that having worked in a hospital environment the pharmaceutical companies to strongly influence the additional education. I can’t speak to the basic four years but certainly beyond that in terms of what drugs to use and when to use them, that sort of thing and the stronger the pharmaceutical company the bigger the influence. There is no question about it having lived through that for all those years.

REP. HENNESSY (127TH): Okay, thank you. No further questions.

SENATOR ABRAMS (13TH): Any other questions? I am just going to pose the question that I posed to Dr. Boisoneau earlier which is from your perspective why do you think it is that Connecticut has been so reluctant to follow through on the prescriptive formulas but not some of these other states?

DR. MARCIA PRENGUBER: I think that Connecticut is a very conservative state in many, many ways. It is an older state and conservative values have not, and I’m not making a judgement about conservative values, I just think that is what is part of it. You know, I watch however states like Oregon and Washington that have good pharmaceutical authority for naturopathic physicians and I watch our students graduate from here, from our University, and go there and practice as primary care physician safely and why the difference of what the states allow is, I’m not really clear on that except that I see a lot of conservative attitudes in terms of medicine in
general. I’ve watched nurse practitioners come to Committee for Scope of Practice opportunities. We also have a physician's assistant program at the University and those students are unable to transfer credits into the naturopathic program because they have so much fewer demands in terms of requirements. Their program is only 28 months in length and we certainly surpass them in terms of training and yet we don’t have the authority that they do.

SENATOR ABRAMS (13TH): So other than legislatively there is no fundamental differences between these states that are allowing this and our state.

DR. MARCIA PRENGUBER: Not in terms of patient need or skill. In terms of training, in terms of our naturopathic students and physicians they are equally trained and skilled.

SENATOR ABRAMS (13TH): Thank you very much. Well thank you very much for your testimony. Oh, I’m sorry I didn’t see you. Representative Carpino.

REP. CARPINO (32ND): Thank you, Madam Chairman. I just wanted to ask you a couple of questions. You brought up the enrollment. You said enrollment has dropped 50 percent.

DR. MARCIA PRENGUBER: In the last two years, yes.

REP. CARPINO (32ND): Can you tell me how that stacks up against some of the other naturopathic schools if the number of Connecticut residents that your students have changed and if that has any bearing on that drop and if you know if your alumni office has been able to chart any differences about concerning where your alumni have settled over the last few years.
DR. MARCIA PRENGUBER: Sure we do surveys regularly and we see a far greater percentage of our students travel to states where there is an increased Scope of Practice than what comes from their alumni to Connecticut or states with a lesser Scope of Practice.

REP. CARPINO (32ND): Thank you and could you, if you don’t mind getting some of that to Committee at least I would like to see that and I’m sure others but can you comment on the enrollment drop and whether or not that is something that the other schools have seen as well and whether or not that has any implication to Connecticut residents of the number of Connecticut residents who have applied and changed.

DR. MARCIA PRENGUBER: The Connecticut residents to the school? I can’t tell you the numbers off the top of my head but just based on my experience just last week watching students from here who, and I didn’t know where they were from, I just assumed they were all from that southwest area but in fact the first one that spoke said no, she’s from here and went there because of the scope and several others chimed in to that.

REP. CARPINO (32ND): And I appreciate the anecdotal comment, we hear them here all the time but if there are any facts or figures from the school it would be appreciated. Thank you. Thank you, Madam.

SENATOR ABRAMS (13TH): Thank you, my apologies again Representative. Any other questions or comments? Thank you very much for your time. Lyndsey Maher.
LYNDSEY MAHER: Thank you Members of the Committee for listening to me speak today.

My name is Lyndsey Maher and I am currently a fourth-year student at the University of Bridgeport, School of Naturopathic Medicine. I will be graduating in a little over three months and have with my doctorate much to consider before then which brings me here.

I am both born and raised in Connecticut, currently residing in Easton. After pursuing my undergraduate education out of state, I did decide to return home to Connecticut as it was time to establish myself as a young professional in the community inclusive of my family. It was at that time, I found Naturopathic Medicine and when I learned that out of only eight schools existing in North America and one of them was in Connecticut, it meant that I didn’t have to move across the country in pursuit of the education I so desired.

Our program is four years as Dr. Pengruber had mentioned as again the first two predominantly didactic and the later two predominately clinical. The University of Bridgeport houses a teaching clinic and community clinics that aid in our training for the last two years of our program, in concert with continued classroom studies and instruction.

Connecticut does not allow naturopathic doctors to practice in accordance with the full extent of their contemporary training, including prescriptive authority. It is no news to this committee regarding the healthcare crisis both at the national and state levels. Our retention of conventionally trained medical doctors in primary care is poor. The Robert
Graham Center projected that even to maintain the current rates of utilization, Connecticut would require an additional 404 primary care physician by the year 2030, while, as of 2014, it is only retaining 19.1 percent of its graduates. Several solutions have been presented including increasing scope for nurse practitioners, physician assistants, and nurse midwives – but no mention of Naturopathic Doctors. Granting a limited scope would mean that we can help to fill the physician shortage here and prevent redundant office visits, should a patient of a naturopathic physician require such interventions.

A large part of our education is spent teaching our patients so that they may make the most informed decision in regard to their healthcare. While pharmaceutical intervention may not be the primary treatment modality for our field, every patient is given their options in their care and if a patient chooses this route for treatment, they have a right to do so.

Last semester, a classmate and I decided we wanted to both aid in our education, further assist in the underserved communities of Bridgeport by raising funds to cover women’s health associated costs. We were able to cover either the cost of their visit or of their lab work that was required. This was a great learning opportunity because the patients were grateful, but also what about if they require intervention? We provided low cost services but now they need to provide a redundant office visit to seek that out. Thank you very much.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Any questions or comments? Representative Hennessy.
REP. HENNESSY (127TH): Thank you, Madam Chair. I’m on a roll [Laughter]. How are you Lyndsey?

LYNDSEY MAHER: I’m well, thanks. How are you?

REP. HENNESSY (127TH): It’s been a year I guess. We came up together to testify before this Committee last year on this very same Bill and it was an interesting experience I’m sure for you and I applaud you for willing to come back to do this again.

LYNDSEY MAHER: You guys didn’t scare me that much [Laughter].

REP. HENNESSY (127TH): Well thank you for all the work that you do in Bridgeport and helping the underserved in Connecticut. Thank you. Nice to see you again.

SENATOR ABRAMS (13TH): Any other questions or comments from the Committee? Thank you very much for your time. Jaquel Patterson. Welcome.

DJAQUEL PATTERSON: Good afternoon, thank you Members of the Public Health Committee. My name is Jaquel Patterson. I am a naturopathic physician and I am also a resident of West Haven. I also want to call to your attention the electronic testimony used by Dr. Katherine Golar who is an internist who is also supporting our Bill who I work closely with in my practice. I am a naturopathic physician who has been practicing for the past 11 years running an integrative medical in Fairfield, Connecticut. I also serve as the President for the National Association, The American Association of Naturopathic Physicians and I can provide some context from the national perspective.
I’ve also served in leadership and administrative roles within the state; previously working as the VP of Operations at Community Health Resources, COO for Norwalk Community Health Center, served on the Provider Advisory Council for the Person-Centered Medical Home, Quality Committee for State Innovation Model, and Training Chair for Integrative Medicine for DMHAS. I have firsthand experience within the standard medical model and know the benefits of utilizing and leveraging knowledge from ND’s in various settings.

I ask you to support inserting language into HB 5902 that allows Connecticut Naturopathic physicians to attain limited prescriptive authority. Passage of this Bill will enable better continuity of care and greater healthcare access to the citizens of Connecticut. Connecticut’s current law trails behind states nationally including our close licensed state, Vermont that has very broad prescriptive rights. Passage of this bill into law will result in many benefits to the citizens of Connecticut.

Lack of prescriptive rights, limit’s our ability to provide a full continuum of care often required. Many of my patients are unhappy that they need to return to their PCP for a prescription when we are trained to do so and they often inquire as to why we can’t prescribe. Examples, an antibiotic for strep throat when a positive culture is returned, Metformin for blood sugar management or thyroid hormone for low thyroid function. This causes unnecessary cost and waste within the medical system.
Citizens of Connecticut are seeking ND’s to more fully manage their care and to be referred as medically necessary. They should have the choice of how they would like to receive their care. In practice, I have an internal medicine consultant and other MD referral sources that I used as needed. ND’s serve an important role in providing primary care and connecting patients in a collaborative way for specific needs.

Nationally, ND’s have a positive track record of prescribing pharmaceuticals in comparison to MDs and Dos and malpractice record actually demonstrates safety. We are also looking to prescribe to take an additional pharmacology course and pass an exam in order to do so. So thank you very much, I’m open to questions.

SENATOR ABRAMS (13TH): Thank you very much. Representative Cook.

REP. COOK (65TH): Thank you, Madam Chair and thank you very much for being here. Your resume is extensive and so I think you might be one of the people that could answer some of the questions that I had asked previously about the length of prescriptive authority and what that might look like?

JAQUEL PATTERSON: A limited prescriptive authority?

REP. COOK (65TH): Correct.

JAQUEL PATTERSON: I think I know Dr. Rick Liva will be speaking later. I know we have an inclusion list of drug categories that you provided me. He could probably actually speak to it in a little more detail as probably myself.
REP. COOK (65TH): So within your testimony I understand you have a relationship with traditional MD?

JAQUEL PATTERSON: Yes so we have an internal medicine consultant and I refer as needed. So for example I gave an example of a patient, I did a physician exam, had Strep throat, sent out for a culture I then had to refer her to the internist as to then get a prescription and so that is a frequent pattern where we have to then get a patient referred out to their PCP. We contact them or urgent care and the patient’s don’t really understand that. They don’t know why we can’t fulfill some of those basic needs or a patient that is managed, has been on the same medication for 20 years and is managed well and when they want to actually get their care, most of their care with a naturopathic physician.

REP. COOK (65TH): So in the situation of what you just described was similar to what I had just mentioned earlier, so I would go to you. You diagnose, you can do the test, you get the results of the test but because you work with a partner with an MD they would take your recommendation to prescribe?

JAQUEL PATTERSON: Exactly. So she would actually then see the person, so then there is an issue with cost, she actually then has to see the patient, do a physical exam again, go through that whole practice and ultimately prescribe what I actually thought the patient should be prescribed. So the MD actually has to see them in person and have another visit. So that is one of the frustrations with patients is now they have to go for another visit to go through
the whole thing to ultimately get what we would have recommended.

REP. COOK (65TH): And so how does that work on the insurance end.

JAQUEL PATTERSON: So we are luckily covered, you know, in terms of insurance accepting it. The piece is they can’t be seen in the same day in terms of physician so they would have to lots of times we end up having to send out the lab work so we won’t have the results in that day so typically it hasn’t been an issue because they would be seeing them the next day potentially. But ideally if we were able to see them right then and there like a rapid Strep culture we would be able to have them leave with the prescription rather than coming back, you know, two days later to follow up.

REP. COOK (65TH): So in essence you’re sending somebody out who you already know has Strep, who is now contagious, who cannot get seen within another 24 hours because insurance will not let you be seen.

JAQUEL PATTERSON: You can’t see a provider.

REP. COOK (65TH): Kinda crazy. All right, no other questions. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments from the Committee? Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. I have one quick question and I think I know the answer to this. So if you get your prescription, right, if you’re able to prescribe me something for Strep throat and then with this Bill does it -- is it covered under
insurance, the prescription? I know the visit is and all that but the insurance would cover?

JAQUEL PATTERSON: The prescription itself, yes, should be covered along as they have insurance it would be. Same as it would be when we run lab work as long as our patients have insurance the lab work is covered.

REP. ZUPKUS (89TH): I know that but vitamins and minerals that are therapeutic that you give, those are not.

JAQUEL PATTERSON: Those are not. They have to do their HSA or SSA account. It would be nice if it could be, but yes that is one of our challenges.

REP. ZUPKUS (89TH): As I said earlier today if I went to a doctor and they prescribed anything, whatever it is, it’s covered. Synthroid, Ritalin anything. If I go to a naturopathic doctor and they prescribe fish oil and vitamins it is not covered.

JAQUEL PATTERSON: It is not covered.

REP. ZUPKUS (89TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions? Any other questions or comments? Thank you very much for your testimony. Nicole Klughers.

NICOLE KLUGHERS: Good afternoon, Senator Abrams, Representative Steinberg and Members of the Public Health Committee. I am Dr. Nicole Klughers and I live in Fairfield, Connecticut. I’m a licensed naturopathic physician, practicing in Rocky Hill since 2016. I testify in support of House Bill 5902.
I’ve earned a doctorate in naturopathic medicine from the University of Bridgeport, which is the only accredited naturopathic medical school in the Eastern United States. Prior to pursuing my career in naturopathic medicine, I was a pharmacist and I hold a Doctor of Pharmacy degree.

Although my passion for helping people first led me to become a pharmacist, I chose to become a naturopathic physician because of the limitations I experienced in the conventional medical model. In the pharmacy setting, I experienced a lack of ability to practice integrative, sustainable and preventative medicine.

When I graduated from naturopathic medical school, I wanted to stay in Connecticut and practice to the best of my ability, providing comprehensive, cost-efficient and results-based patient care. However, the current scope of practice does not allow me to do this in Connecticut.

I have been thoroughly trained to adequately diagnose and treat a condition, yet if the most appropriate treatment at the moment is a prescription for medication, I need to refer these patients to another physician who has prescriptive authority because I have no such authority in the state. This situation dilutes my ability to provide optimal care for patients, delays treatment, increases cost and duplicates services. This process is unnecessary and inefficient for the patient and our healthcare system.

I believe of Connecticut rightfully deserve their choice of the healthcare provider that can serve them comprehensively. Naturopathic physicians must be able to provide appropriate care to people who
chose their services. A law update to allow limited prescriptive authority will foster optimal and cost efficient patient care.

Licensed naturopathic physicians in many other states use drug therapy. The Connecticut scope of practice has failed to keep pace with advances made by other states. The majority of licensed naturopathic physicians in other states, successfully and faithfully practice medicine with prescriptive authority and provide comprehensive patient care, consistent with our training.

If I were practicing naturopathic medicine in many other state, I’d be able to prescribe a medication when necessary, as long as that medication is included in the state’s naturopathic drug formulary.

The Connecticut law regarding naturopathic scope of practice is just under 100 years old. I think it’s time we develop a limited drug formulary and establish naturopathic prescriptive authority to improve healthcare outcomes for people of this state. Naturopathic physicians who wish to prescribe would need to take an additional pharmacology course and pass a board exam. Patient safety will be a top priority.

I look forward to your support on Proposed House Bill 5902. I ask you, as members of the Public Health Committee, to please vote YES on this very important public health issue so that Connecticut can make progress in modernizing naturopathic care.

I’m happy to answer any questions and truly appreciate the opportunity to testify. Thank you for your time and for your service.
SENATOR ABRAMS (13TH): Good timing. Thank you. Any questions or comments from the Committee? Thank you very much for your testimony.

NICOLE KLUGHERS: Thank you.

SENATOR ABRAMS (13TH): Rick Liva.

RICK LIVA: Senator Abrams, Representative Steinberg and Members of the Public Health Committee, I am not going to read my testimony because this would be the sixth time I’ve said the same thing before the Committee.

What I would like to do is try to set the record straight on something that was said at the beginning of the hearing. We did not go through three scope processes with the DPH we went through one. Two years or three years later because we didn’t get anywhere DPH suggested and legislators suggested that we sit down with the medical doctors as well as a whole cadre of other people to try to hash out a formula. We tried to hash out a formulary in the initial scope process and we were met with such resistance that it never went anywhere.

In the second Committee process the same thing happened. We talked, we talk, we talk, nothing ever happened. There was never a formulary put on the table. We tried but what again what we got was resistance.

So you, Representative Cook had some questions about the formulary and I think that’s what this boils down to, to some degree. One of the things I said last year, because I did not ready my testimony last year either, I said there are thousands of naturopathic physicians prescribing drugs in other states, they do it safely. There is a safe record...
that is documented. The Vermont study that allowed Vermont naturopathic physicians, passing one exam only for pharmacology got them full prescriptive authority with education and training and some carveouts like they can’t do oncology drugs and HIV drugs and TB drugs and I don’t know all the carveouts in the formulary but that is what happened in Vermont and it was not done by the MDs and you guys have this because I submitted it with my testimony today. It was done by the Department of Professional Regulation because they had an onerous formulary process and they wanted to get rid of that basically. So I’m happy to answer any question about formulary if you want to do that. But I’ll stop with this. It’s happening somewhere else with thousands of naturopathic doctors treating their patients, why can’t it happen here? It can.

SENATOR ABRAMS (13TH): Thank you. Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. So I haven’t brought this up but it seems to me the memory of this ongoing thing that there was at one point discussions and the question was what would you be comfortable with and the answer was definitive nothing. Is that true.

RICK LIVA: You mean from us?

REP. HENNESSY (127TH): No, no from the medical field.

RICK LIVA: Absolutely. I was in all those meetings, I didn’t miss a one. We tried, we tried, we tried and what we got was nothing but resistance and because apparently we’re not trained well enough. We’re gonna hurt the public but that is not
what is happening in other states. So again we can do it there, why can’t we do it here? Did I answer your question?

REP. HENNESSY (127TH): Yes, yes. It just seems like we’re up here and we negotiate. We come with compromises and with this Bill it just seems like it’s dead on arrival every year on presentation.

RICK LIVA: I’ll say one more thing and, you know, I’ve said this to other people and I’ll say it here in open testimony. DPH opposes us as well. So if the medical doctors are opposing us and DPH is opposing us how do we get anywhere?

REP. HENNESSY (127TH): Point well taken.

SENATOR ABRAMS (13TH): Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman and thank you for your diligence and your dedication to the cause. I think that we come back here trying to, you know, get somewhere wherever somewhere might be is better than where we were last year. So for the record when was the scope, the one scope that we went through when was that?


REP. COOK (65TH): And the outcome of that scope was specifically?

RICK LIVA: Well the DPH basically is sort of like the eyes and ears of everything that goes on between the naturopathic physicians and the medical doctors because when you do a scope process the detractors become part of the committee process. So for instance the chiropractors were there in support of us. They didn’t do much, they were just there in support for us but we did most of our discussions
with medical doctors and DPH wrote the report and I also do not believe that the consensus of DPH is/was reported, I don’t actually remember what they said. It’s been a long time since then but it was not as onerous as you were lead to believe.

REP. COOK (65TH): And in no way have you all ever asked to be able to prescribe Schedule I narcotics or any of those things, correct?

RICK LIVA: Exactly and we did submit a Bill last year which included and we did the same thing this year, there is an exclusionary list and we’re happy to take a look at drugs in general and say, all right you want more things on the exclusionary list, we can probably live with that. But, you know, I think of this as, I would like to have bread and butter drugs for primary care. Bread and butter drugs for primary care or GI drugs, some cardiovascular drugs and on and on like that so that when the person in front of me is saying I’m complaining of X, Y or Z and I’ve tried everything I can do in my natural medicine bag, again it’s not working well sometimes you have to turn to drugs.

The other issue that is extremely important is someone comes in and they are overweight, have hypertension up the wazoo and they say I’m ready to change my diet and my lifestyle, start to exercise, maybe relax a bit and have some more fun in my life but I’m on three drugs for high blood pressure, can you help me get off of them. Well I’m not gonna say just stop them right away, that would be crazy. But there is a process that we would have to go through to help this person reduce their medication, if that’s possible. But in order for me to take someone off medication, I have to have the authority
to put them on in the first place. No authority to put them on, I can’t take them off. I have to say to them go back to your medical doctor and talk to them about getting off of some of your medication. That usually doesn’t work out.

REP. COOK (65TH): So in theory as the patient I don’t have my own choice?

RICK LIVA: Under the current circumstance absolutely.

REP. COOK (65TH): And so as much as we hear that there is a battle between the traditional doctor field and naturopath field where does the insurance industry play a part in this.

RICK LIVA: Well we’re covered by insurance companies, the vast majority of them in the State of Connecticut thanks to Doc Benther but obviously we can’t prescribe a drug. If we could prescribe a drug it would be covered by an insurance company. They wouldn’t have to do a duplication if there was a situation like we’ve talked about.

REP. COOK (65TH): Thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you Dr. Liva for your comments. I was not involved with the prior review and it sounds like you intimately were so that is good information. As I’ve looked at the Scope Review did come out February 17, 2017 so it is about two years and it says in part in the final page, its 12 pages of multiple appendices, “Opponents of naturopathic
prescribing felt that the didactic component refresher course would be helpful but a collaborative relationship with an experienced provider would be critical should prescribing rights be granted by the legislature. Physicians and APRN representatives on the Committee stress that the real learning about prescribing occurs during residency, a collaborative relationship that cannot be fulfilled through didactic education alone.”

And of one that I would agree because, you know, typical MD or OD school you spend the first two-and-an-half, three years in medical school learning about the drugs and other people, you’re writing them and having ‘em cosigned and then you spend three years in a residency, if you go on to a Fellowship it’s an additional three years, so most people have five and a half years of clinical experience before they’re out prescribing on their own. So it seems to be as I look at this, the big crux of it, they seem to be pointing to the clinical training and feeling that they want the naturopaths to have more clinical training and more clinical experience in terms of prescribing medications given the vast array of medications available. So I realize that’s the statement but I wondered if you would comment on that in terms of clinical training naturopaths would be willing to do?

RICK LIVA: Well other than what we’ve already proposed which is we would be willing to, almost as an appeasement, but certainly, this would be an advanced practice thing for naturopathic physicians in the State of Connecticut. Not everybody is gonna get this. You have to jump through some hoops. See egos up by 100 percent, the course that has to be taken is a 45 hour pharmacology course and you have
to pass an exam. In my opinion we could certainly look at what medical doctors do and say, yes you have more clinical hours but at the end of the day, I’m not sure the clinical hours are really the thing that matters because of what I said before. MDs get clinical training. They have a bunch of it actually in their time in school and some MDs do a residency but it is not mandatory and you probably well know that most residencies or if not all of them are subsidized by the Federal Government. Well we don’t have anything like that so we can’t mandate a residency. But my point is this, you get the training that you get. We get the training we get. We can still do or use drugs in a judicious and safe way with the training that we have and one of the stumbling blocks that we seem to be dealing with here is, well I have more marbles in my basked than you have so therefore you shouldn’t be allowed to do this because I have more marbles. That is the way I see it, bring it down to something very simple. Remember what I said, it’s being done in other states and has been for at least 20 to 40 years depending on the state. Oregon’s formulary is huge, they fought for it for years and they can prescribe almost anything. They have some carveouts and some exclusions.

REP. PETIT (22ND): You gave me to good of a straight line here I think, perhaps I think I lost all my marbles when I went from medicine to politics [Laughter].

RICK LIVA: You still have them, I’m sure. [More laughter].

REP. PETIT (22ND): I have another thought there, oh in the MD field I’m just wondering cause you said it
would be like an advance training program, what would you gather from your own experience or surveys you might have seen do half of the MDs out there want to be able to prescribe and half don’t. Do some want to stick with what MDs have done, is the field somewhat divided if you will, people who believe in medications and some who want to avoid them at all costs?

RICK LIVA: That is a good question and I do not specifically know the answer. What I can tell you is there are a lot of MDs in this state that would like authority and I’m sure that there are some who probably will pass on it. That is the answer that I can give you Dr. Petit.

REP. PETIT (22ND): Yeah, I think that’s it. Thank you, Madam Chairman. Thank you, Dr. Liva.

SENATOR ABRAMS (13TH): Are they any other questions? I have a question for you. Several people have mentioned passing an exam. Can you talk a little bit about there, where the exam comes from, who designed it?

RICK LIVA: I have a colleague that is PharmD at Mass College of Pharmacy and we asked them to develop a curriculum for us, that 45-hour curriculum, they have developed it. What we’re waiting for the Law to pass. So it’s there already for us to pull off of the shelf and use it.

SENATOR ABRAMS (13TH): So the exam is associated with the additional education?

RICK LIVA: Exactly. Any other questions or comments? Thank you very much for your testimony. Rob Dudley. Welcome.
ROB DUDLEY: Thank you for the opportunity to testify and for your time. I’m Rob Dudley, I’m a primary care pediatrician and the President of the Connecticut Chapter of the American Academy of Pediatrics. I am testifying on behalf of the nearly 1,000 pediatrician members in this state against the proposed Act.

The American Academy of Pediatrics advocate that every child receives high quality accessible family centered comprehensive care in a medical home and to the optimal pediatric care is best delivered in a team based approach that is led by a primary care provider who assumes responsibility for managing the patient’s care. All professionals who provide pediatric care must hold to the highest standards of education and training and continually demonstrate their skills and competencies. We have grave concerns related to naturopathic having the ability to prescribe, dispense and administer prescription drugs.

During the four years of medical school, medical pharmacology is first approach is biomedical science and later focus is on clinical and therapeutic applications. The study of pharmacology continues during residency which is at least three years long. During that time we focus specifically on the needs and difference of prescribing medications to children from birth to adulthood.

A license to practice naturopathy requires a much smaller number of hours of clinical pharmacology than what your typical allopath or osteopathic provider receives. There is no requirement for postgraduate training and we do not think this is
adequate preparation for prescribing medications to children.

Our other major concern is the traditional antivaccination views present in the naturopathic community. Immunizations are one of the most important pharmacological substances we have in mission to prevent disease and keep children healthy.

We believe strongly in the importance of life-saving needs to vaccinate children and young adults against preventable diseases and we believe that naturopaths do not. We believe there is a value in nontraditional therapy such as acupuncture and massage and certainly share the naturopaths philosophy of the importance of prevention in the form of good nutrition, healthy lifestyles. However practitioners from naturopathy are not fully trained to prescribe medications to kids.

SENATOR ABRAMS (13TH): Thank you very much. We don’t get many people who finish before the bell, so. Are there any questions or comments from the Committee? Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Thank you for your testimony. I truly appreciate your dedication to insuring that our children are taken care of. But I do have a question, do you feel if there was further education, is there room in your vision for naturopaths anywhere at all in this conversation?

ROB DUDLEY: So yes, I practice in a qualified health center where we practice complementary medicine every day. We have a chiropractor on staff. We frequently consult others. I don’t
currently, we don’t currently have naturopaths in our care program but it is certainly something I could imagine folks would be able to collaborate with.

REP. COOK (65TH): But you in your personal opinion do not ever see the ability for a naturopath to be able to prescribe or they could if in fact they went back and had continuing education later on?

ROB DUDLEY: So the amount of education I think we’ve outlined today is pretty extensive, semesters of pharmacology in med school and residency is a continuous process over a three year period of learning how to prescribe recognized disease states and treat children. I know folks have brought up Strep throat as an example a couple of times, it seems like it would be a simple thing to diagnose along with and to treat, it’s not necessarily all said and done is easy.

REP. COOK (65TH): Okay, thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Oh, Representative Betts.

REP. BETTS (78TH): Thank you and thank you, Doctor. I’ve been listening to this for a few hours now and questions have come to my mind. One is I’ve heard repeatedly that other states have allowed naturopathic professionals prescribing in other states, I don’t know what the curriculum is but it has been repeatedly said by the advocates to the proponents that there has been no problems in the other states or adverse events that have been reported. Do you know if in fact that is the case and if it isn’t what is your response or have
anybody looked to see if there had been adverse events with naturopaths in other states that have been given, and I’m assuming a very limited amount of prescriptive authority, has anybody, if I were opposing this I would tell you clearly they don’t have the knowledge or experience and let me cite you some examples in Oregon, Washington or whatever but I’ve not heard any of that testimony.

ROB DUDLEY: So I do not have the knowledge base to answer that question.

REP. BETTS (78TH): Is that a fair question?

ROB DUDLEY: I think that would be something that would warrant investigation.

