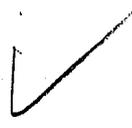


## Legislative History for Connecticut Act

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<b>Act Number:</b>	09-232	
<b>Bill Number:</b>	6678	
<b>Senate Pages:</b>	6145-6146	2
<b>House Pages:</b>	10126-10175	50
<b>Committee:</b>	Public Health: 1963-1973, 1988-1991, 1995-1996, 1997- 2000, 2301-2330, 2456-2500, 2503-2504	98
	<b>Page Total:</b>	<b>150</b>



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SENATE

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5944-6203

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reference into the Senate Journal and the Senate Transcript.

THE CHAIR:

There is a motion on the floor to move all items on Senate Agendas numbers three and four. Without objection, so ordered, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. Mr. President, would like to mark several items on Senate Agendas numbers two and three at this time, to move to take them up for purposes of placing them on the Consent Calendar.

THE CHAIR:

Please proceed, sir.

SENATOR LOONEY:

Thank you, Mr. President. First, on Senate Agenda number two. Under House Bills Favorably Reported, substitute House bill 6678, AN ACT CONCERNING REVISIONS TO THE DEPARTMENT OF PUBLIC HEALTH LICENSING STATUTES. Mr. President, would move to take that item up and place it on the Consent Calendar.

THE CHAIR:

There is a motion on the floor to take up item

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House bill number 6678 and place it on the Consent Calendar, off of Senate Agenda number two. Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, on Senate Agenda number three, under House Bills Favorably Reported, substitute House bill 6552, AN ACT BANNING THE POSSESSION OF POTENTIALLY DANGEROUS ANIMALS AND IMPORTATION, POSSESSION AND LIBERATION OF WILD ANIMALS, Mr. President, would move to take that item up for purposes of placing it on the Consent Calendar.

THE CHAIR:

There's a motion to place items, House bill 6552, on the Consent Calendar. Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, continuing on Senate Agenda number three, under disagreeing actions. First Senate Bill number 586, AN ACT CONCERNING COLLINSVILLE HYDROELECTRIC FACILITY, Mr. President, would move to take that item up for purposes of placing it on the Consent Calendar.

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The House is voting by Roll Call. Members to the Chamber.

DEPUTY SPEAKER ALTOBELLO:

Nearly all Members have voted. The machine will be locked. Will the Clerk please take and announce the tally.

THE CLERK:

Senate Bill Number 457 as amended by Senate "A" in concurrence with the Senate.

Total Number Voting	150
Necessary for Passage	76
Those voting Yea	150
Those voting Nay	0
Those absent and not voting	1

DEPUTY SPEAKER ALTOBELLO:

The Bill as amended By Senate "A" is passed in concurrence with the Senate.

DEPUTY SPEAKER McCLUSKEY:

Will the Clerk please return to the Call of the Calendar and call Calendar Number 404.

THE CLERK:

On Page 38, Calendar Number 404, Substitute for House Bill Number 6678 AN ACT CONCERNING REVISIONS TO

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DEPARTMENT OF PUBLIC HEALTH LICENSING STATUTES.

Favorable Report of the Committee on Judiciary.

DEPUTY SPEAKER McCLUSKEY:

The Honorable Chair of the Public Health Committee, Representative Ritter, you have the floor, madam.

REP. RITTER (38th):

Thank you, Mr. Speaker. I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is acceptance of the Joint Committee's Favorable Report and passage of the Bill. Will you remark?

REP. RITTER (38th):

Yes, I will, Mr. Speaker. Mr. Speaker, the Bill that we have before us makes a large variety of changes to the Public Health licensing statutes, more specifically in the area of funeral home practices and death records, statutes dealing with the Connecticut Tumor Registry, mass gatherings, home health agency inspections and continuing education for veterinarians. I move adoption.

DEPUTY SPEAKER McCLUSKEY:

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The question before the Chamber is on adoption.

Will you remark?

REP. RITTER (38th):

Yes, I will, Mr. Speaker. Mr. Speaker, the Clerk is in possession of an Amendment, LCO Number 9329. I would ask the Clerk to please call the Amendment and that I be granted leave of the Chamber to summarize. Thank you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Will the Clerk please call LCO Number 9329 designated House "A".

THE CLERK:

LCO Number 9329, House "A", offered by  
Representative Ritter and Senator Harris.

DEPUTY SPEAKER McCLUSKEY:

The gentle lady has asked leave of the Chamber to summarize the Amendment. Is there any objection? Is there any objection? If not, madam, please summarize your Amendment.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, this Amendment continues with additional changes to the Department of Public Health's licensing statutes, specifically in the areas of vital records,

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audiologists and speech language pathologists,  
language from the Office of Emergency Management for  
EMTs, and it offers a variety of corrections to the  
statutes that deal with animal crematoriums, barbers  
and swine farmers.

Mr. Speaker, I move adoption.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is adoption of  
House "A". Will you remark? The Honorable Ranking  
Member of the Public Health Committee, Representative  
Giegler, you have the floor, madam. Representative  
Giegler, you have the floor, madam.

REP. GIEGLER (138th):

Mr. Speaker, I would prefer that the Co-Chair be  
allowed to complete her summarization.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, that  
Amendment, which I believe will be designated House  
"A" has been adopted. The Clerk is in possession of--

DEPUTY SPEAKER McCLUSKEY:

No. We're still commenting on House Amendment  
Schedule "A".

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REP. RITTER (38th):

I'm so sorry, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Does anyone further want to comment on House Amendment Schedule "A"? Will you remark? If not, I'll try your minds. All those in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER McCLUSKEY:

All those opposed, Nay. The Ayes have it. House "A" is adopted. Will you remark further? Representative Ritter.

REP. RITTER (38th):

I will, Mr. Speaker. Mr. Speaker, the Clerk is in possession of an Amendment, LCO Number 9326. I would ask that the Clerk please call the Amendment and I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER McCLUSKEY:

Will the Clerk please call LCO Number 9326 to be designated House Amendment Schedule "B".

THE CLERK:

LCO Number 9326, House "B", offered by  
Representative Ritter and Senator Harris.

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DEPUTY SPEAKER McCLUSKEY:

The gentle lady has asked leave of the Chamber to summarize the Amendment. Is there any objection? Is there any objection? If not, ma'am, summarize your Amendment.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, this Amendment takes the provisions of three bills that have come to us from the Senate and adds them on to the underlying Bill.

These bills deal first with the licensure of child day camp day facilities and youth camps. Secondly, with revisions of the Office of Health Care Access certificate of need law, and finally, provisions regarding the establishment of an academic detailing program at the University of Connecticut Medical School.

I urge adoption.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is adoption of House "B". Will you remark? Representative Giegler, you have the floor, madam.

REP. GIEGLER: (138th):

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Thank you, Mr. Speaker. I, too, rise in support of this Amendment. These three bills that were before us came out of the Public Health Committee and they all had public hearings and had the support of the Committee, and I urge my colleagues' support. Thank you.

DEPUTY SPEAKER McCLUSKEY:

Thank you, madam for your remarks. Will you remark further? The gentle lady from Bolton, Representative Sawyer, you have the floor, madam.

REP. SAWYER (55th):

Through you, Mr. Speaker, a question to the Chairwoman.

DEPUTY SPEAKER McCLUSKEY:

Please proceed.

REP. SAWYER (55th):

This particular LCO that I have of Number 9326, could you tell me what section the detailing is in please?

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

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One moment, Mr. Speaker. Yes, Mr. Speaker, I would like to direct the Representative's attention to Section 501.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

Thank you, Mr. Speaker. Could she please describe the differences between the detailing Bill that we saw earlier this year that had a very large fiscal note?

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, I am not aware of a bill that has come before us, this General Assembly body that deals with academic detailing this year. I will let the Representative know that when this particular Bill started, it had differing provisions that made requirements upon the University of Connecticut Medical Center that funding come from the State of Connecticut.

If the Representative takes a look at the Bill before us, she will see that, excuse me, Mr. Speaker,

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she will see in Section 501(d) beginning on Lines 44,  
I believe there is clear language indicating that this  
is to be undertaken if the University of Connecticut  
Medical Center in conjunction with the School of  
Medicine at Yale University is successful at obtaining  
sufficient outside funding, and there would not be a  
cost to the State of Connecticut.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

Thank you, Mr. Speaker. Seeing it's just a  
little bit hard of hearing, I understand that--

DEPUTY SPEAKER McCLUSKEY:

(Gavel.)

REP. SAWYER (55th):

Thank you, sir. The Chairwoman, her voice is  
doing quite well. Looking at this particular  
Amendment for the detailing, I had done some reading  
on this when the issue first came out, and the  
question came up as to where doctors' offices should  
be able to obtain the information on prescriptions.

Can you please describe the other states that  
have put detailing in, if you have that information?

Through you, Mr. Speaker.

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DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, the Bill actually, I believe specifically refers to at least three other states where this has happened, beginning in Lines 37, I'm sorry, the Amendment, Lines 37 through 43. Those would be in Vermont, Pennsylvania and Oregon, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

Thank you very much. That's very helpful. In this particular case, Mr. Speaker, could the gentle woman please describe what was said during the public hearing regarding the detailing?

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, as I understand the Representative's question, she's interested in knowing what was said at the public hearing. That information, Mr. Speaker, is available through the General Assembly's website.

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We did receive some testimony as to the value of an academic detailing program, and its applicability, and its use in these various other states, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

Thank you, Mr. Speaker. Does the gentle lady have an estimate as to how much federal funding it would take to be able to put this into place? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, no.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

If the gentle lady could answer the question then, what type of federal funding would they be seeking? Does she know which agency? Is it something under the stimulus package? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

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REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, I would refer the Representative to Lines 44 through 52, where there is reference in the Bill to seeking funding from a variety of nongovernmental health access foundations for this program.

And Mr. Speaker, and the Representative's question reminds me that at the public hearing there was testimony that funding is available currently and expected to be available. Thank you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

Thank you, Mr. Speaker. And if the Chairwoman could describe, please, what the benefits are to having detailing in the State of Connecticut, something which we have not had in the past, something that has not been brought up on this issue that I have heard of before. This is the first year for this.

So if she could describe what the value is to having that? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

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Thank you, Mr. Speaker. Mr. Speaker, the, an academic detailing program would provide the opportunity for providers to obtain information that was based on evidence-based research and education on therapeutic and cost-effective utilization of the prescription drugs that they would be considering for their patients.

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

And where would the, through you, Mr. Speaker, a follow up question, where would they obtain the information as to the effect of the drugs and that type of information that they would be sharing?

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, it's my understanding that the University of Connecticut Medical Center as well as the Medical School at Yale University has a lot of information and is very willing to be able to share this information and put together in a more

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organized fashion that would be allowable under a program such as this academic detailing program.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER: (55th):

Thank you, Sir. And through you, so in the situation of talking about the dispensing of prescription drugs, would you imagine that they would be getting the information and going directly to some of the drug companies for some of the test results?

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, that could indeed happen.

DEPUTY SPEAKER McCLUSKEY:

Representative Sawyer.

REP. SAWYER (55th):

I would like to thank the gentle woman for her answers. This is one of those situations that's been very interesting in the discussions that I have had through numerous people that have come to me regarding the academic detailing.

Right now, physicians obtaining information on prescriptions and prescription drugs through a number of sources so they can get it on line, they get it at conventions when there are seminars held on it. They get it through the CEUs when they go to seminars as well, and they also get it through the drug representatives who come to their offices who share with them the testing that they do.

So we know that we've had the issue of drug representatives going into offices and the question about whether or not they should be providing meals.

So one of the things that came out in some of these discussions with a group was that in detailing that has been done in other states, what they found was in order to be able to get into the doctor's offices, the only time they could go in was at noontime, and that they had to bring meals also.

So it's sort of an interesting situation where we would have, the information could be coming directly from the horse's mouth and by that I mean directly from the drug companies, or in this case where we would create a second party that would go then back to the drug companies to get the information to bring it in, both cases requiring the issue or the situation of

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finding time in a doctor's schedule to be able to sit down and give them the information.

The original cost, my understanding, Mr. Speaker, was going to be in the millions to be able to set this up, and if my memory is correct, it was over \$8 million to be able to set this whole project up.

It's always a good thing, I think, Mr. Speaker, when we have oversight, but I also am very cautious, Mr. Speaker, at this moment in time of setting up another method, another layer when we do not have the money up front.

It's interesting that this talks about the different ways that they would be able to get the money to be able to set this up, because it talks about, I apologize as I look for it, the money that they would be getting, and it would be going through nongovernmental health access foundations.

Nongovernmental health access foundations, to go back and to do the University of Connecticut, which is a governmental health center.

So here we are saying that we should perhaps go ahead and set up detailing, which says to the third party situation, oh, by the way, we're not going to

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pay for it, and we're going to go outside, and who are these nongovernmental healthcare access agencies?

Do they have specific missions? Do we know what they are? As they gather their money, where does their source of money come from? So I have a lot of questions, Mr. Speaker, because I believe that there is competition and pressure being put on the pharmaceutical companies and they be given a black eye for going in and doing the education in the doctors' offices at lunch time, something that pharmaceutical detailing from experience in the other states has had to do exactly the same way.

I can understand, certainly, an academic reach, and I think it's wonderful that we'd be in consultation with Yale but it doesn't say in connection with Yale, it doesn't say with Yale. It would only be at the Health Center as part of the Connecticut Area Health Education Center, but only in consultation.

Mr. Speaker, I'm concerned that this gets up and running, what's going to happen when that money dries up from the foundations? So there are fiscal questions that go along with this, Mr. Speaker, that I don't believe have been answered.

I can understand, certainly, that there are questions about access, that there have been questions about some atrocities that have happened as far as gifting with the pharmaceuticals.

But Mr. Speaker, this particular project does not have a steady revenue stream to support it. There is an interest, I think, by everyone involved to be able to improve and provide access to doctors to the best, the most current data, when it comes to what is out there for them to be able to offer to their patients or not offer to their patients because Mr. Speaker, as valuable as it is to know what to give your patients, it's just as valuable to know what not to give, what the side effects are, what the repercussions are.

Are we setting up a watchdog agency, Mr. Speaker, or are we setting up a situation where we're having a third party give out, a second party give out the same information that the primary party is giving out anyway?

So this is controversial, Mr. Speaker, and the money is not coming through the government, if I'm looking at the line that the distinguished Chairwoman gave me, that it would be coming from a

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nongovernmental health access foundation, and it doesn't say that it would be in perpetuity.

So I will listen to the rest of the debate, and I thank the Chairwoman for her answers.

DEPUTY SPEAKER McCLUSKEY:

Thank you, madam, for your remarks. Will you remark further on House Amendment Schedule "B"? The honorable gentlemen from Woodstock, Representative Alberts, you have the floor, sir.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. If I may, several questions to the proponent of the Amendment.

DEPUTY SPEAKER McCLUSKEY:

Please proceed, sir.

REP. ALBERTS (50th):

Thank you. Line 68 of the Amendment references the transfer of net assets of a healthcare facility or institution. I want to make sure I understand this correctly. Does this mean any assets that the healthcare facility or institution may have, or is this language designed to refer to the bulk sale of all remaining assets of an institution? That was Line 68.

Through you, Mr. Speaker.

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DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, it's my understanding from the language in this section of the Bill, that it is to clarify that a certificate of need is required only in situations where a transfer of ownership results in a change in governments or control, and it's Line 68, I believe that the Representative has asked about mergers or any sale or transfer of net assets of a healthcare facility or institution.

My understanding would be that that would be as applies to the potential to, as I indicated, change in a government or control. That would be net assets.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. In referring to Line 633 to 641, there is language here discussing a requirement for a sharing of information concerning reports and investigations of suspected child abuse between the Commissioner of Children and Families and the Department of Public Health.

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Am I to understand that this information is not being presently shared? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, it is my understanding that that information is currently shared for substantiated cases that have been investigated by DCF.

The intent of the Bill is to broaden that slightly and allow the Department of Public Health to receive information in cases where there are involved ongoing investigations.

It should be made clear, Mr. Speaker, that should that be occurring and an investigation is determined to be without grounds or invalid, there is a provision in the Bill that would clarify that that practice is to no longer continue to occur and the information would not be shared.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. In looking at Lines 791 through 795, it's contemplated that the Department may

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determine that the health, safety or welfare of a child or staff person at a youth camp requires imperative emergency action and apparently there is language here that would allow a cease and desist order limiting the license and requiring the cessation of the activity.

What types of activity are we referring to?

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Through you, Mr. Speaker, it's my understanding that those would be types of activities that are currently regulated by the Department of Public Health, but that may have been determined to have a negative impact on the health or welfare of the participants at the camp.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. So for clarification, just so I understand, would that be things that would put the individual at risk because of safety concerns?

Through you, Mr. Speaker.

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DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. And then my last question, Lines 956 to 962, we have a lot of lines here, I think we've got seven lines here, and I just want to make sure I understand the gist of this.

The language talks about licensees vacating premises approved by the Department for child daycare services. Is the intent here basically to create an expedited process so that we can transfer access to the daycare facility?

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Through you, Mr. Speaker, this comes from a situation where the person providing the daycare services had abandoned the facility, and the intent of this language is to

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provide an expedited process whereby the facility could become reused for the provision of daycare services.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. In the particular example the proponent cited, was this language, is this language to make sure that the original licensee could have their license restored, or are we talking about a new third party? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, it certainly could become a third party. It's my understanding that this incident resulted from an abandonment of a facility, so it would not in this case be for a reuse by the same operator.

DEPUTY SPEAKER McCLUSKEY:

Representative Alberts.

REP. ALBERTS (50th):

Thank you, Mr. Speaker. I do thank the proponent's answers.

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DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks. Will anyone else want to remark on House Amendment Schedule "B"? Will you remark? Will you remark?

If not, I'll try your minds. All those in favor signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER McCLUSKEY:

All those opposed, Nay. The Ayes have it. House  
"B" is adopted.

Will you remark further on the Bill as amended?  
Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, the Clerk is in possession of an Amendment, LCO Number 9375. I ask the Clerk to please call this Amendment and that I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER McCLUSKEY:

Will the Clerk please call LCO Number 9375 to be designated House Amendment Schedule "C".

THE CLERK:

LCO Number 9375, House "C", offered by  
Representative Ritter and Senator Harris.

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DEPUTY SPEAKER McCLUSKEY:

The gentle lady has asked leave of the Chamber to summarize the Amendment. Is there objection? Is there any objection? If not, ma'am, summarize your Amendment.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, this Amendment makes a very small change to Section 63 in the previous Amendment, and it clarifies that a speech and language pathologist and audiologist would be responsible for obtaining certain continuing education credits. That is the only change. Thank you, Mr. Speaker.

I move adoption.

DEPUTY SPEAKER McCLUSKEY:

The question before the Chamber is adoption of House Amendment Schedule "C". Will you remark? Will you remark?

If not, I'll try your minds. All those in favor signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER McCLUSKEY:

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All those opposed, Nay. The Ayes have it. House  
"C" is adopted. Will you remark further on the Bill  
as amended? Will you remark further on the Bill as  
amended?

The distinguished Ranking Member of the Public  
Health Committee, Representative Giegler, you have the  
floor, madam.

REP. GIEGLER (138th):

Thank you, Mr. Speaker. The Bill before us as  
amended has had a lot of work put into it, and I have  
to commend the Chairs of the Committee, Representative  
Ritter and also Senator Harris, for their cooperation  
and efforts in putting this Bill forth.

As someone who, for the first time, sat within a  
Caucus or Committee room, you really get a new  
appreciation for what goes into the formulation of a  
bill, especially of this magnitude. The work of the  
LCO attorneys, the OLR staff, and even the staff  
within the Committees, there's a lot of effort, a lot  
of compromise and a lot of hard work.

And I have to commend them for their, how they  
stepped forward and set a list of criteria for what  
kind of bills would come out of Public Health this  
year, and I think this Bill is one of those that is a

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representation of just the efforts that they put forth.

This Bill is as diversified as the Department of Public Health, and it really exemplifies a really comprehensive Bill. It has just simple word changes. It cleans up certain statutes, and it fixes bills, which were passed.

But not only that, but it has to do with Yale University, Quinnipiac University, our EMTs, our radiology assistants, our radiology techs, speech and pathology, audiologists, veterinarians, and of course the issue that many of you have gotten to know me by, are funeral issues.

It also deals with education, licensing, construction, mass gatherings and water. It's very comprehensive. It has something in here for everyone. A lot of work went in, a lot of discussions, a lot of fixes. We spent a lot of time yesterday, and hopefully we got all the fixes that were necessary in there.

So I urge my colleagues' support for a very good Bill. Thank you.

DEPUTY SPEAKER McCLUSKEY:

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Thank you, madam, for your remarks. Will you remark further on the Bill as amended? Will you remark further on the Bill as amended? The honorable gentleman from Waterbury, Representative Butler, you have the floor, sir.

REP. BUTLER (72nd):

Thank you, Mr. Speaker. Through you, I have a couple of questions to the honorable Chairperson of Public Health Subcommittee.

DEPUTY SPEAKER McCLUSKEY:

Please proceed, sir.

REP. BUTLER (72nd):

Thank you, Mr. Speaker. I have a couple of brief questions about licensing process of funeral home directors, and specifically, about if they lose their license, what is the difference between their license being revoked and having a rescission, and I wanted to know if anything addressing that is in this Bill.

Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (72nd):

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We'll try that again, Mr. Speaker. Thank you, Mr. Speaker. If a license is revoked, it is removed, or taken away.

If a license is rescinded, it's as if it never existed in the first place. Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Butler.

REP. BUTLER (72nd):

Thank you. And specifically, I wanted to know as it pertains to someone that goes through the process of having a consent decree, which has been before the Public Health Department or the board that oversees this process, is the same answer true for somebody who goes through that process? Through you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

My apologizes to the Representative. I would ask that he repeat his question, please.

DEPUTY SPEAKER McCLUSKEY:

The gentleman please repeat your question.

REP. BUTLER (72nd):

Okay. My question was, specifically to a person that went through the consent decree process, would

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your previous answer about revoking and rescission be true for somebody that came through that process as well?

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, first, I'd like to make sure the Representative understands that a consent decree would be an agreed upon result, and I believe a license would be either revoked or rescinded depending on the terms of the consent decree.

DEPUTY SPEAKER McCLUSKEY:

Representative Butler.

REP. BUTLER (72nd):

Thank you, Mr. Speaker, and thank you for your answer. I have just a couple more questions about this process because there's someone in my city that's going through this process and I just want to get some clarity and I have an Amendment, but I'm not going to call the Amendment.

But I want to. I talked to officials in Public Health Department and the Attorney General's office and about putting together a solution to this

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situation administratively, and I hope to accomplish that.

But I just wanted to bring these questions to the floor because I just want to know, want this body to know that a situation exists that we really need to shore up and I thank you for your answers.

DEPUTY SPEAKER McCLUSKEY:

Thank you, sir, for your remarks. Will you remark further on the Bill as amended? Will you remark further? The gentleman from Shelton, Representative Perillo, you have the floor, sir.

REP. PERILLO (113th):

Mr. Speaker, good afternoon. If I may, a few questions for you, through you, for the proponent.

DEPUTY SPEAKER McCLUSKEY:

Please proceed, sir.

REP. PERILLO (113th):

On Line 12, and in that section, the Bill discusses mass gatherings in the presence of emergency medical personnel at mass gatherings. It cuts down the size it requires, I believe, from 3,000 to 2,000 individuals to trigger a mass gathering, and cuts down to some degree the amount of time it would trigger as well, 18 hours to 12.

In having a little bit of experience in this, 2,000 people is a lot of people, and 12 hours is a very long time. Was there any consideration given by the Public Health Committee to whether or not perhaps that number should have been lower than 2,000 or the number of hours should have been lower than 12.

Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, to the Representative, there was a great deal of discussion around these issues. I would like to point out that the request that came from the Department of Public Health clearly indicated that they felt that the number, say of 3,000 was too large, and we had discussion around all sorts of numbers lower than 3,000.

At this point in time, it was deemed appropriate to settle on 2,000. I understand the Representative's line of questioning. There's a lot of discussion around this and indeed, we may end up with a result that works very well. We may end up with a result that still needs refinement.

Through you, Mr. Speaker.

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DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you, and I thank the gentle lady for her answer, and of course her Committee's attention to that issue. It's a tough one.

And just to clarify, if I may, through you, I am actually working off of LCO Number 9329, so when I refer to line numbers that's what I'm referring to. Just so we're looking at the same thing. There were a couple of versions of this floating around, so I just want to make sure we're on the same page.

If I may refer to Section, I'm sorry, Lines 197 to 201, which refers to minimum equipment requirements. As I understand it now, there are existing minimum equipment requirements and I just was wondering why there's a need to restate this language and whether or not that is going to create perhaps any additional costs to municipalities and/or ambulance services in meeting the needs of those equipment requirements? Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

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Thank you, Mr. Speaker. Mr. Speaker, it is also my understanding that the Representative is correct. There are existing lists of these minimum equipment requirements, but it is my understanding that some of these lists have become, perhaps outdated and in fact, we have situations where there are requirements that certain equipment be carried that actually is not or cannot be used because it's outdated or obsolete.

