REP. STEINBERG (136TH): Good morning, this is the Monday morning addition of the Public Health Committee’s last Public Hearing of the Session. I’m State Representative Jonathan Steinberg, Co-Chair of the Public Health Committee here today with Senator Mary Abrams, the Senate Co-Chair and we have our Vice-Chair and Ranking Member and not all that much else. Good to see all of you. People come in and out, the critical people are here, all very eager to hear the testimony today.

Why don’t we just step right in, the first hour is gives preference to legislators, agencies and municipal leaders and we will begin today’s testimony with Commissioner Pino from DPH.

COMM. PINO: Good morning. My name is Raul Pino and I am the Commissioner for the Department of Public Health and here with me is Barbara Cass, my other better-half at BPH and Barbara is the Branch Chief for Safety and Quality. We are here to testify on Bill, Senate Bill 1035 that is proposing to
considering deemed status for some nonprofits around the State that DPH currently regulates. You have our written testimony. I am going to go over it rather quick to have the time for some questions and I wish I could find stronger words that vehemently for DPH to oppose this Bill. It hits at hardcore of the work that we do to guard the safety and quality of the services that are provided around the State for any patient or anyone who use those services. And we believe that circumventing DPH regulatory activity is not conducive to that end.

We have engaged recently in some work with the idea of making it easier and less cumbersome for some institutions to apply and get DPH regulations in place and we are more than willing to continue to engage in that process. But is troubling for us that at the same time that this body, meaning the legislature has asked us to step-in in other institutions that have personally faced some challenges with quality and safety of the services that they provide that at the same time we are going to promote an activity that will not be conducive to that end.

Barbara is here with me, she has more experience, many years at DPH doing this work and if you have any other questions I will answer those but I really encourage this Committee not to take action on this Bill. Thank you.

REP. STEINBERG (136TH): Okay, we though you were going to have some commentary.

BARBARA CASS: Good morning, Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. Thank you for letting us come to talk this very important subject
today. I think it’s important to note and really underscore the work that we’ve done collectively with DPH, DCF, DDS, DMHAS and the not for profit community. In 2017 a lean work group was convened and all of the agencies were at the lean work group with our community partners. And since 2017, since we finished that lean work it really is important to note all of the collective credible work that we’ve done working together. We do know that work gets done when we work together.

And we have standardized our inspection process. We’ve developed this checklist that we have shared with the provider community so they know what to expect when we come in to do an inspection survey.

Probably in the end stages of getting to release a standardized online application in process, not only for initial applications but for renewal applications that will be shared by all three agencies and again it will be an automated process.

We’ve also had a subcommittee that is working on accessing medical records remotely so that we at the agency could look at the medical records in the office and that would reduce the time spent in the facility with the inspection team. So it is really important to note all of the efficiencies that we’ve done so far and we are really optimistic that we are going to continue to make incredible gains working on the inspection surgery process.

I also want to talk a little bit about what happens at DPH with accrediting organization surveys. On behalf of the Centers of Medicare and Medicaid Services, DPH conducts validation surveys. A validation survey is conducted at the request of CMS after an accrediting organization has conducted the
accrediting organizations survey and would grant them deemed status. And on occasion we have identified significant findings shortly after the accrediting organization has left. So in one recent example, the accrediting organization didn’t identify significant concerns and four weeks later we went in and identified significant concerns with infection control. So that causes us to pause at DPH and question the reliability and the credibility of the organization survey process. Are they looking at the same things we’re looking and with the same rigor that we are at DPH.

So in closing, I would to ask you to consider not taking any action on this Bill. Thank you for your time.

REP. STEINBERG (136TH): Thank you. As you’re aware this is not the first time a Bill of this type has come up and I’m sure you understand the intent of those who put it forward which is to avoid redundant paperwork and activity. I think your comments with regard to you’re ongoing efforts to streamline the process to make it easier to do things online does address a significant part of what we heard from them. Could you comment for a minute with regard to the fact that sometimes those who are most interested in using deemed status maybe doing it based upon a much more limited set of valutative parameters that is often the case? With the kind of work you do is it apples to apples so I guess I’m asking?

BARBARA CASS: I think it depends on the accrediting organization, Representative Steinberg. If the accrediting organization with the CMS process has to be vetted to Congress. So CMS looks at all the
accrediting bodies standards and then compares them with the Federal Standards. There are currently only four accrediting organizations that have been approved by CMS for hospitals. I am not sure that I could say its apples to apples. I have not seen, I am not an accrediting organization expert so I would be remiss if I did opine on that but I think based on our experiences when we are seeing findings after we go in and do a validation survey causes me to pause. I can’t remember the last time we did a validation survey at DPH when we didn’t have findings.

REP. STEINBERG (136TH): Thank you. I’ll ask the question I’ve asked in the past with regard to deemed status how do you respond to the fact that other states seem to be a bit more amenable to that?

COMM. PINO: So it will be interesting also to check how those states are doing on safety and quality issues. The fact that they have it doesn’t mean that it is being all glory. Connecticut’s actually one of the flaccid states when it comes to safety and quality in health care facilities and often highlighted by CMS as the standard for other states to follow. Actually our employees are used to train on a national level for some of these issues. The other states, we would have to go state-by-state and see what the result has been there, but there is a small number of major issues that happen but in war on the war of regulating we find horrific issues and situations that by our presence and constant presence we are able to address not only by our inspections but also by developing consent orders and consent improvement plan working with those again the organizations to remediate those issues. We would lose that ability if we did the Deemed
Status. You know, when these reports come in front of us we have to read the situations that you are often are violated. Those are serious, serious issues that we face at time that we have serious, serious concerns that otherwise we would not have that ability to regulate and premeditate and control.

BARBARA CASS: And, Representative Steinberg I am on a National Board for my Trade Association Meeting and therefore I meet quarterly with states across the country. And I will tell you anecdotally I am hearing a great subtleness nationally with deemed status.

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

REP. PETIT (22ND): Thank you, Mr. Chairman. Good morning, thank you for that testimony. First a general question are either of differentiate between inspecting groups that were CMS certified versus other national accrediting organization, is there a distinction in your mind between something that comes directly through CMS versus otherwise in terms of inspection things in the state?

BARBARA CASS: I will tell you I’m a State of Connecticut employee so I am very proud of the Public Health Code that we have which I believe enhances quality and safety in all of our health care institutions where many states don’t necessarily have a public health code that drives that. So I believe our public health code is in line with our CMS regulations. There are many, many parallels and many similarities. Does that answer your question, Representative Petit?
REP. PETIT (22ND): No, Ma’am. I am wondering if you between an agency that is say CMS accredited versus another accrediting agency, do you think?

BARBARA CASS: Oh I see.

REP. PETIT (22ND): Do you think there is different experience or expertise in terms of accrediting for different national organizations, cause I don’t know the answer so I am wondering if you have an opinion on it?

BARBARA CASS: So I think it depends on the accrediting organization and the provider type. So each different provider type has a set of accrediting organizations that apply to that entity. As I mentioned earlier, CMS does vet all of the standards of the accrediting organizations that they approve and it is passed through Congress and approved through Congress so it does go through a very rigorous extensive review but still the regulations are all a little bit different. I will tell you they are coming in line, I can speak to Joint Commission when we do our training, Joint Commission surveyors now are participating in our surveyor training so there is a desire to bring them in and have them trained in real time along side the state surveyors. So I don’t necessarily have experience, direct experience with accrediting organizations so it is a difficult question for me to respond to.

REP. PETIT (22ND): Is it practically possible for an accrediting organization that’s CMS accredited to come in and do an inspection side-by-side with DPH in terms of time and efficiency or is that practical?
BARBARA CASS: It is not our current practice. I don’t. It would be a different set of standards, I’m thrown some by your questions so I want to think about it for a second. I think it’s, it could be practical, it’s something that could be arranged. I am quite confident that in some of our smaller facilities it would not be practical because of space. The accrediting team would want their own space away from the state survey team. But it certainly be accomplished, it might be cumbersome for a facility because they would be responding to two separate groups of regulators and the accrediting organization so it would potentially be awkward. So I guess the practicality of it, it would require more resources I would foresee on the facility side.

REP. PETIT (22ND): Thank you and back to your prior example where a national organization came in, inspected and you were there or DPH was there four weeks later and identified infectious issues was that a, if you remember the specific example, was that a people issue, in other words, someone who was available day one with the inspection that was very confident in their abilities and someone who is less confident on the reinspection or was it procedures that were not appropriately in place in general?

BARBARA CASS: So when we do our survey activity, we do measure, is it a practitioner issue or a system issue and in this case it was a system issue. A system issue that was protracted, it wasn’t a real in time situation that we had observed.

REP. PETIT (22ND): So essentially missed by the outside agency?

BARBARA CASS: That’s correct.
REP. PETIT (22ND): Thank you for those answers. Thank you, Mr. Chairman.

REP. STEINBERG (136TH): Representative Arnone followed by Senator Anwar.

REP. ARNONE (58TH): Thank you, Mr. Chairman. For the Commissioner. Do you feel this Bill is limiting your authority?

COMM. PINO: Yes.

REP. ARNONE (58TH): And so as I read some of these additions, you can still overrule or and it says, you know, “It is not to be construed to limit the Commissioner’s authority” and I do believe that is important because of the example you just gave now wo if you have complaints of a facility you can still use your authority to overrule this. So could you speak a little bit to that specifically?

COMM. PINO: So only if we know about it. So we have our regulations and inspections we see it as preventative measure to whatever the issue maybe. Now our investigations are complaint based. Those are two different set of standards. We may go more than once in a year or twice depending on what kind of complaint we received from any institution, the family, the members or the patients that are living in that facility or using that facility. But we also have a standard licensing process that depending on the type of institution is the frequency to which those are visited, so those are two different things. So we see our regulatory process and licensing process as a standard inspection to the minimum qualification that that facility needs to have in place to be able to provide those services. And we see that as
preventive public health and then we have the complaint based investigations that are driven by complaints received from the public or providers.

REP. ARNONE (58TH): So it would narrow right now the amount of inspections you are doing now to just those complaint based ones and it would be almost hard to impossible to catch all the others without having the yearly regulatory inspections that you have now?

COMM. PINO: Yeah and our certifies that goes our surveyors that goes into facility are looking to preventify, how can I prevent this and these other things from happening? And based on our code, also their experience at the local level with that facility and all facilities of the same type. Now remember that in many cases accreditation process is an institution or regulated body that comes with whatever frequency you have. For example DPH gets accredited five, every five years. We pay an amount of money, someone comes and reviews of protocols and procedures, they say we provided them with all the protocols and procedures and seems to be in place. DPH inspections are more than that, it’s on the ground, working with the providers, working with individuals but also while we look from the preventive side, how can we accomplish any plans that we put in place and negotiations that take place. With those interventions that would be missing in most accrediting processes.

REP. ARNONE (58TH): Thank you.

REP. STEINBERG (136TH): Representative Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you Commissioner Pino and Ms. Cass for your
testimony. I want to clarify something. When somebody applies for accreditation is it a specific staff person that is dedicated to that specific facility?

COMM. PINO: Well, it all depends on the accrediting body. You mean on the national level?

SENATOR ANWAR (3RD): No, here.

COMM. PINO: Oh, we don’t do. You mean like licensing?

SENATOR ANWAR (3RD): Licensing, sorry, yeah.

COMM. PINO: Oh, well depending on the type of facility we have a working group. For example for mental health facilities we have people who specialize on the type of regulations they have. For clinical service, outpatient clinic, hospital so there are different teams that do a specialized, but it is not one person although they may be working for one individual at the same time depending on the work.

SENATOR ANWAR (3RD): Now can this thought process move in the opposite direction, like if the Department of Public Health in Connecticut is able to oversee licensing can that actually get bypassed accreditation at the CMS, is there something that the federal agencies can help with. In other words, I think the way institutional or groups are interested to reduce the paperwork and their effort. I personally believe that if it’s local management and oversight that it is smarter because if something goes wrong there is a very fast turnaround to be able to address this if it is the same personnel who addressed this before, they are much knowledgeable about the individuals and can
literally pick up the phone and start to get to the bottom of it as opposed to someone sitting somewhere else. So I recognize that and I respect that. But I’m trying to see if there is another way to fix what the intention is.

COMM. PINO: So we have engaged in that process and that would be a continuing process. With regard to double applications to two different state institutions that may very well be the same facility, we are all for that, we don’t want them to have to have to submit twice the amount of paper, twice the effort and just as an example, let’s say a mental institution came by and expected the fire code, well maybe DPH doesn’t have to look at the fire code if it was done in the last, I don’t know, three-four months. So there are things that we could engage in further but the whole idea of clearing an institution from our regulations is concerning to us. But, I mean, you brilliantly make an argument for our case that we should continue to engage in licensing and regulation for those institutions that are looking for deemed status.

SENATOR ANWAR (3RD): Thank you so much. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Other comments or questions? We’re not gonna let you go that easily. There are a couple of other Bills on our agenda which [Laughter] which I would like, if you would like to comment on, specifically there is a Bill, Senate Bill 859 AN ACT CONCERNING COMMUNITY HEALTH WORKERS which does require DPH to manage certification and we’ve often had some conversations on these certifications and I wanted to get your comments on that?
COMM. PINO: So, you got me by surprise. I don’t have that Bill in front of me but I know about the Bill. So DPH decision is we support the developing of the community health workers as a workforce in Connecticut and we support the standardization of their education and we support some kind of regulating activity over those. So there are differences between certification and licensing. And those are critical differences and developing or developing a registry like we have for SOMA licensing but our concern with that Bill is that you put a lot of onerous work on DPH without additional resources to developing the curriculum to developing their certification process or licensing. But as a principle we support it. I think that will help presently where we need to go and if we are going to continue to work on population health, community health workers will be critical to that work.

REP. STEINBERG (136TH): I totally agree with that is a direction that we are going so if you create any bandwidth this would be a very important area and I hope to have an ongoing dialogue about ways in which we can continue to go down that path within your existing resources because we must be able to be sure we have a professionalize community workforce. So thank you for that and we will talk more.

One last Bill, Senate Bill 966 AN ACT CONCERNING THE PRESCRIPTIVE AUTHORITY OF PSYCHOLOGISTS. We’ve heard anecdotally that there are some issues with access to prescribers in the psychological/psychiatric field, this is a pretty significant step to allow psychologists prescriptive authority as we try to deal with the opioid epidemic, medication assisted treatment. I learned over the weekend about office
based opioid treatment model things of that sort, there is a lot of call for the ability to prescribe as a means by which that we can address some of these ongoing issues of addiction and mental health. I know a lot of this is perhaps better suited for DEMHS but obviously I would like to get your point of view on whether or not you would be open to the idea of psychologists have prescriptive authority.

COMM. PINO: So one of the reasons why we don’t have many prescribers as we wish prescribing MIT is because some prescribers refuse to engage in the process. It is a very cumbersome process. I don’t think that opening up that prescription to many others, any type of providers will deal with that issue. I think that we will have to look carefully, does are regulated substances that the Department of Consumer Protections regulate specifically for opioid treatment not DPH and they possible will have to go through a vetting process but in general we think Connecticut is very generous on who prescribes, doctors and nurses have full prescribing rights, PA’s have full prescribing rights except for opioids and the first prescription has to be certified by a provider otherwise those can prescribe. Every time someone is looking for prescription rights we are very careful. It’s not only the ability to prescribe it is also that these professionals in general have to have the necessary training to prescribe. And that is a critical question that DPH has to answer every time. It may be a specific individual that has those qualifications but the profession as whole on the training of the professional that’s a whole, do they have those qualifications to prescribe. It takes more that the knowledge of the name of a pill and
what amount is to be prescribed. It is more complicated than that.

REP. STEINBERG (136TH): Thank you. Any other questions? Commissioner thank you for testifying today.

COMM. PINO: Thank you, sir.

REP. STEINBERG (136TH): Next we have First Selectman Rudy Marconi from Richfield.

RUDY MARCONI: Good morning, Senator Abrams, Representative Steinberg, thank you for giving me this opportunity here today to address Senate Bill 1057 AN ACT CONCERNING OPIOID USE DISORDER.

Back in 2003, in our little town of Richfield we experienced a heroin overdose on Main Street. And at that point it brought to mind that perhaps we were missing something in our town and many of our towns and cities across the State of Connecticut and that is why are we seeing an overdose of heroin on our main streets. And as we began to work together in our community in the form of a coalition this serious situation grew into an epidemic, an epidemic that we now fight today.

Last night I received an Everbridge notice, I don’t know if anyone here in Public Health received that notice that we had approximately 13 overdoses reported Saturday and Sunday and there seemed to be a consistency of what was going on in some of the signs that the hospitals were seeing. Waterbury alone saw seven of those and as you know, and I think the Mayor would be perfectly fine with my speaking on his behalf here today that Waterbury has experienced an incredible number of deaths in their community alone, 2017 I believe we saw 1,038 deaths
this past year 1,017. We felt and I read, and I wish I wasn’t reading it that there had been some kind of progress made as if that slight decrease was beginning to address the issue and when I think situations like we saw last night or this past weekend in our state tell us very much that this issue is very much alive.

Specifically I would like to address MAT Model, Medically Assisted Treatment and seemingly the lack of that model being used in our efforts today. This Bill I support, CCM supports, COST supports and I am also President of HVCASA Housatonic Valley Council against Alcohol and Substance Abuse certainly supports because there are many important steps being taken in this Bill. Not only the availability of Narcan on our college campuses but also the local agencies become more involved, and Medicaid patients being allowed to participate in a study concerning medically assisted treatment.

I have several friends in the medical community and although the Connecticut medical community doesn’t seem to be quite onboard in supporting a MAT Model for our private facilities, I think the time has come that this Committee, the State of Connecticut has to take action requiring that all of these facilities in the State of Connecticut must at least offer and explain and educate to the many people and families that feel there are looking for help and help them understand what a MAT Model is and that it’s not just a 30-day, 45-day that you son, your daughter, your husband, your spouse, your loved one is going to be fine because the recidivism rate that we’re experiencing in this State is all too high, in the 60 percent area. That is not acceptable, we wouldn’t accept it in any other area in the State of
Connecticut and we should not accept it here. We need to do more. And although this Bill is great and it is a step in the right direction we need to do a lot more and I think requiring private rehab facilities to offer the MAT Model to educate people about a medically assisted treatment program is critical to addressing this issue in the State of Connecticut. Thank you.

REP. STEINBERG (136TH): Thank you for taking the time to share with us today, it’s a very strong indication of how much you’re taken by the, as you say, the epidemic proportions of what is transpiring in so many communities across the State of Connecticut and I agree with you some sort of initial optimism with regard to a leveling off on opioid deaths has not necessarily been warranted. I think what we’ve also seen is an evolution from a prescription drug kind of problem to a really shift to heroin and fentanyl which are both often times cheaper to access and also much less clear what you’re getting such that when we see spikes like you described over the weekend it often is case of something else going on with whatever is being distributed out there. From what I’ve learned MAT is a very good solution but you bring up a point, a lot of the medical community, a lot of the facility community has not embraced it, there is still a lot of misconceptions about it. I take your point that access and education to MAT needs to be much more wide spread. It’s not the best answer for everybody but it is the better answer for many but we need more members of the medical community to embrace the concept that become proficient themselves in going forward that that. As I mentioned earlier there seems to be a shift to this OBOT model Office Based
Opioid Treatments, there’s a whole set of protocols now to go with it. I learned about it over the weekend about something called CARE Justice Clinics that really sort of combine healthcare and law enforcement and try a more integrated approach. It seems to be a lot more focus on integration across primary care, behavioral care and law enforcement in more effective ways. You’re right the Bill we have is only a starting point. We’ve done omnibus bills like this for five, six, seven years and this is part of the dialogue that we hope to have today but equally important and subsequent to this as we try to fashion a Bill that addresses some of the gaps that we still see out there everything from prevention and education through early intervention and treatment and recovery. There are a lot of things we need to do. Do you have any other specific suggestion on things that you’ve heard of or seen that are effective as we try to build this sort of modified plan?

RUDY MARCONI: Other programs? Well not as, I am here today to talk about MAT. I’ll be very honest with you, I am not going to make any other recommendations today. I don’t have any other recommendations. I didn’t come prepared to do that. I did come prepared and I did a lot of homework on the MAT model with Dr. Peter Rostenberg who is a suboxone doctor and is very active in this area and believes with all of his heard that we need to do more for people with the MAT model. The 30, 45, 60 day programs and there have been a multitude of these rehab facilities that have sprung up over the last three to five years and very profitable. And they do great work. I am not coming here today to deny what they do. They do good work but is the
work they’re doing the right work that we need to get done. I don’t believe so. I think that those facilities need to be guided in a way that allows them to offer the MAT model. I don’t want to say force them or regulate them but to be honest with you someday we are going to need to be there. I know that Peter told me in his discussions with an operator of a rehab facility that the director told him that two-thirds of the people there were repeat offenders or chronic patients, not repeat offenders, excuse me for saying that. This is a chronic illness. It is not something that can be cured in 30 or 45 days and until we begin to recognize it as a chronic disease, only then can we begin to provide the proper treatment for these people and we need to do it.

REP. STEINBERG (136TH): Very well put. Thank you for that. And I agree with you that, you know, just a few years ago the concept of widespread availability of Narcan was a crazy idea and in a period of years look how far we’ve come. I hope that with more education, there’s more and more access to MAT Programs that are appropriate and available throughout the state. Thank you. Representative Arnone followed by Representative Scanlon.

REP. ARNONE (58TH): Thank you for your testimony. Access to future MAT Programs especially in a Town like Richfield, what is your access now? Give me an idea where an addict would go in your area or is it very difficult to find?

RUDY MARCONI: That’s a great question and is another problem area because not enough doctors are practicing suboxone treatment Vivitrol or whatever
the drug maybe. And speaking with Dr. Pino earlier, perhaps some kind of an incentive needs to be put in place but I think educational alone will help. We don’t have a suboxone doctor in our town. I refer people to go to Peter Rostenberg, but it’s amazing how many people aren’t even aware of what a MAT model is. I am a First Selectman, I’m not a doctor. I’m not a counselor. I’m not a specialist in this area. I am a Jack-of-all-trades if you will but I certainly can’t convince these people that the 30,000, 40,000, 50,000 people have lost their entire savings, their retirement and they have remortgaged their homes because a loved one continues to fall into this pit, into this pit of chronic disease because we’re not recognizing it. I think we have an obligation in the State of Connecticut to incentivize possibly more doctors to get involved, ask more doctors to become involved. I don’t believe we’ve done that.

REP. ARNONE (58TH): You’re right. So in my Town in Enfield 17 deaths last year, unacceptable with a population of 43,000 people. Constant, constant emails cause we track our overdoses also and we try to track them through Social Services. I’ll go one step further with suboxone and we are lucky enough to have a methadone clinic last year open in our town of being the first response to what an addict, I’ve been working closely with the community in my town and methadone is first step, suboxone is second and these can last a lifetime and if you look in France they have a model where every general practitioner is allowed to prescribe and it’s been a little further conversation we have here in the states but this is how important it is to get for lifetime treatment. And you’re right this is not
something you can just take away in four to five weeks of treatment, it’s years. I just hope that we can go further also, we’ve tried to work our police department, social services and hospitals. So admission and then we try to track those persons, the overdoses back to town and have social services just follow them and help them get the need they gave. So, maybe Richfield and Enfield can talk together and see and move through our model to your town to and I would be happy to do that.

RUDY MARCONI: Several years ago I spoke in Enfield on this topic and there is not question that Enfield and every other community in the State of Connecticut is experiencing the same issue whether it is two deaths, 18 or in Waterbury’s case 68 this past year, where are we gonna draw the line, thus far I believe we have been somewhat reactive to the problem and there is nothing wrong with it. Reaction is good but we need to be more proactive and we need to get out in front of it. One of the killers today is fentanyl and I am sure you’ve heard of it, that the concern is carfentanil showing up which is a thousand times more powerful than heroin. Law enforcement is concerned about that because of the absorption through the skin, etc. This problem doesn’t seem to be going away and if anything it continues to increase. Law enforcements say they don’t have enough money that as soon as they break one house, there are five others. It is coming in from everywhere. The governor of Maine blamed Waterbury, Connecticut. The governor of Vermont several years ago in his inaugural speech to his house said, you know, we’ve got heroin, and that was his entire speech dedicated to the problem of heroin and speaking to the state police narcotics task
force they explained to me that Vermont’s problems are our problem and I said, yeah, we have the same problem, that serious, he said, “No” everything is coming into Connecticut. Connecticut is the distribution point for the entire New England States, doesn’t that alarm anyone. Doesn’t that cause us to ask questions, what is going on? What are we trying to do deter this, to stop it? I haven’t heard. I hear millions of dollar being allocated from the federal government five million, eight million, ten million dollars where is it going? Are we doing anything to stop the influx of this, in inflow of this, these types of drugs. We know it’s coming out of Mexico, there is no doubt about it.

REP. ARNONE (58TH): Yes, and that’s a good point. I’m glad you brought that up and thank you for bringing that new conversation up, the pipeline right up through 84 - 91 and its troublesome and again we wonder to what’s happening there. Thank you.

REP. STEINBERG (136TH): Representative Scanlon.

REP. SCANLON (98TH): Thank you, Mr. Chair and good to see your Mr. First Selectman. I know you’ve been before us and worked with us on a lot of these Bills and so I want to thank you for that. Just a couple of questions. On MAT, and you probably know this, the biggest problem that we have is regulated at the federal level. SAMHSA is the one that is doing the guidelines that prohibit people from prescribing more in terms of morphine. They are capping the amount of time the patient can see, there is time that they have to take certain classes, we can’t regulate that. So I’m wondering if you have any
ideas how you think we could possibly incentivize more doctors and physicians to prescribe if we don’t control the guidelines that we are enforcing.

RUDY MARCONI: That’s a good question. I certainly understand that. Again Dr. Rostenberg said they used to be restricted to no more than 100 patients, they increased that a couple of years ago to 200 which is good, a great move, but how do we do it, we do it by taking an interest in becoming more active. We do it my people coming up here today to testify, by incentivizing you, by asking you as our Representatives as our Senators, we need a louder voice. Connecticut needs a louder voice in Washington. We need to get our federal legislators involved in this. We need them to speak on the floor to go to SAMHSA and all the other organizations, the director of Alcohol and Drug Policy at the White House to stimulate more funding to get a more proactive position in this state. We need to stream louder. That’s what we need to do.

REP. SCANLON (98TH): And then also as you know obviously one of the other inhibents or prohibitors from this is that MAT is expensive and insurances don’t always cover that at the rate they cover physical health. In my other life a Chair of the Insurance Committee we tried to address that this year but are you seeing anecdotally from your members talking about somebody is coming to the First Selectman’s office, they’re coming from the police saying, listen I want to get help with this but I can’t get that because my insurance won’t cover that.

RUDY MARCONI: Well I know that Anthem came out with a program a couple of years ago that allows you to
treat at home even to the point of voluntarily wearing an anklet bracelet, ankle bracelet that prevents you from going into your old neighborhoods, your old hangouts, whatever it may be where that sphere of influence exists that you fall back into the trap of using again. There is no question insurance is gonna fight this, it is an expense, but I am sure as the many different disease, the chronic diseases that we have in our society whether it is diabetes do we tell people they can no longer eat sugar. People go on insulin and continue to eat sugar although that is one of the problems that their pancreas can’t address. Heart disease, cancers the many different drugs that are in the pipeline that we see every night but yet nothing in this area. I think that we need to push harder with the insurance industry to begin covering more of these illnesses and once we are able to get society to understand that this is a chronic disease insurance will have to fall in line.

REP. SCANLON (98TH): Got it and last question for you, I know you are here to talk most about MAT but I want to ask you, because you are First Selectman that is not in this Bill but a Bill that I introduced with another member of this Committee Representative Candelora and that would try to address, I think they are going after in this Bill, which I do support, which is to have hospitals start reporting more is to state about the number of people that they are seeing come in having just overdosed. One of the things we had proposed early this year is a separate Bill which would require that if a first responder showed up at a scene in Richfield or Gilford where I live, and somebody did overdose that there is going to be an automatic
transport to the hospital. That person cannot refuse treatment.

RUDY MARCONI: Good Bill.

REP. SCANLON (98TH): Is that one that you think your organization and you as a First Selectman would support?

RUDY MARCONI: Absolutely. One of the issues is getting people, if people deny transport that means they feel better, they don’t want to address the issue. If we can get them into the hospital and if you know our hospitals now are having social workers stationed right in the EDs so that instead of that patient being transported and being admitted to the emergency department which is the most expensive part of health care that we can provide that patient right after diagnoses and stabilization is moved over into the social worker to get them into a program. We need to do a lot more of that and I think what you are addressing accomplishes that.

REP. CANDELORA (86TH): And I appreciate that and honestly Recovery Coach Program I think is working. I think nobody wants to celebrate the fact that we are leveling off but the fact that we are not getting worse as we had every year since 2012 until this year is something that should, we should keep our foot on the gas so to speak. And obviously the legislation I just discussed with you I think would save your town money because the number of people that they are transporting sometimes several times a day, they revive somebody, that person is feeling well, they say, I’m all set and then a few hours later cause they have a disease, they are gonna be right back.
RUDY MARCONI: We saw that in New Haven being transported several times.

REP. CANDELORA (86TH): Correct. So I’m glad to hear that you are into that Bill and I’m looking forward to working with you on the Committee and hopefully trying. Thank you for the work you’ve done.

RUDY MARCONI: Thank you, appreciate it.


SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you for your testimony. In my other life I am an intensive care unit doctor so I had actually at least have one patient that every time in the ICU with this situation and we lose about one patient every four to six weeks and in your region and I guess the numbers are much higher in various parts of our state. I think the leveling off is probably because much more use of Narcan and we’ve seen that for the first time but it has not necessarily fixed the access problem and I thank you for highlighting the fact that New England has a far higher rate than the rest of the country and Connecticut has seen much more that the rest of New England. And this is panic levels, this is beyond the epidemic levels, not it is a panic level issue for our State right now is that our State is be considered as a possible conduit for some of the other neighboring states in some respects. I think though the culprit, if you look at the data, it looks like the fentanyl usage is increased even when somebody is getting heroin that is mixed with some fentanyl and that is actually so much more potent that is actually causing deaths much more. And the issue that you are highlighting is important because a significant proportion of these individuals have addiction
issues but some of them actually using it to hurt themselves, they are intentional overdoses. And not having a support system is part of the problem and I just want to argue for the insurance companies to understand that the cost of care in the intensive care unit is so much more that it could actually provide care to many patients if they were actually managed on the outpatient setting. And the value of life, of course, is you cannot measure that in dollars about the life saved but also the number of people who reduce the readmissions to the hospital, would be the insurances companies will make money rather than lose money. I’m sorry, I think that is something that if we can try to hammer this somehow to the insurance industry that this is not only their responsibility but also financially a smart thing to do and then for the community to save lives is going to actually be a smart thing to do which I am sure they are interested in as well. But your testimony again highlights the importance of collaboration that would be necessary at this time between the community but the towns, and the State and the Federal Government. And I think if we don’t get all hands on deck, we are not going to be able to be successful. But that’s the whole point, so thank you so much.

RUDY MARCONI: Thank you.

SENATOR ANWAR (3RD): Thank you, Mr. Chair.

REP. STEINBERG (136TH): Other comments or questions? One last question before you, I was acquainted with a program I was not familiar with. So many of our opioid problems have mental health antecedents, I was wondering to what degree you are aware of the age distribution of those who have died
of overdoses. I was made aware of a program that is being trained around the State, particularly now schools, mental health first-aid and there is a specific youth program on that. It is something you might want to look into and talk to your superintendent of schools. We certainly want to have this conversation with the State Board of Education in terms of early intervention and early identification of some of the causes that might lead people to addiction, so if these is a specific issue among young people that is something else we need to look into.

RUDY MARCONI: There most definitely is. In our community in talking with nurses in the schools I ask the question of young children who present with different ailments during the day, how many of those are actually physical versus mental issues and they said over 50 percent are mental issues. And opioid workgroup that we have in Bethel, Connecticut once a month I ask Dr. Charles Herrick from Emery Hospital head of psychiatry what he thought of that and he said, “I thought it would have been a lot higher.” And I’m afraid he is right that a lot of it is mental health, especially at the younger age and one thing he brought to light was the fact that we don’t see it yet but if you read the medical examiner’s reports, toxicology reports, the presence of benzodiazepines is becoming more and more prevalent. And we are introducing our young people today at the elementary school level into the pill society that will all due respect to every psychiatrist in this state, in this country they’re well meaning and they do a great job and I don’t know where we would be without them, but it doesn’t take long to get a prescription for benzo, if you mention the word
depression, you mention the work anxiety, you leave there with a prescription and your son or daughter in those elementary years are now on their way to having pills become a part of their life and I shouldn’t generalize like that because it is not everyone and I know there are a lot of people here that they take exception to that, we have to give thought to how we are addressing that mental health in the schools and I commend the State of Connecticut and the Department of Public Health and DMHAS for forcing us to merge our mental health like the Northwest Regional Mental Health Board that covers Northwest Connecticut and the RAC that handles all of the addiction education and forcing those two agencies to become one and it wasn’t easy. We are almost there, we were supposed to have completed that merger on March 15th but as always there are always some hanging chads if you will but the fact that we are beginning to take a more holistic approach to mental health care and the relationship it has to substance abuse, etc. and catchin it early I think is very, very critical and something that we need to pay a lot more attention on in our schools.

REP. STEINBERG (136TH): I agree with you, integration seems to be where everybody is going. I wish we had more resources to support those groups that are doing such important work. I just want to say thank you First Selectman who describes himself as being a Jack-of-all-trades, you seem very invested and very knowledgeable on this subject. Thank you, Rudy. Next up is Commissioner Scheff.

COMM. JORDAN SCHEFF: Good morning, Representative Steinberg and Esteemed Members of the Committee. I am here to testify on Senate Bill Number 1035 AN ACT
AUTHORIZING DEEMED STATUS LICENSE RENEWALS FOR CERTAIN NONPROFIT COMMUNITY SERVICE PROVIDERS. I have a very lengthy testimony that has been provided to you in writing. I chose not to read it for you today but I ask you to please take the time to review it. While we are very supportive of continued engagement in our provider community to remove or review unnecessary regulations and some archaic language and obstacles to efficient operations I am here to testify today to ask you to not take action on this Bill.

Very simply I believe the proponents of the Bill have indicated that there is potential savings of money in that. We do not believe that is true and we believe the proponents feel that the accreditation bodies measure outcomes and quality in the same manner that our licensing units do and we do not believe that is true either. So with that I will ask you to review my written testimony and I am available for any questions you may have.

REP. STEINBERG (136TH): Thank you, Commissioner. You heard the dialogue we had with Commissioner Pino. Obviously the issues before your Agency are somewhat different but could you just give us a sense of, you’ve heard to those talk about how Deemed status would potentially be more efficient, less redundant and alike. Could you explain why that is problematic for you?

COMM. SCHEFF: So I’ll offer you two different examples of how that is problematic. As a for instance we have agencies who have been accredited by these outside bodies where we have found as Barbara Cass indicated in her work similarly adverse outcomes for individuals receiving care in those
facilities that have our licensing unit also not reviewed the matters could have potentially resulted in a problematic outcome. More specifically, I’ll give you an example, then I think it is an example, there are many. So from a health perspective one of the issues that we have faced in recent years was a problem related to dysphagia, a risk of choking and aspiration. I do not believe based on my experience with the accrediting bodies that they would look for the type of connection in the paperwork and in the training and in the medical documentation that would ensure for me as the Commissioner that a protocol is in place to prevent somebody from aspirating or choking. And as an example in our level of need tool which we’ve talked about, it would indicate that someone was a potential choking or aspiration risk from that our licensers would know to look at the person’s individual plan that would talk about the staffing intensity necessary required at mealtimes. They would also look at the health documentation to ensure that there had been a swallowing evaluation done, there would be an outcome from that swallowing evaluation and that evaluation would recommend the consistency and size of food, there would be a training protocol that they would know to look for to make sure that we had trained staff to cook and prepare that as well as feed that and a loop that comes back to us to make sure that is happening on an ongoing basis and reviewed periodically and I don’t believed Deemed status would that accrediting bodies would look at that level of specificity. And we have seen prior to instituting a number of years ago, the safe swallowing protocol a decrease in negative outcomes for individuals at risk for dysphagia and that is just an example of many where we think, it has
continued to be necessary to do the type of work we are doing now while continuing to engage with the provider community about areas where it makes sense to look at things differently.

REP. STEINBERG (136TH): Speaking of looking at things differently, you heard DPH testify that they put a lot of effort into streamlining, into online systems. Are you looking at similar things?

COMM. SCHEFF: We have developed what we call E-Licensing and Electronic Licensing System. We have waived some fees with regards to licensing if the group homes were required at $50.00 dollar application fee. We’ve worked with our sister agencies and the Office of Policy and Management on a statewide Lean process and while we have found some commonalities between our sister agencies in areas where we could create some efficiency we are also able to identify internally for us a longlist of things that we could do differently and we have done where we can, to make difference in the efficiency and the bureaucracy and the red tape for providers.

REP. STEINBERG (136TH): It’s good to hear that bureaucracies are capable of reform [Laughter]. It’s something we will ask every year I imagine. Are there other comments or questions? It not, thank you for testifying we will read your extensive testimony.

COMM. SCHEFF: Thank you, kindly.

REP. STEINBERG (136TH): We are now up on the first hour and we will begin shifting back and forth from members of the public and elected officials and
agencies. First up on Senate Bill 1058 is Kelly Green.

KELLY GREEN: My name is Kelly Green and I am here to represent Bill 1058. Thank you all for having us here today. We formed about two years ago officially for Connecticut Association for Professional Tattooers. We deem that is necessary for tattooers to have a voice in our laws and regulations.

As of 2014 we are now required to have a license. When this license went into effect no tattooer was asked for input. I think that with all intentions of making this a public safety issues, I think tattooers definitely need to be involved. If we are not involved that are a lot of things and loopholes that have been made. I would also like to say that I am in support of this Bill but with exceptions. The current language of this Raised Bill is not what we proposed at the Connecticut Association for Professional tattooers. What is actually raised right now as far as the language which is our first draft, we worked directly with the DPH to write the final draft which I believe our association and the DPH is very excellent. We covered a lot of the loopholes that are in current statutes.

So of the things that are missing are ratios for apprentices which they call student tattoo technicians. Right now there is no cap on that limit. We believe that there should be an 1:1 so one mentor to one apprentice. This is very crucial in order to provide a good future for the future tattooers. If there is no cap that means there could be 30 to one mentor which is not what our tradition has been before all of these laws.
Tattooing is something we take very seriously. It is sacred, there is a lot of public risk involved and I think there is not the attention from the very beginning it can be dangerous. We also worked together to do statewide guidelines for individuals and shop inspections but most important we need to be involved. If we are not involved the people who do this every day can’t have a say in what we do. Thank you again for listening to us. Thank you.

REP. STEINBERG (136TH): Thank you. Are there comments or questions? If not, Kelly thank you we will look at your testimony carefully. We appreciate your commentary on how we might make this better. Most important is the fact that those in this industry appreciate appropriate regulations so that we can protect all those who are your clients.

KELLY GREEN: Thank you.

REP. STEINBERG (136TH): Next up we are going back to agencies, Commissioner Delphin Rittman from DMHAS.

COMM. RITTMAN: Good morning. Good morning, Senator Steinberg, and Senator Abrams and distinguished Members of the Public Health Committee. I am Miriam Delphin Rittman, Commissioner of DMHAS and I am here to testify and grateful for the opportunity to testify on Senate Bill 1035 AN ACT AUTHORIZING DEEMED STATUS LICENSE RENEWALS FOR CERTAIN NONPROFIT COMMUNITY SERVICE PROVIDERS and Senate Bill 1057 AN ACT CONCERNING OPIOID USE DISORDER.