REP. BETTS (78TH): No, but I’m just asking is that a fair point? If I were to look into that and I researched it and it turned out for the sake of discussion here that I was unable to identify here or verify any adverse event would that change your thinking or opinion in terms of what is being discussed now?

ROB DUDLEY: So I think that question hinges a great deal on the Scope of Practice that is outline and what qualities of medications are being prescribed and how they are being used.

REP. BETTS (78TH): Okay I think one of the problems is I think the people think that if they have some kind of prescriptive authority they are at the same level as a doctor who has had extensive clinical training and a lot more knowledge. I as a consumer would not view it that way. Now maybe I’m not typical and maybe I’m different, I look at it as a consumer choice, some people may be interested in wholistic medicine, I don’t even know if that works.
If it does, okay good for the consumer but at least it is a choice. Is there a reason not to allow people or encourage them to have choices in the way they get treated?

ROB DUDLEY: So choices are very important for everyone. You know the allopathic physician’s perspective is one that is evidence based. Sometimes the hardest things to say to a consumer or a patient is the word, “No”, right. It is very easy to say yes I can give you some antibiotics for what I think might be Strep throat and what you might think might be Strep throat but it is a much longer, more difficult a nuance conversation to say to a family your rapid Strep test is negative, I am not going to provide you with antibiotic today because that would be inappropriately exposing you to chemicals that might do your child harm and in two days if your culture comes back positive I’m going to call you back and get you a prescription for some medication and go over it and have my nurse go over it with you. So I think that prescriptive authority comes with the opposite end which is to also be able to explain to folks when things aren’t appropriate and to safeguard those antibiotics for the right time of use so that we don’t bread, you know, the resistant antibiotic bacteria that is going to cause a lot more trouble for us.

REP. BETTS (78TH): Okay, thank you so much.

SENATOR ABRAMS (13TH): Any other questions or comments from the Committee? Thank you very much for your testimony. Katelyn Lieb.

KATELYN LIEB: Thank you for listening to my testimony this afternoon. My name is Katelyn Lieb and I am a third year student at the University of
Bridgeport School of Naturopathic Medicine. I am pursuing a doctoral degree in naturopathic medicine. I currently live in Fairfield, Connecticut. I decided to study here in Connecticut for a variety of reasons, the quality of the program, the opportunity to build professional connections on the east coast and being close to my home and family.

Unfortunately the laws surrounding naturopathic medicine do not reflect the education, training that modern naturopathic physicians receive and significantly limit the type of care naturopathic physicians can offer to patients. In particular despite our training Connecticut does not afford naturopathic physicians any form of prescriptive authority while other states do. A patient under the care of a naturopathic physician in need of a simple prescriptive medication like an antibiotic need to meet with another physician such as at a walk-in clinic or an emergency room in order to obtain that medication. This duplicate services and additional costs to patients and unnecessary strain on our already burdened healthcare system. We are able to diagnose conditions in office that require medications but in order for patients to obtain them we must refer them to additional providers.

We are educated on the appropriate use of prescription medications but do not have the opportunity to prescribe them ourselves in this state.

Many new graduates from our program decide to leave the state due to the limited Scope of Practice in Connecticut. This is especially unfortunate when you consider that the University of Bridgeport School of Naturopathic Medicine is the only
accredited naturopathic medical program on the east coast. I look forward to pursuing my dream of practicing naturopathic medicine hopefully here in Connecticut but without a change in the current Scope of Practice to allow at least some level of prescriptive authority I would strongly consider relocating to Vermont, New Hampshire, Washington, D.C. or any other state on the east coast as well as many outside the northeast that allow me to practice fully with a formulary and have more professional opportunities.

This is a time when Connecticut can and should be doing more to promote young professionals to remain in Connecticut, raising a family here, working here and opening businesses here. This change to support our field I feel is long overdue. The education we receive is identical to what would qualify us to have access to formulary in other states so why not here? For nearly 100 years Connecticut has supported diversity in the healthcare system by licensing naturopathic physicians. We are modern physicians and it is time to modernize with us.

On behalf of naturopathic medical students like, me and on behalf of the patients that we currently serve and will serve in the future, I am asking for your support on Proposed House Bill 5902 to afford us the ability to practice here in Connecticut within our educational background. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Thank you for your testimony. Della Barros, is Della Barros here? Okay, Dian Dossias.

DIAN DOSSIAS: Good afternoon Esteemed Members of the Public Health Committee. My name is Dian
Dossias and I am here to speak in favor of Proposed Bill 5902. I was gonna read my testimony and I will be honest, I did submit a written testimony so obviously most of that you can read from that.

I want to point out because of some of the comments that were made today about prescriptive medications and the fact that naturopaths, you know, they’re concerned about either over prescribing or having, you know, issues with treating patients. I was actually on my deathbed. I went to a PCP over a three year period trying to figure out exactly what was going on. Interestingly enough I have lead poisoning, that was not discovered by the PCP. It was actually discovered by an naturopath. Another point I would like to make is vaccines were certainly suggested to me over this period of time, come to find out I have some genetic mutations and things that would have actually been very, very damaging and very, very concerning for my future and potentially putting me in a disabling situation. My medical condition quite frankly, I did become disabled. I had to leave a 28-year career. I could not figure out exactly what was going on and it wasn’t until I saw a naturopath that I was able to get healthy. I was able to recover, I was able to treat and I was able to sit here in front of your today.

What’s interesting too, I do go to a naturopath that does have a combination of providers on her staff. She is also on the faculty of the Institute of Functional Medicine and is world renown. She does have a medical doctor on her staff in order to allow for prescription medications. So when I need to get my thyroid medication I do need to go to a second appointment with this medical doctor just to be able
to fill or refill my prescription. I want you to know I also have a daughter who has been dealing with some difficult situations. She does also have an autoimmune as I do. She has been seen by Dr. Klughers who had testified previously and, you know, again we’re limited in what she can do with her treatment because she does not have prescriptive authority. She has definitely helped my daughter improve her health. We are in a situation where we are both doing much, much better and this is after the conventional medical system has actually failed in treating us.

SENATOR ABRAMS (13TH): Thank you for your testimony. Are there any questions or comments from the Committee? Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman and thank you for your testimony. I am glad to see that you are doing better. Could you just briefly describe the difference between a visit between your traditional family doctor and a naturopath?

DIAN DOSSIAS: Wow, yeah. Absolutely fortunately with the conventional medical system I probably get an average of 10-15 minutes and will tell you again over that three year period I had to see that doctor almost monthly but I wasn’t getting anywhere I really felt discouraged and disheartened by the fact that I just, you know, was not getting proper care and unfortunately again, I’ll say it’s interesting he was prescribing sleep medication, anxiety medication, antidepressants and I knew in my heart that is not the issue and that wasn’t the root cause. So the naturopaths, both of them, obviously my doctor as well as my daughter’s doctor every time we see them it is an hour, it’s an hour visit.
REP. COOK (65TH): Thank you. Thank you, Madam Chairman.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for being here today. We will try Bella Barrows one more time before we move on. No. She testified previously? Okay, thank you. Moving home to House Bill 7132. Rebecca Ruitto. Is Rebecca here? She already testified, thank you very much. Norja Cunningham. Welcome.

NORJA CUNNINGHAM: Thank you so much. Great evening to you all. I am here, Norja Cunningham again, I am a PhD as well as a licensed marriage and family therapist. I teach over at Southern Connecticut State University as well as have a private practice that is located in Bridgeport and Richfield locations. So thank you so much for your time. I am here in support of House Bill No. 7132 concerning the associate license.

Why is this important? Not only because of my own experience in being in Connecticut and receiving my Masters from Central Connecticut State University and then moving to New Hampshire for a bit of time while being able to obtain my Doctoral degree but recognizing that it would have been very important or helpful to be able to have the associate license so after graduating with your Masters’ you are able to establish, taking the exam, pass the exam and then be able to be licensed in order to be able to utilize that within context of being a licensed professional within an agency while also obtaining a degree or for those whom I’ve had pleasure to speak with that have had experiences with, because of not being able to have an associate license sometimes having to leave the profession in order to supply
for their family until they were able to gather enough hours unpaid to then go back to the profession and then be able to provide services and we know how important it is especially in the State of Connecticut to be able to support those whom are in need, not only individuals but couples and families that are dealing with things of this particular nature like trauma or even crisis intervention that occurs within homes and families with domestic violence as well as our current opioid crisis which is a national crisis that we’re dealing with. But there are individuals that need support and we need as many therapists as possible, especially marriage and family therapists that would be able to support because we look at supporting families clinically but also in a very systemic way. So we’re looking at not only how we can support that person but also how we can support the entire system which we all may have deal with some personal experience and I’m not here to therapize anyone but at the same time I would say that substance use and trauma not only affects the individual but it affects the entire family and those of whom are connected even in their community. So to be very helpful to have that associate license.

I have also had an experience while working in an agency as clinical program director. I had someone who was under me that was a marriage and family therapist and actually was implementing, my last point, was only meeting with five or six clients because they worked in a group home setting. So consider how long it takes to gather 1,000 hours that are face-to-face hours. So what it meant is she spent eight years at an agency that she loved the work she did but ultimately had to leave because
it took her that long to get licensed. So there is some, you know, literal gaps I would say that are in the law that would help support someone like that, that’s really in the work because they love what they do and want to support their clients but maybe in a different context that requires and associate as a bridge to the full license. Thank you so much for your time.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Thank you very much for your testimony. Michael Shavel. Welcome.

MICHAEL SHAVEL: Good evening. Thank you, I am Michael Shavel. I am a Licensed Professional Counselor, a resident of Stratford and the current President of the Connecticut Counseling Association CCA for short and I am here to express our support for House Bill 7132.

We have already submitted detailed written testimony regarding this and a common theme that has come up tonight is retention of new graduates in the State of Connecticut who obtain degrees from various programs and that includes mental health counseling. Currently an individual who is a new graduate must acquire 3,000 hours of on the job experience, 100 hours of supervision, pass an exam then apply for the license. Many employers who are hiring are looking for individuals who currently have the licenses.

So it presents at Catch-22 for recent graduates who’ve invested in Connecticut Universities and Colleges, many of whom are here tonight from Southern Connecticut, St. Joseph’s, Central, West Conn, Fairfield University and there are
approximately about 100 graduates who obtain this degree in Connecticut annually.

The second reason why we support this it would provide important consumer protection. This means an individual who obtains the LPCA the Licensed Professional Counselor Associate would receive formal oversight from the Department of Public Health. They would be a licensed individual. The client, the consumer could verify that license on the Department of Public Health website. They would receive proper supervision and they would be required to attend all the continuing education requirements regarding professional ethics, multicultural populations and Veterans issues.

I have a degree from Southern Connecticut State University, my internship was at the VA, the Vet Center in West Haven where I learned a lot about post traumatic stress disorder and providing counseling to Veterans.

Currently there is already another profession that has the two-tier licensure that would be social workers. So we are looking to be on equal footing with another profession that already has this in place and has had it since 2014. In addition, as you will hear testimony from other individuals who work in other states that have the two-tier licensure, Connecticut is one of ten states that does not, 40 other states have the two-tier licensure for professional counselors. Also we’re not seeking any changes to the Scope of Practice under this Bill, that’s important to emphasize and the process, the implementation process would just require one document to be completed immediately upon a graduation so the individual could obtain the
LPCA soon after graduation rather than two to three years after they’ve met all the requirements. I’d be happy to answer any questions.

SENATOR ABRAMS (13TH): Thank you very much. I’m sorry to cut you off. Welcome to all the students. Nice to have you here. Are there any questions or comments from the Committee? Yes, Representative Young.

REP. YOUNG (120TH): Thank you Michael, thank you teachers and students. You being one of my constituents, I’m very happy to see you people all filling up advocating for yourselves. It is important to us to see these kinds of things and hear your testimonies. So I just wanted to say thank you all and if we pass this I want to make sure that all of you stay here in Connecticut. So I’ll check up on ya.

SENATOR ABRAMS (13TH): In your district I assume?

REP. YOUNG (120TH): Yes [Laughter]. That’s right.

SENATOR ABRAMS (13TH): Representative Demicco.

REP. DEMICCO (21ST): Thank you, Madam Chair. Thank you for coming to testify. I just want to try to understand, this is not the first time that we’ve had this legislation before us. So what has been the sticking point in previous years as far as you know?

MICHAEL SHAVEL: Well it may have to do with what is the perceived amount of labor involved in processing the application by the Department of Public Health and we’re proposing this Bill, what the outcome would mean is some of the paperwork would be processed earlier than if they were to wait to meet
all the other requirements but that would enable individuals to obtain their license that much sooner, yes.

REP. DEMICCO (21ST): One more question Madam Chair if I could, so just so that I understand. So what is the practical implication here. In other words what is, and again, I know you talked about it earlier but I just want to make sure I understand, what is the conundrum that somebody finds themselves in that were trying to solve here?

MICHAEL SHAVEL: You have graduates of a master’s degree program that are entering the job market, that have invested the time and may have difficulty competing with other professions that have a license. And we have another profession in Connecticut that has the two-tier structure and has been in place for five years, so the job market is always competitive and you have graduates and there are about 100 total per year statewide entering the job market who will need to compete with licensed professionals. This would enable them to obtain and maintain employment in the state.

REP. DEMICCO (21ST): Thank you, great. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments from the Committee? Thank you for your testimony. Laura Furey. Welcome.

LAURA FUREY: Thank you. To the Public Health Committee I thank you for this opportunity to offer my strong support of House Bill 7132. My name is Laura Furey and I am a clinical mental health counseling student at Southern Connecticut State, a current resident of New Haven and a longtime
resident of Connecticut. It is for these reasons I feel strongly about advocating for this issue.

I am here on behalf of myself and my fellow classmates who will be impacted greatly by the future of this Bill. As you know, this Bill will allow recent counseling graduates to be immediately licensed as an LPCA. Social work students are already offered a two-tier license system with an LSW versus LCSW. Approximately 40 other states offer a two-tiered licensure system. A two-tiered system is going to allow for a clear professional identity when looking for employment.

As counselors we are required to obtain 3,000 hours of supervised work experience in order to obtain a license. This is in addition to the requirement for our graduate degree of a 600 hour supervised internship as well as 100 hours supervised practicum. This currently can be difficult to do when employers prefer to hire a social worker graduate who is already licensed. This Bill is not only going to help recent graduates but is also going to strengthen the identity of the counseling field. Social workers are already well-established with employers which is requiring counseling to have to work unnecessarily hard to be seen with the same credibility. It will also better insure better oversight during supervision only strengthening the profession but benefiting the public.

I was advised before applying to graduate school that social worker had better employment opportunities here within the state but I felt counseling better aligned with my career goals in helping people with a curriculum that is heavily concentrated in psychotherapy. I have a very
specific career vision and plan to work with those struggling with chronic illness, the Hispanic population as I am fluent in Spanish, chronic pain as well as addictions to help this Nation’s and State’s opioid crisis. All of these populations are in great need of practitioners and I hope to be able to do the work that I would like to do. I have great respect for social work and have many friends in the field but I am discouraged that I see as a potential barrier being seen as less qualified as my peers strictly because of this system.

Further as a Connecticut resident, I believe this Bill could only draw more interest to the university system here that is offering counseling programs. As we all know the state economy has been struggling and we have difficulty retaining recent graduates. I am a proud graduate of our public university system with an undergrad degree from the University of Connecticut Storrs now pursuing my master’s at Southern. However when I was considering grad school I highly thought about leaving the state because of the struggling economy here. It was only after speaking with the faculty at Southern who greatly impressed me and I also realized how much I would like to give back to my local community and I hope to be able to do this.

I think of future students because graduates from these types of programs, I only have one more, prefer to stay within the state which they completed their study but at this point in time current graduates are going to be encouraged to look for employment in a state that deems them as a licensed practitioner such as New York and our surrounding states that are working to achieve this. We should do everything we can to support our economy and
growth of Connecticut and we can do so by supporting the counseling field and it’s recent graduates. I urge the Committee to support House Bill 7132 and I thank you for your time and consideration today.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Thank you for your testimony. Elaine Lang. Welcome.

ELAINE LANG: Hello, thank you. I am here in support of House Bill 7132. I am a first year student at the University of St. Joseph in the clinical mental health counseling program as part of a midlife career change from public service and politics.

We’ve heard addressed the parity issue American Family Therapists and professional mental health counselors have a very similar educational background and supervision requirements to our colleagues in the social work field. We also work in mental health and the issues of parity and fairness have been covered and I think that’s really important that we are on equal footing within the mental health profession.

But this isn’t just about parity and fairness. This Bill is good public policy. It is not unduly burdensome on the stretched budget or on stretched state workers. There are no increase in our Scope of Practice for either profession. There will be no increase in the number of professionals who are licensed. It is merely an earlier entry into the public health system. And most importantly the benefits to the people of the State of Connecticut are huge. Enhancing the professional status of clinical mental health counselors and marriage and family therapists allows greater access to mental
health services for people in this state and that is something that is sorely needed. Also enhancing these professions makes them more accessible to people in different backgrounds and allows people from communities who are underrepresented in the mental health profession to have greater access to work in these fields. So I urge this Committee to carefully consider this Bill and give it its support and allow it to finally reach the floor. I’m happy to answer any questions.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from Members of the Committee? No. Thank you for your testimony. Kelly Hopkins Alvarez. Welcome.

KELLY HOPKINS-ALVAREZ: Thank you, its been a long day, glad to be sitting here. I am a Licensed Professional Counselor here to support my student colleagues and my colleagues here in the Licensed Marriage and Family Therapy Association. I am a Licensed Professional Counselor and also have a Masters in Ed and a master’s in counseling as well and I have certification in Connecticut as a school counselor and also an elementary ed teacher.

You are probably wondering why I’m here. I have my LONG-TERM CARE. I didn’t have to spend the whole day here at the Capital. I am here because of a few things. I am here to represent the patients in our state that are showing up in community mental health settings and they are in crisis. This is a result of sexual trauma, as victims of domestic violence, or thoughts or attempts of suicide all of which fall under the umbrella of severe trauma and PTSD.

We should not be restricting qualified mental health professionals in this state. We should be allowing a
path forward for these qualified graduates to utilize the incredible skills that they’ve developed and honed over three years in their master’s program including the 600 hour internship and 100 hour practicum. It would be very disappointing if these new students decided to leave the state to work in New York or New Jersey both states that have the two-tiered licensure of the 39 other states, 38 other states that have the same licensure that we are asking for.

Please see the testimony provided by our colleagues in the social work area. They have provided testimony in support of us and that was terrific. They are not opposing us. One of you I think asked the question basically how would this impact graduates. So when graduates finish typically entry level jobs are in community mental health agencies. What many people don’t know is that in those agencies they bill insurance, quite often it is state insurance known as HUSKY so imagine the many graduates here that would be competing with social workers as well as the LMSTs that are here, they would not be able to gain employment in those community non-profit mental health agencies because their employers cannot bill insurance on their behalf. So that is really I’ll take questions with after if you really need more information about that and is really what I wanted to bring forward. We see clients that have tremendous distress in those community health agencies. We’re dealing with the opioid crisis in the state and in the Nation and I hope that everyone here that is elected today will really let this be the last year that we’re here.

In closing with passage of the Bill Connecticut’s neediest residents will not have access to mental
health care. I urge everyone here to make it a priority to increase the number of licensed professional counselor and licensed marriage and family therapists which this Bill provides for. And thank you so much for your time today.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments from the Committee? Thank you for your testimony. Kathryn Henderson.

KATHRYN HENDERSON: Hi, thank you for welcoming me and for your time. My name is Kathryn Henderson and I am a resident of Newington.

I moved here in the summer of 2017 having been a counselor educator and a practitioner in counseling in three other states. I was in Louisiana, Texas and Georgia and I was surprised when I moved here to learn that there is not an associate level license for the counseling field. All of the other states I’ve lived in have had that license and it was something that I was not expecting or prepared for cause unfortunately the reality is if you do not have a credential you do not get a job. That is just the competitive nature of the market that we’re in and so it places social worker at an unfair advantage in the job market here in Connecticut.

What it appears as me coming in as a new Connecticut resident is that the state is passively has a favorite in the mental health field, whether that is unintentional and that social workers are given that state based preference for these jobs simply by having a credential for them that is not available to the sister mental health field especially when we are all standing together in support of this change.

Connecticut has a fairly solid law but I understand it is a little older and it’s time for an update
that our State Association has been working on. I recently served as a job reference for one of our graduates at St. Joe’s who is looking for a job in New York and she has been successful in obtaining that with the credentials that New York offers for an associate level license. I understand from our counseling association here that implementing this process we’re wanting it to be simple, that we’re not changing any of the supporting documentation that is currently required for full licensure. We’re simply stretching out the timeline that one part will be done early and the last part will be completed later. And right now that is the service that is already being done for social work and it’s simply inequitable so I urge you to please support this Bill and support our students, I mean all citizens of the State of Connecticut. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Thank you for your testimony. Sarah Smith. Welcome.

SARAH SMITH: Thank you. Thank you to the Public Health Committee for the opportunity to offer my strong support of House Bill 7132. My name is Sarah Smith and I am currently working at Kids In Crisis agency as a pre-licensed counselor and I am a current resident of Norwalk.

I am a recent transplant to Connecticut. My husband and I moved last January from Dallas, Texas. I received my master’s in counseling from Southern Methodist University, passed my National Counseling Exam, and was acquiring my 3,000 hours for my LPC license. Texas is one of approximately 40 other states that currently have some form of two-tiered licensing for professional counselors. I was
considered an LPC-Intern which is the equivalent of an LPC-Associate. With that license, I was able to work in most settings. LPC’s in Texas are in very high demand, and my graduating class and peers had no trouble getting jobs in hospitals, schools, agencies, and private practices. Before moving to Connecticut, I was working in a private practice with highly qualified LPC’s specializing in substance abuse, depression, anxiety, and family systems.

I have lived in Connecticut for over a year now and have been looking for a job for 10 months. I have applied to nearly 50 different agencies and hospitals in the surrounding area. While most of the applications say, “LMSW preferred”, I thought I would give it a shot because I am a pre-licensed LPC, which is nearly identical education and experience as a LMSW. I have a graduate degree and have passed the national exam. I believe these organizations want fully licensed LPC’s or “first tier” LMSW’s. That leaves pre-licensed counselors to be at a huge disadvantage. It has been a very frustrating process for me. In Texas, they saw us as practicing counselors, who just needed to reach our full potential by completing the 3,000 hours under supervision and participating in the continuing education programs. Here in Connecticut, I do not see outside professionals viewing us as competent counselors until we are fully licensed.

I currently have a part-time job, and that is solely because I did not have to have a license to work in Connecticut. This has to change and I may even have to leave the state and go to New York to provide for my family. People have their own lives and need to provide for themselves and their own families. How
are we supposed to get our 3,000 hours, if no one will hire us? Let’s stand together and make this change.

I urge the committee to support House Bill 7132 and provide licensure for professional counselor associates. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Thank you for your testimony. Leonard Adams. Welcome.

LEONARD ADAMS: Good evening. My name is Leonard Adams. I am a resident of West Haven, Connecticut. I have lived here my entire life.

I first came to counseling as a child. I was in seventh grade and had two classmates commit suicide in that year. There was need then, there is a need now. Two months later we dealt with an additional suicide, and my journey began. I became a teacher. I’ve seen the impact of working with school-based counselors and outside intervention specialists. I attended Southern Connecticut State and received my Master’s in School Counseling in December 2016. I am currently a graduate student in the Clinical Mental Health Counseling Program and I hope to provide additional support outside of the school setting. I’ve also served in the Connecticut Army National Guard for the past 18 years, where I work alongside the Behavioral Health Team. In the next few years, my military career will come to an end, but I wish to continue to work with the Connecticut Military Department as a Licensed Professional Counselor and provided the mental health services we need to support our Veterans and our current service members. We don’t need to lose any more of them.
My concerns are very simple, I am extremely passionate about this field and am looking to help many in the community including our military members who serve our nation. I am concerned going forward the issues I would deal with licensure that I may encounter. I’m not going to read this. [Laughter].

You would think dealing with 25 students in front of me all day, I could do this, but it’s still emotional. There is an issue when you go out into the field to work and get your 3,000 hours that you’re there working under an exception. We’re not an exception. We have a license. Well, we have a degree. I’ll have two degrees. I’ll have a school counselor and a clinic mental health degree. You know, having work as an exception kind of makes us feel like were second rate, and we’re not. We’re completely capable. We’re the same as an MST. We are the same as a social worker, we’re the same as a school counselor. But to be called an exception is kind of an insult to us, the same as working as an aide to somebody else. We’ve done all the same rigorous requirements. We don’t the 1,000, you know the 600 hour internship. We done the 100 hours practicum then we have 3,000 hours ahead of us and that is a long time. If you really think how long 3,000 hours is that can mean two years, that can mean four years, that can mean six years. I just, you know, we need to be placed in a better position and especially lined-up with our social work. I work alongside social workers in our schools every day. They’ve got an LMSW and they’ve sat behind the same desk.

I just want to thank you and I hope that you can give us your support and move forward.
SENATOR ABRAMS (13TH): Thank you. Any questions or comments from the Committee members? Thank you for your testimony. Okay, we are going to move on Senate Bill 388. Is Adam Hittleman here? Welcome, Dr. Hittleman.

DR. ADAM HITTLEMAN: Thank you. Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. Thank you for allowing me the opportunity to present testimony against Bill 388. My name is Adam Hittleman and I am a pediatric urologist practicing at Yale School of Medicine and Yale New Haven Children’s Hospital.

As many of you know urologists match [Inaudible-07:52:54] of the kidneys, bladder other aspects of the urinary tract as well as the genitalia. The children with intersex conditions make up a subset of the children that I care for and I am here today to advocate for them and their families.

For clarity children with intersex conditions have a discrepancy between the appearance of the external genitalia, their genetic makeup, their hormones, testicles and ovaries. Today, I will specifically address my comments to Item No. 2 of this Bill which proposes legislation to “prohibit any licensed health care provider from engaging in medically unnecessary surgeries on an intersex person without such person’s consent.”

I believe that this exact language as it stands present two major problems. The statement, “unnecessary surgeries” is problematic, it is ill-defined potentially leading to overly wide interpretation for which surgeries are prohibited. Similarly the definition of intersex can be utilized to cast a wide net incorporating children that we in
the medical community may not define as intersex as well as many patients who do not consider themselves to be intersex.

The International Intersex Consensus Conference has calculated intersex to be present in 1 in 4,500 children though proponents of this bill estimate the Bill to be significantly higher. This potentially allows them to restrict access to surgery for patients who may not truly fall into the intersex category. In other states considering similar bills introduced which initially focused on intersex though quickly expanded to incorporate genital surgery on non-intersex conditions including healthy male babies with differences in the penis though no other genetic or fertility problems.

As you can imagine when children are born, any deviation from the expected anatomy can be deeply upsetting and frightening to the families. It is not our role as physicians to assign gender or dictate gender defining surgeries rather it is our responsibility to educate and support families in this distressing and confusing times to help them understand their child’s condition. For this reason we have developed multidisciplinary clinics providing a variety of expertise including endocrinologists, urologists, gynecologists and social workers all working together to help support the family through this decision making process. While it is essentially for us to educate the families on all options of care including both surgical and nonsurgical choices I strongly support parental autonomy in hopefully choosing the right care for the baby.
I believe it would be a real hardship on families to legislate away their ability to decide how they would care for their child. I see many families that do chose early surgeries and we resent having this option taken away from them. Parents are making decisions out of love and for what they believe is best for their child whenever possible they want to allow the child to have autonomy and participate in their care. The delayed or nonintervention option is not always without risk rather than active decisions with potential consequences. I believe and this is supported by many other providers that in some cases delayed surgery can be a potential psychosocial consequences, increase complexity of surgery and prolong emotional distress for patients and families. It has been my honor and privilege, a distinct privilege to have families allow me to participate in the care of their children. I want to thank you for allowing me to speak on their behalf today.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments? Representative Petit.