So the purpose of this Section, Mr. Speaker, is to ensure that those lists are updated in a timely manner.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLLO (113th):

Mr. Speaker, thank you, and that was actually exactly the point of my question. Currently ambulances are required by the State of Connecticut to carry stuff that they are not even authorized to use by their medical oversight or medical control, and I was just hoping that indeed the intention was that we would be able to cull some of that out of the list so that's actually very, very good news.

If I may refer to Lines 175 through 177, there is some very cryptic language in here, which changes,

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what I believe changes certain providers in their title from emergency medical technician intermediates to what is now being referred to as advanced emergency medical technicians.

I'm just wondering what impact that has on the provision of care for these providers? Through you.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, it's my understanding that this request was, came from the Department of Public Health with the knowledge that this more closely conforms our statutes to language and professional designations that is used nationally.

It is also my understanding that this is a necessary prelude to a review of the regulations that the Department has enforced around precisely these issues.

So once this is finished, the Department will be able to begin its procedure of looking at the regulations.

Thank you, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

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REP. PERILLO (113th):

Mr. Speaker, thank you, and again, I thank the distinguished Chair for her answer.

A question about that, and I have suspected that perhaps this was going to change the State of Connecticut to a more national guideline for advanced emergency medical technician.

The question I have, though is, is there a different level of training required between an advanced EMT and an EMT intermediate, and whether or not that has any impact on cost and things of that nature? Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker. Mr. Speaker, it's my understanding that this does not in any way change the current training or scope for these professions, scope or practice for these professions.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Thank you. I was under the impression that an advanced EMT under national guidelines was a class

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that had additional hours, and more so when I say additional, I mean in comparison to an EMT intermediate.

So I'm just wondering if, in order for municipalities and ambulance services to continue providing level, care at an advanced or an intermediate level, that there's going to be an additional cost in terms of the additional, that I believe, may be 250 hours of training that's required for an advanced EMT. Is that accurate?

Through you, Sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, it's my understanding that that, we are indeed interested in using as a goal, moving toward these national standards, but at this time there is not contemplated the changes that the Representative is concerned about.

Down the road, that very well may be the case, but that is not included in the provisions of this Bill.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

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REP. PERILLO (113th):

Mr. Speaker, thank you. So in this Bill there's not a requirement that there be any change for practitioners? We're simply saying that there is a change in the title and that no additional training is required? Through you.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, correct.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Excellent. I thank the gentle lady for her answer on that. That was not what I expected, but it is very helpful.

If the goal, though, is to move forward toward advanced emergency medical technician, and that's our expectation, again I wonder that we are setting up, I mean, let's be honest. We are setting up an increased cost for the ability to take these classes. If the hours are longer, the classes are going to be more expensive.

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If that's indeed the case, do we expect there will be a financial impact in the out years on this?

Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Mr. Speaker, thank you. It's my understanding from the Department of Health that it very well may occur that we begin that process, but that's a process involving at least five years as well as engagement of all of the relevant professional groups and advocates, including a thorough review of the regulations around the provision of all of these services, and again, that is not something that is contemplated right now in the provisions of this Bill and it is not required by the provisions of this Bill.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, I thank you and I thank the gentle lady for her answer on that. One of the things I wonder about this, and trust me, I'm not necessarily saying it's a bad thing, but as you increase the number of hours of a class that people need to get to

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a certain level of proficiency, you do run the risk that not as many people will do that, and we currently have a level of proficiency here in the State of Connecticut called EMT Intermediate. It's about 120 or 130 hours, I believe, of training in and above that of an EMT and my understanding that advanced EMT is even more hours beyond that.

So I wonder if we are setting ourselves up as a state for a situation in which we don't have any, or very many providers at that advanced or intermediate level. Now we call it intermediate. It will be called advanced going forward.

So I just wonder if we are setting ourselves up for a situation where we have EMTs, we have paramedics, but we have no level of provision in between.

Again, I'm not necessarily saying that's a bad thing for the State of Connecticut, but I do think this is something that we need to be aware of, that in this Bill as amended, that is a very possible outcome.

But I do thank the gentle lady for her answers and her attention to the issue. Clearly, the Public Health Committee is on top of it.

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I have one last set of questions if I may, and again, in LCO Number 9329, Section 39, Lines 396 to 404 discusses crematories, and if I could, just a very, very simple question. Why is this change being made?

Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker. Mr. Speaker, it's my understanding that the particular provision in mind is a provision that is applicable through the planning and zoning process at the local municipality.

This change moves it from its current statutory home in the public health regulations to the more relevant regulations in the zoning law.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

I understand. So this is not something that is governed, or that we intend to govern any more in the Public Health Code, but it will be governed through zoning.

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Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, yes.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you. I would ask her very simply again, an elementary question. Is there a health issue involving crematories, and what is the reason to have them 500 feet from residential areas? It's just an area I'm not familiar with. Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, and actually the Representative's question speaks to the wisdom of doing this. There is not, to my knowledge, a public health issue around the siting of crematories.

It would be a zoning issue, and that would be the issue for the change.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

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Mr. Speaker, thank you, and that is exactly what I thought. So it begets the question, if there is not a public health risk, why would we be taking local control away from zoning boards and mandating that crematories not be within 500 feet of a residential area?

It is very feasible that you know, I think, you know, many towns in the State of Connecticut have downtown areas. There is mixed use. There is industrial, you know, manufacturing, industrial and manufacturing near residential, near commercial.

If there's not a health risk associated with crematories, why then would we be implementing what may or may not be a somewhat artificial buffer. If the lady can, and I know this is not necessarily a public health issue, but it is a public health Bill. If the distinguished Chair could answer that, I would appreciate it. Thank you.

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, we are not changing or implementing any different kind of buffer. We are

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merely removing this particular statutory requirement from the public health law to the law around zoning.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you, and I understand that. But if, indeed, the Department of Public Health and the Public Health Committee understands and recognizes there is not a public health issue here, I still don't understand.

Then why didn't we simply remove the buffer entirely. Why would we transfer the buffer, even though there's not a public health issue, why would we move that over to zoning?

DEPUTY SPEAKER McCLUSKEY:

Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, there was not an attempt to remove or change this buffer, only to locate it more correctly in the State Statutes.

I am not aware of any public health issue specific to this but I am not, Mr. Speaker, also stating an intention to remove the necessity to have a

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buffer at all, only that that is more clearly applicable to the laws around zoning.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you. I think that this, the public health aspects of this Bill are right on the money. The one issue I am a little bit concerned about is this one that we're discussing right now, where we are essentially dictating to municipalities how they will handle some of their zoning, and in this case, zoning as to crematories.

To me it is pretty clear that there is a buffer here. I agree with the Chair that this doesn't belong in Public Health Code, and I think that's a very good move.

But I still don't, I just don't understand why the language is here, and I would, just one last question.

Was there any specific instances, through you, sir, that would require us to have a buffer that would lead us to want to implement a buffer? Through you, sir.

DEPUTY SPEAKER McCLUSKEY:

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Representative Ritter.

REP. RITTER (38th):

Through you, Mr. Speaker, I will once again explain to the Representative that this change does not cause us to implement a new buffer that does not exist now. It changes the location in the statutes.

There is still a required adherence to the laws of the state, whether that is done at the municipal or the personal level, and that would apply to this buffer.

So there is no change created and the burden of a municipality to pay attention to this law is not changed by the fact that it is moved from the statutes applying to public health to the statutes that apply to zoning.

It did come from a specific instance in the Town of Durham where this was questioned, and it became very clear that it is rather unadvisedly, perhaps, placed in the body of law dealing to public health, a place where perhaps a local zoning board might not routinely look, and it made a lot more sense to simply make this change.

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I cannot iterate it more strongly to the Representative, that it does not create or change an existing law in that respect, Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you. And I thank the distinguished Chair again for her answers on that.

I do understand that this is not a change and it does not add anything new. I just question whether or not we should have kept it in the first place. We've made a lateral move to another section of statute, and that's all well and good.

I just wonder whether we shouldn't have just cut it out entirely. I tend not to like the State of Connecticut dictating local zoning to local zoning boards, that's why local residents elect their municipal zoning boards and planning boards.

I understand what the attempt is here, and it's not something that doesn't make sense, but at the same time, I don't know why we still have this buffer here, and I don't know why we're taking power, we're continuing to take power away from local zoning boards, in this case.

That concludes my questions, and I sincerely thank the distinguished Chair for her time in answering them.

Thank you, sir.

DEPUTY SPEAKER McCLUSKEY:

Thank you for your remarks, sir. Will you remark further on the bill as amended? Will you remark further on the Bill as amended?

If not, will staff and guests please come to the Well of the House. Will the Members please take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber, please.

DEPUTY SPEAKER McCLUSKEY:

Have all the Members voted? Have all the Members voted? Will Members please walk quickly, don't trip, take your time. Okay.

Now I do believe all the Members have voted. Will the Members please check the board to determine if your vote has been properly cast.

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If all the Members have voted, the machine will be locked. Will the Clerk please take and announce the tally.

THE CLERK:

House Bill Number 6678 as amended by House Schedules "A", "B" and "C".

Total Number Voting	150
Necessary for Passage	76
Those voting Yea	149
Those voting Nay	0
Those absent and not voting	18

DEPUTY SPEAKER McCLUSKEY:

The Bill as amended passes.

REP. MERRILL (54th):

Mr. Speaker.

DEPUTY SPEAKER McCLUSKEY:

Representative Merrill.

REP. MERRILL (54th):

Thank you. I move for the immediate transmittal of all items needing further business to the Senate.

DEPUTY SPEAKER McCLUSKEY:

Is there any objection? Is there any objection?  
If not, the items are transmitted to the Senate.

Representative Merrill.

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everybody is facing and also just to make sure that continuity of service and some of the others items that you mentioned were being taken into account in the process. That's what the purpose of the bill is.

GALE MATTISON: That was my assumption but sometimes we do things and six months or a year later it comes back and --

SENATOR HARRIS: Yup.

GALE MATTISON: -- bites us a little differently.

SENATOR HARRIS: Well, thank you, very much, for your testimony.

Any questions, further questions?

Thank you, very much.

GALE MATTISON: Thank you.

SENATOR HARRIS: Next we have Jen Filippone, followed by Carol Salsburg, and then Senator Hartley.

JENNIFER FILIPPONE: Good morning, Senator Harris, Representative Ritter, distinguished members of the committee. My name is Jennifer Filippone with the Department of Public Health.

HB 5630

HB 6674

HB 6676

I'm here this morning to testify on behalf of the department in support of House Bill 6678. Let me start by thanking the committee for raising this very important bill. As many of you know, it's commonly referred to as the "DPH tech bill" and generally includes both DPH proposals as well as proposals that have been brought before this committee.

In the interest of time, I'm going to focus my testimony on those portions of the bill for which we're looking for the opportunity to work with the committee on amendments just to clarify some of those provisions.

Sections 1, 13, 19, and 21 address issues related to the funeral service industry which we've been working closely with Representative Giegler on. The department respectfully requests the opportunity to submit revised language which would authorize schools of mortuary science to install working preparation rooms for the purpose of providing students with practical training in embalming.

We would also appreciate the opportunity to work with the committee to address issues that would -- related to Section 21 -- which would require that any body that will not reach its final disposition or destination within 48 hours from the time of death must be embalmed unless it is contrary to the religious beliefs of the deceased or the body is stored in a climate-controlled room.

To ensure complete and timely surveillance of cancer incidents in the State of Connecticut, revisions to the statute as identified in Section 7 would provide the department with authority to enforce reporting requirements and deadlines. The department respectfully requests the opportunity to submit amended language to clarify those provisions.

Sections 10 and 11 establish mandatory continuing education requirements for veterinarians. And there is a small, technical change that we would like to submit to the committee for its consideration.

The intent of Section 12 is to eliminate delays in cremation, based upon the unavailability of a registrar to issue cremation permits. When -- while the proposed language will allow a subregistrar to issue cremation permits during the hours when the Office of Vital Records is closed or in the event of a state emergency, it eliminates the checks and balances that are currently in place in the system to better ensure that persons responsible for disposition of bodies properly carry out their duties. The department respectfully requests the opportunity to submit amended language to address that issue.

Sections 14 and 15 clarify provisions related to transporting patients between licensed health care institutions. The department has worked very closely with providers concerning these requirements and, again, respectfully requests the opportunity to submit amended language.

Section 16 addresses the frequency of inspections for home health care agencies but needs further clarification. If the intent of the proposed language is to provide for state licensure inspections every three years for these institutions that participate in Title XVIII, the department requests the opportunity to submit language that would clarify that.

Section 17 would require the Department of Higher Education to seek certification from the Department of Public Health prior to authorizing an educational institution to offer a program related to a health service profession and would prohibit DHE from approving such program if the profession is not licensed. Not all professions are

regulated or licensed by the Department of Public Health, so DPH would welcome the opportunity to work with the committee and DHE to try and address the issue that this is intended.

Section 20 requires sextons to return a copy of all removal transit burial permits to the town of death within 30 days after final disposition and that the local registrar shall attach such permit to the death certificate. It also requires that language be added to the burial permit. Some of these provisions were already added in last year's legislative session under Public Act 08-184. The department is in support of the provision to send a copy of the burial permit to the town of death within the 30 day time frame, however local registrars oppose the requirement to actually attach the permit to death certificates as it interferes with their current filing systems. The department respectfully requests the opportunity to submit amended language to clarify the duties of the sextons and to ensure that sexton -- the sexton follows parallel procedures when completing and filing permits.

Finally, the department would like to request the opportunity to amend this bill by submitting language that would make revisions to the statutes pertaining to the Office of Emergency Medical Services. Changes would include replacing outdated language with modern terminologies, allowing the Commissioner to annually approve a list that sets the minimum equipment requirements for ambulances, motorcycles, and other rescue vehicles. Other changes include making the renewal cycle for EMT certification consistent for all providers.

Thank you for your time and consideration of the department's views on this bill. I'm here with several of my colleagues this morning, should you have any questions about it.

REP. RITTER: Thank you, Jen.

Are there questions from the committee?

Representative Nardello.

REP. NARDELLO: Thank you, Jennifer, for being here this morning.

Just a couple of questions on 5630: The department is opposing the bill based on the fiscal note, but I was wondering if the department was willing to work with the committee to find ways to reduce the fiscal note.

JENNIFER FILIPPONE: Of course we are.

REP. NARDELLO: And then the second thing I wanted to ask you is -- and I might state for the record, by the way, the department has actually been involved in this issue for several years and meetings gone on with the department. It's been ongoing for several years, and we're trying to bring some resolution to it. And I wanted to know if the department could comment on the bill's stated purpose of increasing access to dental care by establishing a mid-level provider that can provide more effective resources and more effective use of resources. So does the department have any thoughts on that, after having gone through all of the iterations and the years of meetings and such? If you could comment on that, I'd appreciate it.

JENNIFER FILIPPONE: Sure; I can provide some brief comment on the access issues.

As you know, Representative Nardello, my specialty is licensing, but we have been working on this issue for a number of years. And certainly this is one of the models that we've been looking at for a significant period of time. I think that, as you indicated and as indicated in the testimony, the -- the opposition in relation to the fiscal note has to do with any costs that are associated with implementation of a new licensing program which is currently not in the budget. And that applies to any category, not only this particular category. But certainly we're willing to work on looking at the language to address both those issues as well as some other clarifications that we were seeking.

REP. NARDELLO: Thank you, very much, Jennifer.

REP. RITTER: Further comments from the committee?

I might add one or two, so you can't leave quite yet. I had a question -- one moment -- oh, a general question, first, or request, actually, is that as you are as aware of our calendar as we are, so I would hope that our discussions can be fairly promptly gotten underway on these requests for amended language.

JENNIFER FILIPPONE: I've already started.

REP. RITTER: Very good. My feeling is that there may have to be additional discussions before we can move on them, and I'm hopeful that that'll go fairly quickly, particularly your last request concerning the Office of Emergency Medical Services. I -- I anticipate a large discussion about that. Thank you.

The other thing is I'm surprised, also. I -- I -- obviously you chose to give us testimony on this bill, so my next request is will we be anticipating further written testimony from the department on some of the other bills, specifically in addition to Representative Nardello's request, 6676 -- I'm sorry, no -- wrong bill; I knew that would be too easy -- 6674 and also 6676. Those are the issues involving the APRNs and the social workers.

JENNIFER FILIPPONE: We did submit written testimony on both of those bills.

REP. RITTER: Oh, perhaps I just don't have it here. Very good; I'll be looking forward to that.

Are there further questions from the committee?

Representative Bartlett.

REP. BARTLETT: Thank you, Madam Chair.

The Commission on Health Equity, is that still -- when do they meet? And I'm glad you -- you amended and put gender as one of the charges, but I'm kind of interested as to when this meets. And is it fully -- are all these folks that are listed on here actually appointed and are they involved in the commission; are they meeting regularly? And just tell me a little bit. In all the suggested budget cuts, there's a lot of folks that -- from the Governor's budget -- that are listed on here. I'm kind of interested to see where this commission stands.

HB6678

JENNIFER FILIPPONE: I actually see one of my colleagues coming up to assist me, because it's not my area of expertise.

REP. BARTLETT: Thank you.

JENNIFER FILIPPONE: So let me move over.

MEG HOOPER: Good morning. I'm Meg Hooper with the Department of Public Health.

Actually, the Office of Health Care Advocate is overseeing the Healthcare Diversity Commission, so they've actually established this. It's not under the purview of the department. We're simply asking that gender be utilized as a term appropriate for those representatives instead of sex. It's simply a -- a clarification of terms.

But, in fact, the Department of Public Health has its own Office of Multicultural Health which is a member of the Health Disparities Council established under previous legislation and administered through the Office of Healthcare Advocate.

REP. BARTLETT: So this entire commission is under the Department of Healthcare Advocate?

MEG HOOPER: That's correct.

JENNIFER FILIPPONE: Thank you.

REP. BARTLETT: Thank you.

REP. RITTER: Thank you.

Are there further?

Rep -- Senator Stillman.

SENATOR STILLMAN: Thank you.

Thank you, Representative Ritter. I don't think -- here I am, over here.

Bill 6676, which is not one that you testified on but one that we have language -- we have testimony on, and it's for those listening, it's concerning licensure of clinical social workers. The department opposes it. Is it strictly for fiscal reasons that the department is in opposition to this new licensing program?

JENNIFER FILIPPONE: I think that that's one of the reasons that we oppose the bill. We also had some other concerns about how the language was drafted and have actually been working very closely with the association. And -- and should the bill move forward, we would like the opportunity to continue to work with them to try and clarify some of the provisions that are within the bill.

SENATOR STILLMAN: In -- in -- in -- I'm glad to hear that you're talking with folks who are interested in this bill. I mean, I -- I don't know whether -- where this bill is going this year, but certainly it's -- it's an issue

Could you give us some sense -- unless you -- you'd -- you have an agreement not to talk about it publicly -- as to what the issues are that are a concern if not just fiscal?

JENNIFER FILIPPONE: From the department's perspective?

SENATOR STILLMAN: Exactly.

JENNIFER FILIPPONE: Just the way that some of the language has been drafted, quite honestly, in terms of supervision requirements, being sure that all of the language is consistent with how some of the other licensure programs work, making sure it's consistent and doesn't conflict with the current licensing statutes

relative to licensed clinical social workers. There is some overlap of practice there, so we just want to be sure that kind of everything is in order and that it all makes sense.

SENATOR STILLMAN: And one last question on this: When you first saw this bill, you must have run some numbers in terms of the cost. What -- and -- and obviously you said you're talking about the bill. Do you have any idea what kind of an impact it would have on the agents or the -- the state budget?

JENNIFER FILIPPONE: I don't have a specific number but I can talk to you a little bit about what goes into any new licensure program. You know, once there's a statute that's passed that enacts any new program, you know, we need to begin implementation. Implementation includes designing a new application form and an application process, updated our current systems, data base and others to incorporate a new profession into that process. It includes staff that would be involved in actually receiving application materials and disseminating that information to the public, answering questions. It involves staff who would be reviewing those application materials to see if someone, indeed, did qualify for the license based on all the eligibility requirements, and then actually issuing a license.

In the event that there's a complaint that's brought to the attention of the department, it involves investigating that complaint. And then, obviously, there's the further-out costs related to any prosecution of any practitioner who's been found to be in violation, and then adjudicating that complaint. Social workers is one of the professions that does not have a board in Connecticut, so those duties rely and

are based within the Department of Public Health in terms of hearing officers and making decisions about practitioners who have been in violation.

SENATOR STILLMAN: It -- it sounds as though if this was to move forward, that you might need about a dozen people. Isn't -- aren't there some people within the agency that -- I mean, not everybody in Connecticut would be asking to be licensed, number one; and, number two, and I know people are busy and -- and their time is stretched, but have you any idea how many people you might be talking about?

JENNIFER FILIPPONE: And that's why I said I didn't have a -- an exact number, unfortunately. We've actually been working, as I said, closely with the association on looking at the issues that brought rise to them bringing the bill forward and actually trying to identify how many practitioners this might involve so that we could actually put a more accurate fiscal note on it. You're correct; we would not need, you know, 12 people to -- to do this. But I, without knowing, really, the relative number of applicants we'd be looking at, we're trying to figure that number out so that we could better articulate what the exact cost would be. But those are the kinds of things that we'd be considering.

And, quite frankly, right now with the resources that we have within the department, it would be very difficult to take on any new category without any new resources.

SENATOR STILLMAN: Thank you, very much.

Thank you, Madam Chair.

and the first would be Charles MacKenzie, on the public.

Morning, Senator.

JOAN HARTLEY: Good morning, Senator Harris. And thank you to yourself and the committee for allowing us this opportunity to be before you this morning.

I would like to say a particular thanks for your thoughtful suggestion. And I appear here to speak specifically in reference to House Bill 6678, especially Section 22, An Act Concerning The Revisions Of The Department Of Public Health license -- Licensing Statutes.

And, Senator Harris, thank you very much for your interest in this subject and particularly Section 22 which speaks to the improper and the excessive use of prescribing of highly addictive, controlled substances.

I appear before you on behalf of my constituents, Barbara and Kevin Woods this morning, whose devastating story you will have an opportunity to hear later on, in the course of public testimony. It's a story that should be told, not so much because it's going to change the irreparable damage that the Woods' family experienced, because that cannot be changed, but because it's a story that should be told in the hopes that we will ensure that the proper safeguards are in place with regard to the prescribing of highly addictive substances and that no one else would have to endure the nightmare that befelled the Wood family.

I'll briefly recount the events that bring me before you this morning, and you will have an opportunity to hear specifically from Barbara

and Kevin Woods on the -- the graphic details. Barbara's son Kevin suffered a neck injury and he presented himself to his family physician, at which time the physician prescribed Oxycontin for him. During the course of his treatment, the physician continued to prescribe excessively and increasingly amounts of Oxycontin; and, in fact, a particular regiment would have been presenting himself on a Monday, getting a prescription, a 30-day prescription for Oxycontin and then coming in on Wednesday and getting another prescription for Oxycontin. And, in fact, Barbara just shared with me -- and she has all the specifics -- one, three-day cycle, for example, Kevin was prescribed 360 pills.

So the practice continued and escalated to the extent that Kevin would present to the doctor and not even see the physician, but the secretary would change the dates on the prescription and readminister, regive him the prescription. And, also, in addition to that, he would be given multiple prescriptions which he then would, in turn, go to multiple pharmacies and -- and have filled.

Now, Chairman Harris, and members of the committee, I recognize that the legislature has passed -- I guess it was effective July of 2008 -- legislation which requires the reporting of controlled substances by pharmacies to the Public Health Department, and I also recognize at the same time that there is a need for the proper and judicious prescribing of such controlled substances for purposes of acute pain management. So I ask this morning, Chairman Harris, and members of the committee, that after hearing Barbara and Kevin's story, that the committee might determine if, in fact, the public is being well served and the public interest is being

protected from what appears to have been the excessive, indiscriminate, and ultimately devastating fact pattern that befelled the Woods' family.

So I thank you, very much, for this opportunity and for your interest to look at this issue.

SENATOR HARRIS: Thank you, Senator.

Any questions?

Senator, I want to thank you very much for coming here today. I know how busy you are. And I also wanted to thank you for bringing this very important issue to the committee's attention. I know that out of tragedy hopefully that we can get information out there and make a positive impact.

JOAN HARTLEY: Thanks, very much, Chairman Harris. And I really do appreciate you putting it in this bill for the purposes of having this story told.

SENATOR HARRIS: Thank you.

And -- and I would just -- will throw that out there, perhaps the Woods can answer this, but I'm curious to know what happened to this practitioner and the people in the office. Were they disciplined by the department? If you know that, you can answer.

JOAN HARTLEY: I -- I don't have those details. I know that they did --

SENATOR HARRIS: Right.

JOAN HARTLEY: -- share this story with the AG's Office and Consumer Protection.

And with respect to the prescribing physician, I think they'll probably have to answer that for you --

SENATOR HARRIS: Thank you.

JOAN HARTLEY: -- Mr. Chairman.

SENATOR HARRIS: I appreciate that. Sorry to put you on the spot there.

JOAN HARTLEY: No. No, not at all. I -- I do appreciate your time. Thank you --

SENATOR HARRIS: Thank you.

JOAN HARTLEY: -- so much.

