PA 11-040

HB6373

House	954-959	6
Public Health	357, 358, 444-462, 652, 681-682	24
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H – 1094

CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2011

VOL.54
PART 3
705 – 1039

Necessary for adoption	73
Those voting Yea	107
Those voting Nay	38
Those absent and not voting	5

DEPUTY SPEAKER GODFREY:

The bill, as amended, is passed.

Will the Clerk please call Calendar 85.

THE CLERK:

On page 7, Calendar 85, House Bill 6373, AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY-INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS, favorable report of the Committee on Public Health.

DEPUTY SPEAKER GODFREY:

The distinguished chair of the Public Health Committee, Representative Betsy Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker.

I move acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER GODFREY:

Question is on acceptance and passage.

Will you explain the bill, please, madam.

Actually, before that Representative Ritter, just getting a little noisy.

Representative Ritter.

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill directs the Department of Public Health to adopt regulations to allow registered nurses qualified in intravenous therapy that are either employed by or contracted by a nursing home or rest home to administer a peripherally-inserted central catheter, known as PICC. Current regulations allow only a physician to do this. This bill will improve the quality of care in our -- for our nursing home residents, decrease, overall institutional care costs for facilities and reduce state expenditures for Medicaid recipients.

Connecticut is one of a few remaining states that does not allow this to be done in the long-term care facility by appropriately qualified registered nurses. I urge adoption.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

The distinguished ranking member of the Public Health Committee, Representative Perillo.

REP. PERILLO (113th):

Mr. Speaker, thank you very much.

I rise in support of the bill before us today and the

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two things that are most important to me and the two things that come to mind immediately are benefit to the patient clinically and benefit to the system in terms of cost. Everything shown to us during the committee indicates that this is something very safe for patients. There are no concerns as to whether or not a hospital stay is necessary. So from that perspective, from clinical perspective, it works.

The second thing is cost and it does have potential benefit specifically in the Medicaid area, where we could see savings in that we're not sending patients via ambulance to emergency departments and then sending them back to skilled-nursing facilities. This is a win-win all around. I support the bill before us and I urge its -- I urge others to support it as well.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Representative Larry Miller.

REP. MILLER (122nd):

Thank you, Mr. Speaker.

I rise to ask a question regarding the bill.

DEPUTY SPEAKER GODFREY:

Please frame your question, sir.

REP. MILLER (122nd):

There was a concern -- I spoke to a number of people in the medical profession and there was a concern about infections when the -- the PICC touched by somebody who may not be an RN. Could you reply to that. Thank you.

DEPUTY SPEAKER GODFREY:

Representative Ritter, do you care to respond.

REP. RITTER (38th):

Thank you, Mr. Speaker.

Mr. Speaker, Representative Miller is correct. There were some concerns at the public hearing that were widely discussed and discussed in detail. And in addition we received information through the Department of Public Health to this point.

And the point being that this was not an issue particularly. And this satisfied the physicians because the bill requires that regulations be established by the Department of Public Health to ensure the appropriate and proper training and conditions around the insertion of these PICC lines.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Representative Miller.

REP. MILLER (122nd):

I know that even with an RN who does the procedure

to disconnect sometimes you'll have some infections that do take place. And I know of a number of them from my own experience in the medical field.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Thank you, sir.

Will you remark further on the bill? Will you remark further on the bill? If not, staff and guests please come to the well of the House. Members take their seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the Chamber. Members to the Chamber. The House is voting by roll call.

DEPUTY SPEAKER GODFREY:

Have all the members voted? Have all the members voted? If so, the machine will be locked. The Clerk will take a tally. And the clerk will announce the tally.

THE CLERK:

House Bill Number 6373.

Total Number voting	146
Necessary for adoption	74
Those voting Yea	146
Those voting Nay	0

Those absent and not voting 4

DEPUTY SPEAKER GODFREY:

The bill is passed.

Will the Clerk please call Calendar 81.

THE CLERK:

On page 6, Calendar 81, substitute for House Bill Number 6330, AN ACT CONCERNING TECHNICAL AND MINOR REVISIONS TO ELECTIONS RELATED STATUTES, favorable report of the Committee on Government Administration and Elections.

DEPUTY SPEAKER GODFREY:

If we could clear the path between me and Representative Morin, I'd appreciate it. Thank you.

The distinguished Chairman of the Government Administration and Elections Commission, Representative Morin.

REP. MORIN (28th):

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Good afternoon, sir.

REP. MORIN (28th):

I move for acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER GODFREY:

JOINT STANDING COMMITTEE HEARINGS

PUBLIC HEALTH PART 2 332 - 697

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list. Claudia Gross or Grass. As I said, please identify yourself when you sit down to speak because we can't always read handwritings, to be followed by Nicholas Piccolo. Welcome.

If you just hit the button on the bottom there.