REP. PETIT (22ND): Thank you for your testimony. I appreciate that. It is my understanding in practice as an endocrinologist, not a lot of pediatrics, but at a gender identity clinic for about ten years that the National Pediatric Urological Societies and the AMA both have consistent stances on this that the parents be allowed a control in terms of procedures that the child would undergo at birth and I certainly know the endocrinologist associated at the gender identity clinic that the children can then change their minds later on in life if they chose to do so at a different age. Is that your
understanding of what the national organizations that deal with this topic?

DR. ADAM HITTLEMAN: I have brought it to the AMA and Judiciary Committee spent a lot of time investigating this and ultimately they stood by parental rights, they did not support a moratorium on all surgeries. Urology is here and it’s in their letter as well.

REP. PETIT (22ND): And you touched on it briefly, maybe not everybody caught it but there can be situations where it’s not truly intersex or semantic sexual differentiation disorder but surgery is required and sometimes prohibition on surgery could interfere with someone in terms of appropriate functioning, bladder, bowel, urinary tract other functioning. Can you comment on that a little bit further?

DR. ADAM HITTLEMAN: So I think the way it gets presented can be complicated and the goal is to preserve function. The surgeries that are being done and I think a common example would be a surgery on children with congenital adrenal hyperplasia, children’s who adrenal glands are producing testosterone. They are having difficulty with steroid production, a group who I should say does not consider themselves intersex although often it is calculated in these percentages, with the extra testosterone develop so that the urethra, the tube that we pee through and the vagina come out a single opening, they form a single tube and to allow them to urinate without urine collecting in the vagina, which would put them at risk for infection, when they stand up their urine will drain and so it puts them at risk for urinary incontinence beyond potty-
training. We do surgeries to separate out the urethra and the vagina. We separate the urogenital sinus as we call it but proponents of the Bill would describe that as a vaginoplasty. They would say we are doing surgeries to create vaginas on these babies which is not the goal of the surgery. The goal is to separate the urethra from the vagina. How is that a vaginoplasty now. It may be some technical terms and billing aspects, some may use the vaginoplasty but that is not the goal of the surgery. The goal of the surgery is to return normal function as you said to allow them to urinate without urine collecting in the vagina creating two separate openings.

REP. PETIT (22ND): Thank you for that. Thank you, Madam Chair. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair and thank you, Dr. Hittleman for your testimony. I notice that your testimony is confined to the second prong of the Bill. It does not speak to the first or third prongs, the one about creating nondiscrimination rights for intersex people and the other regarding a third option for birth certificates. Do that mean you are not in opposition to either of those?

DR. ADAM HITTLEMAN: So my personal opinion, I support groups. I think a lot of the arguments that come forward is against binary sex. I support that. I am opposed to bias. I do not support discrimination. My personal support would be to make statements in that direction. I think it is very different than the second item, I’m not sure why they’ve been put together as it makes it very complicated cause you are putting together things
that many people would support with something that is being pulled together and I think it is very divisive. But yes, I personally would support that.

SENATOR LESSER (9TH): Thank you for that answer and I’m certainly intending to get to Number 2 but my hope certainly is the first and third items would be noncontroversial in this Committee and I appreciate your support.

DR. ADAM HITTLEMAN: Can I have one more statement to that? So many physicians that work in clinics that support these intersex patients also work in clinics that support transgender patients. I personally have done gender affirmation surgeries. I support the population. I clinically would be happy to be involved in their care but you’re putting the same physicians in a position where they are now giving the appearance of not supporting all their patients. It’s complicated.

SENATOR LESSER (9TH): So I want to return a comment you just had a minute ago with our Honorable Ranking Member, Representative Petit, in which he asked you about, I guess your comment that spoke to what you see as medically necessary surgeries. As I read the Bill and the Bill is only one sentence long, it prohibits only medically unnecessary surgeries. You describe in your initial testimony as being ill-defined. Would you have any objection to us defining that by eliminating specific surgical procedures that we would say are purely cosmetic and not medically necessary.

DR. ADAM HITTLEMAN: So, I’ll get you answers to that. So I think that within this population you can have varying degrees of severity and when you try to limit the definition as to what is considered
medically necessary it gets very complicated. Medically necessary, if I said I’m taking out cancer it is a black and white answer. But if I say medically necessary to allow this child to urinate and not get urinary tract infections you may say how do I know they’re gonna get urinary tract infections and I say I don’t know, I’m trying to prevent it. So in the sense that is so easy to define medically necessary I really think that gets complicated. But the other issue that comes with that, we’ve seen it happen in other states, and I think this is intentional, is to present a Bill with a very ill-defined definition, try to get it supported and quickly expand it because as you expand it you are going to increase the number of patients that you can define and artificially increase the denominator, the number of patients that would fall in the intersex category, the only way that we can say this is affecting a large population the folks this really describes is 1 in 4,500 children. It is a very small number of children. So as we start saying necessary surgeries on children it depends on what you define intersex in the first place.

SENATOR LESSER (9TH): So I guess I’m confused. I’m looking at a Bill before us, not, you seem to be saying that we have some agenda about increasing the number of.

DR. ADAM HITTLEMAN: I’m trying to prevent a historical perspective.

SENATOR LESSER (9TH): So with regards to your other comments, I did ask a specific question about what constitutes medically necessary and what constitutes medically unnecessary surgeries. Is it in your belief, is it your professional belief that a
clitorectomy is a medically necessary surgical procedure?

DR. ADAM HITTLEMAN: An I am glad you phrased it that way because I would absolutely say clitorectomy is never a necessary surgery and I am not sure you chose the term clitorectomy on purpose or not because we do not perform clitorectomies which is often stated and is a complete misstatement. We perform cliteroplasties or clitoral reductions which is extremely different that clitorectomies. There is no moral comparison.

SENATOR LESSER (9TH): So that goes to my next question. Is a clitoral reduction a medically necessary procedure?

DR. ADAM HITTLEMAN: So I think it depends on the situation. I think for many children it is not a necessary surgery. I think there are definitely some surgeries we can delay and allow for family intervention and patients’ have autonomy in how they chose it. You will be committing that patient to multiple surgeries so there are some aspects that are delaying care. You are changing some of the aspects of the surgery and the outcome of what may be the families themselves are seeking so there are some aspects of it. But if you are asking me medically necessary to define life and death, I would say, no it’s not life and death. Do I support delaying such surgeries, I do?

SENATOR LESSER (9TH): Thank you. So a clitoral reduction is not a medically necessary surgery?

DR. ADAM HITTLEMAN: I think you are summarizing not what I said. And I did not say medically necessary in all cases, I said you were committing a patient
to more surgeries. I think you are changing the definition of what the parent may interpret as medically necessary. You’re changing the goal of some of their care so I think you are taking away parental autonomy. So I think it’s life and death or completely necessary, I think some of that is in the eyes of the beholder.

SENATOR LESSER (9TH): Is a clitoral recession a medically necessary surgery?

DR. ADAM HITTLEMAN: Are you defining clitoral recession as surgery on the labia to try to bring the skin over the clitoris so it is hidden? How do you define clitoral recession?

SENATOR LESSER (9TH): Well Doctor, I would lean on your expert medical advice in this area.

DR. ADAM HITTLEMAN: I think you are leading me in a direction for a reason and I am not trying to be confrontational, I’m just not sure what the direction is going towards, so I would say is that not all clitoral reductions or clitoral recessions are medically necessary in all cases.

SENATOR LESSER (9TH): So I don’t mean to belabor it, I have a long list of medical interventions that I would be happy to have a conversation with you or other people here on, but I guess my point is that, you know, when I heard your testimony you brought up what seems to be an area where there could be a legitimate question about whether or not it’s medically necessary, but I think there is a whole lot of procedures being done on children in our state that don’t seem to raise that complicated question that are quite simple. They are cosmetic procedures and if you are telling me that the Public
Health Committee working with the medical profession can’t identify what is in fact a cosmetic procedure and what isn’t, then I’m skeptical of that and I think when you just answered the previous question I think you were able to dive into that and help me figure out what is cosmetic and what is medically necessary and that is what we are trying to do here today.

DR. ADAM HITTLEMAN: Sure and I would ask you would try to stay away from the terminology cosmetic. I think that in some ways it can be divisive and I don’t want to be confrontational. I think we should be careful how we use our terminology. I don’t think that families would view it as necessarily cosmetic. I think there some other aspects that go with it. I think if we look at long-term psychosocial aspects there is a lot more to it. I think we are over simplifying a very complex problem and again I am not trying to be confrontational I think we can both get a list of medical conditions and medical procedures on the side. I know we’ve invited you to our Chart Clinic, we would love to have you come join us and we could introduce you to the patient population. But I don’t want to over simplify this. Not that I want to try to muddy the water and make is sound like it’s such a difficult process but it depends on how you define things. It depends if you’re defining it from the patient’s perspective. It depends if you’re defining it from the physician’s perspective or the parent’s perspective. It’s not so simple.

SENATOR LESSER (9TH): So thinking of the first principle as I understand it of medicine as I understand it is to do no harm. You spoke in your testimony to the psychosocial impact of not
performing medical interventions on intersex children at a young age. Can you speak to what research you are relying on that indicates that there is a harm to delaying surgical interventions?

DR. ADAM HITTLEMAN: So I think this has come up a lot. A lot of people have referenced literature and often the same literature with different perspectives with different interpretations. This is the problem with statistics. I would be happy and this is probably not the best setting so I know I’ve taken up a lot of your time, to provide you with literature. I have other colleagues who are going to be speaking today, talking on this as well and I think this is a conversation that we could definitely have and I would be happy to provide literature but I think some things in science are not always black and white and interpretation of statistics can be very complicated. I think that would be a conversation I would more than happy to have with you.

SENATOR LESSER (9TH): Do you accept the Journal of Pediatric Urology is a point of common agreement as a reference point?

DR. ADAM HITTLEMAN: I do.

SENATOR LESSER (9TH): So there is a 2017 article in it, you’re probably familiar with it by Drs. Sieminski, etal that attempts to look at the psychosocial impact of this procedure on intersex youth. Are you familiar with that general article?

DR. ADAM HITTLEMAN: You know, I don’t have that particular article in front of me, I would have to take a look at it. I know some of the articles that have been referenced in some of the other statements
that I’ve read, we’ve actually written some of those authors and I know Dr. Canning himself has sent contradictory arguments saying that people are misrepresenting his research, this is often a problem and again for that kind of discussion I would be more than happy to sit down and review the literature with you.

SENATOR LESSER (9TH): I would certainly welcome that opportunity. I would have hoped we would have been prepared to do that tonight as this is the only opportunity the Public Health Committee will have to review the literature.

DR. ADAM HITTLEMAN: And that’s why we have other colleagues to sit down. We’ve kind of divided up how we’re gonna present this so there will be the opportunity to speak with him as well.

SENATOR LESSER (9TH): Thank you.

SENATOR ABRAMS (13TH): Doctor, just a minute please.

DR. ADAM HITTLEMAN: Oh, sorry.

SENATOR ABRAMS (13TH): There might be other people with questions or comments. Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you for your testimony this evening. I agree with you that it is a very complicated issue, it’s not black and white and I am not somebody who would support listing procedure because they have to have context around them, it’s something that is very situational at some point and like you said you have to take the physician, the parent, and the child’s perspective into play here. Can you tell me Doctor, in your experience, have you seen in your practice parents
subject a child to a surgery that you would not consider necessary?

DR. ADAM HITTLEMAN: So I think that is a difficult question. If we’re talking about my general practice I can tell you I was in clinic today before I came up. I saw probably four parents that brought their children in who want to have their circumcision revised. We are not taking intersex, we’re talking a child that had a circumcision. They were very upset about the appearance of the circumcision. I tried to reassure them that this is something that is very common. A lot of children as they grow may look different and we try to avoid subjecting our children to anesthesia for all procedures. Now I think our interpretation of what is necessary surgery, I think as we are focused on intersex conditions I think in terms of, as a urologist, we see a lot of families are focused on genitalia. This something that is very sensitive to a lot of people. So for me to say to someone that their concerns are unwarranted or that what they consider important or necessary is not something that I give relevance to. It is very difficult. Now do I try to convince folks, or instruct folks, or educate folks, or assist folks in making decisions that I think may be better for their choice for their child with the expand of intersex do I support early surgery on everything, I don’t. And if, you know, you were to speak to some of our patients some folks will be coming forward we are not telling surgery to everybody. Surgery is not a black-white answer. So have I had parents approach me with surgery I felt to be medically necessary, in my opinion, I try to reassure parents that surgery is not the fix for everything.
SENATOR SOMERS (18TH): So you make your assessment based on your medical judgement and your experience that when it comes to in particular intersex situations with young people, if a parent felt strongly about having a procedure you might not agree with that, you talk, that is what every other physician does. They talk to their patient, they walk them through the pros and cons and, you know, you would rely on your medical expertise to make the decisions that is the appropriate one in that context of whatever that particular situation is and if we as legislators who are not MDs in this circle except for a few, tries to legislate what you can or cannot do would you consider that an infringement on the right between the patient and the child, I’m sorry, the doctor and the parent.

DR. ADAM HITTLEMAN: You know, I think what we’re talking about a pediatric population, parental rights play a very big role. Parents have both ethical and legal responsibility for their children, they are acting on their children’s behalf, they are acting out of love and while people may have different interpretations, again what needs to be surgically corrected and what is an appropriate intervention, I think that could be a difficult thing in the eyes of different people but we try to give parents autonomy and help them plan for the autonomy for their children and part of their responsibility is to care for their child but also try to develop a child that is going to have their own independent autonomy and eventually make their own decisions. So I think it depends on what the condition is and what the impact would be on not intervening. It is not uncommon for us in our program, multidisciplinary program to say to
families this is something that can wait. It should wait until the child can participate in their own decision-making process, it does not need to be addressed right now and if it does not cause undo harm to the child we should allow them to participate in this decision. That is not an uncommon path. I support that. Are there times when I think that there is more medical risk to the child when we would recommend intervening earlier whether the parents want to do something we think is appropriate or we are trying to convince them maybe this isn’t appropriate yet, so the complicated conversation happen and the goal and the reason we have a multidisciplinary program is to try to all work together to try to come to the best terms in the multidisciplinary approach to education, to try to give the risk, benefit, alternatives of any surgery and we want to discuss that rationale to help them come to the terms together.

SENATOR SOMERS (18TH): Thank you for that answer and I would just like to point out to members of the Committee as far as No.3 the Department of Public Health if you read their testimony they have provided a solution for No. 3. They have offered to work with the Committee on what they can do to accommodate the requirement or they ask on No. 3 if you have a chance you can take a look at that. But I appreciate your testimony. Thank you.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments from the Members of the Committee? Thank you, Doctor. Priya Phulwani. Welcome.
DR. PRIYA PHULWANI: Thank you. So my name is Priya Phulwani. I’m an endocrinologists and it might surprise some of my patients I am opposing Bill 388.

So along with urology and mental health support I have been Codirector and part of the Connecticut Children’s Clinic for Variations in Sexual Development since 2011. I fully support and welcome adding intersex status to antidiscrimination laws and the third option for gender designation on all documents, but yes, I oppose two. I am coming at if from a different angle as I just don’t think legislation is the answer. So I have seen multiple terms since I’ve been this codirector and it has been a while for me in both clinics. Intersex, and then disorders, and differences, and then variations of sexual development all the terms have been used by patients, parents, medical literature, lay press, social media. Our approach on definitions has evolved as more genes have been identified in this area. I am also the Director of the Clinic for Youth with Gender Incongruence so I see transgender, A-gender, gender fluid and gender queer youth and I have an adult practice as well were I follow all of these patients. Adam was very correct, you put us in a very difficulty position as looking at people that are opposing all of these communities when we talk were about just one particular prong of the Bill.

Anyway when we reference LGBTQI we put together different categories, right? So we have LGB referring to sexuality and in my opinion should include asexual and pansexual. TQ for identity like trans, or queer or transgender. I for intersex and I realize for some individuals intersex is a statement, it is part of their identity. But when we
purely medically define this, the international consensus guidelines, these guidelines by the way are by the Pediatric Endocrine Society U.S. and European and its “congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical” So to put in context I see about four intersex patients per month in my clinic for sexual development. No the prevalence of gender incongruence is one percent and in my separate clinic there I have over 200 patients. When you look at these guidelines.

SENATOR ABRAMS (13TH): That’s the time, could you sum-up please?

DR. PRIYA PHULWANI: When you look at these guidelines CH is actually the most common cause of intersex but many CH patients won’t identify that way. I have intersex patients who are CH who identify as females, some had surgery, some didn’t. Some are happy with either option some aren’t and so to put all these categories and define intersex I think that for me is way the Bill phrases it is problematic it leaves it very open and it’s not very clear.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Senator Lessor.

SENATOR LESSER (9TH): Thank you and I thank you Madam Chair and I want to thank you, Doctor for your support of the first and third parts of it. I guess I am still going to ask the same question that I asked the previous doctor about you know, referencing the lack of clarity we could elect to make the section more clear by specifically spelling out what we’re talking about. Would you be objecting to that?
DR. PRIYA PHULWANI: I think it would help when you define intersex in the Bill to list exactly which conditions you are referencing to but I also think part of the Bill doesn’t take into account the way the clinic works. So when we are in a multidisciplinary clinic, I think people forget that we offer observation as an option. There is so much emphasis on we’re promoting medical unnecessary surgeries or not, but one of the actual options that we always present, I know, I’m in that clinic and I always say, listen one option is observation. I have adult patients who regretted that their parents chose to have surgery. This particular part of the surgery is not cosmetically necessary. I want you to hear the surgeon for pros and cons and doing it now versus later. I want you to know that through your life I am going to disclose to your child and I let the parents know that, full and complete disclosure age appropriate as they grow about their condition and whether or not they had surgery is critical so I feel that we are emphasizing surgery but not that the multidisciplinary clinic promotes the other options of observation as well and yeah, I have to also agree that the medically unnecessary bit gets a little complicated. When you see a parent and they think it is very much medically necessary to do this, it takes time, multiple visits to differentiate between what is and what isn’t something that can wait because you also have to take into account the family’s relationship with the kid, are they actually going to be unsafe or disengaged with connecting with their child because they view the genital as the genitalia as atypical. So I think that is something you have to work with each family about. I just don’t think legislation is the way to do it. I fully agree that observation
s needs to happen, multidisciplinary clinic teams need to emphasize that and that is part of their goal. I submitted another article on the ideal multidisciplinary clinic and what they’re supposed to do and I can say that in Connecticut we do that. We require repeated access. One of the other terms I didn’t appreciate “consent” implies age of consent, 18. But what about the kid who wants to have surgery, she should have a voice in this and our clinics repeatedly obtain over time. I have multiple issues with the phrasing of that of prong two of your Bill.

SENATOR LESSER (9TH): Thank you and I appreciate your thoughtful comments but you know you did submit and I read your written testimony and I appreciate it. You referenced the multidisciplinary team that you recommended and you cited a journal article written in part by Dr. Katrina Karkazis at Yale and Dr. Karkazis submitted testimony in support of this legislation here tonight. I don’t know if you had a chance to read her testimony and why she thinks that even as you develop a multidisciplinary panel to address the needs of intersex children that you might want to not move forward on medically unnecessary surgeries especially given the lack of data that shows if there is any improved outcome and there may be some significant psychosocial harm by doing these surgeries.

DR. PRIYA PHULWANI: You know, I think we lack date honestly on both ends. So that it is not there is enough data for doing surgery or not, both are probably lacking in terms of data. That’s when we’re looking at do we have data that doing the surgery is good or not, we have problems with not having enough
data on both ends. We have historic experience, we have traumatic terrible experiences, horrendous that should never have happened to patients absolutely in the past but we also lack data on what happens if you don’t have it for significant virilization, say a self-identified female, say she’s 10 years old now, I know her gender identity is female, she is very virialized and she comes to me and says Dr. Phulwani this bothers me, I want to have clitoral resection are we then not then saying that is an option for her. I feel like that discussion needs to be free and I need to be free presenting her with all the options and the reason for it and against it. And I think that we need research for both ends, yes for what happens when we did these surgeries, how the surgery has changed, do we have data on the new procedures that are more clitoral sparing and long-term and do we have data on people who didn’t have surgeries and I feel like that is the solution, not legislation and we have a far way to go in terms of educating both medical communities and general communities on what is gender normalcy and gender behaviors and convincing people not to panic about what the babysitter or grandparent, education is the way around this. Research is the way around this, long-term follow up of patients and compassionate comprehensive care is the way around this. But to say that I can’t discuss the option of any kind of surgery when the parent might be coming from that angle that is actually going to limit me so now the conversation about all the options you see. The parent won’t come in my door if you say surgery is not an option and their vision of genital normalcy is one direction. I need to have them come to my door to say, that’s one option but you know what here are some other options and you can love
and engage that child and these are also normal genitalia so that conversation, if you put a ban on certain procedures, you can’t have that conversation.

SENATOR LESSER (9TH): So I guess I disagree. I think the reason I disagree is because I think that just having that option out there it enhances the stigma associated with these conditions. I think it creates the societal, the society in which it is much more difficult for children. But I have just a couple of other questions and I do want to thank the Committee for it’s time. I don’t know if you’re familiar, this Committee is also considering legislation, we just voted to draft legislation banning female genitalia mutilation. In that particular case, you’re talking about, that Bill is actually less defined than this one is I think but would you say if a parent came to you and asked for advice there would you consider that to be an option or would you reject that as [Cross-talking] medical community.

DR. PRIYA PHULWANI: I think the thing genital mutilation is less vague than saying intersex is absolutely inaccurate. If somebody said to me genital mutilation surgery I know what that mean and I have a problem. I don’t appreciate that you’re saying that is less distinct or more vague than this is not. So of course I would say no way does my program support, at all, any form of genital mutilation or female genitalia mutilation, not at all, Sir.

SENATOR LESSER (9TH): But you would not support a ban on the use of clitoral reductions,
clitorectomies, clitoral resections or any of the other procedures that we talked about.

DR. PRIYA PHULWANI: So we’re listing them now right? So again I don’t advertise my program, “I’m pro clitoral reduction come and see me” so when you say that, you know, we’re putting out this option there and that is wrong. We’re not putting out, this is a multidisciplinary clinic, we are going to review all your options. Here’s what I think and why, here’s what the surgeon thinks and why, let’s educate you, your school, your community that is what I’m putting out there.

SENATOR LESSER (9TH): You said earlier and I totally agree with something that you said, which is the data on this is mixed. I think there is a lot of, in terms of outcomes, in terms of psychosocial effects. We’ve gotten a lot of testimony from medical ethicists who are deeply troubled by the practice of nonmedically necessary surgeries but maybe you could help us figure out how you sort of puzzle through what is medically ethical and what isn’t. When there is a lack of evidence is that something that would normally cause you to want to recommend a surgery or not? What would be your normal?

DR. PRIYA PHULWANI: So I would actually be perfectly honest with them and I am. So if I have a family coming in and there is a clitoral solid structure, we’re still waiting on all the tests to come back, I many not even have the condition name, I am going to tell them that here’s what we know and here’s what we don’t know. We don’t know if we don’t do these procedures, and is your child going to come back in 10 or 20 years from now and say why didn’t
you do this surgery and I can’t guarantee that if we do it they won’t come back 10-20 years from now and say why did you do this surgery. I’m very honest with families that based on your child’s condition this is what we know about the long-term, this is what we don’t know. There is a lot of grey area that we don’t know about and I will tell them that. Once I get some of the test results are back and if hormones are back and I know if its CH, if the parent asks me well what are the chances that my child will identify as female and male, I might have some data about that particular condition, some other conditions I may not so I may not be able to tell them, and I’ll say, you know what this particular case may be partial androgen sensitive well this is very rare and it is mixed data on the terms of gender which they identify and partial maybe the gonadal blastoma is maybe 30 percent and complete androgen may be just one or two percent. You should know those rates because you as parents who love your child and must engage and provide for your child need to understand what are you going to say to your child when your child comes back and says why did you make that decision. So I think that when you say, you know, what do you say to them, I give them the truth. I tell them what I know and don’t know for their particular condition to the best of my knowledge.

SENATOR LESSER (9TH): We do know this. I mean I think the numbers are small but we do know that peer review article in the Journal of Urology found that 40 percent of patients who chose surgery for children with distal hypospadias “experienced moderately strong decisional regret”, 20 percent of patients who had congenital adrenal hypoplasia “had
decisional regret” in a 2017 study. We have enough evidence that there are enough people out there who are regretting these surgeries that I think we should really have pause both as legislators but I would also hope as members of the medical community to really reevaluate to figure out if these surgeries are in the best interest of the children. But I thank the Committee for the time, I’ve been quite longwinded.

SENATOR ABRAMS (13TH): Is there any other questions or comments? Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you Dr. Phulwani for your testimony. It is a very complex issue and I thank you for your efforts in this area. Could you explain to the Committee what would typically make up a group that would approach, and I’ll use the term a gender identity problem with a child, how many people are involved in trying to come to a decision that will be in the best interest of the child and the family.

DR. PRIYA PHULWANI: So first I have to distinguish between when you are talking about intersex versus gender dysphoria, right? So you mean for my intersex clinic because they are two separate and different situations, we don’t want to say that gender dysphoria patients are intersex. So in my clinic for what I like to call variations in sexual development in that clinic, our multidisciplinary program consists of, and as I submitted, the guidelines recommend that you have to have a pediatric endocrinologist, you need to have a urologist and you need to have a mental health support clinician. And I am glad you asked me that question because I never got to that, I was over
three minutes. But we always have that person as well and it is important because that person not only balances all our opinions and gives their own, but also hooks up the family to. Would you like to meet or speak with a parent who chose surgery or didn’t? Would you like to have support groups? Would you like to have resources? So that is the third person is also very important in our multidisciplinary program so that would be the basic constituents. Then we pull in from genetics as needed and the other specialties psychology, psychiatry etc. as needed but the three main components are support clinician, the urologist and the endocrinologist.

REP. PETIT (22ND): Is the general pediatrician typically or neonatologists involved right after birth?

DR. PRIYA PHULWANI: So those are also right. So the genetics on neonatologists are recommended to be part of the clinic. They don’t necessarily need to be at the multidisciplinary visit, each visit because well the neonatologist job is done after birth but yes we involve. Once every few years I have a talk for the nursery folks to remind them of what to order and what to do and how to engage our consultations when you have a baby with genitalia that might be a bit atypical so that we come to the consult immediately post-birth and we avoid the parents having distress and spending anytime without us coming to the floor right away. So the neonatologists are involved in that sense yeah.

REP. PETIT (22ND): And hopefully the hypothetical item, I hope I don’t go too far off here, you can correct me. So with an intersex case, say there was
a prohibition the team thought surgery was appropriate and there was a prohibition what types of harms can be had when a child enters the public domain if you will in terms of daycare, in terms of preschool other areas without a defined?

DR. PRIYA PHULWANI: So I think that if the family is part of the multidisciplinary team, coming to their visits, you’re gonna get support around that. I never tell a family that you should have clitoral recession or reduction because I don’t want your babysitter to be afraid or the grandparent to be afraid. I think it is about educating them in the community. But if you don’t present to the multi visit clinic where we give you all the options and all they hear is I don’t want to go to that clinic cause they’re not even offer surgery and I don’t think my kid’s genitals are normal then they don’t come to the door to see me. They don’t get the support and resources then they do panic every time someone else panics and has a reaction to the genitalia. So I’m actually doing a disservice by not encouraging them to come to these clinics and part of the reason they come to these clinics is they think all options are offered, which they are, even though you may educate them and over time they will come to agree that certain things can wait at least until gender identity development which might be three, four, five or six years old.