SENATOR HARRIS: Now we will start alternating between the public officials and the public. The first bill for the public is House Bill 6677, and we have Charles MacKenzie, followed by Dr. Carver, and then back to the public, followed by Sean Fitzpatrick.

CHARLES MACKENZIE: Good morning, Senator Harris, Health Committee. I appreciate the time and opportunity to speak a little bit on behalf of the revised Uniform Anatomical Gift Act.

Maybe a little bit of background is appropriate; I'm not sure everybody's familiarity with organ and tissue procurement processes. I'll get right to the bottom line first and then sort of give you how -- how it is that we address this tremendous need. We have 100,000 United States residents on the organ donor waiting list. We've got about a hundred or 900 Connecticut residents on the organ donor waiting list. We will probably have over a million tissue recipients in the United States this year, so a tremendous

Seeing none, Dr. Carver, followed by Deb Migneault.

WAYNE CARVER: Good morning; it's good to be back.

And, first of all, I'd like to thank the committee for the joint favorable on 6598, the genetic material. It's going to do a few kids some real good.

I'd like to speak about two bills. And contrary to my proclivity, I'll try to be brief. One is 6678, An Act Concerning Revisions To Department Of Public Health Licensing Statutes. This bill is 15 pages long, and I have a little concern about one sentence; and that is the provision that subregistrars can issue cremation permits.

HB 6677

Just to give you some orientation, there's a thing called a "cremation certificate," which is what we issue as a statement that we don't need the body for further examinations. A cremation permit is a creature of the Registrar of Vital Statistics. It says that they have our permit -- our certificate, a death certificate, and permission from the family, and they collect a fee.

We are subregistrars and traditionally limited to issuing of burial and transit permits, which we do about ten a year. If we were -- had the authority to issue burial -- excuse me -- cremation permits, I could foresee a floodgate of convenience when the funeral directors are either at our office or we're at their office and the registrars who are open full time are closing down their hours because of economic conditions.

I put some numbers in here. They're worse-case scenario, but we're really talking

about a full-time equivalent and significant modifications to our computer system.

About five minutes ago, the people from the Registrar of Vital Statistics showed me language in their testimony, written testimony concerning this bill, which would limit our role as subregistrars to burial transit permits, period. This solves my problem. Okay? How often does a bureaucrat get that, a solvable problem? And so please do that.

And the other thing I wanted to talk briefly about, 6677, which was just mentioned. There's two sections in this, 21 and 22, that go into really sort of painful detail about the relationship between the organ procurement agencies and the Medical Examiner's Office.

As a matter of principle, having been in government for 30 years, I find that when you put great details in statute, eventually you end up regretting it because it ties your hands, particularly here, as the law, the common law -- and we all know that the common law can -- can change very quickly from a judge's pen, or the science can change.

As an example of that, one of the provisions here is allowing medical examiners to go into the operating room when organs are harvested. This is already changed. We tried that 20 years ago. We mutually gave it up because it was of no value and wasted a lot of time.

You can go over some of my written testimony as well, but what I would request, that instead of Section 21 and 22, we start out with the first section -- the first sentence of Section 21, which is: "The Office of the Chief Medical Examiner shall cooperate with

procurement organizations to maximize the opportunity to recover anatomic gifts for the purpose of transplantation, therapy, research or education," which is the existing sentence, and then comma, as long as it does not interfere with its statutory mandate under Connecticut General Statutes 19a400 et seq., which is our governing statute. This is what we'd say now. We will try to do anything we can to help with transplantation, provided it doesn't interfere with our fiduciary responsibilities. It works well. I think this would be a simple solution.

SENATOR HARRIS: Thank you, Dr. Carver.

Any questions?

Representative Giegler.

REP. GIEGLER: Thank you, Mr. Chairman.

Thank you, Dr. Carver, for coming.

My question to you relates to the subregistrar. An issue that has come up is that due to -- as you made reference to -- economic issues, some of the towns, specifically I know in Danbury, they close the city hall now on Friday. And then we have had snow days. We've had, you know, maybe a holiday that's run into that. We could go as much as five days without having access to the city hall. So how would you address, and with the proposal of subregistrar, so we're -- so funeral homes are not having to hold bodies for as much as five or six days before they can proceed, especially for the -- the families? What is your suggestion then?

HB 6678

WAYNE CARVER: Well, obviously we have -- we have a problem that's arisen here, due to

decentralization of services. And each small group is struggling to keep up. And I think that the -- the -- the solution would be redundancy, that the funeral director in need could go someplace else. It's just that if I'm the someplace else, it's -- it's gonna put burdens on our office that we're not prepared to shoulder at this point.

I know that electronic death registry systems are in the works. I've been a proponent of this for at least 15 and almost 20 years. This is a creature of the Health Department, not me, but we're heavily involved in it since we write about 10 percent of the death certificates in the state and all of cremation certificates. And my understanding is that that's on a track to be implemented sometime in the early part of 2010. When all of this permitting process is on the Web, office hours won't matter. That doesn't help anybody from now until 2010, but -- but that, I think, is the eventual best solution.

REP. GIEGLER: Because you state, you know, that you are authorized to be a subregistrar currently, but the request is not to make you so much the subregistrar but to have one available within the towns.

WAYNE CARVER: Oh, that's fine. Okay.

REP. GIEGLER: You know, that's -- that's --

WAYNE CARVER: But as long --

REP. GIEGLER: -- what we're looking at.

WAYNE CARVER: -- as it's not me.

REP. GIEGLER: No, it wasn't you, because you already sign off on the -- the death certificate.

WAYNE CARVER: We issue -- well, we -- we -- we sign -- we -- we issue what's called a "cremation certificate." It's a document that says we've investigated the death to the point of being able to say we don't need the body for other parts of our investigation. Okay? We sometimes in those cases will issue the death certificate, if it's our authority to do otherwise; sometimes it isn't. Most of the time the death certificate comes from a private sector doctor.

That cremation certificate -- in the lingo, the "green slip," because we print it on green paper -- is one of the documents the Registrar of Vital Statistics needs to issue the cremation permit; the other is a death certificate and signature from the next of kin. It's the cremation permit that's at issue here, and it's the cremation permit that's the thing that the funeral director needs to get the crematorium working. Okay?

So if there are subregistrars wherever, redundancy, whether there's one statewide on a computer or some sort of redundancy in -- in individual towns, then the individual funeral directors and the families they represent -- which is what's this all about -- okay, can -- can get their needs met when the registrar is closed on Fridays.

And -- and I -- I -- I know the Health Department has some questions about governance about who's checking up on whom. I'm -- I'm not going to address that issue. I don't know enough about it. Okay? But -- but our office is just not -- it hasn't got the -- the chops

to -- to pick up this burden for all  
169 registrars.

REP. GIEGLER: It's actually -- the legislation was  
not at all meant for your office, and was --

WAYNE CARVER: I understand that, and part of  
the --

REP. GIEGLER: And part of the -- part of it now,  
Vital Records has not submitted -- I've met  
with them on a number of occasions -- we have  
not seen the language. They haven't given it  
to us, the ultimate language.

WAYNE CARVER: Okay.

REP. GIEGLER: But the concern was, with them, it  
didn't seem to be an issue with some of the  
funeral homes that we spoke to. Their  
concerns were checks and balances when it's a  
subregistrar was an actual, the funeral  
director and he'd be signing off on his own.  
I don't know what your thoughts on the matter.

WAYNE CARVER: I agree in principle that that's  
potentially bothersome. But the only  
authority I have to address that is the fact  
that you asked me here. But we would face the  
same problem, too; we would be signing off on  
our own cremation certificate, which does  
bother me a little bit or actually a lot.

But the real -- the real problem is the volume  
of -- of -- of paperwork, outgoing mail,  
accounts receivable and accounts payable that  
I would envision that I'd have to deal with.

REP. GIEGLER: All right. Thank you. I appreciate  
your answer.

SENATOR HARRIS: Thank you.

JOINT  
STANDING  
COMMITTEE  
HEARINGS

PUBLIC  
HEALTH

PART 8

2194-2508

2009

On to 6678. We can Carolyn Reid, Kim Skehan, and then Sam Olmstead.

CAROLYN REID: Senator Harris, Representative Ritter, and members of the Public Health Committee, my name is Carolyn Reid and I'm the minis -- the Administrator of Masonic Care Partners Home Health Agency and Hospice.

We're a state licensed, Medicare-certified, home health agency and hospice, providing over 200,000 home visits a year to 4400 Connecticut families in the greater-Hartford County.

I'm pleased to provide comments in support of Section 16 of HB 6678, An Act Concerning Revisions To The Department Of Health Public Licensing Statutes.

Home is where the residents of Connecticut want to be. Home is also the -- often the most cost-effective setting in which to provide health care. With federal reimbursement shrinking and state reimbursement for home care below costs, home health providers are struggling to survive. Recognizing the government as well as private industry is facing equally daunting deficits, we look for ways to save dollars while maintaining quality. Reducing unnecessary, administrative burden is one way we feel this may be established.

Home health agencies have unannounced site surveys by the Department of Public Health every two years for state licensure and every three years for Medicare certification. Most of the regulations are very similar. Although the Department of Public Health attempts to coordinate and minimize redundancy, the current discrepancy between the routine licensure visits for the state's licensure

survey and the Medicare survey frequency result in instances where in relatively short periods of time surveyors look at exactly the same issues, despite no findings on the previous survey.

One Hartford County agency had two surveys looking at the same things within a six-month time period because of this discrepancy. The change we provoke -- propose would have no impact on the quality of care, as this proposal does not limit surveys performed for complaints or quality-of-care issues. Complaints or problems will continue to result in more frequent surveys, as required by the Medicare survey frequency regulation.

In the current economic crisis, home care providers come to partner with you to identify any ways we can capture efficiencies while maintaining quality. This proposal will not decrease quality oversight but instead align the survey process to improve efficiencies for both the Department of Public Health as well as home health agencies. It's a way to save money. For the state, it reduces redundancy. For the home care providers, the survey process is both time-consuming and expensive, taking staff away from their patients, necessitating time for coordination of patient visits, and supervisory staff time to coordinate survey events and follow-up.

We support this proposal as a way to decrease the burden on the State Department of Public Health and home health agencies while maintaining appropriate oversight. I thank you for the opportunity to provide testimony today.

And I will be glad to answer any questions you might have.

SENATOR HARRIS: Thank you, Miss Reid, for your testimony.

Any questions?

Thank you, and thanks for the care that you give.

CAROLYN REID: Thank you.

SENATOR HARRIS: Kim Skehan, followed by Sam Olmstead, and then Pat Tadel.

KIM SKEHAN: Good evening, Senator Harris, Representative Ritter, and members of the Public Health Committee.

My name is Kimberly Skehan. I am Vice President for Clinical and Regulatory Services for the Connecticut Association for Home Care and Hospice, whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens. The association supports Section 15 of House Bill 6678, which will align the frequency of State of Connecticut licensure inspections with Medicare certification surveys for home health agency. This is a common-sense proposal that will help both the state and home health agencies conserve resources while maintaining appropriate quality oversight.

The association has received clear direction from the General Assembly to provide ideas that would make the system more efficient in these difficult budget times. The proposal would eliminate unnecessary duplication of DPH federal surveys and state licensure inspections within a short period of time when no quality-of-care issues have been identified. Aligning federal survey and state licensure inspections would free up DPH

surveyors to focus their efforts on agencies requiring extra attention. This proposal does not limit surveys for complaints or quality-of-care issues, as these issues would still result in more frequent surveys, as per Medicare survey frequency requirement.

We support continued oversight by DPH to ensure quality of care and have enjoyed a collaborative relationship with the department. Working together to ensure that quality care is provided to our patients at home, DPH attempts to coordinate and minimize survey redundancy, but it still occurs. Alignment of routine surveys will save resources for both the state and home health agencies as the survey process involves considerable time to coordinate, and involves many staff members and the routines. These surveys last about one week.

This is an example of one proposal that our association and members support to improve regulatory efficiency and meet the needs of patients at home. In addition, the association would also support a proposal for a two-year moratorium on licensure for new home health agencies in order to free -- further free up DPH resources to focus on existing agencies and prevent new agencies from entering the market and cherry picking Medicare patients to the exclusion of Medicaid.

Existing member agencies have identified declining Medicare referrals is a major problem. A two-year moratorium on new home health agencies would provide time for a more comprehensive approach to rethinking the regulatory structure of home care and addressing inadequate Medicaid rates.

In summary, we support these proposals for the reasons I have previously stated in my testimony, and we look forward to working with the General Assembly to ensure that our Connecticut citizens receive appropriate, high quality home care services.

And for your information, I also have attached some minor technical wording changes to our testimony as well.

Thank you for consideration of our testimony.

And I will be pleased to answer my questions that I may have.

SENATOR HARRIS: Thank you, Kimberly.

Any questions?

Thank you, very much.

Next, Sam Olmstead, followed by Pat Tadel, and then Nicole Granados.

SAM OLMSTEAD: Good evening, Senator Harris, Representative Ritter, and members of the committee. Thank you for your time this evening.

My name is Sam Olmstead. I'm the associate Director of Utilities Engineering at Yale University, and I here to testify in support of House Bill 6678, specifically, Section 23. As you may be aware, the university has a significant commitment to green house gas reduction of 20 percent below our 1990 levels by year 2020.

We are currently contemplating a number of technologies to support the achieving of that goal. One among them is ground source heating

and cooling systems, geothermal systems. The use of state-of-the-art geothermal systems is a -- a key component of the planning for our current residential college project, which is two new Yale residential colleges that will allow us to have 800 students and -- and the attendant, obviously faculty and staff positions that go along with that.

The -- the systems we would like to use currently are difficult to site in a complex, urban environment such as New Haven, and unfortunately, the current public health code does not really allow the Department of Public Health to contemplate this type of installation. We seek this change to work collaboratively with the Department of Public Health and the Department of Environmental Protection, as well as Consumer Protection, in order to evaluate this technology further and prove that it is safe and reliable. We believe this is an important step in making both the university and Connecticut more sustainable in the future.

Thank you, for your time.

And I'd be happy to answer any questions you may have.

SENATOR HARRIS: Thank you.

Questions?

Representative Giegler.

REP. GIEGLER: Thank you, Mr. Chair.

I -- I just have a question. I know this is really interesting technology, and my husband actually installed one recently in a house, you know --

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SAM OLMSTEAD: Oh, really?

REP. GIEGLER: -- a residential home down in the Ridgefield area.

But my question to you is what kind of -- because I know it's primarily been used to -- like in more southern than it has more northern, based on temperature, outside temperature. Now, installing this in New Haven, would you be having backup heat that works along with this if the temperature dropping below a certain degree?

SAM OLMSTEAD: We -- we have the ability to serve either the whole load of the facility from a system such as this or, as you suggest, to optimize the size of the system to provide heating and cooling when it's most appropriate and to use backup systems when that's most appropriate. So it's -- it can be done either way and in -- in the Connecticut climate.

REP. GIEGLER: That was my only question to you.

And thank you, very much.

SAM OLMSTEAD: Sure.

REP. GIEGLER: You have to invite us when you get this up, because --

SAM OLMSTEAD: We --

REP. GIEGLER: -- it's really --

SAM OLMSTEAD: We love visits.

REP. GIEGLER: -- fascinating.

SAM OLMSTEAD: We'd be -- we'd be happy to have you.

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REP. GIEGLER: All right.

SENATOR HARRIS: Representative Ritter.

REP. RITTER: Thank you.

Thank you for waiting so long to get to do this. That's why we have to ask you questions, to reward you for your patience.

SAM OLMSTEAD: Fair enough.

REP. RITTER: I -- I did have a question. Very early this -- many hours ago -- many, many hours ago, the Department of Public Health, in their testimony, suggested that in this, in Lines 802 and 803, we eliminate where the words "in New Haven, Connecticut." And I just had a -- I question as to whether you know anything about this technology in other places in the state? It was my understanding, when we first discussed it, this was really pretty unique. But maybe standing column geothermal wells are, indeed, becoming more pervasive in the state, and I was just curious about your thoughts on that.

SAM OLMSTEAD: I don't know of any other installations, but we are very comfortable with the department's comments. We, in no means, intend to limit it. I mean, we -- we think this is a great technology and, you know, consistent with our mission of -- of education and advancement of knowledge. I would think it's appropriate wherever -- wherever that's appropriate. That wasn't a great sentence but --

REP. RITTER: Thank you, very much.

SENATOR HARRIS: Thank you.

Any further questions?

Thank you, Sam.

SAM OLMSTEAD: Thank you, for your time.

SENATOR HARRIS: Next, Pat Tadel, followed by Nicole Granados, and then Patrick Killeen.

PAT TADEL: Good evening, Senator Harris, Representative Ritter, and members of the Public Health Committee.

My name is pat Tadel. I'm a National Patient Care Administrator for Vitas Innovative Hospice Care which operates two Medicare-certified hospice programs in the greater-Waterbury, Hartford, and Bridgeport areas of Connecticut.

I'm here this afternoon to testify in support of Section 16 of raised House Bill Number 6678, which aligns home health state licensure inspections which occur every two years with the Medicare survey cycle for home health agencies which occur every three years, resulting in a survey almost every year.

The legislation before you today is a common-sense approach that does not decrease quality oversight but instead aligns the survey process to improve efficiencies for both the department and provider agencies. This proposal would require the Department of Public Health to survey home health agencies and hospices every three years for both their Medicare and state licensure inspections. This proposal makes sense and is cost effective for both the state and home health and the hospice agencies. It also preserves quality of care for patients and their families as it does not limit surveys for

complaints or quality-of-care issues. In fact, any complaint or problem will result in more frequent surveys, as part of the Medicare survey frequency requirements. We support this proposal as a way to decrease burden on the state and home health and hospice agencies and to avoid duplication of efforts while maintaining appropriate oversight. Hospice care has grown to the point where there is a significant part of how persons receive care at the end of life.

On the state and federal level, Vitas supports regulatory and legislative proposals that maintain the integrity of the medical hospice benefit and the public's trust in the hospice provider community. Beyond raised Bill 6678, Vitas is eager to work with the Connecticut Association for Home Care and Hospice, the Department of Public Health, the Public Health Committee and other interested parties to explore ways we can further enhance the provision of quality home care -- health and hospice care in Connecticut.

In conclusion, hospice provides the quality care patients and families deserve and increasingly desire at the end of life. I urge your support of Section 16, raised Bill 6678 which allows home health and hospice providers in Connecticut to continue their mission while giving consumers appropriate protections to ensure we adhere to regulatory govern -- regulations governing our operations.

Thank you for your consideration and this opportunity to speak with you.

I'd be pleased to answer any questions you might have.

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REP. RITTER: Thank you, very much.

Any questions?

Thanks.

PAT TADEL: Thank you.

REP. RITTER: Next, Nicole Granados, followed by Patrick Killeen, and then Barbara Wood.

NICOLE GRANADOS: Good evening, Senator Harris, Representative Ritter, and members of the Public Health Committee.

My name is Nicole Granados, and I have been a licensed funeral director and embalmer with practical experience for 14 years. As Legislative Chair, I respectfully submit this testimony on behalf of the Connecticut Funeral Directors Association, which represents nearly 70 percent of the funeral homes in Connecticut.

With the matter of House Bill 6678, the Connecticut Funeral Directors Association supports this proposed bill as drafted with the sole exception of Section 21, Subsection 2, Lines 761 to 770, and that's found on page 25. This subsection would require the unnecessary embalming of a deceased body whose death was not due to a reportable disease and will not reach its final disposition or destination within 48 hours from the time of death. We respectfully recommend that these lines be deleted, for the following reasons -- and what I'll do is I'll just summarize; I have five reasons there, and I'll summarize them:

Number 1, is most bodies do not reach their final disposition or destination within 48

hours. That alone would trigger the embalming requirement for most families. By existing Statute, cremation cannot take place within 48 hours from the time of death.

Number 2, the -- the subsection is not consistent with existing Statute which states that a funeral director/embalmer shall prepare a body whose death resulted from a reportable disease, such as anthrax, smallpox or the plague by having such body washed, embalmed or wrapped. To wrap is to place the body in a pouch of not more than -- not less than 4 millimeters of plastic. Wrapping provides for public health safety, is not invasive, and it's also less costly -- less costly for the families that we serve.

Number 3, embalming is typically required by a funeral home for viewing. Establishing a 48 hour rule will force families who do not wish to have their loved one viewed, it will force them to pay for embalming.

SENATOR HARRIS: Can you finish up?

NICOLE GRANADOS: Thank you.

SENATOR HARRIS: We feel that by a forceful embalming, it will impose a fiscal impact to the families that we serve, which is certainly not we -- what we would want to do to our families.

Another implication could be families who chose to prepay their funeral arrangements. We would actually have to be charging embalming during the -- the prearrangement because we don't know the timing as to when the disposition might occur.

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My last point in the written testimony is during a mass fatality event or a pandemic, it would be impossible to embalm all human remains. And even climate-controlled rooms, which many funeral homes have already would be limited and perhaps nonexistent if temporary storage sites were utilized.

Thank you.

SENATOR HARRIS: Thank you.

Representative Giegler.

REP. GIEGLER: Thank you, Mr. Chair.

And thank you, Nicole, for coming.

I -- we've actually met a number of times, you know, CFDA and -- and myself on this very concern, and so I'm not really going to address it other than to thank you for the time that you're spending in order to draft a lot of the pieces of this bill so that it works for all.

But you did make mention, I think, in one of our conversations that you -- if a funeral home does, in fact, embalm a body, even though the family doesn't agree, that it's at the cost of the funeral home. Is that correct? Would --

NICOLE GRANADOS: Correct.

REP. GIEGLER: -- you state that?

NICOLE GRANADOS: The only way that a funeral home can collect a fee for embalming is with the permission of the family, and that's typically exclusive for viewing purposes or perhaps if the body is to be transported by common

carrier and it's a requirement of the common carrier. But if we perform an embalming without the permission, we cannot collect that fee, no.

REP. GIEGLER: Okay.

And -- and I thank you, very much. And I know we'll be meeting again on some subsections.

A VOICE: Yes.

NICOLE GRANADOS: Thank you.

REP. GIEGLER: Thank you.

SENATOR HARRIS: Thank you.

Any further questions?

Yes, Representative Lesser.

REP. LESSER: Thank you, Mr. Chair.

Good evening.

I'm really amazed weeding through the Statute, just the length of regulations that surround the operation of funeral homes and crematories in the state. Do you have any -- you know, this is -- doesn't really come to the subject of your testimony -- but do you have any sense of why -- why we have such extensive and voluminous regulations? You know, what -- what is our concern in the legislature how you operate in this basis?

NICOLE GRANADOS: As funeral directors and embalmers and is just the nature of what we do, we assist the living and we care for the dead. So we are regulated for those, the families that we serve and we're regulated for

the public health safety as well as the -- the safety of the funeral home's employees with concern for the dead. So that's why I believe that there's so many Statutes, as their should be, because it's -- we're just really not so much a self-entity but we rely on other agencies, such as crematories, interactions with physicians and medical examiners, cemeteries. So there's so many pieces that come together; that's why there's so -- so many regulations.

REP. LESSER: And -- and I -- I -- I certainly understand the concern in -- in the area, the issue that you -- you mentioned first which is the concern for families and making -- and the respect, certainly. I can imagine we care about the respect that, you know, that we -- we owe to the wishes of a deceased. And I understand that the state has -- has an interest there. But you also mentioned the public health aspect, and I just wanted to know if you could discuss some of the -- just some of the general issues that crop up in -- in sort of bringing a state interest into making sure that funeral homes and crematories are -- are operated safely or -- or -- or -- or in whatever manner we prescribe.

NICOLE GRANADOS: Well, the association feels that with the existing Statute, which is actually required for a body that dies of a reportable disease --

REP. LESSER: Um-hum.

NICOLE GRANADOS: -- that the body can be washed, embalmed or wrapped. We feel that that is what's in practice for providing for public health.

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As far as funeral directors and embalmers, right from the beginning when we're called and we come into contact with the person who has died, we are practicing universal precautions with every bar -- with every body, regardless of the time frame of when they're under our care to when they're taken to their final disposition.

REP. LESSER: Now, if -- if you weren't taking those precautions, do you think that could potentially create a public health hazard?

NICOLE GRANADOS: If we?

REP. LESSER: If -- if -- if you -- you talk about the, in a -- with the Chair's indulgence. I hate to go on this tangent but I -- that you -- you talk about the cares that your members take. And I'm sure that they do take an extraordinary amount of care. Is there -- if -- if they didn't, would that potentially create a public health problem?

NICOLE GRANADOS: If funeral directors did not take any precautions?

REP. LESSER: In terms of -- in terms of washing or -- you know, that you -- you were just describing in your testimony the steps that your members take in order to safeguard public health.

NICOLE GRANADOS: I imagine if -- if a funeral director, embalmer did not have the body either one of these three options and then put in an area where it wouldn't be accessible to the public, so to speak, which is why often funeral homes require embalming for viewing, because --

REP. LESSER: Um-hum.

NICOLE GRANADOS: -- we know the public will be in contact, then I would imagine that there could be a potential threat.

REP. LESSER: Were -- were you aware that there are zero regulations present that govern the care disposal of large animals in the state?

NICOLE GRANADOS: I'm not familiar with the --

REP. LESSER: Okay.