CLAUDIA GRUSS: Because my comments are brief and will be within the three-minute time limit, I'd like to comment on two bills if that's okay with the Chairs.

My name is Dr. Claudia Gruss. I am a physician from Fairfield County and Secretary of the Connecticut State Medical Society.

Senator Stillman, Representative Ripper, Ritter, excuse me, members of the Public Health Committee, on behalf of the more than 7,000 physicians and physicians-in-training members, I thank you for the opportunity to present this testimony to you in opposition to House Bill 5289 AN ACT PROHIBITING MEDICAL PROCEDURES THAT MAY POTENTIALLY BLOCK A PERSON'S AIR PASSAGES and House Bill 6373 AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS.

Both bills will negatively impact the practice of medicine in Connecticut, as well as the quality of care we provide our patients.

The first bill, House Bill 5289 AN ACT PROHIBITING MEDICAL PROCEDURES THAT MAY POTENTIALLY BLOCK A PERSON'S AIR PASSAGES raises questions to me personally as a specialist in gastroenterology. There are procedures that we do every day that could potentially block a person's air passages.

However, we are highly trained and skilled physicians practicing to nationally established

standards of care. We take into consideration the risks and benefits of any procedure before we recommend any treatment plan to our patients.

Prohibiting certain procedures in state statutes could prohibit some procedures that are critical to our patients' care.

The second bill, House Bill 6373 AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS would allow certain procedures to be done by individuals without the expertise and experience needed to insert central catheters in long-term care facilities.

Complications from central catheters are a national problem. Nationwide, our hospitals have been able to lower the complications by following certain strict guidelines and sterility protocols.

We question whether there would be a sufficient volume in long-term care settings to have nurses with the appropriate expertise to ensure the institution of strict practices needed to guarantee best practice to warrant this change in statute. Thank you.

SENATOR STILLMAN: Thank you very much, Doctor. Does anyone have any questions for Dr. Gruss? Thank you very much.

Next is Nicholas Piccolo. Welcome.

HB 5289

NICHOLAS PICCOLO: Good morning, Public Health Committee members and the general public. My name is Nick Piccolo from Southington. The law that I'm proposing is an act prohibiting procedures when they potentially block a person's breathing passages.

REP. RITTER: Next we'll be hearing from Barry Simon. Is Barry here? Nope. Maybe not. One moment.

The next bill for which we have people signed up to speak is item number 12 on your agenda, House Bill 6373 AN ACT CONCERNING THE ADMINISTRATION OF PERIPHERALLY INSERTED CENTRAL CATHETERS IN LONG-TERM CARE SETTINGS.

And we will be hearing from Claudia Gruss and she will be followed by Eve Curtin. Is Claudia here?

CLAUDIA GRUSS: Yes. Thank you, Representative Ritter. I previously testified on this bill in combination with the first bill that I testified on, and I would refer you to that testimony. Thank you.

REP. LYDDY: Thank you very much. The next speaker is going to be Eve Curtin. She's here? Great.

EVE CURTIN: -- I'm also a member of the National (inaudible) Society and the Connecticut Chapter of the Nurses Infusion Society.

In addition, I am the owner of High-Tech nursing Services in Connecticut. High-Tech Nursing Services is a team of nurses that have been inserting lines, peripheral lines in long-term care facilities in Connecticut since 1994, 1995.

In 94-95 the medication, intravenous medication, that I'm speaking of were far less complex, much simpler in those days than they are now and this year of 2010-11.

What we're seeing in long-term care now is a combination of very problematic intravenous drugs that are given through inappropriate lines.

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So Bill 6373 is to have the Department of Public Health add to their code that the nurse that is educated, trained, competent, knowledgeable in inserting a peripherally inserted central catheter in long-term care patients in Connecticut.

The nurses that work for High-Tech Nursing Services are highly educated and competent. In Massachusetts, Connecticut, I mean New Jersey, Rhode Island, nurses are allowed to insert these lines at this time. Connecticut is the only one that denies this therapy to its long-term care residents.

Nurses that are competent and trained can insert these lines in hospitals, in (inaudible) centers, even in their own homes.

So, previous testimony said that this was a detrimental technique to use in long-term care facilities. I think there is confusion there in that the assumption is that the nurses that are currently working in long-term care, doing patient care, are the nurses that would be responsible for inserting these lines. This is not so.

The lines would be inserted by the nurses that are trained and competent to do so, and that is High-Tech Nursing Services, the company that I own.

REP. LYDDY: Thank you very much for your testimony. I have one quick question. You repeatedly talk about highly trained and competent nurses and I would assume most nurses are highly trained and competent.

In regards to this very specific item that we're talking about, what additional training, or

clarify what highly trained and competent means to you.

EVE CURTIN: There are special education classes that the nurses have taken and they get the didactic and they actually get the hands on training at the same time.

So yes, there is, we have competencies that shows that they are competent to do this. This is all part of their personnel files and their records.