REP. PETIT (22ND): And is there any, you develop a good relationship presumably, most of the people stay in your system and work with you. Do you find some people seek out other systems, other states, other countries for this kind of thing? I know the people you never see, you don’t know they’re out there, but people that you see do you find that many
people leave the systems that you’re in to seek out other possibilities?

DR. PRIYA PHULWANI: No, I always welcome of course any doctor should welcome, if somebody says is it okay if I get a second opinion, sure. But I’ll say it is very rare for someone who comes to out multidisciplinary clinic, meets with everybody, gets to know us to say I’m done with this clinic I need to go elsewhere.

REP. PETIT (22ND): Thank you very much. Thank you, Madam Chairman.

SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you, Doctor for your testimony. I was wondering if your colleagues or you know of any other state that tried to limit someone in your practice from recommending surgery should you deem it necessary after you go through the whole process that you just described? Is there any other state that lists certain procedures that you are prohibited from doing or limit your expertise as a medical doctor to help frame the decision of the parents?

DR. PRIYA PHULWANI: I think you might be asking a surgery question, so I don’t really know. I’m not a surgeon, so we could ask our surgeons if they know which states they’re permitted in and what their experiences have been.

SENATOR SOMERS (18TH): Okay, thank you.

SENATOR ABRAMS (13TH): Okay, thank you very much. Any other questions or comments? Thank you for your time, Doctor. Val D. Is Val here? Can you give us your full name please?
VALERIE DAVIS: Valerie Davis. Good Evening and thank you Distinguished Members of the House Committee. My name is Valerie Davis and this is my husband Jason Davis. We are here to share our testimony in opposition to Bill SB 388 specifically concerning genital surgery performed on girls with genital adrenal hyperplasia.

We have two children affected by congenital adrenal Hyperplasia (CAH). A 7-year-old boy and a 15 month girl. Our daughter was born with Ambiguous Genitalia. This occurs because she received extra testosterone in the womb due to a hormone deficiency. To put this into perspective she was considered a 3.5 on the Prader scale. She did not look like a male but she was unable to fully function fully as a female. For the 6 years prior to the birth of our daughter I had done substantial amounts of research and knew that if we decided to have another child that ambiguous genitalia could be a complication as a direct link to CAH in utero.

Before we decided if surgery was the right choice for our daughter, we did our research. I reached out to the online community and talked with other women with CAH that have had the surgery and listened to their testimonies, I’ve read the books, I spoke with other mothers going through this at the same time that I was, I researched the surgeons that specialized in this particular surgery, I spoke with the CARES Foundation who have always been a great resource, plus I already had 6 years of processing this possibility after the birth of our son because I knew that this may potentially be a decisions we would have to make one day.
As parents we only want what’s best for our daughter and this choice was not an easy one to make. Many questions arose during our deliberations that could have become reality should we chose not to go forth with the procedure. Will she feel like she is different from her friends? If she does feel different will this affect her self-esteem or make her think of herself as more masculinized? Then medically, how will she be able to have a period and since her vagina is connected to her urethra will she be susceptible to UTIs, potentially putting her at risk for a life-threatening condition called adrenal crisis.

After taking the time to weigh out our options we made our educated decision that surgery was right for our daughter. I contacted and proceeded to utilize one of the top surgeons that specialized in ambiguous genitalia surgery on CAH girls. Please note that at no time did I feel pressured by medical professionals to choose surgery. Her surgery went well and our daughter’s recovery was remarkable. They bounce back so quickly at this age. The day after surgery she was trying to pull herself up in the bed and engaging in the recreational classes offered at the hospital, smiling, laughing, and singing along.

We chose for our daughter to have surgery because she has a complete pair of XX chromosome biologically defining her as female. Because having this surgery as an infant eliminates anxiety, fear, and PTSD. Because healing and scarring have a huge advantage due to circulating hormones leftover from the pregnancy. Because she deserves the have the best quality of life free from self-esteem concerns and free from misinformed critics. Because we
didn’t wish her to have to make this tough decision as a preteen, just so she can proceed with puberty. And because some day, if she chooses, she will be able to carry babies of her own, because she’s a girl. Thank you.

SENATOR ABRAMS (13TH): Thank you so much for that testimony, to be willing to share your story. That’s one thing that has been very important to hear from physicians who are involved in this kind of thing but to hear the actual story of the wrenching decisions you had to make but how well it turned out and your reasonings behind it, very important for us to hear so thank you your that. Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and like you I want to thank you for sharing your story and I think we can argue about legislation and what any Bill does but I don’t think any member of this Committee is questioning anybody’s decisions as a parent or how you want to act in the best interests of your children and your daughter in particular. So I want to thank you for being here. I know it’s not easy to come before a roomful of legislators and talk about this issue and I want to thank you for that. I just want to say that, you know, based solely on what I heard from you just a minute ago, it doesn’t to me sound like what you did was necessarily affected by the Bill before us but I think that may be something we’re gonna talk about some more with doctors and others as this comes before us but I think just based on my own interpretation of the Bill and hearing what you said, it does sound like the surgery your daughter had might have very well been medically necessary
and would not have been covered by this Bill, but I want to thank you for coming.

REP. STEINBERG (136TH): Thank you, Senator. Any other comments or questions? Yes, Senator Somers.

SENATOR SOMERS (18TH): Yes, I wanted to thank you both for sharing your story. I was particularly glad to hear that you didn’t feel pressure and that you had an opportunity to weigh all your options and that you reached out to, you said, an online community for other people that were experiencing the same thing that you had and that the results have been positive for your daughter and I can understand when you read the language of this Bill how it would cause you pause and I want to thank you for taking off from work and spending time away from your children to come here today because I think it is really important to hear from you. And I advocate that you made an informed decision for what you felt was best for your child with the support system of the physicians, and the mental health workers and other people who had been through the same type of situation that you have. I think that is important. We can’t lose sight of that relationship that between you and your clinician that is not replaced by legislation and I wish you the best going forward for your daughter. Thank you.

REP. STEINBERG (136TH): Thank you, Senator. Any other comments or questions? If not, again thank you for coming to share with us today. Dr. Christina Kim.

DR. CHRISTINA KIM: Hello, thank you to Co-Chairs Abrams, Steinberg and all the Committee members. My name is Christina Kim. I am speaking in opposition
of point No. 2, item 2 of Bill SB 388 but I support personally item 1 and item 3.

I am a pediatric urologist who has practiced in Connecticut for the past 15 years. I am also a mother of three and a resident of Simsbury, Connecticut. As a health care provider and as a mother, I am an advocate for patient centered care. I am not here to promote surgery or to convince anyone to have surgery. But I believe every patient and family deserves the right to choose. When I take my children to the doctor, I expect that visit to be focused on my child’s situation.

Ironically, my daughter has a chronic condition of her kidney and she is followed by pediatric urology. When younger, her kidney issue was in a gray zone—where some would choose surgery and some would not. But it was ultimately up to my spouse and myself to choose what we thought was in her best interest. And we made that choice after gathering input from her medical team and considering her clinical situation. It would have been unfair to have withheld the option of surgery. My 13-year-old daughter is not the same as anyone else, and her treatment plan should be individualized to her circumstances. And I am always making choices in my child and I am always trying to help patients and families do the same. But their best interest you have to keep in mind and keep the scope of both medical, social and emotional factors and I don’t think those kind of nuanced choices should be restricted by others.

The American Medical Association spent nearly two years reviewing data surrounding this issue about genital surgery on patients with intersex and
confirmed in 2016 that they do NOT support a moratorium on genital surgery for patients with DSD. They recognize the variable data and there is variable interpretation and they want to maintain parents’ ability to protect and empower their child in making the best decision possible.

In 2018, other professional organizations reviewed the data and statements and voiced their support of the AMA’s position. This includes professional organizations from Psychiatry, Endocrinology, Obstetrics/Gynecology and Urology.

They specifically outline concerns that “If we close the window of early surgery, we cannot undo the consequences of waiving treatment in the past. And this may adversely affect psychological, psychosocial, and developmental health”

In point to something that has been brought up here, they believe the term “medically unnecessary” is too narrow to use in this complex patient population because the World Health Organization defines health encompassing psychological, psychosocial, and developmental health.

So with that I can speak to some of the things that were brought up in regard to the Szymanski report, decisional regrets that have to do with that report, the interpretation of “medically necessary” and some of the challenges that come with that but I know I’ve taken my three minutes so thank you.

REP. STEINBERG (136TH): Well, thank you for your testimony. I particularly appreciated your insight to how the physicians across the spectrum consider this, you know, an ongoing process whereby they’re constantly thinking about whether or not their
current protocol is working for folks and it is good to hear to this point they are still in agreement on the best course forward, so thank you for your testimony. Any other comments or questions?

Senator Lesser.

SENATOR LESSER (9TH): Thank you. You know I do appreciate your testimony, Dr. Kim and I appreciate these indulgence on this. You know, first off I always think it is valuable to hear your personal story and you talking about your own family and of course in the example you mention, I think it is clear beyond any question your daughter had a medically necessary condition that required treatment and I think the questions we’re not talking about is parents have a right or an opportunity to make medical decisions for their children. The question is about nonmedical decisions or nonmedically necessary decisions. You mentioned at the end or sort of eluded to it, a desire to speak to some of the literature on how many patients go on to regret that these surgeries were performed on them. I think there are a couple, there are a number of peer review studies that seem to suggest that the number can be quite large depending on what condition we’re talking about and what intervention we’re talking about. So maybe speak to that and how you sort of see that in that bedrock principle of medical ethics, the “Do no harm.”

DR. CHRISTINA KIM: Sure, well I think there’s a few things to consider. I mean in the article you’re referring to, the Szymanski article looked at decisional regret by parents at a few different surgical treatments for their child and the decisional regret is based on a score of 0-100 and
as you eluded to the decisional regrets was around 40 percent for patients who had genital restorations surgery. But if you look the decisional regret for pediatric cancer treatment was 61-72 percent and the decisional regret for tonsillectomy was 41-45 percent so I think that all parents have struggles when you’re making decisions for your child and you see them go through a procedure, go through anesthesia, recover and there is variability in how each patient adult or child does with a medical procedure. But no parent preferred delaying surgery even those who had some decisional regret. So I think that it is a complex situation and every patient is different and speaking to this family who shared their story, we on the medical side have seen many patients who have had a multitude of different things that come across their family situations and that makes it challenging and so when we get into what is medically necessary or unnecessary people are not trying to be evasive by not answering that because it would be easy if there was a check-box, it’s this, it’s this but that is not the reality of the situation because when you look at a family and they are trying to decide what is in the best interest of their child, they are taking it into account the physiology and the anatomy, the psychosocial, the psychiatric all of the components that go into their child’s medical condition or medical situation and that is why we cannot identify what is medically necessary or unnecessary and it would be, it would be honestly ludicrous for me to say that I could identify that when the American Medical Association, the American College of Obstetrics/Gynecology, the Endocrine Society, the American Urological Association they cannot come up with terms that and procedures that they say are
medically necessary or unnecessary in this patient population. Again going back to the fact that the term intersex in and of itself is not agreed upon. So when you can’t agree upon the definition of the categorization of the patient and then you cannot come to a defined definition of what is medically necessary or unnecessary how can we put forth legislation that would prohibit one line of therapy that is definitely something that is possible that has had studies that show success, happy outcomes, not all of them, but many and so just as it was said, if someone came into the clinic and you said this arm is not even an option for you I think everyone here would find it equally offensive if someone came in and said surgery is the only option for you. And so what we’re, what I’m trying to say and my colleagues are trying to say is how can we limited patients and their experience and their choices to what we dictate, what we have not proven, no one has proven that the outcomes of no surgery of beneficial and better than the outcomes of surgery. I am here to say people deserve the choice, they deserve the choice to do what they believe in the best interest of their child.

SENATOR LESSER (9TH): I would respectfully say we limit choice all the time. We pass laws all the time about what procedures are available and what aren’t and I would just point to one example of this that this Committee voted about a week ago to draft legislation regarding genital mutilation as just one of many examples where this Committee and this legislature have weighed in and spoken on matters of medical ethics. Have you had a chance to review the testimony that we’ve received by medical ethicists or urologists who disagree with your view?
DR. CHRISTINA KIM: I apologize, I have not seen the exact testimony that has been submitted to you. I will say that I think that part of the, I’m not saying there are no circumstances by which parameters need to be outlined, or course that is logical but in this situation what some, what one person thinks is mutilation and can sometimes be crossed over into things that others find, the definition is subjective by some, and so it is just a, it’s a difficult terrain to walk when you think logically yes of course there is some categorization that we can all agree upon but unfortunately the realistic situation is whether it has to do with this surgery or other social things that come up in our society that some people will put things under that umbrella that not all the masses agree upon and so that’s where a lot of times people don’t necessarily answer definitive yes or no. But again I point to these established societies and associations that represent multiple disciplines in the field of medicine cannot agree upon what is medically unnecessary in a patient population. So I respect what you are saying but in this situation that is why the language in item #2 is so difficult that is why I oppose it strongly.

SENATOR LESSER (9TH): Thank you and I appreciate your support for #1 and #3 and maybe we need to flush out #2 some more. Thank you. Thank you, Mr. Chairman for the time.

REP. STEINBERG (136TH): You know two out of three ain’t bad sometimes [Laughter]. Any other comments or questions? If not, thank you for your testimony, Doctor. Next up is Dr. Courtney Rowe.
DR. COURTNEY ROWE: So thank you Honorable Chair and Members of the Public Health Committee. My name is Courtney Rowe and I am probably one of the more recent physician recruits here to your lovely state. As a mother and a new Connecticut resident and voter I do support Part 1 and Part 3 of Proposed Bill 388 as does the Connecticut AAP.

But as a pediatric urologist at Connecticut Children’s Hospital I am strongly opposed to Part 2. I expect that after we speak as physicians we are going to hear a lot of testimony from people in the room who have had very difficult situations in an era in which medicine frankly has failed the intersex community as they did many people who identified as nonbinary. Frankly my heart breaks for those people who are subjected to shame and judgement and genital surgeries whose goal may have been to help them but the ultimate effect was physical, mental trauma and scars. I think the medical community has made great strides in the past decade in care for this population and we can and will continue to improve with more research, more listening to the intersex population and I would like to hope more collaboration between the patient groups and our medical community.

But I do believe banning surgery, taking options and choices away from families this goes too far. In the weeks since I learned this Bill was introduced I talk to the patients in my clinic about it and the parents and they were shocked and appalled that their parental rights to chose medical and surgical care on behalf of their children could be taken from them if their child had been born with a difference in their genitalia, chromosomes or hormones. They couldn’t believe this is happening in their state.
So I will be submitting a written response to some of the research that was presented by supporters of this surgery ban including some of the interact activists coming from Arizona and from California as well as to the pediatric Urologist Dr. Wong who is writing from Pennsylvania but in addition to that research I wanted to address some of the questions that you had Dr. Lesser and talking about some of this research. I think Dr. Kim did a really lovely job reviewing some of the decisional regret about comparing distal hypospadias and tonsillectomies. But I think that when we focus on the decisional regret of the parents I think that we are missing in some ways the stories of the families and the patients. We know that there is PTSD that is seen in the families that does decrease after genital surgery, not sure that should be the reason we do genital surgery but we know that there is an affect on the family dynamics. We know that patients who have had their diagnosis and surgeries delayed specifically because they were in China, 74 to 78 percent of them regret the delay in surgery. In terms of men with difference in their penile genitalia we know that men with uncorrected hypospadias and choree have difficulty with intercourse. They have more unhealthy days and they are unhappy with the appearance of their penis. We know that men with Pyronine’s disease which is a condition that causes a curvature similar to choree, we know that these men have a 50 percent rate of depression. So I think that we, if we’re being specific we do not know what the outcome is in delay but we have many studies that concern us and make us very worried that denying surgery to appropriately counseled, appropriately identified patients will cause harm. I know that some of our
transgender patients will talk about their experiences. I know they will talk about the benefit of gender affirming care and I would like to advocate for my families in Connecticut who have children with differences so that they too may be able access gender affirming care when appropriate. Thank you, sorry to be over.

REP. STEINBERG (136TH): No, thank you for your testimony that. Senator Lesser.

SENATOR LESSER (9TH): Thank you, I have not in fact graduated from medical school but thank you.

DR. CHRISTINA KIM: Did I call you Doctor?

SENATOR LESSER (9TH): You did. [Laughter]

DR. CHRISTINA KIM: Sorry, I live in a really narrow world like all of us.

SENATOR LESSER (9TH): That’s okay and I appreciate the compliment but I do defer to people in the medical profession actually and I want to say at the onset that I really do appreciate that you have chosen to move to Connecticut and welcome to Connecticut. Just a quick question, you did mention, you said that you thought once upon a time these surgeries had been harmful and things have changed in the last ten years. I guess my question is what sort of evidence are you relying on to suggest that the surgeries that you admitted were once harmful are now no longer harmful.

DR. CHRISTINA KIM: Oh no, I don’t mean that the surgeries were or were not harmful. I mean that our entire view of gender of sex and of identity was wrong. I think that in the 1950s they was a guy named Don Mooney and he believed that gender was
social. He thought that if you raised somebody a
girl they would feel like a girl, if you raised them
up a boy they would feel like a boy. Cleary that’s
wrong and I think that a lot of unfortunate harm was
done because that was the belief of the medical
system at the time. Because of this there was a lot
of secrecy. Parents were told not to tell their
children that they had a difference in their
genitalia or their hormones. They were told to hid
it. The surgeries were performed so that it could
be hidden and I think it has less to do with the
surgical techniques and more to do with the attitude
and the approach. I find it interesting to hear for
example from advocates who underwent things like a
gonadectomy for example and I don’t know their
medical story, I don’t know if it was medically
indicated or not medically indicated. I do know
that many, many gonadectomies are medically
indicated. Many of these gonads are not going to
provide fertility and many of them have many high
cancer risks and I think you can really debate how
much cancer risk is medically indicated, how much
did we take out, one percent, ten percent that is up
for debate and as with so many things you will find
that physicians really struggle with that term
“medically necessary.” But I read this rally
fascinating article by an advocate who had gonads
removed at age 13 and felt that something really
precious had been taken. I am so sad because I know
that with appropriate understanding and counseling
with appropriate support by a multidisciplinary
team, a therapist, getting a chance to meet other
people what that condition, I feel as though when we
take care of patients like that today they are not
left with that trauma of feeling that something was
ripped from them or denied from them. They can feel
as though they are part of a community. They can feel whole and so I am saddened to see this psychosocial aspect get tied into the medical aspect. But also I recognize that they are united and if we don’t provide psychosocial care for patients who have differences in their genitalia, in their hormones, in their chromosomes they will feel harm. And that is what happened in the 1950s, 70s, 80 and almost up to 90s. You have to remember our specialty as pediatric urologists we only became a specialty in 2007 so we really are only just establishing ourselves, are only just coming out to say this is the way things should be doing, the way we should be doing things. This is the standard of care. I do think we made great strides because of these stories and the testimony from patients who were harmed and I am very sad that winds have turned and that a lot of the patient groups are now choosing not to collaborate with us anymore but to work against and in opposition to us. I think this is a really sad, a really sad shift that has happened in the community and before I really became involved with this issue and I would like to hope that in the future we can heal some of this.

SENATOR LESSER (9TH): I guess some of the difficulty in dealing in some of that seems to be that if you’re talking about a procedure that could have scarred someone, a gonadectomy that could have scarred someone in the 50s, 60s, 70s, 80s and 90s and you are saying that you don’t think these procedures should be left in the past but should continue to the present and you have no evidence to suggest that they are any less harmful now than they were in the past. That to me indicates to me an unwillingness to leave the past behind and that is
exactly the problem that we are trying to address
today. So I appreciate the multidisciplinary
approach. I think that is helpful. It certainly
sounds that way and I would just point out what I
mentioned to the doctor that testified a few minutes
ago that the author, one of the coauthors of that
paper who suggested that approach has testified in
support of this legislation.

DR. CHRISTINA KIM: Yeah I think there are a lot of
letters from the InterACT groups that read very
similarly. Again I think it is unfortunate that this
group is coming in and is providing so much evidence
and testimony. We will be submitting some replies
from some of the authors of some of the papers. For
example there was some quotes taken out of context
from the letter from Dr. Wong from Dr. Rink, Rick
Rink and from Dr. Doug Canning. When I did forward
that letter on to them they were quite startled to
see their words taken out of context. They have
provided response letters which we will be
submitting to the Committee. As Dr. Szymanski whose
paper that you quoted I think that he provides a
really nuance interpretation of the paper which
hopefully will give a much better interpretation
than even I could give.

SENATOR LESSER (9TH): Thank you.

REP. STEINBERG (136TH): Any other comments or
questions? Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you for your
testimony this evening. We heard a lot about
evidence being, no evidence is being shown that
continuing to perform certain procedures is not
harmful. Do we have or do you, can you direct us to
any evidence that currently shows or supports that
the way that we are engaging or making recommendations or providing supportive decision making is harmful? Is there any data to show that, you know, within the community that you work with, with the parents, with the young person, the child, with the supportive network around it with the mental health clinician and the medical community when you provide options for parents and they chose one that fits the right choice for their family is there evidence that we have that says or shows that that is detrimental?

DR. CHRISTINA KIM: No it’s actually the opposite. There has actually been a prospective multicenter trial, they’ve now sort of evaluated psychological outcomes for families before at six months and one year after choosing or not choosing surgery. This is in the population mostly, most of the patients are intersex are comprised of CAH patients. It just my numbers is just the bulk of the patients that we do see. So most of these children are children with CAH and so most of them did elect feminizing genitoplasty because the incidents of genital dysphoria in this population is probably similar to the general population about 1.5 percent is transgender, that number might be low in both in the CAH and the transgender population as this becomes more acceptable to talk about. So most of those families do chose feminizing genitoplasty. A year after their surgery their rates of PTSD and distress do go down. We also know from our adult patients who have had feminizing genitoplasties that about 90 percent of them are happy that they had early surgery, they do appreciate that. And this is coming from patients who have undergone this procedure who can comment on it which I certainly
cannot comment on and they appreciate the opportunity for early surgery.

SENATOR SOMERS (18TH): Thank you for that answer.

REP. STEINBERG (136TH): Thank you, Senator. Are there any other comments or questions? If not, thank you for sharing tonight. Next up we have Jacey Long.

JACEY LONG: Hi, my name is Jacey Long. I have the honor of being the first person to speak in favor of the Bill. This is, so I’m gonna read from my written testimony I have submitted.

So I have lived in Connecticut my whole life, and I grew up in the town of Cromwell and I currently, I was recently appointed to their newly forming LGBT committee. I attend school at Middlesex Community College and there I serve as the President of Students Promoting Equality Acceptance and Knowledge we call it SPEAK. So it is a club dedicated to serving the needs of LGBTQIA+ students and the greater LGBTQ community. I would like to start off by thanking every group that has supported this bill so far, but I would especially like to thank InterACT, as I think it is important to hear directly from members of the intersex community when considering a bill that directly affects their lives in such a monumental way.

So obviously I would also like to thank, you know the conversations I think we’ve had that are very important. I think what I’ve heard stressed a lot that there is many things here we can have debates on and that the medical community has, the medical community is having debates on. But I would also like to stress that like certain accusations that
had been levied against people supporting this Bill such as by the doctor who had spoken at the beginning saying that we’re trying, to you know, like increase the amount of people like that this Bill could affect which I don’t this is the case. Being the way I see it is I think that mostly what we’re trying to do is s, you know, maximize the amount of people that are satisfied with their care and satisfied with their surgeries and I think that is very important.

I would also like to address the part where it said, you know, that #2 that part, that you know, it’s so sad that it’s like, you know, that had been added to this Bill cause it is so controversial and that the other two things are so easy. Well, you know, I would love to be having conversation that was, you know, uncontroversial I think, but I also think it is important to have, you know, talk and have difficult conversations like this because, you know, then that way the real facts can be found, the truth can be brought closer to if everyone kept silent about thing because they were afraid speaking up about raising issues. I don’t think anyone in this room would agree with that.

So I would just like to thank everyone for their time and I am open for questions.

REP. STEINBERG (136TH): Thank you for your testimony. Senator Lesser. No. Thank you for sharing, this does offer the perspective we did need to hear additionally. Thank you for taking the time to be here tonight and anybody else have any questions or comments? If not, Jacey, thank you.
Next up is Diana Lombardi. Heidi Fernandez? Andrea Boisseau.

ANDREA BOISSEAU: Thank you Members of the Public Health Committee. I'm Elder Andreá V. Boisseau. I am a Certified Peer Support Specialist and I am the New England Director of Intersex Campaign for Equality which is the US Branch of the Organization Intersex International which is a worldwide organization who help people who are born with various intersex medical conditions.

I am in favor of this Act concerning people who are born intersex. But you have a written testimony anyways. This Bill definitely needs to be passed. Intersex people suffer from unneeded, unwanted genital plastic surgeries to make others more comfortable with how their bodies are. I was born with partial androgen sensitivity syndrome with accompanying hypospadias. So basically oh, about 30 percent of my body does not react to testosterone. So I developed a small penis, vagina, mixed gonads a bit of both and I am cisgender which means I identify as my birth sex both male and female. The doctor’s put “X” on my birth certificate to certify me being intersex back in ’58. I had sexual assignment surgery at 8 months old to officially try to repair the hypospadias. Unfortunately I had 14 failed hypospadias repair surgeries which resulted in the last one having to be amputated because the urethra was so plugged up with scar tissue it could not pass any urine. So I was rushed to the hospital and the penis was amputated.

I am here today to express my support of this Bill, all three points, which will affirm the bodily autonomy of children born with natural differences
in genital anatomy, often called intersex. Unnecessary procedures like vaginoplasties, clitoral reductions, and gonadectomies which I received all three in childhood. As few as two days old there are two girls that I know who come to me, they had sex change operations from male to female at two days old because their penis was a bit small. That was the only reason. Unfortunately they didn’t give it thought, they just said yes, I’m still boy no matter what they do. These invasive surgeries can basically be delayed until the individuals can decide for themselves if that want to those surgeries. The surgeries should not be occurring in Connecticut and I would wrap up by saying that is should be held off until the patient can decide for themselves. Unfortunately I don’t have my penis anymore I am forced to be female because my male organs were torn from me and they were working. My gonads produced enough hormones for me, maybe not for your levels but for my levels it was perfectly fine and that was also ripped from me because there may or may not hold cancer which they never did. I know people who have kept their gonads intact and they never had cancers and they produce enough hormones for themselves. So I’ll wrap up, thank you very much. Any questions?

REP. STEINBERG (136TH): Thank you for your testimony. Senator Lesser?

SENATOR LESSER (9TH): Thank you for your testimony and thank you, Mr. Chairman. I mean I think your voice is why we’re here tonight. You’re speaking to the problem and the issue that we are trying to address which is not a problem for parents, or doctors but it is a problem for the patient. It is a problem for someone born with a condition and the
question is how do we deal with their condition? So I really appreciate you coming out and sharing your story and what you’ve gone through. And my only question for you is this, you said you were born in 1958, is that right?

ANDREA BOISSEAU: Yep.

SENATOR LESSER (9TH): Is there any procedure that was performed on you in 1958, any of the things that you talked about that is currently illegal or not currently happening in Connecticut today in 2019?

ANDREA BOISSEAU: It is still happening today unfortunately. There are five people per day who have sex change operations as babies because they are born intersex. My surgery was when I was eight months old would be in the summer of ’59 because it took ‘em eight months to figure out, you know, what to do with me. I’m glad they did delay but they should have left me alone and let me decide. I was cheated out of my penis.


MATTHEW LONG: Evening. Hi to Co-Chairs, Representative Steinberg and Senator Abrams, Ranking Members, Representative Petit and Senator Somers. I thank you very much for giving me the opportunity to speak today as well as to the Dignified Members of the Committee on Public Health. I would also like to thank Senator Lesser for introducing this Bill it does mean a lot to me personally and by the way I should probably introduce myself, my name is Matthew Long and I am elected official in the Town of
Cromwell, Connecticut where I serve on the Board of Assessment Appeals.