I have also submitted written testimony on a number of other Bills that relate to DMHAS and so you have those before you. In the interest of time I’ll just
talk about two specific Bills and happy to answer questions about there.

As you’ve heard already Senate Bill 1035 would allow community residences providing services under DMHAS contract to forgo site visit evaluations essentially under the Deemed status, under Deemed status. As you’ve heard from other agencies, we are not in support of this as well. DMHAS has been very active with other state agencies putting together and working on LEAN activities to help streamline and reduce the burden, administrative burden for providers and so we have been involved in that ongoing process.

We believe that while national accreditation can enhance services DMHAS also believes state agencies as well as stewards of state dollars and experts in state and federal regulation are best positions to evaluate services paid for by state dollars or serving the state’s most vulnerable populations. DMHAS and DPH insure that state statutes and regulations are followed and we collaborate closely on working to streamline different reporting regulations so that process is underway currently.

I’d also like to testify on Senate Bill 1057. Section 1 of this Bill requires Institutions of Higher Education to address and make available opioid antagonists in the event of an opioid overdose. DMHAS is in support of the widespread availability of opioid antagonists as a means of reducing tragic, unnecessary deaths related to the opioid crisis in Connecticut. As a leader addressing the opioid crisis, DMHAS has recently made opioid antagonists available to all hospitals around the state. That is something we did recently with our
state opioid grant funds. While DMHAS is not able to provide this lifesaving medication to every college, so that would be beyond our current resources. And we are very interested in collaborating with colleges and providing training around administration of opioid antagonists.

Section 2 of this bill requires DMHAS to conduct a study of the efficacy of home health care agencies providing MAT for opioid use disorders. DMHAS does not have the resources to perform a comprehensive study of this nature but would be able to do a literature review related this topic as well as provide information on how this service could potentially fit within the current robust continuum of services that we currently offer. So we currently offer a range of services. DMHAS would defer to the Department of Social Services related to the feasibility of expanding Medicaid reimbursement for this type of service.

Sections 3 and 5 of the Bill which outlines good clinical practice for practitioners treating individuals for opioid use disorders. We would also like to clarify the definition in Section 3 for “opioid use disorder.” Currently, the statute states: “Opioid use disorder’ means a problematic pattern of opioid use leading to clinically significant impairment or distress.” And so stigma is of major concern in health providers’ responses to patients with opioid use disorder, it is less stigmatizing to define opioid use disorder as a medical condition. So we respectfully request that the Committee consider changing the suggested language to define “opioid use disorder” as a condition characterized by problematic pattern of opioid use and misuse leading to clinically
significant impairment or distress.”

DHMAS has been a proponent of mental health first aid training and offer this training in schools and with other organizations as well. Thank you and in the interest of time, I’m happy to take any questions you may have.

REP. STEINBERG (136TH): I imagine we will have a few. Thank you, Commissioner. So let’s start where you left off. I’m relatively new to the Mental Health First Aid Program. What degree of adoption or penetration do we have in the State and which aspects of our broader infrastructure have embraced the concept?

COMM. RITTMAN: Yes, so we’ve done quite a bit of mental health first aid training over the years. Currently one of our community providers, Wheeler Clinic, is in charge of that work around the state. We’ve trained schools. We also do Train-the-Trainer around mental health first aid to allow schools and other organizations that have their own internal capacity to do this training and train others on mental health first aid. We’ve also been part of a collaboration to develop youth mental health first aid and with our current state opioid response grant funds we have enhanced and continued the mental health first aid training around the state. I can get that data in terms of the level of penetration but what I can say is that a number of schools and communities have participated in the mental health first aid training. We were previously funded prior to the SOR Grant we were funded by SAMSA for a number of years and again I can get that data on the Mental Health First Aid Initiative which is an evidenced based practice at the federal level and so we were one of the states that was funded to
implement that really across the state. And again we focus on schools, community organizations and in some instance faith communities, anybody that requests to have that training.

REP. STEINBERG (136TH): You heard First Selectman Marconi talk a lot about MAT and we recognize that this is potentially an area for greater opportunity in the State of Connecticut. There was mention in his conversation with Representative Scanlon about the insurance side of things but obviously it was mentioned federal limitations on what we can do. Has Connecticut sought waivers, have they tried to find ways to expand access to those on Medicaid and things of that sort?

COMM. RITTMAN: Yes, so we absolutely have worked to expand access to medication assisted treatments around the state. This has been key focus of our state opioid response grant so we’ve trained a number of providers. We’ve done a series of provider specific trainings geared towards increasing the number of providers certified to provide medication assisted treatments and so that has been a focus of our work with the SOR Grant. In terms of reimbursement, so there are a number of methadone clinics around the state. We have about 25 of those that are, and those are reimbursed by Medicaid and then in terms of buprenorphine we’ve done training all over the state to increase the number of providers that are certified that are able to prescribe buprenorphine. We’ve also in terms of our, you know, you talked about this earlier, in terms of integration in terms of our local mental health authorities we’ve also done some work to increase their capacity and their ability to provide medication assisted treatment and some of the
thinking is to essentially create no wrong door, or multiple entryways into for an individual to access MAT, so multiple entryways to treatment. And so if an individual is struggling with comorbid so mental health and primary care conditions and is seen within one of our local mental health authorities then they can have access to MAT through that LMHA.

REP. STEINBERG (136TH): You mentioned integration which often runs right in the face of our Yankee stubborn 169 hometown rule approach. Yet we’ve also heard how important it is to have further integration with law enforcement, which is often very localized, to what degree are we making progress with changing the culture in the law enforcement community and getting people to CARE or an MAT program earlier rather than later?

COMM. RITTMAN: You know I would say as a state we are making progress there as well. We have a number of initiatives, there is one for example in Hartford and in New Haven, we call it LEAD so it’s Law Enforcement Assisted Diversion. The goal of that initiative is for individuals who come in contact with law enforcement. Law enforcement then collaborating with a whole network of providers in those areas, so in New Haven and in Hartford. Some of the thinking is that, you know, this is not something we can arrest our way out of that the goal is to have law enforcement also part of the process of helping individuals get connected to service and care. So the LEAD program again we have that in Hartford and New Haven. There is also another program call the HOPE Program in Manchester. It is a similar model so it is a model where individuals who if they come in contact with law enforcement or if they go to a police department in that area and
need help the law enforcement will help them get connected to services and so forth. So I think this is something that we are seeing that’s taking root here in Connecticut and really across the country we are seeing more of these models popping up across the country.

REP. STEINBERG (136TH): I have a lot of new information I just picked up over the weekend so I’m dangerous at this point [Laughter]. Are you familiar with the project ECHO Telemonitoring Program, we are trying to increase capacity and get more access to MAT? Is this something we’ve looked at?

COMM. RITTMAN: Yes so we do have an ECHO Program as well and I don’t have that information or data with me but would be happy to sort of talk more with you about that initiative. It is not something.

REP. STEINBERG (136TH): I’ve been monopolizing but I’ll ask one more question, getting back to the Bill that is specific to DMHAS. I want to afford you a little more of an opportunity to talk about progress at Whiting and anything else you would chose to share with us at time.

COMM. RITTMAN: Yeah, thank you for that opportunity. So Whiting as you know is now a separate hospital. One of the things that we did which we felt would be really important would be to separate Whiting from CVH and to essentially put into place a whole new leadership team. So Whiting now has it’s own executive director, medical director, a chief fiscal officer, chief compliance office, it’s own medical director really it’s own leadership team onto itself. We’ve also done a number of trainings with staff around customer
service, around trauma informed care, around reporting, you know the need for mandatory reporting if they see anything. We’ve also hired a number of trainers again who do that training and we have individuals who come on site and there are a series of subcommittees so we have a subcommittee on, we have on enhancing customer service, we have another on improving and enhancing the organizational climate there. We have one on safety and so those are committees that anyone throughout Whiting can participate in those. So leadership is a part of that but also staff, it’s an opportunity for people throughout the organization to participate in the change process. We’ve also increased surveillance so we have video cameras all over campus at Whiting but then around the campus more broadly and we have a security service that views that video in real time so that’s been an additional enhancement.

REP. STEINBERG (136TH): Sorry to interrupt on that, do you have a specific protocol with regard to monitoring video and response protocol?

COMM. RITTMAN: Yeah, absolutely. So the video is viewed with real time by security service that we have there on-site but then if there is, we also have periodic reviews of the video regularly by leadership on-site. So the nursing director views the video if there is a question about a person either not paying attention or falling asleep, there is opportunities to review the video then as well. And actually we put out a video policy recently around retrospective review of the video because we do at times get requests for video review by individuals outside of Whiting as well.
REP. STEINBERG (136TH): I would submit that having videos is only the beginning, it’s the use of the video respecting privacy but also to, at the very least, serve as a service improvement tool to make sure that everybody is looking after the best interest of the residents.

COMM. RITTMAN: That’s right and we’ve had increased managerial presence on site. I think that’s another important part of the change process there, so managers on all shifts that are there to help with the milieu, to help with any issues that come up and I think that is another important change that we’ve seen.

REP. STEINBERG (136TH): Just before I hand off, could you comment on staffing levels?

COMM. RITTMAN: Yes so the staffing levels, so that’s something we have been continually working on as well. We are in compliance with the various staffing regulations in terms of required staffing. We often staff, it’s fluid, we staff according to acuity so if there are increased numbers of individuals or people that are referred to us or the units are getting close to capacity then we will increase staffing to be able to staff appropriately or if there are individuals that are particularly struggling we will increase staffing to be able, for example, be able to two-to-ones, or one-to-ones if we need to do that. It is a diverse mix of staff so we have physicians, nurses, FTS’s those are called forensic treatment specialists, we have rehab staff so it’s an interdisciplinary staffing complement that we have at all times on the unit.

REP. STEINBERG (136TH): So I also heard there are occasions where you have challenging episodes where
you have to do at least two-on-ones and maybe more. You also have a protocol in place what that means in terms of supervision and availability of staff at those times?

COMM. RITTMAN: Yes, so if we have to increase the number of two-to-ones, and individual is having situations were it warrants two-to-one or even a one-to-one we will bring in additional staff if necessary to be able to have the individual be able to be at a two-to-one but then also be able to appropriately staffed throughout the rest of the unit. So we do have processes and procedures in place for that as well.

REP. STEINBERG (136TH): Thank you, Commissioner. I’m sure we will have more conversation on this subject. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Commissioner for your testimony. I wanted to clarify something as I think you touched on this. You said that you may not have enough resources for opioid antagonist to be available at various campuses.

COMM. RITTMAN: Yes, so we do, so at campuses all across the state. So we do provide Narcan to hospitals, to Department of Public Health, Department of Corrections and so for us to be able to provide this Narcan across the entire campus system would be beyond our current capacity. But I think there is a role that we can still play there. We can offer training around the administration of Narcan. Narcan is also available if individuals have insurance so there is potential saporosity or an avenue for college campuses to be able for
individuals on college campuses to be able to access Narcan.

SENATOR ANWAR (3RD): So in the last few years we obviously have seen an expeditious increase in mental health issues which are manifesting in the form of various ways one of them being opioid use and subsequent complications from that. So we discussed that earlier and the long-term and the short-term implications that we are dealing with right now. In the past may years for a variety of reasons because of the resources, the number of inpatient beds, outpatient facilities we have been scaling back at least in the past in this state to some degree but with the new realities what can the legislature do to help your department address the disasters we are dealing with because you are not necessarily prepared and that you are the frontline in many respects. What can we do to help you? Besides getting Bills to make you do more things [Laughter] to get you your resources

COMM. RITTMAN: Well I mean, Connecticut has been the leader in terms of the Bills that have been passed and so I think that is something that as a state we can certainly be proud of. Those Bills have made a difference. You know in terms of what additional can be done, I mean, the Bill, the opioid Bill that is before you today I think that has a number of important pieces that are included in that, certainly Mental Health First Aid we know can make a difference, helping people be able to identify some of the early signs and symptoms of mental health issue for many individuals there is a connection and so I think, you know, that certainly is much of what’s in this Bill we support and I think would be value add.
SENATOR ANWAR (3RD): Let me ask you from another, you need more resources for the department to address the challenges, is that fair?

COMM. RITTMAN: Certainly we are always open to additional resources that is why we often apply for the federal various opioid response grants. Those resources have been so valuable in terms of our being able to put in place a number of prevention, treatment and recovery interventions that we believe are making a difference.

SENATOR ANWAR (3RD): I think, again this is just my understanding, is that with this epidemic we are looking at your department would need far more resources because whether there is training, whether there is opportunities for prescribing or providing medication that can actually save lives in immediate time or it is helping oversee the training programs and also maybe facilities so that is what we will need. And I know when the times when everybody wants to minimize the resources and wants to make the government smaller and much, much, much more smaller as we plan to do some of those things, I think this is an area where we are in an epidemic situation and this would be the responsible thing would be to actually empower the Department to be able to take care of this disaster. That’ at least how I am seeing it. So thank you for your testimony again.

COMM. RITTMAN: Thank you.

REP. STEINBERG (136TH): Thank you, Senator. Are there any comments or questions? Pretty quiet today. Commissioner, thank you for your testimony. As I mentioned earlier we’ll be taking more in the coming days. Thank you again. We return to the
members of the public and Senate Bill 1058 next is Ernestine Halloway. Reverend? Okay? I’m sorry, maybe later then? We will next go to Peter O’Sullivan.

PETER O’SULLIVAN: Good morning Senators and Representatives. Thank you for this opportunity. I’m Peter O’Sullivan. I am the owner and operator of the Beauty Mark Tattooing now celebrating our 40th year working in Connecticut. I am also a member of the Connecticut Association of Professional Tattooers. I am here to support Raised Bill 1058 support with exceptions for statewide guidelines in public safety regulations in the interest of our industry and the proliferation of our business.

The tattoo industry has been ahead of the curve in regard to regulating itself in health and safety practices. It is important for future cooperation between our industry and the Department of Public Health to enforce practical universal safety guidelines and practices to avoid legislation against antiquated practices and to avoid feel-good, sound-good impractical rules or laws that put unnecessary burden on our industry. Cooperation between the industry and that state will ensure the public remains safe. Thank you.

REP. STEINBERG (136TH): Thank you for your testimony. And thank you for pointing out your reservations as well. Well will try to get the Bill in good shape. Are there comments or questions? If not, thank you for your testimony. Returning to officials, we have Dr. Gill the Chief Medical Examiner.

DR. GILL: Good afternoon. I appreciate the opportunity to submit testimony on AN ACT CONCERNING
OPIOID USE DISORDER. We support this legislation and this testimony will help define the opioid and explain how this legislation will help further our understanding of the crisis. The Connecticut Medical Examiners Office is a single, centralized, state-wide medical examiner system that investigates, to some extent, approximately 22,000 of the approximately 30,000 deaths that occur each year in Connecticut. By statute, all suspected drug intoxication deaths must be reported to the Medical Examiner’s Office. Following a review of medical records with detailed forensic toxicological testing, we determine the cause of death and issue a death certificate.

Death certificates are public health surveillance tools that identify and track specific causes and manners of death. Assessing the status of the current opioid crisis largely relies upon death certificate data and is an example of how it can be used to inform the public health. Multiple previous speakers mentioned our work. There is no more categorical datum point than death unfortunately, and death certificates disclose how the opioid crisis is changing, what new drugs are involved, and the effectiveness of new programs aimed to halt it. The number of people who overdose and survive is difficult to know because they may present to a variety of medical personnel across the State. This Bill allows for better tracking of non-fatal overdoses by having medical personnel report them all to one State agency, the Department of Public Health.

In the last two years, the Medical Examiners Office has investigated and certified over 2,000 people who died from drug intoxications. More Connecticut
residents are dying from accidental drug intoxications than the combined total of all homicides, suicides, and motor vehicle collision fatalities in this state. The number of accidental drug intoxication deaths has nearly tripled in the past six years. Our death certificate data is available on websites of the Medical Examiner’s Office and the Connecticut Criminal Justice Policy and Planning Division of the Office of Policy and Management which actually presented graphically and by drug use and age. This data demonstrates that accidental intoxication deaths spare no ethnic, sex, or geographic group that they broadly span ages from late teens to the mid-70s.

Analysis of death certificate data can show how the opioid crisis is changing, is it improving or worsening, what drugs are involved, fentanyl vs. oxycodone vs. heroin. In Connecticut, there has been a dramatic increase in illicit fentanyl use. This is largely due to increased drug prevalence illicit fentanyl and a variety of analogues which are made in clandestine labs are available as well as the potency of these fentanyl drugs which have caused fentanyl to surpass heroin as the most common drug detected in acute intoxication deaths in Connecticut now involved in 75 percent of intoxication deaths. The number of accidental drug intoxication deaths in 2018 was similar to that of 2017 which may represent a plateau. Is this leveling off because we are saving more people and/or because the number of overdoses and therefore the number of people with active opioid use disorder is decreasing? The DPH overdose data collection system which is proposed in this bill will help us to answer that question. I’m available for any questions from the Committee.
REP. STEINBERG (136TH): Well, Doctor thank you for your testimony here today. Let’s start talkin a little bit about the data you described which is very valuable to us. I want to get into that a bit more. You describe perhaps the shift to heroin and fentanyl but also with regard to the potency of the product on the street if you will. Are you also seeing as we saw in New Haven sometime ago other contaminate and things like that also showing up on the blood panel that would indicate that there are other things going on or just the potency?

DR. GILL: We are able to detect a variety of the fentanyl analogs. The issue in New Haven with over 80 or so people that overdosed on the “Green.” That involved a synthetic carbenoid which is something that we are able to test for but it is something that rarely causes death by itself. None of those people actually died in New Haven fortunately. But we do have the ability to test for a broad scope of drugs of abuse.

REP. STEINBERG (136TH): I have to, you saw me shanghai Commissioner Pino so I am going to do the same thing to you. Your office has come up frequently with regard to a couple of other Bills that have been before this Committee and I can’t resist the opportunity to get into that as well. We had on Bill that sought to have your office help us understand deaths that were related to epileptic seizures and the like because we are looking for frankly for the lack of a better term, a convenient way to capture that data. Could you comment on that?

DR. GILL: Sure, we capture that data right now. It is available for any researcher that wants to
contact our office and we can give them a list of every death, every cause of death that is related to a seizure or an epilepsy. We deal with a variety of research from academic groups around the state and provide them with that information already. My concern with that Bill is that it does put a burden on us then to share this information with a nonpublic group and I’m afraid of the slippery slope that may happen that am I gonna get other, are there gonna be other Bills from other, an Alzheimer group, a dementia group that’s gonna ask for the same thing and right now the material’s available bit the onus is on me. The researcher to contact us that’s all we ask, give us a call and we can give them that information tomorrow.

REP. STEINBERG (136TH): Thank you that sounds like a pretty straightforward approach to things. One last question, I’m really going off the reservation. We had a Bill regarding aid in dying and the death certificate has become a significant issue and we understand that some states that have looked at Aid in Dying that maybe somewhat different polices with regard to their hierarchy of indicators on the death certificate. Could you just describe the current state of affairs in the State of Connecticut in terms of how you, the level of detail you provide on death certificates.

DR. GILL: So on a death certificate it has the place, the medical examiner death certificate has a place for the cause of death and the manner of death. So the cause of death is the disease or injury responsible for the death. The manner of death as to do with the circumstances and it’s either homicide, accident, suicide or natural. Only a medical examiner in the state can certify a
natural death. The hospital death certificates don’t even have a place for the manner of death cause they can only be certifying natural deaths. So the issue for us, and I’ve seen in other jurisdictions like Oregon for example, those deaths wouldn’t even get reported to the medical examiner’s office, if they do then it puts is in a compromised position and how do we, you know, by law we have to certify them as suicides. I think in, for example in Oregon, I believe the manner isn’t put on a death certificate.

REP. STEINBERG (136TH): A thorny issue for us that we’re wrestling with right now. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you for your testimony. Can I ask you about this increased use of synthetic analogs and being able to identify them on labs. Are you guys having difficulties finding them?

DR. GILL: Rarely. We have a very good lab that does the testing for us and they are actually there in kind of the forefront in investigating and identifying some of these. Every now and then there has been an instance where we’ve had a death at the scene that looks like a clear opioid type drug death and we can’t identify the specific drug. So in those instances what we can do if we can recover the drug packet from the scene, the state lab will test that for us and it’s much easier to detect the drug from a drug packet than in blood. So they have been very helpful for us in identifying some of these more unusual newer analogs that haven’t really come online yet.

SENATOR ANWAR (3RD): I think we are seeing a trend where the newer analogs that are in the market there
that they are not showing up in the usual test of the classic presentation of opioid overdose and the tests come out negative and this is the new challenge we are dealing with. So there are very few specialty labs that can actually figure that out.

DR. GILL: I think one of the issues that comes up for us to that hospitals don’t included fentanyl in their year end routine drug screens so if you have a person in the ICU and the tox is negative but it looks like it’s an opioid death it’s probably fentanyl, so you don’t know that. So I think getting hospital more being able to do some of that testing, at least that screening testing maybe helpful in some of those people who survive. Imagine notifying them before they are discharge, you know, you overdosed on fentanyl, it wasn’t heroin. Maybe that risk reduction may help in some of that.

SENATOR ANWAR (3RD): Okay, thank you so much.

REP. STEINBERG (136TH): Other questions or comments? If not, thank you for taking the time, Doctor today. I appreciate it. Returning to members of the public, is Reverend Holloway here yet? No, then we’ll go onto Rachel Barbieri.

RACHEL BARBIERI: Good afternoon. Thank you for giving us the opportunity to speak on this today. My name is Rachel Barbieri and I am here in support of Raised Bill 1058. I am a member of Connecticut Association of Professional Tattooers and I’ve been tattooing for about five years. The most important reason why I support the involvement of caps is because tattooing keeps becoming more and more popular. Some of you may even tattoos.
The popularity of tattooing keeps rising yet the awareness of safety while being exposed to blood, sharp objects and possible infection remains very low. There are more than 650 licensed tattoo artists in Connecticut and that number continues to increase. That number is easily multiplied by 20 or more when you are counting each client that is affected by tattooing and now tattoo artists have been regulating themselves for, since the beginning. They know what works and what doesn’t and that is because they practice these things every single day. I have only been tattooing for five years but I can continue to learn from someone who has been tattooing for 20 plus years and I think having input from all skill levels could really benefit the Health Department with inspections and new regulations. I am open for any questions if you guys want to hear my opinion on anything, but.

REP. STEINBERG (136TH): Well thank you for your testimony. I think you are right the prevalence of tattooing seems to be on the increase and we need all the safety measures we can so those who are really doing a good job are not tarnished with the same brush as those that are not. Representative Petit followed by Representative Klarides-Ditria.

REP. PETIT (22ND): Thank you, Mr. Chairman. I may be stealing Representative Klarides-Ditria’s question. There was a comment earlier about supervision, so you are five years and what do you think is an appropriate number for someone to be taught or supervised?

RACHEL BARBIERI: Do you mean how many years should someone have before teaching?
REP. PETIT (22ND): No, if you’re gonna start training new people in the field should you be able to supervise one person, or five or 20 or 50 what do you think is an appropriate number?

RACHEL BARBIERI: I believe the one-to-one ratio would be the most effective because then you can have, you know, the attention that you need. I mean like I said, you are working with blood and you don’t know these people. You’re working with the same tools that you’ve used on someone else and you have to know how to clean them properly, you have to know how to, you know, not cross-contaminate while you are setting up your stating and things like that. I think that is extremely important to know every tiny detail about that before you start working and I think the one-to-one ratio would be the most effective.

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

REP. STEINBERG (136TH): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Through you, Mr. Chair. And to go off what Representative Petit said, someone else that testified on the tattoo bill they said that they don’t want it to be, you know, you could supervise 30 people cause right now as it is written in the Bill it is one person can supervise no more that two. So do you think that’s okay, just two people supervising or do you really want it to be one-to-one.

RACHEL BARBIERI: Personally I think two would be okay, but no more than two. I do know that a lot of other tattoo artists would disagree. We have
discussed this before in a few of our meetings and a lot of people do want it to be one-to-one but personally I think no more than two would be okay.

REP. Klarides-Ditria (105TH): Okay, all right. Well thank you for your testimony and thank you for your art work as I do have a tattoo. {Laughter] Thank you, Mr. Chair.

REP. Steinberg (136TH): Thank you, Representative. Are there any other comments or questions? If not, thank you for taking the time today, we appreciate it. Returning to agencies/elected officials, Representative Hall.

REP. Hall (7TH): Good afternoon, Chairman Steinberg, Senator Abrams, Ranking Members Petit and Senator Somers I am here to testify today but I am going to defer to my two Chiefs of Police, Retired Chief Sferrazza and our actual Chief for Enfield, Chief Fox, he used to be Colonel Fox for the State Police so some of you may recognize him here today. So we are here actually to testify on Senate Bill 1057 which is the opioid Bill you have but we will be talking about the Bill that was submitted for the opioid custody Bill, there were many of them you saw I know. My Bill is 5895 which is very specific to opioid overdoses. So what I’d like to do turn over the mike to Chief Fox and then Chief Sferrazza with your indulgence.

Chief Fox: Good afternoon Ladies and Gentlemen. Thank you for the opportunity to join you today. As you heard a moment ago my name is Alaric Fox. I have the very great pleasure to serve as the Chief of Police for the Enfield Police Department. I’ve been in that position for approximately one year
after finishing a 24-year career with the Connecticut State Police.

I realize that there are multitude of large big picture opioid issues for your consideration. I would draw your attention to one issue in particular that seems to be confounding my community and I suspect the entire state at large. We are seeing repeated instances where an individual opioid overdoses and we are able to successfully use Narcan or some other antagonist to revive that individual. I like you to envision if you will that this person was on the cusp of death and through the good work of fire department, EMS and law enforcement personnel that person was brought back. At this point as we interact with any individual we beg, request and cajole them to go for medical care and sometimes they say, “Yes” and sometimes they say, “No.” And when they say no, and I don’t mean to describe this in a way that sounds smart-alecky, I’m speaking only for dramatic effect, at that point when they say no, we say, “Best of luck” because that is the extent of what our law allows at present.

I believe we have identified for you what I might politely describe as a hiccup in the protective custody statute. An individual who is intoxicated by alcohol we are able to bring for emergency room medical care, an individual who is unable to care for themselves from a psychiatric point of view we are able to bring in for emergency room medical care, and individual who overdoses, who is saved, who thereafter says, “I’m good, I don’t need any further care,” is not covered within the confines of our statute. In Enfield alone I would estimate for you that we are seeing probably an opioid overdose
death per month and I would estimate that we are likely seeing about one Narcan save per week and I don’t know if that later statistic makes me very proud of the men and women of Enfield EMS or it concerns me greatly that we have one save per week. This is a short-coming in our law as it exists. I certainly don’t think it is malicious. I suspect that the law has just not caught up with the current times and we would urge you to consider the ability of law enforcement to take such individuals and route them for appropriate medical care. Thank you.

REP. STEINBERG (136TH): Thank you. Do you want to come as well?

CHIEF SFERRAZZA: Good morning. Thank you for giving me the opportunity to speak in support of this Bill. I don’t have too much to add beyond what Chief Fox has said is spot on. Up until last year I spent 40 years in law enforcement and the last 12 years of my career as Police Chief of Enfield. And I think Chief Fox would agree there is nothing that was more troubling the last few years of my career than to get these phone calls in the middle of the night that we have an overdose death and I always thought right away how that is going to impact that individual’s mom, dad, brother, sister, whatever and they were coming two and three a week at one point. The protective custody statute that we have, we’ve had it for decades was limiting us to just taking action when a person had eminent intentions of harming themselves or ideology of harming others. They weren’t arrested. They were brought to a medical facility, the doctor would evaluate ‘em. This Bill doesn’t broaden that part of it. All it says is if you overdose and you are lucky enough where someone found you in time when our first
responders revive you, you need to get to a hospital, a doctor needs to evaluate you. It isn’t forever. I think the Bill says that it is 72 hours and that 72 hours gives that individual the opportunity to be examined by the doctor to see what treatment they need going forward and also for the family. They now have a couple of days to decide, you know, what kind of placement options are available. If this Bill wouldn’t pass, I can tell you there’s nothing more heartbreaking than an office to make a save only to be back to that house a week later or two weeks later at this time nothing is going to bring that person back. So I would urge you to pass this Bill. I think it is extremely important and I don’t know you quantify how many lives you save but I’m telling you from my perspective even if it’s one, it’s a Bill worth passing. Thank you.

REP. STEINBERG (136TH): Thank you, Chief, Former Chief, Representative for taking the time to join us to today. You’ve obviously are aware of those who are concerned about the coercive aspects of this, the right to privacy forcing somebody to go to the ED who claims that they are now all right is something we’ve struggled with. Yet we certainly appreciate the opportunity presented to actually get that person, not only evaluation but on a path to recovery as well. So how do you respond to those who say that’s too limited?

CHEF FOX: Sir, thank you and I am grateful for the opportunity to respond to that question. Please realize that while we do not do it at all with regularity, I think I would say at all, when we find individuals in these conditions we are finding them in passion of narcotics, in possession of baggies,
in passion of drug paraphernalia, those behaviors are in violation of Connecticut law. I would offer to you and I want to be clear, we are not doing this but I am just trying to illustrate the paradigm for you, the current state of the law would allow us to arrest any individual, to lodge criminal charges against that individual under those circumstance. Now footnoting for you again that we don’t do that because it seems, it does not seem to be the appropriate step to take, what we are really asking for is the lesser step. We have the ability now to charge an individual criminally under these circumstances, we have the ability to subject them to a more invasive process, what we are asking for is the less invasive option because as it stands right now, short of arresting them, which we do not do under those circumstance, we are simply leaving them to overdose again and there have been instances in both my state police career and I’ve seen in Enfield where we are back to treat that person in the same week and some cases twice that I can recall we treated people in the same night. They overdosed, they got saved, they overdosed again. We recognized the concerns that maybe brought in your direction from a civil liberties point of view but I would offer to you that we are asking for less than with this Bill than what the current law allows us to do.

REP. STEINBERG (136TH): Thank you for that clarification. That is what I was going for to a large degree. So much of what we are talking about now with the opioid epidemic and behavioral health with integration and the importance of bringing law enforcement into that integrated picture what you are really describing is not dealing with the
individual from exclusively a law enforcement perspective but putting on the path to kind of get the quality professional medical treatment that they need to perhaps really address the problem, that is the point I wanted to make sure was made. Thank you for being very clear on that point. Representative Klarides-Ditria, followed by Senator Anwar followed by Senator Somers.

REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you, Representative Hall. Thank you Retired Chief and Current Chief for your testimony. I think as a wife of a detective I see firsthand every day, not see but hear the stories every day of what the opioid epidemic is doing. So I do feel this is important legislation to address because we need to help the people that need the help the most and that is your job as, you know first responders and I thank you for everything you both have done and are doing every day and your continued work on the school safety commission. Thank you. Thank you, Representative Hall.


SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Representative and Chiefs. From medical perspective alone the half-life of fentanyl or some of the other medicines are much longer than that of Narcan. So if somebody takes an overdose and you give them Narcan within a matter of less than an hour that is gonna be gone and the initial overdose itself could land them into respiratory failure, that is the prominent cause of death. There is a strong medical argument to actually take them to the emergency room right there even if they are awake because they are probably not competent to make a
decision at that time. But at the same time do recognize the fact that we should give you some legislative protection but a strong argument medically can be made that the individual that is under the influence of substance they cannot make the right judgement and they may have to be brought to the emergency room especially because there is impending respiratory failure as soon as the Narcan is gone from the system. So you have that option available but we should help you out as well. So very good point that you made, thank you so much.

CHIEF FOX: If I may? I thank you and I certainly defer to what I perceived to be a much more advanced degree of medical knowledge than I have or I will ever have. I have had that discussion within the Connecticut Chiefs of Police Association and while I do not speak for them as I sit here today, I can tell you that unofficially or perhaps anecdotally I have heard some chiefs that take that position and have instructed their officers to that effect. I can tell you that there are others and I am one of them that would appreciate any statutory guidance that you could give us to address what appears to be this confluence of medical knowledge but an apparent shortcoming in the statutes.

SENATOR ANWAR (3RD): I agreed with you. Thank you so much.

REP. STEINBERG (136TH): Thank you, Senator.

Senator Somers.

SENATOR SOMERS (18TH): Yes, good morning or afternoon and thank you for being here. I have spoken to many of my police chiefs and they are in agreement that this is something that has to be addressed and a few years ago when we passed our
first opioid legislation one of the things that the Public Health Committee was looking at was how do we have an ability to maybe hold someone in the hospital if they are in there for the fifth time being Narcaned and a very close family friend of mine worked in the ER and had told me stories about the same individual coming in. One evening he was in there four times and angry that each time he had been Narcaned and what was brought to my attention and my husband is also a clinician is, and please correct me from a law enforcement perspective, if you were sent to a call and someone had attempted to hang themselves from a tree, but they were not successful and you were able to cut them down would you then believe them when they said, “Oh, I’m okay now, I’m just gonna go home?”

CHIEF FOX: No, we would not and that of course is the irony of this situation. If there were a universal acceptance that an individual who has overdosed, who at the moment they have been saved, it not able to care for themselves and they are suffering from a psychiatric disability, and I supposed an argument can be made to that effect similar to the attempted suicide that I could certainly go with the statute as it exists now. But once again the practice is that the attempted suicide differs from the person who has been opioid saved who at that point says I decline any further medical care and I think that is the practice because frankly the discomfort with the minimal language of the statute as it currently exists.

SENATOR SOMERS (18TH): Right, I believe the statute speaks a risk to yourself or a risk to others. So I would argue that you are definitely a risk to yourself if you are taking a drug that so in essence
it could kill you if you were not saved by Narcan and that is something that clinicians that I talk to and see everyday are also looking for, some more coverage to be able to hold an individual for 72 hours because as many of them have spoken to me about, if you are just taking heroin and just overdosing maybe mixed with fentanyl or something else, then you are Narcaned, you’re not really in a true frame of mind to be having a conversation about getting the help that you need and they too are asking for the 72 hour hold time where then you can have a more rational conversation perhaps. So I just wanted to bring that, or as you that because I’ve been asked that by mothers saying, geez, you know, if someone attempted something on their life and they were saved the physician has an ability to hold them or the police officer would have an ability to get them the help they need, its ironic that somebody who may have been Narcaned five times would have an ability to just walk away and go home. So I just wanted to see if that’s something and make sure it’s on the record if you found somebody who was in a state, but I don’t know, tried to take their life in some way but they’re not successful and you would not just let them go home.

CHIEF FOX: Correct. The suicide example is the perfect example both for something where we would not let them go home and illustrate the apparent dichotomy that I think exists under the current law.

SENATOR SOMERS (18TH): So perhaps we could look at using language that would say, if you have overdosed and you have been Narcaned you are now considered a risk to yourself and that would fall under that category. We can talk about that.
CHIEF FOX: I think that gets us there as well, yes.

SENATOR SOMERS (18TH): Thank you for being here.

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

REP. PETIT (22ND): Thank you, Mr. Chair. Thank you for your testimony. Just a detailed follow up question from a number of emails I’ve received from people throughout the State that have to do with the, I guess the EMS or police’s responsibility if you find someone in a certain site, give them Narcan or revive them and you deem it to be an area, if you will, where people typically purchase drugs, use drugs, etc. and they don’t want to be transported to a hospital do you typically, would you leave them there or would you transport them to their home or is it completely up to the individual to make a decision as to where they go or don’t go at that point?

CHIEF FOX: I think it is fair to say that we would offer whatever the maximum amount of assistance is that the individual had requested and as I referenced earlier there is a certain degree of cajoling is the word that come to my mind to try to get the person to recognize that they came about as close as they could, can we take you to the emergency department, if they decline that but they want a ride home, rather than stay where they are we would certainly provide them with whatever assistance we could.

REP. PETIT (22ND): But if they wanted to, they could remain wherever the geographic situation they were in they could remain right there?
CHIEF FOX: I’m embarrassed to tell you I think the answer to that is yes.

REP. PETIT (22ND): Thank you. Thank you for that information.

CHIEF FOX: Yes, sir.

REP. STEINBERG (136TH): Okay, sorry I was getting. Representative you had a comment.

REP. HALL (7TH): Just a really quick note, so this Bill I submitted this term is very different from the one I submitted two years ago. I was in front of Judich two years ago. It was a much, I guess, much harsher Bill same intent to try to get these folks help that they needed. What we did was we looked at the very least, if you will, and I think the good Chief talked about the least harm we could do. The biggest, this came about to me personally two years ago when I was approached by our local police saying that they were begged by families to take these people into custody for their own protection and were told that that couldn’t happen because of the way the statute is written now. So this new submission that I know has been submitted by many of my colleagues as well in a different form is a much softer version and I think it definitely addresses the family’s concerns and the family’s requests to get their family members the help that they truly, truly want. So I appreciate your indulgence with the extra time today, I really do and thank you for hearing us.

REP. STEINBERG (136TH): Well thank you, Representative for bringing this forward and for bringing the Chiefs with you today. Obviously you are on the frontlines of this problem and it’s to
your point I believe a save a week is something to be proud of, every life saved ideally we can avoid even more and get to the root causes rather than just deal with the often times symptoms of an underlying problem. So thank you all. Appreciate it. We will move on to members of the public Jim Talmadge.

JIM TALMADGE: Hell, thanks for meeting with me today. My name is James Talmadge. I am a lifelong Connecticut resident, and have been a tattoo artist in this state for thirteen years. I am also the current Vice Chairman of the Connecticut Association of Professional Tattooers, Inc. I am here in support of Bill 1058.

Our goals as an association have been unwavering since our inception, Representing Professional Tattoo Artists by ensuring that regulations reflect the current standards, and educating the public about tattoo safety.

Our clients are a diverse range of everyday people from nurses to police officers, teachers to college students, even State Representatives. We have transitioned from the fringes and now we are in the mainstream. We need to be taken seriously. Infection due to receiving a tattoo has been effectively eliminated by tattoo artists themselves preventing this from becoming an epidemic unto itself. We want our board of professionals to be acknowledged as just that, a board of professionals.

In conjunction the DPH we are the authority on safe tattooing. The necessity for our organization is due to the rapid growth and change of our industry. As provision for the future, we need regular
communication between tattoo artists and the Department of Public Health.

Our association is open to all tattoo artists licensed in Connecticut who work in legitimate tattoo establishments. We have created a consensus of the professional values of those who care to embrace a higher standard of safety. Our members have various levels of experience, those with less experience now are the future of tattooing. Being involved with forming of regulations and understanding the need for and intent of those regulations continues our tradition of respect and commitment to integrity. Thank you.

SENATOR ABRAMS (13TH): Thank you for your testimony. Any other questions or comments from members of the Committee? Thank you very much. Victoria Veltri. Welcome.

VICTORIA VELTRI: Hello Thank you. Good afternoon Senator Abrams, Members of the Public Health Committee. I’m Vickie Veltri. I am the Executive Director of the Office of Health Strategy here today to talk a bit about Senate Bill 859 which is the ACT CONCERNING COMMUNITY HEALTH WORKERS. I brought Tekisha Everette up here with me from Health Equities Solutions, could have brought a bunch of people here who have been working diligently on this work for years but decided that Tekisha was coming up with me. I am just going to talk very briefly cause you do have the testimony. I want to give you a little bit of background.

The work that has led to the Bill today has been several years in the making, even more than that I would say. There has been a lot of workin going on in Connecticut as there is in other states trying to
establish community health workers as part of the primary care strategy across the State of Connecticut to engage people in their healthcare and to pay deep attention to the very significant health and equities we do have in the State of Connecticut.