REP. LYDDY: They are very specific trainings, CEUs.

EVE CURTIN: Very specific. Very specific.

REP. LYDDY: And are there board exams or any type of exam that they would have to take to either certify them as a nurse that would be able to perform this?

EVE CURTIN: Some nurses that do this are certified registered nurses in intravenous therapy. It's not a requirement, but when they finish a program with the didactic and the hands on, they do have to take a test, and they do get a certificate from the program that states they are competent to do this.

REP. LYDDY: Okay, and your organization provides the opportunity for these nurses.

EVE CURTIN: For these nurses to do that.

REP. LYDDY: And who oversees your program? Just curious.

EVE CURTIN: I oversee my own program.

REP. LYDDY: Okay. There's no accrediting body or --

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EVE CURTIN: Well, we are JCAHO accredited, but they really accredit other aspects of what we do, not so much line insertion. But that was a very good question.

REP. LYDDY: Oh, thank you. Okay. So nobody's overseeing that particular piece of your program.

EVE CURTIN: I am.

REP. LYDDY: You are.

EVE CURTIN: I am.

REP. LYDDY: And you're a nurse as well.

EVE CURTIN: I am a nurse. I've been in intravenous therapy all my nursing career.

REP. LYDDY: Fantastic.

EVE CURTIN: And have kept up with the technology. So yes, it is my responsibility to make sure that the nurses that do these insertions are competent to do so.

REP. LYDDY: Okay. Thank you very much. Are there further questions from the Committee? Seeing none, thank you very much.

EVE CURTIN: You're welcome.

REP. LYDDY: Okay. The next two speakers will be Leslie Leon and Alice Cennamo.

LESLIE LEON: Good afternoon. My name is Leslie Leon and I'm testifying on behalf of the Connecticut Infusion Nurses Society.

HB 6373

I'm a registered nurse and I have my CR&I, certified registered nurse intravenous. I've been a nurse for over 23 years and presently a

nurse educator and consultant in Connecticut as well as surrounding states.

I used to do what Eve did, the insertion piece and oversee a team. Now I do more of the education and consulting.

As a nurse specializing in IV therapy and vascular access, I support the same bill, 6373, that would allow insertion and removal of PICCs in long-term care facilities by employees as well as subcontractor registered nurses who are educated and competent in the procedure, reiterating the same remarks.

We would also utilize all of the state and national guidelines. Of special note, there already are state guidelines by the Department of Public Health that were published in 1997 as well as a flow chart that was updated in 2002 that's available on the website.

Some patients in long-term care facilities require intravenous therapy during their stay. I believe this bill can significantly help to improve patient vascular access in long-term care facilities in Connecticut.

Certain therapies require a central venous catheter such as a PICC to be inserted to avoid tissue damage and vein trauma.

Currently, long-term care residents must be transported by ambulance to and from the hospital to have a PICC inserted at a certain cost as well as a distress to the patient, removing them from their residence, having the line inserted, sticking around for a chest x-ray and being re-transported back to the facility, which also could prevent or have a delay in care.

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Therefore, many facilities utilize peripheral catheters, short peripheral when inserting a PICC would be more appropriate for the therapy. The results can be detrimental and can cause preventable patient complication.

Approval of the Bill 6373 would improve care to Connecticut long-term care facility residents and provide cost-effectiveness for the facility.

In addition, the change in legislation would increase compliance with national infusion therapy standards and make the therapy safer for the residents.

We have the technology, portable ultrasound units, qualified RNs per the state guidelines of the State of Connecticut as well as national guidelines here already in place in the State of Connecticut to provide those insertions. Thank you.

REP. RITTER: Thank you for your testimony. Representative Perillo.

REP. PERILLO: Madam Chair, thank you very much. You referenced what currently happens right now wherein a patient is transported from the extended care facility, whatever it may be, to the hospital and then back.

What happens in the hospital besides the insertion that quite frankly would justify the trip?

Okay, let me rephrase that? What happens, period? Forget the end --

LESLIE LEON: What happens. The patient is transported to the hospital setting. The, generally, a PICC would be inserted, peripherally inserted central catheter, could be inserted by

an IV team member in a special room or in a special procedures room, or the patient could go to intervention radiology and have the PICC lines placed under fluoroscopy, one of two is usually what happens, either or.

And then if it was placed by an IV team member, they would need a chest x-ray to confirm tip placement. That's the standard of practice as well as state guidelines.

If it was done under fluoroscopy, fluoroscopy itself tells us where the tip is.

The conclusion of that is making sure the tip is in the right place before the patient leaves the hospital, and then the patient is transported back to the facility, long-term care facility with those appropriate readings, chest x-ray or fluoroscopy to make sure everybody's aware where the tip is so we can utilize the catheter.