I strongly support Senate Bill 388 and I am very grateful for its introduction. I honestly had a lot of trouble figuring out what I wanted to say today because there is a lot I could say and a lot I could have left unsaid. This is pretty tough cause despite being engaged in politics for as long as I have, I actually never testified in front of a Committee so this is a relatively new experience for me so I appreciate all of you for giving it to me.

So there has been quite a lot of testimonies to sort through. Everyone who has submitted has really come from a different perspective. We’ve heard from an endocrinologist, surgeons, from the patients, parents. So I figured well I’m none of those things so what should I offer, I might as well offer my story on how I became an ally.

Well, I was, two years ago I didn’t know anything about this kind of stuff. I was asexual, or still am but social justice issues, LGBT stuff like that. I came across about a year, maybe two years, a year-and-a half ago I came across a report or an article and out of curiosity I started reading it. It was about intersex human rights or I should say lack thereof and some of these types of practices that are current accepted abroad and domestically. I also, you start to read about the stories and you kinda like get, it sticks with you because what happens to a lot of these patients is really unjustifiable. I then read about the report of the special report on torture and other cruel and inhumane or degrading treatment or punishment which was brought to the attention of the United Nations
Human Rights Council and I’ve since seen a lot of similar reports. We’ve had people such as three former surgeon generals, the ACLU Human Rights Watch obviously interact. Some stunning reports about this or just come out in favor of proposals like this.

So this is definitely an issue of concern for myself and I would just like to say when you have an intersex infant, they should first be protected and safeguarded just like anybody else, however they do not have the same right to bodily autonomy as we do and for whatever reason, they are just like everybody else and we should make sure and insure that these children are cared for ethically, compassionately and not denied their right to make irreversible decisions about their bodies. I urge you to take the opportunity to protect innocent children by supporting Senate Bill 388 in its entirety and I am available for questions. Thank you so much.

REP. STEINBERG (136TH): Thank you for your testimony. We’re glad we gave you the chance to have your first testimony before public hearing so as an elected official we should let you know that you could have been here at 10:30, we would have given you preference.

MATTHEW LONG: I actually did try that and I was informed that was totally not allowed only Deputy Mayors, Mayors and like, right? [Laughter] I had to wait all day today.

REP. STEINBERG (136TH): Questions or comments? If none, thank you for being here. Next up is Nicky, I’m gonna do badly on this one Chalynphone, something along that line so you can help us out here.
NICKY CHALEUNPHONE: Sorry, I’m a little nervous so. Okay, what can I say? I do support SB 388 as an intersex person. I was born with Kallmann syndrome and I am taken care of by an endocrinologist, one out of Massachusetts General Hospital, one out of the hospital in Central Connecticut and one out the International Institute of Health in Bethesda, Maryland.

With Kallmann syndrome what I have I have a KAL1 variation. I can’t smell, I’m born deaf, I can’t hear, I have a micro penis and bigger genitalia and I have gynecomastia. When I was born, I was born here at Hartford Hospital, my parents who were not educated very well, didn’t know intersex was yet along what Kellmann syndrome was. They were lead by the doctors and didn’t even tell me what they were doing. There was not even an advocate or social worker on hand. So as a result growing up I was forced to like take the male hormones and say, here take this, you’re gonna be a guy. But 10-20 years later when I got my current endocrinologist, Dr. Kaur that was never gonna happen. All the testosterone in the world was never gonna make me look like a normal male, all it would do is give me the normal male energy to eat every day and just get out of bed. Surprisingly I am one of the few intersex people who serve in the United States Coast Guard. I serve out of Sector Long Island Sound and I’m an Auxiliarist with them so I am living proof that as an intersex person I can serve my country and do my part and I’ve done it very well. I have succeeded a lot of people’s expectations.

But one thing about SB 388 I want to say is that I agree with the Sections on 1 and 3, it would help intersex people like me but would also enhance what
is already on the Americans With Disability Act as well. It would help people like me have a normal life despite being born with an intersex condition, being deaf in one ear, can’t smell and I can’t reproduce and if I can reproduce what Mass General says is going to be like a dartboard game. So that’s about it.

REP. STEINBERG (136TH): Thank you for your testimony offering that perspective and equally important thank you for your service. We really appreciate that despite all your obstacles. Other comments or questions? Senator Lesser.

SENATOR LESSER (9TH): Thank you, Mr. Chairman and thank you again for your courage in testifying. You were terrific but also for your service to your country.

NICKY CHALEUNPHONE: I do serve the State of Connecticut and what I do is during the wintertime we break the ice along the Connecticut River, if you guys don’t have heating oil, guess who you come to? [Laughter] We’re the ones that like, we fly, the route just to survey the ice to see if there is any ice in the Connecticut River and we send the Coast Guard Cutter Broward up there too.

REP. STEINBERG (136TH): I hope everybody when they are warm tonight says a special thanks then. Just looking back, if you had the ability to weigh in, obviously, would you have consented to the procedures that were done to you?

NICKY CHALEUNPHONE: If I was told about this when I was younger and I’ll give you a quick synopsis of the story, when in 1984 when I was at the UConn Health Center in Farmington. I was sitting, there
was a conference room between Dr. Karen Ruben who she’s still at the Connecticut Children’s’ Medical and there was a team there that was trying to decide what to do and when I read the medical reports they stated that if I was very sensitive to testosterone they would cut that micropenis out and make it into a hole. And I didn’t know what the test results were because they buried it a long time ago. What I’m trying to say is this, you gotta have accountability and you gotta give the kids everything possible. People like me never had that choice and we’re like the living relic of what was done back in the 1980s to now. I see intersex growing up having things that I wish I had that in 1983 but I’m living with the scars. Back then I was often told this, that if I didn’t go along with what the doctors told me or what the parents told the doctors to do, they would mislabel me as schizophrenic and throw me in the corner and make me disappear.

SENATOR LESSER (9TH): Thank you and I think one of the important points and we’ve heard it from the medical community is that things hopefully have changed at least to some extent. What I’m still concerned about is that they may not have changed enough that we’re no longer engaging in these surgeries to begin with. We may provide all the support in the world but if there’s something fundamentally wrong with a nonmedically necessary surgery that still may be a problem.

NICKY CHALEUNPHONE: See, I’m for the multidisciplinary team but I also think there should be a social worker or an advocate like a person outside the multidisciplinary team, like a guardian that advocates for the kid’s behalf. Cause
sometimes you can have the medical teams say one thing, parents say the other who’s batting up for the kid? Thank you.

REP. STEINBERG (136TH): Excellent point. Senator Somers.

SENATOR SOMERS (18TH): Yes and thank you for sharing your story tonight and I feel, I feel touched by what you said tonight and what you’ve had to endure and I would not anyone to have to go through that again and I think we also heard from the medical community that things, I don’t want to ask you how old you are, but things have changed.

NICKY CHALEUNPHONE: That’s okay, according to what Dr. Kaur knows I’m 42 years old. I will be 43 in a couple of months but I look like a teenager [Laughter]. So I say this, I say this, there are three women that take care of me, if they ever figure out the key to the fountain of youth I would be in a lab right now. I would like be in basically Building 10, locked in the lab. [Laughter]

SENATOR SOMERS (18TH): Well we’ll have to see later about the fountain of youth but I really appreciate you coming and sharing your story and, you know, having us learn more about what you had to endure and thank you for your service. I know those ice cutters on the Coast Guard, that’s not an easy job.

NICKY CHALEUNPHONE: I’m still in the Coast Guard and I will probably stay in until they physical throw me out, which will be a long time.

SENATOR SOMERS (18TH): Yes, absolutely. So I heard you say and I just want to make sure I’m hearing it correctly that, you know, Number 1 and 3 in the Bill, Number 3 we have testimony from the Department
of Public Health, they have ideas on how they could remedy Number 3 but Number 2 you are not against the idea of this multiple disciplinary approach that we are using now and you have possibly an advocate for the child’s best interest especially like you said your parents, you know, they might not have understood the exactly what was going on when what was done to you was done to you. And I can understand that, you know, it’s complicated. So I just wanted to get, you know, your thoughts if I’m hearing that correctly from you.

NICKY CHALEUNPHONE: It is because when my parents came to this country, my parents came from Laos and Thailand in the fall of ’76 cause they helped out the Americans during the Vietnam War. They didn’t have the education that I have in this country so when they came to this country and they saw a medical problem in me, they thought the doctors were like gods and it wasn’t religiously, without like a second opinion or going to like an advocate or social worker and to have them sit down and explain to them what is goin on with their kid. And that’s what happened with me. I didn’t even have a social worker like tell me like, hey this is what they’re gonna do to you on the operating table, this is what’s gonna happen afterwards. I didn’t have that growing up. Now I see like in 2019, intersex kids having social workers and advocates on their team, even like an outside guardian like advocating for them and saying to the medical team, no you can’t do that to the kid, just wait until the kid reaches to an age where they can say what they want. I didn’t get that choice growing up.

REP. STEINBERG (136TH): Representative Petit.
REP. PETIT (22ND): Thank you, Mr. Chairman. Thank you for your testimony. Listed to most of upstairs on the third floor and came down to say hello, thank you for your service and thank you for your correspondence on a number of health care issues through this session.

NICKY CHALEUNPHONE: Yeah, Dr. Kaur says thanks too. I had to miss her appointment and my excuse I was with him. [Laughter] So I’ll be paying for hell with that in April. Well I’m fortunate to say like this, because of Kallmann syndrome I take testosterone for the rest of my life, there’s no ifs or ands around it. Regardless of like if I want to get off of it or not, there is no way. And every so often I do go to NIH and I do go to Mass General cause sometimes when they do research on people like me, they want to know what’s goin on so I have very good doctors that take care of me and without it I’d be at the mercy of whoever.

REP. STEINBERG (136TH): Well it may have taken a long time but you’re now a very effective advocate on behalf of this issue so thank you for that. Any other questions or comments? Thank you again for your testimony. Next up is Femmaeve MacQueen-Rose.

FEMMAEVE MACQUEEN-ROSE: Hello. Hi, hi everybody. Hi, Esteemed members of this council and patient as well. I’ve been here from about 10:30 so I’m so excited, I’ll set my own timer too.

Oh by the way, my pronouns are they, them, their and we will just right there. I put in some testimony already especially so if anybody on this Committee is against one and three, please read the testimony because these things just don’t affect people who are nonbinary or intersex or transgender, let’s not
get into terms too much because I know the doctors don’t like loose definitions and I really appreciate that as a critical thinker.

So please, look at that okay because it effects everybody, compulsory fifth genderism, compulsory heterosexuality or we could just call it compulsory fifth heteropatriarchy and if you need to find out those definitions I’ll answer those in your questions, is very prevalent okay as is structural oppression. I also want to say that I am currently finishing up my dissertation and I study structural oppression and collective liberation and I would like to put that out there. I wasn’t going to bring that up but I do feel like even though I completely appreciate the testimony, some of the testimony doctors in the room gave today, I need to pushback and say that doctors are not the only people that have expertise in thinking and some expertise in this matter. As a person who is about to get a PhD I have very good critical thinking skills and so instead of reading my testimony I thought I would just review some of the critical thinking that has happened on this debate on 388, especially number two.

So first of all we have this idea that in the past ten years things have changed, right so the AMA and all these things, that’s not really true. I would definitely pushback on that and say that the onus of proof, you know, is really on the AMA, right? They actually have the ability to surgically intervene on bodies that are intersex, right. There should be a moratorium until you all get credit back for the gatekeeping and the violence that you as a group have done to bodies for the past well thousands of years but really in the past say 200 years in this
country. Right, things have not changed enough? So another thing that I’ve heard about is this conflation of urethral issues with say a sex characteristics, right, and again we’re talking about a very specific scope of surgical intervention. I also heard somebody say. Really, that’s fast.

Well I’ll just finish with this, I just heard somebody say, you know this list of things about all this data on, where we’re gonna be taking options from parents, we talk about the decisions with aggressive parents, we talk about how PTSD decreases for the family and we also somebody said we do not know about the outcomes of delay, right. So my questions are like what about the possibility of choices of that child. I think the medical industry is very sensitive about gatekeeping only when it’s being done to them, right. However they have a full history of gatekeeping when it comes to say my need to access certain medical attention and so these are some of the things that I really think this conversation needs to go along and I think that we definitely need to discuss somethings especially the lack of critical thinking on behalf of the medical doctors in the room. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony and your perspectives. I’m sorry three minutes doesn’t seem fair enough.

FEMMAEVE MACQUEEN-ROSE: It’s like time travel [Laughter].

REP. STEINBERG (136TH): I think we have enough to cover today without time travel. So we’ll get there.
FEMMAEVE MACQUEEN-ROSE: I feel like I’m 74 now not 43 in getting out of this chair. [Laughter]. Any questions?

REP. STEINBERG (136TH): Thank you for taking on my role. Anybody else questions? Thank you very much we will review it. Last up on this Bill I believe is Sarah Bromley.

SARAH BROMLEY: I am here as a parent and as an early childhood educator for over 35 years. I’m currently working for the last 13 years with infants and with parents providing them support.

So I am here as a parent because, I have a story. My son had a very minor, very insignificant problem when he was very young. When he was born, and I’m a nurse too, he developed an umbilical hernia. It’s a very minor condition but it made his umbilical stump bulge in such an alarming way and as a first-time parent I was really, really scared. And it also happened I was embarrassed, what will people say. What will people think when they saw it because it was so large, it was actually visible through his clothing, strangers would even comment on it, little children if they saw me change his diapers would come around and ooh and ahh and say what the heck is that and I was so worried about it that I asked our pediatrician about surgery for it. I really would appreciate the fact that he advised me against it. It joked with me about it actually and said, you know if he gets to kindergarten and it still hasn’t resolved maybe we’ll talk about it. He’s like put a Band-aid. What about like he’s at the swimming pool and the kids tease him. He said, put a Superman Band-aid over it, it’ll be okay. That is the kind of medical advice that I think our doctors should be
doing because who’s important here, whose rights are more important the parent’s or the child’s. Whose testimony are we going to value more, the medical profession or the people whose actual lives are on the line being affected by this. What if, what if you have a surgery and you have regrets but what if you wait. You can’t go back and undo these surgeries and these are peoples’ lives, these are not statistics. These are peoples lives and what if ten years from now we say we should have done this, we should have. There is another generation of people out there scared and traumatized and I’m sorry if as a parent I felt uncomfortable. That was about my asking for surgery for my infant son was not about necessarily his well-being but it was more about my discomfort and I could learn to deal with that and that doctor was smart enough to tell me that. So thank you very much for your time.

SENATOR ABRAMS (13TH): Thank you very much. Wait one moment please. Does anyone have any questions or comments? Thank you for your time. We are going to move on to Senate Bill 375. Donna Bernier. Welcome.

DAWN BERNIER: Good afternoon Senator Abrams, Representative Steinberg and the Members of the Public Health Committee. My name is Donna Bernier. I am not going my own testimony today I am giving the testimony for Robert Santos who is a fellow coworker. He had to leave today at five o’clock for nursing school. He really wanted to be here but we felt it was more important that he went to school because it’s something that you can’t miss.
Bob has worked as a Certified Nursing Assistant at Danielson for seven years. He was here today to testify in support of Senate Bill 375.

Bob became a nurses’ aide after his mother developed dementia. Eventually when he wasn’t able to fulfill her needs at home she became a resident at Danielson. It was then that he changed careers and realized how much he enjoyed caring for people. It’s like that is what he was made for.

Over his seven years he has seen resident’s acuity levels increase dramatically. There were more resident who needed total care, more obese residents, more residents with dementia or other more complicated medical diagnosis. These residents required so much care. May of them can’t do anything for themselves, it’s not their fault but they need more help, more care and more contact. With more staff we could provide this kind of care.

The elderly have brittle bones so when they fall it is very common for them to break a bone. It not only has a big impact on them physically but emotionally too. When they can’t move around they need more attention and can easily become depressed. We had a resident that fell and broke both femurs. Before we need one aide to give care now it takes four. It takes twice as long to give him care. I think if we had more staff everyday we would have more time to watch over them and maybe we could prevent these falls.

A lot of falls happen when residents forget they are no longer able to walk anymore. They want to be independent and they know when they need to go to the bathroom. We spend so much time trying to get to people as fast as we can when they need to go,
but it they try to get up by themselves to go to the bathroom, we don’t get to them fast enough they can have falls and injure themselves. Our residents get such pleasure and pride talking to us about their lives. When you don’t have a family many don’t have any visitors at all so we may be the only people they have to talk to. I could continue on but I will just say that at the end of the day all caregivers go home thinking could I have done more.

Everyone wants their loved one to be cared for like it’s their own family and that’s how Bob relates to his residents. Bob urges you to pass the Staffing Bill. Most people don’t know how few staff we have, transparency is really, really powerful. If staffing numbers were posted where loved ones could see them we think family members would be up in arms. Thank you for your time today.

SENATOR ABRAMS (13TH): Thank you Donna and Robert would be very proud I think. You did him well. So are here any questions or comments from the members of the Committee? Thank you very much for your testimony today. Jesse Martin. Welcome.

JESSE MARTIN: Hello. Thank you Senator Abrams, Representative Steinberg and the rest of the Public Health Committee. My name is Jesse Martin and I am a Vice President with SEIU 1199. Represent 26,000 health care workers in the State of Connecticut and in particular 7,000 nursing homes workers in 65 facilities. They do things like they Licensed Practical Nurses, and Registered Nurses, and Certified Nursing Assistants, Dietary and Housekeeping Aides, and housekeeper and dietary workers, laundry workers. They help residents go through some of the most terrible moments of their
life. Sometimes they hold their hands when they are leaving this life and they become family of the residents in the facilities that they care for. Many of our members, like Bob whose testimony you just heard, came to the work after caring for their own family and caring for their own family in their homes and then in nursing homes.

The majority of our members in nursing homes, there is still a large group that still don’t make $15.00 dollars an hour. They still struggle everyday working two or three jobs but they come to work in the nursing homes because they have a passion for the care that they give.

You are going to hear a lot of testimony this evening from many members across 1199 here in Connecticut who are concerned about what they could do better if they were given the resources to be able to do that.

Now Senate Bill 375 provides more transparency when it comes to staffing. CMS, the Federal Government has already instituted new rules to be able to compare payroll records to what nursing homes report. The reason being is that nursing homes are not always honest about what is actually happening in the nursing home when it comes to staffing. The Federal Government saw it and so this Bill sets to make it real time, really absorbable way that a family member can come into a nursing home, look at the nurses’ station and understand how many people, that CNA, that nurse are taking care that night, not three months later. CMS’s new reporting system takes over three months for it to hit the internet and only if the family is able to check.
I’ll quickly sum up in the sense of, you know, we wish the statutory requirements were a lot greater than what they are but that would cost this State a tremendous amount of money. The nursing home industry costs the State of Connecticut $1.2 billion dollars annually and changing the ratios right now, unless we know specifically what we need to change, it cost prohibitive. What this Bill will do would allow family really know how many people are taking care of their loved ones, allow them to advocate for that, hold employers responsible to a greater degree when they cheat about it and to study the problem in a way that we can fix it in the future. Thank you.

SENATOR ABRAMS (13TH): Thank you, Jesse. Are there any questions or comments from the Committee? Thank you very much for your testimony. Mag Morelli. Welcome.

MAG MORELLI: Good evening Senator Abrams, Representative Steinberg and members of the Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit providers serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities. I am pleased to be here on behalf of LeadingAge Connecticut to provide testimony on Senate Bill 375.

The Bill before you today proposes to require the adequate reporting of the number of nursing home staff in order to ensure the safety and well-being of nursing home residents. Fortunately, we believe that recent changes in the mandated federal requirements for reporting and posting of nursing home staffing levels now provides the adequate
reporting that this bill is seeking. We therefore would like to propose some suggested language that would raise the minimum staffing levels as is currently proposed in other bills this session, coordinate the state mandated reporting of staffing data with this new federal system, and promote the use of the consumer-oriented Nursing Home Compare federal website.

In April of 2018, the CMS began utilizing nursing home payroll data collected through what is called the Payroll Based Journal data system, to calculate the case mix adjusted staffing levels for the federal Medicare CMS Nursing Home Compare website. It is on this website that a consumer can read the actual direct care staffing hours, as well as see how those hours convert to the five-star quality rating system. The data is submitted electronically and updated quarterly.

Prior to this system, CMS relied on staffing data manually collected once a year by the state surveyors at the time of the annual inspection. That data was based on just this specific two week time period and the deficiencies in this former system were recognized by the federal government and as a result, the Affordable Care Act now requires facilities to electronically submit the data, the direct care staffing data and it’s based on payroll and other auditable data.

As a result of the ACA mandate, CMS developed the PBJ, the payroll based journal system for nursing facilities to electronically submit staffing and census information on a quarterly basis.

That data collected through the PBJ system is then posted on the CMS Nursing Home Compare website and
is reported by hours of staff per day and by level of licensure or certification. The site is updated quarterly and CMS has already used this system to identify nursing homes with lower weekend staffing levels and has issued new enforcement requirements based on these findings. I gave you a sample of the Nursing Home Compare website in my testimony.

Nursing homes are also required to post nurse staffing information daily basis in the nursing home and what’s included in that daily posting and how it is posted is also a part of the federal requirements and I listed the federal requirements in the testimony also.

As I said, I’ve included in my testimony just some suggestive language that would take these federal requirements, coordinate that with our state requirements, increase our minimum staffing levels that are currently in the Public Health Code which are much too low and then promote the use of Nursing Home Compare to families who are looking for a nursing facility either for short-term rehab or long-term placement so they can use that which not only has staffing data but has quality measures, has a lot of information on the Nursing Home Compare site, can be extremely helpful to a family if they know it’s there and can use it. This is suggested proposed language, we would be happy to help you with this Bill and other Bills related to again services throughout the session.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Are there any questions? Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Hi Meg, how are you? Thanks for being here. So we had
talked earlier there was somebody that was testifying and the question was about being able to falsify the information and then the question was about whether or not you had the RN or the charge nurse doing certain jobs and then the CNA doing other jobs and how that staffing level was actually reported. Can you speak to that specifically and how being somebody that has a father right now in a rehab facility, I know how many people come in and out of the room and how much time is given to him on a given day but that is not always the case. Obviously sometime people are called out and they don’t fill the position so you have, you know, less staff doing more work and so forth and so on. So how can a nursing home fudge for the sake of this conversation that specific data and how would a family member looking at this reporting really get to the crux of what is actually happening?

MAG MORELLI: Sure, well there’s two different systems. There is the Payroll Based Journal System that is updated quarterly, that is on Nursing Home Compare and you actually have to submit your payroll data, you submit it electronically and CMS actually audits it. They go out and they audit it and they do this specifically so they could audit so that people could not misrepresent the staffing data. And, you know, we’ve gone through like the first round of auditing and people have found some discrepancies, usually its mistakes and so that data is pretty accurate and in that data you cannot, the director of nursing and the administrative nursing staff cannot be reported and they are not reported. It separates out your CNAs from your LPNs and RNs that are doing the actual, you know, patient care so administrative staff is not reported on that. ON
the daily postings similar, same requirements but those are manually filled out so if a nursing home is going to misrepresent something, I am not saying they are, but if they were, it would be much easier to do on a daily postings that are filled out. They are required to make the adjustments if someone calls out, they cannot put that person who was supposed to be there in those staffing levels. They’re required to put in only the nursing, it’s also by CAN, RN, LPN on those staffing levels, I’ve put the requirements in the testimony for you to see how they are supposed to set it out. If they are doing something inappropriate, if they are reporting incorrectly they should be reported to the Department of Public Health. The Department of Public Health can then come in, they can audit the payroll data for that day, they can audit the payroll data for last week if they feel this has been a consistently, they have to keep those daily reports for 18 months just for that purpose so the State can review them. So we would, I am not here to defend anyone who is misrepresenting hours and I would say that they should be strictly enforced. That is how someone know when they are walking into a nursing home, what the staffing levels are and if they are coming in for a visit, whether they are choosing to place someone in that nursing home or if they are coming to visit someone who is currently there.

REP. COOK (65TH): Thank you and I wasn’t by no means stating that was happening, I was just curious as to if that was happening and, you know, we have hundreds of facilities, you know, how does one investigate and drilldown so thank you for all that. Thank you for what you do. Thank you, Madam Chair.
SENATOR ABRAMS (13TH): Representative McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair. Quickly, I know it is very important for the consumer to see what direct care is and what the hours but what do you mean in the report where it says they can take those hours and convert them into the Five Star Quality, what is that?

MAG MORELLI: I think the Committee was talking about earlier about acuity levels to the staffing levels and what CMS is attempting to do is to take the hours that are reported so the hours you see are compared, they’re just the hours people are working. But you could have two nursing homes with the same hours with different stars for staffing because they apply a five-star rating to the actual staffing that gets applied to the overall Five Star and if you have a higher acuity level or a lower acuity level that matches with the hours and that’s where your five stars come out. Your certain hours doesn’t necessarily mean a certain five star, it’s got to be the certain hours based on the acuity level that you are caring for in the nursing home at that time and then you get your star rating.

REP. MC CARTY (38TH): So they do try to rate the stars based on your acuity levels.

SENATOR ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Thank you and thank you Mag for the testimony and certainly I think there is a lot of merit to the reporting requirements but I noticed in just the language, or at least in the testimony here, that you offered in terms of having he Committee consider, you had mentioned after October 1, 2019 a minimum staffing ratio of not less than
2.3 nursing staff hours per resident and then you said if the increase cost or expenditures due to that compliance, okay, the Department of Social Services should adjust the Medicaid rate to provide payment. You must have given some thought to this and must be aware of that would mean in terms of the finances. Do you have any numbers in terms of what that might, the range of numbers of what that might result in?

MAG MORELLI: Sure I have put in, I explained later in the testimony the 2.3 level because that was a level that was agreed upon a couple of years ago between the ombudsman and the nursing home association and a couple of other organizations. We are willing to talk about a higher level. The State of Connecticut staff currently at a higher level than 2.3 so they’re probably if we go to 2.3 there probably wouldn’t be much of an impact at all quite fiscally. I could double check for you but back in 2016 it wasn’t going to be a very big, it wasn’t going to be a major hit, maybe a few homes that have needed to increase their staffing to hit 2.3. So we’ve talked, we’re closer to the 3.0 as our minimum staffing, the lowest staffing in the state so if we were to move to a 2.3 - 2.5 it shouldn’t have much or a fiscal impact but I mean I defer to some of my colleagues who might want to clarify that later and I also can check on it for you.

REP. BETTS (78TH): Thank you that would be really helpful so thank you for that. If you could send that to me it would be great. Thank you.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you for your time and your testimony. Chelsea Daniels. Welcome.
CHELSEA DANIELS: Thank you. Good evening Senator Abrams and Representative Steinberg and Members of the Public Health Committee. My name is Chelsea Daniels and I have been a licensed practical nurse at Freshriver Health Care for the past six years. I regularly work on the 3-11 shift, also known as second shift and I am here today to testify in support of Senate Bill 375.

On a daily basis I would with 25 to 35 patients. I make sure their evening goes well, they get their medications in a timely manner and, you know, ultimately that they have the best night that they can. But Freshriver along with many other nursing homes today, they don’t have your traditional resident. Many of the residents I work with are behavioral health, mental health and a lot of them are suffering from addiction. Residents who have behavioral health issues are challenging especially without adequate resources for training and staffing. Many of our residents are younger now. I’ve had teenagers and most of my patients now seem to be in their 40s and 50s. It is frustrating for them to live in a community that was not traditionally designed for them, it was designed for the elderly. Those frustrations mixed with their medical conditions usually result in physician and emotional stress. Having enough staff is vital to making sure that everyone is giving the time and energy so that they can receive the highest level of quality care.