We’ve been working along side community health workers themselves who have been working for years on this issue but a couple of years ago this Committee passed some legislation on that went to the floor and passed creating a statutory definition of community health workers and that Bill also charged the state innovation model which is now underneath the Office of Health Strategies with coming back with recommendations on certifications for community health workers. In that time frame since you passed that original statute, there has been a ton of work going on by Community Health Worker Advisory Committee that is sort of facilitated by the Office of Health Strategies and they came up with a report that we sent to you back in late September with recommendations on certification. On that committee were community health workers, the Department of Public Health was represented as was DSS and some provider, specifically ProHealth physicians, I think that a couple of other physician practices to come up with what we thought was a consensus set of recommendations for you. So that is what is in front of you today is the Bill on that. We are working on language at this moment, still with DPH to modify the language that is currently before you so that we can get consensus among all parties and bring it back to you. I think we are very close on that. But with that I just wanted have Tekisha say a few words because she’s been very deep in the
weeds on this and specifically sort of helping the Office of Health Strategy really incorporate health equity into every single bit of the work we do as an office, but I’m going to let her talk about the CHW part today.

TEKISHA EVERETTE: Thank you so much and good afternoon, Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee. You do have my testimony in front of you so I don’t want to review and read that. I would love to field any questions you may have.

But beforehand I just want to start by saying Health Equity Solutions has a commitment to advancing health equity on a state level in Connecticut. We are committed to working in every way possible to eradicate the health disparities that are experienced in this State by racial and ethnic minorities in this State and we believe community health workers are essential to dealing with those issues.

When we tend to think about health and wellbeing as a nation we often talk about the physical and clinical aspects of medicine rather than the things that are underlying, those social determinants of health if you will, better the underlying factors that really have a key effect on health and healthcare outcomes.

We believe community health workers are an essential step to advancing health equity and getting people to their best health and their optimal wellbeing in our State. So I would love to have many community health workers are here today, you will hear from them themselves about the importance of this Bill but any questions that you may have that I can help
in understanding the importance of this I welcome that. Thank you.

SENATOR ABRAMS (13TH): Thank you so much for your testimony. I have to say that I am a newly elected legislator and immediately people reached out to me, constituents as well as people who worked in healthcare in the cities that I work for and telling me what great work community health workers do and explaining to me the importance of the role that you play in making sure that people receive the healthcare that they need, so I thank you very much for your work. What would be the one thing that you would want people to know about what your mission is or what you are trying to accomplish as a community health care worker?

TEKISHA EVERETTE: Thank you for the question. So I want to start by saying I personally am not a community health care worker except in the fact that many of the community health care worker I work with often explain how the fact that I navigate the healthcare responsibilities of my 75-year-old aunt and my 55-year-old cousin who is on disability that I make all of their medical decisions in concert with them but often have to translate for them the information that they get from their doctors. They all tell me I am a community health care worker but it is not my day job. [Laughter] So I want to start by saying that. But in offering that I think the key thing I would like to say is the most important piece that I would add community health care worker often understand both the individual needs and community needs that a person is living in. So I often talk about my asthma as a kid and how when we had difficulty diagnosing my asthma, if we had a community health care worker who ever came to our
home they would have immediately been able to tell the doctor. I was living with smokers. I was living in an apartment that smoke coming in because of the smokers next door but there was mold in the bathroom and these were all contributing factors to my asthma and why we were having difficulty getting it under control. I didn’t have that. So they’re really important aspect of personally of things that are going on in the home, in the personal community and community health care worker are able to help individuals navigate. Understanding how to translate what physicians are saying and what social services are available to get to your best health are critically important and there are a number of examples but I think other will provide and speak to those today.

REP. STEINBERG (136TH): I can’t help but see the connections in this conversation with the conversations we had earlier with regard to mental health and the opioid epidemic. Integration seems to be the word of the day and for good reason and community health care workers are in the place to actually as you point out record the social determinants which may have a large impact along the continuum of treating things like opioids, health and wellbeing is the first step to focus in on before somebody progresses further down the past where interventions are required. I did speak to Vicki about something I was not familiar with the use of Z-codes and other ways for us to get good data and this is all about what OHS is about, getting good data on social determinants. Is this something you think community health workers could help us get good information?
TEKISHA EVERETTE: Thank you for the question. I do believe one, as an organization we wholeheartedly support the use of Z-codes. They are ICD-10 codes that allow for physicians and healthcare providers to note and notate social determinates of health aspects that are affecting their individual patients. One of the things we know as an organization is that they are grossly underutilized and at the present are not often reimbursable so we do know what you pay for, not to say this in a negative way, but what is paid for doctors pay attention to. So we are really looking at the mechanisms and how we can incorporate Z-codes and educate a lot more on the use of them in the utility. The connection I do believe is as we are looking at a lot of where health care is going, when we are talking about value based care and trying to make sure that we are able to efficiently and effectively get people to their best health and navigating the management of their health, I think community health workers are critically important in informing primary care physicians and other about what is happening in communities that can critically make that link.

And I want to just pause and say on the mental health side one of the great visions that I have in terms of when we’re talking about the opioid crisis is thinking about I was watching “20/20” and they were talking about an overdose situation that happened and I wish I could think of the state right now. But who was the first person to really be able to tell then where the bad drugs were coming from were people who were based in the community who could identify the individuals who were distributing and how that drug was getting out. I think that is
a critical role that community health workers can play because they are trusted individuals in the community and they often know where things are going and what’s happening and they can connect that back to the system.

REP. STEINBERG (136TH): All the more reason to pass this legislation. Before I pass it along, the Office of Health Strategy was created to address a lot of the needs for integration across agencies and some of the things I learned over the weekend I should by way of full disclosure, I attended a conference that had to do with mental health and spent a lot of time taking about opioids and suicide and a lot of related factors. Other states do things differently, there are legislative committees, programs, many of them definitely have specific committees that deal with addiction and things of that sort but it is very important for us to find efficiencies and integration across agencies. Perhaps you could comment on how we are doing in addressing specifically the addiction related services across agencies in a more efficient manner since the creation of OHS where you are in that process of having DPH and DMHAS and whatever agencies, I won’t even get into the law enforcement piece which doesn’t fall into you bailiwick, but how are we doing from a sort of a broad state strategy viewpoint talking to the Feds about waiver programs, all those different things that we need to do if we are going to be more effective.

VICKI VELTRI: We are, I think we are doing pretty well. It’s gonna take a little time for us to get to optimal state but I think as far as opioids go, I think there is already a lot of cross-sector collaboration going on between state agencies and
local communities which is why actually CHW is a critical part of that. I think you are going to see because payment mechanisms are changing, the way we pay for healthcare is changing, there is a lot more natural kind of coordination among communities out across the State on everyone of these issues whether it is opioids, behavioral health integration, whether it is primary care that is the natural way things are progressing in the healthcare space that is in part driven by federal changes that are coming that precede the current administration and it is just a natural outgrowth of being accountable for the quality of care of your patient and the health of your patient not just about, you know, what the current reading is on something but the health and wellbeing of them. So I think to start off we’re doing pretty well. What I would like to see us do is coordinate more across all agencies with a sort of help in all policies approach and what I mean by that is looking at each of your initiatives as a state agency but a lens of health and wellbeing and health equity tied into that lens because everything effects our health and how it effects everything and it is really hard to conceive of a situation where somebody can have a good education if they are not healthy or can have a healthy outcome with stable housing. And I will give you a couple specific examples of what we have already embarked on, in fact I’m missing a meeting right now with the Partnership on Strong Communities, we have participated in health and housing stability workgroup and I am actually looking forward to working with our new Housing Commissioner about how we integrate the homeless information management system with the health data under the health information exchange that we’re
looking at for hotspotting and sort of intervening earlier for people who might be at risk for homelessness. So that is one example.

We embarked on a partnership, and I have another meeting in a few minutes, with the Office of Early Childhood where we’re talking about taking in home visitation for example into primary care settings so that instead of homes the patient is sort of being considered its own separate silo that it is considered a part of regular primary care practice so that we can intervene early for mothers or would be mothers on healthcare. So this is a couple of specific examples. We have a meeting coming up with Josh Duvall this week to talk about or next week to talk about integrating the health information exchange data with the overarching strategy around IT for this state and what the intersection of that is and paring data streams. So are just a few of the things in the hopper.

REP. STEINBERG (136TH): Sounds like you are really are workin’ at it.

VICKI VELTRI: Well, we’re trying.

REP. STEINBERG (136TH): But we count on OHS to also give us the broader strategy so that we can make sure we get all the federal dollars that are available then implement the best practices for our State.

VICKI VELTRI: Yes, absolutely and on that score just a little pitch for some of the primary care work we’re doing. Community health workers actually is just a critical part of some of the strategy we’re thinking about in terms of primary care practice. You know, you have a Bill here about what
is happening in primary care, we need to keep physicians here, we need to modernize primary care, we need to make it more attractive for providers, we also need to make it better for people who are going to primary care for patients and one of the ways we can do that is to either look at flexibility for those practices so they can extend their care teams so that the doctor does what the doctor does and an APRN does what the APRN does, independently or not. A nutritionist maybe could be hired, a community health care worker could be part of that primary care practice team so that we can really address the needs of patients beyond just the do’s office where the majority of things that effect health occur and so that we can improve the practice environment for providers and make it more attractive for providers to practice here. In order to do that and/or some of the work we would like to do invest more in our upstream we call prevention activities out in the communities to reduce child, adverse child events, to pay more attention to healthy way in eating so that we can reduce our Medicare expenditures over time, some of that work requires federal dollars. It might require a federal demonstration project so we are working hand-in-glove with the Center for Medicare and Medicaid Innovations, it is part of the CMS on some kind of strategies we can undertake to derive some federal revenue into this state to achieve those ends.

REP. STEINBERG (136TH): Thank you, I encourage you along those lines. Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you for your testimony and I think that the State of Connecticut has health equality challenges. Our numbers are not as good as they could be but this is
going to be the antidote to that. I think if you look at some of the data that is out there and other states that have implemented something similar they have shown excellent results. The return on investment is phenomenal and not only the communities that need the help the most and the social determinant challenges we can move in the right direction. This is not going to be the solution to everything but it will start to move things in the right direction and help us identify areas of opportunity that we can actually implement further to move things further but I think it is going to be comprehensive strategy but this is going to be a very critical piece of that strategy and very excited that I’m here to be able to support this and looking at the date I hope we can show the same results that some other states have shown, so thank you for this.

VICKE VELTRI: Thank you very much and we do too.

REP. STEINBERG (136TH): Other comments or questions? If not, thank you. This will be part of an ongoing dialogue I assure you. Returning to the members of the public we are back to Senate Bill 1058 Amy Javarachias, something like that? Sorry for the mispronunciation.

AMY JAVARACHIAS: Hello, my name is Amy Javarachias. I am a tattoo artist based in East Windsor, Connecticut. I recently finished up my apprenticeship last year and I am here to talk about the Bill 1058.

I was one-on-one with one mentor. I was able to learn from not only him but all the other artists that were at my shop and everything that I had to learn during my apprenticeship was very extensive.
There was a lot to tattooing. I not only learned from my boss and owner but everybody else gave me input based on how they tattoo, what practices they did so I believe that a one-on-one mentorship which as been in the history of tattooing, one-on-one practicing is appropriate for tattooing and I still learn every single day from people in my shop and people around me and from people in the Connecticut Association of Professional Tattooers. I constantly learn about different practices, how people run their shops and health safety codes and everything. I am open to any questions.

REP. STEINBERG (136TH): Thank you for taking the time to share with us your experience particularly being relatively new to the industry and how it has been working well for you. It’s very important for us to hear that people who are entering the business are getting the appropriate mentoring and training so that your exhibiting the right behavior and protecting your clients. Are there other questions or comments? In not, thank you for taking the time to join us today. We appreciate it. Next we have Tracey Rose.

TRACEY ROSE: Hi, thank you for giving me the time to come up here and speak to you about my support for Bill 1058 with exceptions. My name is Tracey Rose. I am a professional tattoo artist in Connecticut. I have been tattooing for 18 years the last nine of those I have owned a studio and I’m also the President of the Connecticut Association of Professional Tattoo Artists.

It is important and effective to create and maintain universal safety guidelines and practices for professional tattooers and in that way Connecticut
Association of Professional Tattooers was actually established when our licensure came up as a point of contact for the State and the Department of Health. What we would like to do is continue to work with the State and the Health Department the DPH to establish universal guideline for tattoo studio health inspection and ensuring that each tattoo establishment is not only inspected but inspected properly. It is critically important to have continued communication between professional tattoo artists and State Department of Public Health and also that the Connecticut Association of Professional Tattooers is utilized as a point of contact for our combined knowledge in regard to any changes and amendments to our licensure which is why we are here today so I thank you again.

To speak a little bit about why it is important to have the mentor-mentee relationship and the ratio, which was brought up as a question before, the individual mentorship assures that clarity of training and clear understanding by the mentee. I have an apprentice right now, the first time I’ve had one in my professional career, so in looking at the guidelines from the state licensure of 2,000 hours if we were to boil that down to weekly it would be fulltime 38 hours a week roughly and roughly 19 hours part-time. My apprentice is typically there for about 19 hours. So in the question between a one-on-one and two-on-one, I think what we’ve discussed is that considering most people doing apprenticeships are working fulltime jobs as well. They can usually only dedicate about a part-time amount of hours which would then make it, I guess, having two apprentices or two tattoo technicians per one mentor in that cause would boil
out okay. However I do think that a one-on-one is very important. One of the reasons that this was brought to our attention is because in New Haven there was actually a tattoo school put in place and what they do is they pump out as many apprentices and as many artists as they can. They have upwards of 20 apprentices at a time with one to two possibly three mentors and none of these people have been tattooing for very long. So having the five year minimum for mentor is important and I feel that is a minimum requirement because what you know in five years, honesty I’ve been tattooing 18 and I took my first apprentice.

SENATOR ABRAMS (13TH): You time is up so if you could summarize.

TRACEY ROSE: I’m sorry. So I would just like to say that I am in support of the Bill with those exception of changes and I am here to take any questions if you have any.

SENATOR ABRAMS (13TH): Thank you for your testimony. I think you bring up a good point if you are taking two people part-time that would equal out to the one person really. Any questions or comments from the Committee? Thank you very much for your testimony. Michele Stochlinski.

MICHELE STOCHLINSKI: Hi. Thank you for your time. My name is Michele Stochlinski. I’ve been tattooing for 22 years. I’m from Middletown and I wanted to talk quickly about, obviously I’m in support of this Bill.

But tattooing is here to stay. Recently had a ban lifted in my town, Middletown, which is fantastic and basically. Sorry, I’m a horrible speaker,
[Laughter] but I just want to talk about how important it us for us to work together. In all of my 22 years of tattooing it has changed a lot. I did take a few years off when I had my children, during that time is when our licensure happened. Prior to that, on my own terms, I’ve been taking bloodborne pathogen classes in the 90’s even before it was a regulation for us. So working together to keep us safe and keep the public safe is huge. Maybe quickly back to the one-on-one ratio which seems to be one of the biggest things on this Bill right now that we’d like to change, I did an apprenticeship that was one-on-one. I couldn’t imagine sharing that time with other people. It is so important for us to learn about this safety, the history, making sure we are treating our clients with respect because they are giving us their bodies and trusting us. So, you know, we need to work together to create any of the regulations. We have a vast amount of knowledge between everybody in this Association that we can offer from an inside point of view that maybe we can work together to workout kinks. Do you have any questions for me?

SENATOR ABRAMS (13TH): Thank you very much for your testimony. You did a great job.

MICHELE STOCHLINSKI: Yeah, I’m not a speaker. I’m not a good talker.

SENATOR ABRAMS (13TH): You were wonderful.

MICHELE STOCHLINSKI: But it is very important so that’s why I’m here and happy to take any questions.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments from the members of the
Committee? No, thank you very much for your time. James Rosa. Welcome.

JAMES ROSA: Hello, thank you for your time. My name is James Rosa. I’ve been tattooing in East Hartford – Manchester Area since about 2001, fulltime since 2003. I am a member of CPTA as well. So for most people we’re artists and they just look at us like that but I mean it is so much more. We have connection with the people. We cover up scars, we cover up be it medical, be it scars that happened in times of their lives like being emotionally or not. So, it’s not just art. We start building a connection with these clients and I myself personally care a lot about them. So for me my concern is more so about when other people with limited experience say I want to teach about five apprentices. Some people do that through loopholes, some people do that through, you know, where they have their apprentices and they just want to get these people making money for them but they overlook the fact that, the health, and I’ve seen personally where people just are like they want them just to make money. You know, they are not looking over them. So cap to me is really important as well because I see what’s going on in the industry. If I see this going on in the industry, somewhere that I’m working, it bugs me a lot. I want it to be where I feel safe, I want my customers to feel safe because our stories are bonding. How I affect them, I want to affect them in a positive state, in a positive way.

I feel it is really important that cap is involved because it’s, to put it here, the voice is important because we care about the industry and our time that we put in it, our clients and our community. If
rules are made over us they should be made with insight from the community and the industry involved. And I’m shakin’ [Laughs]. [All laughing].

Yeah, thank you very much. I appreciate it and if you have any questions, I’m happy and open.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. I appreciate all of the testimony and how seriously you take your profession and your commitment to keeping people safe. So I greatly appreciate you and your colleagues for being here today. Are there any questions or comments? Thank you very much for your testimony. That is the end of the testimony so we are moving on to Senate Bill 966 and Dr. Greenfield. Welcome.

DR. GREENFIELD: Thank you. Good morning, well actually no I have to change this. Good afternoon, Senator Abrahams, Representative Steinberg and Members of the Public Health Committee. We did pass out some packets, some of them may not have made it to you, but it also on line. I am Dr. David Greenfield and I am an Assistant Clinical Professor of Psychiatry at University of Connecticut School of Medicine. For almost 20 years, I have been training psychiatry residents and supervising their clinical work. I have PhD is psychology and I also have an additional master’s degree in clinical psychopharmacology which I completed recently and have passed my national board exam in prescribing. I have been practicing clinical psychology and addiction medicine in Connecticut for about 32 years, so I’ve been around a while.

I testified here almost 20 years ago, in 2001 looking somewhat younger I might say, on this issue. At that time one psychiatric colleague suggested
that psychologist would likely kill somebody if they were permitted to prescribe. I am happy to report that we have been prescribing in numerous states with more on the way. The Federal Government, Branches of the Military and over 22 years there have been no deaths and a favorable safety record with hundreds of thousands of scripts written by psychologists. Excuse me. I want to add that only appropriately trained psychologists will be certified to prescribe.

Prescribing psychologist training is not the same as psychiatry of nursing but it is an equally effective and safe pathway for prescribing. This is a rigorous medical training program meeting ATA standards designed for practicing psychologists consisting of a ten course, 30 credit sequence leading to the Master of Science including pathophysiology, clinical medicine, lab studies, neuropathology, pharmacology, psychopharmacology and four distinct courses on specific psychiatric and substance abuse disorders as well as ethics, professional issues and research.

For Connecticut this will be followed by a one-year of supervised clinical experience, a National Board exam and 80 hour preceptorship in primary care medicine and 40 hours of yearly continuing ed. The ability to prescribe is also the ability not to prescribe and the data supports that psychologists have and take the time and to integrate the medication with psychotherapy, prescribe fewer drugs and are more likely to take patients off unneeded medications. All providers are required to practice within the scope of their training and expertise. We have always consulted, collaborated, referred as needed to primary care and specialty providers.
Prescribing from Schedules II–V is necessary to treat psychiatric and addiction disorders safely. We appreciate and share safety concerns that limiting a formulary is problematic in that we need the most beneficial drug for the patients’ diagnosis.

SENATOR ABRAMS (13TH): Doctor, I’m going to have to ask you to summarize.

DR. GREENFIELD: I believe that prescribing psychologists will serve our patients safely while increasing needed access and offer another healthcare option to assist needed psychiatric and addiction care. Unfortunately there are far more, there is far more need than there are prescribers. Prescribing psychologists can help fill that gap. Thank you.

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

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you, doctor for your testimony today. As far as the opponents of this Bill, what are their main concerns that you know?

DR. GREENFIELD: Well I think they are concerned about adequacy of training and they are concerned about safety. I think the record speaks that it is safe. We’ve been doing it for a longtime and that shows that the training is adequate. The training is different than existing prescribers in psychiatric medicine but that doesn’t mean that it is inferior.

REP. KLARIDES-DITRIA (105TH): Okay, and as far as other states, I know there are other states that already do this, are there, are those more current
law changes, like I mean within the last five years or have people been doing that for longer than that?

DR. GREENFIELD: That’s a great question, both. Here are several states that have been doing it for close to 20 years that includes New Mexico and Louisiana. There are several states that have passed in within the last five or six years. There are some states that passed it in two or three years, there is a state that is about to pass it this year and there’s about eight or nine states that are working on it currently.

REP. KLARIDES-DITRIA (105TH): That’s great. It seems like the, your post-doctorate work, plus the exam, plus the hours of continuing education and the supervision seem to be pretty rigorous that they are expecting you to do. Is that similar to what other states have done?

DR. GREENFIELD: Yes, it is. It is all based on a national model by the American Psych Association so, and I can attest to the fact having done it, it is rigorous. It took me two years to finish the course work and then of course about six months of studying for the exam.

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

DR. GREENFIELD: Sure, thank you.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Thank you, Dr. Greenfield. Could you back up for the Committee, maybe mostly for me.

DR. GREENFIELD: Sorry, I went a little fast.
REP. PETIT (22ND): No, no I took notes on that. But the training the psychologists would get to get to the point where they start to do this, what’s the background to get this where you are able to apply for this?

DR. GREENFIELD: Well to be certified to prescribe based on the flowchart of our Bill, you would obviously need a Doctorate in Psychology, be licensed to practice psychology already. You would then have to take additional master’s degree in Clinical Psychopharmacology, you’d have to pass the National Board exam and then do an 80 hours preceptorship in primary care medicine before you could be certified to prescribe and then you would begin your one year of supervised clinical experience with a minimum of 400 patient hours and 100 distinct patients but for a 1,000 hour minimum period.

REP. PETIT (22ND): I’m just trying to get a feel for it, so the Doctorial degree in psychology that takes most people four, six, seven. How many years?

DR. GREENFIELD: The average is six to seven years total with internship and residency.

REP. PETIT (22ND): And could you guesstimate the clinical contact hours realizing that at that point people aren’t prescribing what their clinical contacts our [Cross-talking].

DR. GREENFIELD: Thousands. By the time I was licensed independently in Connecticut I had done probably 4,000 or 5,000 hours of practice.

REP. PETIT (22ND): Skipping over to the other state’s or the Department of Defense is there good
data in terms of the efficacy or problems, pro or con data census around New Mexico?

DR. GREENFIELD: Sure, it has very good efficacy and a good safety record. I’m not gonna say that every prescribing experience is perfect because it isn’t for everybody and these are medications that do have side-effects and there are issues with those side-effects as well as sometimes they don’t work and you have to change your path. But overall we’ve had a good track record and we’ve not had any consistent problems that were noted. In fact when the Department of Defense studied this originally 20 plus years ago they found that the training that they were providing was actually too much that they needed to do less and that is how they developed this two year post-doctorate master’s in clinical psychopharm.

REP. PETIT (22ND): Eighty hour primary care preceptorship, is that aimed at letting people see what happens in a primary care setting or is that focused primarily on the primary care patients that are being treated with psych drugs.

DR. GREENFIELD: I think its both. It’s to expose the psychologist to what goes on in the primary care office but also to improve the psychologist’s skills in primary care practice not that he has practicing as a primary care doc but that part of our training involves training in physical exams, laboratory studies and patient physical assessment so giving that psychologist another 80 hour opportunity to experience that first had and to shadow and assist in the process I think would be invaluable.
REP. PETIT (22ND): And when someone’s achieves this or what is happening in other states, is it then a yearly CME requirement ongoing?

DR. GREENFIELD: Typically it is yearly. We positioned to the 40 hour CME which is on top of, I can’t remember if it is on top of or including our existing CME requirement. But we feel like if we are taking on this new responsibility we have to make sure that we are maintain our medical knowledge which is critical.

REP. PETIT (22ND): Thank you very much for those answers. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you, any other questions? Representative Steinberg.

REP. STEINBERG (136TH): Thank you, Madam Chair. Thank you for your testimony today. When we talk about opportunities for access in the State of Connecticut to psychological services as it relates to prescribing, arguably there is more than one way we can accomplish that. We can encourage more psychiatrists to locate here and stay here which means they would have the training, well that may be a lot faster [Laughter], we try and we are going to continue to try. But in terms of the opportunity for prescribing for psychologists, where do you see most of the opportunity, there has been quite a bit of conversation here today about the opioid epidemic, medication assisted treatment a real need to expand capacity to increase MAT in this state? You know that is at the very end of prescribing and potential ramifications, do you see that as a way for us to address that problem as well?
DR. GREENFIELD: Absolutely, for two reasons. One is as it was eluded to earlier in the conversations all substance abuse disorders and addictions have huge psychiatric comorbidity and cooccurrence. In fact I’ve been practicing in the addiction field for 20 plus years, I’m board certified in it. I can tell you that I have rarely seen a case that I treated for substance use disorder of any kind, that hasn’t had significant psychiatric sequela either contributing to the disorder or as a result of the disorder. So you have to treat the psychiatric component along with specific medications that would fall under the MAT pharma to help with those patients. So yes, I would see psychologists being a significant part of it and yes we would have to address the Federal SAMHSA Guideline if we want them to prescribe buprenorphine because right now psychologists are not included in that but just as nurse practitioner and physician's assistant have been included I think that can be accomplished as well and then we would have another group of providers being available for buprenorphine. But there are many other drugs that we could prescribe even before we were able to do buprenorphine that could help with MAT and help with the situation. Addiction is a huge issue but you can’t quite separate them neatly between psychiatric and addiction.

REP. STEINBERG (136TH): I agree with you. But do there need to be any adjustments to the curriculum or training of psychologists who are seeking prescribing for them to be, as you say, the SAMHSA guidelines or any other changes?

DR. GREENFIELD: Yes, so we are trained to do the MAT but of course a big part of our training is also
going to be in the supervision. So for instance if I wanted to do, practice addiction medicine and use a lot of MAT it would be incumbent on me to make sure that my supervisor is experienced in that so I can learn how to do that best. But if you want to get cleared for SAMHSA you would have to take the online course that every prescribed has to take in order to be certified. But again, we are not permitted to do that now, but I am hoping that will change as well.


REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for the second time. My question is once you’ve, as a psychologist, once you’ve finished all your requirements with your master’s level degree how will that now compare to the level of education in pharmacology compared to a psychiatrist?

DR. GREENFIELD: I mean I think in actual courses in pharmacology and clinical psychopharmacology I think it is more. I’m not saying that we have the same preparation in general medicine, it is a focused program specifically and I teach in psychiatry so I know what the training is. The training is guided and specifically focused on all, there is a general medical component because you have to learn pathophysiology and general medicine II but the focus is very much on clinical psychopharmacology and all the variants including metabolism and side-effects and there is a lot of nuances to this and I will say, I will admit fully that I underappreciate the complexity of this until I took this training. It was hands-down the hardest training I’ve ever done and the exam was the hardest Board Exam I have
ever taken. Everybody that does this and develops these courses and exams takes this stuff very, very seriously and I take it seriously. There is a lot of responsibility but I think the preparation and the training is more than adequate.

REP. KLARIDES-DITRIA (105TH): An you think, so it’s save to say that they will be comparable?

DR. GREENFIELD: Yes, I would say be comparable but different.

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

DR. GREENFIELD: No, can I clarify, that doesn’t mean I wouldn’t refer to psychiatry because there may, there very well may be cases that I would want to consult with psychiatry just as I do now. I am not saying that we, the good idea is to be, to know what you know and to know what you don’t know and that is very, very important.

SENATOR ABRAMS (13TH): Thank you, are there any other questions? Senator Somers.

SENATOR SOMERS (18TH): Thank you for being here. I’m sorry I was out of the room when you gave your full testimony but I did have a quick question for you which was how many years currently in other states do you have to work underneath a physician do you know?

DR. GREENFIELD: They vary. Some states it’s one year some states it’s two years. I’ve seen states as high as three and every state does it a little bit differently, some it’s under the Board of Medicine and some it’s under the Board of
Psychology. It really does vary, it's all over the map.

SENATOR SOMERS (18TH): Okay, and could you talk a little bit about how the DOD handles allowing prescription rights?

DR. GREENFIELD: Actually the DOD model is very similar to the ATA model which is what we based our Bill on is very similar to what the DOD does. They do also require a master’s degree in clinical psychopharmacology on top of the Doctoral degree and they do require supervision. They do have a huge amount of latitude in the military because it’s a Federal Agency and it is a little bit different because they don’t have to follow state guidelines but often they do require you to obtain a license in one of the state’s that allows prescribing as well.

SENATOR SOMERS (18TH): So even though they have latitude because it is the Federal Government they have insisted on the same requirements that are listed in this Bill, I want to make sure that is correct?

DR. GREENFIELD: Absolutely.

SENATOR SOMERS (18TH): And you have been doing it for 20 years now?

DR. GREENFIELD: Over 20 years started, yeah.

SENATOR SOMERS (18TH): Can you speak to.

DR. GREENFIELD: And they are in, there are psychologists prescribing in all branches of the military.
SENATOR SOMERS (18TH): Will you be able to speak to how you feel this will impact the access to care in Connecticut if this Bill goes forward?

DR. GREENFIELD: Sure, I’m not naïve and I’m not gonna say that if we allow psychologists to prescribe that it is going to solve our mental health and addiction access issues. It’s just another tool to provide needed and accessible care. I can tell you from my own practice it is difficult sometimes to arrange for medications when I need them and I know when we need them. I’ve been practicing for a long time and it is very obvious when a patient walks in and they would benefit from medication and ethically and I think legally responsible to determine that and when you have to jump through a lot of hoops to make that happen or call a primary care doc which is what I typically do and they don’t really have the time or the inclination to do it. They will do it but they don’t have the time and inclination to really focus on it. And if it is a complex issue pharmacologically they don’t really want to deal with it at all and they rely on my expertise to guide them. I don’t know if I answered your question.

SENATOR SOMERS (18TH): Yes, you did. Thank you very much.

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

DR. GREENFIELD: And I do have a tattoo by the way.

SENATOR ABRAMS (13TH): Good to know. [Laughter]
DR. REENA KAPOOR: Good afternoon. My name is Reena Kapoor. I am a psychiatrist and I am a medical doctor specializing in the treatment of mental illness. I am also an Associate Professor at the Yale School of Medicine and I am here today representing the Connecticut Psychiatric Society, which represents 800 psychiatrists in our state. We oppose Senate bill 966.

I should first that I work in a salaried position at a medical school, and so psychologists prescribing will not affect my livelihood personally at all. I am not here to protect my medical practice or my turf. I am not here to protect my earning potential. I am not here to protect my professional prestige. I am here to protect our patients.

As you may already know, psychiatrists spend 12 years in full-time education and training after high school to practice, 4 years of college, 4 years of medical school, and at least 4 years of psychiatry residency.

Even though we specialize in mental illness, during the course of our training we treat critically ill patients in the ICU, we perform emergency room evaluations we do surgical consultations, we treat neurology patients who had strokes, seizures, meningitis. And we don’t do that because it’s fun. We do it because we recognize that the brain is an organ and it is connected to the rest of your body and doing anything less than that amount of training does put our patient’s lives in danger.

To say it simply, if you don’t enough about how the body works when it is sick and when it’s healthy you do risk killing somebody by accident.
Safe prescribing of medications to psychiatric patients requires comprehensive knowledge of medical illness the kind of knowledge that comes from years of training and experience in a hospital, not the kind that can be learned just from books and online courses. Psychiatric medications are among the riskiest of all medications, sometimes causing life-threatening side effects. Medical illnesses, like brain tumors or thyroid problems sometimes masquerade as mental disorders. It takes a highly skilled person to tell the difference and a highly skilled person to manage these conditions. That person should be a medical doctor.

When you have a loved one is having a heart attack or a gallbladder problem, you want them to see a doctor, and we should insist on nothing less for people with mental illness. If you adopt this bill, you are saying that people with mental illness deserve a lower standard of care, that their problems aren’t worthy of treatment by a person with the same level of skill that physical problems demand. You are endorsing a separate and unequal system of care for mental illness and given all of the work people on this Committee and others have done to increase mental health parity to get mental illness to be taken seriously and the same as physical illness.

I hope you will agree with me that that this Bill is a step in the wrong direction and I hope that you will not support this dangerous course of action. Thank you.

REP. STEINBERG (136TH): Well thank you, Doctor. I’m not sure I agree that you include the four years
of undergraduate among the 12 years being along the path to being a good psychiatrist. For many of us it seems to be a good way to develop your own neurosis as opposed to moving along that path. [Laughter]

DR. KAPOOR: If I could just briefly respond to that, what I mean by that being along the path is that undergraduate training for medical school includes required courses in basic sciences which is very different from what psychologists do, but your point is taken, sir.

REP. STEINBERG (136TH): Thank you. I guess somebody has to take organic chemistry on purpose would definitely qualify for that path. Since you are the first person opposing this you will have to indulge me as I play devil’s advocate. I think anything you said I would counter is that we take this very seriously and the entire reason we are even entertaining the legislation such as this is that we’re very much concerned about real equity in terms of psychological psychiatric services, mental health services in the State of Connecticut and the fact that there is a Bill before the Insurance Committee where we want to assure mental health parity because we recognize particularly from a funding and insurance standpoint that there isn’t real equity and that we need to develop more resources here as well. But you’ve heard it stated here that we have access issues here in the State of Connecticut. We can agree or disagree this is the right means to go about it but failing to address access issues is also inequitable in many different ways. So I know you have demonstrated interest in becoming part of the solution as we try to evaluate the opportunities to encourage more psychiatrists to
stay in the State of Connecticut and things of that sort. But how do you respond to the professed need for more practitioners in this field who have the ability to prescribe in order to take care of these problems?

DR. KAPOOR: Well I think we all agree is that access to care for quality mental health care in Connecticut is a problem as it is in almost every part of the country. That is not the issue here. It’s really just as you said, whether this is the right solution, whether the balance of increasing access and potentially decreasing safety is worth taking that risk. And so what I would say is that there are other ways to increase access to care that don’t involve this level of putting our most vulnerable citizens at risk. So some of those involve integrated care meaning collaboration between primary care and psychiatry either as a consultation model or collocated in the same office. There is Telehealth, you know, I think we all have to move with the times and Telepsychiatry is one of those things that takes advantage of the facts that may prescribers or many providers are in urban areas that could then provide treatment to people in more rural areas through Telemedicine and I think that there are ways through expanding residency programs in psychiatry, loan repayment to incentivize people to work in underserved areas. All of those things are alternatives that allow people with a medical background to better serve our community and those are all things that the Connecticut Psychiatric Society is actively working on and promoting because we agree with you that it is an issue with access to care in our state.
REP. STEINBERG (136TH): Thank you for pointing out all those things many of which we have thought about quite frequently here in the Public Health Committee. I don’t know if you’re familiar with another Bill that is before the Committee today House Bill 7302 which is AN ACT CONCERNING TELEHEALTH and it would require the study of the implications of the state ratifying and approving the psychology interjurisdictional compact. Are you familiar with that and what’s your opinion?

DR. KAPOOR: I am not.

REP. STEINBERG (136TH): That makes it easy. Are there other questions? Yes, Senator Somers.

SENATOR SOMERS (18TH): Yes, thank you for your testimony. I would like your opinion on allowing prescription authority underneath a physician supervision.

DR. KAPOOR: Well, that is a really good question. I think that, that being the history like for example when nurse practitioners or physician's assistants get prescriptive authority that’s been sort of the pathway that’s taken, that has at least in the case of nurse practitioners ended in sort of over a course of many years independent practice. And I think that this is a very different case because I just want to point out that in order to get a PhD in psychology you have to take as much medical training as you do to get a PhD in history or English Literature and so sort of asking a physician to supervise someone who does not have some adequate medical background, I’m not in support of.
SENATOR SOMERS (18TH): I’m just going to read to you from the testimony from the clinician we just heard from which says that, “the training is designed for working practicing psychologists similar to an APRN program. It is cutting edge and comprehensive in biomedical science and clinical medicine and psychopharmacology including comprehensive exam, clinical practicum and follow up by National Board. Training is designed to prepare a psychologist to treat full range of diagnoses and the patient population. It consists of 10 courses, 30 credit sequencing leading to a master’s degree in Science totally 270 credit hours in medical sciences and on average it takes at least two years to complete.” So that is a little bit different than what you just described. So I wanted to know if you could speak to that and also do you know of any adverse situations that have occurred in other states that have allowed prescription rights underneath a doctor’s supervision?

DR. KAPOOR: So those are two separate questions so I will take them in two parts. So what you had just read from the testimony is the master’s in psychopharmacology training that is being proposed. So what I want to point out is that is usually described as sort of 400 hours of online course work. So if you were doing that fulltime, that would take you ten weeks if each week is 40 hours. So the fact that it takes two years speaks to the idea that it is incredibly part-time and so it’s actually a ten week program, training program and so compare that with a medical education which as I just described is sort of four years of medical schools, four years of psychiatry residency, they are really not comparable. The examination that the
The psychologist has to take is certified by the American Psychological Association not by any medical group at all and so it’s sort of like they created this program, and they created an exam, and it’s all internally which is very different than the way medicine is regulated where it is outside of your professional organization. For example in psychiatry it is not the American Psychiatric Association that does your board exam, it is an outside agency and they are outside regulators. That is not the case here. So that is what I would say in response to your question about the training.

I’d also say that 40 hours of preceptorship, sorry 80 hours in a primary care doctor is slightly ludicrous. It’s two weeks in a primary care doctor’s office that is supposed to sort of make you informed enough about medical illness to be able to safely prescribe medicine. And so I don’t think that this training is adequate.

The second part of your question was about are there adverse outcomes? Yes, there are. And so I can provide this to you in writing but essentially so, New Mexico and Louisiana are the only two states that have a significant history meaning more than a couple, four-five years of psychologists prescribing. An in those states psychologists did exactly this, they said we will limit our practice to the treatment of behavioral health conditions and yet the Center for Medicaid and Medicare services, you can sort of search their data base about what psychologists are actually prescribing in those states and there are cases where they have prescribed coumadin a blood thinner, Hytrin, Plavix, Zanaflex all kinds of medications that have absolutely no indication for behavioral health
conditions. So that I think is a really significant safety risk. There’ve also been cases where there have been, you know, lawsuits related to psychologists prescribing what they prescribe, the adequacy of the followup care, the adequacy of consultation with medical providers and I don’t mean for a minute to sit here an suggest that there aren’t also lawsuits about bad psychiatrists but I do think it is false to say that there have been no problems with psychologists prescribing in other states.

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

REP. KLARIDES-DITRIA (105TH): Thank you, Mr. Chair. Thank you for your testimony today. One of my questions is once, in your opinion, once a psychologist finishes this program and their exam and whatever continued education they need to do, how will they compare in their prescriptive authority compared to an APRN?

DR. KAPOOR: The Bill as I understand it does not put any limits on their prescriptive [Cross-talking].

REP. KLARIDES-DITRIA (105TH): I’m talking about their training. Like how would you compare now the psychologist to the ARRN as far as their training to have prescriptive authority?

DR. KAPOOR: I see, well they have significantly less training in terms of again the sort of core medical training. So the way I understand it is sort of psychiatrists you do roughly 20,000 hours of medical training and then APRNs about 8,000, PAs about 5,000 and so then this would be 1,000 is what
they are suggesting which is again sort of roughly well a small fraction of what the APRNs do.

REP. KLARIDES-DITRIA (105TH): So then do you recommend something for like psychologists?