NICOLE GRANADOS: -- disposition of animals.

REP. LESSER: Thank you, very much.

SENATOR HARRIS: Thank you.

NICOLE GRANADOS: Thank you.

SENATOR HARRIS: Any further questions?

Thank you, very much.

Next, Patrick Killeen, followed by Barbara Wood, then Kevin Wood.

TRICIA MARRIOTT: I'm obviously not Patrick Killeen; he had to leave. I'm Trish Marriott; I represent the Connecticut Academy of Physician Assistants.

Hello, Representative Ritter, Senator Harris and stalwart members remaining of the Public Health Committee.

I have submitted our testimony in writing regarding 6678. We are concerned with Section 15, which we find clearly unclear, and we are just asking for clarification because it does not make it clear in the section what we're really talking about. It's regarding neonatal

transport, and the collection of us who have read this several times over, all the way up to our national academy don't really know what the mandate is in that section. And the reason Physician Assistants are concerned is in this state the UConn Transport Team utilizes APRNs and Physician Assistants to transport the very ill and our vulnerable neonates. We want to make sure that the appropriate personnel are placed in charge of those patients, and we want to make sure that the physician is involved as well. And the language is so very unclear; we're just asking for clarification and perhaps some tweaking of that language.

SENATOR HARRIS: Thank you, very much.

Any questions?

Thank you.

Barbara Wood, followed by Kevin Wood, and then Dr. Arnold Goldman.

BARBARA WOOD: Good evening, Senator Harris, Representative Ritter, members of the Public Health Committee.

I wanted to first of all thank the committee for letting me speak at this time. I am speaking to you and pertaining to Section 22 of the Law of 6678.

My name is Barbara Wood, and I am here today because of my son Kevin Wood, a husband and a father of three, who is also present and speaking at this public hearing. Kevin was prescribed narcotics from 2001 until 2007, from his medical doctor, thousands of which included Oxycontin, Oxycodone, Avinza, soma compound, Lexapro, Sevaxin, and other

controlled medications; and I put an attached evidence with the packets.

Even though the prescription was not close to running out, purchases were made from his insurance carrier, charge cards, and cash. I also attached evidence from his insurance carrier pertaining to office visits and prescription history dates paid by anthem. Of course, there's no proof on the cash ones or the charges. We are not able to get a complete history.

Kevin told me he also had his physician's cell phone number which he could call if he needed medication.

The current monitoring system, which the Connecticut State legislator -- Legislature passed in 2007, is a volunteer program on the part of the pharmacies --

SENATOR HARRIS: Keep going.

BARBARA WOOD: -- implementing a central database monitoring system so that narcotics and their prescribed patients cannot fall through the cracks would prove to be beneficial. Red flags should warn pharmacies, insurance carriers, and physicians of a possible abuse and addiction.

Kevin never needed a supplier on the street, because it was so easy to get the narcotics from a physician. If there is a tight monitoring on over-the-counter medications like Sudafed, why can't there be strict monitoring on something that is supposed to be controlled; i.e., narcotics?

There is definitely a lack of communication between providers which contributes to the

problem. This current system definitely failed my son and I'm sure others. I would want not any other family to go through what we went through from September 2007 until his addiction became apparent -- when his addiction became apparent until December 2007 when we finally were able to get help by way of his arrest; and it was not his first. I refused to bail him out and subsequently detoxification was implemented by Kevin.

At this time, Kevin accepted and admitted to his addiction which led to us getting him help. I had tried contings -- contacting several agencies, including drug addiction facilities, state programs, Griffin Hospital, group homes, as well as Connecticut State Police, Consumer Protection Agency, Officer of the atantly -- Attorney General, and the Connecticut court system with no success because I was told it had to be Kevin, himself, who wanted help, and he was not suicidal or hadn't hurt anyone.

At one time, Kevin was found in his car on the side of the road with no vital signs. He was taken to Griffin Hospital, observed, and released because he was no threat to anyone. No one asked about his wife and children.

When arrested in December, while incarcerated, he was served with a restraining order which prevented him from being alone with his children and also served with divorce papers, which have since been rescinded.

Many months of rehabilitation, incarceration, and counselling have made Kevin realize and accept that this will be a lifelong struggle he attends to on a daily basis.

Accountability on the part of the providers is an ethical issue, and I beg you to please make it impossible for other mothers to go through what I have gone through for the past year and a half.

A special thanks to Senator Joan Hartley for taking the time to respond to my letter, meet with me, and make this problem known.  
Respectfully submitted, Barbara Wood.

SENATOR HARRIS: Thank you, very much, Miss Wood, and we appreciate you taking the time and having the courage to use your horrible circumstances to help inform us. And Senator Hartley has done a great job of being your advocate and making sure that we heard this.

I'd asked her earlier today -- I don't know if you were around at point, and --

BARBARA WOOD: Yes, I was.

SENATOR HARRIS: -- if you were, well, then you're very patient and appreciate that, too -- whether the providers that were involved in this overprescribing had any consequences.

BARBARA WOOD: We contacted Pamela Jones from the Department of Consumer Protection, Narcotic Division, and all I'm told is that she can't give us information. She was going to try to find out if he did it to anybody else, but I have never heard another word from her. Because I did call a second time and she said, I told you Mrs. Wood, we cannot let you know any information about what we find out. So the doctor has a brand new office -- I understand it's beautiful -- Kevin is not going to that doctor anymore.

We did try to get an attorney to see if we could go after the doctor, and I was told that nobody was killed, nobody was hurt, so there's nothing that can be done, and not taking into consideration his family was all in counselling. Kevin is not working now, he's on medication. He lost his license for life, and he's got young children that his wife has to drive around all the time.

SENATOR HARRIS: Thank you. And it sounds, also, from your testimony that not only was it a problem with the actual provider, the health care professional but the insurance carrier and, I mean, this was allowed to sort of happen. There were never -- there were -- didn't seem to be any sort of checks on this being able to happen.

BARBARA WOOD: Exactly. I went to CVS and I asked them if Kevin got a -- if -- I made out it was me. I said if I got a prescription at Rite-Aid yesterday for a narcotic and I came into you today with cash and wanted another, the same prescription because the doctor gave me three and four prescriptions at a time, and if I gave you the prescription with cash, would you know that I got it filled the day before at Rite-Aid? And they said, no, there's no way of knowing that. And I said, well, how come the police when they arrested my son right away knew that he had been arrested a couple of times, but the pharmacies, Oxster Pharmacy never knew that CVS was giving it. Brooks didn't know that Rite-Aid was giving it. There has to be some kind of communication.

SENATOR HARRIS: Thank you. We're -- you might have heard today -- we had a bill earlier today, actually two, that -- that talked about technology. And obviously health information

technology is -- is one of the main things we're focussing on. Perhaps through advancing in that area, in that technology, we can try to put this on the table as another component of information that should be effectively shared --

BARBARA WOOD: Yes.

SENATOR HARRIS: -- to prevent this.

BARBARA WOOD: And if somebody comes in and pays a couple thousand dollars for a narcotic, you would think the drugstore would wonder why or check and see. Well, maybe this fella has insurance; let me look it up. But if he didn't buy it at that store before, there's no way of knowing, where if you had had a central database, they could find things out like that.

SENATOR HARRIS: Thank you, very much.

BARBARA WOOD: Thank you.

SENATOR HARRIS: Very appreciated. Any further questions?

BARBARA WOOD: Any other questions?

SENATOR HARRIS: Thank you for -- again, for your patience and for your willingness to come here.

Mr. Wood, followed by Dr. Goldman and then Dr. Halaszynski.

KEVIN WOOD: I was kind of hoping there wouldn't be any doctors left in -- in here.

My reason for -- thank you for listening to me today. My reason for being here today is to

convince the committee to pass a bill that would monitor prescription drug use. I would like the committee to understand that without an innovative system for monitoring prescription drug use, it is effortless to doctors, pharmacies, and insurance companies that are not in communication with each other.

I'm Kevin, that -- that I introduce myself.

The system that is in place now does not provide for monitoring prior to or during addiction. It was easy to go to different pharmacies to have my medications filled. If I went to one pharmacy, Rite-Aid on the first month, I knew I could easy go to another, CVS, or a hospital pharmacy within a couple days because of a lack of communication. Sometimes I could have my scripts filled within five or six days of each other, knowing that by going to different pharmacies, they wouldn't know about the other. Large chain pharmacies, independently owned pharmacies, or hospital pharmacies were all available to me because I knew they did not communicate with -- with each other.

As someone who would like to prevent prescription drug addiction, I know the easiest way is to have a central monitoring system. I had two medical insurance plans, one who was my wife's, the other mine. Two indifferent -- to different insurance companies who I knew did not communicate with each other. When I thought they might -- when I thought they might, I dropped mine and had less to worry about. The one insurance company should have seen the tremendous amount of narcotic I was receiving but for whatever reason kept on paying.

Pharmacies should centralize their systems to talk to each other, from there, the information sent to a monitoring board made up of a type -- the type of professionals and individuals mentioned in this bill, including someone who has manipulated the system prescription drugs. I believe that if a monitoring system with some bite had been in place, I may not be in the situation I'm in now; no driver's license, no job, and a lot of stress. A monitoring system would have made getting the prescriptions filled much harder.

Prescription drug addiction, I believe, is very different from illegal drug addiction. I did not have to go to unpleasant places to get it, so there was never any fear. The majority of the time it only cost me \$10 copay, so my wife didn't think I was spending a lot of money. There were no track marks in my arm or crack pipes in my house. I looked like a regular guy with a wife and three children.

Illegal drugs are illegal and as a -- and as ironic as it sounds, I not -- do not normally break the law. Prescription drug use is easy, cheap, and probably affecting more families than statistics show. I know there are many privacy laws involved when it comes to monitoring prescription drug use and financial considerations.

But as a prescription drug addict who knows how to manipulate the system, I hope this bill does not pass because if I do slip up and start abusing again, I don't want you to make it difficult for me.

SENATOR HARRIS: Thank you, Mr. Wood. I appreciate you coming in, again, turning your experience into something positive. We're going to look into it. You and -- and your -- and your

family through Senate Hartley have helped put this on the table.

I think it's not something that's going to -- because -- because of the complexity of it, actually getting something up and running, I can't say it's something that's going to happen overnight, but we'll put it into the discussion with this health information technology and take a look at how we can do it. So hopefully we'll -- we'll talk to you again in the future.

KEVIN WOOD: Oh, I just -- yeah. You know, I -- could I just add something? I mean prescrip -- and you know, I know there's people that would argue with me, you know, as far as addictions, but I'm just saying prescription drugs are -- are very appealing to someone like myself, a middle-class kind of guy. There's no booze on my breath. You know, it's very easy to pass, you know, it's very, you know, a crack, no crack pipes or track marks or, you know, a lot of -- it's very appealing addiction. It's legal, you know, and it's very subjective. I can complain about pain as much as I want and no one really can tell me I'm full of it. And, you know, it's just, you know, it's probably affecting a lot more people than -- than me.

SENATOR HARRIS: It's a big problem, and as we know, it's been in the news with these things called "pharming parties" that's -- it's spreading more and more to -- to kids, also. And maybe their parents aren't being monitored in what they're doing, and it's ending up in the hands of -- of minors.

So we appreciate it. You're lucky you have a good mother.

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KEVIN WOOD: Yes, I do.

SENATOR HARRIS: So thank you, sir.

KEVIN WOOD: Thank you, very much.

SENATOR HARRIS: Dr. Goldman, and then the final person today, Dr. Halaszynski.

ARNOLD GOLDMAN: Senator Harris, Representative Ritter, members of the Public Health Committee. Good evening, and hopefully it will very soon be a good night.

My name is Arnold gold man, and I'm co-Chair of the Connecticut Veterinary Medical Association Government Affairs Committee. I'm a practicing veterinarian. I'm licensed in Connecticut and Florida, and I've been in practice 23 years.

Thank you for the opportunity to testify in support of, specifically, Section 10 of House Bill 6678. The Connecticut Veterinary Medical Association represents over 95 percent of practicing veterinarians in Connecticut; 6678 would extend to veterinarians a requirement that they obtain regular, continuing education appropriate to their professional duties and employment.

On a national basis, 46 states require continuing education to renew a veterinarian's license to practice, and we believe it appropriate that they do so. Currently, Connecticut and just three other states, Hawaii, Michigan, and New York are in a minority which don't require any continuing education for veterinarians.

Two, veterinarians are unique among Connecticut's highly educated health

professionals in that with are not required in any formal way to seek regular continuing education. We believe the standard of care of veterinary medicine in Connecticut is excellent but we also believe the public deserves and should be able to expect the quality assurance inherent in the regular pursuit and assimilation of new knowledge and professional skills.

In light of the highly sophisticated and rapidly evolving state of veterinary medicine today, we believe such a requirement is necessary and appropriate, commensurate with the responsibility and privilege confirmed upon us by the public in treating their animals. Indeed, the similar premise underpins the continuing education requirements of physicians, dentists, and other health professions, and we believe it should similarly do so with the veterinary profession.

We heard a lot today about continuing education requirements, credentialing for other health professions, and here it is we have a health professional, has no requirement of any kind. We feel that our reputations depend on consumer confidence and that that confidence is partially dependent on public recognition that we also strive to remain current in our professional knowledge. We believe it is well past time to align that public expectation with reality and require continuing education for veterinarians. And this requirement will help ensure a high standard of competence among veterinarians and also ensure each licensee understands that in return for the privilege of holding a practice -- a license to practice veterinary medicine in this state, that the public expects maintenance of current knowledge and

proficiency. HB 6678, Section 10 will accomplish this while incurring no cost to taxpayers.

We urge you to join us in support of HB 6678, and specifically Section 10.

Thank you.

SENATOR HARRIS: Thank you, Doctor.

Any questions?

Thank you, very much.

Finally, Dr. Halaszynski. Thank you, Doctor, for hanging out all day. I think you were like one of our first people up, weren't you, or towards the beginning?

THOMAS HALASZYNSKI: I think so. I believe so, yes.

Well, Senator Harris, and Representative Ritter, members of the committee, thank us all for hanging around here this hour of the evening.

But once again, just briefly, I'm a board-certified anesthesiologist and currently President of the Connecticut State Society of Anesthesiologists and a physician at Yale-New Haven Hospital.

I come before you today in support of HB, House Bill 6678, An Act Concerning Revisions To The Department Of Public Health Licensing Statutes. The American Medical Association and many of the medical subspecialties and specialties including the American Society of Anesthesiologists are, in fact, pushing for

state and federal legislation to address physician misrepresentation.

The Connecticut State Society of Anesthesiologists of course supports these efforts. It is a concern that the American Association of College of Nurses recently announced that advanced practice nurse degrees may be actually converted from the current master's degree level to the doctorate level by the year 2015. Unfortunately, there can be a vast amount of confusion over who the actual licensed health care provider is under these circumstances, leading to misunderstanding and, of course, the ever-present safety concerns for the patient.

The language in HB 6678, in Section 8 B requires that a health care provider who works at a health care facility and provides a direct patient care, that they are -- should wear an identification badge that indicates the provider's name and then most importantly, the type of license or certification that that provider holds to avoid misunderstand on the part of the patients as well as other health care providers. This bill will also allow the health care facility, of course, to develop the policies concerning the size and content of that identification badge.

Truth and transparency are vital to the health care system and the safety of -- continued safety of our patients. I urge the committee to support House Bill 6678.

REP. RITTER: Thank you, very much, for your testimony and your patience and perseverance.

Are there questions from the committee? No?

Thank you, very much.

### *Competitive Procurement Requirement*

Since March 2006, OPM has required the POS agencies to competitively procure their health and human services. This is in keeping with an opinion issued by the Attorney General's Office stating that there is no legal distinction between a personal service agreement (PSA) – which is another type of State contract – and a POS contract.<sup>1</sup> The AG's opinion further states that POS contracts, like PSAs, are subject to the competitive procurements provisions of C.G.S. Sections 4-212 to 4-219, inclusive. Before the AG's opinion, there was an historic pattern of repeatedly funding current POS providers, usually on an annual, non-competitive basis. (For your information, a copy of the AG's opinion is attached.)

The same State statutes also provide for exceptions to the competitive procurement requirement. If a POS agency does not wish to conduct a competitive procurement for a service, the agency can apply to the OPM Secretary for a waiver. Since 2006, the Secretary has made extensive use of his authority to waive the competitive procurement requirement. For example, over 40 percent of the POS requests approved by OPM in 2007 were for waivers from competitive procurement.

### *Procurement Planning Report to Legislature*

In February 2008, pursuant to the requirements of Public Act 07-195,<sup>2</sup> OPM submitted a report to the legislature related to the competitive procurement of health and human services. The purpose of the report was to summarize the principles and policies for competitive procurement that OPM was developing in collaboration with State agencies and in consultation with the CT Nonprofit Human Services Cabinet. The principles and policies OPM outlined in the report provided the framework for State agencies to follow in developing their individual procurement plans.

### *Agency Procurement Plans*

Since July 2008, OPM requires the State's health and human service agencies to submit individual procurement plans to OPM for approval. The current plans cover the three-year period through June 2011. A key component of each plan is the agency's procurement schedule. The schedule includes (1) a list of services that will be procured,

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<sup>1</sup> Office of the Attorney General, *Formal Opinion No. 031* (November 9, 2005)

<sup>2</sup> Pursuant to Public Act 07-195, *An Act Concerning the State Purchase of Human Service Contracts for Health and Human Services*, OPM submitted a report to the legislature, entitled *Principles and Procedures for the Competitive Procurement of Human Services* (February 1, 2008).

by fiscal year, and (2) a list of services, with rationale, for any waivers from competitive procurement requested by the agency. Agencies may amend their schedules, but are required to obtain OPM approval for any changes. Agency implementation of approved plans is currently underway.

### *Current Situation*

#### *Release of Procurement Standards*

One month ago, on February 17, OPM released an updated procurement manual for PSAs and POS contracts. The manual addresses the requirements that all executive branch agencies – including the State’s health and human service agencies – must follow when entering into PSAs or POS contracts. Whereas the manual established certain new administrative standards for the POS agencies, the competitive procurement requirement for POS was not new. This requirement has been in place since 2006 when the AG issued his opinion (as noted above).

#### *OPM Allows Delay of Competitive Procurement Requirement*

The release of the procurement manual was accompanied by a letter from OPM Secretary Genuario to the State’s health and human service commissioners. (See attached.) The letter explicitly stated the following:

*(quote) In light of the current fiscal environment and the resulting constraints on both State agencies and the service providers, I am allowing a delay of the competitive procurement requirement for certain contracts. The delay is effective from February 17, 2009 until June 30, 2011. (unquote)*

The Secretary’s letter went on to explain that the delay of the competitive procurement requirement applied to contracts that maintain the *status quo*. In other words, OPM is allowing agencies to renew any contract that maintains the status quo, without a competitive procurement. In this context, *status quo* means that the cost, term, or scope of the service remains unchanged. If the amount of funding for a service is increased, if the term is extended, or if an agency wishes to make any significant change to the scope of a service, an agency must conduct a competitive procurement for the service. The provisions of the delay are in effect through the end of the current planning period.

The delay of the competitive procurement requirement in no way prohibits a State agency from *voluntarily* conducting a competitive procurement. An agency may decide to do so for any existing service if an agency determines that it is necessary, appropriate, or otherwise in the best interests of the agency’s clients or the State.

So, while there is an *expectation* for POS agencies to competitively procure health and human services, the agencies have the *option* of requesting a waiver from competitive procurement from OPM. OPM has approved – and will continue to approve – waiver requests for certain services, under certain circumstances, including those described in the Secretary’s letter.

### **Conclusion**

To conclude, this legislation imposes a temporary moratorium on the rebidding of contracts between State agencies and private providers of health and human services. This moratorium would apply retroactively, across the board, to all contracts since July 1, 2008 through July 1, 2010. We do not believe that this moratorium, in substance and in timing, is in the best interests of the State or the clients we serve.

First, agencies were asked to look strategically at the current and future needs of their clients, and at their current service mix. They were asked to thoughtfully determine how best to provide services and to develop a schedule to procure these services over the next three years. The moratorium, as proposed in this bill, is unworkable. Agencies have already begun their procurement processes, or have completed them, in accordance with their approved schedules. To stop these activities now will only create chaos and confusion.

Second, the title of the proposed bill refers to the “rebidding” of POS contracts, which presumably includes all *current* or *existing* contracts. OPM is concerned that this language may be interpreted to include the bidding of *new* contracts as well. Such an interpretation would hamper the ability of agencies to meet any new, expanded, or otherwise modified service requirements of the State’s clients going forward.

Finally, putting the moratorium in State statute is unnecessary. The OPM Secretary has already instituted a temporary delay for the competitive procurement that covers a more appropriate time period and is more sensitive to agency and client requirements. We believe agencies are in the best position to know their client needs and how best to meet these needs. If they wish to delay the procurement process, OPM has already provided them with the option of doing so.

Thank you.

### **Attachments**

cc: Senator Dan Debicella  
Representative Janice Giegler

Testimony | Gale Mattison | OPM  
CGA Public Health Committee  
Raised Bill No. 1120 AA Imposing a Moratorium  
on the Rebidding of Purchase of Service Contracts ...  
March 16, 2009

**ATTACHMENT**  
**Attorney General's Opinion**  
**Attorney General, Richard Blumenthal**  
**November 9, 2005**

The Honorable Robert L. Genuario  
Secretary  
Office of Policy and Management  
450 Capitol Avenue  
Hartford, CT 06106-1308

Dear Secretary Genuario:

You have asked for my opinion as to whether there is a legal distinction between a Personal Service Agreement ("PSA") and a Purchase of Service Contract ("POS"). Specifically, you also ask the following questions:

1. What statutory provisions require that a PSA be reviewed by the Attorney General as to form;
2. What distinction exists that exempts a POS from said statutory requirements; and
3. What distinction exists, if any, that exempts a POS from the statutory requirement contained in Conn. Gen. Stat. §4-212, et seq.

In my opinion, there is no legal distinction between a PSA and a POS, even though the Office of Policy and Management ("OPM") may choose to establish certain administrative procedures treating these types of agreements differently; they are both valid vehicles for entering into binding State contracts. As discussed more fully below, the answers to your questions are as follows:

1. The Attorney General's authority to review PSA and POS contracts is contained within Conn. Gen. Stat. §3-125, which provides that the "Attorney General shall have general supervision over all legal matters in which the state is an interested party." Contracts are legal "matters" and the state is "an interested party" in all state contracts.
2. POS contracts are not exempt from review by this office.
3. POS contracts, like Purchase of Service Agreements, are subject to the competitive procurement provisions of Conn. Gen. Stat. § 4-212 et seq.

Discussion

Your question asking whether POS contracts, like PSA contracts, are subject to the competitive procurement provisions of Conn. Gen. Stat. § 4-212 et seq was already answered in an earlier Opinion of the Attorney General, see 2004 Conn. Op. Atty. Gen.

Testimony | Gale Mattison | OPM  
CGA Public Health Committee  
Raised Bill No. 1120 *AA Imposing a Moratorium  
on the Rebidding of Purchase of Service Contracts ...*  
March 16, 2009

020 (2004) (attached for your convenience). This Office concluded in that Opinion that contracts between a state agency and a private entity for the provision of certain human services for the benefit of both the public (typically through a POS) and state agencies (typically through a PSA) are subject to the competitive procurement requirements of Conn. Gen. Stat. § 4-212 et seq. unless otherwise exempted by statute. As we stated in that opinion: "Questions have been raised as to whether Conn. Gen. Stat. § 4-212 applies to contracts for services to the public, or only to contracts for services provided directly to state agencies. An examination of the relevant statutes and their legislative history indicates that Conn. Gen. Stat. § 4-212 applies in both instances."

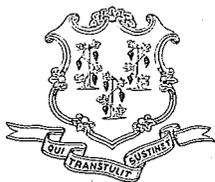
The authority for the Attorney General to review contracts is contained in Conn. Gen. Stat. §3-125, which gives the Attorney General "general supervision over all legal matters in which the state is an interested party. . . ." Contracts are legal documents that set forth the state's rights and obligations, and the state is "an interested party" in every one of its contracts. As such, they are subject to review by this Office as the Attorney General deems it to be appropriate. See *id.*, Op. Atty. Gen. 020 (2004). There is nothing unique about POS contracts that would suggest that they be treated differently from other state contracts or that they should be exempt from review by this Office.

In posing your question of whether there is a legal distinction between a PSA and a POS that exempts a POS from review by this office you reference an August 9, 2001 letter that I wrote to Department of Social Services Commissioner Patricia Wilson-Coker. That letter states that there is no specific statute requiring this Office to review every state contract. While there is no statutory requirement that this office review every state contract, Conn. Gen. Stat. §3-125 gives the Attorney General the specific discretionary authority to determine whether review of all or any particular contract is appropriate and advisable. In regard to the "managed care contracts for the State's Medicaid program," referenced in the August 9, 2001 letter, the Attorney General determined that this office would not review those particular contracts because they were not "consistent with the positions [this office had] taken in related litigation or in the best interests of Connecticut's citizens." Consequently, the statements made to Commissioner Wilson-Coker specifically related only to the 2001 Medicaid managed care contracts and did not relate to PSA or POS contracts generally.