Without enough staff we typically take on additional burdens and work at a pace that is unhealthy for us as caregivers. Most nurses don’t take a lunchbreak.
In most nursing homes the 11 to 7 shift is quiet without incident but because of the new population of residents there is now activity all hours of the day and evening. One night maybe in 2017 I was working on the 11 to 7 shift and about four o’clock in the morning I was charting, I was writing nursing notes, and a younger resident maybe in his early 50s came through the gate, was on a locked behavior unit, he came through the gate and he assaulted me. I was able to call for help and eventually the resident did redirect his own behavior. But these types of incidents are becoming more and more common each day. Without adequate resources from the state for training and staffing we as caregivers are left for ourselves. As an advocate with my union and leading the fight to try to bring higher quality behavior health training to myself and coworkers, I’m in favor of Bill 375. Thank you.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments from the members of the Committee? Thank you for sharing your experience. Adrianne Sewell. Welcome.

ADRIANNE SEWELL: Good evening Public Health Committee. My name is Adrianne Sewell and I am a Certified Nurses’ Assistant Advanced Center for Nursing and Rehabilitation in New Haven, Connecticut. I am here today to testify in support of Senate Bill 375.

I have been a CAN since 2005 and the type of care that is required now has changed dramatically. In 2005 the population of residents that I cared for, who mostly were elderly, my residents had issues like dementia, skin breakdown, aging bone. Today the population that I care for are much younger and
face many different issues than the older population. The issues they face range from drug abuse, alcoholism and mental illness. They are more aggressive, combative and violent. They have greater physical abilities are dealing with emotional ups and downs of addiction. The days of caring for the little old ladies and gentlemen have passed.

My coworkers and I have been doing the best we can to meet needs of each population but our efforts need more support. We need better staffing ratios to be sure that all the residents we care for, older or younger, can live the best life they can. Holding us back is the lack of resources. Without the proper staffing levels we are left to deal with the change in the level of care that we provide on our own.

More staff will allow me more time for individual attention that will help curb the aggravating and sometimes violent behavior that are so common now. Every day I struggle to make sure that I can get everything done while also trying to provide the individual attention that makes a difference in the life of the resident that we care for. We are proud of our work but let’s be serious, it could really be a lot better with enough resources, we can truly make a difference in the life of those who we care for.

We have gone four years without wage increase but our workload has doubled and nearly increased to tripled. Passing this Bill will be a step in the right direction for workers like me. It would help to provide better care for residents and families. It will start a larger conversation in funding the
care that so many residents in Connecticut need. This time is now to make changes that will insure better and healthier outcomes. Thank you for your time.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments from the Committee? Thank you very much. Tiffany Moye. Welcome.

TIFFANY MOYE: Thank you. Good evening Senator Abrams, Representative Steinberg and Members of the Public Health Committee. My name is Tiffany Moye and I am here to speak on behalf of Gloria Plummer. Gloria Plummer wrote this statement so I am going to speak for her.

Gloria Plummer has been a Certified Nursing Assistant (CNA) for 24 years. She currently works at Wintonbury Care Center. I am here today to ask you to support Senate Bill 375 and to tell you firsthand what working in a nursing home is like and how lack of proper funding is impacting caregivers and residents who we care so deeply about.

In order to do our jobs to the best of our ability, we need proper staffing. The work we do as caregivers makes a meaningful difference in our residents’ lives. They need the care that we provide, the depend on us to function. We are constantly understaffed and overworked. We do want to provide the best care to our residents but lack the resources causing us to work so hard that many days I barely have time to take a break.

Having worked in the nursing home field for over 20 years, I’ve seen how the residents we care for have changed. There needs are greater, they have more illness than residents in the past and the burden on
the nursing homes has increased. I used to work the elderly now I work with resident as young as four years old who have very serious mental illness, who suffer from dementia, addiction, bipolar, bad behavior and other mental illness. The care I give isn’t as physically intense as before but it is more emotional and mentally draining. At times I have to breakup fights, stop them from walking around naked, remind my suicidal residents that they matter.

If we had sufficient staffing it would generate better care. The residents should not be deprived of that right. There is never enough time to give the residents proper conversation, proper care or proper contact. We should not have to rush. One of my residents asked if I was mad at her because I never have time to sit down with her anymore.

We look at our residents as our mothers, our fathers, some were lawyers, doctors, nurses, Veterans who have contributed a lot to our country. They stood up for us and our lives and now it is time for us to stand up for them. Put yourself in their shoes. Please, we ask that you pass Senate Bill 375.

SENATOR ABRAMS (13TH): Thank you very much. Any questions? Representative Petit.

REP. PETIT (22ND): Just a comment. Thank you for that testimony and thank you to you and the people who have testified and are gonna testify. You know, the LPNs, RNs, CNAs are the heart and soul taking care of people. It’s difficult work and obviously you are quite dedicated. It’s 8:42 on a Monday night, you’d rather be someplace else and you are here, not even so much for yourself but for your patients, so I thank you for all you really live up
to your name as caregivers to a fragile group of people and hopefully we can have a system that allows for the different levels of acuity and perhaps were hearing a lot about fisticuffs and pugilism that allows for certain levels of fighting that some of the residents do for variety of medical reasons and be able to get better staffing so that you can give better care and better quality of life. So thank you all. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Please tell Gloria that you did a fabulous job on her behalf. Thank you. Denise Panella. Welcome.

DENISE PANELLA: Hi, my name is Denice Panella and I am a Registered Nurse. I have worked in the same nursing home for the 18 years. I am here today to urge you to pass Senate Bill 375.

I started in that facility as CNA, to an LPN to an RN so I know firsthand the struggles of what we as direct hands-on caregivers face. I have seen numerous policies and laws change over the years, but never the number of staffing policies for these residents. It is hard to believe that the State of Connecticut has not changed the patient to staff ratios in nursing homes since 1969. But in the meantime what has change is the higher acuity level patients. I get more obese patients that are over 500 pounds so that is automatically two people. When a person cannot bear weight on their own feet and they have to use a mechanical lift that is automatically two people. We are getting challenging, more psychiatric, younger patients detoxing. That is automatically two people so all these things require more staff and I don’t have the
ability to do everything I have to do in an eight-hour shift.

We are currently and constantly work at the State minimum requirements which are not accurate because the supervisors and managers are also included in the direct hands-on staffing numbers, but they don’t deliver hand-on care. So this need to change.

So I timed myself getting ready, getting out of bed, brushing my teeth, taking a shower, eating breakfast all these things that I could do and it takes a good hour. But all of my staff and my CNAs I mean they are only allotted 10 minutes per person and that is not possible. A lot of my families that come in they don’t realize that I am one nurse, for 32 patients. So how come you’re not fast enough, where’s my stuff. I can’t clone myself. My eight hour shift always turn into a 10-12 hour shift and I have to stay late and more time is spent on the required paperwork than actually caring for the patients. I am only allowed 2 minutes per patient and then it’s never taken into consideration about when there is a facility outbreak like a stomach bug or the flu, we’re still at the state minimums.

So the current staff, like we’re burnt out, like no one is really choosing careers in the nursing homes anymore and every person that comes in and quickly leaves, I’m always like, “No, no wait why are you leaving us” because it’s just too heavy. The assignments are too heavy, the patients are sicker and again we’re just no longer caring for just the elderly. Its detoxing patients and so we do, we need more help and these patients do deserve better. So please pass Senate Bill 375. Thank you.
SENATOR ABRAMS (13TH): Thank you very much. Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. And for everybody that is going to testify that is in this profession, and I know that Representative Petit said it but I think it needs to be said again, thank you very much. You know and what you just said is beyond heartbreaking for me because you have whether it be an elderly person, a person that is going through rehab or whatever the reason why somebody is in a facility, their needs are the most important for them and it is very difficult for somebody especially the elderly or the elderly who is not always in their right mind to understand that there are 30, 40 or 50 other patients and quite frankly that is not their problem.

DENISE PANELLA: Right, but when family members are unhappy who gets yelled at.

REP. COOK (65TH): And that’s what I’m saying and I think it is such an unfair disadvantage for the caregivers meaning you all to be pitted against the family members when it is out of your control.

DENISE PANELLA: And that is happening more and more.

REP. COOK (65TH): And for people that cannot get up on their own, cannot ambulate on their own, cannot feed themselves and to be left because somebody else is having a need, that may or may not be more important, but in their world it is. And then the fear of having a conversation because of the fear of retaliation which nobody would ever necessarily retaliate but when you’re talking about an elderly person that is a huge fear. I just want to say
thank you all for your patience and what you do because we’re all gonna get old someday, God willing, [knocks wood] and I would hope there is still people out there that are taking care of us. So thank you.

DENISE PANELLA: And when we do go to administration to say, hey we need more help, we need more staff, their answer is always, “It’s not in our budget.”

REP. COOK (65TH): So I will tell you that there is a staffing bill that was referred from Human Services to this Committee that I actually put in to raise the minimum staffing levels for CNAs specifically because there is absolutely no way somebody should be responsible for taking care of 10, 15, 20, 25 patients [Audience applause] it doesn’t make sense to me at all so thank you.

SENATOR ABRAMS (13TH): Although I totally understand, I am going to ask you not to applaud. Okay? Thank you. Any other questions or comments? Thank you very much for your testimony. Nancy Minarsky. Welcome.

NANCY MINARSKY: Good evening, Senator Abrams, Representative Steinberg and members of the Public Health Committee. My name is Nancy Minarksy and I’ve been a CNA for, it’s going to be 30 years this November at a large nursing home in Danielson. I am here today to testify in support of Senate Bill 375.

Like many of my coworkers I entered the healthcare field because is always wanted to take care of people. As caregivers we grow relationships with our residents and learn to love them like they are own family. Most people don’t know that staffing requirements for nursing home is every resident is
to receive one hour and 24-minutes of care in every 24 hour period. Stop and think about that. To give you a better idea the majority of my residents need assistance eating, it takes most residents about 20 minutes to eat, they get three meals a day and nearly all of our residents need assistance with toileting. Many are incontinent and wear briefs or pulls-ups to avoid soiling. Many residents need the assistance of two aids with a mechanical lift called a Hoyer to get in and out of bed. It takes two staff members, at least 10 minutes to transfer someone with the Hoyer into bed, remove their soiled brief, clean them, dress them put them back in their wheelchair. All my residents need to be toileted or changed at least every two hours during my eight hour shift. Others may need to be toileted maybe five or six times. They need their bathing, eating, toileting, providing medication that is all part of our one hour and 24 minutes of care.

The problem with these staffing levels is it means we’re rushing just to take care of the resident’s basic needs. We don’t have enough time to pay attention to the person’s emotional needs.

The other day I was taking care of a lady who is deep dementia. I’ve worked on her wing now for about four months and I’ve never heard her say a complete sentence. Others tell me it has been years, she mumbles, sputters but doesn’t really put words or actual sentences together. I have never seen any family members come in to visit her. She was in the dining room and suddenly out of no where she said, “I want to go home” clear as a bell she was alert and just started crying. It was heartbreaking. I went over to her and I said, I know honey, I’m sorry and I put my arms around her
and she said it again but I had to leave her to go to my other resident. If we had more staff I could have stayed with her longer while she made her way out of her dementia.

I’m speaking today as a caregiver but also my 82-year-old mother has been a patient at Davis Place where I work for several years now. She didn’t ask for Alzheimer’s. She didn’t ask to be placed in a nursing home. My mother and all of our residents deserve quality care. The deserve to be acknowledged and have someone care for the soul not just their body. To look at pictures, to go down memory lane and actually listen and be present with them, you can’t put a price tag on that. Please pass Senate Bill 375. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from Committee members? Thank you for your testimony and for the work that you do. Nedra Williams. Welcome.

NEDRA WILLIAMS: Good evening Senator Abrams, Representative Steinberg and Members of the Public Health Committee. My name is Nedra Williams and I work as a Certified Nursing Assistant at Parkville Nursing Home here in Hartford. I am here today to urge you to pass Senate Bill 375.

I work on an Alzheimer’s unit were I feel that residents are our special needs residents. I say that because some of them don’t know the date, time nor the year it’s just a part of their Alzheimer’s disease. There are so many things we have to pay attention to, it is not just keeping them clean and safe, we have to pay attention to their skin condition, their mobility, their food intake,
output. We play the role of a CNA not just to take care of the residents but we are on the forefront.

We see everything before the nurse does half of the time, dieticians and speech therapists. One particular resident that drinks thin liquids, I noticed she had been coughing and I brought it to the dietician’s attention and I told her that she needs to be reevaluated. She got reevaluated and we found out that she needs to be on thick liquids instead of thin. The speech therapist told me that if I hadn’t notice that it could have been a problem and she could have aspirated. As aides we are on the forefront. When we don’t have enough staff we can miss things here and there because we are rushing to take care of everyone’s basic needs. Some of our residents that are bedridden and can’t do nothing for themselves, so that are contracted could get hurt if we were to rush or would also hurt ourselves. In order to give proper care we need enough staff and we need time. Every resident has their own specific need. One may be able to do more while others require a lot more time to care for them. They might not just want their hair to be washed, they might want it to be styled too. They might want to go to the bank to get their money. Sometimes they want to reflect on their life with someone and they get upset and cry and just want you to be there for them.

Care matters. Residents deserve dignity and humanity. Care isn’t just about bathing and showering, it’s not just about keeping residents safe, it is about paying attention to the whole person physically and emotionally.
I urge you to pass this staffing Bill and to help be a positive force for change in our residents lives. Thank you for your time.

SENATOR ABRAMS (13TH): Thank you. Were they any questions or comments from the Committee members? Thank you very much for being here tonight. Matthew Barrett. Welcome.

MATTHEW BARRETT: Thank you Senator Abrams and Distinguished Members of the Public Health Committee. My name is Matt Barrett I am the President and CEO the Connecticut Association of Health Care Facilities which is our state’s trade association with 160 skilled nursing facilities and rehabilitation communities and assisted living communities. I have submitted testimony for the record.

If I could deviate from my prepared remarks and say that it always a pleasure to appear before the Public Health Committee but it was particularly meaningful to be in the audience to hear the representatives, mostly CNAs from Parkville and Wintonbury, Freshriver Advance Nursing. If I could just say that Connecticut Health investigations team has a standing FOIA request in front of the Connecticut Department of Public Health and each month Connecticut newspapers they publish stories about when nursing homes are fined when things don’t go well. But for me it always masks a different story when the thousands of stories when care is very good and I hope the message of our CNAs about when things are going right is a resounding message that has penetrated this evening.

Onto the Bill, my written testimony largely addresses the issue of the very extensive electronic
reporting and manual reporting that takes place on a daily basis in Connecticut nursing facilities and how those reports are translated and calculated into a measure that we hope, we believe, is helpful to consumers when evaluating the quality of care and staffing levels in Connecticut nursing facilities. And so I provide that information into the Committee as background and hope you will consider it as you deliberate on this Bill further.

I do believe we can get a staffing bill. I have profound respect for Representative Cook’s Staffing Bill. The 1.9 per day staffing requirement is outdated and the agreement from 2016 to raise that standard to 2.3 hours I think should be adopted this session and I look forward to working with the Committee and my colleagues and the other nursing home trade association of Connecticut and the Committee on working on these issues for the remainder of the session. I’d be happy to answer any questions you might have.

SENIOR ABRAMS (13TH): Thank you very much. Representative McCarty.

REP. MC CARTY (38TH): Thank you Madam Chair. Good evening Matt. I just want to point out and congratulate and thank all of the CNAs. We know the amount of tremendous work that is done in the nursing homes but I was wondering if you could give an opinion? There has been a lot of discussion with the rebalancing act and moving more and more residents to homecare, that is not to say that we don’t need to have quality skilled nursing homes but do you think in your opinion that if we move more, we get that volunteer resident advocate program up and running and we have more people in the nursing
home to sit and talk to the seniors that are there to give some of the care that we were hearing the CNAs are not, don’t have the time, would that free up more do you think that. What I’m trying to say is maybe it’s not just looking at staffing levels right now, it’s a very comprehensive approach to look at the entire person to see if we can’t improve quality of care.

MATTHEW BARRETT: Representative McCarty thank you so much I do appreciate your question and I do think that if can invigorate the volunteer ombudsman activities that I think have fallen short of everyone’s expectations over the last number of years, I think that can an important part in improving quality but I don’t want to say that in anyway that could replace or minimize the important work that our CNAs are doing in Connecticut nursing homes, 70 percent of our nursing home’s costs are actual hands-on people delivering care and the lion’s share of that work is done by the CNAs and so I would be more focused on efforts to improve the floor on the staffing levels and address an important issue that really is the, frankly it’s the elephant in the room, and that’s the lack of funding Medicaid funding for Connecticut nursing facilities over the last 10-12 years. I often refer to it as a lost decade and while I give praise to Governor Malloy he put wage and benefit increases on the table and made it a priority in administration for nursing home workers and I think that’s helped but the whole range of operational issues remain unaddressed and are caused by a decade of really no general Medicaid rate increases for Connecticut nursing facilities and so I think that the big issue, the big issue for staffing, the big issue to
improve the quality of Connecticut nursing facilities is in Medicaid and I hope that we can work on that as well.

REP. MC CARTY (38TH): Thank you Matt for those answers and I would just like to retract for a moment I wasn’t trying to imply that the volunteers could go in and take the place of the CNAs but just add to the quality of the life of the nursing home while they were there and I will agree with you that the Medicaid reimbursement rates, it seems that it is not just with the nursing home industry we have that issue that we’re all working with. Thank you Matt.

SENATOR ABRAMS (13TH): Representative Cook.

REP. COOK (65TH): Thank you, Madam Chairman. Matt I just wanted to take a minute to say, thank you. After the couple of hours we spent in my office a few weeks ago, I’ve learned more about your dedication to this population and your family’s dedication to this population than I ever knew in the years that I’ve been here. So I cannot thank you enough for having such the heart, and the goal and the desire to ensure that our elderly specifically are cared for in the way you and your family have dedicated your life to doing, so thank you very much.

MATTHEW BARRETT: Thank you, Representative Cook.

SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Hello, Matt. Thank you for being here and thank you for sharing the elephant in the room so to speak about the Medicaid reimbursement. I think that it is important and that’s one of the things that many people even
watching this might not realize is I think the reimbursement is about $190 dollars a day for Medicaid person, is that correct, $187 dollars or something like that.

MATTHEW BARRET: That would, Senator, be on the low end. The average Medicaid per diem would be about $241 dollars but there are some nursing facilities that actually get a $190 dollars per day but it is always important to note that is the gross amount in those expenditures have a 50 percent reimbursement rate under the Federal Medicaid Program and so you can cut them in half right away and then you can also subtract from that the implied income that’s generally their Social Security amount that the recipients have that go towards the cost of their care and Connecticut nursing facilities are quite a bargain when you think about it from that perspective.

SENATOR SOMERS (18TH): There you are taxed also.

MATTHEW BATTETT: And then you’re also, thank you I can’t believe I forgot the provider’s tax. And the provider tax you can take right off the top and the provider tax produces even more than 50 percent in reimbursement and by the way, it doesn’t all go back to Connecticut nursing facilities, it gets spread around the General Fund Budget in variance healthcare areas. Thank you, Senator.

SENATOR SOMERS (18TH): So I guess my point in saying is, you know, its for what we are ultimately spending on care for Medicaid recipients in a nursing home its coming from a similar industry its really hard to keep your lights on and the staffing levels are something that has to be addressed but I don’t think you can do it in a vacuum and we have to
do it holistically. You are also responsible if a patient comes from the hospital to the nursing home and has to go back to the hospital you are held accountable for that once they are released so there is a lot of things that are all factored into, you know, being able to survive and then there is CON for the beds that you have that you don’t want to get rid of so it’s more than just, it’s a holistic, what I think we as a Committee need to look at, not just the staffing levels but the whole nursing home environment and how, you know, money follows the patient has changed the dynamic of nursing homes and I know there has been some discussion in the past about how do we utilize maybe some of the beds that are not utilized in a nursing home. So I think it is a broader discussion than just staffing levels. I think we need to make sure that we have the adequate facilities here that are quality facilities for our aging population and none of us are getting any younger either. So we, you know, as our State ages, it is something that I think is really important but I don’t think it is necessarily prudent of us to look at only one of the varying factors that go into what provides or what could provide Connecticut in having a healthy robust quality care center for those that are aging. So thank you for really kind of, if you put in perspective so, after all is said and done, maybe is $100 dollars right, it costs $1500 dollars a day to keep one patient at Whiting, a big contrast. Thank you.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your testimony. We are going to move on to House Bill 6516. Judah Prero, anything close to that?
JUDAH PRERO: I’ll take it! [Laughter] Co-Chair Abrams and Members of the Committee on Public Health, good evening. My name is Judah Prero and I am here today representing the American Chemistry Council, the ACC and it’s North American Flame Retardant Alliance known as NAFRA.

We appreciate the opportunity to testify today and look forward to additional opportunities to provide information to the legislature on the issues of flame retardants, fire safety, and chemical safety.

Our member companies represent the cutting edge of fire-safety chemistry and technology and are dedicated to improving fire safety performance in a wide-range of products. Our industry is also committed to strong chemical safety regulation, to protect users and those who may be exposed to our products, while also protecting that same population from the dangers of fire by promoting fire safety.

I am respectfully speaking today in opposition to HB 6516 and I would like to highlight three primary objections:

First - Fire safety is a real issue and flame retardants are an important tool to help reduce fires, fire deaths and property damage. The Bill in its current form, could undermine overall product safety and increase fire risk for Connecticut’s citizens, communities and emergency responders.

Second - The legislation prohibits the use of a huge class of substances without any consideration of the actual safety or risk posed by any specific product. Flame retardants include a broad range of products with differing characteristics, formulations and intended uses, so it is not appropriate to make
broad conclusions or impose a one-size fits all regulatory approach for this wide range of substances.

And third - Flame retardants are reviewed for their safety by regulators around the world. This legislation would not only ban substances that government regulators have already determined don’t present a risk but would also new prohibit the new and innovative substances that might be developed in the future and could then be approved by regulators for use. A blanket ban that fails to acknowledge science-based regulatory processes and future developments is not good public policy.

To my first point: Fires have dropped significantly over the past 40 years. A major contributor to the decline in fires and fire deaths was the development of comprehensive set of fire-safety measures that include flame retardants.

But at the same time, fire still represents a very real danger in the United States and this is equally true in the State of Connecticut. One area of particular relevance to this Committee is fire safety in children. According to the U.S. Fire Administration’s 2016 data children younger than 15 were almost 50 percent of those fire deaths.

To wind up my testimony knowing that the day has been long for everyone here, we recognize the importance and the safety of our products but we also acknowledge the importance those products play with regards to fire safety. Lumping together an entire category when it has many different players within the realm just creates confusion and restricts things that may have been approved that are indeed safe and therefore the Bill currently
drafted is one that we can’t support but we look forward with working with you in the future to explore the issues further. So thank you for the opportunity.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments? Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Thank you for coming. I’ve served on Children’s Committee and Public Safety since I’ve been here which is not that long and I have seen this Bill come up before and I hear the same thing over and over is that, and I don’t’ know the terms, pardon me, but there is this group of chemicals that 1) have never been created yet so we are banning, we are tying to ban something that doesn’t even exist and 2) is that they are already regulated by the Federal Government. Is that correct?

JUĐAH PRERO: So chemicals before they can be used in the United States do have to go through an EPA approval process. So yes, the chemicals would be regulated and they are subject to EPA regulation as there have been recent changes to the Federal Regulatory system it is anticipated that there will be heightened scrutiny in the years to come with these chemicals. So secondly going to your first question so we’re working in reverse, so flame-retardants, it’s a category describing a function of certain chemicals. I like to analogize it sometimes to you have pain relievers. There are many different types of pain relievers some like opioids are ones we have serious concerns about but if wanting to regulate opioids we are going to pass legislation that says we’re banning pain relievers well, we’re lumping in that category by defining how they’re
used the acetaminophen, ibuprofen, your Naprosyn which are not what you are trying to get at. So while it’s true there is all these different chemicals in the category but they operate differently, the chemical compositions are different, how they become released is different and therefore it is hard to put them in one category and say you can treat them all the same.

REP. ZUPKUS (89TH): And I believe it was, I don’t know, last year or the year before there were, someone here was trying to ban chemicals that were already banned, you know, so to me I’m really not understanding why this keeps coming back over and over again. Obviously we want to be careful what goes in our kids clothes and our kids mouths everywhere but we also need to keep them protected safely and I think that is being done. So I’m just curious why this keeps coming up and why they exempted car seats out of this, do you have any reason?

JUDAH PRERO: I believe the sponsor might have included that in his testimony so I’ll defer to.

REP. ZUPKUS (89TH): I didn’t read that but I will. That just struck me funny. Well thank you for coming over and over again. Thank you.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Are some of these flame retardants that have been found to be particularly ineffective that are still in use that should be banned even if you are not concerned about toxicity because of their lack of effectiveness?
JUDAH PRERO: As technology develops clearly when all our companies are involved in constant research and development and looking for more effective and safer and safer flame retardants. So I am not going to say they have specific knowledge of any specific product that was found to be not working, not useful but the one thing that I do know is that in the communications that we’ve had with what we call our downstream users, which are like the product manufactures that put the chemicals in their product they don’t want chemical that don’t work in their product.

REP. PETIT (22ND): In terms of exposure especially with kids would you say or is it very compound dependent, is it more due to direct contact saying the flame retardants in pajamas or clothing or is it more to do with the product being macerated and becoming dust and becoming airborne and inhaled and getting into the system that way?

JUDAH PRERO: So at risk of pretending I’m a scientist when I’m not, I am going to defer on the answer to that to one of my colleagues who indeed is a scientist who should be able to address that question when he sits here in a few moments.

REP. PETIT (22ND): Okay, thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for your testimony. Ann Hulick. Welcome.

ANN HULICK: Good evening Senator Abrams, Representative Steinberg, Ranking Members Petit and Somers, Distinguished Members of the Committee. My name is Anne Hulick. I am a nurse, have to digress,
former nursing assistant many, many years ago, a nurse for 25 years, nursing director. I support that past Bill that they were talking about. But not to digress too much.

I lead the Coalition for a Safe and Healthy Connecticut. In my career as a nurse I always wondered why, it there was a link between environmental exposures and the rates of disease in this country and I have spent the last eight years of my career in environmental health studying this very issue and I have submitted testimony in support of House Bill 6516 on bans for CHEMICAL FLAME RETARDANTS IN CHILDREN’S PRODUCTS AND UPHOLSTERED RESIDENTIAL FURNITURE. I won’t read that all here because I know you have a number of questions. My testimony is cited, I cited all the research and the reports and I am happy to provide you with more of that and answer any of your questions.

But the highlights are that it is now pretty well known not only just across the world but here in the U.S. that flame retardants while they sound like good things they do not work. They do not retard flames in any significant sense. They are highly toxic. They are carcinogenic, neurotoxic and disrupt hormones. They are highly bioaccumulative. They off-gas and are commonly found in air and in dust.

Developing babies and young children are particularly vulnerable. Numerous studies show that infants and young children have extremely high rakes in these studies. There are videos out there, there is research, you can Google this. I am happy to provide you studies. But we know that, as I said, these chemicals are neurotoxic carcinogenic and
hormone disruptors. They are linked to lower IQ in children, developmental delays, hyperactivity, decreased fertility and numerous cancers.

Firefighters are also disproportionally impacted from these chemicals as the smoke from the fires is much more toxic because of chemicals exposures. I’ve referenced some studies in my testimony that speak to that. These chemicals have been banned in numerous other states including in Rhode Island last year. There is really no reason that these chemical should be in products, much of the market place is moving away from their use. I can provide you all that information and we really need to be protecting children’s health frankly and the health of firefighters. So I am happy to answer any questions.