DR. KAPOOR: Yes, that they enroll in a PA or APRN program.

REP. KLARIDES-DITRIA (105TH): So there is nothing you recommend as far as additional master’s type program that they could add into that master’s program that would make it satisfactory for you.

DR. KAPOOR: That’s not something I’ve given a lot of thought to, sort of like could we add more hours, could we tweak that, cause I think as a whole it’s just so far from being adequate that I don’t feel comfortable telling you, well if we just added one more course about MAT even this would be okay. I think that it’s sort of in a whole other ballpark of being unsafe, you know, I would also say that I really appreciate what the Committee has to go through with these scope of practice hearings and I appreciate that everybody who comes in here says, safety that’s what I’m concerned about, when in reality when there is a significant amount of sort of professional tribalism and things like that that go into these things. I personally did not testify when the nurse practitioners were expanding their scope of practice because that is a completely different situation from here. You know, those are people with a medical background and again that is what I want to emphasize is missing with the psychologist.

REP. KLARIDES-DITRIA (105TH): Thank you for your testimony. Thank you, Mr. Chair.
REP. STEINBERG (136TH): Representative Betts followed by Senator Anwar.

REP. BETTS (78TH): Thank you very much and thank you for your testimony, I have a couple of questions, one is and you may have answered and I apologize if I didn’t hear it. Does this exist anywhere in the country in terms of psychologists being able to have prescriptive authority either with or under the supervision of a psychiatrist or through some other program?

DR. KAPOOR: Sorry, New Mexico and Louisiana have had this program. The Department of Defense had it for some years and then there are, in the last five years or so, I am aware of Iowa, Illinois and I believe it is Idaho is the last state but don’t quote me on that, that have passed laws but at least like in Illinois they have had significant limitations on what people can prescribe and then they haven’t actually been implemented because people have not completed those requirements yet.

REP. BETTS (78TH): Thank you and that may be an ongoing trend but I know of a few psychologists for example who work very closely or in partnership with psychiatrists and they may discuss a patient’s background or the need for medication but that seems to be a collaborative relationship. Do you feel that could be applied here?

DR. KAPOOR: I think that is the ideal of psychiatric or sort of mental health practice is a recognition that psychiatric treatment is more than medication alone. So the collaboration that I envision is one in which psychologists do what they are excellent at and which is also in short supply which is behavioral therapy, psychotherapy and that
psychiatrists and medical providers do what we are trained to do. So I think collaboration is absolutely the right word as we go forward but I don’t envision a kind of apprenticeship model around prescribing.

REP. BETTS (78TH): And carrying along on that, I appreciate that answer, is as you’ve heard probably earlier on, we really do have an epidemic or crisis here on mental health, do you feel a sufficient number of psychiatrists in the State to be able to meet the demand or how would you recommend that we get a sufficient number if we don’t have it to be able to meet that serious medical problem of mental illness?

DR. KAPOOR: Do you mean mental illness or are you talking about specifically opioids? Sorry.

REP. BETTS (78TH): Both.

DR. KAPOOR: Okay. Well as I mentioned earlier I think there are, you know, so the Psychiatric Society represents about 800 psychiatrists. It is my understanding we have about 1,200 in total in Connecticut and that is per capita a lot more than in many other parts of the country. And so it’s really just an issue of getting the resources to where they’re needed. We could use more mental health professionals, we could use some more psychiatrists but I think it is, it is a complicated issue and I think I would refer you back to the solutions of integrated care, of Telehealth and I know my colleagues will testify a little bit more to later.

REP. BETTS (78TH): Okay, thank you very much. Thank you, Mr. Chair.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Dr. Kapoor for your testimony. I wanted just to clarify a couple of things if you don’t mind. I think I heard you say that as physician who has been trained in this there is approximately 20,000 hours that have gone into the clinical training.

DR. KAPOOR: Yes.

SENATOR ANWAR (3RD): And what is proposed is that to get the same level of prescription, response of prescription legislation that people are interested to approach, just by 1,000 hours?

DR. KAPOOR: Yes, so 1,000 hours of clinical supervised practice and then I believe it is four, roughly 4000 hours of the online course. So 20,000 versus less say 1,400.

SENATOR ANWAR (3RD): So let’s say in the wisdom of this legislature which I am learning more about, we pass something like this just because we have pressure from different entities, are we just destroying the existing institutions? Why would anybody want to become a psychiatrist then?

DR. KAPOOR: I think there are a lot of reasons of why people want to become a psychiatrist and in fact much to my surprise actually psychiatry is increasing in popularity amongst medical specialties. But if I am understanding your question correctly.

SENATOR ANWAR (3RD): [Cross talking] Devaluing medical training and the institutions that are providing that.
DR. KAPOOR: I think that is fair to say, you know and I think that is the tradeoff you have to decide whether expanding access to care is worth risking patient’s safety and devaluing the quality of medical care, some sort of ending in this place where people with mental illness are the only ones who can be prescribed medication by a psychologist, like by someone with no medical training.

SENATOR ANWAR (3RD): Do you consider psychiatry to be a specialty?

DR. KAPOOR: Yes.

SENATOR ANWAR (3RD): Okay, because in this Bill on Page 2, it says, on Section(c), line 3 that “for at least one year, not less that 1,000 hours under the direct supervision of a physician licensed pursuant to Chapter 370 of the General Statues who is certified in psychiatry by American Board of Psychiatry and Neurology or an advance practice registered nurse.” So basically this Bill is suggesting that anyone who is interested just can work with an APRN and that is going to be enough, not even a psychiatrist for that matter.

DR. KAPOOR: That’s right. So a psychiatrist or an APRN, once you’ve done your online training you can be supervised by an APRN. There is sort of no requirement for physician supervision.

SENATOR ANWAR (3RD): And no requirements to be under a persons trained in managing psychiatry as well?

DR. KAPOOR: Right, that is an option, it’s not a requirement.

SENATOR ANWAR (3RD): So this is dangerous.
SENATOR ANWAR (3RD): And do you, is it fair to say that a lot, a lot of medical illnesses overlap with psychiatric illnesses as well, mental illnesses and medical illnesses have a significant overlap that is the largest or fastest growing segment?

DR. KAPOOR: Yes. Most of our patients have medical comorbidities.

SENATOR ANWAR (3RD): Right, so this comorbidity can we just look at the mental illness in isolation and expect everything to work fine?

DR. KAPOOR: No of course not and I will give you an example from my hospital this week which was we had a patient admitted who has cirrhosis, cryptogenic cirrhosis and so also has a number of psychotic symptoms and so trying to figure out which medication is not heptatically excreted but renally excreted, you know, trying to decide what the dosing has to be based on kind of how bad the person’s liver function is. All of those things are things that require significant medical skill.

SENATOR ANWAR (3RD): And earlier there was a testimony by somebody who said that the amount of pharmacological training that they would have is similar to a medical doctor. Can you reflect on that?

DR. KAPOOR: Well I think that what they, what I took it mean was that it was sort of ten courses in the master’s of psychopharmacology curriculum cover the same topic areas as one would learn in medical school. So basic pathophysiology, basic biochemistry those kinds of things, human anatomy but the depth and the breadth of them in a 400 hour
online training versus medical school, four years fulltime in a variety of settings is not comparable.

SENATOR ANWAR (3RD): So its not comparable.

DR. KAPOOR: No.

SENATOR ANWAR (3RD): Even though if somebody has said that it does not make it comparable?

DR. KAPOOR: That’s right.

SENATOR ANWAR (3RD): Okay, and if I may ask you, tell me about the psychiatric medications and the QT interval association with it and what would happen if some medicines are used in that situation.

DR. KAPOOR: Well, so I believe what you are referring to is the potential side-effects with many psychotropic medications in particular antipsychotic medications to lengthen what we call the QT interval but basically is sort of to put someone at risk for arrythmia.

SENATOR ANWAR (3RD): Sudden cardiac death.

DR. KAPOOR: That’s right.

SENATOR ANWAR (3RD): And could you touch on serotonin syndrome and the outcomes of that if not treated and identified in a timely fashion?

DR. KAPOOR: So serotonin syndrome is another potentially very serious even lethal combination of, side-effect, sorry of some of the most commonly prescribed medications and so a psychiatrist has to be very aware of what those symptoms are and also very aware of the potential combinations of medications that can produce serotonin syndrome because many of the most commonly comorbid conditions, for example migraines and depressions,
if you aren’t very careful about which medications you are prescribing to the person you can put them at risk for serotonin syndrome.

SENATOR ANWAR (3RD): And subsequent and significant complications including death?

DR. KAPOOR: Yes.

SENATOR ANWAR (3RD): Okay and when lithium is not used in the right way, what are the potential concerns and issues that can arise?

DR. KAPOOR: Well the lithium when it is not, when it is prescribed in excess, so you have to be very careful about what the level in the blood is, so there are acute complications like lithium toxicity, again potentially fatal, and then in the longer term you have to be, you have to monitor somebody’s renal function very carefully because you can have long-term kidney damage that leaves you in kidney failure.

SENATOR ANWAR (3RD): So again it is people who thankfully may have not had illness of behavioral and medical they may just look at it from the outside, that they are pretty simple processes. You give a pill and the person in a few weeks will turn around and improve, it’s far more complex. The fastest growing illnesses are the comorbidities that we are seeing within the population and with this increase having a fraction of the treatment that somebody else has had and expecting them to have the same level of prescription authority, we will be sitting here actually figuring out what is the next level of, can we create another specialty to deal with the complications that are anticipated. I
understand where you are coming from and I appreciate your testimony. Thank you so much.

DR. KAPOOR: Thank you for your concern.

REP. STEINBERG (136TH): Representative Borer followed by Representative Betts.

REP. BORER (115TH): Thank you Mr. Chairman. Thank you for your testimony. You said that the Department of Defense had this program, do you know why they don’t have it any longer?

DR. KAPOOR: My understanding of the program is that they had started as a pilot and had anticipated and had anticipated recruiting a number of psychologists to prescribe, that they in reality had recruited a total of ten psychologists in the program and they stopped it after six years after concluding that it did not meaningfully expand access to care within the military.

REP. BORER (115TH): Okay great. Thanks. Also you mentioned in those two states that have this program, I think you said Louisiana and.

DR. KAPOOR: New Mexico.

REP. BORER (115TH): New Mexico that those psychologists prescribed medication outside the realm so coumadin, I think was the example that you gave, is there a gatekeeper process at the pharmacies that would disallow a psychologist from prescribing medicines that would not be within the world of psychiatry?

DR. KAPOOR: No and essentially it would be incumbent on their sort of professional ethics and any kind of licensure board to police that. But those processes, you know, generally take a patient
to complain about it so it wouldn’t be like some kind of automatic like computer system at the pharmacy that says, no this is coumadin you can’t prescribe it. There is nothing like that.

REP. BORER (115TH): Great, thank you.

REP. STEINBERG (136TH): Okay, Representative Betts.

REP. BETTS (78TH): Thank you for the second time. As I am sitting here listening to you, I am beginning to appreciate the value and the importance of the pharmacist and as a psychiatrist who has prescriptive authority to prescribe medications have you ever consulted with, talked with or compared notes with pharmacists when doing prescriptions?

DR. KAPOOR: Yes.

REP. BETTS (78TH): Would that also apply to anybody who is doing any kind of prescriptions?

DR. KAPOOR: Yes.

REP. BETTS (78TH): Okay and as far as the gatekeeper question that was just asked, it is my understanding as a layperson having dealt with a pharmacist that is, if they have a concern they will call the doctor whether it is primary care or whether it is psychiatry or whoever to discuss that medication so that the parties will understand the ramifications of it or the concerns of the side-effects, is that not a common practice?

DR. KAPOOR: I can only speak for my own experience and I think it is very hit or miss. There, you know, I think the most common calls from pharmacists that you get are things related to if I give him two of the 10mg pills instead of one of the 20 its cheaper, cause it’s on a formulary, that is probably
the most common thing that I get called about. Sometimes there will be sort of questions about a drug/drug interaction and that is helpful and important but I think it is not a sort of you can count on that as a failsafe method measure to ensure that no bad prescriptions are ever written.

REP. BETTS (78TH): So, the reason why I mentioned it is I know a couple of pharmacists and they take that as you do that job very seriously and they take it upon themselves to say if I’m not satisfied with this or if I have a question or concern about this, they will initiate it because they know they are part of the process for providing that medication. So you really think that pharmacists truly wouldn’t be typically going in and consulting with doctors about medications they had concerns about?

DR. KAPOOR: Oh no, I think they would consult when they have concerns but I think they are subject to the same limits on knowledge as anybody else, patient uses two pharmacies, they don’t know what else they are taking. You know I think that it is always at the end of the day incumbent on the doctor to make sure that what they are prescribing is safe.

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

REP. STEINBERG (136TH): Thank you, Representative. Doctor we’ve kept you pretty involved. Oh, we got one more. Senator Somers.

SENATOR SOMERS (18TH): I just wanted to follow up on a couple of things. First of all the DOD does still have the program, I just looked it up and it actually applied to all military branches and secondly, let me just finish please. The report that I am looking at talks about how initially the
pilot program that you talked about, the graduates were well integrated and provided good care but their effect on the DOD’s readiness which they were talking about, really couldn’t be just because they only allowed at that time ten to have prescription rights, it was too vast if you look through the data. So I had a question on, we talked a lot about adverse reactions like serotonin syndrome and lithium toxicity but wouldn’t that be taught in the pharmacology training that these psychologists would get adverse reaction. I’m being told by their curriculum that yes, they do get that training and in those specific items that you spoke to.

DR. KAPOOR: I think that is a good point. What I would say is that there are no physicians involved in the curriculum that they’ve created. Well, no actually I take that back. There is one who works with the American Psychological Association on that. But I think that what I want to emphasize is that the way that you know what lithium toxicity looks like the way that you know what serotonin syndrome looks like is not because you memorized a bunch of symptoms in a textbook it’s because you were awake at night when the person came into the ER and you were the one on-call and you had to deal with it, and you’re the one who has treated patients in the emergency room, in the ICU, in a doctor’s office, in an outpatient clinic and those hours of training and expertise in a variety of different clinical settings cannot be replicated through an online course.

SENATOR SOMERS (18TH): Okay and I just want to follow up with anytime based on the training that can be paralleled to APRN or a PA actually if you look at it, you could say that these folks would
have actually more training in pharmacology than an APRN or a PA, at anytime would you feel it acceptable to have a limited formulary that they could prescribe under a doctor’s supervision?

DR. KAPOOR: I think I will respond to you the same way that I did earlier is that it is not something that I have given enough thought to about sort of what would be the absolute kind of bare minimum training that I think would be safe to prescribe, for example, Prozac to somebody with no medical comorbidity at all. I think that is something that I would have to give more thought to before answering your question, if that’s all right?

SENATOR MINER (30TH): So do you think that only an MD is qualified enough to write a, to have prescription authority. I know, I’m married to one and many times he doesn’t know about the drugs and he has to rely on a pharmacist to ask the question.

DR. KAPOOR: I’m sorry to hear that because I do think that is a professional responsibility with consultation from pharmacists when appropriate of course, but it is our responsibility, it is our responsibility of the prescribe to make sure that the medication is safe and I do not think the training as proposed by the psychologist is adequate to meet that burden.

SENATOR MINER (30TH): So do you think when you consult with a pharmacist that it is only an MD can consult with a pharmacist and if an MD has to consult with a pharmacist what does that say about their training?

DR. KAPOOR: No, anybody can consult with a pharmacist of course.
SENATOR MINER (30TH): Thank you.

REP. STEINBERG (136TH): Thank you, Senator. I guess you are finally relieved. Thank you, doctor. Next up is Dr. Tichianaa Armah. Is that anywhere close?

DR. TICHIANNA ARMHAH: Good afternoon, Chairs, well Chair now and distinguished Member of the Public Health Committee. My name is Dr. Tichianaa Armah. I am a testifying as a private citizen so I am not representing any organization or institution. However I am a medical doctor, practicing psychiatrist and administrator and I urge your opposition to SB 966. But I come to you not only as someone working in the mental health field but on a deeply personal level.

I decided on this profession as a young child watching my Vietnam Veteran father suffer from PTSD and the impact of him trying to escape his pain through alcohol and drugs. So access to the highest quality of mental health and substance abuse care for all has been my life’s mission. For that reason I have worked and taught psychologists, psychiatric mental health nurse practitioners and psychiatry resident.

In passing this bill as Dr. Kapoor mentioned, people with mental illness would be subject to a new healthcare disparity. In Connecticut they would become the only group in the who would be treated with medications by people without medical background, extensive medical background all in the name of increased access when it is really likely that it will increase because:
One, over 60 percent of psychologists are either opposed or indifferent to this effort. Of those not opposed most have no intention of pursuing prescription authority if it is granted. Locations where psychologists passed this in the state largely mirror where psychiatrists practice. And the other hurdle to access would remain like insurers refusing to cover services and require prior authorizations for routine medicines and routine care. And it’s LCSW or Licensed Clinical Social Workers and primary care providers who are the most prevalent in the regions is a state where we’re low on psychiatric services. But the majority of patients feel more comfortable waking in through the doors of a primary care provider than a psychologist or a psychiatrist. So with or without this proposal PCP, the primary care providers will continue to be the first line of treatment and integrated care and technology are the keys to supporting them with an already extensive medical knowledge and scientific background.

Recently a 65-year-old patient who suffered with debilitating anxiety over 20 years reminded me of the impact of her coordinated care on her ability to live again. On sedatives for year, benzoazocines which were mentioned earlier but still not functioning. We were in a crowded hallway and she grabbed me gleaming, “Do you remember what I came to see you, I could barely walk into this building or even go into the grocery store, but now I feel so free, I could stand here and sing.” Seen at the request of the primary care provider I convinced her to engage in therapy and I got her onto non-sedating medications and they were continued by the primary care provider and the rest is history.
REP. STEINBERG (136TH): I’m going to have to ask you to summarize please.

DR. ARMAH: Yes, in an integrated setting, I am fortunate enough to be able to meet the needs of hundreds more patients in a year than would be possible through a private practice. There are thousands more who are helped through instructing primary care providers on how to prescribe and I will never see those patients. Electronic consults, psychiatry, telepsychiatry and Project ECHO and more all mean care that goes far beyond my local reach but we still need third-party payers to agree to reimburse psychiatry.

In closing, Mental illness is crippling many in our state and I hope that Connecticut will serve as a beacon for our nation and turn down SB 966 and instead focus on strengthening and expanding solutions all already working and in progress that would actually serve to close the gaps in care for the most vulnerable of the vulnerable without sacrificing quality or increasing costs with misplaced investments.

REP. STEINBERG (136TH): Thank you, you can now take a deep breath cause you went very fast [Laughter].

DR. ARMAH: Yeah, thank you.

REP. STEINBERG (136TH): You’ve heard a lot of conversation today particularly as it relates to substance abuse or substance use, I’m trying to get the terminology right, trying to use the right language.

DR. ARMAH: Substance abuse disorder.
REP. STEINBERG (136TH): Thank you and the word of the day is integration and you mentioned the Project ECHO and a number of other things, is this a way in which we can address the seeming access issue that we have in this state, what we really are doing in Connecticut?

DR. ARMAH: Most certainly. So when I came out of residency I was really excited to start prescribing suboxone. I was already certified during my residency and I immediately started to participate in Project ECHO because one of the biggest problems is that people get certified but they don’t necessarily feel comfortable prescribing the medication and so Project ECHO with having a faculty of folks who had been doing this work for a really long time, you know, some longer than I had been alive, working in addictions they sit there, they do this didactics but in addition people bring in cases to them and say, okay this is a patient who I am really struggling with or I would like to prescribe this medications but I’m seeing these certain trends. So that really increases the comfort of folks so when I started I was one of only two who were prescribing suboxone at one of the three different sites that I have been at. One of those individuals then left however out of five people now four of us all are prescribing suboxone. So all of them are able to get into Project ECHO and basically become local experts, then you sort of phase out of it. So I did that for a year but I have continued to prescribe suboxone and then helps to really encourage the folks that are brand-new so that they are also really, you know, engaging in that care and feel supported.
REP. STEINBERG (136TH): If I might ask, what communities do you practice in?

DR. ARMAH: So I work in a Federally Qualified Health Center so I prescribe medications and treat patients from all walks of life. My focus is the underserved population however we don’t discriminate, we will see people with private insurance, state insurance and the uninsured as well.

REP. STEINBERG (136TH): I was referring to geography.

DR. ARMAH: Oh, geography, sorry. So I’m in lower Fairfield County however the people who are participating in this are all over the State of Connecticut.

REP. STEINBERG (136TH): That was really my question was that even for a small state we seem to have access issues yet the, particularly the opioid epidemic knows no boundaries or demographics in that sense so I’m pleased to hear that it really does cover the state in that sense.

DR. ARMAH: Most certainly from Enfield over all the way down to Fairfield County, Waterbury I heard Waterbury and as mentioned Enfield, yeah so when I was here and I was like, I know that you have people who are prescribing several suboxone there.

REP. STEINBERG (136TH): Thank you for that. Any other questions or comments? If not, thank you for your testimony. Really appreciate it. Next is this a trend, we have another physician? Dr. Tanuja Gandhi.
DR TANUJA GHANDI: Good afternoon, Senator Abrams, Representative Steinberg, and Distinguished Members of the Public Health Committee, I am Dr. Tanuja Gandhi. I am an Adult & Forensic Psychiatrist currently pursuing further training in Child Psychiatry so I am able to take care of children and families in need. I had a very lengthy written testimony which is there for your consideration and I am happy to take questions later and will not read it out loud again.

And I was preparing an oral testimony for like the last few days, reflecting on why is it that I want to be here today and why is it that we should be discussing this issue at all and then I thought to myself, maybe the meat of the argument is in the question itself as to why. I think there is a lot of well intention in wanting to provide access to people who need mental health treatment and care but then I think again going back to the why, how do we do that, and in the why lies what is that intention and how do we provide care without doing any harm.

So I would take this minute to ask people to pause for a moment and think about that one moment in your life when a loved one, maybe your parent, your family member or your child was incredibly in need of mental health or even physical health services and who would you take them to. Would you say it’s okay I’ll go to someone who has these many hours of training and get into the semantics of training or would you say it is my child, I would provide them with the best care possible. Well the answer is if it were my child, I would say who is the best doctor in town? Do they know how to diagnose and treat this condition effectively and that is who I would
go to and that is the reason I’m here because I do not expect any less for my patients.

While preparing, I was reminded of the Oath that we take at the end of medical training, “First Do No Harm,” it is the Hippocratic Oath and that is the reason I am here an urge people to think about this whole argument in that context. I practice adult psychiatry. I have been trained in forensics and now I treat children and families and I will give you one example of what a day looks like to me in terms of health and safety. I see patients in a family based Recovery Clinic. Now who I see are not the children but the mothers of the children, some with family or directly expectant from the parent/child therapy perspective. So these are young mothers who have used substances during pregnancy and have been identified as positive on U-Tox and now have been referred to therapy and treatment and I am going the medication evaluation for them making sure that their children are not removed from their care and they are able to balance two needs, one is staying abstinent in recovery and one being a parent. I can’t tell you the number of steps I have to jump thorough to decide if this mother needs medication or not and how is it going to affect the mother and the baby. So the process of medical decision making is much more complicated than made out by opposite training division and is achieved over years of regularly supervised training which is hard to quantify in numbers of supervision or training. So I think in closing I would say that access to care is a real issue but the devil is in the details of what is really an access issue and how it can be provided than providing a temporary
fix by increasing the number of prescription providers for psychotropic medications.

REP. STEINBERG (136TH): Thank you for that perspective. We really do appreciate actually bending your testimony and sort of coming at it from that direction. I think you sense the work, we are very serious about trying to do the right thing in this context. Some of the questioning I had of the last physician that was before us was along the lines of are there other ways in which we can address what we see to be a problem of access into the State. Would you concur that short of giving other people prescribing authority that we are in a position to address the real needs here in the State of Connecticut?

DR. GHANDI: If I may, repeat that question. You are asking are there other ways to address access to care besides providing prescriptive authority? Is that the question?

REP. STEINBERG (136TH): That’s pretty much the question.

DR. GHANDI: So let me start by saying I stand true to my testimony here. I do not support the proposed Bill for several reasons that very, very articulated been highlighted by my colleagues and the colleagues who are to come after me. I thought it was good to take a moment and reflect on the way because that is the reason by me to be here. Now in terms of access to care I think there are a lot of programs ongoing in the state that we don’t know about or don’t take into account like Access Mental Health, I think one of my colleagues will speak to that later but psychiatrists are providing phone consultations to pediatricians who are seeing children and
adolescents in their care seeking mental health treatment. And I would like to say even pediatricians are not comfortable prescribing psychotropic medications knowing very well the limits of their expertise and identifying the need for collaboration and consultation. So I think an important part of these other programs is again knowing what limits of your expertise are. Other programs include the ones that I mentioned, Family Based Recovery. I also do a lot of school based mental health in school consultations and in school based mental health we provide access to mental health evaluation and treatments for children in certain schools in Connecticut it makes my heart sink every time I go to a school and I see a teenager who is talking like confused like it was easier to go buy candy. It’s probably easier to go by marijuana now that it is to go buy candy on break so those are the models that I have been working in.

REP. STEINBERG (136TH): Thank you. Representative Anwar, ah Senator Anwar.

SENATOR ANWAR (3RD): Thank you. Thank you so much for your testimony. I think the words resonated very strongly with me are “Do No Harm” and I think as physicians we abide by that “Do No Harm” as much as humanly possible. I think everybody in any role, whatever that role is in their lives, even if it is as legislators or State Representatives or State Senators we need to also think about that as a rule in our minds that we should not “Do Any Harm” intentionally or unintentionally. So I think this was very powerful for me. Thank you.

DR. GHANDI: Thank you. And I would like to add that I have been trained by psychologists myself in
different aspects of my training and I have an immense amount of respect for my teachers. I’ve grown believing medicine is an art and by no length am trying to say that we do not work well collaboratively or that they are not an invaluable member of our team, they are and that’s the point.

SENATOR ANWAR (3RD): Thank you.

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

DR. GHANDI: Thank you for your consideration.

REP. STEINBERG (136TH): Next is Dr. Falisha Gilman.

DR. FALISHA GILMAN: Good afternoon, Chairman Steinberg and Distinguished Members of the Public Health Committee. My name is Dr. Falisha Gilman, I live in New Haven and I am a psychiatrist training at the Yale School of Medicine.

I am here today to testify in opposition to Senate Bill 966 because it places by patients’ health and safety at risk by allowing inadequately trained professionals to prescribe powerful medications for life threatening illnesses.

Psychiatrists and psychologists are both valued members of a mental healthcare team. As a psychiatrist, I am a medical doctor, that means I have an M.D. and specializing, diagnosing and treating mental illness. I prescribe medications, as well as deliver talk therapy.

In my written testimony I have outlined my training as well as I have attached two figures outlining the difference in training between M.D.s, the proposed psychologist training as well as APRN and physician's assistants. Instead I would like to time
today to discuss the opioid epidemic and how this Bill I do not think would safely increase access to treatment for the opioid epidemic by allowing psychologists to prescribe Medication Assisted Therapy. We know that safe and effective treatment for opioid use disorder exists particularly with suboxone and methadone and this is effective when it is managed by clinicians with an understanding of the basic and clinical science of how these diseases occur and the treatments that work. We need to understand the risks of these medications and these risks do not stop at just the brains, they can affect the entire body such as the adrenal glands, the liver as well as have interactions with other medications that patients may be taking. We also know that there are many associated medical conditions that cooccur with opioid use disorder, in particular HIV and Hepatitis C happen at higher rates in this patients with opioid use disorder compared to the general population and it is my responsibility as a treating physician for that opioid use disorder to always ensure that they have been adequately screened and treated and when appropriate be placed on prophylactic therapy. For example in HIV we have preventative treatment called preexposure prophylaxis, or PrEP, and in our practice it is part of what we do in prescribing medications for patients who are using IV drugs and are at increased risk for HIV.

So in closing, I urge you to oppose the Senate Bill 966 and consider safe and evidence based interventions to address issues of access and cost particularly in relation to treating and combating the opioid use disorder epidemic. Thank you for this opportunity.
REP. STEINBERG (136TH): Thank you, doctor. You may not be aware that we actually have a Bill before this Committee with regard to access to PrEP so it is something that we are aware of.

DR. GILMAN: Wonderful.

REP. STEINBERG (136TH): Let me play the devil’s advocate for a minute. You brought up the importance of treating the whole body, you know, if a psychologist with prescriptive authority thought because of the substance use disorder that the patient was at risk for Hepatitis and then they would have prescriptive authority to be able to provide that, you know, why wouldn’t that work?

DR. GILMAN: The medications that we use in PrEP in particular have side-effects that occur not only short-term but in the long-term. There is extensive screening that has to be done before you can start someone on PrEP and it needs to be done regularly while you are doing it and while I understand that the Bill that has been proposed SB 966 would allow for psychologists to order the tests and order the medications such as PrEP I think the extensive basic science training that I received in medical school as well as the clinical training I received, I spent two years studying every single organ, and two years rotating through every single specialty in medicine I think that is essential to be able to prescribe it safely and to be able to monitor these patients on this medications for months to years.

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

Representative Arnone.

REP. ARNONE (58TH): Thank you, Mr. Chairman. Since you narrowed in on the opioid crisis, so in my, in
Enfield like we said before we are lucky we have CHR and have a very great group of support for addicts, one of the biggest questions, complaints I’ve heard from parents with children that we addicted that the lack of psychiatrists in our area. So if you are not working for CHR it is very difficult for a family to find a psychiatrist without traveling to South Windsor. They actually was one that we had, a lot of people love to go there because they were trying to chose somebody that was right for their child and now I hear numbers of 30 percent could be suicide today of overdoses. So that again is a problem I think psychologists, we don’t just have enough in my area for parents to chose from. What do you say to that when we are trying to just help the situation and we may not be narrowing in on exact right answer but we need help, our children need help.

DR. GILMAN: Absolutely, I mean we are all too familiar with this epidemic and I am going to provide two parts to my response. One, is that there is a map that I believe that one of my fellow psychiatrists will be discussing that outlines in the State of Connecticut where psychiatrists are currently located and where psychologists are currently located in the state and we very much overlap in the areas, we tend to be concentrated in particular areas and not in other areas. And we know that from studies particularly in Louisiana that when psychologists received prescriptive authority they did not move to those underserved areas. So there is nothing to say just because the psychologist gets the authority to prescribe that they are going to move and suddenly be serving a
population that previously did not have access to this lifesaving treatment.

The second part is I think there are other things, and you know, I think the Public Health Committee for their work thinking about Telepsychiatry as well as the workgroup to think about how to recruit physicians to the State of Connecticut getting more residents interested, getting more trainees interested in coming to Connecticut and staying in Connecticut after we finish training is crucial and I think that the Telemedicine Collaborative Care model that was recently discussed is another strong way to reach and work with primary care physicians or pediatricians in areas where a psychiatrist may not be located.

REP. ARNONE (58TH): And one more complaint too I’ve heard over the years is HUSKY and issues with payment towards psychiatrists specifically.

DR. GILMAN: So I actually provided public testimony in the, to the Insurance Committee at a Public Hearing in support of the mental health parity Bill that did not pass out of that Committee. It’s a significant problem particularly here in Connecticut of disparity in reimbursement rates particularly for psychiatry and mental health services and I would be happy to send you information regarding that specific to Connecticut that is outlined in a 2017 report called the “Milliman Report.”

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

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Dr. Gilman for your testimony. I alluded to this earlier now, you mentioned that you are
undergoing residency training right now and who are the people that are training you at this time, what is their training background, the psychiatrists?

DR. GILMAN: So I am currently a third year psychiatrist resident so I am about three-quarters of the way through my training. My supervisor is a medical doctor who has done her residency in psychiatry, has been practicing for several years. I have several supervisors, it’s not just one. We receive four hours of didactics every week in our third year and that is taught primarily by medical doctors but we also have licensed clinical social workers as well as psychologists who help with our training particularly with their therapy and some of the case management services that we assist our patients with in previous years in addition to being trained by physicians who specialize in psychiatry. I have also worked under neurologists as well as medical internal medicine doctors.

SENIOR ANWAR (3RD): So it’s a team of individuals with medical background but neurology background because that is critical because it could be a neurologic disorder that can manifest as psychiatric disorders and then psychiatrists. This Bill that is in front of us suggests that an individual can get 1,000 hours under an APRN, I have nothing against APRNs but this is not a specialty in my mind at least, so and that would qualify them to start to write prescriptions as psychiatrists at the same level, can you reflect on that for a second?

DR. GILMAN: It’s very concerning to me. I did not, I chose psychiatry for many reasons and one is because I like to be able to sit with my patients and really get to know them and get to the root
cause of what is causing them so much psychological distress but I recognize the hours, the thousands of hours that I put in particularly my first year of residency training when I did four months, four-and-a half to five months of internal medicine training and at least two months of neurology training, working, not with a psychiatrist at all just with neurologists and just with internal medicine doctors. We work anywhere between 40 to 80 hours per week, every week through our residency program and it’s like Dr. Kapoor was saying, it is not in the classroom where we are learning these things, it’s part of it, but a lot of it is being the person responsible for treating the emergencies, figuring out what is really going on with these patients and what we can do to treat them. In addition other have eluded to as well that psychiatric diagnoses can present as medical problems and I don’t think that you can be able to accurately make a diagnosis if you haven’t ruled out the potential medical causes and I don’t know how you would know how to do that without the hours working in internal medicine.

SENATOR ANWAR (3RD): So, I’m actually have a teaching position with two medical schools and I train residents and medical students and I tell them that everything you need to know is in a book or on the internet that you can look up, but the art of medicine will require you to work through the clinician and see the patients and see how that is supposed to know how you look at it. And right now I am not sure the amount of time, the amount of training, the situation, the circumstances, supervision of the training is going to solve the access issue that is going to cause more access
issues because we will be dealing with a lot of complications and it will require a lot many people.

DR. GILMAN: And we will be losing an important member of our team. We reach out to psychologists and social workers often to collaborate and provide the care and if psychologists are going to be prescribing medicines, they are going to have to be jockeying they time to build your therapy and that is such an important part of treating mental illness. We know that medication plus therapy is better than either one alone and if we lose the people that have specialized in therapy from that training, from that treatment team, I think that is a real loss.

SENATOR ANWAR (3RD): So one of my other understanding is that for many of the psychiatric disorders for the medicines to start to take action, it would take about six weeks to eight weeks before we will see if they are actually working. And if they are not working or they cause a complication it will take months for those complications to go away. Is that fair understanding that I have?

DR. GILMAN: Absolutely. I have a patient who came to me, she transferred from an outside hospital and I’ve been taking care of her since July and she came with a list of probably ten medications, psychiatric medications, and we’ve been working throughout the year to try to streamline that a little bit because she is starting to have significant complications because of the medications that she’s on. Some of the medications that we prescribe are highly effective for keeping people alive, people with bipolar disorders, schizophrenia or depression but they do come with long-term side-effects including
high cholesterol, and diabetes and now it has gotten to the point where she is going to have to start taking insulin and so thinking about how knowing the impact of these medical side-effects on her but also knowing that she needs to be on medication for mental illness and trying to balance that is a constant dynamic process that has been really challenging this year to work with her as well as with the help of several of my attending physicians. Our patients are sick and they need good quality care for people who have the training and the expertise for looking at complex comorbid medical illnesses and psychiatric illnesses.

SENATOR ANWAR (3RD): So in other words what I’m hearing is that if somebody makes a decision to make a medicine which is not appropriate for that particular illness it could take about eight months of the life of an individual before we will be able to undo that essentially?

DR. GILMAN: At least and it’s a matter, it’s difficult for the patient and it’s difficult for their families and they may have resurgence of symptoms which places them at risk and it’s having, it’s knowing what those risks are of a medication both taking the medication as well as not taking the medication knowing it so well that you are able to tell your patient if we do this, this might happen or this might happen which way should we go because medicine is shared decision making. I don’t tell my patients what medicines to take. We have a discussion about risks and benefits and these are medicines that I’ve been studying for at least the past seven years and still having these conversations is complex and challenging and I take
it very seriously and, cause it impacts my patients’ lives every single day.

SENATOR ANWAR (3RD): Thank you so much for your testimony. Thank you, Mr. Chair.

REP. STEINBERG (136TH): Thank you, Senator. Any other questions or comments? If not, thank you doctor, we very much appreciate it. Next is Dr. Jeffrey Mufson.

DR. JEFFREY MUFSON: Good afternoon Distinguished Members of the Public Health Committee. My name is Dr. Jeffrey Mufson. I am a third year psychiatry resident at the Yale School of Medicine. Thank you for the opportunity to testify in opposition to SB 966.

Prior to training in psychiatry I actually completed a residency in internal medicine and felt strongly, you know, seeing the crisis involving in our current society that mental health was rally where I wanted to be and I think that I am one of many medical school graduates who are increasingly turning to psychiatry because they see the effects that this is having and how important and impactful that we can be. I was actually thinking back to something one of the tattoo artists said earlier when they were discussing how seriously they take their training “clients are giving their bodies to us” and I think that this really resonated to me as far as why I decided to go to medical school and make the sacrifice, the extensive, many, many years of training that it takes to become a physician and feeling that if I were going to be taking responsibility for a person’s health that was the level of competence and experience that I would want and that I would want my patients to expect of me
and that’s what I would want for family members and friends.

I treat psychiatric patients currently at the West Haven VA. I prescribe medications, I treat with psychotherapy, I do both at the same time. Sometimes I don’t prescribe medications and at times I’ve lowered dosages of drugs or discontinued them to reduce the burden of medications and I also with many of my residency colleagues have completed the SAMHSA training for buprenorphine so that we can take part in the solutions to the opioid epidemic.

In my written testimony I describe one of my patients with schizophrenia who presented to my outpatient office several times with declining physical health and had signs and symptoms of medical illness. In these times I would have to make decisions about whether to send him to the emergency room or not and explain to the emergency room what I was concerned about based on his medical history and/or what options I could take to treat him in my office if he didn’t need that. These are the kinds of decisions that I think the years of clinical practice in residency give you the ability to manage these complex medical decisions. These are not the exceptions these types of patients with many, many medical problems and psychiatric issues. Thank you.

REP. STEINBERG (136TH): Thank you, doctor. I appreciate the perspective you offer even being in your third year how much clinical practice you’re already putting in to the process and we very much appreciate you also getting the training to be part of this solution with the opioid use disorder. Questions or comments? Thank you, doctor. Next up
Dr. Katherine Kennedy. The biggest access issue with psychiatrists is that they are all here today [Laughter].

DR. KATHERINE KENNEDY: Good afternoon, Chairman Steinberg and other Distinguished Members of the Public Health Committee. My name is Katherine Kennedy, I reside in Branford, Connecticut and I am a physician specializing in psychiatry. And for over 225 years I have taught and supervised psychiatry residents at Yale as well as the owner of a solo-private practice in New Haven, Connecticut. And I am testifying in opposition to SB 966 because I believe patients with mental health and substance use diagnoses deserve access to safe, quality, evidence-based care by qualified providers with substantive, rigorous medical training and I believe that SB 966 does not create this kind of access.

I’ve submitted written testimony that you can see so I’m just gonna make three points from my written testimony. First of all I want to draw your attention to the map that my colleague Dr. Gilman mentioned a Workforce Map that demonstrates that across the eight counties in Connecticut there is roughly an equivalent distribution of psychologists with medical providers, that’s 8,000 of then constituting PAs, APRNs, primary care providers and psychiatrists. So that is 8,000 of those. So certainly SB 966 would not increase geographic access.