REP. PERILLO: Okay. So if the insertion were to be done in the, you know, extended care facility, whatever it may be, who would make the determination whether or not it was most appropriate to be done under fluoroscopy or otherwise by an IV insertion team?

LESLIE LEON: Wonderful question. I would say that if the resident, generally what we would teach is that if the resident had had other catheters inserted within a fluoroscopy suite, fluoroscopy room, then we would recommend most like the patient go to that fluoroscopy, back to that fluoroscopy suite in order to get it placed again or inserted again.

Generally, I also consult in other states, Rhode Island, Massachusetts, other places. We actually, right on the phone when a PICC line referral is called in, we have a list of

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questions that we ask. Do they have a pacemaker? Do they, you know, all the standard questions so that we know what's their I&R, lab test, and one of them would be, have they had PICC lines inserted under fluoroscopy previously. Do they have fistulas, barriers to us having a successful insertion.

REP. PERILLO: Okay, thank you. You know, the4 reason why I asked is trying to understand if there is a benefit derived from transfer to a hospital that could not be obtained outside the hospital.

LESLIE LEON: Generally with the use of ultrasound technology, which we have wonderful portable ultrasound machines now, to be able to actually see much deeper into the vessels and be much more successful at the insertion process at the bedside, preventing that movement of the patient.

And so, once in a while it doesn't work and the success is not there, and we do need to transport the patient. We try and make that decision before the nurse goes in and makes that visit if at all possible.

They've had more recent insertions under fluoroscopy, we might ten to recommend they go back to that fluoroscopy center to get another line inserted.

REP. PERILLO: do most residential facilities, let me rephrase. Do all residential facilities have the required equipment to insert?

LESLIE LEON: No. They do not. And that's not something that we're recommending. The nurses who would come in by subcontract to be able to insert these lines successfully would carry their own portable ultrasound machines, which are cleanable and sterile for the insertion, as well

as all the equipment to perform the insertion of the PICC itself.

REP. PERILLO: What's the, for the timeline of the insertion of a PICC line, do you know? Is this something that is so time sensitive that waiting for a contractor to come in is unreasonable? I just don't understand. I apologize for my ignorance.

LESLIE LEON: No. No. Generally, in other states, we definitely request that the referral be called in by a certain time limit, let's say 2:00 o'clock because we do want the line, the catheter itself inserted and the chest x-ray performed before nighttime rolls around so that the patient isn't unmonitored overnight without a chest x-ray. So there is a time sensitive piece to it.

We do try and respond to all calls and again, not my company, but generally all calls are responded to, if possible, within a four-hour time window, so to preserve that turnaround time in success while that nurse is also on sight. If necessary, they could insert a short peripheral catheter again if necessary and appropriate to get one dose that way while we're waiting for the confirmation of tip placement.

REP. PERILLO: So I suppose if a request from a facility went out to you know, a contracted nurse to do the insertion and the service were not able to provide that in a timely manner, the facility would still have the option of sending the patient out to a hospital.

LESLIE LEON: Correct. And that option would always be there.

REP. PERILLO: Right.

LESLIE LEON: It obviously would always be there to make sure that the safety of the resident is primary.

REP. PERILLO: Okay. That helps. Thank you very much. I appreciate it.

REP. RITTER: Thank you. Representative Betts.

REP. BETTS: Thank you, Madam Chair. I thought I heard you say, or maybe it was somebody earlier on say that Connecticut was the only state or one of the only states that did not allow for this?

LESLIE LEON: I believe Connecticut, I believe Virginia, and I don't know of any other state that prohibits it right now.

REP. BETTS: And why do you think that is? If I were, for example, to argue against this bill, why would I argue against it? I mean, it seems to make a lot of sense. I'm having difficulty understanding why the state hasn't done it to this point.

LESLIE LEON: Our long-term care facility state laws via the Public Health Code, the last major revision was a few decades ago, and so we are working under some state laws that were written again, decades ago.

So, we've always followed them. We've always followed them. We've always abided by them, and if we want to, if a specific facility wants to do something outside of the Public Health Code they apply for a waiver.

So in order to do this program right now, if a facility wanted to have nurses come in to a specific facility, they could apply for that waiver.

REP. BETTS: Can they do that by regulation rather than having to pass a law? Can this be achieved by some administrative regulation as opposed to passing a law?

LESLIE LEON: Well, it states it in the Public Health Code that only a physician can insert or remove a PICC line in long-term care.

REP. BETTS: Okay. The other question I had was, you said it was cost-effective. I understand the cost-effectiveness in terms of the cost of the ambulance and going to the hospital and all the additional charges.

Is there a range? Can you give me an idea what the range of prices might be to have somebody have, you know, an outside service come in and administer this? How much would that run, do you think, range-wise?

LESLIE LEON: I'd like to ask Eve to comment on that --

REP. BETTS: Sure.

LESLIE LEON: -- since it's not part of my realm.