REP. PETIT (22ND): So I guess the same question. Thank you for that. So this Bill specifically refers to organohalogens. Are there products currently available that could replace organohalogens. Well you say they’re not doing much to begin with, there are products that are better or that could do a better job or similarly poor job if we find out they’re doin a good job.

ANN HULICK: So actually much of the residential upholstered furniture manufactures have moved away from using flame retardants particularly because of the research on this issue over the last 20 years. And he investigative reporting, you can look it up by the Washington Post, it was a very informative series called, “Playing with Fire” that was quite informative and really changed the market place. So
most manufacturers of furniture including Ashley Furniture, Ethan Allan, Macys, Ikea, can’t think of all the others but have moved away from flame retardants in furniture. The California law that the flammability standard that was in place in California that used to require flame retardants in furniture was changed in 2013. I also reference that in my testimony so most of the manufactures no longer put them in furniture and now you will see a tag if you buy a new couch or a sofa that was made for the California market which is really the defector national market, has a tag on it that they have to expressly indicate if flame retardants are added.

REP. PETIT (22ND): An is suppose I could ask the proposer but the Bill talks about children’s products does that include any products that is clothing and car seats, toys?

ANN HULICK: So children’s products are generally things like mats, nursing pillows, crib mattresses all of those kinds of things that have polyurethane foam. Car seats have generally been exempted because they are regulated, right now, although this is probably going to change in the near future, they have been regulated under a Federal law that pertains to cars so car seats have traditionally been exempted in state laws because of that fact.

REP. PETIT (22ND): Thank you. Thank you for that.

ANN HULICK: Many, I’m sorry, many of the children’s products that I just mentioned are beginning to shift away from flame retardants for this very reason, parents are increasingly aware and don’t want these chemicals in their products and again the
research has shown that they are not only not effective, they are harmful to human health.

SENATOR ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): So the organohalogens, [Clears throat] excuse me. I read they partition themselves from the media and then actually into living tissues so how does that actually this work there they are getting into the body, are they actually absorbing through the skin?

ANN HULICK: Generally through, they off-gas from products so if they are in your couch, they will off-gas, they get into the air and dust in your home. There’s numerous studies showing the presence of flame retardants in dust. There has even been studies in college dorms because of concerns about this issue. So they get into the air and dust. They are ingested or inhaled. They, wives and kids and young children are particularly vulnerable not only because children don’t have the ability to metabolize and excrete chemicals as adults do but also they have more hands in mouth activity, they are lower to the, you know, laying on the couches, they are jumping on the, their laying on the baby mattresses for 22 hours a day or whatever. They have much more higher levels of exposure than an adult and they also, young children take in more air per pound of body weight than we do as adults.

REP. ARNONE (58TH): And they’re accumulators in the body and in the soil everywhere, forever chemicals and disruptors of DNA I’ve read also.

ANN HULICK: They, yes so many of them are mutagenic which means they mutate genes, mutate DNA and in the 1970s when they were in children’s pajamas there was
a public outcry when that became known that these chemicals were mutagenic and the industry voluntarily pulled them out of children’s pajamas. However they put them in everything else. So they just kind of shifted where those chemicals were used and so exposure, children’s exposure has been high.

REP. ARNONE (58TH): Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments? Senator Somers.

SENATOR SOMERS (18TH): Hello. Thank you for being here today. I just have a question. I’ve been listening to everything that you said and I’ve read the data that has been provided and done some research so if these flame retardants don’t really work that well as you stated, why are we using them?

ANN HULICK: I think because well I would urge you to review that series, “Playing with Fire” it was an incredible documentary about how this happened but when.

SENATOR SOMERS (18TH): No, I’m just asking like why would a manufacturer add something to a mattress or a couch if it is not working, it’s an added cost so what, why would they be doing that?

ANN HULICK: I think right now we are in a transition. Many manufactures as I said are moving away from it. But back in 60s, 70s, 80s there was huge lobbying effort by the chemical industry to say that we needed these chemicals in products to prevent to promote fire safety. Now we know that those chemicals don’t work and there has been a huge push to move away from the continued use of that but there has always been fears, trepidation, industry claims that we still need them so it has just been a
slow process to take them out. But frankly over the last five years, there has been quite a rapid shift of manufacturers moving away from them.

SENATOR SOMERS (18TH): So in a follow up that if manufacturers are moving away from the chemical, what is it, organohalogen chemicals, what -- are they replacing it with something else that has been proven to work more effectively or are they just not?

ANN HULICK: No, just do not use them. And the issue is now that as the previous gentleman pointed out fire deaths and injury from fires have gone down and that is not due to chemical flame retardants it is due to people are not smoking in their homes as much as they used to, many people, most people have fire detectors in their homes. We have fire detectors and smoke detectors in our workplaces, we have sprinkler systems so there has been this whole industry of initiatives and public, you know, actions that we’ve all taken that have significantly and effectively reduced fire deaths and fire injuries.

SENATOR SOMERS (18TH): Do firefighters have flame retardants on the uniforms that they wear to attend fires?

ANN HULICK: Yes.

SENATOR SOMERS (18TH): Has here been any correlation or data done on linking these chemicals to any kind of increased mutation and/or illness?

ANN HULICK: Yes. There has been numerous studies on firefighters in particular which I referenced in my testimony, a huge one was the National Institute of Occupational Safety and Health which looked at
30,000 career firefighters and found higher rates of several types of cancers and they concluded that obviously they’re exposed to a lot of chemicals in the fire situation and much of them are the tested chemical flame retardants when they catch fire. A meta-analysis of 32 studies in other firefighters showed similar results and then a Nordic study of five Nordic countries that looked at 16,422 firefighters found very similar results, very high disproportionately high incidents of cancers in firefighters and there is general consensus now that is related to the chemical exposure that they face in a fire and that even though they have their protective gear on it gets on the gear and gets in their clothing that is then transported back to the fire station and back even into their homes.

SENATOR SOMERS (18TH): Okay, I yeah, I’ll have to look at the data. I mean that could also be not just the chemicals from flame retardants but all the things that are burning that they are exposed to also. And then is there any acceptable level that is considered safe on these chemicals. I know we talk about chemicals but for me its like delusion is the solution. There is a certain level that maybe consider acceptable and if you go over that level then it’s not. Do we have the data on that because it’s like saying, you know, the sun is bad for you on some levels, its about exposure and how much exposure so I am curious and if you can’t answer that you can get back to me and. I had another question it’s escaping me. Exposure, it’ll come back to me, I’m sorry.

ANN HULICK: I can generally say that among independent scientists there is the belief that there is no safe level of flame retardants in our
bodies. We all have them in our bodies right now, 99 percent, 97 percent of the population has them because we sit on chairs, you know, older furniture that still has these chemicals. But there, again this is an international push to get these chemicals out of the environment. With endocrine disruptive chemicals in particular that delusion is the solution really isn’t true. So recently toxicological research shows that particularly with young children with endocrine disruptors actual lower levels of these chemicals, extremely low levels often cause more harm because it is not just about the level of the chemical per se it is actually when the chemical is, they call them critical windows of development, and when a child or a fetus is exposed to those chemicals and particularly when endocrine disruptors that mimic hormones there is a U-shaped curve rather than the higher the dose the higher the toxicity, it actually goes the other way so it is new research over the last 20 to 30 years that really recognizes the health implications and it is when someone, when a child is exposed not necessarily how much overtime. Like for example we used to think 5 mg/dL or whatever of lead is safe. We now know that is not true.

SENATOR SOMERS (18TH): I would like to, and I don’t want to belabor this, I would like to see, and I will have to look through more of your testimony but is there conclusive evidence that shows that being exposed to this particular chemical group causes this in humans not just, you know, general endocrine issues but what are the specifics cause of effect being exposed to this chemical that would be important for me to see. But I am also concerned
that I talk to firefighters that are concerned on some levels they go in, and they can tell you, my grandfather was a firefighter in New York City about something that has a flame retardants versus something that doesn’t and how quickly the fire, we don’t have as many fires that’s true but some of the fires that we’ve had we all have seen are deadly and that concerns me too. So I would just like to have all the data before, you know, I would make a decision on that and if we could have actual conclusive evidence showing this exposure to this particular group causes this I think that report [Cross-talking].

ANN HULICK: There is no human studies that, nothing in medicine will show you that, you know, even cigarettes there is not conclusive evidence that if I smoke that I am going to get cancer so in the medical field what we have is research that overtime and through different models demonstrates that there is links to disease from exposure and that research is so sophisticated now that it really is down to where they, you know, we work with a Center for Environmental Health at Mt. Sinai in New York and they are the ones that really do preeminent research on this critical windows of development and have gotten so sophisticated that they can tell when, you know, for different chemicals like BPA for example, if you are exposed at three-months gestation you are more likely to get cancer at a certain later in life. But we, obviously we can’t do human studies so there is nothing 100 percent conclusive that if I am exposed to benzine, you know, from gasoline, that I am going to get cancer at a certain point in my life. Is it more likely, yes and there is a lot of probability for that but there are no studies out
there that will conclusively say, you know, if I smoke ten cigarettes a day for five years that I am going to get lung cancer at age 30?

SENATOR SOMERS (18TH): So there are no, there is no data on that, just that.

ANN HULICK: On how I described it, there is no studies out there that will conclusively say we can’t do medical research like that on humans so there is no ability to do a study like that.

SENATOR SOMERS (18TH): I’m not sure that 100 percent agree with how you are phrasing that but that’s okay. And then my last question, I remembered what it was, we talked about off-gassing, how long do these products off-gas for because they don’t off-gas forever so how long would they off-gas and is exposure to these chemicals any different than exposure to what you described, you know, being exposed to gasoline or being exposed to formaldehyde coming off this rug how do we put in perspective so that we’re not scaring people that might have flame retardant couch in their house right now, you know is there a way to put in perspective just so that we’re more informed.

ANN HULICK: Yup, I think that, you know certainly we don’t want to scare people just like I think what the laws do and what you as a legislative body do is put as you learn the science, you learn the data, you hear about what the issues are, you put measures into place that, you know, within your purview protect health. So while we don’t want to terrify people we have done things over the past like putting labels on packages of cigarettes or restricted people from buying cigarettes under age 21 or restricted drinking limits or all of those
kinds of things, the same here that we have pushed the market place by public demand and by the research that has come out but we also need laws to help enforce that to push the market place even further. So that is where your value as a legislative body come into play that not to scare people to death but to give people, to shift the public policy so that we are having safer and safer products in our universe.

SENATOR SOMERS (18TH): Yes, I will tell you there are articles that are published that show the human data on smoking cigarettes and causing lung cancer and I can pull them up for you if you want to stay after.

SENATOR ABRAMS (13TH): Any other questions or comments. Representative Carpino.

REP. CARPINO (32ND): Thank you, Madam Chairman. One of my concerns in this building and has been for years is whether or not I agree with the piece of legislation. I get really concerned when we use terms that can be widely interpreted so when you are talking about children’s products I just want to make sure that you are talking about the definition in the Federal Code and not something that could be misinterpreted to anybody’s particular whim should this Bill pass.

ANN HULICK: I think that is really important. How was it written in the past here in the state is there is a definition of children’s products so we’ve always just consistently used that and it has been, I can’t quote it off the top of my head but it has been pretty much consistent with other states have used so it lists out exactly, it defines what a children’s product is.
REP. CARPINO (32ND): Thank you and if this does move forward I want to be sure that we were quite clear as to what is defined as a children’s product.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your testimony. Tom Osmitz. Welcome.

TOM OSMITZ: Thank you very much, good evening and I appreciate you all hanging in here this late. I’ll try to be brief. Madam Chairwoman and Committee Members I would like to just address a few of the questions that have come up. My name is Tom Osmitz. By way of background I have a PhD in toxicology. I am certified in toxicology in the United States and also a registered toxicologist in Europe. I am here at the request of the American Chemistry Council. I Chair a Science Advisory Council for them on flame retardants that include both fire scientists and toxicologists and we evaluate various public policy issues but usually science that underlies the policy issue. So I Chair that group, speaking on behalf of myself but at their request.

Speaking really in opposition to the Bill for two reasons. One, I think the tendency to group all organohalogens as similar with regard to hazard and risk just isn’t supported by the science and this is where I think I would disagree with the previous testifier who talked about flame retardants in a general sense. They are not all the same and I can give you plenty of examples of flame retardants that have been tested that are not carcinogens, not endocrine disruptors, not genotoxic, etc. Some are and those are the ones that I think should be focused on.
So two points: One grouping them together doesn’t do the science justice. And two, the presence of a chemical in the environment whether it’s in dust or in the air doesn’t necessary mean there is harm. And that is not just my opinion I can just read a brief quote that’s in my testimony too from the Centers for Disease Control which I think is a very reasonable and very health cautious organization and they deal with biomonitoring data. So they deal with data where they find flame retardants got in the blood or in tissues and the quote from them is, “The presence of an environmental chemical in people’s blood or urine does not mean that it will cause effects or disease. The toxicity of the chemical is related to its dose or concentration in addition to a person’s individual susceptibility. Small amounts may be of no health consequences where large amounts may cause adverse effects.” And that is the key part that is missing in the legislation to me is trying to take a look at really where are the exposures? Are they coming from car seats, are they coming from blankets, from crib lining? Where that’s coming from is where you should focus the public health action not generally across all uses because it doesn’t do the science right and you’re not protecting anybody by doing that.

With regard to some of the questions that came up about what do we know about flame retardants are the safe levels, well you don’t have to listen to my opinion but there’s several risk assessments published by authoritative bodies that say indeed there are and I’ve got references to those in my testimony but the European Union assessed TBBP one of the flame retardants, Environmental Canada similarly and there have two or three published
studies that looks specifically at human exposure including dust and including the children and based on scientifically accepted principles, we are looking at exposure and risk as being that is no unacceptable risk and I can provide those references as well.

So thank you very much for the opportunity to talk and I’d be happy to answer your questions. And two points one grouping them together really isn’t justify the science to protecting public health and number two it is important to prioritize the actions based on actual exposure and risk, not a blanket prohibition. Thank you very much.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Okay thank you for your time. Okay, do you have a question? I’m sorry about that Representative Petit.

REP. PETIT (22ND): Just when you do a quick look at the area there is a lot of opinion out there that says many of the flame retardants aren’t very effective. Would you disagree with that, are there varieties that are effective enough to be utilized or is that not your area of expertise?

TOM OSMITZ: You know, I’m not a fire scientist. What I see there is probably some uses that are effective and some not as much but that is really not for me to address but there is some pretty good science behind it and a lot of it gets into how you actually define what effective means. The one thing that I do know and when I first got involved in flame retardants I had a misunderstanding but the primary purpose of the flame retardant is to retard the combustion. It gives people time to get out of a room, it doesn’t mean things don’t burn. They are
going to burn that I do know as a citizen not as a fire scientist but having those extra seconds to escape when you’ve got the alarms going off that is truly the benefit I understand flame retardants provide.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for your testimony. Allie Esielonis, I know I’m not saying that right. You’re being generous. Welcome.

ALLIE ESIELONIS: Good evening. My name is Allie Esielonis and I am here on behalf of the Juvenile Products Manufacturers Association. Thank you Chairwoman Abrams and Chairman Steinberg and Members of the Committee for the opportunity to provide testimony today expressing our concerns with House Bill 6516. Thank you all for just being here to hear us speak as the hour get late. My comments will largely pertain to House Bill 7197, which contains drafted language on this matter.

So quickly, the JPMA is a national not-for-profit trade association representing 95 percent of the prenatal to preschool industry including the producers, importers and distributors of a broad range of childcare articles that provide protection to infants and assistance to their caregivers. JPMA strives to ensure that all parents and caregivers are confident that the juvenile products they purchase are designed and built with the utmost safety in mind, and fully comply with the strictest safety standards in the country.

JPMA collaborates with government officials, consumer groups, and industry leaders on programs to educate consumers on the safe selection and use of juvenile products. We have also have previously
supported efforts to reduce the required use of polymeric flame-retardants in juvenile products where feasible, in states like California. However, this Bill’s ban on flame retardants would go farther than any other state law in the country and would put a serious burden on manufacturers.

We would respectfully ask the Committee to exempt inaccessible electronic components in children’s products from the flame retardant restrictions in HB 6516 and House Bill 7197. The use of flame retardant materials in these inaccessible components is necessary to meet the performance requirements and safety standards including those administered by Underwriters Laboratories. Products such as motorized baby swings which wouldn’t be considered a “consumer electronics,” do contain electronic components that utilize flame retardants in the same way that other electronic products do and they must meet these UL standards. Other impacted products would include nursery monitors which help check baby’s movement and respiration which are particularly for newborns and babies born prematurely.

Inaccessible components, such as printed circuit boards and wiring which can contain thousands of subcomponents and elements are specifically designed to never come in contact with a child through reasonable and foreseeable use and abuse. This high standard considers the real world use of a product to ensure that there is no exposure to the inaccessible components. As such, every other state that has adopted a children’s chemical safety law or regulated flame-retardants in children’s products has exempted inaccessible components.
So just to conclude and say that the materials used in juvenile product components are evaluated and designed to mitigate health concern and consistency with other states on this issue is critical to avoid an unnecessary burden on manufactures and it also wouldn’t advance any safety concerns. So thank you for the opportunity to testify, I would be happy to answer any questions.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments from the Committee members? Thank you very much for your testimony. Okay we’re going to move on to Senate Bill 858. Cassandra Sespecler [Phonetic]. Cassandra? Diana Bump. Welcome.

DIANA BUMP: Thank you Madam Chair. Esteemed Members of the Committee. I am here to request that you oppose proposed Bill 858 and 6540.

Bill 858 bill allows for minor children to be treated and/or vaccinated for sexually transmitted diseases without a parent's knowledge or consent. No. 6540 is vague and leaves the door to treating minors with preventative drugs without parental consent. This is a violation of parental rights and an overreach on the state's part to intervene in family healthcare decisions for their children. There are many other ways in which families can decide to prevent sexually transmitted diseases for their children. Parents have their children's best interests in mind and are best equipped to make decisions having all the information necessary to choose the safest and most effective ways to protect their children. I was personally injured by the HPV vaccination brand name Gardasil at age 17 and had I received this vaccine without my parent's knowledge,
they may not have known what was wrong with me. I suffered for over a year with physical and neurological ailments that have continued to affect me until this day, eleven years later. If I had received this vaccine without my parent's knowledge, they could have asked another healthcare provider to administer it a second time unknowingly duplicating the treatment and amplifying my injury. Without parental consent, there could be preexisting conditions, allergies or contraindications that may not be known to healthcare workers before providing vaccination or treatment. Children may not be aware of the risks of duplicating treatments, nor may they always have an understanding of pre-existing conditions or allergies that they may have, especially if they have special needs.

In regards to Truvada, side-effects include kidney failure, liver failure, and lactic acidosis which the manufacture admits plainly could lead to death. In the event of minor experiences a serious effect from this drug being prescribed without parental knowledge or consent, who exactly will be liable for this. In Connecticut between the years 2013 and 2017 the average number of people diagnosed with HIV under age 20 was 13 people far less than all other age groups and includes adults ages 18, 19 and 20 years of age.

House Bill 6540 and Senate Bill 858 does not address how children with cognitive delays or other special needs will be able to provide informed consent for their own treatment. Treating children who may have an unknown cognitive impairment without parental knowledge is unethical. Healthcare workers offering treatment may be unaware of such impairments and unfamiliar with the patient.
The difference between the existing Statues and HB 6540 is the existing Statue provides healthcare workers the ability to provide treatment that could be life-saving to an individual diagnosed with HIV or another serious sexually transmitted disease. This Bill permits treating children with no diagnosis and preventative treatment for children that involves risks should always involve the parents. Please do the right thing, preserve parental rights and the safety of children and oppose both of the Bills.

SENATOR ABRAMS (13TH): Thank you. Any questions or comments from the Committee Members? Thank you very much for your testimony. Kevin Barry. Welcome.

KEVIN BARRY: Thank you and I am very impressed with all of your patience in sitting through this marathon session. My name is Kevin Barry. I am a former federal lawyer. I am the author of the book, “Vaccine Whistleblower” which talks about fraud, vaccine safety research at the CDC and I am testifying in opposition to SB-58.

Gardasil currently -- the global revenue for Gardasil is $2.4 billion dollars. At $2.4 billion dollars per year that is $6.5 million dollars a day and every day year around that buys a lot of advertising that buys a lot of public relations campaigns that make people think that there is a market for this. Their projections, they are hoping to grow before 2025, from the $2.4 billion dollars now to $3.3 to $5 billion dollars which is either a 37 percent increase to a 50 percent increase, that is published anywhere, you look at any financial papers. To get there they need to open new markets, that is what 858 does. It might not be your
motivation but it is looking to open the Connecticut middle school market and I hope you will reject opening a new market for that. They also recently opened a new market by increasing the age, the FDA just approved the age increase for Gardasil from age 26 to 45, so again to increase the sales, to hit their 37 to 50 percent increased revenue they need new markets. That is what they are trying to do by lowering the age, by removing parental consent, by increase the age of people, by offering it, by suggesting to people who don’t have cervixes. I have three sons, zero cervixes.

Again it might not be your motivation but that is the effect. I hope you will remove that. And as you heard earlier from Eileen Iorio who is one of the authors of “HPV On Trial” hopefully you will all take one of these books home. Only one-half of one percent of HPV infections proceed to cancer so on one side of the scale you have that tragic story of the girl who stood up here today in a wheelchair who was a softball player who had a freeride and now she is paralyzed, and on the other hand one-half of one percent proceed into cancer. Eileen is not a doctor but Luc Montagnier is. He wrote the forward to this book. He has endorsed it and he is a Nobel Prize winner for discovering the HIV virus.

And one other thing I want to mention, Emily Tarsell, she was mentioned earlier as one of the girls who was compensated, who died from HPV, here award from Vaccine Court was $250,000 dollars, that is the statutory aware for her death. $60,000 dollars for pain and suffering to the family and $130.00 dollars for unreimbursed expenses. So I started digging in what’s the unreimbursed expense? It is the third dose of Gardasil cost $130.00
dollars, that is the dose that killed her and they reimbursed her for the dose that killed her. She paid for the first two doses, they reimbursed her for the death dose.

I want to correct two things that were heard earlier about whenever the talk of safe vaccines, it is safe and effective and unavoidably unsafe. That is the bait and switch. It is safe and effective and you will always see these words from the CDD, safe and effective on a population basis. But the reason they have liability protection is they are unavoidably unsafe, they are classified legally for each individual. So the same product when the money is coming in, it is safe and effective when the money could be going out, did we say it’s safe and effective, we meant unavoidably unsafe. So you should be very careful about mandating products like this. The head of the AAP, he is not here anymore, but the American Academy of Pediatrics offers philosophical and religious exempts to their members and they oppose them for citizens in all 50 states. If that is not the height of hypocrisy I don’t know what it. Thank you.

SENATOR ABRAMS (13TH): I’m sorry, I gonna have to stop you there. Thank you. Are there any questions or comments? Representative Hennessy.

REP. HENNESSY (127TH): Thank you, Madam Chair. Doc earlier said that thiomersal was removed from all vaccines is that true?

KEVIN BARRY: No, it was put back in vaccines back in 2004 in the flu shot and currently this is accurate as of 2019, it is in these multidose influenza shots, it is in Afluria, Afluria Quad, Fluvax Quad, Fluvial Quad, Fluvirin, Fluzone Quad.
It is in the Japanese encephalitis vaccination. It is in meningococcal Menomune A/C/Y-135 and it is in the tetanus diphtheria toxoids, not the DTP but the one that is just the tetanus diphtheria. So again it is very causal how like the pediatricians and medical people just don’t know. This is the CDC, this is the Johns Hopkins website. They are told that there is no thiomersal in the vaccines then they pare it out without looking to see whether it is accurate.

REP. HENNESSY (127TH): Thank you. So there’s lots of vaccine Bills before the legislature, is this unique to Connecticut?

KEVIN BARRY: No, it’s happening nationwide. There is a big push to restrict vaccination and to restrict mandates. Again to increase sales more than anything else and it’s 270 vaccines under development so if you lose the ability to opt out now, you are accepting the future vaccine schedule in addition to the present one. And here’s a Tweet from Peter Hotez who is going to be testifying in Washington, in addition to state houses, Congress is getting involved in this measles hysteric. The House of Representatives is having a hearing on Wednesday and the Senate is having one on March 5th. And here is what Peter Hotez is Tweeting, “What needs to solve the measles problem in America requires both 1) a policy solution to close the school vaccine exemptions and begin dismantling the anti-vax media empire” which is kind of hilarious. We’re moms and dads, baby wearing people versus like CNN and, you know, all the major media but it is also advocate issues. They need to rebuild the public partnership with Google, Twitter, Facebook. Again hilarious because they are spending billions of dollars on all
those platforms and they are trying to censor this message and why is this message resonating because it is true, right? My kids, I am not here for my kids, my kids are aged out. My kids are 22, 21 and one is 16. But seeing these other small kids who are here, who are gonna be -- have this silly idea that the state, any state, any nation knows how to treat those kids better than their parents. To me it is preposterous and also any other medical issue. You have people here, it was very educational to sit here today, everyone is saying parental choice. Everyone is saying individual choice, don’t force, don’t force but then the word vaccine comes in and everybody’s brain turns off. Right? Your brain turns off, again if at two months you have to go get six infant drugs instead of six vaccines maybe you might not want to get six infant drugs. But the word vaccine comes in and your brain shuts off.

REP. HENNESSY (127TH): Can I have one more question? Thank you, Madam Chair. It was mentioned earlier that there is 80,000 deaths from flu across the country. Would you say that is an accurate?

KEVIN BARRY: It is not an accurate number. It’s true that the Surgeon General said that, but if you try to dig in behind the smoke, there is nothing there. In order to get even -- they used to say 36,000 a year which is also not true, but to try to get to that number they used every pneumonia death in the country which was mostly people aged 75 and higher, the real high numbers were 85 and up and they were using that as an excuse to try to get mandates onto young children and young children mortality from flu it’s like in the double digits maximum in any given year.
REP. HENNESSY (127TH): Thank you for your testimony. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much for being here tonight.

KEVIN BARRY: Just one last thing, take this book there’s 95 pages of notes in here.

SENATOR ABRAMS (13TH): Thank you. Sinthy Khamsaeng.

SINTHY KHAMSAENG: Good evening, my name is Sinthy Khamsaeng and I am here to testify to oppose SB 858, AN ACT CONCERNING THE PROPHYLACTIC TREATMENT OF MINORS FOR SEXUALLY TRANSMITTED DISEASES without the consent of a parent or guardian.

I have deep concerns regarding this Bill as it is the government’s overreach of my rights as a parent in raising and caring for my children. As refugees, my family and I came here over forty years ago. We are proud citizens of this country which affords the protection of liberty, justice and places restriction on the powers of the government that we once did not have in our birth country. Lately, I have been seeing many pieces of legislation, similar to this one that violate these rights that many have fought so hard to protect. Rather than moving forward by learning from our rich history and creating policy that will enrich the lives of citizens as well as this country, we are moving backwards I feel.

So I oppose this Bill for a couple of reasons. IF feel that SB 858 allows for risk of improper treatment and harm to children. This is a medical procedure and come with risk. As a parent, I have
comprehensive knowledge of my children’s health, medical history, and can properly assess any contraindications with recommended treatments. Minor children, especially those with cognitive delays and impairments, are not capable of making informed decisions. If the treatment resulted in an adverse reaction, my children would be harmed and I would not have the knowledge to seek proper care. Who would be responsible for any adverse reactions or injury?

Also per the National Childhood Injury Act of 1986 all parents must be given the vaccine information statement for all vaccines given to a minor child. A minor cannot comprehend the complexities of these statements and have true informed consent. According to the CDC the information statements are written at tenth grade level.