Another issue has to do with an exciting development in Connecticut around access which is that last Monday, a week ago today, Yale Internal Medicine Associates brought online a brand-new evidence based collaborative care model. The development of this
was funded by CMS and this is a really exciting model because it’s going to be using new CPT Codes and so this is really a little bit about what we’ve been waiting for and I am very excited that hopefully as this is implemented we work out the bugs that this can be, this evidence based care model can be used in other primary care settings.

And lastly I just want to talk to you about my experience as a provider and help you to understand it’s not just training it’s the way that I see patients in my office every day. The purpose of diagnosis is a constant, it’s not a static one. I don’t make a diagnosis, give someone a prescription and that’s it. Every time, and I’ll try to wrap up, just giving you a sense. Every time I see a patient I’m constantly reevaluating what is going on with them in terms of their medical diagnosis, their life stressors and their psychiatric diagnosis and a lot of times I’ll change a medication, stop one, change the dosage even if they’ve been on it for a long time. And I would be happy to give you a couple of examples, but I know my time is up and so I’m also happy to take questions.

REP. STEINBERG (136TH): Thank you, doctor. Let’s start with the news you provided with us with the new program at Yale. Help us understand how having the use of the CPT codes are gonna make a difference going forward.

DR. KENNEDY: So my understanding is that, well the CPT codes right now only provide payment for face-to-face service. But these new CPT Codes will allow payment for services when it is not face-to-face and so that will allow a primary care clinician and behavioral specialist in that office to be able to
consult with a psychiatrist around being able to triage their patients that they screen in their office especially for visits in evidence based for primarily depressive disorders. To be able to triage these patients and better identify patients that might not ever be brought to light and so this is a really new development, it’s very exciting.

REP. STEINBERG (136TH): So is for mostly the, let’s say the Telepsych, Telemedicine or?

DR. KENNEDY: Yes, actually so the psychiatrists could be off-site and would according to this model would provide maybe weekly, hourly consultation. It depends on the number of patients that a primary care office has but they would, all the primary care patients would have behavioral inhouse behavioral care specialists, sometimes a psychologist or social worker. Often times they would be administering screening tests like Q9 or other tests and then they would report back in an online meeting to be able to help triage those patients. Psychiatrists would also be able to provide backup for any urgent or semi-urgent cases that would come to light during that process.

REP. STEINBERG (136TH): I’m getting a little off the beaten path, but when we talk about telemedicine Bills in the past, there have been plenty of physicians in our Committee who felt very strongly that the initial contact should always be face-to-face. Would that be occurring here or the psychiatrist would potentially never have direct contact with the patient?

DR. KENNEDY: This model would not require that the psychiatrist to have face-to-face contact with the patient in this consultation role. It would be a
contact with the behavioral care specialist and the primary care provider. Obviously if the patient needed to be seen then that would be a face-to-face contact but that is not what the broad model would begin with.

REP. STEINBERG (136TH): And you say this is a CMS sponsored program and has this been done in other states?

DR. KENNEDY: So I honestly can’t speak to that right now in terms of other states. I think that it has been done effectively in Washington State and I can certainly get you more information around that but I do know that CMS provided funding for the development of this model and is onboard with this.

REP. STEINBERG (136TH): I know this is a bit off topic from your testimony but the whole point of this is we are going to consider going as far as taking this step to give psychologists prescribing authority would be also very interested in alternative approaches to addressing the needs of our population and this sounds like another interesting wrinkle on how we might go about that. Are there other questions or comments? Not, Doctor, thank you as always for your testimony. Next is Dr. Michael Pantalon.

DR. MICHAEL PANTALON: Chairman Steinberg, Senator Abrams and Members of the Public Health Committee thank you for the opportunity to speak. My name is Dr. Michael Pantalon and I am speaking on behalf and in favor of SB 966 AAC THE PRESCRIPTIVE AUTHORITY OF PSYCHOLOGISTS.

I have been a faculty member at Yale School of Medicine, both in the departments of psychiatry and
emergency medicine since 1997. At Yale I teach medical students, residents and Fellows and conduct clinical research on the integration of medication and counseling treatments for addiction as well as MAT. I have also been in private practice for 25 years and beyond my Doctorate in Clinical and School Psychology, I have a Master’s in Science and Clinical Psychopharmacology, the same level of training approved and maintained by the six states who have prescriptive authority as well as all the Armed Forces.

I support this Bill because there is huge problem of access to evidence based addiction and treatment in our State and nationally and because there are solutions and solutions that I believe we can, everyone in this room can work on together because there is no time to waste and I do believe we do need all-hands-on-deck. In fact only one in twelve people with addiction are in any form of treatment and of those only 10 percent receive safe and effective medications for their addiction. This is a problem that also hits home for me. Two of my best friends growing up, brothers, the ones that taught me how to play the guitar when I was a kid died of opioid overdoses. They had nowhere to get help and sadly for many this problem persists today and not withstanding all the great arguments we’ve heard from all sides, more than 1,000 Connecticut citizens lost their lives to opioids in 2018. That is almost three people every day. This is largely because there are simply not enough medical or psychiatry providers to help these folks.

To address this my colleagues and I, some of the same folks who set up that CMS System you just heard about have worked tirelessly for over two decades to
motivate and train office based physicians with no specialty in psychiatry to prescribe medications to treat addiction, cause you’re right that is where they go first. And sometimes that is the only place they go and sometimes I get the call from them.

Other of my psychologist colleagues at Yale have discovered medications for cocaine and alcohol addiction but here’s the focus. It’s Suboxone. It cuts the opioid overdose death rate by 50 percent and yet only five percent of physicians are approved to prescribe it. They don’t go for the training, eight hours of online training for that. We do have more of those would be Suboxone prescribers in our state per capita then many other states. The programs haven’t worked. Time is up. We need more prescribers, that is the clear solution and that has been seconded by the Director of SAMHSA, Dr. Eleanor McCance-Katz a former colleague of mine at Yale, has made the move towards Allied Health Professionals becoming prescribers.

With this passage, with the passage of this Bill would not bring back my friends or the thousands of lives that have been lost but I am certain that it would increase access to evidence based addiction and treatment and potentially save the lives of those who are still struggling. So I implore this Committee to consider the fact that we don’t have time to suffer double the rates of opioid overdose deaths that we would have versus if we had Suboxone more broadly. Thank you very much.

REP. STEINBERG (136TH): Thank you, Doctor and obviously been monitoring the dialogue we’ve had with both the agencies and with physicians today with regard to the opioid use disorder and epidemic
we have in this state. But again let me play
devil’s advocate. There is a difference between
saying that we’ve got a crisis, we need to do more
and taking the rather bold step of greatly
broadening prescription authority to meet that
specific need. You’ve heard me ask a lot of
questions of folks here about are there other ways
to do that. We’ve talked a lot about alternative
models for treatment that would sort of expand
capacity for MAT and other things and you know
certainly there is a difference between people
going trained to administer Suboxone and much more
broad prescriptive authority. Help me understand
why we can’t address the very issue raise, and I am
sorry for your loss of your friends with something
short of really taking this leap.

DR. PANTALON: Because time is not on our side and
because the solutions that have been brought forward
are paltry in my opinion. You need prescribers who
are willing to prescribe Suboxone to get them on
Telepsychiatry or Telehealth type platforms. We
simply do not have that. Only five percent of would
be prescribes ever opt to get the training, which I
might add is online and only eight hours, which I
might add APRNs and PAs who get less training that
is proposed in our Bill can and do prescribe at this
point. The other thing is that I’ve spent time with
my emergency medicine and primary care providers,
doctors of all sorts over the last 20 years trying
to motivate the greatest portion of providers who
could provide Suboxone which are primary care
doctors and we are not motivating or training them
at a fast enough clip. We simply don’t have enough
providers and another year will go by and if I know
the data, because opioid addiction is my field,
Suboxone cuts the opioid overdose death rate by 50 percent. Do we want to tolerate double the number of opioid overdose deaths than we need to. So there are great solutions but we still need more prescribers.

REP. STEINBERG (136TH): Again I am going to continue along the lines of devil’s advocate. Why not just mandate that all practitioners get the Suboxone training and provide some other incentives for them to prescribe versus again going into the significant step of offering prescriptive authority to those without the significant clinical medical training?

DR. PANTALON: That is a great question and that I something that my colleagues and I tried in Vermont in the early 90s when even methadone was not allowed and there was a great, great battle over that. That is simply not going to happen in my estimation.

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

REP. ARNONE (58TH): So on the Suboxone can you speak a little bit about the Federal Government and to and the hurdles that we have and with Methadone too, the hurdles we have to go through on the Federal Government level in order, we could legislate all day long, but the Federal Government is only going to allow us to do so much with these drugs.

DR. PANTALON: The Federal Government. That is a great question. The Federal Government came this close to adding the phrase Allied Health Professionals which generally includes APRNs, PAs and licensed psychologists. When they changed the
law to allow APRNs and PAs to have less training that we would have to prescribe Suboxone that is how close they came and that is a push within SAMHSA. However what I’ve heard from SAMSHA and the DEA is that they are not going to go first. It is completely irrelevant for them to even signal beyond these papers that I’ve read or communications privately that they would do so until States, you know, in their sovereign capacity say, yes this is something that we need to do. Florida just passed this and I think there is more discussion with SAMHSA simply because of that from last week.

REP. ARNONE (58TH): Yeah and that’s really where the push has to be to and the same with methadone. In order to apply for the program you have to have your birth certificate, you Social Security number. You have to have a job. These are things that most addicted people do not have access to anymore and it’s ridiculous if we put through hoops in order to get into a medicated program and that needs to stop and I agree with you right there that those drugs need to be expanded in order to help this terrible, terrible situation.

DR. PANTALON: I completely agree and that is a great point. But may I clarify one thing? So when we take medication assisted treatment and back to the mandating component, a lot of DMHAS and court support services programs have been de facto mandated to do medication assisted treatments. But what do they do, they prescribe only Vivitrol which is blocker if you will. It’s the medication, the opioid antagonist that would make someone ill thought not dangerously so if they use opioids on top of it and they check that box and say, “yes” we are providing a MAT. The real issue is that
methadone and Suboxone only reduce the overdose death rate by 50 percent. Methadone has regulatory hurdles that are ridiculous at this point. We are losing lives every day, 17 in your town half of whom are not necessary if we had these medications. So methadone will not be the broad approach Suboxone will. Who’s gonna do it? Primary care physicians, a lot of them don’t want to do it. Psychologists want to prescribe and while I agree that they won’t be moving into Connecticut in droves some may, the psychology field is growing while the numbers of psychiatrists going into residency is dramatically going down. There have been papers written by the Chair of our Department in Psychiatry about how we cannot incentivize our way out of this problem. But with one prescriber added, motivate prescriber that could mean 250 opioid use disorder patients in that person’s practice in due course.

REP. ARNONE (58TH): Yep, thank you.

REP. STEINBERG (136TH): Yes and you do raise a good point which is still a stigma and a bias against prescribing something which some doctors still view as making the problem worse instead of better and that we have so much more to do by way of education. Any other questions? If not, thank you for your time. Next up is Shirley Glynn.

ANNE KLEE: She’s not here, may I read her testimony.


ANNE KLEE: I’m sorry, I’m Anne Klee.

REP. STEINBERG (136TH): We don’t want to put a lot of pressure on you if that would be easier.
ANNE KLEE: Would that be okay.

REP. STEINBERG (136TH): Why don’t we do that. Until that time we will have Mirela Loftus.

MIRELLA LOFTUS: Hi, good afternoon Chairman Steinberg and Distinguished Members of the Committee. My name is Mirela Loftus and I am a Child and Adolescent Psychiatrist at the Institute of Living Hartford Hospital which is just right up the road from here. I am here to testify in opposition to SB 966. I am here as a practicing psychiatrist working with children and adolescents on an inpatient unit, so hospitalized, as well as the President of the Connecticut Council of Child and Adolescent Psychiatrists. I have submitted written testimony.

I’m gonna keep it short but just one point. I want to highlight the difference in training between a psychologist and psychiatrist. So psychiatrists are medical doctors with anywhere between 12 and 14 years of medical training in disciplines like biology, anatomy, microbiology, pharmacology, chemistry and a whole lot of other biomedical coursework. This training includes four years of college with a major in biological sciences, four years of medical school with extensive training in all medical fields other than psychiatry such as internal medicine, hematology, surgery. Four years of adult psychiatry, residency training and for child and adolescent psychiatry some additional two years called Fellowship.

In addition to the above mentioned training the psychiatrist needs to be Board Certified by the American Board of Psychiatry and Neurology which entails a very rigorous national exam entailing both
a written portion as well as an assessment of clinical skills to a live exam with a patient. And this certification is only valid for 10 years and needs to be renewed through a similar exam every 10 years. In fact on a personal note I am 52 years old and I am still studying. My Board recertification is in two weeks. In addition to these trainings we also analyze medical records, lab results and as an example, I wanted to give you just a quick clinical vignette scenario just to exemplify the need for having all this background knowledge.

So for example, the most common diagnosis is depression or anxiety and the most common medication treatment is Prozac. I think pretty much everyone with some medical knowledge will say, “Well if you’re depressed, how about we prescribe Prozac?” Well how about only a person with medical knowledge and extensive medical experience beyond psychiatry would realized that up to 70 percent of patients prescribed Prozac will present in the first week with symptoms that look like depression such as weakness, lethargy, headaches which can erroneously attributed to depression when in fact they are a complication side-effects of the medication known as hyponatremia which can cause seizures, coma and death. So without the background to actually know what, how to react to such symptom one might be inclined to increase the medication instead of treating it as medical emergency.

So with that in mind, then that is just a simple example off the cuff. I have tens of more examples similar to this one. I am opening for any questions.
REP. STEINBERG (136TH): Thank you, doctor that was a good example and we will look at the other ones that you provided us. Questions or comments? None. Thank you for that testimony. We really appreciate it. Dr. Klee would you like to come up again? Just identify yourself again for the record.

DR. ANNE KLEE: Sure, my name is Anne Klee and I am speaking for Shirley Glynn. Thank you Senator Somers and Representative Steinberg for having us.

So my name is Shirley Glynn and I prepared this statement with my sister Mary Glynn. We grew up in Bristol. Mary now lives in Plainville and is an MRI technician. I am now a clinical research psychologist at UCLA and specialize in clinical research and intervention with serious psychiatric illness. Mary’s and my life have been profoundly impacted by the serious mental illness and addiction in our loved ones in Connecticut. We wanted to speak a bit about the challenges we have encountered in piecing together strong mental health treatment in Connecticut, and the need for more coordinated, humane, evidence-based care. We think permitting psychologists to have prescription privileges (after appropriate training) may help this effort.

Both my grandmother and her sister, my great aunt, who helped raise us, spent a great deal of time in state psychiatric hospitals in Connecticut, my grandmother at Connecticut Valley in Middletown and my great aunt in Fairfield Hills in Newtown. Thus, from an early age, our family had a sensitivity and awareness of psychiatric illness. Of course, this was years ago before the wide spread growth of the recovery movement, and the availability of new
medications and psychosocial treatments to improve outcomes in illnesses such as schizophrenia.

Unfortunately, our mother struggled with mental illness much of her life. We estimate she was hospitalized for schizoaffective disorder at least 20 times in Connecticut Hospitals. She was a devoted mother to me, my sister, Mary, and our three siblings, but her illness was hard on us and our father, Philip. When she was well, she was a wonderful mother—creative, energetic, fun, compassionate, but when she was psychotic, her behavior was bizarre, embarrassing, and scary. While her symptoms responded well to medication, she experienced very bad side-effects and for much of our growing up it was a continuing cycle of our mother experiencing a psychotic symptom exacerbation, hospitalization, her getting stabilized on medication and discharged, coming home shaky but wanting to take care of us, 6-12 months of good functioning, her finally feeling mentally strong and bothered enough by side-effects that going without medication seemed like a good option, and relapsing again within a couple of months. On the plus side, our mother was able to get reasonable care both state and community hospitals, but it continues to amaze us that when she was discharged to the community, there was often little outreach or coordination of care—for example, in all the years she was ill, only once did any mental health professional reach out to us kids to try to help us or see what we needed. My mother had private health insurance and saw a community psychiatrist but very little was offered to her or us in the way of psychosocial treatment. We view that as a profound failure in the system.
In spite of their challenges, our parents had dreams and aspirations for all five of us kids. As we grew up, observers thought we were incredibly resilient. We each made it into college, four of us graduated, several of us married, some had children, we all had careers. None of us ended up in the psychiatric hospital. From the outside, we seemed to be doing fine.

However, we now see the insidious and corrosive aspects of growing up under the specter of serious psychiatric illness without enough support were apparent even then. While we both survived, as adults we lost one beloved brother, Peter, to a fatal motor vehicle accident with alcohol involvement.

REP. STEINBERG (136TH): Doctor, I’m going to have to ask you to take on the role of editor here.

DR. KLEE: Okay, well it gets exciting now. So we lost another beloved brother, Philip, to suicide, and we lost our lovely sister Theresa to a heroin overdose. We could speak for hours on their suffering. The daughters in our family spent much of our adulthood caring for our mother who lived in Bristol for most of her adult life helping her access good mental health and physical care. For several years, as our mother aged, Shirley flew from California to Connecticut every other weekend to help our mother. We had many opportunities to see the mental health care system in Connecticut close-up.

When we consider what might have helped us as a family prevail more successfully against the devastating effects of schizoaffective disorder, we think mental health providers who had a broader
scope, who looked at problems from a biopsychosocial, rather than medical model, may have been able see our wider range of needs and be able to help address them. Here a psychologist with special training in psychopharmacology may have been able to better oversee our mother’s care and recognize her needs for illness management strategies and other psychosocial treatment as well as the rest of our family members needs to best understand what was happening and learn to take care of ourselves in difficult circumstances. The devastation resulting from serious psychiatric illness is wide and deep and requires clinicians who can integrate information from a variety of domains—mental health, physical health, social and community functioning, interpersonal relationships—and develop and implement a comprehensive treatment plan. It can be very difficult for consumers who often have significant functioning impairments to interact with multiple treaters who may have conflicting treatment plans and views of the consumer and often are not reimbursed in any way for coordination of care. This is particularly true when patching together a care team with private insurance. A single treater with broad knowledge, such as a psychologist with prescribing privileges, overcomes this obstacle.

REP. STEINBERG (136TH): Thank you and very well done. It’s good to get a perspective from the family as well here. I would argue and I’m not going to do a thesis defense on what you just read but there seems to be such a trend to team approach in integration and not reliance on a single practitioner. I think you could probably argue that both ways. But thank you for that. Yes, Representative Petit.
REP. PETIT (22ND): Thank you, Mr. Chairman. Just wanted to thank you for staying out and thank you for the excellent testimony and since you’ve now been here for four-and-a-half, five hours she owes you dinner at a minimum [Laughter].

REP. STEINBERG (136TH): And I’ll add say, “Hello” to your husband. Next up is Susan Kelly.

SUSAN KELLY: Good afternoon, Representative Steinberg, and members of the Public Health Committee, thank you for the opportunity to testify today. My name is Susan Kelley, and I am the Advocacy and Policy Director for National Alliance on Mental Illness - NAMI Connecticut. NAMI state chapter of national NAMI, that is the largest grassroots mental health organization in the United States.

I am here testifying regarding Senate Bill 966. NAMI Connecticut is neutral regarding this bill. We have had a lot of testimony today from physicians, psychologists, psychiatrists and family member now and NAMI Connecticut has many psychiatrists members as well as psychologist members.

In just brief talking to other members, non-clinicians, and they are for and against this Bill. Our view is that while we recognize that serious shortages in the mental health professional workforce in Connecticut, particularly regarding psychiatrists for children and adults, there is no current data or evidence indicating that expanding prescriptive authority to psychologists will effectively address these shortages.

We have heard somethings about SAMHSA, doctors are saying XY and Z but there really isn’t a body of
research out there showing that expanding prescriptive authority would expand, I’m sorry, would improve access and help our shortages.

So interestingly when you all polled, when you, I guess Representative Steinberg, well you said, well all these psychiatrists are here today, I would be curious to know of all those psychiatrists who takes insurance. Because I think that is a huge problem with access is that not enough psychiatrists take insurance and I say it, you know, anecdotally but I think we all are aware of the mental health parity issue and it’s possible that with the passage of Mental Health Parity, if it passes this year, that there will be improvements in terms of reimbursement rates and so forth. But, until that time, even though we both understand the value and the current authority rests with psychiatrists which we think is appropriate, but we also understand the role of psychologists and the important role they play, but we feel this is premature at this time and we’re not just punting because we can’t make a difficult decision, it’s that we believe that it is not wise to do so without addressing whether or not this really would improve access that is very much needed. Thank you.

REP. STEINBERG (136TH): So thank you, Susan and for all the work that you and NAMI does. I was at this conference and so many states refer to NAMI as being a critical partner on the frontlines of dealing with a lot of our behavioral issues. So I want to thank you for that. And I think you raise an interesting point. If we are going to be evidence based we have to be sure that making such a change would actually bring benefit. Representative Petit.
REP. PETIT (22ND): Thank you, Mr. Chair. Thank you for that testimony. A little bit outside the specific prevue here but we heard a lot of testimony today on MAT and I wondered if we get your insight a minute or two as to why so few people are involved. Does it have to do that it’s a very difficult population and that it’s the training, the reimbursement or some summary of all of the above?

SUSAN KELLY: When you said MAT.

REP. PETIT (22ND): Medication Assisted Therapy, you said the Suboxone.

SUSAN KELLY: Right, so many acronyms, like which. I guess that, I think what you are asking me is whether or not there is something in specific that is critical to improve access or it’s just a combination? I’m not quite sure?

REP. PETIT (22ND): Why there’s inadequate providers providing that service for people? Is it because reimbursement is very difficult, because the people training is too difficult, because the patient population is obviously not easy to work with, etc.?

SUSAN KELLY: Right. I do think it is not one thing, it’s a lot of those things and I guess when I brought up the issue of reimbursement I find that is probably the thing that is most talked about and I think about my own family situation in terms of, I have a son who suffers from mental health challenges and lack of, the frustration that I’ve had to be able to try to find a psychiatrist who takes insurance otherwise I’m out of pocket. I mean a lot of money which we’ve been willing to pay for the most part but, you know, I just know there is so
many other people out there who don’t have that ability and so they are going to forego the treatment. So I guess it is both personal and professional in that regard.

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

REP. STEINBERG (136TH): Thank you, Representative. Other questions or comments? Not. Susan, thank you very much for your testimony. Next up Dr. Shaukat Kahn.

DR. SHAUKAT KAHN: Good afternoon, Chair Representative Steinberg, Distinguished Members of the Public Health Committee. My name is Shaukat Khan. I am a psychiatrist practicing who works at the VA. I get my salary from the DOD and in a clinic in Hamden. I am also president of the Connecticut Psychiatric Society.

Two weeks ago, I came to this building to testify on a Bill for parity between treatment for patients with medical and mental health illness and substance use disorders. It was a very uplifting moment at that time. Many groups came together to support a common cause.

Today, I am testifying against the Bill SB 966, which allows psychologists to prescribe medications. I feel bad to do so because, I have many psychologist friends. In fact we work together in the same location for the last 15-20 years within the boundaries of our own expertise with collaboration as needed. But, what motivated me to come today is my Hippocratic Oath as somebody mentioned before, “first do no harm.” When you are talking about the harm training is very much related to appropriate treatment so we talked about the
numbers, I though what a psychiatrist trained our, what the number of hours that APRN and physician's assistant are trained, and if we look at this chart, the bottom line, maybe you cannot see from the back, is the training for the suggested training for the psychologist and you see here the psychiatrist, you can see the nurse’s training and you see the PA’s training and the bottom here, which is barely out of the baseline is the suggested training for the psychologist. And this is just prepared by American Psychiatric Association. An association of 25,000 psychiatrists around the world.

As I try not to do harm to my patients I don’t want to see them being harmed by inadequate treatment. So I was talking to a psychologist friend before the testimony, his final words about his education were that his two years of master’s in psychology and three years of doctorate taught him more to be a researcher than a clinical psychologist. He admitted that he does not have any training in psychopharmacology and he really did not care about psychologists prescribing.

Now I know that a lot of training issues were talked about but I want to share my personal medical experience. I know there is a great need for mental health care for our patients, especially given the current opioid epidemics. But we will have to understand the availability of access is not the only factor for improving the mental health care. NIMH has also described some barriers for care that includes cost, idea of self-cure, lack of information, distance from the health care system.

I strongly believe stigma is a major barrier. My son is a decorated Iraq and Afghanistan Veteran, a
Marine. He is at home now. I know he needs mental health support and he also understands that but he will not go to the VA Hospital because people will look at him as weak. He is a Marine. Once a Marine always a Marine. So stigma is a major factor. This is not about only the access issue, stigma, knowledge, we have to deal with that. Let’s do that. Let’s talk about collaborative care, let’s talk about Telepsychiatry. Let’s talk about mental health parity that will bring most patients to care. act, let’s talk about collaborative care. The network inadequacy is an issue not only to psychiatrists it’s the same issue to psychotherapist.

I gave an example in my written testimony of how a young man that I know used to go to a psychotherapist, paid $235 dollars of the initial visit and then $150 dollars for every visit but then he couldn’t get reimbursement because the psychotherapist was out-of-network.

I know of a gentleman who told me the other day that his son was going to a psychologist, he was diagnosed with depression and he was being treated for that. Finally when he was getting worse, he was taken to a psychiatrist, and the psychiatrist diagnosed him with Bipolar Disorder and you know, the psychiatrist is sitting here. When a patient with Bipolar Disorder is treated for depression, that doesn’t make any sense. [Cross-talking]

REP. STEINBERG (136TH): Doctor, I’m going to have to ask you to summarize please.

DR. KAHN: Okay, sure. So lastly, that I want to summarize this way. Let’s not have a quick fix, a knee-jerk response to a major crisis like this which
needs more thoughtful, long-term planning, safer, more visible and appropriate intervention. This Bill is a step-backward from the parity and my colleagues have already testified here and have given a lot of experience, a lot of ideas and their experiences so, I end here.

REP. STEINBERG (136TH): Thank you, Doctor and thank you for all your work with all the psychiatrists in the State, we very much appreciate it. Are there questions or comments? No. Thank you, we really appreciate it. And now Dr. Jessica Chapkin, I'm not sure. You write like a physician. [Laughter]

DR. JESSICA CHAPKIN: Not a compliment. Good afternoon, Representative Steinberg and the rest of the Members of the Public Health Committee. My name is Jessica Chapkin and I am a second year psychiatry resident at the Yale School of Medicine. I am here today to speak in opposition of Senate Bill 966.

As I think, the most junior psychiatrist here, I did want to highlight some of the training that we’ve done, cause I think I’m the closest to the medical training. And I do think that my training as a physician and subsequently a psychiatrist stated in undergraduate and when I chose was to take premedical classes and dedicate a lot of my time to that. And I actually knew I wanted to work with people with mental illness and made the decision and do I want to be a psychologist or do I want to be a psychiatrist. And I made that very intentional decision knowing that medication was an important tool that I wanted to know how to use appropriately and faithfully. And so then I went on to do four years of medical school and I am now in my residency. And I am in my second year of residency
meaning that last year I spent most of the year doing internal medicine and neurology only now to then specialize in psychiatry. And I think those months and lots of time on those other units was crucial for me to be able to treat my patients. I needed to be on an internal medicine service to see what hypothyroidism looks like and way that is different than depression. I needed to know how to do an appropriate physical exam to pickup on someone who has slow reflexes or someone who has high reflexes and is at risk for serotonin syndrome.

I needed to be on a neurology service to see what psychogenic nonepileptic seizures looked like compared to epileptic seizures. I needed to know those things and I needed to see them and needed to be trained by people who treat them every single day in order to be able to point them out in my patients and treat them effectively and faithfully. And I just think that it’s incredibly important and one of the one ways that we can really make sure our treatment is effective and safe for everyone.

The other thing I wanted to point out is that I was lucky enough to be one of the residents that got to work with recruitments this year and recruiting new psychiatrists into the residency program. I will say that psychiatry resident numbers are increasing so there are more people interested in psychiatry so even just if we look at the number of psychiatry resident applicants in 2016 it was 850 and in 2018 it was over 1200. So the number of psychiatry applicants is increasing and then the number or psychiatry residents starting is also increasing. So this year compared to last year we had 163 more psychiatry residents that last year. So I would like to wrap up by saying that I think medical
training is extremely important because you’re a physician first and then a psychiatrist and I do think that we can expand on our interest in psychiatry and bring more people into that field.

REP. STEINBERG (136TH): Thank you for your testimony and for providing that perspective. I think your point about all the different clinical experiences experiential teaching that is involved is very pertinent and I am also very pleased to hear that we seem to finally be trending in the right direction in this state with regard to psychiatrists. So we will take that as a positive sign. Comments or questions? Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chair. Just sort of nuts and bolts because have asked me and you are way closer to it than I am, you are in a big health system in terms of the drug, drug, drug other interactions. Do you mainly rely on, in your role, the electronic medical record that will kick back things that you are working on a daily basis one-on-one or on the floor or with a pharmacologist or pharmacist in terms of the complex patients in the drug/drug interactions?

DR. CHAPKIN: I would say, I mean I rely on both and also my own knowledge. So I think it is important that I know what I’m prescribing and what is going to interact first and foremost. I do consult with a pharmacist very regularly especially when you work in the hospital there is always one that’s available and then I do the electronic medical record help to have sort of warnings in place but I don’t think that is our primary method.
REP. PETIT (22ND): And if you’ve had much exposure to outpatient, do most of the outpatient psychiatrists that you’ve worked with function the same way or are most people keeping separate electronic records or written records, or what’s the standard in psychiatry in 2019 for record keeping?

DR. CHAPKIN: I would love to answer that question, unfortunately you don’t do much outpatient directly until your third year, so maybe ask me next year. [Laughter].

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

DR. BARBARA BUNK: Good afternoon Senator Abrams, Representative Steinberg and all the Distinguished Members of this Committee. My name is Dr. Barbara S. Bunk. I am a psychologist from Glastonbury, in practice for many year and I also teach at UConn’s Psychology Department Graduate students and I am here today of course to talk with you as the Co-Chair of Connecticut Psychological Association’s Task Force on Prescriptive Authority.

You have heard a lot about our training or the proposed training and it’s comparison to medical training. You also heard a lot already today about some miscommunications actually about psychologists and how much support there is in the psychology field and many other things. But I decided that instead of, that I was going to bring us back to what I actually prepared to talk today about which is the access issue to just fill that out a little.

Access to effective and efficient mental health care is a profound problem for the people of Connecticut.
Psychiatrists generally have long waiting lists or are in some way otherwise available for the increasing needs of the patient. The adoption of into law of Senate Bill 966 is not a magic bullet. It will be a part of the solution, a step forward for integrated care. Just as APRNs and PAs, other things that we’ve already mentioned today, Telehealth, Access Mental Health and other programs are a part of the solution.

Research has consistently shown that psychotherapy plus medication is most effective and the demand for psychiatric medication is rising. Psychiatry visits are now often focused on medication management only, and most patients consequently see two separate providers. Prescribing psychologists can help address these needs.

As you will see in my submitted testimony the numbers are truly astounding. One in five adults in America experience mental illness. One in four adults is diagnosed with depression or anxiety.

For children, the need is even more critical 50 percent of all lifetime mental illness begins by age 14 and the average delay of the onset of symptoms and intervention for children is eight to ten years. These numbers speak to the complexity of mental health.

Mental health symptoms are not always observable like a broken wrist might be observable and with children symptoms can often seem like normal age appropriate behaviors. The child that refuses bedtime because he can’t get away from the video game which escalates into a nightly family conflict. Most parents have had this experiences and wouldn’t necessarily think of it as the beginning of
addiction. For the youngster who wants to keep her room just so, cries and complains if the rock collection is not placed exactly how she wants it, would a parent or perhaps even a PCP pediatrician quickly think that it is anxiety of obsessive/compulsive disorder, probably not. We might even think it is great that she’s so careful about keeping her room clean and neat.

REP. STEINBERG (136TH): Could I ask you to summarize please?

DR BUNK: Certainly. I’m not suggesting that those normative experiences are necessarily pathological. I’m just saying that psychologists have been trained in integrating care. We know very clearly and fully now, different from 20 years ago, that the physical health and psychological health are integrally entwined with one another. That we need to address both. Just in final summary of the question about the training that we are proposing, this is really the basis of the difference between the proposed training and medical training. I am not suggesting that medical training is inferior nor is the psychological proposal here is superior. I am simply saying that we, of course, share the concerns that Connecticut’s patients must be kept safe.

REP. STEINBERG (136TH): Doctor, I think you’ve framed the problem very well. I think that we all agree that integrated care mind and body are critical in this context but you’ve also heard a number of psychiatrists come up here and say there is not an effective substitute in the proposed language of what we would ask psychologists to do to get prescribing authority that would approach the level of both classroom and clinical experience
necessary to be really address some of the more complex issues related to pharmacology interactions, comorbidities and like that. How would you respond to that?

DR. BUNK: Two fold, one is I would say that the data that has been collected over the many years has shown that there is safety in the training that is being proposed. Secondly and perhaps more importantly we would happily collaborate with the other healthcare professions to ascertain that the training that is provided and the supervision and whatever and the preceptorship becomes much more acceptable to the entire healthcare community. We want our patients to be safe also. We understand the complexity of both their psychological issues as well as how it is entwined with the physical issues. We welcome the collaboration and consultation.

REP. STEINBERG (136TH): Thank you, Doctor. Questions or comments? None. Thank you for your time. The last person to testify on Senate Bill 966 is Dr. Elizabeth Burch.

DR. ELIZABETH BURCH: Good morning, Mr. Chairman and Distinguished Committee Members. I’m sorry, good afternoon. I’ve been waiting awhile here. I am here to express my opposition to Bill 966. My name is Elizabeth Burch and I am currently a Fellow in forensic psychiatry at Yale University in New Haven. Prior to that I completed my residency at Hartford Hospital in the Institute of Living. In July I will be going back to the Institute of Living to work fulltime as an inpatient psychiatrist there.

As a rising psychiatrist in the State of Connecticut I am very concerned about the proposed Bill before you now. I share the concerns about safety and
adequacy of training but in addition I want to express that I do not believe that expanding prescribing privileges to psychologists will ultimately give the severely mentally ill greater access to the care they need.

You’ve heard that the solution to access problems for mental health is adding more prescribers to the system. I want to pushback on that a little bit. There is a wealth of evidence that you’ve also heard that for almost all psychiatric diagnoses therapy and various community supports is frequently just as important for successful treatment as medication management. You have also heard personal testimony from a couple of people about the need for psychosocial support in treatment. In my experience this is best achieved when patients see a provider who is an expert in medication management and a provider who is an expert in providing psychotherapy. I was fortunate enough as a resident to have experience in providing care in that kind of an integrated model for a few of my patients and in my humble opinion it worked really well. I coordinated very closely with a psychologist and we provided excellent care for a very complicated patient and I think a level of stability.

In spite of knowing this is the best model, I think many people would admit that it’s the best model, very few patients are receiving access to that kind of model. Frequently they show up when they do get to see a provider they are prescribed medications and that’s it. Their treatment is inadequate I think often because of that and they continue to present with ongoing mental health issues and it just creates a burden on the prescribers because
they keep having to address issues that aren’t being adequately treated.

This bring me to the Bill before you. I think those in favor of psychologists prescribing would argue that psychologists are in a unique position to provide integrated care because if given prescribing privileges they could offer both therapy and medication in one visit. As an explanation for solving the problem, this confuses me because the fact of the matter is the State of Connecticut already has a group of professionals that are fully qualified to provide medication and therapy and those are psychiatrists. All psychiatrists are qualified to provide therapy. So the real question is why don’t they? And to put it bluntly, therapy just doesn’t pay. Most psychiatrists have found that when they have an option to bill for therapy or for medication management it is much more lucrative to bill for medication management and to refer people elsewhere for therapy. So I am at a loss in trying to imagine how if given the ability to prescribe psychologists will avoid that same fate. I don’t believe the outcome will be greater access to the right kind of care for the severely mentally ill. I fear the outcome will be more prescribers with less training than any current prescriber. Fewer professionals providing intensive therapy to the severally mentally ill and fewer people getting care for an integrated system that research has definitively told us is the best way for individuals to achieve relief from mental illness and wellness in their lives.

REP. STEINBERG (136TH): Thank you for your testimony. Once again we’ve done a really good job of defining that we’ve got a problem. I’m
distressed the example you gave again, is suboptimal, that we are not necessarily meeting the need. Do you feel that the training you’ve received is gonna put you in a position to take on a leadership role in more integrated care in trying to bring in more of a team approach to allow us to more appropriately address some of the problems that you described?

DR. BURCH: That is very much my hope. An interest in leadership is part of the reason I’m here today is because I have an interest in speaking out about these issues and I’ve already talked to some of the people where I am going to be working, obviously I have a relationship because I trained there about some of the ways I would like to change the way they do things on the inpatient unit providing a more integrative model. And I would add that one of my great mentors and someone who I’ll be working with when I go back is the person, the psychologist who runs the training there at the department.

REP. STEINBERG (136TH): Good to hear that you’re in an environment where you have both inpatient and resources so you’re in an environment where there are more practitioners in some part of the State that is actually more of an issue.

DR. BURCH: Yes.

REP. STEINBERG (136TH): Senator Abrams. Hi. Thank you so much for defining what has been an issue that I’ve personally had to deal with. I was a special education teacher and a high school administrator and worked with many students who had social emotional issues and it was always a struggle to help them first of all, find them a psychiatrist that were available and taking new patients and that
would see them for the integrated care that they needed so often they ended up going to some other kind of clinician, usually a psychologist to get therapy and there wasn’t always communication between the two. You’ll be working in an environment like Representative Steinberg said where that is gonna happen organically more often but, you know, a lot of parents had a lot of heartache and struggles trying to get their adolescent help and it was hard enough to get their adolescent to go see someone for therapy no less follow up on the medication and they were sometimes only seeing their psychiatrist every six months and, you know, they weren’t always medication compliant, and all of those issues were happening. So, I appreciate your saying that you don’t want to see this clinical psychologist just fall into the same trap of just becoming prescribers and I really do appreciate you talking about the fact that I agree that psychiatrists are wonderful with their therapy if they are given the chance and the opportunity to do that. But that is the struggle, so that is where I’m coming from on this Bill that I know there is a need out there and so how do we fill that need. Before we achieve the vision that you have which I applaud, are there things other than this that you think we can do or are you vehemently against doing this? I’m not quite sure.

DR. BURCH: So, I mean, I guess I would answer yes to both of those. So I think there are things that can be done, many of my colleagues before me have testified about Telehealth, integrated care and primary care settings and all of that and I think that all of that is great as well as I said emphasizing reimbursement of the proper model of
care for patients. You know, I think I didn’t emphasize in my testimony to have such a brief time and I think I do really share the extreme level of concern about safety of prescribing medications and just the real vast difference in training between psychologists and psychiatrists. I know one of the residents already testified that she made the decision early on about being an psychologist or a psychiatrist and I also was on track to be a psychologist back in undergraduate school and I can tell you that when I made the decision to go to medical school my life in undergraduate school changed dramatically and what I learned started to change dramatically and so I just think the level of training is vastly different. So I am opposed to this Bill.