REP. RITTER: That's fine. Just make sure to introduce yourself for the record.

EVE CURTIN: Yes. My name is Eve Curtin. I'm a registered nurse. All right. What I have here is a quote from 2005-2006 and we have, the difference between an inpatient reimbursement, how much it would cost for a physician and how much it would cost in outpatient to have us come in and do this procedure.

So, average cost back then, now I don't have the figures for recently, but back then, and it does give us an idea. In 2006 a PICC insertion in a

hospital setting was in the area of $900. And to have this done, if it could have been done in long-term care, which is what we would like to see done under portable ultrasound, it would be in the range of $150 for a nurse to come in with the equipment and do this procedure in long-term care.

Now, what that does for us, it certainly saves the State of Connecticut money, one way or another. But depending on the patient's insurance.

The other thing is, there's a great consideration here for patient comfort. It's difficult for a patient to be removed from the long-term care facility, their home, and moved to a hospital, wait for this procedure and then come back. So it is uncomfortable for the patient.

But the third thing is, there's some nursing time involved here for the nurses in the long-term care facility. They have to prepare paperwork to send the patient out, and they have to prepare paperwork to receive a patient back in.

So there's some very good reasons to do this.

REP. BETTS: Thank you very much.

EVE CURTIN: You're welcome.

REP. RITTER: Thank you, and thank you for coming back to the microphone. Are there further questions from the Committee? Yes. Senator Welch.

SENATOR WELCH: Thank you, Madam Chair. What are the potential complications that can arise from inserting the PICC line that would require some kind of acute care not available at a long-term facility, and what are the chances that that happen per insertion?

LESLIE LEON: General complications from a PICC insertion could be very similar to a short peripheral or a mid-line insertion, which we presently do, could be bleeding. It could also be venous spasm.

We could hit an artery instead of a nerve, hit an artery instead of a vein, hit a nerve. These are all risks of short peripheral insertion as well as mid-line insertion, which we presently do. So those are all commonalities.

The catheter itself we're very highly trained on how to measure appropriately for catheter insertion. If the catheter should go in too far it could tickle the right atrium and tickle the SA node, which is where your heart firing center is, so we could have an arrhythmia. But pulling the catheter back slightly, it would become non-existent.

So, could things happen? Sure they could. There is a consent form that most of the facilities within their policy manual would discuss with the patient prior to insertion.

I think the commonalities of short peripheral, mid-line, the biggest difference with a PICC is the length of the PICC and the tip sits in the lower SBC, which is right above the right atrium of your heart. So those are the complications.

SENATOR WELCH: Any other complications?

EVE CURTIN: May I speak again?

REP. RITTER: Yes. Please come to the microphone.

EVE CURTIN: Yes. My name is Eve Curtin and I am a registered nurse. Nurses that work in long-term care are currently monitoring these lines already

because the patient has to go out and have them inserted and return to the facility. So the nurses that work in these facilities are knowledgeable with monitoring these lines.

All we're asking is, and it's not all, I realize it's a big change to what is currently done. What we're asking is that we come in and insert these lines and let the nurse that works in the facility monitor them for the time that the patient needs the medication and then we would come and remove the device at the end of that therapy.

So the thing is that nurses that work in long-term care already are monitoring all kinds of central lines, PICC Lines, chest lines, whatever.

SENATOR WELCH: Thanks. I'm trying to get at just some core questions here. And did you guys describe already the universe of complications with the prior testimony or is there more to add to that?

LESLIE LEON: Any other complications that you can --

EVE CURTIN: No.

SENATOR WELCH: And then, within that universe of complications, are long-term care facilities set up to address those complications if they should arise?

EVE CURTIN: They are.

SENATOR WELCH: Or are there, okay. Are there any instances, then, where you wouldn't be, and you'd have to transport the patient to somewhere where emergency care --

EVE CURTIN: The only time they would be transported if there is a therapy that the patient requires

that is not acceptable in long-term care at this time, and there are certain therapies such as total (inaudible) attrition. That's one of them and chemo-therapy for example. Patients wouldn't receive those things in long-term care in Connecticut at this tine because it's not approved by the Department of Public Health.

SENATOR WELCH: Okay, thank you. Thank you, Madam Chair.

REP. RITTER: Any other questions? Representative Carter,

REP. CARTER: Thank you, Madam Chair. One very quick question. We were talking about the difference when somebody goes to the, I guess the hospital and gets a fluoroscopy and then it's backed up with a chest x-ray to see where the tip is. Do I understand that correctly?

LESLIE LEON: If it's fluoroscopy generally we don't do a chest x-ray post because the fluoroscopy tells us where the tip is. If the IV team inserted it, yes, there is a chest x-ray.

REP. CARTER: So if the IV, that's the difference. Now, how long have portable ultrasounds been used to do this, and is it something that's widely recognized as safe.

LESLIE LEON: Correct. Yes.