So the way I see it I think there are many options that should be left to the parent. I want to be the one to decide what types of treatment is best for my children to prevent sexually transmitted diseases. So I do urge you to oppose SB 858. Thank you.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments from the Committee? Thank you very much for being here tonight. Monica Szymonik. Welcome.

MONICA SZYMONIK: Hello Distinguished Members of the Committee. Thank you for being here so late. My name is Monica Szymonik. Some of you may be familiar with my husband Peter Szymonik. He and I met in this building about six years ago and we advocate very strongly for Family Court reform. My husband and I are very knowledgeable in what it feels like to have parental rights completely
stripped away while we’ve lost all three of our sons in the Family Court System and so this topic of, you know, the administration of vaccines without informed consent, without parental consent is very near and dear to my heart because we have already experienced the loss of our own parental rights.

So, my husband and I each have a biological son who is unfortunately part of the autism tsunami, these two young gentlemen are going to be entering a workforce that is not prepared for them. My son is 12, my step-son is 17 both autistic, both vaccine damaged. Vaccines do cause autism. I am tired of hearing, not from anyone here, but in general the media is always saying vaccines don’t cause autism, vaccines don’t cause autism, they absolutely do. You can’t prove a negative. I know that I have the burden of proof, we have the burden of proof of proving that vaccines do cause autism and we have the proof because our children are autistic. They enter the pediatrician room bouncing, playing with toys and they leave the pediatrician room and three days later they lose their speech.

That is the proof. We have already met the burden of proof and to say that vaccines don’t cause autism is extremely dated media soundbites. The vaccines that cause the autism tsunami is going to be in competition with the baby boomers who are aging out, aging slowly and you know, Generation X and Y will be left holding the bag caring for these two populations, these bookend populations. The autism pandemic costs us $300 billion dollars a year and as of now the number is 1 in 36 children born today will eventually be diagnosed with autism. My husband and I, we are the study. We are the double-blind study because we have two children who are not
vaccinated at all and two sons who are fully vaccinated and it is night and day raising there four children as thing are. I am going to strongly oppose the passage of Bill 858 because, again, it is just more injections of toxins into our children’s bodies. We don’t anymore toxins in our generation. Thank you very much.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments from the Committee? Thank you very much for being here today. We are going to move on to House Bill 6540. Krystn Wagner. Welcome.

DR. KRYSTN WAGNER: Good evening Senator Abrams, Representative Steinberg and Members of the Public Health Committee. Thank you for this opportunity to testify in support of House Bill 6540 and youth access to HIV prevention. I just want to say two things of clarification at the outset. This Bill is to essentially update or amend existing legislation that provides youths with access to sexual health services without parental consent. This is not a new concept. We are simply broadening the options for minors to include HIV prevention. I also want to clarify that this refers to access to a medication for prevention of HIV, the medication is Truvada and this is not a vaccine or a vaccination.

So I am the Medical Director of HIV and Infectious Disease at the Fair Haven Community Health Center in New Haven. This is predominantly Hispanic community and I have been practicing HIV medicine now for between 20 to 25 years. During the three decades that I’ve been practicing, I’ve witnessed a tremendous loss of people to HIV AIDS as well as continued stigma and discrimination. While there
have been tremendous advances in treatment as you know we continue to have high rates of HIV diagnoses in the country with 40,000 new HIV cases annually and one-fifth of those cases are among 13 to 24-year old’s. So a large number of youths are affected by this infection.

In 2017 there were 281 new case in Connecticut and of those 70 percent were among African Americans and Hispanic minorities and nearly half among gay and bisexual men. Looking at age categories the highest percentage of new HIV cases in Connecticut were among 23 to 29-year old’s, and undoubtedly some of those were infected as teenagers.

It really is extraordinary, I think you would agree, that we now have a pill which refer to have preexposure prophylaxis for HIV prevention. And it is over 90 percent effective in preventing HIV. This oral medication Truvada contains two reverse transcriptase inhibitors which prevent one of the early steps in HIV replication in the cell and thereby blocks the virus from establishing a permanent infection. Truvada does not induce an immune response and is not a vaccine but it does effectively prevent a person from becoming HIV infected and requiring a lifetime of care.

I guess I just want to remind you of earlier today that one of my patients Sam Smith testified before you. He did not have access to PrEP as an adolescent. He very honestly acknowledged to all of us that he was not able to disclose to his family at that time that he was sexually active and that he was gay and he did not, he did not go on PrEP He is now 20-years old and he is under my care for HIV and he wishes for all of your and all of us to recognize
the importance of access to us particularly to LGBT youths who are not comfortable talking about sexual orientation with their families.

SENATOR ABRAMS (13TH): Thank you very much. Are there questions or comments? Senator Lesser? Anyone else have any questions or comments? Thank you very much. I appreciate you being here all day. We started our day with you so I thank you very much. Alice Rosenthal.

ALICE ROSENTHAL: Good evening Distinguished Members of the Public Health Committee. I really do appreciate you all staying for so long today, we waited all day to be here and I appreciate you taking the time to stay.

I work at the Center for Children’s Advocacy, I am a lawyer. We are a public-interest law firm representing Connecticut’s most at-risk children and youth and I coordinate our Medical-Legal Partnership Project at Yale New Haven Children’s Hospital where I work very closely with medical providers to address legal issues impacting children’s health. I know that you have heard a lot of testimony today but I just want to really clarify the legal aspect of it since I am a lawyer.

I just want to put the legal context in a little bit of perspective. I wrote a lot in my written testimony but I just want to be really clear that this Bill is nothing more than an extension of the existing Statutory pattern and Constitutional framework that provides minors with the ability to access healthcare when they are most at-risk.

Connecticut has a deliberate thoughtful long history of enacting laws that support the right of youth to
access healthcare in a confidential manner. We have a longstanding history of protecting those rights in the area of reproductive health, testing and treatment of STDs, mental health, substance abuse and most importantly HIV and AIDS. This proposed bill is simply an amendment of a Connecticut Statute already in place §19a-592 and this would just add, in addition to being able to consent confidentially for testing and treatment, if the testing came back negative and they had a conversation with their healthcare provider about their sexual activity that they could offer them something that would prevent the infection of HIV.

All we are asking today is that this Bill be passed out of Committee so that we can talk about providing youth with the ability to prevent them being afflicted with a lifetime infection of HIV, just closing a small gap that is currently in our Connecticut Statute.

My office put together a book on Adolescent Healthcare Rights that I know I’ve give some of your but if anyone else is interested in it we are happy to give you free copies of them. In there we sorta outline all the different teen legal rights that we have in Connecticut that are already in place and highlight those for you. So I am happy to provide those. Thank you for giving me the opportunity to testify today.

SENATOR ABRAMS (13TH): Thank you very much. Any questions, comments? Senator Lesser.

SENATOR LESSER (9TH): Thank you, Madam Chair and thank you Alice for your testimony. I think you helped clarify some of the aspects of this Bill that I think are important. But there was a fair amount
of testimony on it earlier, most of it I think sort of in passing and I didn’t know if there were any other areas that you wanted to just sort of clarify from past statements that had been made earlier in the day.

ALICE ROSENTHAL: No, the only thing would be to say that I really think when we look at the history of the Connecticut Legislature we have the spirit in Connecticut of providing adolescents with that confidentiality in things that might be a little more difficult to communicate with their parents and in all of the laws, again you can see that we’ve outlined in our book, but is also obviously in the Connecticut Statutes, they often say we encourage them to talk to a parent or only after finding that it is not feasible or if they had to talk to their parent it would be dangerous to the youth. There is many things in the language including in the HIV Statute §19a-592 is says that after the physician has found that would be detrimental to the young person to talk to their parent.

SENATOR ABRAMS (13TH): Representative Carpino.

REP. CARPINO (32ND): Thank you. Just one question and I should know the answer, in the event that a minor does seek out this treatment and uses insurance so then does it show up on the EOB?

ALICE ROSENTHAL: Yes, but there is a part in the HIV AIDS Statute already in the §19a-592 that says you shouldn’t be sending the bill even to the parent if the minor does not consent to that. So it probably wound not and with Medicaid patients they don’t get an EOB anyway.
REP. CARPINO (32ND): You know what, I understand that but I’m trying to understand for private insurance because it impacts everybody and we shouldn’t generalize on the population that could be at risk so if a minor does get this medication, I’m trying to find out is a parent going to find out anyway?

ALICE ROSENTHAL: Isn’t the Statute written in a way that it might not be, but we with Representative Curry we are hoping that we can Amend the Statute to also include protection around the EOB.

REP. CARPINO (32ND): Okay, thank you.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. When you talk about minors what age are you talking about going down to?

ALICE ROSENTHAL: We are not going to delineate in this Bill or we were not suggesting that. Minors are under the age of 18 but I know that for, it’s a weight based in terms of what a doctor would prescribe so it is not in the HIV AIDS Statute as it is written and there is no age limit on there. There are separate protections under the Department of Children and Families that say if a provider hears about a youth 12 and under who is sexually active they do need to report it and an investigation can take place.

REP. ZUPKUS (89TH): And report it to who, DCS?

ALICE ROSENTHAL: DCS and DCS would investigate. It’s a nuance in the law right where DCS would investigate but yet it is confidential.

REP. ZUPKUS (89TH): Thank you.
SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Yes I think my question was answered on the question there is necessarily no age limit and it is by weight. So you could have a child who is six years old or seven years old who weighs 77 pounds for all intents would be able to be prescribed. I would like to have a copy of that book that you mentioned because I think it is important for me to learn exactly what it says in the Statute as far as adolescents. If you define adolescents by medical terms it is between 10 and 19 it is not six or seven or anything, you know, below 10. So I personally do not like that there is no age listed on this particular. And then if there is a report to DCS how do you investigate and keep it confidential? That would be kinda tricky wouldn’t it? How does that work?

ALICE ROSENTHAL: That I don’t know the logistics of how that works. There hasn’t been a case that I’ve had and I would have to defer to the Department of Children and Families on how they would move forward.

SENATOR SOMERS (18TH): So my question is even if they pass this, as a lawyer, let’s say this gets passed and I have a child that is 10 years old that goes and has this treatment and has an adverse reaction or something doesn’t work out. What are my rights as a parent that that is my child, to come back and sue the State of Connecticut because you did something to my child without my permission?

ALICE ROSENTHAL: If it was under the Law that you were permitted as a provider to provide medical treatment that would be the same liability that you would have if you were providing it for anybody else
so it would depend on the type of treatment and the type of liability that you were talking about. Can I just address the age limit thing? In the book but also in the Statute it is variable depending on whether we’re talking about reproductive health or mental health or substance abuse about the age limits, so there is, it’s very complicated that is why we put together the book to sort of help home in on those differences.

SENATOR SOMERS (18TH): So if it’s complicated wouldn’t you want to put an age definition on here or is it, why is there no age definition on this particular bill?

ALICE ROSENTHAL: We are just in-line with the current Statute as it is written there is no age limit and so this is just adding a piece. So there is no age limit currently for youths to get testing for HIV or treatment in the Connecticut Statutes and so we are just adding in the prevention piece of it. I didn’t want to change what the Legislature had already promulgated in the past.

SENATOR SOMERS (18TH): Thank you for that answer.

SENATOR ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): Thank you. So the key, I think here, is minor are at risk. So can you explain what the intent of that would be if I was a minor at risk at a doctor what the process is to go through the doctor and what at risk means, and to place it in some kind of age appropriateness here because again you have to be at risk? So you would be involved in some actions already that would put you in a place to take this in the first place.
ALICE ROSENTHAL: I might have to defer that to doctor cause I’m not a doctor and I’m not in the room but I do work with lots of the pediatricians at Yale Children’s Hospital and I know that adolescent providers and some of them provided testimony in support of this Bill that there is often a conversation with young people about privacy issues. So I know I am a parent of a 12-year-old myself and they would ask me to step out of the room and so in that conversation it is allowing youth to express things that they might not feel comfortable expressing in front of their parent for fear of anything as little as embarrassment all the way to abuse and neglect and so they often encourage youths to talk to their parents about an issue or at least find some caring adult who can support them through that. But I do want to give it over to Dr. Wagner if she could if that sounds satisfactory.

DR. KRYSTEN WAGNER: So these are very real-world scenarios. So a 17-year-old at Wilbur Cross High School that I saw at our health center who was sexually active with older men, so men that he would meet on dating apps like Grinder and they were men in their 20s, people that he didn’t know, anonymous sexual relationships. And they’re very intimate conversations but you as a responsible physician you ask questions that you think will help you to determine what their risk is and certainly that individual was at high risk of becoming HIV infected and he did not go on PrEP and like Sam who you met this morning this 17-year-old is not HIV infected. It is not hard really to predict who is going to become HIV positive. It isn’t. There are some people who I have concerns about their sexual health risks and risk of other sexually transmitted
infections but HIV risk is not, it’s not hard to predict.

REP. ARNONE (58TH): Thank you.

SENATOR ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Thank you. And thank you again Doctor and I’m sitting here pondering something that is truly troubling me. I am a parent, you have kids, my understanding, my belief is that I am responsible along with my wife with the well-being, and health and development of my child until they reach the age of adulthood or 19 years old. In doing something like what is being proposed today, it seems to me that the State is interfering with that relationship or my responsibility, our responsibility for raising and working with our children. We are making a judgement about parents or assuming that something uncomfortable that a child wants to share with a parent is going to automatically have a bad outcome. Is that the role of state government? Do you think we should be passing laws making judgements about that?

ALICE ROSENTHAL: Thank you for your comments. I do think I understand the spirit of your comment and question. I think that as a State, as I mentioned before, we have encouraged youth to access healthcare that they might not access and a lot of studies have shown they would not access but for the confidentiality of the conversation that they have with their provider and so to think of it not as taking away parental rights but insuring the health and safety and well-being of Connecticut citizens.

REP. BETTS (78TH): And I appreciate that. I appreciate the testimony I heard before because it
is very real. But when you say that it is designed
to give them access but you are not taking away the
rights of the parents I respectfully disagree
because how can I help or support or do anything
with a child if I am completely unaware of it?

ALICE ROSENTHAL: And like I said earlier at least
the adolescent medicine doctors I work with often,
every time, encourage youth to connect with their
parent or caring adult so that they have that
support and that the youth is coming in asking for
help. We’re hoping we can give them help to prevent
the infection of HIV which is a lifelong disease.

SENATOR ABRAMS (13TH): Any other questions or
comments? Senator Somers.

SENATOR SOMERS (18TH): You are testifying on 858,
correct.

ALICE ROSENTHAL: No, 6540.

SENATOR SOMERS (18TH): Sorry, I just wanted to be
clear on that because that 858 the way I read this
the HIV PrEP could be included in that don’t you
think because the way it says for prophylactic
treatment of sexually transmitted diseases? That
could fall under this category also.

ALICE ROSENTHAL: It could but we are not supporting
that Bill today. We are supporting 6540.

SENATOR SOMERS (18TH): Right, I just wanted to make
that clear only this would apply to the HPV vaccine
but it could be interpreted to apply to the HIV PrEP
because it is similar.

ALICE ROSENTHAL: Absolutely and we want it to be
really clear that we are just focusing on the
prevention of HIV. DPH put out in December of 2018
Getting to Zero Report and perhaps that is one of the main ways of getting to zero in Connecticut so we fell like this Bill is specifically just focused on HIV not HPV.

SENATOR SOMERS (18TH): And I understand wanting to treat adolescents that are in the high-risk category because we don’t want anyone to end up with HIV if they don’t need to be unnecessarily. What I struggle with is thinking about it in the context of now I can have my child on my insurance because they are 26 years old and you are responsible but yet I could have a 9-year-old go and get HIV PrEP cause that’s the way it reads in this Bill cause it doesn’t have an age, that weighs 77 pounds, and I would have no idea, there would be no bill sent to me. I struggle with that age, the age limit. You know I can understand as you get closer to adulthood but the idea that, I know there’s children that are in my daughter’s class, a year ahead of her that are in fourth grade that weigh that right now so it is all based on weight I’m struggling with the age and I understand that they would go through the process and talk to somebody and, you know, determine that they are high risk category or not. But I’m just letting you know that I’m struggling with that as a parent to think of it in those terms and I do think. We heard a lot of testimony today of people saying, I’m the parent, I want to know and have the right to help my child or vaccinate my child or not vaccinate my child or give them access to medication or not, you know, we just heard about a potential chemical, you know, something that might have a trace of a chemical in it that we are gonna ban from everything and here we are giving a medication to a 9-year-old without the parents. I’m struggling with that. I
just want to let you know that. I understand where you want to go but I’m struggling with how this is written.

SENATOR ABRAMS (13TH): Senator Lesser.

SENATOR LESSER (9TH): Yes, thank you, Madam Chair. I guess the question, we’ve heard a couple, I’m just sort of following up on Senator Somers comments. My understanding of how this would work in practice is that a teenager would be engaging in risky behavior and would be going to -- having a conversation off in a school setting, I would tend to think much younger children would probably not engaging in consensual sex that would expose them to high risk setting and that is something that would probably, I assume, I’m just guessing, is that the kind of thing would likely result in a police response or something like that if a super young child we’re talking about that kind of a response.

ALICE ROSENTHAL: Yes just to repeat what we said earlier, for a minor 12 and younger who the provider finds out they are sexually active it is a mandatory report to DCS. And again I don’t know how providers would actually implement that in terms of maybe asking the youth to talk to their parents first but that protection for the 12 and under there are a lot of other protections about providers being mandatory reporters in terms or age limits about 12 and again it is very complicated but it’s in the book. I just want to be clear, we didn’t put a weight limit in the Bill either so it’s just again amending the Statute the way it’s already written to just add in the preventions.

SENATOR LESSER (9TH): Thank you very much for that clarification.
SENATOR ABRAMS (13TH): Thank you. Senator Sommers.

SENATOR SOMERS (18TH): Sorry, but she said something that I just need clarification on and I’ll make it quick. So when you said you didn’t put the age limit in here, it just says minor which can be anybody under 18, right? But when you look to the insert for the particular drug it says 77 pounds so I just want to let you know that but it’s in the ICU.

DR. KRYS T EN WAGNER: I think, well we knew it was important that this was FDA approved for minors and in the FDA approval they indicated there was a weight cutoff so they were not going to approve Truvada is you weighed less than 70 pounds. I just don’t think that in anyway translates into what we will do in clinical practice. I am not going to prescribe Truvada or PrEP to a nine-year-old. The real world is that I’m gonna see a 16-17-year-old with syphilis and three-quarters of syphilis cases are now in young men having sex in young men and it is a predictor of their risk of HIV. So I want to have that conversation with them about HIV prevention and if they can’t comfortably talk to their parent I want them to say and I am going to prescribe PrEP if you pass this legislation so that they remain HIV negative.

SENATOR ABRAMS (13TH): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you. You made a comment just a second ago about the 12-year-old and younger that if they came in and sexually abused or and that could be they were at school and somebody pulled their shirt up and so all of a sudden that, my daughter tells you that, I’m in the waiting room and now you call DCS. Is that correct? Is that what?
ALICE ROENTHAL: No, there are mandatory reporting guidelines that are through the Department of Children and Families that I wasn’t going into too much detail it was more about mandatory reporting for understanding when someone is sexually active and they are 12 and under. That is getting into other detail that I don’t feel I have the information for you today.

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

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much. Jesus Morales Sanchez. Patrick Comerford.

PATRICK COMERFORD: Hello, to the Distinguished members of the Public Health Committee. My name is Pat Comerford, I live in New Haven and I am testifying in support of H.B. 6540 and I am not going to explain to you, in my written testimony I bore you with the details of how PrEP works, you don’t need that you just got a thorough explanation.

I just want to share with you why this Bill is so important to me. I came out as gay at the age of 11 in 1992 and I was what would be considered a high-risk case very shortly thereafter. That same year, 335,000 AIDS cases were diagnosed in the U.S. and over 190,000 people died most of whom were gay men just like me and who I was growing up to be. There was no reliable treatment and there was certainly no bill that could have prevented transmission. Stigma, homophobia and the lack of information meant I quietly assumed, it was not a question if I would contract HIV it was a question of when. And that was the reality of life then as a teenager. I stopped planning for my future because it was so uncertain. I didn’t bother to strive academically, only
finished by undergraduate education a year ago at the age of 37 as a matter of fact. Adults in my life did not push me to pursue much of a future. As a teenager in the mid-1990s I understood that AIDS was a death sentence and couldn’t see the point in bothering to plan for a future that wasn’t mine to have.

Today there is a pill that can prevent transmission. There is a future for young folks and there is a way to give those young folks the agency they deserve to control their health and their lives. I am not going to bore you with statistics that are also in my written testimony.

But I do want to directly address the idea of parental rights and the right of the parent to make decisions and the idea that someone would be taking away that right. The reality is for many LGBQT+ folks, many parents because of homophobia and stigma have already abdicated that right and are already not a safe place for many young folks who need protection to go to. That is the reality for at risk young folks. This is not a relationship. I heard a lot about parents who care deeply about their children and I love to hear that, right. I also know that is not the reality for many young LGBTQ+ people and we need to be honest about that and young folks need what this would provide, right, the ability to go and take control of their body, take control of their lives. When I was young I knew I couldn’t go to my pediatrician because I knew that my pediatrician wasn’t supportive and wasn’t safe and I knew my parents would be outraged. That hasn’t changed much with all the advance we’ve made around LGBQT+ rights, right, for many young folks.

And so I just urge the Committee to really strongly
support this Bill and put many young folks who are forced to take care of their own health and take control of that and they deserve access to PrEP so I appreciate your time.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from members of the Committee? Thank you for your testimony. Gretchen Raffa, I don’t think I’ve seen her. I think this says John Board, is that correct? Welcome.

JOHN BOARD: Chairman Abrams, Chairman Steinberg, Ranking Members Somers and Pettit. I am here to speak to you guys this evening on House Bill 6540, AN ACT CONCERNING THE PREVENTION OF HIV.

I currently serve as the President of New Britain Pride, a civic organization with the mission of celebrating and educating the greater New Britain area about LGBTQ+ individuals and our community as a whole.

I believe that this Bill is important because, despite progress being made in HIV treatment. HIV remains a significant public health concern. More than 10,000 people are living with HIV in Connecticut. Young gay and bisexual men of color are particularly at risk. There is no cure available for HIV, and the treatment is complex, expensive, and life-long. By allowing minors to consent to PrEP, we will be reduce the risk of HIV infections.

My testimony was submitted for the record so I won’t bore you guys with anything, the details as the night is aging at this point but I would strongly urge you to support 6540 and urge members of this Committee to vote this important piece of legislation. The best thing we can do as a society
is to ensure that we provide preventative measures. This Bill does that to ensure that our youth have access to PrEP before as a preventative measure. I want to thank you for your consideration and I am here to answer any questions or comments which the Members of the Committee may have. Thank you.

SENATOR ABRAMS (13TH): Thank you very much Any comments or questions from the members of the Committee? Dr. Petit.

REP. PETIT (22ND): John, thank you for staying here for 12 hours and 10 minutes. I think you got here before then. Put you on the spot if you are willing, in your situation, which I don’t know the details which would you have been able to have this discussion in your family when you’re 12, 13 or 14?

JOHN BOARD: Yeah, ah I mean I can tell you personally my story coming out was one of I recognized that I was gay when I was in third grade. I decided to come out to my peers and to my friends around seventh grade, I still remember the first boy I liked in fourth grade. But I didn’t feel comfortable. I didn’t come out to my parents actually until I was actually, until I was 18. But my parents always had that inclination. My mother always knew. My mother had that mother’s intuition, like any good mother does have. But it is a process that every individual goes through at their own pace. To I think that a 14-year-old could have that conversation if they’re ready, I think absolutely. I think definitely over, I’d say the last 10 years or so society has become a lot more accepting and culturally we’ve been able to have those discussions I think at a younger age.
REP. PETIT (22ND): Thank you for that. Thank you, Madam Chairman.

SENATOR ABRAMS (13TH): Thank you. Any other questions or comments? Thank you very much for being here today.

JOHN BOARD: And thank you all for staying at this late hour.

SENATOR ABRAMS (13TH): Okay, we are going to move on House Bill 6546. Is Kenneth Kreyeske here? Thank you for your patience. Welcome.

KENNETH KREYESKE: Thank you, my name is Ken Kreyeske and I am a Hartford resident and with Attorney Devon Ward I represent five plaintiff’s in a proposed Class Action against the Connecticut Department of Corrections Commissioner Scott Semple it will be changed to the new commissioner by order of law as soon as the new commissioner is approved.

But essentially our five plaintiff’s are seeking Class Action Status in the United States District Court for the District of Connecticut in an attempt to have their right to be treated with directing acting antivirals recognized and they would like to have their hepatitis C cured. Connecticut is the 11th State in the United States where such a class action has been filed. The Class Actions in Massachusetts, Pennsylvania and Colorado and California have all been settled by legislative action and this entire cause of action came to our awareness, Attorney Ward astutely recognized during our discover in the famous Wayne World case where if people recall, Mr. World was a prisoner whose cutaneous T-cell lymphoma was mistreated as psoriasis for several years while he was a prisoner
at Osborn and during discover of this we came to understand that hepatitis C was being ignored by the Department of Corrections. For example when I deposed Dr. Johnny Woo, the former Director of Medical Services at Correctional Managed Health Care with UConn we did the deposition down at Rutgers because Dr. Woo was now the Medical Director in New Jersey for correctional health care down there. He said to us he had secured a $300,000 dollar grant from Gilead Science in order to do a census of all members or all inmates in the Department of Corrections who had Hepatitis C but a territorial war with the Department of Corrections prevented him from actually accepting this $300,000 dollar grant to do a census of all inmates and determine their HCV status.

And then we did a deposition of a gentleman named Dr. Johnny Wright and he is a primary care physician as Osborn Correction Institute and in his deposition he said five in 10 of the patients that he sees at Osborn have hepatitis C. There have been, Dr. Woo in public statements, only four people had Hepatitis C, so there is a vast disparity between public statements and actions and what we’re hearing on the ground from doctors and we have multiple cases against the Department of Correction right now where we’re able to do discovery and sometimes we’re able to ask what they know about hepatitis C and all the doctors indicate that it is a substantial problem.

So we are here to testify in front of this Public Health Committee and we thank you for raising this Bill and I thank you for the opportunity to speak. But we think HB 6546 is integral. In Massachusetts the settlement was for. I’ve said all that I can say, the Class Action settlement that we think, if
this case is settled will require legislative approval because it will be for more than $2.5 million dollars because if there are 13,000 prisoners and Dr. Wright is correct that one in two has it, that means there are 6,000 people in the Department of Correction who have hepatitis C, 6,000 times $20,000 dollars per DAA treatment is a lot of money.

SENATOR ABRAMS (13TH): Thank you very much for your testimony.

KENNETH KREYESKE: Thank you for considering.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. I realize you’re not sort of a health epidemiologist or Medicaid expert but looking at this across the country do you think we have any hope in getting Federal Regulations changed to get this covered under Medicaid? I guess part of the issue is that people lose their coverage in prison and it is not covered under Medicaid insurance that people have.

KENNETH KREYESKE: If I may I would seed the answer to this question to Attorney Ward who is understanding what is going on in Rhode Island regarding this.

SENATOR ABRAMS (13TH): Excuse me one second, can you give us your full name please?

DEVON WARD: For the record Attorney Devone Ward, Hartford, Connecticut. In Rhode Island not through litigation but through legislation expanded their Medicaid coverage to include hepatitis C so they were able to get some federal reimbursement by applying for a waiver, a Medicaid waver. So that is
also an option that Connecticut can certainly look into as well. But I was really encouraged to see in the Bill that it does contemplate having this discussion in conjunction with the Department of Insurance and the comptroller to really try to figure out where the best cost savings could be achieved once they do decide to start providing this treatment to inmates.

REP. PETIT (22ND): Thank you, that is great information. Very helpful, thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you so much for being here tonight. I think we’re all set. Thank you all so much for staying and for your good energy all day. We’ll see you soon.