SENATOR ABRAMS (13TH): Thank you. Can you help me maybe as a lay person understand the argument about a psychiatrist overseeing the medication in a different way than a clinical psychologist with this training would be able to do so when from my perspective a person, and I’m particularly talking here about adolescents, you know, I’m not talking about an adult who facilitates their healthcare a little more, you know, a little more successfully let’s say, but an adolescent who the parent brings them to the psychiatrist, they prescribe a medication. Again in my experience they might not see that psychiatrist again for six months so how is anybody monitoring that? How is that person who is prescribing it monitoring it for all of these things that could be happening as opposed to the person who they are seeing weekly for counseling who is actually seeing them sitting down, talking to them on a weekly basis? So help me understand this.
DR. BURCH: Yeah, I mean, I guess it is difficult to answer that because I think it depends on the provider. I think the experiences that I’ve had, and I’m not a child psychiatrist although I have done some training in child psychiatry as part of my residency, that is not really how it works there in that clinic and obviously is specialized in working with very complex patients that there were intimately involved in talking and communicating with the therapist that was seeing the person on a regular basis it certainly wasn’t six month at least by the clinic’s standards as we know if they saw a patient that far out they saw them more frequently than not. I’ve also worked on an inpatient child and adolescent unit and it was the same there as well that there was a tremendous effort to have integrated care. What was the second part to your question?

SENATOR ABRAMS (13TH): I just was having trouble understanding how someone who doesn’t see the child regularly would be in a better position to monitor their reaction to medication than someone who saw them, you know, like on a weekly basis for therapy let’s say.

DR. BURCH: Well, I don’t know that is necessarily they would be without getting input from the people who do see them regularly which is why I think many prescribers do reach out and coordinate closely with people who are providing therapy and with the family and to get an assessment of how things are going in response to that medication. But I want to emphasize and I think a lot of my colleagues have talked about this as well is providing medication for mental illness goes much further than getting an accurate diagnosis and picking the right medication
that reduces symptoms. It is, I mean, it’s just so far beyond that and all of the things you have to take into consideration and I can tell you that when I write prescriptions for patients such as for lithium I think someone mentioned that, all of the things that I think about don’t come necessarily from my training and residency, they go all the way back to my, you know, anatomy and physiology, and medical school and the tubules in the kidneys and lithium, and in and out and all that stuff, and the experience I had of a patient on the consult service who had to have dialysis from lithium toxicity and all the time I spent in the dialysis unit as a medical student being questioned by the nephrologist, I mean all of that co-electives, when I go to write a prescription for a patient, and I think that just can’t be replaced in any other way.

SENATOR ABRAMS (13TH): I think that you’re talking about the communication happening and I appreciate that when it happens it is a wonderful thing, but I think similarly to psychiatrists not having the time to devote to therapy necessarily in their practice because of all the reasons that you mentioned, it is also very difficulty to make that communication happen has been some of the experiences that I’ve had or seen happen with students that I’ve worked with. So, I agree with you in terms of that communication being but that is almost one of negatives for it because the person who is prescribing over here and the communication doesn’t always happen and then it become difficult. Thank you very much for your honest answers, I appreciate it. Are there any other questions or comments from members of the Committee? I thank you.
DR. BURCH: I don’t know if I could respond. Someone asked a question earlier that my colleague wasn’t able to answer about an outpatient setting when there is a question about prescribing and referring to, you know, what kind of support you got when you’re not sure what to do with medication and having practiced in an outpatient setting I just wanted to add that frequently I think the experience has been that you reach out either to colleagues or superiors who know more. At times I think it can be helpful to consult a pharmacologist particularly if they are a psychopharmacologist that is, you know, I think that’s a lot of it is related on the professional experience and I know many people who have gone into private practice who have setup kind of peer supervision type networks and stuff like that so they have a network to reach out to, so I just wanted to respond to that question. Thank you.

REP. PETIT (22ND): Thank you for your testimony and I guess the other part of it was perhaps trying to get into the clandestine world of outpatient psychiatrist do they actually use electronic medical records given anything and everything can be hacked, do actually psychiatrists are they the few people that actually do write things down now and don’t keep track of them electronically anymore?

DR. BURCH: So I think that depends certainly in the bigger places that, you know, bigger hospital systems they tend to use electronic medical records but I think people in private practice probably use paper records. There are some free electronic medical records out there, I don’t know how commonly they are used and I don’t know a lot about their security.
SENATOR ABRAMS (13TH): Thank you very much. We are going to move on to Senate Bill 1101 and Kathy Flaherty.

KATHY FLAHERTY: Good afternoon, Senator Abrams and Distinguished Members of the Public Health Committee. My name is Kathy Flaherty and I’m the Executive Director of Connecticut Legal Rights Project, the Co-Chair of Keep the Promise and a member of the steering Committee of the Cross Disability Lifespan Alliance.

For whatever reason, even though I submitted my testimony electronically it still isn’t up on the website but I would encourage all the Members of the Committee to read it there when it’s available and also look at the testimony of Al Shehadi who is not here because he is in Middleton Court attending the trial of the forensic nurse specialist who has been accused of eight counts of abusing his brother.

I agree with the suggestions in his Bill. I do come here with props, I am very disturbed by Bill 1101 and I’ll tell you why. If you haven’t read by Op-Ed in the Hartford Courant I encourage you to read it because one of the things that I’d like to point out that I think is very important is this legislature last session passed a Bill establishing this Task Force. That Bill was effective upon passage and the date that the former governor signed it into Law was June 4, 2018. That Bill said that members of this Task Force shall be appointed within 60 days of passage. That date was August third. The preliminary report of this Task Force was due January 1, 2019. This Op-Ed was published February 10, 2019. Several appointments to the Task Force were not made until after that Op-Ed appeared. I
want to be very clear with the members of this Committee and the members of this General Assembly that this Bill that is pending before you, cannot be used to postpone the very needed action of this Task Force for another couple of years.

We should not be waiting until this new Bill is effective to get the members of the Task Force who have already been appointed to meet. And I would encourage you to remove the language that talks about the focus of this Task Force because I do not know why you would want to focus the Task Force in an intention to direct the conclusions of the Task Force before it has had a single meeting. I want to acknowledge all the good work that has been done by the Department of Mental Health and Addiction Services and there have been changes at Whiting but I’ve got to tell you, I still have to go to Whiting every single time I meet clients and they ask me, do people up here even care about us. Do people remember us? And I don’t know what any of you want me to tell them anymore. I ask them if they wanted to submit any testimony and I said I would bring it up here for them today in person, none of them gave it to me because none of them believe that you’re actually going to do anything and that is creditably frustrating for me as Executive Director for CLRP, as a Representative of those people and as a taxpayer of this State whose tax dollars are going to pay pensions of the 40 people who have been separated from their employment because of what happened there. So I just will stop because the bell rang, open it up to questions, but I just want to make it very clear I have feelings about this Bill and I hope you will give me the opportunity to answer questions.
SENATOR ABRAMS (13TH): I just wanted to speak to a couple of points that you made. The Task Force is filled in and we are working on setting the meeting so I want you to know that, that this Bill was never intended in anyway to delay that, quite the opposite. We are really trying to move it forward and make sure that we do what it was supposed to do initially. Likewise with any of the things that you read more of the directive or automatic outcome, anything that we’re doing, I think we are on the same page honestly. And that was never meant to be in anyway directive or limiting to the Task Force. So I think that, you know, I speak for many members of the Committee that this is very important to us and that it is our intention to get the task force up and going.

KATHY FLAHERTY: I’m very encouraged to hear that. One other suggestion I would have is that if you are considering changing the language, I would make it a mandate. If you guys really want to direct and make this Task Force more effective, don’t just say that the Task Force may hold a public meeting, tell them they shall and tell them that they shall hold at least one meeting on the campus of Connecticut Valley Hospital so that the people who are most effected by what happens and the changes the Department has made, or hasn’t made or still needs to make have the opportunity to participate in those Task Force hearings.

SENATOR ABRAMS (13TH): Thank you. We certainly, I will look and see what our options are in terms of how direct we can be with a totally voluntary Task Force that way but you make some good points though. Senator Somers, did you have?
SENATOR SOMERS (18TH): Thank you for your testimony. I would like to reiterate your frustration with getting this Task Force up and running. I think there is still actually one spot that has to be filled, I know there is an interview going on for that right now and I have been advocating for people to get appointed on this Task Force since the day the Bill passed. The appointments on my side were made immediately, I am not sure what took so long, it’s very frustrating but we’re almost there. We’re almost across the finish line and I know that the leadership of the Public Health Committee will be meeting with this new Task Force that is supposed to be completely independent. You will see some language in this bill that talks about if a employee want to speak to the Task Force, unfortunately one of these appointees works for Whiting, so it is not truly independent, I’m not sure how that happened, but within this language we wanted to ensure that people will feel comfortable going to speak to them so we are requiring or asking if there is an employee of Whiting that they will have to remove themselves from the time that individual who maybe worked for Whiting or is a patient there can go and have a confidential conversation without fear of retribution or response so that is something that is important in this language.

We were giving them direction but they are not limited to what we’ve requested and I will say that in our original legislation we tried to require that they hold, and I know that Doctor Representative Srinivasan was adamant as we were that we wanted the hearing held at CVH to make is accessible for those who are working there or patients there and we had a
lot of pushback on that. That is something I think is very important and I hope that we can get that passed this time. So I wanted to ask you a few questions about what you’ve seen because you are at the facility quite a often and it is hard for us to assess, again, the whole idea of having an independent Task Force was so that we could hear independently how these changes that we’re hearing about are going on at the facility, how are they really working because obviously we are getting one perspective? So from your perspective from somebody who’s there in the role that you undertake, what have you seen as the changes since Whiting has been separated from CVH and can you speak to the culture that you’re experiencing within the organization? I know a lot of people have questions about that. So if you could speak to that it would be helpful.

KATHY FLAHERTY: I will do my best. People should be aware that CLRP changed the way we serve our clients who are inpatient at Whiting as a result of what happened in this. Prior to this whole scandal breaking we used to meet with our clients in the Professional Visiting Room at Whiting which is a room like is not on the unit, it is a room that you get to after you go through the sally port and is before the big visiting room. But we used to not really go on the units. Now it is either me or our Legal Director Kirk Lowry who actually physically goes to the facility and physically go on the units and we do among other things meeting with individuals who are clients but also attending Unit Steering Committee meetings, the facility wide Steering Committee meetings although we have not bee able to go to them as often as we would like because, often for me, cause I’m here. But I think
on some levels in terms of the institutional functioning, there have been huge improvements since that separation came into being. Having Hal Smith and Dr. Wasser in charge of the facility, we have found it very useful to continue our meetings with them and have found opportunities to collaborate with them when we raise issues. So on one level that has always been the case. The people who are high up in the institution when we meet with them, say the right things at the meetings. The problem is it doesn’t always seem to translate through to the ground level frontline folks doing the work. And I just want to say because I’ve been on those hospital wards as a patient too, it is not an easy job. I will never say that there job is easy but I think one of the things we have to recognize is that there are people there who have chose that as their career and should know going in that it is not going to be an easy job versus the people who are there as patients usually when you’re talking at Whiting, they are not there by choice. They are either, you know, have been found guilty be reason of insanity, have been civilly committed there. There may be a few people that actually technically signed voluntaries but voluntary within the psychiatry field is never really a truly voluntary admission and it’s like a jail. I mean honestly, if you have not been into the facility I challenge you to go because it does not feel like a hospital. It feels very correctional and that’s why I do think it really is important that the people who serve on this Committee take the time to go down there and meet with the people, especially the people who’ve been there a super longtime and at least in my opinion don’t necessarily need to be there.
SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Ms. Flaherty, thank you for your advocacy. Representative Carpino who has left for another meeting at the moment and I spent a good three or four hours there this fall I guess now and had a very good visit and had a few of about half a dozen different units. It appeared as you say to us that with the new leadership administratively and medically that they are on the right track in terms of attempting to change the culture. When you visit with a client now and they have complaints is it handled in any different way than it was say two years ago with the new administration, new medical director in place?

KATHY FLAHERTY: I would say on some levels things are getting resolve more expeditiously which is good and when there is the opportunity for, you know, DMHAS needs to follow with their own policies cause the Department actually has some really good and really strong policies that on paper are very respectful of the legal rights of the people they serve, but again it is too often where it turns out in practice that doesn’t always happen. But when we have the opportunity to intervene and remind people in the Department of these are your own policies let’s try to follow them that does seem to happen. I have very few of my own cases. It is really Kirk Lowery who is our Legal Director who provides the individual case services to a lot of the folks at Whiting so I can certainly reach out to him and try to get you some more feedback. But I think both of us would agree that the administration of the hospital has been responsive and there have been opportunities for us to work together and sometimes
because of the nature of the things that we’re talking about, they can do so much that is within their control but then there’s some other things that happen that they don’t control. Like one example of that is that in every other DMHAS operated facility CLRP folks either have the keys to the unit or our badge unlocks the door so we can go to the units any time of day because our consent decree that we were established under gives us reasonable access to peoples living areas and that was one of the things that we weren’t using when it came to Whiting before and it is one of the things that we changed after this happened. Not saying that any of this would have necessarily been prevented if we had visited Whiting the same way we are regularly on every other unit in other DMHAS operated facilities but, you know, we go there on weekends. We can go there anytime of day. The problem is that when we do go to Whiting and this doesn’t happen as much anymore, so I am very pleased to see it, we have to wait for somebody from a unit to come back to the sally port to get us to escort us to the unit. Any other facility we can just walk to it and, you know, there were times when we first started going down there that we were waiting a long time and it there is anyway to frustrate an attorney is to make them wait needlessly to get over that barrier to just meet with their client. But we were able to address that and that is not happening so much anymore, so that is a very tiny example but I think that it does show that there is a bit of change.

REP. PETIT (22ND): My only observation from those three or four hours was that I thought it was very interesting that most of the inpatients knew the
name of the medical director and the administrator no matter which unit we were on, they seemed to greet them warmly so clearly they had been around and everybody knew who they were. They weren’t just hiding in their offices and not reaching out to people. I saw that as a positive sign.

KATHY FLAHERTY: And I agree, it is. There’s no question in that our clients have even told us sometimes when they reach out to us they have already reached out to Dr. Wasser or to Health Meds and just for whatever reason, you know, people sometimes need to have more realistic expectations about when people will get back to them even when they are dealing with us but there definitely is, they are not people hiding in an office. They’re there.

REP. PETIT (22ND): Getting back to the comments you made about meeting with folks, maybe I missed the import of it, so where you were meeting with people was not a good place to meet or was a good place to meet or you need some other place to meet, I didn’t understand the comment?

KATHY FLAHERTY: Well if you remember when you visited Whiting and you go in and you go through the bubble and you get past the first door and you hang a right. Right before that big first visiting room there is a tiny little room that is labeled Professional Visiting Room. That is where we used to meet with our clients which means they would have to be escorted from their unit to meet with us. So was it a bad place to meet with somebody? No. But did it require more staff time to, you know, do even just that simple transport but it also meant that we didn’t have the opportunity to just get a sense of
what was going on on the unit by physically being there.

REP. PETIT (22ND): Understood now. Thank you very much. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Senator Somers.

SENATOR SOMERS (18TH): Thank you. I wanted to ask you as a follow up to what you said, could you give us a specific example as to DMHAS policy being good in writing and followed by the upper administration but when it gets to, you know, be it on the floor it wasn’t implemented, could you give us an example of something like that?

KATHY FLAHERTY: Yeah. I’m not sure this necessarily relates to Whiting but just in general, the Department has a great policy when it comes to the use of involuntary medication, cause a lot of people think that, oh and especially hearing some of the discussion here today about prescriptive authority for psychologists. A lot of people think, oh if people would only just take their meds everything would be fine and that is discussion for another day but what people need to know is that when people don’t just agree to take their meds, what that means if it’s a true emergency or if it gets to the point where there has been a court order for involuntary medication that somebody is not complying with, it means you get held down, you get restrained, you get tied to a bed and you get injected with really powerful drugs. I don’t know that people realize the reality of that and how traumatizing that is for people but when it comes to DMHAS’s policy on the use of involuntary medication, what it actually says is you are supposed to engage with the patient first and establish that
therapeutic alliance and encourage voluntary and truly informed consent to medication. My experience as a patient has been when you agree with what your doctor, or clinician or your prescriber is suggesting that you do. There is never a question about your capacity to give consent. It’s when you start asking questions or you reject their advice is when questions get raised about your capacity to make decisions with regard to informed consent. What we have been able to do is say, follow your own policy. If somebody is disagreeing with you your first reaction should not just be, oh let me go to probate court and get an order for a conservator to be appointed to make that decision for you. Let’s have a conversation and a discussion even in a public psychiatric system, I acknowledge they are probably isn’t time for that but that is what should be done. A lot of what we’ve found is there have been times where we have encouraged DMHAS to go back to the beginning part of that policy, have the discussion and it turns out once the person gets their questions answered and feel like they have been listened to they agree to take the medication. You know, and they’ve that of truly informed choice. So I think that is one example that I can think of off the top of my head.

SENATOR SOMERS (18TH): Thank you for that.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you very much. Thank you for your work and thank you for your testimony. Carolyn Howard. Go right ahead.

CAROLYN HOWARD: Are you asking me questions or am I just going to speak?
SENATOR ABRAMS (13TH): You have three minutes to speak on your own what you would like to share and then we can ask you questions.

CAROLYN HOWARD: I would like to let everybody know that the names change for Whiting is just a name change. Nothing has changed there except things are worse. It is a very oppressive environment to work in. That speaker before me, policies are not followed. As an employee we are held responsible to the “T” to anything but the administration is not. I said it was very oppressive place to work. We have people out constantly on administrative leave or suspensions. I don’t know any other place that operates that way and to cover the lack of staffing people are mandated constantly.

We have about, at least, six directors of nursing at that work at Whiting for a hospital that houses about 80 patients. That is unheard of. I think the corrections has on DN for maybe thousands of prisoners. I don’t know of any hospital that has that many DNs or convalescent homes. The overhead is ridiculous. As a taxpayer I think people should be outraged. That’s what I want to say. [Sighs] Oh yeah, there’s also a situation where people are forced to transport patients, normally that is done with usually another staff, that would be two staff and at least one officer. We are being forced to transport some patients by ourselves. While in the hospital under maximum security, lock and key, everything is secure, everything is on camera, everything is being watched by each other, we watch each other’s backs constantly but we’re forced to go out into the public just a patient and the people we are responsible for have committed heinous crimes. Am I done?
SENATOR ABRAMS (13TH): You can continue for another minute or two.

CAROLYN HOWARD: I think the community needs to be aware of that, putting people at risk especially the worker that is going out with the patient. People don’t really know what goes on at Whiting.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Do you work at Whiting?

CAROLYN HOWARD: Yes, I have been there 17 years.

SENATOR ABRAMS (13TH): Seventeen years, and you said that you feel like things have gotten worse, can you give an example [Cross-talking] is that a new thing being alone with patients or was that always going on?

CAROLYN HOWARD: What was going on with patients.

SENATOR ABRAMS (13TH): Where you would travel just alone with the patient was that always happening or is that something new?

CAROLYN HOWARD: Yeah, we transport patients routinely but I haven’t had to go alone but I know other people that have had to go. I think it is a very serious situation.

SENATOR ABRAMS (13TH): Is that an example of something that you’ve seen that is different than it was before?

CAROLYN HOWARD: That is definitely different.

SENATOR ABRAMS (13TH): Is there any other examples you have as to how things, how you said things have gotten worse? I just wondered if you have any other.
CAROLYN HOWARD: It is a very punitive environment. It seems like there is a lot of retaliation for the administration against the staff. I think most of it comes from the situation that happened two years ago. I think we are being punished, like anybody that has been there, I think we are viewed as, I know that we are viewed as patient abusers because our CEO said that during a staff meeting that I attended.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): Thank you. Thank you, Madam Chair. Thank you for your courage coming here, I know it’s probably difficult for you. What is your specific job or job description?

CAROLYN HOWARD: I’m a forensic treatment specialist.

REP. PETIT (22ND): So you typically work one-on-one with the inpatients or with a group?

CAROLYN HOWARD: In a group.

REP. PETIT (22ND): Do you feel that the culture in the last six months has changed compared to three years ago, five years ago? You’ve been there 17 years have you noticed any change at all?

CAROLYN HOWARD: Definitely.

REP. PETIT (22ND): I’m sorry, go ahead. Definitely has changed.

REP. PETIT (22ND): For the better?

CAROLYN HOWARD: No.

REP. PETIT (22ND): For the worse?
CAROLYN HOWARD: For the worse.

REP. PETIT (22ND): Do you feel that if the Task Force comes into place that you think that would be a group that you could come to voice your concerns with.

CAROLYN HOWARD: I would that it did.

REP. PETIT (22ND): To voice your concerns with if you felt you’re, you were protected?

CAROLYN HOWARD: I would hope so, we need something. I think something is needed, there is no transparency. There is really nowhere to go. I mean the mandated report thing. Things don’t always go the way they are supposed to go at Whiting.

REP. PETIT (22ND): You mentioned and I don’t know if you can really answer, you said there is a great many people who are out on administrative leave. Do you know why people are put on leave, is it for things they’ve done or perceived to have done or not done?

CAROLYN HOWARD: People don’t know why they are on leave and it seems to be just retaliation.

REP. PETIT (22ND): Retaliation for?

CAROLYN HOWARD: For whatever that they, for whatever unpopular thing you may have said or didn’t agree with personality wise.

REP. PETIT (22ND): Are you concerned that you will be retaliated against for coming here today?

CAROLYN HOWARD: I probably will be. I’ve already been the victim of some of the retaliation. There was two other people that were just on leave and they were put back to work, they don’t even know
what they did or why they were put back or taken out.

REP. PETIT (22ND): What protections do you feel like you have right now if you come forward to talk about issues that you think impact?

CAROLYN HOWARD: I don’t have any protection. I don’t even think 1199 is even helping us, they kind of bailed on us. I think any remedy that I would have would be outside of Whiting with maybe a personal attorney.

REP. PETIT (22ND): Well, I appreciate you coming here. I hope that when we get the Task Force moving I hope it can be an independent Task Force so someone like you can come in and give a variety of details that the Task Force needs to hear that might be better said to a group. So thank you. Thank you, Madam Chair.

CAROLYN HOWARD: I hope so to.

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

REP. STEINBERG (136TH): Don’t go anywhere quite yet. We have a number of more questions for you, if you don’t mind. You mentioned being put on leave in retaliation, that’s done by the administrators?

CAROLYN HOWARD: Yes.

REP. STEINBERG (136TH): And since the expose of the problems at Whiting, how many administrators have changed? How many new ones do you have or are they roughly the same people as before?

CAROLYN HOWARD: I’m gonna say off the top of my head we have a whole new administration.
REP. STEINBERG (136TH): Well I guess what I hear you saying is even though the administration people have changed, the culture has not, the way which you are dealt with has not changed, so it wasn’t a specific individual, it’s just the culture of the institution?

CAROLYN HOWARD: Well we have the same Commissioner.

REP. STEINBERG (136TH): Okay. How often do you see people from DMHAS touring the facility?

CAROLYN HOWARD: More regularly now that even. I do have to say that people coming in unannounced is a little disruptive, I have to defend that a little bit. Because we have to protect people, you know, at all times and like it’s good to know if people are coming on to the unit so that we can offer protection. We just can’t have people walking around, not know who they are, if we’ve got someone violent or just ready to go off or had recently gone off.

REP. STEINBERG (136TH): I guess they are trying not to have it too much of a coordinated thing where you can be ready for them. So it’s a hard one for both sides. Thank you.

CAROLYN HOWARD: Am I done? [Laughter]


SENATOR SOMERS (18TH): Thank you for coming today and thank you for sharing your story. I do have a few questions because some of the language that you used, I really don’t understand what it means so I am going to ask you some detailed questions. You talked about that someone can be put out on
administrative leave and not know why. How does that happen? I mean somebody comes to you and they say, I’m sorry, you are not going to be able to work for the next two weeks, where do you go, are you paid, you know, or what kind of things leads to that? Did you speak out against some policy and the next thing you know you’re on administrative leave or could you talk more about that?

CAROLYN HOWARD: I can share my own story with you. I was put out with what they call the “penalty box.”

SENATOR SOMERS (18TH): A what?

CAROLYN HOWARD: A penalty box.

SENATOR SOMERS (18TH): A penalty box, like hockey?

CAROLYN HOWARD: Yeah, like hockey.

SENATOR SOMERS (18TH): In the facility or?

CAROLYN HOWARD: Yes, it is a room with just a blank room.

SENATOR SOMERS (18TH): It’s an empty room at Whiting?

CAROLYN HOWARD: It does have a computer but you can’t touch it unless it is for work related. And I was put out there and I asked why and I was told they couldn’t tell me. The policy is that you are supposed to be told I three to five days but that didn’t happen.

SENATOR SOMERS (18TH): So the DMHAS policy is if your are sent, do they actually use the word penalty box in their policy?

CAROLYN HOWARD: It’s kind of what we call it.
SENATOR SOMERS (18TH): Okay, so the DMHAS policy says if you are put on leave in this room within three to five days you are supposed to find out what you did wrong?

CAROLYN HOWARD: Yes.

SENATOR SOMERS (18TH): Not before you are sent to the room?

CAROLYN HOWARD: No, because I asked and I was told that they couldn’t tell me.

SENATOR SOMERS (18TH): Can you go on?

CAROLYN HOWARD: And then the maximum you are supposed to be in the room is 60 days but I’ve been out there past 60 days and other people, there are two others that were out there past 60 days to.

SENATOR SOMERS (18TH): Okay, so you go into a penalty box for 60 days.

CAROLYN HOWARD: Maximum supposed to be.

SENATOR SOMERS (18TH): Supposed to be, and people have been there longer. How many people are in this room and are you paid and what do you do all day.

CAROLYN HOWARD: I’m paid less that what I would be paid if I were on the floor, but yeah, I’m paid.

SENATOR SOMERS (18TH): And what do you do all day. I’m not saying what do you all day but what do you do in a room with a computer you can’t use. Do you just sit there.

CAROLYN HOWARD: Well I brought in a book so I would have something to read.
SENATOR SOMERS (18TH): Okay, and did you ever find out why you were put in the penalty box or any of the others? How many people are in the penalty box?

CAROLYN HOWARD: I’m in there by myself but on second shift there was two people that were just put back on the floor and there was no reason, they just all of a sudden came in and said you can go back into work now. I saw myself out there after I went home, I was still, I went home sick and I had previously reported, this is what you call mandated reporting, I reported, I unofficially reported bullying and harassment. I quickly found myself in the penalty box. So that is the kind of retaliation I’m talking about. You know, I went home ill, I recently reported harassment and bullying. The next day I’m in the penalty box.

SENATOR SOMERS (18TH): So when you report something like harassment or bullying do you report that to the director of nursing or where does that?

CAROLYN HOWARD: Well we have to follow chain of command.

SENATOR SOMERS (18TH): So what would that be?

CAROLYN HOWARD: The head nurse, I reported it in an email to the head nurse.

SENATOR SOMERS (18TH): And then did you get a response from the nurse?

CAROLYN HOWARD: It was like maybe five days later I met with the, so many titles, so many overhead, I don’t.

SENATOR SOMERS (18TH): Another supervisor?

CAROLYN HOWARD: Yes.
SENATOR SOMERS (18TH): So did you ever get a response in writing to the harassment?

CAROLYN HOWARD: Yes.

SENATOR SOMERS (18TH): And were you in the box then or were you out of the box?

CAROLYN HOWARD: I was still in the box.

SENATOR SOMERS (18TH): Still in the box, okay. So and how did all, was there investigation or?

CAROLYN HOWARD: Yeah, its under investigation currently.

SENATOR SOMERS (18TH): It was two years ago during our public hearing for the original Whiting Bill I was provided a copy of a bullying survey from 2012-2014 which showed that 75 percent of the people working at CVAs including Whiting felt bullied. They felt intimidated and 85 percent of them I believe, I have it written down, felt that it was not resolved and they feared retaliation from the administration. So one of the things we’ve asked this Task Force to do is to try to conduct another survey of this kind. Originally the survey I saw just said, you know, bullying survey and then there was another exact copy of it and it said the same thing but on the top it said Confidential -Internal Use Only, so it was clear that that information did not want to get out of that facility but based on that information do you think that the bullying, the retaliation has improved at all or are you seeing the same?

CAROLYN HOWARD: Well I just gave you an example of my reporting a situation and where it got me. That’s an example of retaliation. I think it’s much
worse. I think the administration are the biggest offenders of bullying.

SENATOR SOMERS (18TH): Have you always had this penalty box or is that new for this new administration?

CAROLYN HOWARD: Kinda new. I would say, well we had maybe the last four years but it is used regularly now.

SENATOR SOMERS (18TH): You know, I have to share with the Committee, I’ve received a lot of, many emails that are anonyms because they are afraid to testify because they were afraid of retaliation here today so I’ve shown that information with Representative Steinberg and some others so that made me feel very uncomfortable that there is people that wanted to be here today but they didn’t feel that they could because they were afraid that they would be retaliated against and they talked, one of the persons in particular talked about being written up for being, “Un-attentive” to a patient but there was no definition of un-attentive. They said that they were just sort of talking, somebody looking in a different direction. Can you speak, have you heard of what un-attentive means as far as DMHAS is concerned?

CAROLYN HOWARD: Yeah, that’s a common form that they use for retaliation because inattentive could be anything. Inattentive could be are you feeling fatigued, inattentive could be, you know, door slamming turn your head to look at the door, it could be, you know, patient walks by and you look. You are supposed to be attentive to everything, so if you turn your head to look at a patient they would say that is inattentive. It is whatever they
deem it to be. Inattentive to me means you are not paying attention. I can be driving a car and know what my kids are doing in the backseat, I am attentive to that.

SENATOR SOMERS (18TH): You have eyes in the back of your head like every mom, right?

CAROLYN HOWARD: You can, yeah. And you are attentive to that but at Whiting it is different set of rules, and that’s what they use for retaliation, that is the most common form of retaliation. And they won’t call it inattentive, they will call it workplace violence and they call it patient abuse. And that could be you turning your head if the door slams. You are inattentive and now you. But as long as they are calling it patient abuse, they haven’t reported it as mandated reporters. So they are not following through with their own policies.

SENATOR SOMERS (18TH): So I want other people to ask, but this penalty thing has got me going. So when you are in the penalty box, who is filling your spot? You don’t know why you are in there, like do they have to pay somebody overtime, do they have to mandate?

CAROLYN HOWARD: Usually somebody is mandated. I’ve sat in the penalty box and they run the building short with everybody mandated that they could mandate and then there isn’t even enough people to work and then there’s other nights when we have, I know on Wednesday nights we are maybe 17 plus, I don’t know how taxpayers feel about having 17 extra workers on the unit.

SENATOR SOMERS (18TH): So you are saying when people are in the penalty box, even if they mandate
everybody to come in, you’re still not at your proper staffing, there is not enough staff there?

CAROLYN HOWARD: Exactly. Yes. It is complete incompetency in the building.

SENATOR SOMERS (18TH): Okay, I’m going to let other people as questions because I know I will have more. So go.

SENATOR ABRAMS (13TH): So I have a couple of question based on what you were just asking about. So when you went through, when you were asked to start reporting I guess every day, you go into work, you go into this room, this penalty box.

CAROLYN HOWARD: Yes.

SENATOR ABRAMS (13TH): Is that how it works? Was your union involved at all, did you have any kind of due process or did you sit down and talk to anybody or?

CAROLYN HOWARD: No. I guess what would happen is I would probably have to reach out to the union. I don’t really feel they are attainable so I actually did do it at the last minute when I needed a delegate for a meeting. I was going to go to the meeting by myself but I took a delegate at the last minute.

SENATOR ABRAMS (13TH): And did that change anything or?

CAROLYN HOWARD: No. Nothing. I’m probably gonna get the maximum penalty for doing nothing, I totally expect that.

SENATOR ABRAMS (13TH): What’s that. I don’t understand what is the maximum penalty.
CAROLYN HOWARD: I’ll probably get some kind of suspension even though the views will be unsubstantiated because I can’t substantiate it because it didn’t happen and I’ll get a suspension. Because that’s what happens to other people there.

SENATOR ABRAMS (13TH): So is that like somehow you got accused of abuse so they put you in this penalty box until they resolve that? Is that what your [Cross-talking].

CAROLYN HOWARD: Yeah, well they are saying I am inattentive because they routinely use that as the end all and, you know, that is patient abuse and, you know which is a crime which I should be, you know, held liable for, I should be arrested for that if it were true.

SENATOR ABRAMS (13TH): So that is like they make that accusation and then you are to wait in this like limbo of the penalty box until they make a determination about it, is that how it works?

CAROLYN HOWARD: Yes. It would be nice if the union would come in and say, hey hold up, wait a minute, something doesn’t seem right here, how are you gonna call that patient abuse, you know, but the union has not done that for us.

SENATOR ABRAMS (13TH): And then I just had a question about the bullying and harassment. You reported bullying and harassment what were the circumstances of that? Were you the victim of the bullying, did you observe someone else, like what were the circumstances.

CAROLYN HOWARD: I was abused from another staff person. I was the victim of it.
SENATOR ABRAMS (13TH): You were the victim from another staff member. Okay, thank you. I think Representative McCarty, did you have some questions?

REP. MCCARTY (38TH): Yes. Thank you, Madam Chair. And I apologize we’re in Education a good part of the day but I wanted to tell you coming from there to this Committee it reminds me so much of what our first Bill on the agenda was looking at school safety, climate plan and there was a component of that dealing with if there is, you know, to protect teachers from any form of retaliation in anyway so it made me think that while this Task Force is in place to look at, evaluate and comment on the culture, the conditions and operations. Maybe part of the goal should also be as they are doing that to have a process really identified and in place so that employees and staff, so something is truly outlined there so no one should feel that they can’t freely go forward and have it totally outlined. So I guess what I’m saying is that the Task Force would be expanded not only to review and evaluate but to offer the recommendations on how to improve the entire culture so that we can have limited, that we can really curtail any of this and be sure that everyone is treated fairly throughout that process. So I apologize for making the analogy but it kind of jogged my memory that we it just seems, you know, when you have someone higher in charge we have to make sure that everybody is on the same page and working together and to find those solutions so that all parties are treated fairly. I mean the idea, when we separated the two was that we would have oversight and evaluation with the hope that the conditions on all sides would improve greatly. So I think this Task Force is needed and it will serve a
good purpose and I would just like to add that it, so hopefully it won’t just be evaluating the current situation but offering solutions on how to get to a better place. So, thank you for that opportunity.

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

REP. KENNEDY (119TH): Thank you, Madam Chair. Just follow up on something in response to Senator Somers questions, so you came here to testify today. I do really appreciate you coming here and doing so but you came here knowing that you possibly will receive some kind of a punishment if you will or you said you will likely, is that, I just want to be clear, that is what you said?

CAROLYN HOWARD: Um-hum.

REP. KENNEDY (119TH): Okay, thank you very much Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Petit.

REP. PETIT (22ND): For the second time, thank you, Madam Chair. Do you know of other people, Senator Somers referred to anonymous emails but do you know personally of other people who would have been here weren’t as brave as you were to come and said, I’m not putting myself out there to come and testify?

CAROLYN HOWARD: Yes, I do.

REP. PETIT (22ND): One, two, five, ten what would you guess, how many people?

CAROLYN HOWARD: Probably 50, 60, 70, yeah. Most of the people would probably have a complaint and want to voice it. Nobody feels safe to be able to speak out there.
REP. PETIT (22ND): We heard some information I think it was earlier today or a different part of the session about the new training for the forensic specialists on units. Have you received the new training that I think DMHAS was going to institute?

CAROLYN HOWARD: I’m not sure what they call training. I’ve had a lot of online, as they call it, LMS that we have to do. I’ve done several of those if that is what they call training.

REP. PETIT (22ND): Different than information you’ve been asked to study or look at before?

CAROLYN HOWARD: It’s just been more of the same thing.

REP. PETIT (22ND): Any further information on appropriate and/or inappropriate use of restraints when you are trying to control someone or to give medication, etc. even if it’s under orders? Any further training in that specific area?

CAROLYN HOWARD: No, but we just really prefer to keep hands off of patients, especially in light of what happened, you know. FTS and the nurses all across the board will do anything to not have a situation go to that point, you know, without administrative telling us to. We just prefer not to go to that extent.

REP. PETIT (22ND): Is your perception at that, your approach, the hands-off approach has made things better, worse or has not impacted it one way or another like your safety, their safety?

CAROLYN HOWARD: Well, I think it has made things a bit worse in the sense that the patients know they can go that extra mile, you know, and they do. They
take it to that next step. I do want to say though that I feel more comfortable with the patients than I do with the administration.

REP. PETIT (22ND): Thank you, that’s a pretty amazing statement. Appreciate your testimony. Thank you. Thank you, Madam Chair.

SENATOR SOMERS (18TH): Thank you. Any other questions or comments? Thank you for your testimony and your time today, appreciate it. Marcus Spinner. Welcome.

MARCUS SPINNER: Good afternoon, Senator Abrams, Representative Steinberg and Members of the Public Health Committee. My name is Marcus Spinner. I am a lead Mental Health Assistant and Whiting Forensic Hospital. Before I begin my testimony I do want to echo the sentiments of my coworker here. I do speak as well under fear of retaliation from administration. But I’ve spent my entire career to get to this point because I believe that we could do something better than what we have and with that being said.

I spent the entirety of last night if I was going to write this down or if I was going to speak from the heart and I think it is best just to speak from the heart.

There are two glaring issues that I see that need to be resolved immediately at Whiting. One is staffing and two is safety. Saturday the entirety of second shift was mandated. Everybody who came in at three in the afternoon was told at some point between three and 11:30 that they would not be going home and they would have to stay until seven in the morning, the entirety of second shift was mandated
onto third shift and forced to work until seven in the morning. If there is one thing that is important with working with the people at Whiting it would be patience. Our folks struggle with severe mental illness and patience is one of the most important things you could have at this job. But I don’t know how you could have a unit full of patient, caring emphyteutic staff at four in the morning after they’ve worked for 14 hours. The entire building was mandated.

Secondly it’s safety. Many of your sit on the Appropriations Committee who reviewed the DMHAS budget this year and saw privatization due to cuts for seven million dollars. Amid seven million dollars in cuts and proposed privatizing young adult services, capital region, the third floor the research floor New Haven and the fifth floor the transitional living center New Haven, but they also made $3.5 million dollars in increases in worker’s comp in the last year. That is an increase of 27 percent. Again 27 percent increase in worker’s comp. Why is that? That is because staff are afraid to provide restraints to patients who are violent out of fear of being accused of neglect and abuse. Staff are much more likely to be assaulted because they are afraid which results in staff getting assaulted and saying, you know what, I don’t want to go back to work. I’ve been there for two years. In November I was assaulted by a patient. I was punched in the face. We’re good buddies now, and that guy, we’re cool. But I could tell you, I’ve never had a job where I was assaulted.

And if I could say one more thing, and I’m sure you’ll ask me tons of questions, I work with people who have committed serious, violent crimes, murder,
manslaughter, serial sexual assault. We are asked to be on camera 24 hours a day throughout our entire shift. These are extremely violent people who are not allowed to be out in the community due to the nature of their crime, and we’re on camera. So I ask you why is the police department, why our municipal police department’s and state police department not mandated to wear body cameras like we are every single day? Thank you.

SENATOR ABRAMS (13TH): Thank you very much for your testimony. Can you explain to me why that happens if you know, where an entire shift is asked to stay for the next shift?

MARCUS SPINNER: If people call out they have to fill a hole. If someone is put in the penalty box, they have to fill that hole. For example, my coworker was caught on a cellphone. He shouldn’t have been on his cellphone at work, he said he was ready to get his sentence, but instead what they did they put him in the penalty box. He was put in the penalty box for 45 days, where he was put in a very brightly lit room with no stimuli, and no work responsibilities and he was told to sit there while they conducted his investigation. There is no investigation. He was caught with his phone. He was witnessed by one person, that one person’s making allegation, there is no need for further investigation but he was put there for 45 days and during that time, they have to either provide overtime or mandate in order to fill his hole. So he was paid to do nothing, and someone else was paid time-and-a-half of double-time to fill his spot and that person who was paid time-and-a-half or double time was not as skilled as he was at his job because they were being floated from another position.
SENATOR ABRAMS (13TH): What is the average amount of people, workers like per shift?