REP. CARTER: They were doing it a long time.

LESLIE LEON: Widely recognized. Over ten years.

REP. CARTER: You mentioned, earlier in your testimony you had mentioned that in the institution that that's the way the state recognizes it be done, when it's a fluoroscopy or the chest x-ray after the IV team?

LESLIE LEON: In order to confirm tip placement?

REP. CARTER: Yes.

LESLIE LEON: Correct.

REP. CARTER: The state recommends that?

LESLIE LEON: National guidelines do.

REP. CARTER: National guidelines. Good. I want to make sure. So the national guidelines also recognize ultrasound.

LESLIE LEON: Yes.

REP. CARTER: Thank you. Okay. Thanks for your time.

REP. RITTER: Thank you. Any other questions from the Committee? And I will apologize. I missed the earlier speakers, so if my questions are, have already been answered.

Well, I guess my first question might be that I hope you perhaps have left testimony with us that I don't yet see available? I know some of the earlier other speakers have, but some of the points that you made I'll be interested in reviewing when I review the testimony. Great. Thank you.

I did leave me with I think one or two other questions. I believe we reviewed fairly thoroughly the decision whether it's to be done with fluoroscopy or not, relying on the institution.

Did you talk about the percentage of cases in general when this is the instance? In other words, I assume for which this would make no difference. About how many?

LESLIE LEON: Percentage of cases that we would potentially recommend the patient to go to the hospital --

REP. RITTER: Correct.

LESLIE LEON: -- instead of having the insertion in the long-term care facility? With ultrasound I think our success rate with ultrasound is over 95 percent, so it's a very small percentage of patients that would get recommended, just based on their history, that they go to the hospital for a fluoroscopy PICC placement.

REP. RITTER: Okay. I think that may be one of the few remaining questions. I know how to find you if I have more.

LESLIE LEON: Okay.

REP. RITTER: Thank you very much. Our next speaker is Alice Cennamo.

ALICE CENNAMO: Hello. My name is Alice Cennamo. I'm a registered nurse and I'm here representing the Connecticut Infusion Nurses Society also.

I'm a registered nurse and former president of the Connecticut Infusion Nurses Society, and I'm a current member and chairperson for that group.

As a nurse specializing in IV therapy and vascular access, I support the passage of the bill 6373 that would allow the insertion and removal of PICC lines in long-term care facilities.

I specialize in IV therapy, vascular access since 1997. I am certified by the National Infusion Nurses Society and I'm board certified by the Vascular Access Certification Corporation.

And it's important to note that there are many nurses in the State of Connecticut with credentials similar to mine that are capable of safely inserting PICC line catheters in long-term care.

I don't want to repeat everything that Eve Curtin and Leslie Leon said. I pretty much can make the same statements and I agree with it. But I do think that it is very important to note that these PICC lines are already being inserted in acute care and rehab throughout our state and it's these very nurses that are doing it.

So we're not asking to have general long-term care facility nurses insert these lines, and we're not even asking for a change in practice as far as caring for the lines or to have more PICC lines inserted that are not appropriate for long-term care.

What we're saying is that there are IV nurses specially trained in PICC insertion and removal, and these are the nurses that would be qualified to do this.

So PICC lines are not and should not be inserted by nurses who are not specially trained, and there are already guidelines in place, put in place by the Board of Nursing Examiners in the State of Connecticut to guide us, and which nurses would be appropriate to do these procedures.

So they already talked about the cost savings and that nurses in these facilities are already caring for these lines.

I think that's pretty much what I wanted to say, and to just let you know that the nurse --

000462

REP. RITTER: Go ahead.

ALICE CENNAMO: -- that will be inserting the lines are properly trained and certified nurses are already appropriate to do these procedures.

REP. RITTER: Thank you very much. I appreciate hearing that emphasized again. Are there questions from the Committee? Representative Carter.

REP. CARTER: Thank you, Madam Chair. I did have one question I wish I'd asked earlier, and maybe I'll have you come back.

Does a physician still control whether or not the PICC line is going to be inserted or taken out, and if there's going to be anti-coagulant therapy added later? Does a physician still control all that?

ALICE CENNAMO: Yes. A physician has to give the order, a physician or advanced practitioner that's authorized.

REP. CARTER: Thank you. Thank you, Madam Chair.

REP. RITTER: Thank you. Any other questions from the Committee? Thank you for your testimony.

We're going to move to our next bill, which is Senate Bill Number 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS. And our first speaker will be Mary Consoli, to be followed by Kirk Lowry.

MARY CONSOLI: Good afternoon, Senator Stillman and Representative Ritter and the Committee for Public Health. Thank you for raising this bill and giving me the opportunity, along with my colleague Helene Andrews to address you.