I trust this letter provides you with the answers to your questions. If you need further information, please contact me.

Very truly yours,  
RICHARD BLUMENTHAL

Source: <http://www.ct.gov/ag/cwp/view.asp?A=1770&Q=306482>



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

### TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE March 16, 2009

Jennifer Filippone, Chief, Practitioner Licensing and Investigations, (860) 509-7414

#### House Bill 6678 - An Act Concerning Revisions to Department of Public Health Licensing Statutes

The Department of Public Health supports House Bill 6678 and thanks the Committee for raising this important bill.

#### Sections 1, 13, 19, and 21

Address issues related to the funeral service industry. The Department respectfully requests the opportunity to submit revised language to clarify the provisions of Section 19, which would authorize schools of mortuary science to install working preparation embalming rooms for the purpose of providing students with practical instruction in embalming. In addition, we would appreciate the opportunity to work with the Committee on language that would address issues related to Section 21, which would require that any body that will not reach its final disposition or destination within forty-eight hours from the time of death must be embalmed unless it is contrary to the religious beliefs of the deceased person or the body is stored in a climate controlled room.

#### Sections 2, 3, 4 and 18

Make technical revisions concerning the Department's authority to take appropriate disciplinary action against certain practitioners, the definition of "public health facility" as related to the provision of dental services, and existing mandatory continuing education requirements for physicians.

#### Sections 5 and 6

With any mass gathering it is critically important to include the local emergency medical services primary service area responder into the planning stage of the event. If there is not a primary service area responder, then the provider of local emergency medical care and transport service must be consulted in the planning stage. This would assure that proper access and egress to the event site is identified and can be maintained in the even of medical emergency. This would also allow the local and mutual aid emergency medical services to plan and "gear up" as necessary to assure that day-to-day operations are met as well as the needs of the mass gathering event are properly addressed,

#### Section 7

The current Connecticut statutes lack authorizing language for the Connecticut Tumor Registry to address the failure of healthcare providers to provide access to appropriate records to the registry. Current statutes reflect reporting practices and guidelines that are not in current practice. The proposed changes would update the reporting statutes to reflect current practice. In addition, changes to the statute allow for flexibility with reporting requirements, which change over time due to changes in diagnosis, treatment and prognostic considerations in oncology.

To ensure complete and timely surveillance of cancer incidence in the State of Connecticut, revisions to the statutes would provide the Department authority to enforce reporting deadlines. The Department respectfully requests the opportunity to submit amended language to clarify the provisions of Section 7.



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**Section 8**

Requires health care providers in many settings to wear clear and visible identification badges.

**Sections 10 and 11**

Establish mandatory continuing education requirements for licensed veterinarians. The Department respectfully requests the opportunity to submit amended language to clarify the provisions of Section 10.

**Section 12**

The language in section 12 will allow a subregistrar to issue cremation permits during the hours when the office of vital records is closed or in the event of a state of emergency declared by the government. Presently, subregistrars are only permitted to issue burial permits. The purpose of this proposal is to eliminate delays in cremation based upon the unavailability of the registrar to issue the cremation permit. This proposal will resolve that issue, but at the same time eliminates the checks and balances in the system to better ensure that persons responsible for disposition of bodies properly carry out their duties. In order to keep the checks and balances in the system, while at the same time resolving the issue of delaying cremation, the Department respectfully requests the opportunity to submit amended language to clarify the provisions of Section 12.

**Sections 14 and 15**

Clarify provisions related to transporting patients between licensed health care institutions. The Department has worked closely with providers concerning these requirements and respectfully requests the opportunity to submit amended language to clarify the provisions of these sections.

**Section 16**

Subsection (a) of Section 19a-493 is being revised, but the new language regarding frequency of inspections of home health care agencies needs to be clarified. Only home health care agencies can qualify for Medicare reimbursement. Homemaker-home health aide agencies [subsection (e) of 19a-490] and homemaker-home health aide services [subsection (f)] do not qualify for Medicare benefits. Additionally if the purpose of the language is to provide for state licensure inspections every three years for home health care agencies that participate in Title 18 perhaps the language could be simplified.

**Section 17**

Would require the Department of Higher Education (DHE) to seek certification from the Department of Public Health (DPH) prior to authorizing an educational institution to offer a program related to a health care profession and would prohibit DHE from approving such program if the profession is not licensed, certified or registered by DPH. All health care professions, however, do not require DPH licensure, certification or registration. DPH would welcome the opportunity to work with the Committee and DHE to address the issues that lead to the proposed language.

**Section 20**

Requires sextons to return a copy of all removal transit burial permits to the town of death within 30 days after final disposition, and that the local registrar shall attach such permit to the death certificate. It also requires that language be added to the burial permit. Some of these provisions were already added in last year's legislative session under Public Act 08-184. This section includes new language for the 30-day time frame and the requirement that the burial permit be attached to the death record. **The Department is in support of the provision to send a copy of the burial permit to the town of death within the 30-day time frame.** However, Local registrars oppose the requirement to actually attach the permit to the death certificate, as this interferes with their filing systems.

Though the amendments to section 7-66 as proposed in this bill provide little change to the statute, we are in agreement that this statute, as well as other death statutes are in need of revision and clarification. The Department respectfully requests the opportunity to submit amended language for section 20 to clarify the duties of the sextons and to ensure that the sexton follows parallel procedures when completing and filing disinterment permits.

**Section 23**

Allows the Department of Public Health in concurrence with the Departments of Consumer Protection and Environmental Protection to issue a variance to the regulations of Connecticut State Agencies to an institution of higher education for the installation and study of standing column geothermal wells. The Department is supportive of this initiative however we suggest amending the bill to delete "In New Haven" in order to make this a state-wide effort.

In addition, the Department would like to amend this bill by submitting language that would make revisions to the statutes pertaining to the Office of Emergency Medical Services. Changes would include replacing outdated language with modern terminologies, allowing the Commissioner to annually approve a list that sets the minimum equipment requirements for ambulances, motorcycles and other rescue vehicles. Other changes include making the renewal cycle for EMT certification consistent for all providers, regardless of how long the provider has been certified.

Thank you for your consideration of the Department's views on this bill.

TESTIMONY BEFORE THE PUBLIC HEALTH COMMITTEE  
REGARDING HB 6678 AN ACT CONCERNING REVISIONS TO DEPARTMENT OF  
PUBLIC HEALTH LICENSING STATUTES.

March 16, 2008

Senator Harris and Representative Ritter, and members of the Public Health Committee, my name is Carolyn Reid and I am the Administrator for Masonicare Partners Home Health and Hospice. We are a state licensed and Medicare certified home health agency and hospice providing over 200,000 visits to 4,400 Connecticut families in the greater Hartford county annually. I am pleased to provide comments **in support** of Section 16 of HB 6678, An Act Concerning Revisions to the Department of Public Health Licensing Statutes.

Home is where the residents of Connecticut want to be...home is also often the most cost effective setting in which to provide health care. With federal reimbursement shrinking and state reimbursement for homecare below cost- home health providers are struggling to survive. Recognizing that government as well as private industry is facing equally daunting deficits- we look for ways to save dollars while maintaining quality.

Reducing *unnecessary* administrative burden is one way this may be accomplished.

Home health agencies have unannounced site surveys by the Department of Public Health every 2 years for state licensure and every 3 years for Medicare certification. Many of the regulations are similar. Although DPH attempts to coordinate and minimize redundancy, the current discrepancy between routine licensure survey frequency and Medicare survey frequency results in instances where, in a short period of time, surveyors look at the exact same issues, despite no findings on the previous survey. One Hartford county agency had two surveys looking at the same things in a 6-month time period because of this discrepancy.

This would have no impact on quality of care as this proposal does not limit surveys performed for complaints or quality of care issues. Complaints or problems will continue to result in more frequent surveys as per Medicare survey frequency requirements.

In the current economic crisis, home care providers come to partner with you to identify ways we can capture efficiencies, while maintaining quality. This proposal will not decrease quality oversight, but instead align the survey processes to improve efficiencies for both the Department of Public Health as well as for home health agencies.

This is a way to save money for the State by decreasing redundancy in the survey process, as well as for agencies as the survey process is both time consuming and expensive taking staff away from their patients, necessitating time for coordination of patient visits and manager/office staff time to coordinate survey events and follow up.

We support this proposal as a way to decrease burden on the State and home health agencies and to avoid duplication of efforts while maintaining appropriate oversight.

I thank you for the opportunity to provide testimony today. I will be glad to answer any questions you may have at this time.

HB 6678

Kevin Wood  
54 Rees Dr  
Oxford, Ct 06478  
REM1530@Hotmail.com

March 16, 2009

My reason for being here today is to convince the committee to pass a bill that would monitor prescription drug use. I would like the committee to understand that without an innovative system for monitoring prescription drug use it is effortless to find doctors, pharmacies and insurance companies that are not in communication with each other.

The system that is in place now does not provide for monitoring prior to or during addiction. It was easy to go to different pharmacies to have my medications filled. If I went to one pharmacy (Rite Aid) on the first of the month, I knew I could easily go to another (CVS) or hospital pharmacy within a couple days because of a lack of communication. Sometimes I could have my scripts filled within five or six days of each other knowing that by going to different pharmacies they wouldn't know about the other. Large chain pharmacies, independently owned pharmacies or hospital pharmacies were all available to me because I knew they did not communicate with each other.

As someone who would like to prevent prescription drug addiction, I know the easiest way is to have a central monitoring system.

I had two medical insurance plans; one was my wife's and the other mine. Two different insurance companies who I knew did not communicate with each other. When I thought they might I dropped mine and had less to worry about. The one insurance company should have seen the tremendous amount of narcotics I was receiving, but for whatever reason, kept on paying.

Pharmacies should centralize their systems to talk to each other, from there the information sent to a monitoring board made up of the type of professionals and individuals mentioned in this bill, including someone who has manipulated the system of prescription drugs.

I believe that if a monitoring system, with some bite had been in place I may not be in the situation I'm in now. No drivers license, no job and a lot of stress. A monitoring system would have made getting the prescriptions filled much harder.

Prescription drug addiction, I believe is very different from illegal drug addiction. I did not have to go to unpleasant places to get it, so there was never any fear. The majority of the time it only cost me \$10.00 co-pay, so my wife didn't think I was spending a lot of money. There were no track marks in my arm or crack pipes in my house; I looked like a regular guy with a wife and three children. Illegal drugs are illegal and as ironic as it sounds I do not normally break the law.

Prescription drug use is easy, cheap and probably affecting more families than statistics show.

I know that there are many privacy laws involved when it comes to monitoring prescription drug use and financial considerations but as a prescription drug addict who knows how to manipulate the system, I hope this bill does not pass because if I do slip up and start abusing again I don't want you to make it difficult for me.

March 16, 2009

HB6678

My name is Barbara Wood and I am here today because of my son, Kevin Wood, a husband and father of three who is also present and speaking at this public hearing.

Kevin was prescribed narcotics from 2001 until 2007 from his medical doctor; thousands of which included oxycontin/oxycodone, avinza, soma compound, lexapro, suboxone and other controlled medications (see attached evidence). Even though the prescription was not close to running out, purchases were made from his insurance carrier, charge cards and cash. (I also attached evidence from his insurance carrier pertaining to office visits and prescription history dates paid by Anthem. We were not able to get a complete history). Kevin told me he also had his physician's cell phone number which he could call if he needed medications.

The current monitoring system which the Connecticut State Legislature passed in 2007 is a volunteer program on the part of the pharmacies. Implementing a central data base monitoring system so that narcotics and their prescribed patients cannot fall through the cracks would prove to be beneficial. Red flags should warn pharmacies, insurance carriers and physicians of a possible abuse and addiction. Kevin never needed a supplier on the street because it was so easy to get narcotics from a physician. If there is such a tight monitoring on over the counter medications like Sudafed, why can't there be strict monitoring for something that is suppose to be controlled i.e. narcotics? There is definitely a lack of communication between providers which contributes to the problem. This current system definitely failed my son and I am sure others. I would not want any other family to go through what we went through from Sept. 2007, when his addiction became apparent, until Dec. 2007 when we finally were able to get help by way of his arrest (not the first). I refused to bail him out and subsequently detoxication was implemented by himself. At this time Kevin accepted and admitted to his addiction which led to us getting him help. I had tried contacting several agencies including drug addiction facilities, state programs, Griffin Hospital, group homes as well as CT State Police, Consumer Protection Agency, Office of the Attorney General and the CT court system with no success because I was told it had to be Kevin, himself, who wanted help and he was not suicidal or hadn't hurt anyone. (At one time Kevin was found in his car on the side of the road with no vital signs. He was taken to Griffin Hospital, observed, and released because he was of no threat to anyone. No one asked about his wife and children.) When arrested in Dec., while incarcerated, he was served with a restraining order which prevented him from being alone with his children and also served with divorce papers, which have all since been rescinded. Many months of rehabilitation, incarceration and counseling have made Kevin realize and accept that this will be a life long struggle that he attends to on a daily basis.

Accountability on the part of the providers is an ethical issue and I beg you to please make it impossible for other mothers to go through what I have gone through for the last year and a half. A special thanks to Senator Joan Hartley for taking the time to respond to my letter, meet with me and make this problem known.

BARBARA Wood  
42 Highland Dr

Wtlby Ct 06708  
203 7569690

Respectfully submitted by

*Barbara Wood*  
Barbara Wood

## Anthem® Prescription

KEVIN WOOD  
54 REES DRIVE  
OXFORD, CT 064781838

Dear Valued member:

Per Your recent request, included is a record of your Prescription History and EOB Summaries. This includes prescriptions between 01/01/2003 through 12/31/2003. Please retain this information for your records. If you should require additional assistance, please do not hesitate to contact us using the number on the back of your health plan identification card.

Date Filled/ Processed	Type DAys Supp Qty	Rx Number/ Medication	Total Cost	Member Paid	Plan Paid	Co-Pay	Deduct.	Amount Exceeded Max	Member Paid Diff
07/29/2003 07/29/2003	Retail 7 30	0786848 HYDROCO/APAP TAB 7.5-750	\$6.20	\$5.00	\$1.20	\$5.00	\$0.00	\$0.00	\$0.00
06/30/2003 06/30/2003	Retail 5 30	0164154 ROXICODONE TAB 15MG	\$20.48	\$10.00	\$10.48	\$10.00	\$0.00	\$0.00	\$0.00
06/18/2003 06/18/2003	Retail 30 90	0489881 CARISOPRODOL TAB 350MG <i>Soma copy</i>	\$17.99	\$5.00	\$12.99	\$5.00	\$0.00	\$0.00	\$0.00
06/05/2003 06/05/2003	Retail 22 90	0500071 ROXICODONE TAB 15MG	\$58.16	\$10.00	\$48.16	\$10.00	\$0.00	\$0.00	\$0.00
05/08/2003 05/08/2003	Retail 15 90	0496366 ROXICODONE TAB 15MG	\$58.16	\$10.00	\$48.16	\$10.00	\$0.00	\$0.00	\$0.00
05/06/2003 05/06/2003	Retail 30 90	0489881 CARISOPRODOL TAB 350MG	\$17.99	\$5.00	\$12.99	\$5.00	\$0.00	\$0.00	\$0.00
04/17/2003 04/17/2003	Retail 15 90	0155256 ROXICODONE TAB 15MG	\$58.26	\$10.00	\$48.26	\$10.00	\$0.00	\$0.00	\$0.00
		Totals	\$237.24	\$55.00	\$182.24	\$55.00	\$0.00	\$0.00	\$0.00

Anthem<sup>®</sup> Prescription

KEVIN WOOD  
54 REES DRIVE  
OXFORD, CT 064781838

Dear Valued member:

Per Your recent request, included is a record of your Prescription History and EOB Summaries. This includes prescriptions between 01/01/2006 through 12/31/2006. Please retain this information for your records. If you should require additional assistance, please do not hesitate to contact us using the number on the back of your health plan identification card.

Date Filled/ Processed	Type DAys Supp Qty	Rx Number/ Medication	Total Cost	Member Paid	Plan Paid	Co-Pay	Deduct.	Amount Exceeded Max	Member Paid Diff
09/13/2006 09/13/2006	Retail 30 90	0226669 AVINZA CAP 120MG CR	\$868.60	\$20.00	\$848.60	\$20.00	\$0.00	\$0.00	\$0.00
09/11/2006 09/11/2006	Retail 18 180	2227479 OXYCODONE TAB 30MG	\$139.11	\$5.00	\$134.11	\$5.00	\$0.00	\$0.00	\$0.00
09/11/2006 09/11/2006	Retail 30 120	6214673 CARISOPRODOL TAB 350MG	\$11.11	\$5.00	\$6.11	\$5.00	\$0.00	\$0.00	\$0.00
09/11/2006 09/11/2006	Retail 6 21	6214674 METHYLPRED PAK 4MG	\$5.00	\$5.00	\$0.00	\$5.00	\$0.00	\$0.00	\$0.00
09/05/2006 09/05/2006	Retail 6 240	4429815 HYDROCOD/GG SYP 5-100/5	\$13.02	\$5.00	\$8.02	\$5.00	\$0.00	\$0.00	\$0.00
09/05/2006 09/05/2006	Retail 10 20	6214357 CLARITHROMYC TAB 500MG	\$35.17	\$5.00	\$30.17	\$5.00	\$0.00	\$0.00	\$0.00
08/28/2006 08/28/2006	Retail 15 180	0660425 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
08/14/2006 08/14/2006	Retail 15 180	0077119 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
08/14/2006 08/14/2006	Retail 30 90	0217186 AVINZA CAP 120MG CR	\$868.60	\$20.00	\$848.60	\$20.00	\$0.00	\$0.00	\$0.00
08/07/2006 08/07/2006	Retail 30 120	2227155 OXYCODONE TAB 30MG	\$93.40	\$5.00	\$88.40	\$5.00	\$0.00	\$0.00	\$0.00
08/01/2006 08/01/2006	Retail 30 120	0302417 CARISOPRODOL TAB 350MG	\$11.61	\$5.00	\$6.61	\$5.00	\$0.00	\$0.00	\$0.00
07/24/2006 07/24/2006	Retail 15 180	0075189 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00

## Review Rx History

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07/17/2006 07/17/2006	Retail 30 90	0208271 AVINZA CAP 120MG CR	\$868.60	\$20.00	\$848.60	\$20.00	\$0.00	\$0.00	\$0.00
07/16/2006 07/16/2006	Retail 6 20	0300259 CYCLOBENZAPR TAB 10MG	\$5.27	\$5.00	\$0.27	\$5.00	\$0.00	\$0.00	\$0.00
07/10/2006 07/10/2006	Retail 15 180	0073887 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
07/07/2006 07/07/2006	Retail 7 90	0653444 OXYCODONE TAB 15MG	\$35.57	\$5.00	\$30.57	\$5.00	\$0.00	\$0.00	\$0.00
06/27/2006 06/27/2006	Retail 15 180	0202225 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
06/19/2006 06/19/2006	Retail 10 80	0072162 OXYCODONE TAB 80MG ER	\$396.03	\$5.00	\$391.03	\$5.00	\$0.00	\$0.00	\$0.00
06/18/2006 06/18/2006	Retail 30 90	0198989 AVINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
06/12/2006 6/ 2/2 6	Retail 5 180	0071529 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
05/30/2006 05/30 2 6	Retail 21 90	0647895 OXYCODONE TAB 80MG ER	\$445.22	\$5.00	\$440.22	\$5.00	\$0.00	\$0.00	\$0.00
05/24/2006 05/24/2006	Retail 3 120	0290513 CARISOPRODOL TAB 350MG	\$11.61	\$5.00	\$6.61	\$5.00	\$0.00	\$0.00	\$0.00
05/22/2006 5/ 1/ 6	Retail 3 90	0189634 VINZA C P 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
05/20/2006 5 20/2 6	Retail 180	0646639 OXYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
05/17/2006 5 17/2 6	Retail 30	0188238 OXYCODONE TAB 80MG ER	\$150.07	\$5.00	\$145.07	\$5.00	\$0.00	\$0.00	\$0.00
05/01/2006 05/0 12 6	Retail 120	0290513 C RIS PR DOL TAB 350MG	\$11.61	\$5.00	\$6.61	\$5.00	\$0.00	\$0.00	\$0.00
04/29/2006 04/ 9 6	Retail 2	0290319 DI ZEP M TAB 10MG	\$5.00	\$5.00	\$0.00	\$5.00	\$0.00	\$0.00	\$0.00
04/26/2006 04 26/2	Retail 180	0067441 XYCODONE TAB 30MG	\$139.61	\$5.00	\$134.61	\$5.00	\$0.00	\$0.00	\$0.00
04/24/2006 4/ 4/ 6	Retail 3 90	0180286 VINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
04/24/2006 04/24/2	Retail 7 36	0642590 OXYCODONE TAB 15MG	\$15.73	\$5.00	\$10.73	\$5.00	\$0.00	\$0.00	\$0.00

## Review Rx History

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04/18/2006 04/18/2006	Retail 15 45	0641848 OXYCODONE TAB 80MG ER	\$252.61	\$5.00	\$247.61	\$5.00	\$0.00	\$0.00	\$0.00
04/10/2006 04/10/2006	Retail 18 180	0640645 OXYCODONE TAB 30MG	\$169.94	\$5.00	\$164.94	\$5.00	\$0.00	\$0.00	\$0.00
03/29/2006 03/29/2006	Retail 30 90	0577849 AVINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
03/27/2006 03/27/2006	Retail 18 180	0638498 OXYCODONE TAB 30MG	\$169.94	\$5.00	\$164.94	\$5.00	\$0.00	\$0.00	\$0.00
03/27/2006 03/27/2006	Retail 30 120	0638499 CARISOPRODOL TAB 350MG	\$11.61	\$5.00	\$6.61	\$5.00	\$0.00	\$0.00	\$0.00
03/22/2006 03/22/2006	Retail 8 25	0637811 OXYCODONE TAB 80MG ER	\$141.45	\$5.00	\$136.45	\$5.00	\$0.00	\$0.00	\$0.00
03/22/2006 03/22/2006	Retail 30 30	0637812 WARFARIN TAB 10MG	\$14.88	\$5.00	\$9.88	\$5.00	\$0.00	\$0.00	\$0.00
03/14/2006 03/14/2006	Retail 15 150	0636693 OXYCODONE TAB 30MG	\$142.03	\$5.00	\$137.03	\$5.00	\$0.00	\$0.00	\$0.00
03/04/2006 03/04/2006	Retail 30 90	0566761 AVINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
03/02/2006 03/03/2006	Retail 7 14	0634963 LOVENOX INJ 100/1ML	\$911.67	\$20.00	\$891.67	\$20.00	\$0.00	\$0.00	\$0.00
03/01/2006 03/01/2006	Retail 30 32	0634939 WARFARIN TAB 5MG	\$10.05	\$5.00	\$5.05	\$5.00	\$0.00	\$0.00	\$0.00
02/28/2006 02/28/2006	Retail 30 150	0634746 OXYCODONE TAB 30MG	\$142.03	\$5.00	\$137.03	\$5.00	\$0.00	\$0.00	\$0.00
02/24/2006 02/24/2006	Retail 5 45	0634175 OXYCODONE TAB 30MG	\$44.36	\$5.00	\$39.36	\$5.00	\$0.00	\$0.00	\$0.00
02/08/2006 02/08/2006	Retail 30 90	0556267 AVINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
01/31/2006 01/31/2006	Retail 30 120	0620671 CARISOPRODOL TAB 350MG	\$11.61	\$5.00	\$6.61	\$5.00	\$0.00	\$0.00	\$0.00
01/31/2006 01/31/2006	Retail 30 150	0630659 OXYCODONE TAB 30MG	\$142.03	\$5.00	\$137.03	\$5.00	\$0.00	\$0.00	\$0.00
01/13/2006 01/13/2006	Retail 30 90	0545291 AVINZA CAP 120MG CR	\$819.52	\$20.00	\$799.52	\$20.00	\$0.00	\$0.00	\$0.00
01/07/2006 01/07/2006	Retail 30 120	0620671 CARISOPRODOL TAB 350MG	\$11.81	\$5.00	\$6.81	\$5.00	\$0.00	\$0.00	\$0.00
01/03/2006	Retail	0626215	\$170.14	\$5.00	\$165.14	\$5.00	\$0.00	\$0.00	\$0.00

## Review Rx History

01/03/2006	30 180	OXYCODONE TAB 30MG							
		Totals	\$13,190.01	\$410.00	\$12,780.01	\$410.00	\$0.00	\$0.00	\$0.00

## Anthem® Prescription

KEVIN WOOD  
54 REES DRIVE  
OXFORD, CT 064781838

Dear Valued member:

Per Your recent request, included is a record of your Prescription History and EOB Summaries. This includes prescriptions between 01/01/2007 through 02/25/2008. Please retain this information for your records. If you should require additional assistance, please do not hesitate to contact us using the number on the back of your health plan identification card.