MARCUS SPINNER: The average.

SENATOR ABRAMS (13TH): Just give me a ballpark.

MARCUS SPINNER: I work at Dutcher, so Dutcher is a different staffing ratio compared to Whiting Max, we are both under the same umbrella but my ward has on average two to three nurses and three to four mental health assistants like myself.

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

REP. STEINBERG (136TH): Thanks for being here and testifying today. We’ve heard prior testimony that indicates there is a fairly significant administrative layer but there is also from what I understand, Dr. Wasser has a responsibility for a large portion of this. Do you have access to these people. Who hands down the penalty box prescriptions and things like that?

MARCUS SPINNER: So, I have heard in earlier testimony that the administration is much more available at Whiting Max, I don’t really see administration too much in Dutcher Hall. In regard to the access to administration, if you were a union delegate we do have labor management meetings on a regular basis but at Dutcher I don’t see administration to much, but I do see the director of nursing who does walk through periodically to make sure that everything is up to par. But beyond that, we don’t see much interaction with senior management.
REP. STEINBERG (136TH): So who tells you you’re in the penalty box?

MARCUS SPINNER: Oh, the director of nursing or the nursing supervisor. They would catch you doing something wrong, and then they would report it to the director of nursing and then HR would take over and the next day that you report to work you would be, in the morning you see a staffing sheet where you are going to your worksite and your worksite would say, TO or time office is where our penalty box is. And that time office is where you’re put to sit there and do nothing and get paid for it while they investigate you for 45 days.

REP. STEINBERG (136TH): And you don’t know necessarily how long that investigation will take place or do they tell you right out it’s 45 days.

MARCUS SPINNER: It’s indefinite. So this person was under investigation, he was given an extension, an extension, and extension until he was finally interviewed and then allowed back on the ward.

SENATOR ABRAMS (13TH): And when did that happen.

MARCUS SPINNER: Maybe a month ago.

SENATOR ABRAMS (13TH): Okay, thank you. Other questions? Representative Michel.

REP. MICHEL (146TH): Thank you, Madam Chair. This is like unbelievable. When you end up in that room or when the person ends up in that time off, they are just there and have nothing to do? Do they have to call for someone in order to get out of the room, or is it locked, or not locked, or? [Laughter]

MARCUS SPINNER: I know, it sounds, I mean the nature of what we’re talking about right, it’s a
psych ward and so you are hearing these stories that sound absurd, but yes, you are kept in the room, you are allowed to come and go as you please but you are at work so you are expected to stay at your work site which is the penalty box and you sit there and read a book or just twiddle your thumbs. I don’t know I haven’t been in there but I’ve checked in on my coworker periodically throughout the shift and he’s just like, eh got nothing to do.

REP. MICHEL (146TH): And another question, the director of nursing or the nursing supervisor that directs the employee to be on the time off, but you said it there was an extension, an extension in that case. An extension to how much time was the initial time? Is there no initial time? Is there a decision of anything?

MARCUS SPINNER: It is indefinite, so you’re under investigation and the duration of the investigation is what it is and they will notify you as they have updates. I’ve served as a union delegate during these investigations, I’ve pressured management to get some more insight as to why the investigation is taking as long as it is, and I’ve still struggles to get really concrete answers as to why it would take 45 days to investigate why someone was, that someone was using their phone when they shouldn’t have been.

REP. MICHEL (146TH): So they are not necessarily responsive to union delegates either?

MARCUS SPINNER: They will do what they can to sideline us, yeah.

REP. MICHEL (146TH): Okay, thank you very much for your testimony.
SENATOR ABRAMS (13TH): Other questions or comments? Senator Somers.

SENATOR SOMERS (18TH): Thank you for testifying today and we appreciate you coming out and, I’m going to say being brave to come out and if you are fearful that you are going to be retaliated against that is not a good place to be and it should not be the case in the State of Connecticut. I have to tell you this time out box of whatever you call it, this penalty box, is the most ridiculous thing that I have ever heard. As an employer of over 100 people I cannot imagine every doing that, under any circumstances. If somebody was talking on a cellphone and it was against the company rules you would have a conversation about put your cellphone away, discipline and it’s over. You’re not stuck in a well lite box doing nothing for 45 days. It is obscene that we are having this conversation actually and I feel very sorry for anybody who is in this box. So what happens if you don’t show up to go to your penalty box, if you just say, I’m not going to the penalty box. Are you fired?

MARCUS SPINNER: Unauthorized leave is another write up.

SENATOR SOMERS (18TH): Okay, so who is doing the investigation? Who does the investigation on, you were on your cellphone, there is no way for you to say, yes I was on my cellphone, I was bad, I’m in trouble, it’s over.

MARCUS SPINNER: I’m glad you asked that question because I really wanted to touch on this subject. When Whiting Forensic Hospital was split from Connecticut Valley Hospital administrative staff were switched but the human resources department was
kept and you are under investigation by the same human resources department that investigates Connecticut Valley Hospital. In addition to that I just want to mention that while we do have new administration at Whiting Forensic Hospital it is the same administration at Connecticut Valley Hospital which oversaw Whiting Forensic Hospital during the patient abuse case. So again, the same administrators, they’re there now at Connecticut Valley Hospital are the ones that oversaw the entire umbrella operation during the patient abuse scandal.

SENATOR SOMERS (18TH): So, it is the same HR administrator as before who does this investigation. I mean are they so busy that they have to have a million investigations that it takes 45 days to figure out if somebody was on their cellphone or not?

MARCUS SPINNER: Exactly, they are that busy, that is because in light of the patient abuse scandal every single misstep, every single allegation has to be investigated to the fullest extent of the law and so if a patient with no basis says that I called them a name, and they have to pull me out of patient care and investigate me and again with no basis because again, what would happen and it was so heinous I understand why we have to get to that standard but again, it has become weaponized and again this is a particular population which sometimes will weaponize abuse allegations and I don’t say that lightly, it sounds accusatory but I do mean it and I’ve seen it happen. It has become weaponized so that patient will say I’m gonna get you kicked off the ward. The guy who punched me in the face said this himself, you better dot your I’s and cross your t’s cause I’m gonna get you kicked
off this ward. And so human resources is tied up with investigations much like that.

SENATOR SOMERS (18TH): It is an interesting choice of works, I can see how you use it that there. So do you feel that the administration is weaponizing this process against certain employees they may not like that speak out also and the reverse as far as like we heard like bullying from the administration today, retaliation and obviously people are fearful to speak and there is no process in which somebody can say, yes, I called the patient a name or yes, I used my cellphone and it’s over? You have to go through this laborious process and investigate even for a minor infraction.

MARCUS SPINNER: That’s the difficult thing. That during the course of those 45 days, there was maybe one interview where they would say, yes, I used my phone, here is why I used my phone what is my punishment. But that process in between the incident and the interview could be three weeks.

SENATOR SOMERS (18TH): So I know Senator Abrams had asked you about how does it happen that an entire shift calls out and you have to mandate, you know? In your opinion working there now, under I guess two separate administrations so to speak, are you having trouble with the environment and the culture there recruiting new people. I mean could we, are we completely understaffed that we are having to mandate or do we need to hire more people to make sure that we are at a certain staffing ratio so that we don’t have to mandate folks and pay double time or time-and-a-half for them to do a job, as you said they are not necessarily qualified for at times or they are floating between maybe that was Whiting
floating between jobs where they are not as skilled as some others.

MARCUS SPINNER: Right. The staffing situation at Whiting, I don’t know if I have a direct answer for that. I think there are two things, one is there’s a chart which assigns vacant positions to available units. There has been a lot of issues with the charting in terms of some units are much more well-staffed than others so they fill the holes in one unit but not the holes in the other unit and that can be resolved internally. But again a lot of issues we have is attrition. Someone retires and then they don’t post that position to be rehired so it remains vacant and then it is filled with overtime. So again it is an issue of internally, some of the staffing charts could be worked out within the organization but in addition to that getting authorization from the Department of Administrative Services and making it, you know, intended to hire new staff. But there is an issue with hiring nurses. I’ve spoken with nurses who’ve done internships at Whiting and I’ve spoken with nurses who work at Whiting and there is a grave concern over their losing their license due to some of the working conditions that they put nurses in, particularly the surprise mandates until seven in the morning that is a standard that. You know, my mom is in the hospital right now and I spoke with the nurses on the ward and I spoke with the patient care techs and I said do you guys get mandated? They said, what’s that? I said, well you go work your eight hour shift and then an hour before you go home they tell ya you gotta stay for another right hours. They said no, why’s that. Now imagine pouring meds at six in the morning at your 15th hour
of work and you are expected to get those meds right.

SENATOR SOMERS (18TH): Yeah, I think this is something that came up during our last hearing that, you know, in nonstate hospitals, you can certainly pickup a shift as a nurse if you chose, but mandating somebody to work those hours and this is, you know, the same patient everyday in a very compromising complex and difficult situation is very different that a hospital where you are rotating the patients in and out. If you could give us advise on how we can improve the culture at CVH and Whiting as a Committee going through this Task Force that needs to be truly independent, where people can come and talk freely about what is truly happening, you know, on the ground cause that’s were all the issues were also, what would you say to us?

MARCUS SPINNER: Staff the Task Force, hold the meetings, listen to the recommendations but also provide opportunities for some of my hard working coworkers to have some input as to have that organization is run. You very rarely hear from folks like myself and from my coworker about how that place functions and in addition from very rarely hearing from us, we are very rarely given an opportunity to provide input on how the place works. I know that the Commissioner said that there are policy Committees, etc. but those are very difficult to access for line staff. There is very little opportunity for direct care staff to have a say in how the facility works. If I could summarize, I would say that they need to listen to the people who work with the patients on how that place could be better run. Cause I can’t stress enough, it’s a tough job and everybody on my ward in particular, I
haven’t seen a like a shred of what happened at Whiting. We have created a little home on our ward, very cute and I don’t want to talk about it too much because I get choked up, but that being said, they never ask us, how we can make it better.

SENATOR SOMERS (18TH): So you feel it is very top down like this is how it is going to change. There is no input from the ground up, the people actually doing the work, working with the patients. The patients are supposed to be your number one concern.

MARCUS SPINNER: Right, and in testimony at the public forum you had last year on Whiting I don’t know if it was Kathy Flaherty or someone else they did research into previous investigations at Whiting going back to the 70s and they said that it has been like that since the 70s. It has been very top-down with the people at the top centralizing power and then dictating that power down to the line staff and what could ultimately be described as an oppressive environment.

SENATOR SOMERS (18TH): Right and every successful young entrepreneurial company it doesn’t work like that anymore. It’s all grassroots from the bottom up, everybody works together as a team and there is input at all levels. So do you think having this independent Task Force at a place that could hold hearings where or even a forum where employees working in one particular unit whether it be at Dutcher or Whiting feel comfortable that can provide input would be a first step?

MARCUS SPINNER: I would be a first-step but unfortunately I’m pessimistic at the idea that staff will come forward to the Task Force. It is pretty deeply ingrained the fear of retaliation and I don’t
think that anyone would set foot in the capital even if they were told, you are allowed to be here, and that you are not going to be retaliated against. I don’t think folks would step-forward and come to participate as much as they would just like kind of like complain in the back office at work because I have conversations every day. People have very serious criticisms but they will not come forward to talk about it because they don’t want to lose their job.

SENATOR SOMERS (18TH): I can tell you I have volumes in my office of people who have come forward and so does Representative Carpino, maybe or maybe not I have their names but issues they have encountered and how they would like things to be fixed. What can we do to make employees feel comfortable coming forward because we are not going to fix this over Committee if we don’t hear it from you all that are actually doing the job and the last thing we want it maybe we should put the penalty box here, so we could go in and talk to people. We are not going to be able to fix it if we don’t hear from the people who are doing the job and I think that is important that you encourage your coworkers that, you know, this Committee needs to be safe space for them to be able to talk to use or else it is very difficult for us to try to fix it because we only hear one side if we don’t hear from you.

MARCUS SPINNER: I guess I’ll use myself as reference. What would make me feel safer leaving this Committee Room today is when I go back to work maybe six months from now, if I get written up, I have been there for two years and I haven’t been written up. Six months from now, if I get written up, and I follow up with you and I say this feels
like retaliation that someone higher up might look into it, I think would make people feel a lot more comfortable.

SENATOR ABRAMS (13TH): Representative Michel.

REP. MICHEL (146TH): Thank you, Madam Chair. I am just wanting to follow up on something you mentioned the word retaliation and I know we are talking about the time off. Are there any other retaliation, and if there is, under what forms and what kind of examples of retaliation?

MARCUS SPINNER: I’m very glad you asked that question because I left out something very important. The patient abuse at Whiting was enabled through a culture of retaliation to people who reported patient abuse. People didn’t report patient abuse because they were afraid that if they told administration they would get fired. That is how it was enabled to happen. If you wrote up I observed patient abuse, on this date, it would be shredded because the paper document and then they would investigate you and watch you like a hawk until you made a mistake and then they would write you up and get rid of you.

REP. MICHEL (146TH): Okay, it might be the worst word to use but this is insane. Thank you.

SENATOR ABRAMS (13TH): Representative Carpino.

REP. CARPINO (32ND): Thank you for coming forward. I do have a few questions, I don’t think any of my colleagues got to yet. Who shredded the documents?

MARCUS SPINNER: I didn’t work there at the time, I’m sorry, I do not know.
REP. CARPINO (32ND): And I do understand that if you want to talk to me after, I don’t want to jeopardize you at all but that is so alarming to me on so many levels as a legislator, as a taxpayer, as a human being as an HR Professional and I could go down the line. Can you tell me which department allegedly shredded those write-ups.

MARCUS SPINNER: I didn’t work there at the time, I was hired during the patient abuse scandal so all I was able to say is that there are rumors which I am sure some of your emails in regards to some administrators who looked the other way and were asked to resign and then offered positions elsewhere in state government.

REP. CARPINO (32ND): I’m following you more closely than you perhaps realize. Are any of those alleged individuals still in the human resources department at either Whiting or CVH currently without you giving me any names?

MARCUS SPINNER: I don’t know the extent of it because again I did not work there and I don’t know the org chart at the time prior to reconstruction.

REP. CARPINO (32ND): So let me ask you about the delays that you said are causing to sit in the penalty box or the time out box, I understand you said it is because of the volume of complaints that they are currently investigating do I understand? Are you aware of any of the complaints in your two years of being there that allege abuse being substantiated?

MARCUS SPINNER: I don’t want to waste your time with my pondering but.
REP. CARPINO (32ND): I’ve got all the time in the world if this is important in this matter.

MARCUS SPINNER: So one investigation I saw that was substantiated that could be categorized as neglect was someone who did fall asleep. All right you’re not supposed to fall asleep at work, that’ll get you in trouble. But I will say falling asleep is much different that name calling or putting hands on somebody or doing something to the extent of what happened in the past.

REP. CARPINO (32ND): Thank you and I think you said you were at Dutcher, were you ever assigned to Whiting?

MARCUS SPINNER: No, Dutcher staff, I’m a mental health assistant it is a separate job title from the forensic treatment specialist so I do not float between the two buildings as there is a very different culture between the two buildings. I’ve maybe been at the front entry port you would call it at Whiting, I’ve never really gone beyond the double locked doors but there is an entirely different staff at Whiting Max then there is a Dutcher and to the best I understand that is a different culture as well.

REP. CARPINO (32ND): And I have actually been in both so I understand what you say when you indicate there is a different culture. Can you tell me if there are any categories of healthcare workers that do float between the two facilities?

MARCUS SPINNER: You could transfer, so if I was to transfer to the Whiting it would be a promotion to a forensic treatment specialist. If you are a forensic nurse you could transfer to be a regular
nurse at Dutcher but that would be a new dedicated
job position, it would not be a float as you would
as if today you are going to work at Whiting and
tomorrow you’re gonna work at Dutcher.

REP. CARPINO (32ND): Thank you and that is exactly
why I was asking when we were talking about overtime
and I was trying to understand who limited out pool
of individuals is for each facility. I thank you
for your courage. People are listening. This
Committee is listening and I’ll make myself
available to you or any of your coworkers who want
to speak. Thank you, Madam Chairwoman.

SENATOR ABRAMS (13TH): Are there any other
questions. Just a minute please. Representative
McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair and
just very quickly, one thank you for your work.
Two, thank you for being here to testify today. So
I am just curious as the staff, because it seemed a
little arbitrary to me when you talked about
somebody had their cellphone taken and then they
went to the penalty box, they didn’t know how much
time, they didn’t know the duration of when the case
would be resolved. So my question really is does
the staff receive any education or training and a
list and what they can and can’t do and what the
penalty would be. I tend to agree with Senator
Somers that the whole notion of this kind of penalty
box reminds me of like 50 years ago as sending a kid
over to the corner, so I’m just trying to get a
handle on what is actually going on in that culture
and I think today the discussion really centered on
culture. I am always very optimistic hopefully we
can find the right solutions that’s why I go back to
the, if everyone knows their duty and you have to have some common sense to this, I think the motivation and the impetus behind all of this was to improve the culture but the separation, have good oversight and let’s make sure that both the patients and the staff and everyone is protected. So my question goes back to is there some, because it seemed like you were mentioning a few items here and there but I would think in a like a company would run these are your responsibilities, this is what happens and you have an idea of what’s going on.

MARCUS SPINNER: Yeah, there’s several hundreds of policies. It is very well understood that you are not supposed to be on your phone, I’m not making any apologies for being on your phone but it is so well understood that if you get caught on your phone, you are going to get suspended for five days, this is clear. No one really argues it because that’s the rule. You knew going in, don’t pull your phone out, you’re gonna get suspended for five days. That being said, if I am caught on my phone and the supervisor catches me, I expect a five day suspension but I don’t suspect or I don’t expect to be in the penalty box for 45 days while they figure out whether or not I did it. And in addition to that I just have to stress when we talk about culture, I can’t speak highly enough for the folks that I work with every day. We really have like a nice little, a nice little unit at work, and I see people get better and I see people make miles and miles of growth and improvement in managing their mental health and I see people get discharged and in my time of working at DMHAS once every three months I might see someone in the community whose like, I don’t even recognize em and they’re doin great. And
the last time I saw them they were throwing their bodies against the wall and dropping to their knees and spitting up their food and now they are great, walking with a cane and they are talking junk at me, making fun of me. So I can’t stress enough what I’ve observed to be a couple of, I didn’t observe but what I see is the incident that happened at Whiting is not emblematic of the whole. Those are my coworkers, I really, if there is anything that you capture from this is that.

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

SENATOR ABRAMS (13TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you for your testimony. I missed part of it but I just wanted to make a couple of observations. First of course I want to thank you for coming forward and sharing your concerns. As I look through the Bill and maybe it’s not a question for you but it could be for anyone else who would like to weigh in or maybe just my comments, that if we make a Task Force it takes sometimes forever to have a Task Force and then in this particular scenario we are actually getting the Task Force report by January 1, 2022. If this concern about neglect is concern about how things are being managed in real time, I’m not sure this is the best vehicle to adjust this because I don’t want to wait until 2022 to find out what’s wrong. I want to find out yesterday. If something is not right especially if there is a concern about neglect there is something about inappropriate management of the staff. So I know this is a step to try and find a solution. This is not fast enough in my opinion. And in also when you are in front of
a larger Committee it gets challenging to, for the staff to come forward. So as I understand what you are trying to do, I am not yet convinced that what is in the Bill is going to be the solution. So I will leave it up to us for figuring out if this is going to require a little bit of modification but waiting until 2022 is probably not the way I would approach this and the Task Force is probably not the way I would approach this either. I’d probably have somebody in an important position appoint and individual to do a thorough evaluation and do it as soon as possible and be able to have complete access to all employees and staff to get an understanding and give us a preliminary report and then we start to look at what we can do. At least what is going through my mind I would support something being done but this is probably not the best way. Thank you. I don’t know if you want to reflect on what I’ve said.

MARCUS SPINNER: I have feelings on both side. I like the idea of a Task Force because Whiting in particular is a very unique environment. Unlike a typical psych ward where people are just dealing with severe and persistent mental illness, unique to Whiting is some folks also have a manipulative antisocial element which makes treatment very different and treatment than in a general psych ward. So for example in an environment where we have to do restraints. I knew I was going to be assaulted. He walked up to me and punched me because I have foresight. I can see that he was escalating, I could see that, you know, there were circumstances early in the night that resulted to the assault. There was another assault on my ward that I could, I could tell, right they are not doin
well that night, and you know, I’m a little bit worried about this person. But that being said, there are also moments when you could never tell, where you are going about your day, doing your census count and you peek in a room to make sure that they are alive and breathing and then you walk down the hall and someone walks out of their room and punches you in the back of the head, knocks you out. That is an antisocial intentional act that makes treatment at Whiting that much more dangerous but also that much more different than a general psych ward and so the Task Force has an interdisciplinary team of people from different fields. I do agree that it is going to take a long time. I do wish that we had something that would come sooner but I think it is more of an all of the above approach than it is one or the other. I think the Task Force will be a great vehicle for staff to, if they feel comfortable, communicate some of the issues that they see with how the place functions but I would also like to see something a little bit, happen a little bit more quickly because I do have some trouble with retaining nurses.

SENATOR ANWAR (3RD): Okay, thank you so much. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you are there any other questions or comments? Thank you so much for your time and your testimony. Very much appreciated.

We are moving on to Senate Bill 859 now. Senator McCrory.

SENATOR MCCRARY (2ND): Good to be on the other side. My testimony will be very brief. I am just here to support Senate Bill 895 the title being AN ACT CONCERNING COMMUNITY HEALTH WORKERS.
Last, about a year to 16 months ago I held a forum in my district in regards to health disparities and things that we can do as a State to help alleviate some of those health disparities and one of the conversations we had was we need individuals inside our communities that can work as a liaison between the health providers and the patients. What we found historically I can recite a number of cases that have taken place that has led to a distrust between the medical community and residents of our community. Therefore I think it is imperative that we have people who can play that role as the negotiator, the liaison, the followup person and encourager to make sure people gain access to proper healthcare.

I think this Bill will go a long way making sure that individuals are provided professional development, certification type program to make sure they understand the importance of the work that they are doing and the work that they do do. So, you know, I again, I think we tried to do this a couple of years ago and it failed, I think we have an opportunity now to do some things that are very important in regards to healthcare in closing the health disparities that exist in our communities and within our country. So, any questions, I’ll would love to answer.

SENATOR ABRAMS (13TH): Thank you very much. Are there any questions or comments? Senator McCarty.

REP. MC CARTY (38TH): Senator McCarty? I have to say something. I’ve seen ’em all today [Laughter]. I thank you for coming in with your testimony and do you see a role with the community health workers as far as sometimes crossing that barrier between
cultural differences and perhaps even language barriers?

SENIOR MC CORY (2ND): Absolutely. I am glad you asked that question. Absolutely. Sometimes there is a miscommunication and it’s not necessarily how, it’s not what you say, it’s how you say it and how it can be interpreted is very important so again, someone like a person who is a community health worker, they can negotiate those differences and culturally. I mean they can reach [Laughter]. So in summary [Laughter] some of you might know what that means.

SENIOR ABRAMS (13TH): We give a full three minutes here, Senator.

SENIOR MC CORY (2ND): No but I think that can breakdown those barriers of the lack of trust. Like I said, and those community health workers they can meet the individuals where they are cause many times people don’t want, they are not comfortable going to a clinic or maybe coming to the hospital for the services they need but you can have someone come into their community, come into their neighborhood, come into their homes and provide the resources and information. I think that will go along way. I’ve seen it happen. Like I said, many times grandparents, especially our elderly, you know, they come from an age where, you know, things weren’t done correctly and that trust is not there. So having some of our younger people communicate to them in their churches which is a good place to have these conversations, I think will go a long way in alleviating that, those disparities.

REP. MC CARTY (38TH): Thank you.
SENATOR ABRAMS (13TH): Thank you very much. Are there any other questions or comments. If not, you had a long day, go and enjoy. Thank you for being here. Next we have Dr. Glenn Flores. Welcome.

DR. GLENN FLORES: Good evening, I am Dr. Glenn Flores a pediatrician and Chief Research Office and Director of the Health Service Research Institute at Connecticut Children’s Medical Center. I am testifying in support of this proposed legislation because I am a national expert on community health workers.

I spent two decades conducting research on community health workers, rigorous evidence shows community health workers are highly effective in improving health outcomes, healthcare quality and patient satisfaction while saving money and actually creating jobs. I pioneered a kind of community health worker called Parent Mentors who are parents who bring experience with caring for their own child with a particular condition such as asthma or lacking health insurance. These parents then receive community health worker training consisting of additional instruction about the specific condition, consenting patients and families to healthcare services, helping patients and families obtain medical and dental homes and addressing social determents of health such as food insufficiency, housing and poverty.

Our research team conducted randomized controlled trial on the effects of parent mentors on minority children with asthma and the studies show that parent mentors reduced wheezing, asthma exacerbations, emergency department visits and missed parental workdays while improving parental
self-efficacy and saving $600 dollars for each asthma attack avoided.

A second NIH funded randomized controlled trial by our team showed parent mentors are significantly more effective than traditional methods in ensuring uninsured minority children obtain that insurance faster, renewing the coverage, improving access to the primary dental and specialty care reducing out-of-pocket costs achieving parental satisfaction and care quality and sustaining long-term coverage, not only did this intervention eliminate healthcare disparities but only cost $637 dollars per child per year and was impressively cost effective saving over $6,045 dollars per child per year which is an astounding 850 percent return on an investment.

The striking success of Parent Mentors resulted in extensive media coverage and me drafting 2018 Federal Legislation signed into law by Congress and the President as part of the Children’s Health Insurance Program or CHIP Reauthorization. So particularly exciting and relevant to Senate Bill 859 is this Federal legislation makes organization that use Parent Mentors eligible for $120 million dollars in grant for CHIP Outreach and Well Men from the Centers for Medicare and Medicaid Services including organizations in Connecticut.

So in conclusion, rigorous evidence shows community health workers provide powerful benefits including insuring the uninsured, improving access to healthcare and parental satisfaction enhancing care quality, saving thousands of dollars per patient, creating jobs and eliminating disparities and potentially saving our state millions of dollars. Creating a community health worker certification
program is a critical next-step for allowing our State to reap the tremendous benefits of community health workers. Thank you.

SENATOR ABRAMS (13TH): Thank you so much for that testimony. It is just great information to have that just confirms what I think a lot of us believe about the importance of community health workers. So I really appreciate you sharing all that and did you submit written testimony?

DR. FLORES: I did as well with lots of resources there and articles as well.

SENATOR ABRAMS (13TH): Thank you, I appreciate that. Any comments or questions from the Committee? Well thank you very much for your testimony. Tisha Everett. You’ve been very patient, did you want to testify again? No, okay. We’re good with that.

MARIA MILLAR: Good afternoon, Distinguished Members of the Public Health Committee. My name is Maria Millar. I am here to testify in support of SB 859, AN ACT CONCERNING COMMUNITY HEALTH WORKERS.

I am a community health worker. I have been working for the City of Stamford for almost two decades. My main role in the Social Services Department is to assist Stamford residents to get health insurance. Because of my personal experience I am committed to promoting health insurance literacy as an instrument in achieving the goal of eliminating the barriers to accessing better health.

When my family and I first arrived here, 22 years ago, we had no health insurance and even though I saw the HUSKY fliers in my school I never applied for it. I didn’t apply because no one told me that
they could. On day I had to take my daughter to the emergency room. I was terrified of getting the bill. My husband was the only one working, making $400.00 dollars per week, our rent was $1200 dollar per month so you can imagine how I felt when I received the bill. I relate to my clients in one way or another and it gives me great comfort knowing that I can alleviate their troubles by making their lives a little easier.

I want to share a story that recently happened to me. A couple with a daughter came to my office looking for health insurance. They always had insurance through the husband’s employer until he lost his job. He was ashamed of asking for help and terrified at the same time because he didn’t know that HUSKY was available. The next day after enrolling them in HUSKY I received the following email and I quote, “Hi, Maria, thank you so much for helping my family out yesterday. We really appreciate that, also treating us with dignity and honor in such a hard time we are passing through. You are doing your job but you are doing it well and with passion to help Connecticut citizens in the most proper and classy way. Thank you and God Bless you.” Lack of education on available services is what makes those situations the same as mine. My vision as community health worker is to empower the community through education. Education is the most powerful weapon you can use to change the world. Empowering the community we provide them with the necessary tools to have better access to programs and services and to have healthier and longer lives.

I urge you to support SB 859 and move the Bill forward so community health workers in Connecticut can be recognized for their expertise and knowledge
to promote professional work growth within their careers in order to advance public health and health equity in our state. Thank you very much for listening to my testimony today.

SENATOR ABRAMS (13TH): Thank you very much for that testimony and thank you for the work that you are doing. I think that it’s, I said earlier today, I don’t know if you were here this morning but it was one of the first things I learned about as an elected official, just the great work that community health workers are doing and how much they are needed so, I really thank you for what you are doing. Are there any questions or comments? Thank you very much. Next is Pat Baker. Welcome.

ARIEL LEVIN BECKER: Senator Abrams, Representative Steinberg, and members of the Public Health Committee. Thank you for the opportunity to address the committee. I am Ariel Levin Becker, Communications Director for the Connecticut Health Foundation. I am here on behalf of Patricia Baker, our President and CEO who send here regrets that she couldn’t be here this evening.

THE Connecticut Health Foundation is an independent foundation with a mission of improving the health of Connecticut residents. Our focus is on eliminating racial and ethnic health disparities and assuring that all Connecticut residents have access to quality, affordable health care.

As the committee is considering legislation related to community health workers, I would like to provide information that could be useful in your deliberations.
Community health workers are frontline public health workers who serve as a bridge between their communities and the health care and social service systems. They are trusted people in their communities, people others can turn to for advice and assistance. They can help people address barriers to taking care of their health, including the nonmedical factors that influence health, such as housing, food insecurity, and transportation.

Extensive research has identified the value of community health workers in improving health outcomes, reducing health care costs, and reducing health disparities. One review of the research found that a key feature of community health workers is their ability to spend significant time with patients.

Research the foundation commissioned identified models for community health worker interventions that could both improve health outcomes and produce a positive return on investment for the healthcare system. Examples include models in which community health workers provide services such as home visits, care coordination, and health education to adults with type II diabetes, families of children with uncontrolled asthma, people who frequently visit emergency departments, and adults with risk factors for cardiovascular disease. Depending on the model, these could save between $1.12 and $2.40 for every dollar invested.

Connecticut is far from alone in seeking to advance the role of community health workers. According to the National Academy for State Health Policy, 47 states and the District of Columbia are working to integrate the role of community health workers into
their health care systems. One common approach is to create a certification process for community health workers. This credential can help to bring recognition to the workforce and to provide assurances to potential payers and employers that community health workers meet certain standards of training and experience.

More than a dozen states now certify community health workers. In Connecticut, the State Innovation Model Community Health Worker Advisory Committee, which studied the issue, recommended that the state pursue a voluntary certification process. The committee identified certification as a way to promote the use of community health workers, which could benefit the state by improving health outcomes, reducing health inequities, and ultimately reducing health care.

Connecticut has striking disparities in health outcomes between people of color and their white counterparts, and research tells us that community health workers can be a critical part of eliminating these gaps. Thank you.

SENATOR ABRAMS (13TH): Thank you very much. Any questions or comments from the Committee? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Actually, thank you for the testimony and thank Pat Baker and everybody at the Connecticut Health Foundation. The Connecticut Health Foundation has been actually the pioneers in doing the ground work to bring this to the State of Connecticut. So thank you for all the work that the foundation has done. Thank you.
SENATOR ABRAMS (13TH): Any other questions or comments? Representative McCarty.

REP. MC CARTY (38TH): Thank you, Madam Chair. Just very quickly, does your foundation work with the Community Action Agencies at all?

ARIEL LEVIN BECKER: I don’t know that we currently have any grants for them, but yes we have worked with them and we work with members of their organizations in our leadership programs and believe we have funded some of their work in the past.

REP. MC CARTY (38TH): And the only reason I ask is because I think the social service agencies already have the infrastructure out there that could really help with this initiative in looking through some of the testimony there are like over 115 community health works that they could already continue to work to bring out though, I’m just trying to say that the infrastructure is there so this makes a lot of sense. thank you for your testimony.

SENATOR ABRAMS (13TH): Thank you, anything else? Thank you very much for being here tonight. Lauren Rosato. Welcome.

LAUREN ROSATO: Thank you. Good afternoon. My name is Lauren Rosato. Senator Abrams, Representative Steinberg and distinguished members of the Public Health Committee. I work for Planned Parenthood of Southern New England and am a member of the Community Health Worker Advisory Committee and I am here to testify in support of Senate Bill 859.

We call them many things, community health workers, we call them patient navigators, outreach workers, care coordinators. These are frontline health
workers who play a critical role in improving health outcomes for the communities they serve.

Community health workers are able to reach people in their community because they speak the same language, they share the culture and lived experience, and are trusted by their community as our first speaker said today. It is this TRUST that builds bridges to the health care system, that helps to improve the health outcomes and save money by ensuring people get the right care when they need it. Community health workers are especially effective in reaching people who are not currently well served by the health care system.

This bill is an important step in linking community and clinical care. It proposes a certification process for community health workers. It will mainstream the field. It will lead to greater recognition and greater sustainability in the workforce.

Planned Parenthood of Southern New England is the largest provider of family planning and reproductive health care in Connecticut. We have 17 health centers statewide, serving over 65,000 women and men annually. Planned Parenthood is also a Person Centered Medical Home in Hartford and Stamford offering complete primary care, referrals and direct access to behavioral health care.

We employ a community health worker to great advantage in this city’s North End, an extremely diverse neighborhood characterized by both low income and high unmet need for basic health services. Our patients tend to be young adults who don’t usually access the health system except for acute care or reproductive care needs.
But we are finding that our patients suffer from complex care needs including mental health which we talked a lot about today in this room, hypertension, diabetes, and weight management needs. Our community health worker is instrumental in helping our patients get healthy so that these complex conditions don’t develop into larger health problems later in our young patient’s life.

For example, a young woman came to Planned Parenthood for birth control. She had high blood pressure so she was started on blood pressure medication. The community health worker counseled her on dietary and lifestyle changes and connected her to programs in the community. The patient started exercising regularly and improved her diet. She lost 30 pounds and her blood pressure improved so significantly that she no longer needs medication to control her blood pressure. So we fully support Senate Bill 859. Thank you.

SENATOR ABRAMS (13TH): Thank you very much for all the work that you are doing. Any questions or comments from the Committee? Thank you. Maria Ortiz. Welcome.

MARIA ORTIZ: Good afternoon Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. My name is Maria Ortiz and I work for the Hispanic Health Council. I am community liaison for victims of domestic violence and today I am here to advocate for the community by asking your support for SB 859.

Community health workers are able to meet people where they are most comfortable, in their homes, even at their break at McDonald’s when they are working a shift, wherever they need us to go, we ill
go there. We help families navigate the system to receive the services they need and not fall through the cracks. And as a community liaison for domestic violence, I dedicate time and energy and all my efforts to spend with each client to help establish a relationship of trust and they feel safe to disclose any issues of domestic violence with me because they know that I care. And it isn’t easy to disclose being a victim of domestic violence. I know, because I also was one.

Unfortunately many women in our society and our community don’t realize that they are in an intimate partner violence relationship and I am in a unique position as a survivor and as a community health workers to gain their trust and to provide them one-on-one service for as long as they need for them to decide to make that decision.

I’d like to share with you an example of a client that I had been working with for several months. She kept complaining that her husband was threatening her, he was going to kill her but she just kept denying. She was in denial and didn’t want to accept that it was really going to happen. He had never laid a hand on her and so she thought that he was just venting. But one day he came very close, he was choking her and he came very close to taking her life and she called in the next day and said, “Maria, I’m ready. I’m ready, he’s gone to work and I’m ready to leave.” She had three children under the age of 5 years old and she came to my office and she couldn’t take anything with her, she just said I called my mother who lived in another state and said I just need help getting there. So I sat with her, I listened to her, you know, and we came to a consensus what she wanted to
do for herself, where she wanted to go and we called the services needed to get her transportation for her to go to the other state. That’s what we do as community health workers. We help people make life changes, decisions. We help save lives and again I want to ask that you support Bill SB 859 and I thank you very much for listening to my testimony.

SENATOR ABRAMS (13TH): Thank you very much. Thank you for the work that you are doing. Any questions or comments? Thank you. Biana Noronas. Elena Padin. Welcome.

ELENA PADIN: Good afternoon. Senator Abrams, Representative Steinberg and Distinguished Members of the Public Health Committee. thank you for the opportunity to testify in support to Senate Bill 859 AN ACT CONCERNING COMMUNITY HEALTH WORKERS. My name is Elena Padin and for the past 10 years I’ve worked as an outreach worker in Southwest Community Health Centers, school based health centers.

My official role in school is student enrollment in health insurance to their parents and families. I have become a familiar face in the seven schools Southwest serves and overtime this position has become much more that anticipated. I have become a trusted face to the families we serve. I move families through the barriers and personal crisis that put family lives on hold. These barriers include everyday issues like lack of insurance, prescriptions, information on where you can receive social services, solving financial debt for services rendered either at a hospital of for transportation, educating and sharing information on health literacy or on oral health, housing, senior services and legal matters, domestic violence, immigration and
employment opportunities. In life our comfort zone can easily be rattled so when it happens to you, how do you know who to turn to.

I believe community health workers play massive rolls in to motivate and provide peace of mind by successfully problem solving. Referring someone to the right connection, translating, or simply just listening. I believe it is our responsibility to look up at each other for response. It is why I support community health workers. The Senate Bill 859 would allow me to be recognized as someone who thrives and someone who has taken the initiative as community health workers to gain the knowledge necessary to address the importance of this care and address some of the social determinants of health that exists. The Senate Bill 859 would not only help me further develop the profession but validate my efforts on the importance of being a vital part of the health care scene. It will also allow me the opportunity to want to further my education and gain more knowledge in the field of public service. For these reasons stated above, I am asking that you support Senate Bill 859 AN ACT CONCERNING COMMUNITY HEALTH WORKERS. Thank you for your attention to his very important matter.

SENATOR ABRAMS (13TH): Thank you for your work and thank you for your testimony. Are there any other questions or comments from the Committee members? Thank you so much for being here. Grace Damio. Welcome.

GRACE DAMIO: Thank you and good evening, Senator Abrams, Representative Steinberg and distinguished members of the Committee. My name is Grace Damio
and I am here in support of Senate Bill 859, An Act Concerning Community Health Workers.

I am privileged to work at the Hispanic Health Council, a state wide organization that seeks to improve the health and well-being of Latinos and other diverse communities. We do that through research, service, training and as advocacy. And over decades we have developed, implemented, after needs assessment indicating a need, we’ve developed the interventions many of them around community health workers services and evaluated some of them through randomized control trials and produced compelling evidence of the effectiveness of models of how community health workers work both in regarding health promotions, for example breast feeding support and chronic disease management such as diabetes management.

Our organization operates on a sacred trust with the community and our community health workers have a sacred trust with the people that they work with.

As you have heard community health workers and others today, they have a very unique role to play. And it’s a role that one, enhances clinical. They are able to expand the ability of clinical work by reinforcing guidance but also by being in the context of a patient in their home, in their community, to understand the different setting what their conditions and needs are and helping to address them. Therefor they are more likely to keep an appointment, more likely to follow clinical guidance and then more likely as has been said earlier, to be able to address the social determinants of health those of which actually impact health more than clinical care does.
So given that, I’m just going to give you a little anecdote which is a member of our board of directors, she requested to be on our board because she in her words, “the Hispanic Health Council saved my life.” Years ago she arrived in Hartford, young, pregnant and vulnerable without access to services and our community health worker got her access to insurance, prenatal care and all of the related services that she needed to have a healthy pregnancy but also to become more stable and move forward in her life to the point now where she is a certified public accountant, has a successful business and has moved forward in her life and then chosen to become a member of our board. The example of her and the thousands, you’ve heard many of them today, and given the unique and really lifesaving work that community health workers do and the amazing and compelling evidence both the effectiveness and cost effectiveness.

I urge you to please support Senate Bill 859. Thank you very much.

SENATOR ABRAMS (13TH): Thank you for your testimony and for that wonderful story. That is really nice to hear.

GRACE DAMIO: Thank you.

SENATOR ABRAMS (13TH): Any questions or comments from the Committee? Thank you very much. Bianca Noronas, are you here now? Okay, great. I thought that might be you, we called you earlier but was told you were getting your daughter who is adorable. Thank you for being here.

BIANCA NORONAS: Thank you Senator Abrams, Representative Steinberg and distinguished members
of the Public Health Committee, My name is Bianca Noroñas and I work as a Community Health Worker at the Hispanic Health Council and I live in Hartford. I am here to testify in support of SB 859, AN ACT CONCERNING COMMUNITY HEALTH WORKERS.

Four of my five years as a Community Health Worker were in Puerto Rico. Last year, the winds of Hurricane Maria brought me to Hartford, an extended piece of my homeland. Just after I arrived, I began to volunteer at the Hispanic Health Council. I am grateful for the support my daughter and I received upon our arrival and wanted in return to contribute to improving the health and well-being of my people in Hartford.

Fortunately, a Community Health Worker position opened at the Hispanic Health Council. I work in a program called Comadrona, which provides case management, support and health education to low-income pregnant and post-partum women.

CHWs provide a unique and vital service, to the communities they serve. We are the link that connects the neediest in our community with ways to meet their needs and move forward in their lives.

I help my participants with issues including health insurance, access to clinical services, oral health, smoking, perinatal depression, domestic violence, breastfeeding, infant development, positive parenting and safety. I also help them to address basic needs, such as food, housing, and clothing, and to move forward in their lives, through education, English classes and employment. Community Health Workers are critically important because we
establish a comfort level that helps us to identify issues that don't show up in the clinical setting. We work together with participants to create an action plan and support them in achieving their goals.

Here is one example of the role that I play. This participant is a mother, with an income under $500 per month and without a stable home. She was diagnosed with depression during her pregnancy, and then learned that her headaches were due to brain cancer. She has no support from family or friends. As her community health worker, I fill the critical gap that enables her to not only receive prenatal and cancer care, but also to meet her family's basic needs. I also provide important emotional support and help her find ways to strengthen her own support networks.

Every day I am more convinced of the need for Community Health Worker certification in Connecticut. Certification is an important step towards strengthening and stabilizing current Community Health Worker services. Community health workers improve health and strengthen lives. Stronger families means stronger communities. That is why I invite you to support this important opportunity to strengthen communities through community health workers. Please support Bill SB 859. Thank you very much.

SENATOR ABRAMS (13TH): Thank you for that testimony and for what you’ve done. Wait a moment, people might have questions for you, so you need to wait. I want to say that I am sorry for the circumstances that brought you here, but how lucky we are to have you here now. So thank you for giving back to your
community and I don’t know if you’ve testified before, but you did an amazing job and having your daughter connect with you the whole time. So that is something else. Are there any questions or comments? Thank you so much for being here.

BIANCA NORONAS: Thank you to everybody for the opportunity.

SENATOR ABRAMS (13TH): Thank you. S.B. Chatterjee.

S.B. CHATTERJEE: Good evening, all. My name is Supriyo B. Chatterjee and I reside in West Hartford, Connecticut and work in Healthcare Economics & Technology. I just want to add that I am also a member of the Practice Transformation Group, which is part of the State Healthcare Innovation model, the SIM model. I am also a member of one of the population health design groups. I would like to submit my public comments in support of SB 859 - AN ACT CONCERNING COMMUNITY HEALTH WORKERS.

Connecticut’s fiscal situation and changes in Federal Medicaid expenditures with proposed use of block grants puts more pressure on our State’s Medicaid budget. Using Community Health Workers in healthcare delivery is a cost-effective way for adding value, improving health outcomes, and addressing health equity. As healthcare payments are moving from a fee-based service to a holistic value-based service participation of trained and certified Community Health Workers will be increasingly vital.

Community Health Workers are trusted members of their community and share similar ethnicity, language, and socioeconomic positions with other members. They can bridge the sociocultural gaps between members and local service providers. They
can be instrumental in mitigating mistrust that individuals may have of healthcare organizations. Addressing social and behavioral determinants of health can bring achievement in health outcomes at lesser costs.

In clinical settings, Community Health Workers can provide the non-medical necessities of care. Their participation in healthcare delivery can be made meaningful by encouraging tests and screening, medication management, transportation, and promoting a healthy living lifestyle. In a 2014 University of Pennsylvania School of Medicine intervention, Community Health Workers played a pivotal role in improving post hospital outcomes and reduction in readmission rates.

In another study, there were Medicaid savings when Community Health Workers matched the needs of home and community care. Deploying Community Health Workers can help bridge gaps, reduce costs and improvements in healthcare delivery.

Another area where Community Health Workers can provide valuable services is with School Based Health Centers. The benefits in deploying and using SBHCs are well known. With the availability of additional resources Community Health Workers and enhanced SBHCs healthcare delivery can improve outcomes and provide a broader outreach for health equity.

Lastly, trained and certified Community Health Workers may feel inspired to pursue a career path in healthcare. The experience gained in working with nurses, APRNs, and physicians can deeply influence a CHW to make the effort to study more for the
healthcare professions. This can contribute to Connecticut’s critical healthcare industry.

I urge you to consider, pardon me, Bill 859 and ensure healthier people in our state. Thank you for your time.

REP. STEINBERG (136TH): Thank you for your testimony. You really covered a lot of ground. I appreciate your point. This may be a career path as well for many people. Senator Anwar.

SENATOR ANWAR (3RD): Hi, Mr. Chatterjee, how are you? Finally get to meet you. I’ve been reading your work for quite some time. I think you have great insight in healthcare related issues that you’ve been writing about and then working for our State. So, thank you for your work.

B. J. CHATTERJEE: Thank you, I’m honored.


DR. BRUCE GOULD: Chairs, Members of the Committee, I want to thank you for the opportunity to testify for this Bill 859. My name is Bruce Gould. I am an internist and primary care physician and serve as Associate Dean for Primary Care at UConn School of Medicine and Director of the Connecticut Area Health Education Center Program also known as AHEC.

As part of my AHEC duties, in 1997 with a couple of medical students, started a migrant farmworker outreach program, mobile clinic during the summer. We’re out there three nights a week at farms across the state providing really primary care basic needs. We are fully integrated into the Community Health
Center movement, into the federally qualified health center so it provides access.

Also, I am Medical Director for the Health Department in Hartford as a pro bono position as well as the Chief Medical Office for the Community Health Center Association of Connecticut and it’s 16 federally qualified health centers. I am the Chair of the Community Health Committee for the Hartford County Medical Association and for 27 years I practiced medicine in the north end of Hartford as Medical Director of the Bergdorf Health Center serving one of the poorest communities in the State of Connecticut and providing for their needs. In 2015 I became the PI, the principal investigator of the Community Health Workers Work Force Initiative for the SIM, the state innovation model.

And so the reason why I went through all that is I’ve sorta gotten to see community health workers, healthcare, underserved populations from sort of a lot of different aspects. And whether from any of those points of view, whether it is an individual patient I am treating on the north end who was enormous headwinds as far as getting any care at all let alone being successful or as a volunteer clinician out at a migrant farm worker camp where sometimes even language stands between them and healthcare as well as a whole bunch of other challenges, or you know frankly working with the Health Department in Hartford in trying to make gold out of lead, trying to get services to the folks that live in those communities.

In all these roles I really found community health workers to be an essential link unfortunately often a missing link in connecting patients with care and
actually trying to actuate, trying to make real the things that certainly we as clinicians, as physicians, as healthcare providers feel patients should have access to and yet often they can’t and it is only that community health worker that does it. For the past four years I’ve been working with SIM and AHEC, you’re gonna hear a little more from us in a minute trying to look at community health workers and how to really create that workforce within the State of Connecticut. Early on in my tenure with the SIM, in discussions with vice-presidents at insurance companies, healthcare executives, hospital executives, etc. in trying to pitch ‘em, I’m a little bit of a salesman, I might have missed my calling, trying to pitch the whole community health worker workforce as a profession, I was told that until I can validate to my Board of Directors that these individuals have the competencies to do what I am paying them for, I will not hire them on the healthcare dollar. Okay and so really certification is that essential step in trying to say this individual actually has these skills and can do this work. Until we pay them from a sustainable source of funding, i.e., billions and billions and billions of dollars that are kicking around in the healthcare system, as part of that team we will not fully integrate them into the healthcare team and it will not be, until they are integrated into that team we are really not going to reap the benefits that community health workers offer. And so, from the depth of my being, I urge you to please put this Bill forward and let’s really create this workforce in Connecticut. Thank you.

REP. STEINBERG (136TH): Thank you, doctor you’ve expanded our understanding of all the different ways
community health workers are part of this solution. But if you can point us to the billions and billions of dollars that are kickin around this system.

DR. BRUCE GOULD: There are billions and billions, whose pocket’s there in is a different issue. Lots of dollars in the healthcare system, we have to spend the more wisely. And community health workers may be in fact one of the ways that we can target our most at risk and actually have a much more cost effective healthcare system.

REP. STEINBERG (136TH): We will need to get the Feds involved in that. Representative Petit.

REP. PETIT (22ND): Thank you, Mr. Chairman and thank you, Dr. Gould. Bruce, I’ll say for the Committee that was a long list of accomplishments but Dr. Gould is someone who doesn’t just talk the talk, he walks the walk. He’s taken care of people all over the state, especially Hartford and I only did maybe two trips with the migrant farmworkers and it is an amazing program taking care of people who otherwise would have no access to healthcare and it is an amazing challenge attempting to examine people by the side of the field, in a parking lot and different places where they’re set up. So, I think your input is invaluable cause you’ve been at the frontlines of primary care for the people who have very little access to care for 30 years, so thank you for your years of service.

DR. BRUCE GOULD: You know and I would add last Thursday night I was in Canterbury which I really had never been in Canterbury before, I don’t want it, you know, it’s out there and there is a large nursery in town and they had workers and we were there until about eleven at night and we had two
outreach workers from Generations Community Health Center with us and I found folks with blood pressures of 200 and rashes that they had for a year-and-a-half and all sorts of issues and was able to bring them over to the health workers who had a modem and a computer and were able to actually hook them into a visit. They will then come back to those individuals to potentially check blood pressures, etc. and then get them to healthcare and that, you know, is both a righteous thing to do, you know, it’s the right thing. I always say to my students and to my colleagues that sometimes you do the right thing just cause it’s the right thing to do but I will also save us a lot of money in the long run. So on all fronts I think this is a good decision.


SENATOR ANWAR (3RD): Thank you, Mr. Chair. Dr. Gould thank you so much for being here and I just want to echo what Dr. Petit has said. Actually, thank you. About almost November 2017 you organized volunteers to help Puerto Rico, thank you for that work and then thank you for being in all places serving all different communities who are underserved in so many ways. So, thank you for your testimony especially because you are a person who lives this and understands this far more than anybody else has a lot of value. So thank you.

REP. STEINBERG (136TH): Given all your roles the fact that you are here today to talk about community health workers surely does say quite a bit. Your investment and time here today are much appreciated. Representative McCarty.
REP. MC CARTY (38TH): Thank you very much, Mr. Chair and just very quickly, thank you for coming in today and talking about the certification process because it looks like that’s the avenue to really get the community health workers integrated into the full healthcare system. But my question is so we need to be somewhat cautious I would think about the certification process because it seems to me that we had some community health workers that are out in the community now doing valuable and good work, so could you just comment about what you think that should involve?

DR. BRUCE GOULD: Yea, I think from the very beginning in our work certainly what I felt and voiced as well as our team is to make sure that whatever we do is not to onerous for the folks doing this work. As has been mentioned before community health workers, you really want that, in fact the way you are supposed to hire one is really to look for that individual who is connected into their community, hire them and then potentially train them to do what they need to do to have the skills that they need to have. Certification process and again our counsel, our advisor counsel that sort of looked at this after the last Bill 16 months ago or whatever, was very careful to both take the needs of those who will choose to be certified and this is voluntary versus those that will, for whatever circumstances chose not to be certified, or not yet certified, and so we actually have a number of pathways so someone can gain certification through their experience and there is a whole sort of pathway or from training, you know a competency based training modality. There really will not be any discrimination to individuals who are not
certified however to be honest again, the hope is that looking at large systems, accountable care organizations, hospitals, insurance companies, is that the certification will allow them to start hiring community health workers. Now at some point in the future, it may be to get certain jobs you will have to be certified. We’re not looking at being the ones that decide that. The employers actually will be the ones but the hope is that both levels, both pathways will be taken advantage of and there are going to be lots of folks that will be doing this in their churches, doing this in their communities and eventually they can take that experience, we should make sure they know they should document it and they can turn that into certification.

REP. MC CARTY (38TH): And thank you very much for that explanation and for the work they have.

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

DR. BRUCE GOULD: You are very welcome.


FERNANDO MORALES: Good evening, everyone. Senator Abrams, Representative Steinberg and Distinguished Members of Public Health Committee, my name is Fernando Morales and I reside in Manchester, Connecticut. I am providing testimony in support of SB 859 AN ACT CONCERNING COMMUNITY HEALTH WORKERS.
This bill is an important next step in linking community and clinical care. In 2017, Connecticut defined community health workers or CHWs into statute, recognizing the important work these front-line public health outreach workers provide for community members. Now, the SB 859 proposes a certification process for CHWs, which will mainstream the field, leading to greater recognition and greater sustainability in the workforce.

I am employed with Southwestern AHEC which is a branch of the AHEC umbrella and we are housed in Shelton and I think for the last year, at least for me, I’ve been involved in really the design process of the Community Health Workers Initiative. WE, alongside my colleagues, my execute director and other members from the CHW Advisory Committee and other leadership, we kind of created this document that really laid out the whole foundation of what the process would be for a certification program her in Connecticut. I mean I don’t want to leave out of course the Office of Health Strategy which was obviously one of the folks that funded all this.

So, this is an important opportunity to recognize a workforce that for so many years have provided grassroots services to address social determinants of health and really other health issues to those marginalized populations, not just in Connecticut, but nationally and really even globally as well. Connecticut is poised to become one of several states that have introduced and passed Certification Legislation for the workforce that have been pivotal in improving health outcomes of clients by being trusted members of their communities and understanding the needs of people that they serve.
So with that, I urge you to please support and pass this 859 legislation and that way we can get this workforce in Connecticut for having a certification for this workforce. Thank you very much.

SENATOR ABRAMS (13TH): Thank you, are there any questions or comments from Members of the Committee? Thank you for your testimony. Lisa Ortega. Lisa Ortega here? No, that is the end of the 859 unless there is someone here, are people who didn’t come up? No, okay we are going to move on to House Bill 7302 and Dr. Chris Gargamelli.

DR. CHRIS GARGAMELLI: Good afternoon Senator Abrams, Representative Steinberg, Senator Somers and Members of the Public Health Committee. My name is Dr. Chris Gargamelli and I am a veterinarian practicing in West Hartford. I represent the Connecticut Veterinary Medical Association, the largest professional organization of veterinarians in the state.

So why is a veterinarian testifying on a bill regarding psychology. I know it’s been a long day but I am neither lost nor confused. [Laughter]. While 7302 addresses it also addresses Telehealth which not only affects psychology and other human healthcare professions but affects the practice of veterinary medicine.

We urge you to amend 7302 to include provisions for veterinarian medicine in Telehealth. There is a glaring hole in current state statutes allowing for potential harm to the health, safety, and welfare entrusted to licensed veterinarians. There are no regulations regarding veterinary medicine in Telehealth. Amending 7302 to include veterinary medicine would close this glaring hole by defining
the veterinary-client-patient relationship commonly referred to as VCPR, including the veterinarian, the client and the patient. By establishing the VCPR as the basis of veterinary care, the legislature ensures that the licensed veterinarian has adequate knowledge of his or her patient in order to provide proper care.

The patient may be a single dog or cat or an entire herd or flock.

It is only the District of Columbia, Alaska, Connecticut, and Delaware that do not refer to the VCPR. While Connecticut is generally a progressive state on the forefront of issues, in regard to the VCPR we are far behind most other states. Without a VCPR, a veterinarian who may neither be located nor licensed in Connecticut could diagnose or treat a patient in Connecticut via electronic or telephonic communication. That animal and its owner would not be protected by the regulatory powers of the Connecticut Board of Veterinary Medicine.

As shown by 7302, Telehealth has gained increasing popularity in human medicine. However, a human psychologist or medical doctor can ask his or her patient a multitude of questions to reach a diagnosis - Where does it hurt? How are you feeling today? In veterinary medicine, we do not have that luxury. I often joke with pet owners we all talk to our pets a lot, it’s only a problem if they talk back to us. Given that patients do not talk and often hide their illnesses and injuries the hands-on physical exam is key in diagnosing our patients.

Amending House Bill 7302 would elevate Connecticut up to the standard of care of 47 other states that already have this and in policy that is well-vetted
policy of the American Veterinary Medical Association. We urge you to Amend the Bill, thank you.

SENATOR ABRAMS (13TH): Thank you very much, that was very interesting. In amending the Bill, all that would need to be done is adding veterinarians?

DR. CHRIS GARGAMELLI: It would actually modify in the Telehealth portion of it, we actually have suggested language to establish the veterinary-client-patient relationship. That is the key factor, so by adding the language of veterinary-client-patient relationship that would bring us inline with 47 other states.

SENATOR ABRAMS (13TH): If you could send us that language it would be very helpful.

DR. CHRIS GARGAMELLI: We will take care of that.

SENATOR ABRAMS (13TH): Very much appreciate it. Representative Steinberg.

REP. STEINBERG (136TH): I very much appreciate your testimony but I have to say I’m very disappointed that you didn’t bring any patients with you to [Laughter] too.

DR. CHRIS GARGAMELLI: They always steal the show.

SENATOR ABRAMS (13TH): Any other questions or comments? Thank you so much. And that you for helping us with that so we can look it over. So we are on to Senate Bill 1035, Ben Shaiken. Welcome.

BEN SHAIKEN: Hi. Good evening Senator Abrams, Representative Steinberg, Senator Somers, Members of the Committee, my name is Ben Shaiken. I am a Manager of Advocacy & Public Policy at the
Connecticut Community Nonprofit Alliance. We are the statewide advocacy organization representing nonprofits over 300 across the state. Nonprofits as you all know deliver essential services to more than half a million people each year and employ almost 14 percent of Connecticut’s workforce.

I am here today in support of Senate Bill 1035 which would expand Deemed Status in Connecticut to certain nonprofit community providers of human services. It’s been a number of hours since we’ve heard about Deemed Status but I will try to bring you all back.

So what is Deemed Status and what would this Bill do. First of all, we think it would save nonprofits and the state money. Nonprofit providers of human services often maintain multiple licenses, each facility maintains it’s own separate license, often facilities serve both adult and children which are licensed by two separate departments. Many providers in the state have voluntarily achieved accreditation by a national accrediting body, two examples are CARF and the Joint-Commission, the Commission on Accreditation of Rehabilitation Facilities but there are others.

Those standards they achieved through accreditation are often equal to or higher than state licensure standards. So the Bill would allow these nonprofits to fully achieve and maintain accreditation to forego some of the requirements of licensure that are duplicative to accreditation. It would reduce the frequency of these visits but it would not eliminate them and that is a really important point. It would apply only to renewals of licenses, not new licenses, the state would still hold the license and state agencies would very much maintain their
authority to conduct announced and unannounced inspections as in the case of a critical incident or an allegation of abuse and neglect.

And I want to be clear that we have no intention in our support of this Bill to reduce any of the health and safety of the people who are served by nonprofits in this state we believe simply that this eliminating duplicative licensure.

I just want to end and I will wrap-up by touching on the history and I am happy to address it a little more if anyone has questions. The legislature has been talking about this issue for eight years now, first passed the Bill in 2011 that created a workgroup that studied the issue and they issued their report in 2015 and two years ago it took it up again in 2017, this Committee, Representative Betts introduce the Bill and Representative Demicco introduced a Bill that ended up in GAE where is passed and became the licensure and certification workgroup that you heard about earlier today. I want to be really clear and make sure that I say this in my testimony, the Alliance really appreciates the work that the workgroup is going, has done. It’s really produce some real results and there is a lot more in the hopper to streamline and make better the licensure system and it is a model of what our government should be, right, it’s state agencies all working together to make the system better but also at the table with a number of nonprofit providers. So before you over the last several years and other Committee use this as a model as you look to make change. But we really see it as separate from Deemed Status and we think that Deemed Status stands on it’s own as good public policy. It would compliment the work of licensure
and certification workgroup should Senate Bill 1035 become law. So even with the more efficient and streamline state licensure certification system that the workgroup is working to create and has made progress on so far, you know, the Deemed Status designation being available would, we think, further increase efficiencies and reduce redundancies for accredited programs. So I am happy to go into more detail about any of that, but that’s what I’ve got for today. Thank you.

SENATOR ABRAMS (13TH): Thank you, are there any questions or comments? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Ben, thank you for waiting and for your testimony. So today earlier we had three commissioners that came earlier. I don’t know if you heard them at the time, they all came in pretty strong views opposed to this. So there is a strong opposition and I am trying to navigate this and understand because they feel it will have an impact on their authority even though the Bill itself said it would not. But they feel that it is going to have an impact on their authority and maybe there is a slippery slope perspective or concern that they may have. It makes it a little difficult to, if it was one commissioner we would say, okay maybe we’ll have a conversation with them one-to-one meeting and discussion but three commissioners came out pretty strongly. Do you want to reflect on that?

BEN SHAIKEN: Sure, it’s a very good question. As folks on the leadership of this Committee and Senator I think we had most of these meetings before your election, so I apologize, there’s another Senate Vice-Chair in the room for them. I’ll just
say and we don’t usually share this sort of inside baseball, you know, in public hearings but in the interest of full-disclosure the reason that we sought to come forward this year which this proposal and ask the Public Health Committee to raise it and thank you for doing so. We have a new governor and a new administration so there have been two passes made at this. One in the first year of Governor Malloy’s administration and one in 2017 and we wanted to have an avenue to have this conversation with Governor Lamott and his team in this office as well as, you know, new commissioners and leaders across the executive branch. An so we are as informed I think by the opposition from three commissioners today as you are and want to be able to continue to have that conversation. You know, like I said, we still think that this is good public policy. We still think it can be designed and implemented in a way that ensures the health and safety and quality of programs that are offered to people across the state while recognizing that national accreditation from certain accrediting bodies is, you know, matches one-to-one or as in most cases more stringent that state licensure requirements and in other states can, does stand in place of some licensure requirements for these facilities and in Connecticut in fact does stand for hospitals and some hospital services as well. So this has really just been an expansion of something that we do already in certain settings and something that a number of other states do as well. And, you know, as the commissioner said, what is what, nine hours ago, every state does this a little bit differently but it is something that exists in a substantial number of other states, Connecticut is
among the number because of what the hospital system
does.

SENATOR ANWAR (3RD): So one of the questions I
asked them was, this is how I see things, if
something goes wrong it is going to be the
Department of Public Health or another department
that would actually oversee that situation. If they
are already involved and they have done their due
diligence and they have a point of contact, it’s
easier for them to address issues if there is a
complaint of any kind and if we use a national
accreditation organization or national licensing
entity then the local hands-on approach is weakened
a little bit. That is how I was looking at it when
I asked that question and they felt similarly in
their concerns.

BEN SHAiken: Yea I understand that. This is a
different model that what we have, it’s a change in
how the system works. There is a difference between
licensure and accreditation and it’s different in
focus and attitude even the factors that they are
looking at are the same and that is a little bit, I
think of where we are coming from. The
accreditation bodies work from very high level broad
perspective before they did down into the specifics
of sort of continuous practice improvement so that
is why a lot of our members voluntarily seek the
accreditation because they have an internal
commitment to that and they want to do the best that
they can. The concern about, well if something bad
happens, it is going to be on the state who has an
oversight, are very proper and correct oversight
role over these services. That is exactly why this
proposal does not stand to replace licensure it just
stands to lessen the frequency of the visits.
SENATOR ANWAR (3RD): So, it is reducing the burden on the various institutions because they are spending half the year working with various entities to get their accreditation and licensure?

BEN SHAIKEN: Correct.

SENATOR ANWAR (3RD): Okay, so I believe if that is the issue, maybe there is a way to being strong that further. But thank you as it’s helping me quite a bit to understand to navigate this.

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

REP. MC CARTY (38TH): Thank you. Very quickly so thank you for being here and your testimony but the doctor just kind of highlighted as I was trying to understand to and I think you are trying to reduce some of the burdens that the nonprofits may have to go through but it you look at DDS their concern, you’re not trying to take away from DDS, they would still have oversight in the licensure and they would still be able to evaluate the programs and go through that entire process, so you’re specifically looking for some relief in, and if you would end that sentence.

BEN SHAIKEN: Yes, we are specifically this Bill would reduce the frequency of renewal licensure visits if an organization has achieved accreditation. Importantly the Bill does not say it is going to be this accrediting body and this accrediting body it allows the state agencies to develop a program to evaluate the standards. A lot of that work has been done already by the first workgroup that was created in 2011. They spent several years, the report came out in 2015 doing
crosswalks of this requirement, the upper requirements of accreditation versus licensure. So it really would just reduce the frequency and for organizations that hold multiple licenses sort of keeping up with all of those visits is particularly, obviously is part of operating these things in these kinds of organizations so folks figure out how to do it. And I will also say to Commissioner Scheff’s testimony specifically earlier and more broadly to the work of the licensure and certification workgroup DDS in particular but through the workgroup the other state agencies have in their LEAN Process that they went through because of the action of the legislature took in 2017 have really identified a lot of changes and have implemented them or are in the process of implementing them, making the system better than it was two or three years ago for nonprofits without jeopardizing any of the health and safety and making it, I think, probably, you know, a place were it will be even better in the future as that workgroup continues. Like I said we still think Deemed Status is a good idea and it will still alleviate some of the administrative burdens that licensure creates.

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

SENATOR ABRAMS (13TH): Anything else? Thank you very much for your testimony. So we are moving on to Senate Bill 1057. Gloria Meritt. Welcome.

GLORIA MERRITT: Thank you. And thank you very body for hanging in there all day long, you’re almost finished with your evening, I believe. My name is Gloria Merritt. I am a nurse within the State of Connecticut and I am currently the Regional Director
of Behavioral Health Services with New England Home Care.

I’ve been a nurse in the psychiatric community for more than 40 years and through those 40 years have witnessed a great deal in terms of changes and the delivery of services, changes in the perception of what is needed in the role of a psychiatric nurse and what is needed in the community of psychiatric services. I started out being a nurse liaison for alcoholism and psychiatry at Greenwich Hospital. I’ve watched the evolution of the system become more behavioral health driven and the integration of mental health and substance use take on a life of its own and really that integration created a very powerful community.

Currently I am here in support of Bill 1057 and looking at the opioid crisis in the State of Connecticut and the country. But for our purposes really looking to see what can be done with the years of experience that we’ve had. Within home care we are seeing and we are the eyes and the ears of the community providers. You’ve heard witnesses talking about the different providers in the community, the physicians, the psychiatrists, the psychologists. We work with them all. One of the things that we have learned is the collaboration of services, the integration, the communication has created that very powerful presence and homecare is right there to bring all those services together.

What happens in recovery? In recovery people connect with other people. They connect with us in their home. We connect with their providers and I am here to say that moving forward I really hope that you to can see the value of homecare in the present and in the delivery of a systematic approach to
being able to alleviate and do something to the devastation that is being created to our families and our clients and our people. And I didn’t read one thing on my paper [Laughter].

SENATOR ABRAMS (13TH):  Good job, good job.

GLORIA MERRITT:  I had it all planned so I didn’t get disorganized or fragmented and I did not read on thing.

SENATOR ABRAMS (13TH):  Well I hope you said everything that you wanted to say. Thank you very much for your testimony. Representative Steinberg.

REP. STEINBERG (136TH):  Thank you for your testimony and the work that you do. But here we are, what’s ya got for us, any ideas explicitly? How homecare can help us with this that we are not doing currently that you’re getting involved with.

GLORIA MERRITT:  Yes, I think that there are, we have become kind of masters of partnering with the mental health, the traditional mental health, behavioral health sites, the DMHAS sites, the docs in the community, the providers in the community and we have done that very, very well. We haven’t done it as acutely with those providers in the community that are really at substance use disorders, opioid use disorders and I am thinking that we can take our expertise cause we have become experts with what we see in the home and how we bring that to the other providers and create a network of approach.

REP. STEINBERG (136TH):  What’s keeping you from doing that?

GLORIA MERRITT:  Pardon?
REP. STEINBERG (136TH): What’s keeping you from doing that?

GLORIA MERRITT: A few things. We do some of that. We would like to do it more extensively. Right now in terms of the reimbursement for homecare for psychiatric behavioral home healthcare it really falls under a much more traditional behavioral health system of reimbursement. We are hoping that we can expand that so that it does include those individuals who might not have the mental health disorder but they do have the substance use disorder and the opioid use disorder which right now there is not a specific reimbursement for that.

REP. STEINBERG (136TH): Thank you, other questions or comments? No, thank you for waiting so long to talk with us, appreciate it. Next is Heidi Pugliese.

HEIDI PUGLIESE: So good evening everybody. Good evening Senator Abrams, Representative Steinberg and all the Distinguished Members of the Public Health Committee. My name is Heidi Pugliese and I am the Vice-President of Behavioral Health Service of Elara Caring also the New England Home Care. I work with Gloria and I am a Mastered degree prepared Registered Nurse specializing in Behavioral Health care and I have about 28yrs experience in both SUD and behavioral health.

I have worked with the state agencies very closely, the Behavioral Health ASO and I am here to support the Raised Bill 1057 AN ACT CONCERNING OPIOID USE DISORDER.

We’ve heard much testimony today of many different reasons as Gloria pointed out from the
psychiatrists, the psychologists, all of which were very interesting and definitely provided a lot of variables that go into the opioid use crisis.

To provide some background on homecare, on a daily basis, Connecticut’s homecare industry services approximately 6,000 Medicaid covered individuals every day. New England Home Care covers and provides care for about 3,000 of those members who are diagnosed with behavioral health issues and/or substance use disorder. We are longstanding commitments to providing services to those in need in the community. New England Home Care encourages support for this Bill.

As we heard in prior testimonies the number of overdose deaths related to opioids is staggering. Last year in 2018 there were over 70,000 deaths in the United States and over 1,000 in Connecticut. The misuse of opioids is a national crisis which we all agree upon and that is affecting not only the public health but the welfare of all.

Leading mental health authorities, such as ASAM, SAMHSA and The New England Journal of Medicine have already cite multiple studies already completed that establish MAT, medication assisted treatment, as an evidenced based best practice. The studies indicate MAT significantly reduces opioid use and with increased access, which is what I am here to talk about today, can reduce overdose fatalities. However, MAT is often unavailable to those in need because of inadequate funding for treatment and lack of qualified providers.

In collaboration with the state agencies and the Behavioral ASO, New England Home Care can play a key role along the healthcare continuum to address this
need and promote recovery for Medicaid recipients struggling with opioid use disorder. Specifically, as outlined in proposed providing community based medication assisted treatment to those Medicaid recipients presenting to an emergency department as a result of opioid use/overdose.

In addition to community based MAT administration, New England Home Care’s specially trained behavioral health nurses can provide the necessary medication education, including Narcan training, to both the individual patient and families and those folks were in the home. Utilizing home health agencies such as New England Home Care can also increase the number of individuals who seek out treatment. By providing this service in the comfort of one’s home, it addresses the barrier of stigma that we talked about earlier today. Sometimes the stigma prevents individuals from seeking care. With this ability to provide mental health assessments, screening, and medication management in the home, these services form the bridge to transition individuals safely back to the community from both inpatient facilities and emergency departments.

Due to the urgent nature of this crisis, rather than a study, we propose the legislature support resources already provided in Governor Lamont’s budget under DSS, which enables DSS to develop a plan for community based OUD treatment possibly through the use of section 1115 Medicaid demonstration waiver. New England Home Care would appreciate the opportunity to partner with the State in this effort.

We support Raised Bill 1057 as it seeks to strengthen the overall health care delivery system,
by combatting the opioid crisis, and providing increased access to a much needed service.

I thank you for the opportunity to provide testimony today and all that you do to ensure the integrity of both medical and behavioral health services to Connecticut residents.

REP. STEINBERG (136TH): Thank you. You made mention of the 1115 waiver, are you saying that your understanding of the Governor’s budget that would be funds to pursue, is it predicated on getting 1115 waiver to have sufficient funds?

HEIDI PUGLIESE: Right.

REP. STEINBERG (136TH): To support the program?

HEIDI PUGLIESE: Yes, as far as. Yes, in 1115 waiver it talks about substance use to put aside monies for a Medicaid demonstration waiver that uses community services to combat substance use disorder and instead of a study for this particular Bill we are proposing that this is the demonstration model.

REP. STEINBERG (136TH): Connecticut is, has embraced the ASO model for so much of the way that we’re delivering healthcare. In your opinion is that an effective model for Connecticut, how’s it working, how do you relate to that?

HEIDI PUGLIESE: You mean ASO the Administrative Service Organization? Well having, I worked at the Administrative Service Office for many years as their Assistant Vice President. I oversaw the clinical services there and a lot of the recovery model that we taught many of the home care agencies including New England is based on the evidence based research model that SAMHSA supports as well as, you
know, most of the other NAMI support sets as well as a lot of the leading mental health authorities support that and that is based all on, you know, working in a recovery team model that would also utilize our providers, utilize the psychologists, the psychiatrists, the clinics as part of the recovery team but at the helm of the recovery team is the patient. And I think we talked a lot about that today, about empowering the patient to make healthcare decisions and homecare is uniquely positioned to really fill the gap in the system and implement that recovery model using care coordination, you’re in someone’s home and you can build that team with the rest of the providers and follow the patient throughout the continuum and not just when they are discharged from the emergency room. So, homecare I think can really fill in that gap to do through all of the aspects that we heard today, I heard a lot about medical assessments and physical assessments and integrated care teams and specially trained behavioral health nurses are trained in both medical and behavioral health modalities. They are trained in care coordination. They are certified in behavioral health. They are extensively aware of all the resources in the community including peer support services, including CCAR, the resources in the community that a lot of providers are not aware of. In addition to that, I think that homecare can be astutely aware of the many variables that happen in the home that lead to someone using opioids or substances again. There’s many variables that you don’t seen in a 15 minute physician office or a clinic or an ED or in the hospital that a nurse who’s trained in all of these modalities can see when they are in the home with the patient and their family. And I think that is
the role that a home care agency can play in this and certainly a trained behavioral health nurse.

REP. STEINBERG (136TH): Well, I would encourage you to find ways to participate in the crafting of a demonstration project such as waiver would allow us to do, sounds like home healthcare are be part of a solution. Thank you. Other questions? Comments? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. I think this is quite interesting now. I’m sure you’ve heard the conversation you have had about the community health workers but the community health workers are more helping communication, navigation process but for the specific condition that we are talking about they would help identify next level of care in the outpatient setting but the homecare management and medication administration is missing.

HEIDI PUGLIESE: Yes.

SENATOR ANWAR (3RD): Do you have data to support how effective that would be?

HEIDI PUGLIESE: As far as utilizing?

SENATOR ANWAR (3RD): Rehabilitation part with visiting nurses, home nurses managing the rehabilitation aspect.

HEIDI PUGLIESE: So I think I can’t cite specific studies but certainly the MAT information and the MAT data supports that medication administration therapy is significant -- can significantly reduce the opioid use and fatalities. The difference in using, certainly we support community health workers but they play a very different role than trained registered nurses do. The piece about medication
adherence in the home is huge because, and this also speaks to increasing capacity within the clinics and for psychiatrists to see more patients to induct them onto medication administration therapy. Right now with the Suboxone protocols the patient actually has to go into the clinic everyday for a period of at least seven days to be monitored and this model that we’re proposing they would have to be inducted in the clinic or with a psychiatrist, or prescriber and then the homecare nurse would do the administration of the Suboxone in the home and they would monitor the patient and do the teaching and certainly teach those around the person, you know, the whole medication management piece because very rarely do we have someone who is just on Suboxone, there’s probably other medications that the patient would need to have some training on in addition to the Narcan training, teaching the family, where to hold it, how to give it and I think that is the piece were the homecare nurse can play a huge role. Not only does that increase capacity in the system so physicians can see more patients and as we heard earlier today, but it also provides that continuum of care post-acute care and follow the patient and address the other social determinants that effect their health and it’s too many to name.

SENATOR ANWAR (3RD): And could you describe a little bit again but extra training that the nurses will get for this specific thing, cause there is gonna be behavioral component, there is a medical component for sure but there is a behavioral component. How much and they’re a little different in the skills?

HEIDI PUGLIESE: Yes. So, New England Home Care, you know, like I said before follows about 3000
behavioral health patient every day. So we have a very large program right now that we are following and the nurses who New England Home Care hires are specifically trained in behavioral health, some are certified, some are LADC’s such as Gloria and myself and a lot of the nurses have master degrees and have done behavioral health their whole career. So they would be specifically trained on Suboxone, Vivitrol, and methadone administration and the postinduction phase and the symptomatology of monitoring for side-effects, and all of the teaching that goes along with that.

SENATOR ANWAR (3RD): This makes perfect sense to me. I think this is something worth pursuing or looking into. Thank you so much.


SENATOR SOMERS (18TH): Good evening, thank you for waiting so long today to testify. When you came in to speak with us in the Public Health Leadership Committee I just thought this was a great idea, a great way to ensure or help ensure compliance cause that is one of the most difficult issue and all the training that you talked about for the family and the individual and you actually said if they are not there we will go find them, is what you told us, go look for them. So I think that is one of the most important things is compliance and support around once you are home or seeking treatment and I would even go as far as, you know, it’s gonna take a period of time to have the waiver filed, approved and I think that maybe the Committee should look at establishing a pilot program and figuring out a way to fund it to see what the outcomes are and if we can track it. That would really give us some good
information going forward because it may cost us some money now, but in the long run it will be, you know, the best for all of us when you think of what we heard earlier today from the coroner’s office, etc., so I fully support what you’re doing. It’s a really interesting model and I just wanted you to know that.

HEIDI PUGLIESE: Thank you so much and certainly, you know we support whatever the Committee thinks is the best model at this time. I think it provides a much needed service and you’re right. You know, we do go look for. I wanted to stress the issue of stigma because it came up before and I think when we had met previously I didn’t really bring that up but I think that is a huge issue. I think a lot of folks in all different socioeconomic classes, not just Medicaid, hesitate to go seek treatment because of the stigma associated with this and I can’t think of a better model than to have a nurse come into your home or come to where you are and provide those services and that training and that teaching and work with no only you, but your family and not even the family those people you surround, your friends if the patient gives consent.

REP. STEINBERG (136TH): Representative McCarty.

REP. MC CARTY (38TH): Thank you very much and very quickly again thank you for your testimony and I’m just wondering cause I’m trying to place this. I heard you say peer support. So when we talk about integration is there a way to have the homecare involved with what we can see with people working peer-to-peer support and then identify? I’m just trying to figure out how that would work but if you could just comment quickly on that?
HEIDI PUGLIESE:

RECORDING STOPS ABRUPTLY AT THIS POINT