160 St Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society Testimony in Opposition to House Bill 5289 An Act Prohibiting Medical Procedures that May Potentially Block a Person's Air Passages And House Bill 6373 An Act Concerning The Administration of Peripherally-Inserted Central Catheters In Long Term Care Settings Presented to the Public Health Committee February 23, 2011

Senator Stillman, Representative Ritter and members of the Public Health Committee, my name is Dr. Claudia Gruss. I am a physician from Fairfield County and Secretary of the Connecticut State Medical Society. On behalf of the more than 7,000 physicians and physician in training members, I thank you for the opportunity to present this testimony to you in opposition to House Bill 5289, An Act Prohibiting Medical Procedures that May Potentially Block a Person's Air Passages, and House Bill 6373, An Act Concerning The Administration of Peripherally-Inserted Central Catheters In Long Term Care Settings. Both bills would negatively impact the practice of medicine in Connecticut as well as the quality of care we provide to our patients.

The first bill, House Bill 5289, An Act Prohibiting Medical Procedures that May Potentially Block a Person's Air Passages, raises questions to me personally as a specialist in gastroenterology. There are procedures we do that could potentially block a person's air passages. However, we are highly trained and skilled physicians practicing to nationally established standards of care. We take into consideration the risks and benefits of any procedure before we recommend any treatment plan to our patients. Prohibiting certain procedures in state statute could prohibit some procedures that are critical to our patients' care.

The second bill, House Bill 6373, An Act Concerning The Administration of Peripherally-Inserted Central Catheters In Long Term Care Settings, would allow certain procedures to be done by individuals without the expertise and experience needed to insert central catheters in long term care facilities. Complications from central catheters are a national problem. Nationwide, our hospitals have been able to lower the complications by following certain strict guidelines and sterility protocols. We question whether there would be a sufficient volume in long term care settings to have nurses with the appropriate expertise to ensure the institution of the strict practices needed to guarantee best practices to warrant such an increased scope of practice.

HB 6373

I am a AMDA Certified Medical Director (CMD) for Long Term Care and Board Certified in Internal Medicine. I am also the new president of the Connecticut Chapter of the American Medical Directors Association. I am the medical director at one Skilled Nursing Facility. A question has arisen over the last year concerning the legal ability of the mid-level practitioners: Nurse Practitioners (APRNs) or Physician Assistants (PAs) to be able to remove PERIPHERALLY inserted central lines(PICC). The APRNs have been removing these lines when the patients are done receiving their antibiotics. Recently it was noted by one Long Term Care pharmacy that there is a DPH law (19.28 #3) which states "Only a physician may initiate and terminate a central vein access"

I believe this law was written when patients were sent out with femoral, internal jugular or sub-clavian central lines and before PICC lines were in common use. Patients are almost never sent out with the older type CENTRALLY inserted central lines any more.

The hard part is inserting the PICC lines and this is often done in hospitals by IV nurses who are only RNs and not even APRNs.

Removing a PICC line is very similar to removing any other peripheral hep lock IV from the arm, the exception being that the tubing of the PICC catheter is longer. This is a very low risk procedure that any nurse could really do safely and certainly the mid-level practitioners, (APRNs or PAs) ought to be able to do. Many nursing homes have credentialed mid-level practitioners to deliver care in the building. They are often more readily available to remove a PICC line than their collaborating or supervising physicians. Allowing them to remove the PICC lines can reduce potential morbidity for the patients who otherwise would have to await the physician to visit the facility and risk thrombosis or infection of the PICC line, or be sent out to the hosptial to have their PICC lines pulled out in the emergency room (which certainly is an imappropriate utilization of the Emergency Departments).

Perhaps the law needs to be amended to keep up with current practice of PICC lines and authorize at least mid-level practitioners (if not all nurses) to be able to remove PICC lines, a very similar practice to removing peripheral hep locks which they do already.

I appreciate your consideration and await your reply. Please to not hesitate to call on me if I can be of further assistance.

Jeffrey M. Kagan, MD, CMD
365 Willard Avenue, Suite 2-D
Newington, Connecticut 06111
Tel. 860-665-1571

Jeffrey M. Kagan, MD

HB6373

Dear Representative,

With the transformation of health care we are looking for changes that benefit the patient and are cost-effective. This bill does both. More and more patients in the long-term care facilities are requiring intravenous therapies during their stay. Certain IV therapies require a central catheter such as a PICC line in order to avoid vein and tissue damage that can occur when given through peripheral lines. Currently, long-term care residents must be transported by ambulance to and from the hospital to have the PICC line inserted at great distress to the patient and cost to all. Therefore, many facilities may utilize peripheral lines when a PICC line is more appropriate for the ordered therapy. The results can be detrimental.

This change in legislation would increase compliance with national infusion therapy standards, make the therapy safer for the patient, and decrease costs and liability.