Date Filled/ Processed	Type DAys Supp Qty	Rx Number/ Medication	Total Cost	Member Paid	Plan Paid	Co-Pay	Deduct.	Amount Exceeded Max	Member Paid Diff
02/23/2008 02/23/2008	Retail 30 30	0379737 FOLIC ACID TAB 1MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
02/10/2008 02/10/2008	Retail 30 30	0378274 LEXAPRO TAB 20MG	\$78.79	\$20.00	\$58.79	\$20.00	\$0.00	\$0.00	\$0.00
01/30/2008 01/30/2008	Retail 15 200	4520927 SUBOXONE SUB 2-0.5MG	\$561.50	\$20.00	\$541.50	\$20.00	\$0.00	\$0.00	\$0.00
01/29/2008 01/29/2008	Retail 30 90	0434536 LEXAPRO TAB 10MG	\$226.37	\$20.00	\$206.37	\$20.00	\$0.00	\$0.00	\$0.00
01/29/2008 01/29/2008	Retail 30 60	0434537 SEROQUEL TAB 50MG	\$215.11	\$20.00	\$195.11	\$20.00	\$0.00	\$0.00	\$0.00
01/25/2008 01/25/2008	Retail 30 30	0433457 FOLIC ACID TAB 1MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
01/07/2008 01/07/2008	Retail 30 30	6791197 LEXAPRO TAB 20MG	\$79.72	\$20.00	\$59.72	\$20.00	\$0.00	\$0.00	\$0.00
01/03/2008 01/03/2008	Retail 30 60	6791036 SEROQUEL TAB 50MG	\$197.83	\$20.00	\$177.83	\$20.00	\$0.00	\$0.00	\$0.00
01/02/2008 01/02/2008	Retail 30 90	6790866 IBUPROFEN TAB 800MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
12/28/2007 12/28/2007	Retail 30 30	6790689 FOLIC ACID TAB 1MG	\$7.95	\$7.95	\$0.00	\$7.95	\$0.00	\$0.00	\$0.00
12/26/2007 12/26/2007	Retail 10 20	1373156 DEPAKOTE ER TAB 500MG	\$50.20	\$20.00	\$30.20	\$20.00	\$0.00	\$0.00	\$0.00
12/26/2007 12/26/2007	Retail 30 30	1373157 LEXAPRO TAB 10MG	\$76.45	\$20.00	\$56.45	\$20.00	\$0.00	\$0.00	\$0.00

## Review Rx History

12/26/2007	Retail	1373158	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
12/26/2007	30	TRAZODONE							
	30	TAB 50MG							
11/23/2007	Retail	0351430	\$11.36	\$10.00	\$1.36	\$10.00	\$0.00	\$0.00	\$0.00
11/23/2007	30	CARISOPRODOL							
	120	TAB 350MG							
10/31/2007	Retail	0351430	\$11.61	\$10.00	\$1.61	\$10.00	\$0.00	\$0.00	\$0.00
10/31/2007	30	CARISOPRODOL							
	120	TAB 350MG							
10/31/2007	Retail	0363414	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
10/31/2007	30	DIAZEPAM TAB							
	60	5MG							
10/30/2007	Retail	4432855	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
10/30/2007	30	CLONAZEPAM							
	30	TAB 0.5MG							
10/30/2007	Retail	6234783	\$179.08	\$25.00	\$154.08	\$25.00	\$0.00	\$0.00	\$0.00
10/30/2007	30	LIDODERM DIS							
	30	5%							
10/19/2007	Retail	4432767	\$282.13	\$20.00	\$262.13	\$20.00	\$0.00	\$0.00	\$0.00
10/19/2007	30	SUBOXONE SUB							
	60	8-2MG							
10/12/2007	Retail	4432722	\$239.36	\$20.00	\$219.36	\$20.00	\$0.00	\$0.00	\$0.00
10/12/2007	30	SUBOXONE SUB							
	90	2-0.5MG							
10/11/2007	Retail	6232327	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
10/11/2007	30	CARISOPRODOL							
	120	TAB 350MG							
10/09/2007	Retail	2230963	\$224.81	\$10.00	\$214.81	\$10.00	\$0.00	\$0.00	\$0.00
10/09/2007	10	OXYCODONE							
	30	TAB 80MG ER							
10/04/2007	Retail	2230926	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
10/04/2007	15	OXYCODONE							
	180	TAB 30MG							
09/28/2007	Retail	2230877	\$150.51	\$10.00	\$140.51	\$10.00	\$0.00	\$0.00	\$0.00
09/28/2007	30	FENTANYL DIS							
	10	50MCG/HR							
09/26/2007	Retail	4432612	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
09/26/2007	10	DIAZEPAM TAB							
	30	10MG							
09/24/2007	Retail	2230839	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
09/24/2007	15	OXYCODONE							
	180	TAB 30MG							
09/22/2007	Retail	2230832	\$868.60	\$25.00	\$843.60	\$25.00	\$0.00	\$0.00	\$0.00
09/22/2007	30	AVINZA CAP							
	90	120MG CR							
09/17/2007	Retail	2230776	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
09/17/2007	10	OXYCODONE							
	180	TAB 80MG ER							
09/13/2007	Retail	6232489	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
09/13/2007	7	AMOXICILLIN							
	21	CAP 500MG							
09/10/2007	Retail	2230719	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
09/10/2007	15	OXYCODONE							
	180	TAB 30MG							

## Review Rx History

08/31/2007 08/31/2007	Retail 15 180	2230660 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
08/27/2007 08/27/2007	Retail 15 180	2230608 OXYCODONE TAB 80MG ER	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
08/20/2007 08/20/2007	Retail 30 120	6226874 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
08/17/2007 08/17/2007	Retail 30 90	0336843 AVINZA CAP 120MG ER	\$946.64	\$25.00	\$921.64	\$25.00	\$0.00	\$0.00	\$0.00
08/10/2007 08/10/2007	Retail 30 180	0772107 OXYCODONE TAB 30MG	\$139.61	\$10.00	\$129.61	\$10.00	\$0.00	\$0.00	\$0.00
08/02/2007 08/02/2007	Retail 15 180	2230407 OXYCODONE TAB 80MG ER	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
08/01/2007 08/01/2007	Retail 30 120	0351430 CARISOPRODOL TAB 350MG	\$11.61	\$10.00	\$1.61	\$10.00	\$0.00	\$0.00	\$0.00
07/30/2007 07/30/2007	Retail 15 180	2230375 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
07/12/2007 07/12/2007	Retail 15 180	2230232 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
07/09/2007 07/09/2007	Retail 30 120	6226874 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
07/05/2007 07/05/2007	Retail 15 180	2230178 OXYCODONE TAB 80MG ER	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
06/30/2007 06/30/2007	Retail 15 180	2230150 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
06/28/2007 06/28/2007	Retail 30 90	2230138 AVINZA CAP 120MG CR	\$868.60	\$25.00	\$843.60	\$25.00	\$0.00	\$0.00	\$0.00
06/25/2007 06/25/2007	Retail 10 40	6228884 CEPHALEXIN CAP 500MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
06/18/2007 06/18/2007	Retail 15 180	2230034 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
06/18/2007 06/18/2007	Retail 30 120	6226874 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
06/11/2007 06/11/2007	Retail 15 180	2229962 OXYCODONE TAB 80MG ER	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
06/07/2007 06/07/2007	Retail 17 180	2229947 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
05/29/2007	Retail	6226874	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00

## Review Rx History

05/29/2007	30	CARISOPRODOL							
	120	TAB 350MG							
05/21/2007	Retail	2229802	\$868.60	\$25.00	\$843.60	\$25.00	\$0.00	\$0.00	\$0.00
05/21/2007	30	AVINZA CAP							
	90	120MG CR							
05/21/2007	Retail	2229803	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
05/21/ 007	0	OXYCODONE							
	180	TAB 30MG							
05/14/2007	Retail	2229731	\$1,338.87	\$10.00	\$1,328.87	\$10.00	\$0.00	\$0.00	\$0.00
05/14/2007	15	OXYCODONE							
	180	TAB 80MG ER							
05/14/2007	Retail	6222823	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
05/14/2007	20	CARISOPRODOL							
	120	TAB 350MG							
05/10/2007	Retail	2229708	\$70.55	\$10.00	\$60.55	\$10.00	\$0.00	\$0.00	\$0.00
05/10/2007	15	OXYCODONE							
	90	TAB 30MG							
05/10/2007	Retail	6226776	\$36.04	\$10.00	\$26.04	\$10.00	\$0.00	\$0.00	\$0.00
05/10/2007	10	AMOX/K CLAV							
	20	TAB 875MG							
05/06/2007	Retail	0757827	\$448.12	\$10.00	\$438.12	\$10.00	\$0.00	\$0.00	\$0.00
05/06/2007	10	OXYCODONE							
	60	TAB 80MG ER							
05/01/2007	Retail	6226327	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
05/01/2007	7	PENICILLN VK							
	28	TAB 500MG							
04/30/2007	Retail	2229623	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
04/30/2007	15	OXYCODONE							
	180	TAB 30MG							
04/30/2007	Retail	6222823	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
04/30/2007	20	CARISOPRODOL							
	120	TAB 350MG							
04/23/2007	Retail	2229556	\$893.24	\$10.00	\$883.24	\$10.00	\$0.00	\$0.00	\$0.00
04/23/2007	20	OXYCODONE							
	120	TAB 80MG ER							
04/16/2007	ai	0296985	\$218.98	\$20.00	\$198.98	\$20.00	\$0.00	\$0.00	\$0.00
	30	WELLBUTRIN							
	60	TAB XL 150MG							
04/12/2007	Retail	6222823	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
04/12/2007	20	CARISOPRODOL							
	120	TAB 350MG							
04/10/2007	Retail	2229449	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
04/10/2007	20	OXYCODONE							
	180	TAB 30MG							
04/04/2007	Retail	2229400	\$893.24	\$10.00	\$883.24	\$10.00	\$0.00	\$0.00	\$0.00
04/04/2007	30	OXYCODONE							
	120	TAB 80MG ER							
03/30/2007	Retail	2229355	\$297.12	\$10.00	\$287.12	\$10.00	\$0.00	\$0.00	\$0.00
03/30/2007	30	FENTANYL DIS							
	10	100MCG/H							
03/27/2007	Retail	0328497	\$79.72	\$20.00	\$59.72	\$20.00	\$0.00	\$0.00	\$0.00
03/27/2007	30	LEXAPRO TAB							
	30	20MG							
03/25/2007	Retail	0751525	\$731.52	\$10.00	\$721.52	\$10.00	\$0.00	\$0.00	\$0.00

## Review Rx History

03/25/2007	10 180	OXYCODONE TAB 80MG CR							
03/24/2007 03/24/2007	Retail 30 120	0302417 CARISOPRODOL TAB 350MG	\$11.61	\$10.00	\$1.61	\$10.00	\$0.00	\$0.00	\$0.00
03/21/2007 03/21/2007	Retail 30 60	0099639 AVINZA CAP (120MG ER)	\$579.57	\$25.00	\$554.57	\$25.00	\$0.00	\$0.00	\$0.00
03/21/2007 03/21/2007	Retail 30 60	0099640 DIAZEPAM TAB 10MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
03/15/2007 03/15/2007	Retail 17 180	2229221 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
03/12/2007 03/12/2007	Retail 20 120	2229192 OXYCODONE TAB 80MG ER	\$488.01	\$10.00	\$478.01	\$10.00	\$0.00	\$0.00	\$0.00
03/03/2007 03/12/2007	Retail 17 180	2229115 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
02/25/2007 02/25/2007	Retail 10 180	0747398 OXYCODONE TAB 80MG ER	\$731.52	\$10.00	\$721.52	\$10.00	\$0.00	\$0.00	\$0.00
02/22/2007 02/22/2007	Retail 15 180	0096698 OXYCODONE TAB 30MG	\$139.61	\$10.00	\$129.61	\$10.00	\$0.00	\$0.00	\$0.00
02/22/2007 02/22/2007	Retail 10 10	0096699 DIAZEPAM TAB 5MG	\$10.00	\$10.00	\$0.00	\$10.00	\$0.00	\$0.00	\$0.00
02/19/2007 02/19/2007	Retail 30 10	2228968 FENTANYL DIS 100MCG/H	\$297.12	\$10.00	\$287.12	\$10.00	\$0.00	\$0.00	\$0.00
02/19/2007 02/19/2007	Retail 20 120	6222823 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
02/16/2007 02/16/2007	Retail 20 120	2228944 OXYCODONE TAB 80MG ER	\$488.01	\$10.00	\$478.01	\$10.00	\$0.00	\$0.00	\$0.00
02/13/2007 02/13/2007	Retail 30 30	0328497 LEXAPRO TAB 20MG	\$75.29	\$20.00	\$55.29	\$20.00	\$0.00	\$0.00	\$0.00
02/08/2007 02/08/2007	Retail 15 180	2228867 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
01/27/2007 01/27/2007	Retail 15 180	2228754 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
01/26/2007 01/26/2007	Retail 20 120	6221739 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
01/22/2007 01/22/2007	Retail 30 10	2228704 FENTANYL DIS 100MCG/H	\$297.12	\$10.00	\$287.12	\$10.00	\$0.00	\$0.00	\$0.00
01/22/2007 01/22/2007	Retail 30	2228709 OXYCODONE	\$731.02	\$10.00	\$721.02	\$10.00	\$0.00	\$0.00	\$0.00

## Review Rx History

01/17/2007	180	TAB 80MG ER							
01/17/2007	Retail 15 180	0324745 OXYCODONE TAB 30MG	\$139.61	\$10.00	\$129.61	\$10.00	\$0.00	\$0.00	\$0.00
01/16/2007	Retail 30 30	6219438 LEXAPRO TAB 20MG	\$75.29	\$20.00	\$55.29	\$20.00	\$0.00	\$0.00	\$0.00
01/15/2007	Retail 30 30	0324296 AMBIEN CR TAB 12.5MG	\$98.80	\$25.00	\$73.80	\$25.00	\$0.00	\$0.00	\$0.00
01/11/2007	Retail 7 45	2228596 AVINZA CAP 120MG CR	\$435.05	\$25.00	\$410.05	\$25.00	\$0.00	\$0.00	\$0.00
01/08/2007	Retail 15 180	2228565 OXYCODONE TAB 30MG	\$139.11	\$10.00	\$129.11	\$10.00	\$0.00	\$0.00	\$0.00
01/02/2007	Retail 30 180	2228505 OXYCODONE TAB 80MG ER	\$605.20	\$10.00	\$595.20	\$10.00	\$0.00	\$0.00	\$0.00
01/02/2007	Retail 30 120	6220319 CARISOPRODOL TAB 350MG	\$11.11	\$10.00	\$1.11	\$10.00	\$0.00	\$0.00	\$0.00
		Totals	\$25,798.10	\$1,177.95	\$24,620.15	\$1,177.95	\$0.00	\$0.00	\$0.00

2005  
Oct - Dec.

10/17/05 - visit  
avinzal - 10/17/05

10/27/05 - visit  
oxycodone - 10/27/05  
oxycodone - 10/27/05  
carisoprodol - 10/31/05

11/7/05 - visit  
avinzal - 11/7/05  
oxycodone - 11/7/05

11/22/05 - visit  
carisoprodol - 11/22/05  
avinzal - 11/26/05

12/5/05 - visit  
oxycodone - 12/5/05

12/13/05 - visit  
carisoprodol - 12/16/05  
avinzal - 12/19/05

2006  
Jan - Sept

1/3/06 - visit

Oxycodone - 1/3/06

Carisoprodol - 1/7/06

Avinza - 1/13/06

1/31/06 - visit

Oxycodone - 1/31/06

Carisoprodol - 1/31/06

Avinza - 2/8/06

Riffin  
Hospital

Oxycodone - 2/24/06

(This is when I  
brought the note to  
Mahabir for Kevin)

2/28/06 - visit

Oxycodone - 2/28/06

3/3/06 - visit

lovenox - 3/3/06

Avinza - 3/4/06

4/6/06 - visit

1/10/06 - visit

Oxycodone - 3/14/06

Warfarin - 3/22/06

Oxycodone - 3/22/06

3/23/06 - VISIT

3/27/06 - VISIT

Carisoprodol - 3/27/06

Oxycodone - 3/27/06

3/28/06 - VISIT

Avinza - 3/29/06

Oxycodone - 4/10/06

4/11/06 - VISIT

Oxycodone - 4/18/06

4/24/06 - VISIT

Oxycodone - 4/24/06

Avinza - 4/24/06

Oxycodone - 4/26/06

Diazepam - 4/29/06

Carisoprodol - 5/1/06

Oxycodone - 5/17/06

5/18/06 - VISIT

Oxycodone - 5/20/06

Avinza - 5/22/06

Carisoprodol

5/31/06 - VISIT  
Oxycodone

Oxycodone - 1/21/07  
Carisoprodol 1/21/07

1/8/07 - VISIT  
Oxycodone

1/9/07 - VISIT  
Avinza - 1/11/07  
Ambien - 1/15/07

Oxycodone 1/17/07

Oxycodone 1/22/07

Fentanyl 1/22/07

Carisoprodol - 1/24/07

Oxycodone - 1/27/07

2/2/07 - VISIT  
Oxycodone - 2/8/07  
Lexapro - 2/13/07  
Oxycodone 2/16/07

2/19/07 - VISIT  
Carisoprodol - 2/19/07  
Fentanyl - 2/19/07  
Diazepam - 2/22/07  
Oxycodone - 2/22/07  
Oxycodone - 2/25/07  
Oxycodone 3/12/07  
Oxycodone 3/12/07  
Oxycodone 3/15/07

3/19/07 - VISIT

Diazepam - 3/21/07  
Avinza - 3/21/07  
Carisoprodol - 3/24/07  
Oxycodone - 3/25/07

3/24/07 - VISIT  
Lexapro - 3/27/07

3/30/07 - VISIT  
Fentanyl - 3/30/07  
Oxycodone - 4/4/07  
Oxycodone - 4/10/07  
Carisoprodol - 4/12/07

4/16/07 - VISIT  
Wellbutrin - 4/16/07  
Oxycodone - 4/23/07  
Carisoprodol - 4/30/07  
Oxycodone - 4/30/07  
Oxycodone 5/6/07  
Oxycodone 5/10/07

5/14/07 - VISIT  
Oxycodone 5/14/07  
Carisoprodol 5/14/07

5/21/07 - visit

Oxycodone - 5/21/07

Avinza - 5/21/07

Carisoprodol - 5/29/07

Oxycodone - 6/7/07

2007

6/11/07 - visit

Oxycodone - 6/11/07

Carisoprodol - 6/18/07

6/25/07 - visit

Cephalexin - 6/25/07

Avinza - 6/28/07

Oxycodone - 6/30/07

Oxycodone - 7/5/07

7/9/07 - visit

Carisoprodol - 7/9/07

Oxycodone - 7/12/07

7/30/07 - visit

Oxycodone - 7/30/07

Carisoprodol - 8/1/07

Oxycodone - 8/2/07

Oxycodone - 8/10/07

Avinza - 8/17/07

Carisoprodol 8/20/07

8/27/07 - visit

Oxycodone - 8/27/07  
Oxycodone - 8/31/07  
Oxycodone - 9/10/07

9/17/07 - visit

Oxycodone - 9/17/07  
Avinza - 9/22/07

9/24/07 - visit

Oxycodone - 9/24/07  
diazepam - 9/26/07  
fentanyl - 9/28/07  
Oxycodone - 10/4/07

10/8/07 - visit

Oxycodone - 10/9/07  
Carisoprodol - 10/11/07

Suboxone - 10/12/07

10/15/07 - visit

10/16/07 - visit

10/19/07 - visit

Suboxone - 10/19/07

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008  
SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCES	MESSAGE CODES
P607823700	JUDITH	10/27/07-10/27/07	MCLEAN	45.00	0.00	0.00	44.00	PROVIDER	01/24/08	141 932
P607823700	JUDITH	10/27/07-10/27/07	MCLEAN	120.00	0.00	0.00	117.43	PROVIDER	01/24/08	141 932
P623224700	KEVIN	11/15/04-11/15/04	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	11/19/04	141 784
P642361800	KEVIN	11/22/04-11/22/04	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	11/30/04	141 784
P645515300	KEVIN	11/22/04-11/22/04	MAHABIR	105.00	0.00	0.00	0.00		11/30/04	881
P654054600	KEVIN	11/30/04-11/30/04	BATSON	125.00	0.00	15.00	57.51	PROVIDER	12/01/04	141 784
P727452700	KEVIN	12/14/04-12/14/04	LEVI	300.00	0.00	15.00	220.02	PROVIDER	12/22/04	141 784
P763571900	KEVIN	12/21/04-12/21/04	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	01/05/05	141 784
P819741700	KEVIN	01/17/05-01/17/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	01/21/05	141 784
P953176700	KEVIN	02/08/05-02/08/05	LEVI	80.00	0.00	15.00	57.51	PROVIDER	03/03/05	141 784
P916372700	KEVIN	02/11/05-02/11/05	MAHABIR	155.00	0.00	15.00	90.60	PROVIDER	02/18/05	141 784
P973156800	KEVIN	03/01/05-03/01/05	MAHABIR	155.00	0.00	0.00	105.60	PROVIDER	03/08/05	141 932
P973156800	KEVIN	03/01/05-03/01/05	MAHABIR	155.00	0.00	15.00	90.60	PROVIDER	03/08/05	141 784
P006575100	KEVIN	03/11/05-03/11/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	03/18/05	141 784
P132139900	KEVIN	04/08/05-04/08/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	04/25/05	141 784
P208794600	KEVIN	04/08/05-04/08/05	MAHABIR	105.00	0.00	0.00	0.00		05/17/05	881
P208794700	KEVIN	04/26/05-04/26/05	MAHABIR	105.00	0.00	0.00	0.00		05/17/05	881
P157397700	KEVIN	04/26/05-04/26/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	05/03/05	141 784
P200055400	KEVIN	05/09/05-05/09/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	05/13/05	141 784
P208794800	KEVIN	05/09/05-05/09/05	MAHABIR	105.00	0.00	0.00	0.00		05/17/05	881
P291752300	KEVIN	06/06/05-06/06/05	MAHABIR	105.00	0.00	15.00	52.68	PROVIDER	06/10/05	141 784

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008

SUBSCRIBER NAME: JUDITH F WOOD  
54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCESSED	MESSAGE CODES
P334236300	KEVIN	06/21/05-06/21/05	MAHABIR	155.00	105.60	0.00	15.00	90.60	PROVIDER	06/24/05	141 784
P379961200	KEVIN	07/05/05-07/05/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	07/08/05	141 784
P701465600	KEVIN	07/26/05-07/26/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	10/17/05	141 784
P536182900	KEVIN	08/23/05-08/23/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	08/26/05	141 784
P594548600	KEVIN	09/09/05-09/09/05	MAHABIR	155.00	107.91	0.00	15.00	92.91	PROVIDER	09/15/05	141 784
P723011600	KEVIN	10/17/05-10/17/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	10/21/05	141 784
P744417000	KEVIN	10/27/05-10/27/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	10/28/05	141 784
P791481000	KEVIN	11/07/05-11/07/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	11/11/05	141 784
P842571800	KEVIN	11/22/05-11/22/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	11/29/05	141 784
P878107000	KEVIN	12/05/05-12/05/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	12/08/05	141 784
P917601600	KEVIN	12/13/05-12/13/05	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	12/19/05	141 784
P967294900	KEVIN	01/03/06-01/03/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	01/05/06	141 784
P086913900	KEVIN	01/31/06-01/31/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	02/09/06	141 784
P178167300	KEVIN	02/23/06-02/23/06	CONNECTICUT R	236.00	74.64	0.00	0.00	74.64	PROVIDER	03/07/06	141
P178167300	KEVIN	02/23/06-02/23/06	CONNECTICUT R	257.00	81.34	0.00	0.00	81.34	PROVIDER	03/07/06	141
P178165600	KEVIN	02/23/06-02/23/06	CONNECTICUT R	57.00	18.66	0.00	0.00	18.66	PROVIDER	03/07/06	141
P178166700	KEVIN	02/24/06-02/24/06	CONNECTICUT R	101.00	32.53	0.00	0.00	32.53	PROVIDER	03/07/06	141
P178166800	KEVIN	02/24/06-02/24/06	CONNECTICUT R	57.00	18.66	0.00	0.00	18.66	PROVIDER	03/07/06	141
90K0184001	KEVIN	02/24/06-02/24/06	GRIFFIN HOSPI	150.00	150.00	0.00	0.00	-150.00	MEMBER	04/24/06	
90K0184000	KEVIN	02/24/06-02/24/06	GRIFFIN HOSPI	150.00	150.00	0.00	0.00	150.00	MEMBER	04/24/06	
90K0184100	KEVIN	02/24/06-02/24/06	MEDEIROS	150.00	150.00	0.00	0.00	150.00	MEMBER	11/22/06	

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008  
SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO	DATE PROCES	MESSAGE CODES
91K3218000	KEVIN	02/24/06-02/24/06	MEDEIROS	150.00	0.00	0.00	0.00	0.00		11/22/06	881
90K0184002	KEVIN	02/24/06-02/24/06	GRIFFIN HOSPI	150.00	0.00	0.00	0.00	0.00		12/20/06	
P182176700	KEVIN	02/24/06-02/24/06	RAHIMYAR	195.00	147.51	0.00	0.00	147.51	PROVIDER	03/08/06	141 932
P451485800	KEVIN	02/24/06-02/24/06	SCHWARTZ	225.00	129.20	0.00	0.00	129.20	PROVIDER	05/23/06	141 932
P451485900	KEVIN	02/25/06-02/25/06	SCHWARTZ	95.00	72.77	0.00	0.00	72.77	PROVIDER	05/23/06	141 932
P223919400	KEVIN	02/28/06-02/28/06	MAHABIR	155.00	107.91	0.00	15.00	92.91	PROVIDER	03/21/06	141 784
P197640600	KEVIN	03/01/06-03/01/06	CONNECTICUT R	99.00	32.05	0.00	0.00	32.05	PROVIDER	03/13/06	141
P238537500	KEVIN	03/03/06-03/03/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	03/24/06	141 784
P238537500	KEVIN	03/03/06-03/03/06	MAHABIR	11.00	0.00	0.00	0.00	0.00		03/24/06	
P238537500	KEVIN	03/03/06-03/03/06	MAHABIR	7.50	3.00	0.00	0.00	3.00	PROVIDER	03/24/06	141 932
P238537600	KEVIN	03/06/06-03/06/06	MAHABIR	11.00	0.00	0.00	0.00	0.00		03/24/06	
P238537600	KEVIN	03/06/06-03/06/06	MAHABIR	7.50	3.00	0.00	0.00	3.00	PROVIDER	03/24/06	141 932
P220587800	KEVIN	03/10/06-03/10/06	MAHABIR	155.00	107.91	0.00	15.00	92.91	PROVIDER	03/20/06	141 784
P248261300	KEVIN	03/23/06-03/23/06	MAHABIR	155.00	107.91	0.00	15.00	92.91	PROVIDER	03/27/06	141 784
P276409100	KEVIN	03/27/06-03/27/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	04/04/06	141 784
P276409200	KEVIN	03/28/06-03/28/06	MAHABIR	11.00	0.00	0.00	0.00	0.00		04/04/06	
P276409200	KEVIN	03/28/06-03/28/06	MAHABIR	7.50	3.00	0.00	0.00	3.00	PROVIDER	04/04/06	141 932
85K3297000	KEVIN	03/31/06-03/31/06	MARGULES	334.00	173.21	0.00	15.00	158.21	PROVIDER	04/17/06	141 784
82K6386000	KEVIN	04/03/06-04/03/06	MARGULES	198.00	32.59	0.00	0.00	32.59	PROVIDER	04/13/06	141 932
84K5519000	KEVIN	04/07/06-04/07/06	MARGULES	106.00	54.53	0.00	15.00	39.53	PROVIDER	04/14/06	141 784
P317272600	KEVIN	04/11/06-04/11/06	MAHABIR	155.00	107.91	0.00	15.00	92.91	PROVIDER	04/14/06	141 784

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

CURRENT DATE: 03/04/2008

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

PAGE: 16

SUBSCRIBER NAME: JUDITH F. WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCESSED	MESSAGE CODES
P317272600	KEVIN	04/11/06-04/11/06	MAHABIR	11.00	0.00	0.00	0.00	0.00		04/14/06	
P317272600	KEVIN	04/11/06-04/11/06	MAHABIR	7.50	3.00	0.00	0.00	3.00	PROVIDER	04/14/06	141 932
P362652400	KEVIN	04/24/06-04/24/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	04/28/06	141 784
P448386900	KEVIN	05/02/06-05/02/06	DANBURY RADIO	381.00	114.50	0.00	0.00	114.50	PROVIDER	05/23/06	141
P408974200	KEVIN	05/05/06-05/05/06	SANDERSON	400.00	243.78	0.00	15.00	228.78	PROVIDER	05/11/06	141 784
P455634500	KEVIN	05/18/06-05/18/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	05/24/06	141 784
P487025100	KEVIN	05/30/06-05/30/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	06/05/06	141 784
P533559700	KEVIN	06/12/06-06/12/06	MAHABIR	105.00	68.81	0.00	15.00	53.81	PROVIDER	06/19/06	141 784
P628251200	KEVIN	07/10/06-07/10/06	MAHABIR	105.00	70.89	0.00	15.00	55.89	PROVIDER	07/18/06	141 784
P700879300	KEVIN	07/25/06-07/25/06	MAHABIR	105.00	70.89	0.00	15.00	55.89	PROVIDER	08/09/06	141 784
O9K6620000	KEVIN	08/08/06-08/08/06	KATZ	350.00	184.62	0.00	15.00	169.62	PROVIDER	08/15/06	141 784
P723370200	KEVIN	08/14/06-08/14/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	08/17/06	141 784
P743756000	KEVIN	08/21/06-08/21/06	ESTRELLA	60.00	21.53	0.00	0.00	21.53	PROVIDER	08/24/06	141 932
P743756000	KEVIN	08/21/06-08/21/06	ESTRELLA	60.00	9.80	0.00	0.00	9.80	PROVIDER	08/24/06	141 932
P743756000	KEVIN	08/21/06-08/21/06	ESTRELLA	50.00	11.97	0.00	0.00	11.97	PROVIDER	08/24/06	141 932
P743756000	KEVIN	08/21/06-08/21/06	ESTRELLA	30.00	4.02	0.00	0.00	4.02	PROVIDER	08/24/06	141 932
P743756000	KEVIN	08/21/06-08/21/06	ESTRELLA	150.00	63.32	0.00	0.00	63.32	PROVIDER	08/24/06	141 932
P750886200	KEVIN	08/23/06-08/23/06	ESTRELLA	120.00	19.60	0.00	0.00	19.60	PROVIDER	08/28/06	141 932
P750886200	KEVIN	08/23/06-08/23/06	ESTRELLA	50.00	11.97	0.00	0.00	11.97	PROVIDER	08/28/06	141 932
P750886200	KEVIN	08/23/06-08/23/06	ESTRELLA	30.00	4.02	0.00	0.00	4.02	PROVIDER	08/28/06	141 932
P756283300	KEVIN	08/24/06-08/24/06	LOYER	60.00	21.53	0.00	0.00	21.53	PROVIDER	08/29/06	141 932

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

EXPLANATION OF BENEFITS

REQUESTOR: PUB

SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCES	MESSAGE CODES
P756283300	KEVIN	08/24/06-08/24/06	LOYER	60.00	9.80	0.00	0.00	9.80	PROVIDER	08/29/06	141 932
P756283300	KEVIN	08/24/06-08/24/06	LOYER	50.00	11.97	0.00	0.00	11.97	PROVIDER	08/29/06	141 932
P756283300	KEVIN	08/24/06-08/24/06	LOYER	30.00	4.02	0.00	0.00	4.02	PROVIDER	08/29/06	141 932
P764863200	KEVIN	08/28/06-08/28/06	ESTRELLA	60.00	21.53	0.00	0.00	21.53	PROVIDER	08/31/06	141 932
P764863200	KEVIN	08/28/06-08/28/06	ESTRELLA	60.00	9.80	0.00	0.00	9.80	PROVIDER	08/31/06	141 932
P764863200	KEVIN	08/28/06-08/28/06	ESTRELLA	50.00	11.97	0.00	0.00	11.97	PROVIDER	08/31/06	141 932
P764863200	KEVIN	08/28/06-08/28/06	ESTRELLA	30.00	4.02	0.00	0.00	4.02	PROVIDER	08/31/06	141 932
P773933700	KEVIN	08/30/06-08/30/06	ESTRELLA	60.00	21.53	0.00	0.00	21.53	PROVIDER	09/01/06	141 932
P773933700	KEVIN	08/30/06-08/30/06	ESTRELLA	60.00	9.80	0.00	0.00	9.80	PROVIDER	09/01/06	141 932
P773933700	KEVIN	08/30/06-08/30/06	ESTRELLA	50.00	11.97	0.00	0.00	11.97	PROVIDER	09/01/06	141 932
P773933700	KEVIN	08/30/06-08/30/06	ESTRELLA	30.00	4.02	0.00	0.00	4.02	PROVIDER	09/01/06	141 932
P780831300	KEVIN	08/31/06-08/31/06	LOYER	60.00	22.79	0.00	0.00	22.79	PROVIDER	09/05/06	141 932
P780831300	KEVIN	08/31/06-08/31/06	LOYER	60.00	9.80	0.00	0.00	9.80	PROVIDER	09/05/06	141 932
P780831300	KEVIN	08/31/06-08/31/06	LOYER	50.00	11.97	0.00	0.00	11.97	PROVIDER	09/05/06	141 932
P780831300	KEVIN	08/31/06-08/31/06	LOYER	30.00	4.02	0.00	0.00	4.02	PROVIDER	09/05/06	141 932
P787403600	KEVIN	09/05/06-09/05/06	LOYER	60.00	22.79	0.00	0.00	22.79	PROVIDER	09/07/06	141 932
P787403600	KEVIN	09/05/06-09/05/06	LOYER	60.00	9.80	0.00	0.00	9.80	PROVIDER	09/07/06	141 932
P787403600	KEVIN	09/05/06-09/05/06	LOYER	50.00	11.97	0.00	0.00	11.97	PROVIDER	09/07/06	141 932
P787403600	KEVIN	09/05/06-09/05/06	LOYER	30.00	4.02	0.00	0.00	4.02	PROVIDER	09/07/06	141 932
P797041100	KEVIN	09/05/06-09/05/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	09/11/06	141 784
P791563800	KEVIN	09/06/06-09/06/06	ELSEMORE	60.00	21.53	0.00	0.00	21.53	PROVIDER	09/08/06	141 932

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANITEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2000

SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE COVERED	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID TO PROVIDER	DATE PROCESSED	MESSAGE CODES
P791563800	KEVIN	09/06/06-09/06/06	ELSEMORE	120.00	45.58	0.00	0.00	45.58	09/08/06	141 932
P796516300	KEVIN	09/07/06-09/07/06	LOVER	60.00	21.53	0.00	0.00	21.53	09/11/06	141 932
P796516300	KEVIN	09/07/06-09/07/06	LOVER	120.00	45.58	0.00	0.00	45.58	09/11/06	141 932
P806102400	KEVIN	09/11/06-09/11/06	MAHABIR	155.00	115.62	0.00	15.00	100.62	09/14/06	141 784
P900068300	KEVIN	10/09/06-10/09/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	10/11/06	141 784
77K7951000	KEVIN	10/10/06-10/10/06	KATZ	95.00	70.89	0.00	15.00	55.89	10/19/06	141 784
P951426500	KEVIN	10/23/06-10/23/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	10/27/06	141 784
P977390400	KEVIN	10/26/06-10/26/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	11/06/06	141 784
P998223300	KEVIN	11/06/06-11/06/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	11/09/06	141 784
P030307400	KEVIN	11/13/06-11/13/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	11/17/06	141 784
P053316700	KEVIN	11/17/06-11/17/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	11/27/06	141 784
P070883800	KEVIN	11/27/06-11/27/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	11/30/06	141 784
29K0418000	KEVIN	12/05/06-12/05/06	KATZ	95.00	70.89	0.00	15.00	55.89	12/14/06	141 784
P125991600	KEVIN	12/11/06-12/11/06	MAHABIR	105.00	73.72	0.00	15.00	58.72	12/14/06	141 784
P260419900	KEVIN	01/08/07-01/08/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	01/23/07	141 784
P260420000	KEVIN	01/09/07-01/09/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	01/23/07	141 784
P324094200	KEVIN	02/02/07-02/02/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	02/07/07	141 784
P382401300	KEVIN	02/19/07-02/19/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	02/22/07	141 784
P487857800	KEVIN	03/19/07-03/19/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	03/21/07	141 784
P534044000	KEVIN	03/23/07-03/23/07	DANBURY RADIO	107.00	26.00	0.00	0.00	26.00	04/04/07	141
P514550200	KEVIN	03/26/07-03/26/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	03/29/07	141 784

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008

SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCESSED	MESSAGE CODES
P524639200	KEVIN	03/28/07-03/28/07	ESTRELLA	60.00	0.00	0.00	24.14	PROVIDER	03/30/07	141 932
P524639200	KEVIN	03/28/07-03/28/07	ESTRELLA	60.00	0.00	0.00	21.53	PROVIDER	03/30/07	141 932
P524639200	KEVIN	03/28/07-03/28/07	ESTRELLA	60.00	0.00	0.00	22.79	PROVIDER	03/30/07	141 932
P524639200	KEVIN	03/28/07-03/28/07	ESTRELLA	30.00	0.00	0.00	4.02	PROVIDER	03/30/07	141 932
P524639200	KEVIN	03/28/07-03/28/07	ESTRELLA	150.00	0.00	15.00	48.32	PROVIDER	03/30/07	141 784
P533469600	KEVIN	03/30/07-03/30/07	ELSEMORE	120.00	0.00	15.00	28.06	PROVIDER	04/04/07	141 784
P533469600	KEVIN	03/30/07-03/30/07	ELSEMORE	60.00	0.00	0.00	22.79	PROVIDER	04/04/07	141 932
P542972400	KEVIN	03/30/07-03/30/07	MAHABIR	105.00	0.00	15.00	58.72	PROVIDER	04/05/07	141 784
P540664500	KEVIN	04/02/07-04/02/07	ELSEMORE	60.00	0.00	0.00	11.97	PROVIDER	04/05/07	141 932
P540664500	KEVIN	04/02/07-04/02/07	ELSEMORE	30.00	0.00	0.00	4.02	PROVIDER	04/05/07	141 932
P540664500	KEVIN	04/02/07-04/02/07	ELSEMORE	120.00	0.00	15.00	28.06	PROVIDER	04/05/07	141 784
P540664500	KEVIN	04/02/07-04/02/07	ELSEMORE	60.00	0.00	0.00	22.79	PROVIDER	04/05/07	141 932
P553171700	KEVIN	04/04/07-04/04/07	ELSEMORE	60.00	0.00	15.00	6.53	PROVIDER	04/06/07	141 784
P553171700	KEVIN	04/04/07-04/04/07	ELSEMORE	60.00	0.00	0.00	11.97	PROVIDER	04/06/07	141 932
P553171700	KEVIN	04/04/07-04/04/07	ELSEMORE	30.00	0.00	0.00	4.02	PROVIDER	04/06/07	141 932
P559432400	KEVIN	04/06/07-04/06/07	CIOCHETTI	60.00	0.00	15.00	6.53	PROVIDER	04/11/07	141 784
P559432400	KEVIN	04/06/07-04/06/07	CIOCHETTI	60.00	0.00	0.00	11.97	PROVIDER	04/11/07	141 932
P559432400	KEVIN	04/06/07-04/06/07	CIOCHETTI	30.00	0.00	0.00	4.02	PROVIDER	04/11/07	141 932
P574246500	KEVIN	04/11/07-04/11/07	ELSEMORE	60.00	0.00	0.00	21.53	PROVIDER	04/13/07	141 932
P574246500	KEVIN	04/11/07-04/11/07	ELSEMORE	60.00	0.00	15.00	7.79	PROVIDER	04/13/07	141 784
P574246500	KEVIN	04/11/07-04/11/07	ELSEMORE	60.00	0.00	0.00	11.97	PROVIDER	04/13/07	141 932

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008

SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCES	MESSAGE CODES
P574246500	KEVIN	04/11/07-04/11/07	ELSEMDRE	30.00	4.02	0.00	0.00	4.02	PROVIDER	04/13/07	141 932
P585045000	KEVIN	04/13/07-04/13/07	CIOCHETTI	60.00	21.53	0.00	0.00	21.53	PROVIDER	04/17/07	141 932
P585045000	KEVIN	04/13/07-04/13/07	CIOCHETTI	60.00	22.79	0.00	15.00	7.79	PROVIDER	04/17/07	141 784
P585045000	KEVIN	04/13/07-04/13/07	CIOCHETTI	60.00	11.97	0.00	0.00	11.97	PROVIDER	04/17/07	141 932
P585045000	KEVIN	04/13/07-04/13/07	CIOCHETTI	30.00	4.02	0.00	0.00	4.02	PROVIDER	04/17/07	141 932
P609886900	KEVIN	04/14/07-04/14/07	DANBURY RADIO	381.00	114.50	0.00	0.00	114.50	PROVIDER	04/24/07	141
P589737300	KEVIN	04/16/07-04/16/07	ELSEMDRE	60.00	21.53	0.00	0.00	21.53	PROVIDER	04/19/07	141 932
P589737300	KEVIN	04/16/07-04/16/07	ELSEMDRE	60.00	22.79	0.00	15.00	7.79	PROVIDER	04/19/07	141 784
P589737300	KEVIN	04/16/07-04/16/07	ELSEMDRE	60.00	11.97	0.00	0.00	11.97	PROVIDER	04/19/07	141 932
P589737300	KEVIN	04/16/07-04/16/07	ELSEMDRE	30.00	4.02	0.00	0.00	4.02	PROVIDER	04/19/07	141 932
P601671300	KEVIN	04/16/07-04/16/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	04/20/07	141 784
P610192900	KEVIN	04/21/07-04/21/07	CIOCHETTI	60.00	21.53	0.00	15.00	6.53	PROVIDER	04/24/07	141 784
P610192900	KEVIN	04/21/07-04/21/07	CIOCHETTI	60.00	11.97	0.00	0.00	11.97	PROVIDER	04/24/07	141 932
P610192900	KEVIN	04/21/07-04/21/07	CIOCHETTI	30.00	4.02	0.00	0.00	4.02	PROVIDER	04/24/07	141 932
P643286500	KEVIN	04/30/07-04/30/07	ELSEMDRE	60.00	21.53	0.00	15.00	6.53	PROVIDER	05/03/07	141 784
P643286500	KEVIN	04/30/07-04/30/07	ELSEMDRE	60.00	11.97	0.00	0.00	11.97	PROVIDER	05/03/07	141 932
P643286500	KEVIN	04/30/07-04/30/07	ELSEMDRE	30.00	4.02	0.00	0.00	4.02	PROVIDER	05/03/07	141 932
P698014100	KEVIN	05/14/07-05/14/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	05/17/07	141 784
P726923900	KEVIN	05/21/07-05/21/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	05/25/07	141 784
P794458900	KEVIN	06/11/07-06/11/07	MAHABIR	105.00	73.72	0.00	15.00	58.72	PROVIDER	06/14/07	141 784
P824007900	KEVIN	06/14/07-06/14/07	BATSON	125.00	75.14	0.00	15.00	60.14	PROVIDER	06/22/07	141 784

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

ANTHEM BLUE CROSS & BLUE SHIELD  
EXPLANATION OF BENEFITS

CURRENT DATE: 03/04/2008

SUBSCRIBER NAME: JUDITH F WOOD  
ADDRESS: 54 REES DRIVE  
OXFORD CT 06478-1838

REQUESTOR: PUB

CLAIM NUMBER	PATIENT FIRST NAME	DATES OF SERVICE	PROVIDER NAME	TOTAL CHARGE	AMOUNT COVERED	DEDUCT AMOUNT	CO-PAY CO-INS	TOTAL PAID	PAID TO PROVIDER	DATE PROCES	MESSAGE CODES
P846763200	KEVIN	06/25/07-06/25/07	MAHABIR	155.00	115.62	0.00	15.00	100.62	PROVIDER	06/28/07	141 784
P895882500	KEVIN	07/09/07-07/09/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	07/25/07	141 784
P977567700	KEVIN	07/30/07-07/30/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	08/03/07	141 784
P079702500	KEVIN	08/27/07-08/27/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	08/30/07	141 784
P144219300	KEVIN	09/17/07-09/17/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	09/20/07	141 784
P169965900	KEVIN	09/24/07-09/24/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	09/27/07	141 784
P301426000	KEVIN	10/08/07-10/08/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	11/01/07	141 784
P250006900	KEVIN	10/15/07-10/15/07	MAHABIR	230.00	161.61	0.00	15.00	146.61	PROVIDER	10/19/07	141 784
P250007000	KEVIN	10/16/07-10/16/07	MAHABIR	155.00	119.09	0.00	15.00	104.09	PROVIDER	10/19/07	141 784
P284179700	KEVIN	10/19/07-10/19/07	MAHABIR	155.00	119.09	0.00	15.00	104.09	PROVIDER	10/29/07	141 784
P331597400	KEVIN	10/30/07-10/30/07	MAHABIR	105.00	78.44	0.00	15.00	63.44	PROVIDER	11/08/07	141 784
P347034000	KEVIN	11/02/07-11/02/07	SEYMOUR AMBUL	448.00	448.00	0.00	0.00	448.00	PROVIDER	11/13/07	141
P347034000	KEVIN	11/02/07-11/02/07	SEYMOUR AMBUL	58.40	58.40	0.00	0.00	58.40	PROVIDER	11/13/07	141
P354948000	KEVIN	11/02/07-11/02/07	VALLEY EMS IN	493.00	493.00	0.00	0.00	493.00	PROVIDER	11/27/07	141
ZP29765000	KEVIN	12/05/07-12/05/07	OXFORD VOL AM	74.00	0.00	0.00	0.00	0.00		02/11/08	481
ZP29765000	KEVIN	12/05/07-12/05/07	OXFORD VOL AM	433.00	433.00	0.00	0.00	433.00	PROVIDER	02/11/08	141
ZP29765000	KEVIN	12/05/07-12/05/07	OXFORD VOL AM	112.00	112.00	0.00	0.00	112.00	PROVIDER	02/11/08	141
P453379100	KEVIN	12/05/07-12/05/07	BATSON	125.00	79.20	0.00	15.00	64.20	PROVIDER	12/11/07	141 784
P500897800	KEVIN	12/06/07-12/06/07	NEW HAVEN RAD	251.00	112.88	0.00	0.00	112.88	PROVIDER	12/24/07	141
P500897800	KEVIN	12/06/07-12/06/07	NEW HAVEN RAD	184.00	82.96	0.00	0.00	82.96	PROVIDER	12/24/07	141
P500911400	KEVIN	12/06/07-12/06/07	NEW HAVEN RAD	48.00	21.76	0.00	0.00	21.76	PROVIDER	12/24/07	141

SEE ATTACHED LISTING FOR EXPLANATION OF MESSAGE CODES

**CVMA TESTIMONY: CONTINUING EDUCATION REQUIREMENT FOR VETERINARIANS**

Representative Ritter, Senator Harris and members of the Public Health Committee,

Thank you for the opportunity to testify, and submit written testimony, in favor of RB6678. My name is Dr. Arnold Goldman and I am Co-Chair of the CVMA's Government Affairs Committee. We represent the Connecticut Veterinary Medical Association (CVMA), which includes as its members, over 95% of all Connecticut licensed veterinarians. Our Association strongly supports RB6678.

Sections 10 and 11 of RB6678 would extend to veterinarians a requirement they obtain regular continuing education appropriate to their professional duties and employment. The CVMA supports such a requirement.

On a national basis, forty-six states require continuing education to renew a veterinarian's license to practice and we believe it is right that they do so. Currently Connecticut and just three other states, Hawaii, Michigan and New York are in a minority, which do not require continuing education for veterinarians. Further, veterinarians are unique among Connecticut's highly educated healing professions, in that they are not required, in any formal way, to seek regular, continuing education.

We do not believe a systemic problem currently exists with substandard veterinary care related to inadequate knowledge or skill. We do believe the public deserves and should be able to expect, the quality assurance inherent in the regular pursuit and assimilation of new knowledge and professional skills. Further, in light of the highly sophisticated and rapidly evolving state of veterinary medical practice today, we believe such a requirement is necessary and appropriate, commensurate with the responsibility and privilege conferred upon us by the public.

Indeed, the same premise underpins the continuing education requirements of physicians and dentists, and other health professions, and we believe it should similarly do so with the veterinary profession. Our reputations depend on consumer confidence and too, the public perceives we should strive to remain current. We believe it is well past time to align that expectation with reality, and require mandatory continuing education for veterinarians.

This requirement will ensure a minimum level of competence among veterinarians and serves notice to every licensee that in return for the privilege of a license to practice veterinary medicine in this state, the expectation of society is the maintenance of current knowledge and proficiency. RB6678 will accomplish this goal, while incurring no cost to taxpayers or to government. We urge you to join us in support of RB6678. Thank you.

Very respectfully,

Eva Ceranowicz DVM  
Arnold L. Goldman DVM  
Government Affairs Committee Co-Chairs  
Connecticut Veterinary Medical Association

Robert Belden DVM  
President  
Connecticut Veterinary Medical Association

Testimony of  
Thomas M. Halaszynski, M.D., D.M.D.  
on  
HB 6678  
“An Act Concerning Revisions To Department Of Public Health  
Licensing Statutes”  
before the  
Public Health Committee  
March 16, 2009

Senator Harris, Representative Ritter, members of the committee, my name is Thomas Halaszynski. I am a Board Certified Anesthesiologist, President of the Connecticut State Society of Anesthesiologists and a practicing physician at Yale-New Haven Hospital. I come before you today in support of HB 6678, “An Act Concerning Revisions To Department Of Public Health Licensing Statutes”.

The American Medical Association and many medical specialties, including the American Society of Anesthesiologists, are pushing for state and federal legislation to address physician misrepresentation. The CT State Society of Anesthesiologists supports these efforts. It is a concern that The American Association of Colleges of Nursing recently announced that advanced practice nurse degrees may be converted from a master's degree level to a doctorate degree level by 2015. Unfortunately, there can be confusion over who the actual licensed health care provider is, leading to misunderstanding and safety concerns for the patient.

The language in HB 6678 in section 8(b) requires a health care provider who works at a health care facility and provides direct patient care to wear an identification badge that indicates the provider's name and type of license or certificate that the provider holds. This bill would also allow the health care facility to develop the policies concerning the size and content of the identification badge.

Truth and transparency are vital to the health care system. **I urge the committee to support HB 6678.**

Katherine Lutz

3/16/2009

Raised Bill No. 6678

**AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH LICENSING STATUTES  
An act to separate the licensing statute for Audiologists and Speech Language Pathologists**

Good Morning Co-Chairs Senator Harris, Representative Ritter, and members of the Public Health Committee,

The CT Academy of Audiology (CTAA) presents today to support our proposal to create two separate statutes that define the licensing of audiologists and speech language pathologists (SLP's). Currently, our joint statute is found under Title 20, Chapter 399 Sections 20-408 to 20-417.

Audiologists and speech language pathologists are the only professions in the state that share a licensing statute. When our licensing statute was first drafted in 1974 by audiologist Thomas Giolas and speech pathologist Marie Johnson the graduate and post graduate certification programs for both disciplines were accredited by the American Speech, Language and Hearing Association (ASHA). Certification from ASHA was a requirement on both a federal and local level to practice speech pathology or audiology.

In the years since, certification from ASHA is no longer a requirement to practice audiology (re: Social Security Act §1861 (11)(4)(b)). The respective scopes of practice and educational requirements for each profession have diverged, evolved and expanded. The profession of audiology has advanced its minimum education requirement to the doctoral level as of January 1, 2007.

The concept of a standalone statute for each profession was brought to the attention of the Department of Public Health Office of Governmental Affairs and the Department of Public Health Practitioner Licensing and Investigation Section in December 2008 by our academy. The proposal was well received as administratively it allows for streamlined and simplified responses to statute/licensure inquires regarding each profession without the burden of filtering thru the other's language. It also allows for more efficient refinements in the years to come as our respective professions' scope of practice continue to evolve with advances in science, technology, and education.

Our proposal first takes the existing joint statute and removes all references to audiologists to create a standalone SLP statute. Secondly, we have taken the same statute and removed all references to SLP's to create the framework for a standalone audiologist statute. As you will note in the audiologist statute, we have not only removed references to SLP's but we have also refined the statute language in key areas that required updating as follows:

- o the definition of an audiologist reflects our expanded scope of practice and is adapted from our national standards recommended by the American Academy of Audiology
- o definitions already in the public health code are carried over to the statute for consistency and clarity of interpretation
- o Audiology Assistant supervision and restrictions are defined
- o Supervision of services by certified industrial audiometric technicians and occupational hearing conservationists by licensed audiologists or physicians is noted.

While the statute is open for revision, the CT Speech Language Hearing Association (CSHA) that represents primarily SLP's in the state, but also audiologists, is proposing a continuing education requirement for license renewal for SLP's. This is a concept that the CT Academy of Audiology supports not only for SLP's but also for audiologists. A recent CTAA sponsored poll of audiologists in the state revealed a majority consensus to add a CEU requirement and both CTAA and CSHA are actively working towards appropriate CEU language within the respective statute for each profession. The Department of Public Health Office of Governmental Affairs is also closely involved with this transition to a CEU requirement.

The audiologist in the state look forward to a standalone licensing statute that reflects the autonomous doctoring profession we have grown to be and anticipate continued dialogue with the DPH to make this a reality. Please feel free to contact us for any further information you may need.

Sincerely,

Cathleen A Alex, Au.D.  
President, CTAA  
[calex@ctaud.org](mailto:calex@ctaud.org)

Nancy McMahan, Au.D.  
VP Governmental Affairs, CTAA  
[nmcmahan@ctaud.org](mailto:nmcmahan@ctaud.org)



Connecticut Association for  
**HOME CARE  
& HOSPICE**

Leadership | Education | Advocacy | Information | Collaboration

TESTIMONY BEFORE THE PUBLIC HEALTH COMMITTEE  
REGARDING HB 6678  
AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH  
LICENSING STATUTES

March 16, 2009

Senator Harris, Representative Ritter and members of the Public Health Committee, my name is Kimberly Skehan, RN, MSN and I am Vice President for Clinical & Regulatory Services for the Connecticut Association for Home Care & Hospice, whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens.

The Association **supports** Section 16 of HB 6678, which will align the frequency of State of CT licensure inspections (currently every two years) with Medicare certification surveys for home health agencies (currently every three years). We have a minor suggestion for wording revisions attached. This is a common sense proposal that will help both the State and home health agencies conserve resources, while maintaining appropriate quality oversight.

The Association has received clear direction from the General Assembly to provide ideas that would make the system more efficient in these difficult budget times. This proposal would eliminate unnecessary duplication of Department of Public Health (DPH) federal surveys and State licensure inspections within a short period of time when no quality of care issues have been identified.

Aligning federal survey and State licensure inspections would free up DPH surveyors to focus their efforts on agencies requiring extra attention. This proposal does not limit surveys for complaints or quality of care issues; complaints or problems will result in more frequent surveys as per Medicare survey frequency requirements.<sup>1</sup>

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<sup>1</sup> CMS State Operations Manual PUB 100-7, Chapter 2, Sections 2008E-2008F

We support continued oversight by DPH to ensure quality of care and have enjoyed a collaborative relationship with the Department, working together to ensure that quality care is provided to our patients at home. DPH attempts to coordinate and minimize survey redundancy, but it still occurs. Aligning routine surveys will save resources for both the State and home health agencies, as the survey process involves considerable time to coordinate and involves many staff members, and they routinely last about one week.

This is an example of one proposal that our Association and members support to improve regulatory efficiency and meet the needs of patients at home. In addition, the Association would support a proposal for a 2-year moratorium on licensure of new home health agencies in order to further free up DPH resources to focus on existing agencies and prevent new agencies from entering the market and “cherry-picking” Medicare patients to the exclusion of Medicaid. Existing member agencies have identified declining Medicare referrals as a major problem. A two-year moratorium on new home health agencies would provide time for a more comprehensive approach to rethinking the regulatory structure of home care and addressing inadequate Medicaid rates.

In summary, we support these proposals as a way to decrease burden on the State and home health agencies and to avoid duplication of efforts while maintaining appropriate oversight. We look forward to working with the General Assembly to insure that our CT citizens receive appropriate, high quality home care services.

Thank you for consideration of our testimony. I will be pleased to answer any questions you may have.

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**Proposed wording revision to Section 16, HB 6678:**

“...unless such institution is also certified as a provider under the Medicare program and such inspection would result in more frequent reviews than are required under the Medicare program for home health agencies, *in which case such institutions will be inspected in accordance with the Medicare survey frequency.*”

**Testimony to the Public Health Committee, Connecticut General Assembly, on  
HB 6678 and its Provision to Permit Use of State-of-the-art Geothermal Well Technology**

**by Samuel W. Olmstead, Associate Director of Utilities, Yale University**  
2 Whitney Avenue © New Haven, CT 06511 © samuel.olmstead@yale.edu

Dear Senator Harris, Representative Ritter, and Members of the Committee:

My name is Sam Olmstead and I represent Yale University.

As you may know, we at Yale University have a strong commitment to sustainability and have set an aggressive goal of reducing its greenhouse gas emissions by 10% below our 1990 levels by 2020, even as we develop the campus. In order to do this, we are employing multiple strategies as part of a comprehensive sustainability plan. The use of state-of-the-art geothermal well systems is a key component of our strategy.

The standing column geothermal well systems that we propose for future developments will allow us to get the maximum benefit for the environment. However, such systems cannot be deployed in key future developments – especially the building of two new residential colleges – under current Connecticut statutes and regulations, even though such systems have proven reliable and safe in other places.

These two new colleges will be important for economic development in Connecticut, as they will allow Yale College to add 800 more students. This addition of students will in turn lead to more permanent faculty and staff, in addition to the hundreds of construction jobs on the project itself. Just as we hope to maximize the economic benefits of this future growth for Connecticut, so too we hope to maximize the sustainability of this project for the environment.

We thus seek change in the statutes to enable us to be sure that we can design and build a standing column geothermal well system in our new residential colleges. While these colleges will not be constructed for a few years, planning is now underway in earnest and it is important that our design team know whether or not they can move forward with confidence in including the best possible geothermal well system in the plans, which is why we seek your action this session.

We have been working closely with the Department of Public Health on this issue and we greatly appreciate the language they have drafted to enable us to apply for permission to construct standing column geothermal wells. This language, incorporated in House Bill 6678, will achieve the goal we have of utilizing the most effective geothermal well technology and it will also allow the State to use our project as an important study for how to revise statutes and regulations in the future. The language in the bill will help Connecticut be more sustainable and we urge its approval.

Thank you for your consideration and I would be happy to answer any questions you may have.

*Attachment: background document on geothermal well technology*

## Standing Column Geothermal Systems

### Yale University

Geothermal systems planned for Yale University use standing column wells. As described and illustrated below, the design, hydraulics and engineering controls of a standing column geothermal system are unique.

#### Characteristics of a Standing Column Well

A standing column geothermal system differs significantly in design and operation from the open loop system described in *Report to the General Assembly: Recommendations for Regulation of Geothermal Wells*.<sup>1</sup> In particular, a standing column well has the following characteristics:

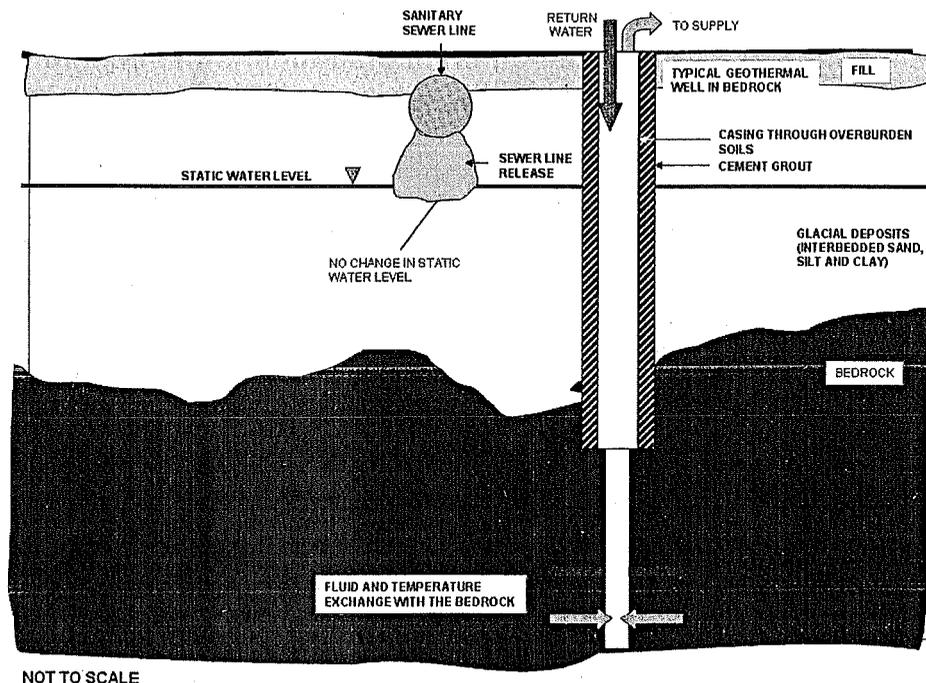
- There is no net extraction of water from a standing column well.
  - The system is not a "withdraw-recharge" open geothermal system where the groundwater is drawn from a production well and then re-injected to the subsurface at a separate well or wells.
  - The Yale system is designed and constructed to have no bleed to a storm drain, sewer or infiltration structure,
  - The extraction rate from a standing column well is equal to its return rate. The building control system is programmed to continuously monitor the water level in the wells and the flow to each well, and can automatically adjust valves to control the extraction rate so that it equals the return rate.
- A standing column well does not create a hydraulic gradient because the water is circulated within the well and borehole.
  - Because the net extraction rate is essentially zero from all the wells, a standing-column geothermal system does not create a cone of depression or capture zone that could alter the movement of groundwater.

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<sup>1</sup> *Report to the General Assembly: Recommendations for Regulation of Geothermal Wells*, Connecticut Department of Public Health, Revision 2.0, March 5, 2007.

- o Because the standing column geothermal system creates no hydraulic gradient, nearby contamination (if present) is not drawn into the well. A standing column well does not act as a "sink" for potential contamination. As a result, the risk of contamination from shallow sources, such as sewer lines, is insignificant.
- o A standing column well's operation does not displace or re-direct contaminants toward other potential receptors, such as water supply wells or other water resources. Based on Yale's regional and local setting, a standing column geothermal well poses no risk of altering groundwater flow patterns that would direct contaminants toward public water supplies.
- A standing column well is not designed to operate as a water supply well.

### Schematic Illustration of a Standing Column Geothermal Well



**Other System Design and Operational Features**

Other design features protect the potable water supply and prevent near surface contaminants (such as from a leaky sewer line or wastewater leaching field) from migrating to the underlying bedrock.

- The groundwater is used for heat transfer only. In the building, the groundwater flows through a sediment filter and a heat exchanger. A portion of the groundwater may flow through a water softener before it is returned to the well.
- The piping for the geothermal system is isolated from the potable water supply by two backflow preventers, in series. The first backflow preventer isolates the building potable water supply from the public main. The second backflow preventer isolates the mechanical room water supply from the building potable water supply. Accessible piping will be prominently labeled as "Non-Potable."
- The standing-column wells draw from bedrock. Wells are typically 8-in. diameter and 1,500-ft deep.
- Unlike the typical bedrock water supply well, the casing of a standing column geothermal well is grouted to isolate the overburden soils and groundwater from the underlying bedrock. The well's steel casing is advanced deeper into the rock (typically around 30 ft). The well is an open rock borehole below the casing.
- New storm drains and sewers constructed in proximity of the system will meet the tight pipe criteria listed in the Table 2-C of the Technical Standards for Subsurface Sewage Disposal Systems."<sup>2</sup>
- A standing column well requires a well pit for maintenance access. To prevent surface water from entering the well via the well pit, piping and conduits entering the well have sanitary seals that make water-tight connections.

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<sup>2</sup> "Accepted Tight Pipe for Building Sewer & distribution Piping within 25 Feet of open Water course or Drain, or Groundwater or Surface Water Piping within 25 Feet of Subsurface Sewage Disposal System," Connecticut Public Health Code Regulations, January 2007.

**Local Factors Also Reduce the Risk of Standing Column Systems**

A municipal water supply system is the source of drinking water in the area of Yale University's proposed new standing column geothermal systems. These sites are within a groundwater zone classified by the State of Connecticut as GB. GB groundwater is "presumed not suitable for human consumption without treatment," according to the Connecticut Department of Environmental Protection (DEP) Water Quality Standards and Classifications. Because of this classification, and because municipal water is available, it is highly unlikely that groundwater in the vicinity will ever be used as a source of drinking water.

**Alternate Requirements for Standing Column Systems**

The Connecticut Department of Environmental Protection (DEP) requires permits for water diversion and discharge for the geothermal systems described above. Yale will obtain these water diversion and discharge permits.

The Connecticut Department of Public Health (DPH) has applied water supply well standards to standing column geothermal systems. However, because of the unique hydraulics and engineering controls described above, the location standards for standing column geothermal wells need not be so restrictive.

Further, DPH's application of water supply standards to geothermal systems severely limits their use in urban areas. In urban areas, space for drilling and installing wells is limited, and sewers and storm drains are commonly located in roadways. These site constraints prevent standing column wells from meeting water supply well requirements for separation distances from city drains and sewers, as well as other setback and location requirements in Connecticut Public Health Code Section 19-13-B51d.



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**Public Health Committee Public Hearing  
March 16, 2009**

**Testimony of Pat Tadel, RN, MSN  
National Patient Care Administrator, VITAS Innovative Hospice Care ®**

Good afternoon Senator Harris, Representative Ritter and members of the Public Health Committee, my name is Pat Tadel. I am a National Patient Care Administrator for VITAS Innovative Hospice Care ® ("VITAS"), which operates two Medicare certified hospice programs in the Greater Waterbury, Hartford and Bridgeport areas of Connecticut. I am an advanced practice registered nurse and I have been working in hospice and palliative care for over 16 years. I am a thanatologist and hold a post-doctoral certificate in clinical ethics.

I am here this morning to testify in support of Section 16 of Raised House Bill No. 6678 which aligns home health state licensure inspections with the Medicare survey cycle for home health agencies.

I would like briefly to describe VITAS Innovative Hospice Care, the nation's largest provider of end-of-life care. VITAS has been a pioneer and leader in the hospice movement since 1978. VITAS (pronounced VEE-tahs) operates 46 hospice programs in 15 states (California, Connecticut, Delaware, Florida, Georgia, Illinois, Kansas, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin) and the District of Columbia. VITAS employs 9,000 professionals who care for terminally ill patients daily, primarily in the patients' homes, but also in the company's 24 inpatient hospice units as well as in hospitals, nursing homes and assisted living communities/residential care facilities for the elderly.

Our philosophy and care practices demonstrate to our patients, their families, other health care providers, and the government regulators that hospice is the most comprehensive model for delivering quality end-of-life care.

The legislation before you today is a common sense approach that aligns home health state licensure inspections, which occur every two years, with the Medicare survey cycle for home health agencies, which occur every three years. The current Department of Public Health survey process results in a survey almost every year causing a burden on the Department of Public Health and home health and hospice care administrators and staff. This proposal would require the Department of Public Health to survey home health agencies and hospices every three years for both their Medicare and state licensure inspections.

This proposal makes sense and is cost effective for both the State and home health and hospice agencies. It also preserves quality of care for patients and their families as it does not limit surveys for complaints or quality of care issues. In fact, any complaints or problems will result in more frequent surveys as part of the Medicare survey frequency requirements.

This proposal will not decrease quality oversight, but instead align the survey processes to improve efficiencies for both the Department and provider agencies. This is a way to save money for the State by decreasing redundancy in the survey process, as the survey process is time consuming and expensive for agencies (staff time out of field, coordination of patient visits and manager/office staff time to coordinate survey events and follow up).

We support this proposal as a way to decrease burden on the State and home health and hospice agencies and to avoid duplication of efforts while maintaining appropriate oversight.

Hospice care has grown to the point where it is a significant part of how Americans receive care at the end of life. The growth is laudable and should continue to be encouraged so that all those who can benefit from hospice are able to receive appropriate care. On the state and federal level, VITAS supports regulatory and legislative proposals that maintain the integrity of the Medicare Hospice Benefit and the public's trust in the hospice provider community, leading hospices support several key program enhancements. For example, we support changes that promote measurable quality of care, transparency, and intolerance for fraudulent activities. As a leader in the hospice movement, VITAS embraces the quality elements outlined in the proposed Medicare Conditions of Participation with particular focus on tangible and reportable measures like pain and symptom management and family satisfaction. Additionally, we support the creation of a uniform patient assessment tool to guide hospices especially for the evaluation of non-cancer patients.

Beyond Raised Bill 6678, VITAS is eager to work with the Connecticut Association for Homecare and Hospice, the Department Public Health, the Public Health Committee and other interested parties to explore ways in which we can further enhance the provision of quality home health and hospice care in Connecticut. For example, measures that encourage hospices to report their effectiveness in pain management as well as the satisfaction of the services they provide are laudable. We support these appropriate enhancements to the Medicare regulations and would be pleased to collaborate with you on their adoption.

In conclusion, hospice provides the quality care patients and families deserve and increasingly desire at the end of life. Raised Bill 6678 will allow home health and hospice providers in Connecticut to continue and their important mission while giving consumers appropriate protections to insure these important care providers adhere to regulations governing their operation. I urge your support of Section 16 of Raised Bill 6678 and appreciate your consideration. Thank you for this opportunity to speak to you. I would be pleased to answer any questions you may have for me at this time.



## Connecticut Academy of Physician Assistants

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Public Hearing re: HB 6678

*AN ACT CONCERNING REVISIONS TO DEPARTMENT OF PUBLIC HEALTH LICENSING  
STATUTES*

March 16, 2009

Representative Ritter, Senator Harris, and members of the Public Health Committee:

Thank you for the opportunity to speak with you today about House Bill 6678. My name is Patrick Killeen, and I have been a physician assistant for 22 years, 18 of which have been in the practice of pediatrics. I am here today to represent the Connecticut Academy of Physician Assistants (ConnAPA).

ConnAPA respectfully requests that the Committee consider amending section 15 of this bill, which relates to neonatal and pediatric specialty care transport. We agree that neonatal and pediatric specialty care transports should be accompanied by qualified health care professionals who have the appropriate training and experience in caring for neonatal and/or pediatric patients.

However, Section 15, as currently drafted, is subject to interpretation, and appears to say that only licensed registered nurses can be authorized to support a neonatal or pediatric specialty care transport. We believe that limiting the staffing of these transports to only one profession could potentially limit access to care for our state's most vulnerable patients, and create workforce issues for the neonatal transport system.

Currently, the University of Connecticut Health Center utilizes physician assistants and advanced practice nurses to staff the Neonatal Intensive Care Unit and the neonatal transport program. Each member of the transport team is certified by the American Academy of Pediatrics' Neonatal Resuscitation Program, and re-certifies every 2 years. There are currently 4 PAs on the transport team, one of whom, at the direction of a supervising physician, has been providing high-level neonatal care for over 15 years.

If section 15 is passed without amendment, PAs and other qualified health care providers could potentially be prohibited from continuing to deliver the high-level care that has characterized UCONN's neonatal transport program for years. Even pediatricians and neonatologists could be excluded, unless section 15 is amended in a way that clarifies that PAs and other qualified health care providers can accompany neonatal and pediatric specialty care patients in transport.

ConnAPA would be happy to provide the Committee with possible language for such an amendment upon request.

Thank you for your attention, and I would be happy to answer any questions that members of the Committee might have.

Respectfully,

Patrick E. Killeen, MS, PA-C

**CT Funeral Directors Association, Inc.**

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Written Testimony of  
Nicole I. Granados, CFSP, CPC, Legislative Chair  
Connecticut Funeral Directors Association, Inc.

**Proposed Bill No. 6678, An Act Concerning Revisions to Department of Public Health Licensing Statutes**

Date: March 16, 2009

State of Connecticut - General Assembly - Public Health Committee

Good day, Senator Harris, Representative Ritter and members of the Public Health Committee, my name is Nicole Granados and I have been a licensed funeral director and embalmer with practical experience for 14 years. As Legislative Chair, I respectfully submit this testimony on behalf of the Connecticut Funeral Directors Association (CFDA) which represents nearly 70-percent of the funeral homes in Connecticut.

With the matter of House Bill 6678, the Connecticut Funeral Directors Association supports this proposed bill with the sole exception of Sec. 21, Subsection (2) lines 761-770 (page 25). This subsection would require the unnecessary embalming of a deceased body whose death was not due to a reportable disease and will not reach its final disposition or destination within 48 hours from the time of death. We respectfully recommend that these lines be **deleted** for the following reasons:

1. Most bodies do NOT reach their final disposition or destination within 48 hours from the time of death. This alone would trigger the embalming requirement for most families, including ALL who select cremation. **By existing statute, cremation cannot take place within 48 hours from the time of death.**
2. This subsection is not consistent with existing statute (Chapter 368a Dept. of Public Health Sec. 19a-91 Sec.(c) which states that the funeral director/embalmer shall prepare a body whose death resulted from a reportable disease, such as anthrax, smallpox or plague, by having such body washed, embalmed or wrapped as soon as practicable. To "wrap" is to place the body in a burial or cremation pouch made of not less than 4 millimeters of plastic. Wrapping provides for public health safety, is non-invasive and less costly for the families. If wrapping is sufficient for a body of a reportable disease to protect public health then this standard should be consistent with the body of a non-reportable disease.
3. Embalming is typically required by a funeral home for viewing purposes. Establishing a 48 hour rule will FORCE families, who do not choose viewing, to pay for embalming. When an unembalmed body is moved after 48 hours, for disposition or funeral services in a chapel, function room or church that is not climate controlled, the embalming requirement would inadvertently be triggered. Furthermore, a 48 hour rule is irrelevant as a body does not suddenly become a public health threat only upon the 48th hour. Funeral directors concern themselves with public health and use universal precautions for all bodies regardless of the time that elapsed after death. In the unlikely event that a family is unable to reach a disposition decision in a timely manner the funeral director may charge a "sheltering of remains" fee per day. The funeral director can also explain and enforce a practical time-frame when the results of embalming for viewing purposes, would be hindered due to decomposition.
4. This subsection will impose a "fiscal impact" to families that will place unnecessary financial burdens on families during a difficult time and economic climate. As stated earlier, families would be forced to pay embalming fees, regardless of their personal wishes/selections. Families who pre-pay their funeral selections will also be affected as the timing and date of death, the availability of the certifying practitioner and the business hours of the registrar, cemetery and/or crematory that are necessary to carry out final disposition will be an uncertainty ahead of time. All deaths occurring on a Friday or early Saturday would require embalming.
5. During a pandemic or mass fatality event, it would be impossible to embalm all deceased human remains. Climate controlled rooms will be limited and perhaps non-existent if temporary storage sites are utilized.

Thank you for this opportunity to testify. I welcome any questions or concerns that you may have.