We have the technology (portable ultrasound machines) available NOW that can be taken to the bedside, and the PICC line safely inserted by a skilled, educated, credentialed and validated Registered Nurse. These same skilled, educated, credentialed and validated Registered Nurses could also remove the PICCs in the Long Term Care Facility. Connecticut is one of the few states in the country that does not allow this procedure to be done in a Long Term Care Facility. Our neighbor states Massachusetts and Rhode Island have been performing PICC insertions and removals in Long Term Care successfully for many years. We already have the skilled Registered Nurses and the technology to safely insert and remove PICC lines. Connecticut is ready to move forward.

Thank-you,

Eve Curtin RN CRNI
President/Owner
High Tech Nursing Services/Infusion Plus Inc

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CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2011

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Is there objection to placing this item on the consent calendar? Is there objection? Seeing none, so ordered.

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, greatly appreciate the cooperation this afternoon. I have two additional items to place on the consent calendar at this time.

And the -- if we might stand at ease for just a moment.

THE CHAIR:

The Senate may stand at ease.

(Chamber at ease.)

SENATOR LOONEY:

Yes. Thank you, Mr. President.

Mr. President, I do have one additional item to place on consent at this time and that is calendar page 9, Calendar 330, would place that item on the consent calendar at this time.

HB6373

And then if the Clerk would call calendar

page 36, Calendar 273. I believe that item will be offered with an amendment.

Thank you, Mr. President.

THE CHAIR:

Without objection, Calendar 330 may be placed on the consent calendar.

And Mr. Clerk.

THE CLERK:

Calendar page 36, Calendar Number 273, file Number 455, Substitute for Senate Bill 1115, AN ACT CONCERNING THE REGULATION OF CERTAIN LOW EMISSION VEHICLES, IONIZING RADIATION AND STREAM CHANNEL ENCROACHMENT LINES BY THE DEPARTMENT OF ENVIRONMENTAL PROTECTION, favorable report by the Committees on Environment, judiciary and Transportation. The Clerk is in possession of one amendment.

THE CHAIR:

The gentleman from the 12th, Senator Meyer.

SENATOR MEYER:

Thank you, Mr. President.

I move acceptance of the committee's joint and favorable report and move passage of this bill.

THE CHAIR:

Number 5558, Madam President, move to place that item on the foot of the calendar.

THE CHAIR:

So ordered.

SENATOR LOONEY:

And one additional item, Madam President, calendar page 45, Calendar 452, Senate Bill Number 1059, Madam President, move to refer that item to the Appropriations Committee.

THE CHAIR:

So ordered.

SENATOR LOONEY:

Thank you, Madam President.

And Madam President, if the Clerk would call the second consent calendar.

THE CHAIR:

Mr. Clerk.

SENATOR LOONEY:

One additional item. Excuse me. And one additional item, Madam President, to place on the consent calendar. Madam President, that is calendar page 14, Calendar 432, Senate Bill 1192, would also move to place that item on the consent calendar.

THE CHAIR:

Thank you.

Mr. Clerk, would you read the bill.

THE CLERK:

Immediate roll call has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber. Immediate roll call has been ordered in the Senate on the consent calendar. Will all Senators please return to the Chamber.

Madam President, the items placed on Consent Calendar Number 2 begin on calendar page 3, Calendar 101, House Bill 6096; calendar page 6, Calendar 229, Substitute for Senate Bill 205; calendar page 9, Calendar 330, House Bill 6373; calendar page 14, Calendar Number 432; Calendar page 20, Calendar 483, Substitute for House Bill 5045.

SB1192

Calendar page 26, Calendar 51, Substitute for Senate Bill 852; calendar page 28, Calendar 108, Substitute for Senate Bill 1039; calendar page 29, Calendar 122, Substitute for Senate Bill 844; and calendar page 36, calendar 273, substitute for Senate Bill 1115.

Madam President, I believe that completes those items placed on Consent Calendar Number 2.

THE CHAIR:

Thank you, sir.

Will you once again announce the roll call vote. And the machine will be open.

THE CLERK:

The Senate is now voting by roll call on the second consent calendar. Will all Senators please return to the Chamber. The Senate is now voting by roll call on the second consent calendar. Will all Senators please return to the Chamber.

THE CHAIR:

All members have voted. All members have voted. The machine will be locked. Mr. Clerk, will you call the tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 2.

Total Number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The consent calendar has been adopted, Consent Calendar Number 2.

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Madam President.

Madam President, an additional item to mark go at the present time, calendar page 34, Calendar 242, Senate Bill 1173.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calendar page 34, Calendar 242, File Number 433 Senate Bill 1173, AN ACT CONCERNING QUALIFIED PRIVATE INVESTMENTS FOR CONNECTICUT INNOVATIONS, INCORPORATED'S PRESEED PROGRAM, favorable report of the Committee on Commerce and Export, Higher Education and Appropriations.

THE CHAIR:

Senator LeBeau.

SENATOR LeBEAU:

Good afternoon, Madam President. How are you today?

THE CHAIR: