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a continual flow of love coming Ms. Kirkley-Bey through my mailbox into my house and I want to thank you here and now for that.

Thank you for all your support and you know what, I'm always a phone call away and there I am.

Thank you, Madam.

DEPUTY SPEAKER KIRKLEY-BEY:

You're welcome, sir.

(Speaker Donovan in the Chair.)

SPEAKER DONOVAN:

Let's thank Marie Kirkley-Bey.

Deputy Speaker, long-time friend we were community organizers way back before you were all born. Thank you very much, Marie Kirkley-Bey, goodbye, God bless you.

DEPUTY SPEAKER KIRKLEY-BEY:

Thank you.

SPEAKER DONOVAN:

And will the Clerk please call calendar 348.

THE CLERK:

On page 13, Calendar 348, Substitute for House Bill Number 5514, AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES, favorable report by the Committee

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on Public Health.

SPEAKER DONOVAN:

Representative Betsy Ritter, you have the floor,
Madam.

REP. RITTER: (38th):

Thank you very much, Mr. Speaker.

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

SPEAKER DONOVAN:

Question is on acceptance of the joint committee's
favorable report and passage of the bill.

Will you remark?

REP. RITTER: (38th):

Yes, I will, thank you, Mr. Speaker.

As the bill's title implies this bill concerns
various, and I will say more than several, revisions to
the public health statutes.

Mr. Speaker, the Clerk is in possession of an
amendment, LCO 5017. I would ask that the Clerk please
call the amendment and that I be granted leave of Chamber
to summarize.

SPEAKER DONOVAN:

Will the Clerk please call LCO 5017 which will be
designated House Amendment Schedule "A".

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THE CLERK:

LCO 5017, House "A", offered by Representative
Ritter, et al.

SPEAKER DONOVAN:

Representative seeks leave of the Chamber to
summarize.

Any objection?

Hearing none, Representative you may proceed.

REP. RITTER: (38th):

Thank you very much, Mr. Speaker.

Mr. Speaker, this amendment is a strike all
amendment. It contains 48 sections. It deals, as I have
said earlier, with many various revisions to the public
health statutes. As I've indicated there are 48 of them.
I will quickly mention a few of perhaps the most salient
and I'm sure we may have questions later on.

Thank you mis -- yes -- thank you.

Mr. Speaker, very briefly these revisions concern the
following items and I'm going to be fast: fetal death
certificates, marriage licenses, the Connecticut tumor
registry, patients with tuberculosis, qualifications to
be the state director of the Office of Oral Public Health,
ground water and regulations for subsurface sewage
disposal systems installers, youth camp physicians,

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massage therapy, AEDs in institutes of higher education, the lupus advisory panel, licensure requirements for drug and alcohol counselors, psychiatrists.

Four bills that came to us from the Senate, Mr. Speaker, Senate Bills 414, 276, 55 and 368 and in addition House Bill 5333 which concerns organ donation education and awareness.

Mr. Speaker, in example -- in addition we have a section on physician assistants who wish to take the fluoroscopy exam and a short section on advance practice registered nurses.

I move adoption.

SPEAKER DONOVAN:

The motion is on adoption.

Will you remark further? Will you care to remark further?

Representative Perillo.

REP. PERILLO: (113th):

Mr. Speaker, thank you very much.

As -- as the Representative stated this is a very lengthy piece of legislation. There are a number of different sections so I would try -- I would like to try and do my best to ask some questions about those sections so we have a better understanding of exactly what it is

we have before us.

So if I may, through you, a few questions to the proponent.

SPEAKER DONOVAN:

Please proceed, sir.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

In -- in Section 3 which addresses the state tumor registry, we are adding that pathology reports shall be information that is obtained. If -- if the Chair of the Public Health Committee could just give us a better understanding of exactly what that means. What information this would bring to the tumor registry.

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

Yes. Current law requires significant information to be included with items that come to the Connecticut tumor registry but does not currently specify the complete pathology report. This requirement brings that report to the tumor registry.

Through you, Mr. Speaker.

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SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And I appreciate the answer to the question as it pertains to the tumor registry. I would like to, if we could, move to Section 4 of the bill which begins at line 52 for reference and here we are discussing reciprocal agreements for the transportation -- interstate transportation of individuals afflicted with tuberculosis and for the medical treatment of those individuals.

So my question is, are there specific facilities -- state run facilities in the State of Connecticut where we direct and treat and house our patients who do have tuberculosis?

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

And I thank the Representative for this question. Currently, we can treat tuberculosis in the State of Connecticut but as many members of the Chamber may know this has been in more recent years complicated by the fact

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that in many cases we have multi jug -- drug resistant strains of tuberculosis that require very specialized care and Connecticut does not currently offer that.

There are institutions in both Massachusetts and New Jersey and this change in the statute would enable those reciprocal agreements to be made so that patients can take advantage of that treatment.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And, again, I thank the Chair of the Public Health Committee for that answer.

If we could just briefly move to Section 5 which begins at line 58, we are changing in this section the qualifications to be the director of the Office of Oral Public Health. Currently in statute it states that that individual shall have a graduate degree in public health and we are changing graduate degree to experience in public health.

And just a -- a very, very simple question why is that? Is that because we're having difficulty attracting individuals with graduate degrees? Is it because there's

somebody really great in mind who doesn't have a graduate degree but who has tremendous experience?

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Yes, the Representative is correct. We heard from the Department of Public Health that we have had difficulty in filling this job and this change should enable them to overcome that difficulty.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

And, again, I thank the Chair of the Public Health Committee for that answer.

If we could move to Section 7 of the bill, this is somewhat complex, maybe difficult for folks in the Chamber to understand. Admittedly, I -- I don't understand what all of these things are but if, you know, the Chair could offer some explanation of what, you know, by -- by removing the word radionuclides and replacing it with a litany of

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other specific items, could there be some -- a very, very brief and -- and elementary explanation as to what that impact is by changing this language.

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Current law requires private residential well testing for all radiomuclia -- nuclides. Those are radioactive contaminants that could be found in groundwater. Instead, this change allows the local public health's directors to require testing for specific substances and those more specific substances mentioned are arsenic, radium, uranium, radon or gross alpha emitters.

By law, local public health directors can only require this testing if -- if there's reasonable grounds to suspect that these contaminants are present. And in addition, they are, as we've heard in testimony on previous bills, able to require such testing for other pesticides, herbicides or organic items.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

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Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And I thank -- I greatly thank the Chair of the Public Health Committee for that answer to a very complex question.

If we could move briefly though to Section 8 which discusses subsurface sewage disposal systems.

Just -- just very briefly in -- in lines 99 and 100 we are changing the definition of a subsurface sewage disposal system cleaner from any person who regularly offers services of cleaning to any person who offers. We're removing the word regularly. I am wondering what impact that has on the industry of subsurface -- some -- subsurface sewage disposal system cleaners.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this change will allow the Department to take action against individuals that practice the work of a subsurface sewage disposal system cleaner or installer in many cases without a license. Essentially

it will tighten the requirements around requiring
licensure in order to do this work.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

And just a follow up to that though, you know by
removing the word regularly it would suggest to me that
if an individual occasionally as in once a year, you know,
does this type of work and perhaps even does this type of
work on their own property in their own system would need
to be licensed. Is -- is that correct?

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I believe that to be the case.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much.

And I appreciate that so to clarify even if you do

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it. And I understand this is pretty technical and you're not necessarily going to be the kind of guy who gets all this equipment and does it once a year on their own property but I did just want to clarify that this would apply to everyone.

Further in that section, though, we -- we do see a bit of a significant change in terms of penalties for engaging in the occupation without a license. Currently, that penalty is \$100 and we are changing that penalty to \$10,000. That is a giant leap and I am just wondering what the rationale is behind that massive change. We are, (a), requiring that more people be licensed and we're, you know, hitting them over the head with a sledge hammer if they're not so what was the rationale behind the change from \$100 to 10,000?

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, I would first like to point out that it raises the maximum penalty to \$10,000, not necessarily stipulating that that be the only penalty. But also, Mr. Speaker, we heard in testimony from the agency, from the

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Department of Public Health, that the problem is that many individuals who pro -- who chose to practice without a license, as I previously discussed with the Representative, will chose to absorb that \$100 fine and may then proceed to provide substandard work.

The cost to the homeowner in this case, and I will also add the surrounding homeowners, can be extremely significant, thousands and thousands of dollars to fix these mistakes. That is the rationale for the change.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And, again, I thank the Chair for her answer to the question.

If we could move though to Section 10, I -- I do believe this is something that's very, very important and will help our youth camps here in the State of Connecticut. But what we are doing here is changing the types of physicians who can actually provide care in those youth camps and we are eliminating some language though that does give me some cause for concern.

We are eliminating the requirement that the in -- that

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the physician be board certified in pediatrics or family medicine. Now, these youth camps obviously have children. One would expect that any physician providing care in that youth camp would have some sort of expertise in the treatment of pri -- you know primary care or children.

So I'm wondering, I mean, are we leaving ourselves in a situation where a podiatrist is going to be, you know, on call at a youth camp to treat children. I -- I'm not sure whether that's something we really should be exploring.

Maybe I'm overanalyzing this, but if the Chair could give some sort of sense as to what the intent is here.

Through you.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, this change allows any physician or surgeon, licensed and in good standing in any state, to practice here as a youth camp physician for up to nine weeks and we did hear from the agency that there have sometimes been difficulties in obtaining the services of a licensed and in good standing practitioner -- medical practitioner

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to do this work and that is the reason for the change.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And, again, I thank the Chair of the Public Health Committee for her answer to the question.

If we could move though to Section 15 where we are discussing the practice of massage therapy, this sort of seems to be the session for that. I note though in -- beginning on line 265 we're stating that in order to engage in the practice of massage therapy one must have passed the National Certification Examination for Therapeutic Massage and Bodywork.

However, on line 267 it states that the Nation -- well this is language we're adding by the way, it states that the National Certification Board for Therapeutic Massage and Bodywork's national examination for state licensing option shall not satisfy the examination requirements.

So on line 265, we're saying that you need to have passed the examination from this organization and then we're saying this organization's exam -- or one of this organization's exams does not qualify. If there could be

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some sort of clarification.

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The request from the Department of Public Health is made in this manner so that we can speak specifically to the education that is required of someone to graduate from one of these schools and that is the reason for this specific change.

Through you, Mr. -- and in addition, Mr. Speaker, the national exam that is mentioned in lines 267 to 269 speaks to licensure and the agency has requested this as I said to address the specific educational requirements.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And, again, I thank the Chair of the Public Health Committee for her answer to the question.

If we could move briefly to the next section, Section 16, you know this -- this is actually something that I think

is very, very good, something that has been discussed over many years and its time has come but as we look at some of the details of it I do have some questions specifically beginning on line 277 where it's stating that institutions of higher ed must provide and maintain in a central location that is not more than one-quarter mile from an athletic facility at least one automatic external defibrillator.

I'm concerned though that in some cases there may not be a central location that is within one-quarter mile of a specific athletic facility. Do we foresee that as being a problem? Is -- is it expected that an organization -- a -- a facility could work with DPH to come up with an amenable situation? If there could just be some clarity.

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Hello -- oh through you, Mr. Speaker, sorry about that, yes and thank you.

In answer to the Representative's question, that is precisely what occurred when we addressed this specific language. We did hear testimony from the independent

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colleges as well as from the state universities in Connecticut expressing some concern about how this was worded and it was precisely this requirement that in -- in crafting this requirement it met the physical issues at those institutions and they are quite comfortable with it.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

And a follow up to that. I can imagine there might be an institution of higher education, then in fact I would imagine most have multiple premises where, you know, athletic activity takes place. It is conceivable -- well if there were a situation where in those multiple premises they were not close enough such that one AED could be within one-quarter mile of all of them, is it anticipated that some institutions of higher education would require more than one AED to meet the requirement in the amendment?

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

While we can't speak to every possible circumstance and it's clearly always possible that that could happen, it is our understanding that this language works for those institutions.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

And further on in that section, where we're getting away from the location of AEDs to the training of individuals who would be utilizing these AEDs, we are stating in -- beginning in line 284 that at least one licensed trainer or other individual who's trained in CPR and the use of the AED shall be basically onsite and it states specifically on the premises used by the athletic department during all hours of intercollegiate sport practice, training or competition.

And I'm just wondering does that include situations where it is not an organized team, where perhaps it is some sort of intramural team or whether it is just students in a pickup game of basketball. To which instances would this apply?

Through you, sir.

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SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I believe the language was specifically crafted to involved a sport practice, training and competition and not to involve those informal uses of these facilities that may not necessarily be planned.

Again, this language was drafted along with the affected institutions and it is my understanding that they are also comfortable with this section.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, and I -- I appreciate the answer to that question. I -- I did want to mention one section of this language that does bother me, and I have discussed this with the Chair of the Public Health Committee. In the language, it does state that if an AED is utilized in these premises, that after utilization of that AED there would be a requirement that the user of the AED notify -- you know -- you know dial 911 or -- or notify the emergency medical services.

However, it should be noted that the American Heart Association's guidelines state that for adults that 911 -- 911 call be made before use of the AED and not after so this may be something we should address in the upcoming year perhaps in this -- next year's version of this bill just to make sure we clean that up and we're not, you know, putting into law something that is inconsistent with best practice in the treatment of cardiac arrest.

But I would like to move on a little bit and let me -- let me make sure I find the section so -- so the Representative can catch up. I'm now moving to Section 43 which is on page 30 -- begins on page 36 of the bill at line 1085.

And we're -- we're moving into the world of acupuncture here. I'm specifically looking at the paragraph that begins on line 1147.

SPEAKER DONOVAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I apologize to the Representative, if he could restate his question.

SPEAKER DONOVAN:

Representative Perillo please proceed.

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REP. PERILLO: (113th):

Thank you.

The reality is -- I didn't state a question yet. I just wanted to make sure the Representative was able to get to the section before I asked it.

But it looks like she's --

REP. RITTER: (38th):

She's working on it.

REP. PERILLO: (113th):

-- there so I'll ask my question. Specifically on line 1151, we're talking about the qualifications needed for license renewal. On line 1151, it says earn not less than 30 contact hours of continuing education approved by the National Certification Commission for acupuncture and oriental medicine.

If there could just be some clarity as to what contact hours are. So those 30 contact hours, what is a contact hour? So that, you know, perhaps for the benefit of the Chamber and those individuals who are seeking a license renewal they can understand exactly what they need to do during those 30 hours.

Through you, sir.

SPEAKER DONOVAN:

Representative Ritter.

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REP. RITTER: (38th):

Through you, Mr. Speaker.

In my opinion, that would represent a face-to-face discussion in the education process and I will contrast that perhaps with many of the forms of online education that we have heard about that would not qualify, in my opinion, as a contact hour.

Through you, Mr. Speaker.

SPEAKER DONOVAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Mr. Speaker.

So to clarify, this is not necessarily clinical time where acupuncture would be practiced.

REP. RITTER: (38th):

Right.

REP. PERILLO: (113th):

This is just simply in class contact time where there is one-on-one education, just to clarify.

Through you, Mr. Speaker.

Welcome, Mr. Speaker, it's good to see you up there.

(Deputy Speaker Ryan in the Chair.)

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DEPUTY SPEAKER RYAN:

Representative Ritter.

It's nice to be seen.

REP. RITTER: (38th):

It's a pleasure to see you also, Mr. Speaker.

Through you, Mr. Speaker.

I would agree with the Representative's description.

DEPUTY SPEAKER RYAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And I thank the -- the Chair of the Public Health Committee again for her answer to yet another question.

If we could move to Section 44, which begins at line 1244, I do have a brief question where we're discussing an advisory council on organ and tissue donation education. This is actually something where we saw an earlier version of this bill and discussed it in committee and it was something that was actually a little bit controversial. It involved the Department of Motor Vehicles and perhaps would have involved additional fees on li -- on vehicle registration.

So just to clarify is there any cost associated with this and is there any revenue that would be necessary in

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order to make this advisory council work properly?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The Representative is correct. This is a different or pared-down version from the original proposal that we saw to address organ and tissue awareness and education and there is no revenue stream or cost anticipated with this bill and this particular section.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And, again, I thank the Chair of the Public Health Committee for her answer to the question.

The last section of the amendment before us, Section 48, is -- is a little bit different in that it seems to involve the licensure of advanced practice registered nurses. It is in addition to the language that currently exists in statute and -- and it is stating that an

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individual may become licensed as an APRN if on or before December 31, 2004 they've completed an -- an APRN program that a national certifying body identified and Sub 2, Sub A recognized for certification of an APRN, clinical nurse specialist or nurse anesthetist and I'll get to the rest later but I'm wondering how we came up with the date of December 31, 2004.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

That date was arrived at with discussions between the APRN's association, the Department of Public Health and most specifically its licensing division.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

So just to further clarify, we are stating, in lines 1660 through 1661, that the national certifying body must be recognized for certification of a nurse practitioner, clinical nurse specialist or nurse anesthetist and I just want to clarify that those are indeed ors and not ands

because I would imagine there may be some boards
that -- that don't include all of those individuals.

So just to clarify, is that the case?

Through you, sir.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Yes.

DEPUTY SPEAKER RYAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much.

And, again, I appreciate the answer.

In line 1662, and this may be my last question about
this, it says the applicant must hold a current license
as an APRN in another state that requires a master's degree
in nursing or a related field for such licensure.

So my -- my question very simply is how many -- do
all other states require a master's degree in nursing or
a related field? Are -- are we limiting the number of
states or is this basically for the other 49?

Through you, sir.

DEPUTY SPEAKER RYAN:

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Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

This section would limit it to states that specifically require that master's degree.

Through you.

DEPUTY SPEAKER RYAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

So we have a date of December 31, 2004 triggered by certification in another state only two of which exist. This seems to be kind of narrow in scope. How many individuals do we expect would be impacted by this particular section of the bill?

Through you, sir.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I can tell the Chamber that in our discussions with the Department of Public Health, we were aware of one individual in this circumstance. I also think it's fair to represent the Department's position as thinking there

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might be a very few others in the future but it would be a small number.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And -- and that is the answer I expected but -- but I -- I appreciate what the Chair has said. One final question on this area. On line 1664 it states that an individual must -- that the state must require a master's degree in nursing or a related field for such licensure.

I'm just curious as to whether or not there's some sort of definition or guidance as to what a related field would be.

Through you, sir.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

That's a great question. It is not addressed in this amendment.

Through you, Mr. Speaker.

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DEPUTY SPEAKER RYAN:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Mr. Speaker.

And I -- I appreciate the Chair of the Public Health Committee's time in answering those questions. I -- I do want to say that this amendment is something that was worked on in a very bipartisan basis. It is something that brought all stakeholders to the table on all of these issues.

It is something that the committee does very methodically and very thoroughly to ensure that appropriate issues are addressed and that they are addressed properly and I -- I really do think that quite frankly it is a model as to how all committees should pursue bills like this to ensure that, to the best of our ability, what we're doing and what we're putting into statutes does actually make sense, that it is workable and that it is fair.

And -- and I do believe that the process that we utilize in the Public Health Committee does exactly that. I would urge adoption of the amendment that is before us. You know as -- as the Chair did say with her opening remarks this is a lengthy amendment. It covers a number of

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different areas. There's probably a ton of stuff to love. There may or may not be one or two things not to love but this is a very, very good amendment and I would urge adoption of this Chamber.

Through you. Thank you.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative O'Neill of the 69th district.

Representative O'Neill is rising to speak. I'd just ask the Chamber to quiet down. It is getting kind of loud. There's a very interesting exchange going on between Representative Ritter and the various individuals asking her questions and I think we'd all want to be interested in this. If you do have conversations, could you please take them outside?

Thank you.

Please proceed, sir.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

I have a few questions if I may for the Chair of the Public Health Committee.

The first one relates to I guess it's Section 9 where the -- and I'm looking at particularly line 114, where the penalty for someone who does subsurface sewage type work

and disposal is going from \$100 to \$10,000. I -- I don't recollect whether the previous speaker had asked question -- I know he'd asked a question about this section but I don't remember if he asked specifically about the -- the fine that's involved here.

So my question is first off why is it being increased by what seems like an enormous amount? I think it's a hundredfold increase in the amount of the fine.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

As we had previously discussed on this particular section, the current fine of \$100 is being proposed to be increased to a maximum of \$10,000 and the Representative might also note that we had some previous discussion that the problem that is being addressed here is that there are people that work perhaps occasionally in this area of subsurface sewage disposal system installation without a license and when that happens currently we've had situations where individuals who do practice without that license may chose to absorb the current fine of \$100 and then provide substandard work.

In many cases, as many people may know to their sorrow, substandard work in this area can produce mistakes that cost the homeowners thousands of dollars to fix and so it was at the request of the Department of Public Health that we do this to remove that incentive.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

But the -- the amount here of \$10,000, I guess my question is how was that number arrived at since we started out at such a small number previously?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The agency came to us with a -- a discussion about instances where their current size of the fine, the \$100, was considered so insufficient that people were working as installers without being licensed. Their desire was to increase this maximum penalty to the point where indeed it would become very much of a penalty to do this work

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without benefits of licensure and that was their request.

I will tell you, Mr. Speaker, that in oral discussion in the Committee we asked about other states and how this penalty measured up against the situations in other states and the information that we received from the agency was that it's compared to what happens in other states reasonable.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative O'Neill.

REP. O'NEILL (69th):

Yes, and thank you, Mr. Speaker.

Well, I guess I'm just wondering why it stayed at \$100. When was the last time this was changed or when was this last looked at as -- as far as this penalty since we've been -- I mean the installation of subsurface sewage systems and the cleaning of them is certainly not something that's just started to happen in the State of Connecticut. It's been going on for decades.

So I'm just curious as to, in effect, why, if it's a serious problem, why hasn't it been addressed previously? Why is it still \$100 which sounds like a very low fine?

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Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I do not know the date that this was last addressed.

Through you.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And are there any other actions that the Department of Health can take besides this particular fine? Is there any kind of sort of pursuit of some sort of damages that are involved, aside from the homeowner who might be damaged, but is the Department in a position to seek a restraining order or to do anything besides this \$10,000 fine?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

We did not discuss other actions in conjunction with

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discussing the increasing of this fine.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And serving on the Judiciary Committee, we frequently see bills that come from other committees that contain fines and I believe that the rules call for (inaudible) matters to be referred to the Judiciary Committee if I believe the civil penalty and I believe that's what this -- well let me ask that -- stop there and ask is this supposed to be a civil penalty? It just says a penalty and it talks about a fine. Is this intended to be a civil penalty?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you -- I'm searching for the language, Mr. Speaker.

If the Representative could please cite the line number it would be helpful.

REP. O'NEILL (69th):

The line number in question in the amendment is line 114 -- actually it starts on line 113 and 114 and then 115 of Section 9.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

My understanding, and it may or may not be correct, is that that would be a civil penalty, Mr. Speaker. There is no criminal component mentioned in this language.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And so following on with -- now that we know that it's a civil penalty and civil penalties -- I believe that if they exceed \$2,000 are supposed to be referred to the Judiciary Committee. I'm just wondering why this matter was not referred to the Judiciary Committee.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

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Thank you, Mr. Speaker.

Mr. Speaker, this went through our usual process and there was no referral to the Committee on Judiciary that I am aware of.

Through you.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

Does the Chair have a recollection as to when this bill was JF'd out of the Public Health Committee?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I believe that date would have been on about -- on or about March 28th, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

It's -- it's my recollection that the Judiciary's JF deadline was in April. I'm just wondering was there ever

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any thought given to sending it to the Judiciary Committee instead of sending it to the floor?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I do not believe I specifically recall any discussion in the Committee on Public Health as to whether that should or should not occur.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And I understand the -- the comment was made that the matter went through a -- the -- the normal referral process and -- and I'm -- I'm not quite exactly sure what that means. I -- I know I once served on the Bill Review Committee on the -- on the -- on this side of the aisle but I'm not quite sure what the process looks like on the other side of the aisle since the bills are sort of -- initially sort of steered and -- and directed on that side.

But is -- is the Chair of the Judiciary Committee consulted as to whether or not a bill like this would be referred to the Judiciary Committee?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative -- your question is directed to the Chair of -- of Public Health, sir, right?

REP. O'NEILL (69th):

Yes -- yes Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

I apologize, Mr. Speaker, if the Representative could please restate his question.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Yes, the question is is the -- as part of that referral process is the Chair of the Committee, which is at least possible and in this case Judiciary, is the Chair of the Judiciary Committee consulted to determine whether or not a matter should have been referred or should be referred to the Judiciary Committee?

Through you, Mr. Speaker.

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DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, I would like to yield to the Chair of the Committee on the Judiciary to answer the Representative's question.

REP. O'NEILL (69th):

Mr. Speaker, I -- I don't believe yields in this circumstance are appropriate.

DEPUTY SPEAKER RYAN:

Right, I -- I think she's --

REP. RITTER: (38th):

I'm sorry, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Excuse me. I believe she's not understanding and I think my hand signal threw her off too.

You're asking her a question about the chairman of Judiciary. Right?

REP. O'NEILL (69th):

Well, yes, Mr. Speaker. I'm trying to -- she said it was a normal referral process. I'm just wondering if the Chair of Judiciary is consulted. Perhaps the two co-chair -- the chairs of the committees talk about which

bills should go to which committee if that's part of the referral process or not.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

At the time, I am not aware of any discussions either I or my co-chair had with either of the chairs of the Committee on Judiciary.

Through you.

DEPUTY SPEAKER RYAN:

Representative O'Neill, it's kind of -- it's been brought to my attention that we should be really talking about the amendment and the content of the amendment itself, not about the process.

If you have a question about the process, possibly that should be directed to the Majority -- the Speaker or the -- or the Majority Leader.

REP. O'NEILL (69th):

Well, Mr. Speaker, this -- when we look at our rules the cognizance of the Committee of Judiciary covers matters that are I believe it's either 2,000 or 5,000, I think it's still \$2,000, any civil penalty. This is

clearly a civil penalty. It's clearly in excess of the \$2,000. It's a pretty substantial increase. If it was going from 9 to 10,000 one might say that the incremental change is relatively small but in this case we're talking about a one hundredfold increase in a penalty that's, you know, pretty substantial where one might think that it's the kind of thing that should go to the committee that's suppose to review penalties.

And so I -- I think since this is in the amendment, it's not in the underlying bill, it's part of the amendment, to determine whether or not this material -- it is also in the underlying bill but to determine whether or not a -- a penalty of this dimension should be looked at by the Judiciary Committee I think is an appropriate question to put to the Public Health Committee.

As I say, I don't really understand how the referral process works and all of its details. I know that there is a bill screening committee that eventually looks at these things and the Speaker makes allocations or decisions about where to direct matters for the post-JF report after the first committee. They decide how to do it but it's -- it's a process, the details of which I'm not familiar with.

So that's what I was trying to get at to try to find

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out if perhaps the Judiciary Committee co-chairs had already passed on this and looked at it and decided it wasn't worthy of the attention of the Judiciary Committee or it wasn't something that was -- that they should be looking at. That's -- that's the purpose here because I'm trying to get a sense of when a matter really belongs -- since the rules say it should be going to the committee if the civil penalty exceeds \$2,000, why this one didn't since it's clearly seen as something important enough to bump the penalty up to this \$10,000 level.

Perhaps I could direct the question, as a parliamentary inquiry to the -- the Speaker.

DEPUTY SPEAKER RYAN:

I wish you would.

REP. O'NEILL (69th):

Why was this -- was this considered and if not why not?

DEPUTY SPEAKER RYAN:

Actually, when you began to ask the question initially I turned to find out if my answer was going to be correct and I've been confirmed in my response is that the threshold on this particular fine does not reach the level that we would make it a referral and they're double checking to make sure that I'm right in that answer.

Do you want to just stand at ease for a second?

REP. O'NEILL (69th):

Thank you.

(Chamber at ease.)

DEPUTY SPEAKER RYAN:

The Chamber will come back to order.

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

If I may, I would like to direct a question or -- or two to the Chair of the Judiciary Committee.

DEPUTY SPEAKER RYAN:

Please proceed, sir. I believe the Chairman's ready for you.

REP. O'NEILL (69th):

Through you, Mr. Speaker.

Has the chairman of the Judiciary Committee had an opportunity to take a glance at the bill before us -- the amendment actually which is LCO 5017 and the underlying bill?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

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Representative Fox.

REP. FOX: (146th):

Through you, Mr. Speaker.

I -- I have had an opportunity to take a glance at the -- the pages that we -- that are -- that are being referred to dealing with the penalty.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

In -- in the -- in the amendment as well as the underlying bill there's reference made to an increase of a fine that's in Section 9 of the -- the amendment at lines 113, 14 and 15, bumping a fine from \$100 up to \$10,000.

It is my understanding that, ordinarily, a matter where a fine is being imposed or increased to that level would merit a referral to the Judiciary Committee and that this bill never was so referred. But I would ask the Chair of the Judiciary Committee if he could indicate whether, based on the earlier colloquy indicating that there is a serious problem of installers ignoring the fine, absorbing it as a cost of doing business, that the \$10,000 fine does it -- does it seem to be an appropriately sized fine given the other kinds of other regulatory civil fines that are imposed?

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Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Fox.

REP. FOX: (146th):

Thank you, Mr. Speaker.

And through you, it -- it does appear to me at least that the current fine of \$100 would be a willfully low amount given the -- the type of damage that can be caused by those who are not licensed who may perform this work. The -- what is the correct fine could be, you know, a matter of -- of judgment that people may disagree with but, you know, a \$10,000 cap would seem appropriate given the -- the type of damage that can be caused when this work is done incorrectly.

So through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And I thank the chairman for his -- his answer. I had not intended to bring the process to quite a halt when I asked that question and I -- I agree. I think a \$10,000 fine seems appropriate given the amount of damage that can be caused if a sewage system is improperly serviced or a

septic system is improperly installed could cause significant environmental damage and I would note that I think we have seen fines go through the Judiciary Committee this year alone where numbers of \$100,000 are attached to matters that could cause environmental damage and pollution releases which I -- I imagine could occur in -- in this circumstance as well.

I -- I do have one more question for the co-chair of the Public Health Committee and it is on line 386 of the amendment and it is the word, it's being added there. Initially when I read it I thought it was psychiatrist and that it was misspelled. I'm assuming that it is, in fact, some other kind of medical personnel. It's a physiatrist I guess if that's the right pronunciation. Through you, Mr. Speaker, if I could just have an explanation as to what exactly is that type of person?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Yes, I would thank the Representative for that question. We all learned something. A physiatrist who, under this -- the terms of this language would then be

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defined as a pain management specialist, is a rehabilitation physician specializing in nerve, muscle and bone injuries or illnesses that affect how a person moves.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

So is -- is this someone who does something like physical therapy type work? In other words that they work on helping people move or massaged or -- or what is exactly -- do we have a better idea? I mean I understand it's suppose -- what it's suppose -- the end result is suppose to be but I'm wondering how they get there.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

This specialist is a physician trained in the specialty of physiatry and deals with issues around pain management whether that be in the area -- or from movement or from illness and it very well those treatments may

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involve rehabilitation of a type one commonly associates with physical therapy that would be delivered either by that person, the medical doctor, or a physical therapist depending, of course, on the diagnosis and the condition of the patient.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative O'Neill.

REP. O'NEILL (69th):

Thank you, Mr. Speaker.

And I thank the co-chair for her answers to my questions and I believe that's the end of them.

Thank you very much, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, sir.

Representative Srinivasan of the 31st, you have the floor, sir.

REP. SRINIVASAN: (31st):

Good afternoon, Mr. Speaker.

This afternoon we're looking at a huge document, almost about 55 pages, and I want to ahead of time thank the esteemed chairwoman of the Public Health Depart -- Committee for the questions which we may be put -- which I will be posing to her and some of them,

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hopefully not redundant, but just for my own clarification for areas that were briefly touched upon by our ranking member a short while ago.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Please proceed, sir.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker, lines 82 -- and I know we have -- we have addressed this issue briefly earlier this afternoon, this radionuclides are these the ones that are listed individually? Are they the only radionuclides or could they be others as well?

Through you, Madam Speaker -- through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I don't believe there is anything in this section that would lead one to think there might not be other ones. I cannot name them.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

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REP. SRINIVASAN: (31st):

I'm sorry, Mr. Speaker, I did not -- there's so much noise that I did not -- I was not able to hear what the chairwoman said.

Thank you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Once again, we're having trouble hearing questions and answers. We'd ask people to take their conversations outside and try to keep the noise to a low roar in here.

Representative Scrinivasn, if you'd like to repeat your question -- or actually I think Representative Ritter you want to repeat your answer I believe is what is the problem. He did not hear your answer, Ma'am.

REP. RITTER: (38th):

Thank you.

Through you, Mr. Speaker.

Mr. Speaker, I do not believe there is anything in this section of the amendment that indicates that there may not be other kinds of radionuclides that are not mentioned, I just don't know what they are.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you.

Representative Srinivasan.

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REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

I thank you for that answer, it is very clear now. So if these radionuclides that are being listed here -- are these the only ones, through you Mr. Speaker, that they will have to be evaluated?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, that is my understanding.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

Will the cost for the property owner be any different when this evaluation has to be done?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

This amendment does not change the assessment of the costs from the current law.

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Through you.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

Through you, Mr. Speaker.

Was there a request or a specific reason why these had to be looked down on an individual basis?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The specific request came from the Department of Public Health and they specifically named the substances: arsenic, radium, uranium, radon or gross alpha emitters.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you.

Through you, Mr. Speaker.

Going to lines 119 that talk about the youth camps, once again, my concern, through you Mr. Speaker, is the

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background of the physicians who are going to be taking care of our youth that come to these camps. The children, the youth that come to the camps a) are away from home. They do not have their own physician that has been taking care of them for whatever length of time, years, and now they are in this new location at a camp and my concern is the physician taking care of them may not have the adequate training because it can be a physician -- I'm well aware a physician with a license but that license does not have to be in a) pediatrics or b) in family medicine.

Through you, Mr. Speaker.

Was there a reason other than that physicians are not easy to get during the summer months with a youth camp that we had to change from the -- the -- the pediatrician and the family practitioner? I heard earlier in the conversation with Representative Perillo that the request was because physicians were not there that they could come to these camps. Is that the reason?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

It is my understanding from discussions with the

Department of Public Health that there have been instances where there may have been either problems obtaining a specific physician as falls under the definition of the current statute, or indeed situations where there might be a need to have or a desire to have a physician who will have a license in good standing from another state and that would be a physician or surgeon to do this work.

I would point out, Mr. Speaker, that this pertains only to youth camps of a duration of up to nine weeks.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker, for that clarification from the esteemed Chair.

Through you, Mr. Speaker.

Am I to then understand that if only a primary care physician, a pediatrician or a family practitioner is not available for that youth camp for that nine week period, then only will we be going to a licensed physician with the good standing?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

That very well could be the circumstance. It might be the desire of the youth camp but this amendment only states that it may be a physician or a surgeon with a license in good standing from another state.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

It is -- is it then the intent that it is up to the -- youth camp executives or managers or whatever you call them, it is up to them to decide as to what physician they're going to get to take care of the youth for the nine week period?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The physician is hired by the youth camp. That would be their decision.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

Will the families sending the children to this youth camp, will they be notified in any way that the physician who is going to be taking care -- or in charge of a youth camp for nine weeks, is a physician with a license in good standing but not necessarily a pediatrician or a family practitioner?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

There is nothing in this amendment that requires a specified notification.

Through you.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you for that answer.

Through you, Mr. Speaker.

We -- we had referred to the massage therapists and their certification and I was not clear with the answer

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that I heard earlier in the afternoon in the conversation with our ranking member.

So I just -- for me to comprehend that, through you, Mr. Speaker, the massage therapists will be getting the National Board Exam requirements but having passed that I was not clear that that pass -- the passing of that exam was adequate enough and they'd need some other thing, the state passing scores for them to be able to qualify and have a massage parlor.

Through you, Madam Speak -- Mr. Speaker -- I keep -- through you, Mr. Speaker, would you be kind enough to have the chairwoman explain the difference between those two exams, one by the National Board and the other through the state.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Before answering that question, I'd like to correct a misimpression that may have been given by the Representative. This does not address the operation or definition actually of a massage parlor. This section discusses professionals who might engage in the practice

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of massage therapy and I -- I just wanted to first clarify that.

Through you, Mr. Speaker.

This section mandates that a person who graduates from a school of massage therapy that that school must be assigned a current school code by the National Certification Board for Therapeutic Massage and Bodywork. That would be necessary for their educational requirements to satisfy the requirements of the State of Connecticut prior to licensure.

So as I had stated before, this language deals with the education requirements necessary to become licensed as a massage therapist in the State of Connecticut.

Through you.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

And I do want to thank the chairwoman for that -- for that clarification. I did mean massage therapist as well though I did the use word massage parlor and I appreciate that very much.

Going to lines 277, where we talk about the external defibrillator which has been touched upon earlier in our

conversation this afternoon, through you, Mr. Speaker, a central location of this external defibrillator, through you, Mr. Speaker, who determines the central location in the athletic field?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

One moment, Mr. Speaker.

Mr. Speaker, it's my understanding from a reading of the language that the central location would be chosen by the institute of higher education.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

Is the -- through you, Mr. Speaker, is the number of defibrillators that are needed based on the size of the athletic field?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, no.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

Through you, Mr. Speaker.

If multiple events are going on in these athletic fields, which obviously happens all the time, do we need one defibrillator per event or is just one enough to cover the entire athletic field though multiple events could be occurring at the same time?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I would point the Representative to the language on line 280. It states that the requirement is at least one.

Through you.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

When college kids get together in these athletic

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fields to practice, to train, and when they do that every single time is it necessary to have the athletic director trained in CPR and the use of a defibrillator?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, the requirements are found in -- beginning in line 280 where -- I'm sorry, excuse me, 284, where it specifies that there must be at least one licensed athletic trainer or other person appropriately trained in the use of this on the premises of the athletic department during the hours of sport practice, training and competition.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

Going through lines 328, where we talk about the contact hour of training or education in any five of the ten mandatory topics, through you, Mr. Speaker, this continuing education, is that any different than the -- the

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hours that we can get in the other forms of education?

Through you.

Can they be -- do they have to be a live education? Could it be on the web? Could it be on the internet? Is that -- is -- are these hours any different for getting the necessary credits?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, and for the purposes of the Chamber.

We are now talking about continuing education requirements for dentists and the language states that that be a contact hour of training or education. We had a previous discussion about the definition of contact hour which I informally described as a face-to-face implying contact activity.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

I appreciate that clarification and that is why the

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confusion of it is contact hour or education so I could not understand the or there. Is it all contact or is -- can be education and in work form?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

My reading would be that it would be one contact hour of either training or education.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Through you, Mr. Speaker.

So if we have one contact hour of one hour of education, we do not need that one hour of contact training?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

It's my -- I will restate my understanding of this

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language on line 328 and it would be that it could be either one contact hour of training or one contact hour of education and, as we discussed earlier, that would imply something more like a face-to-face situation rather than perhaps an online process.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

Just give me a moment to get to the next lines in this huge -- through you, Mr. Speaker, moving all the way from 328 to line 1186 and that why -- that's why it took me a couple of moments to move those pages and I appreciate that indulgence, Mr. Speaker.

Through you, Mr. Speaker.

When for reasons of medical disability or illness a the commissioner can grant a waiver of continuing education and in this case they are looking at acupuncturists. Obviously we are covering a whole landscape here of healthcare, moving from dentists to acupuncturists now. Now when the licensee who now wants to come back requires in line 1186 a completion of 15 contact hours of continuing education within the one hour

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period preceding the reinstatement, for my clarification, through you, Mr. Speaker -- so for the -- for the acupuncturist is this a pre-requirement before that license is reinstated or is it in the process while they are back in their practice they need to make sure that they -- these requirements are met as well?

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

If I could prevail upon the Representative perhaps to restate his question. I'm not exactly sure of the question.

. Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative, could you restate your question for a better understanding?

REP. SRINIVASAN: (31st):

It would be my privilege.

Through you, Mr. Speaker.

An acupuncturist who has been on medical disability or illness now re -- is requesting a reinstatement of his or her license and in lines 186 -- 1186 it talks about a successful completion of 15 contact hours of continuing

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education within that one -- one year period preceding the application.

So when this disability or illness occurs, through you, Mr. Speaker, will this pre-requirement or the -- have to be met before the license is reinstated within that one year?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

My reading of this statute indicates that those 15 contact hours of education would have to be successfully completed within a one year period immediately preceding the application for reinstatement. That would be correct.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

And my final an -- question, through you, Mr. Speaker, in lines 1612 and 1613 where we are talking about the note -- the notification of -- of the privacy practices

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to patients. Through you, Mr. Speaker, the development of privacy practices and procedures to notify patients of the collection of data, are we just notifying them, through you, Mr. Speaker, or are we also getting their consent? Is it only notification or consent as well?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

My reading of this language I believe indicates that they are report -- required to report on the development of privacy practices and procedures to notify patients concerning the collection of this information and the use of that information in the state-wide Health Information Exchange.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Srinivasan.

REP. SRINIVASAN: (31st):

Thank you, Mr. Speaker.

And I want to take this opportunity to thank the esteemed chairwoman of the Public Health Department. It has been a privilege, a pleasure for me to work with you,

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Madam Chair, and I'm looking forward -- I'm not sure if I'll have the opportunity this evening to address you again. I do want to thank you for all the courtesies you've extended to me.

Thank you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Albis of the 99th, you have the floor, sir.

REP. ALBIS: (99th):

Thank you, Mr. Speaker, good afternoon.

DEPUTY SPEAKER RYAN:

Good afternoon, sir.

REP. ALBIS: (99th):

I rise in full support of this amendment, specifically Section 44 which deals with creating an advisory council for organ donation and -- and -- organ and tissue donation awareness and education. This is the work of a -- a bunch of folks here in the Chamber including especially I'd like to thank Representative Betsy Ritter and also the work of the group Donate Life Connecticut.

Connecticut currently lags behind the national average when we talk about registered organ donors in the state. The -- the national average is at about 42 percent. Connecticut is under 40 percent so I -- I think introducing

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this -- this language into our -- our statutes will help to raise the number of -- of donors in the state. The more donors that we have the -- the more lives we can save and I've learned a bunch of interesting facts myself when doing my research for this -- this particular piece of legislation including that one -- one donor can be -- or can help up to 75 individuals through -- through not only a bone but also tissues and -- and organs.

So I think this is a great piece of legislation. There -- there's more work to do in terms of this area but -- but I'm very happy that it is included in this bill.

So thank you very much, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative LeGeyt of the 17th, who's not here.

Okay. We'll go to Representative Carter of the 2nd then.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

A few questions, through you, to the proponent of the amendment.

DEPUTY SPEAKER RYAN:

Please proceed, sir.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

In the beginning, Section 2 of the amendment, I noticed that with respect to licenses issues by the registrar, that the license is sworn by multiple applicants. It's done by the later date that was changed from earlier. What was it that changed that?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Thank -- thank you, Mr. Speaker.

Mr. Speaker, that request came to us from the Department of Public Health and the local vital records registrars.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

And as I understand it, through you, Mr. Speaker, that only applies to licenses to marry. Is that correct?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

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Through you, Mr. Speaker, yes.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd): Thank you, sir.

Through you, Mr. Speaker.

When we move on to Section 5, line 63, they established the Department of Public Or -- Public Health Oral Public Health office. They were -- they changed from graduate degree to experience in public health as a -- as a requirement for that office.

Through you, Mr. Speaker.

What -- what actually constitutes experience in that office that they're looking for if that was conveyed to the chairman?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

This is the requirement that was conveyed to us by the agency.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you. Thank you, Mr. Speaker.

Through you, Mr. Speaker.

In Section 7, line 83, we were talking about the private resident -- residential wells and at one time what was required. I guess it used to be just radionuclides. Now I think arsenic seems to be the only addition. Is that true?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

The previous requirement in the statute can be seen in line 63 and was just described as radionuclides. The change would be to take that more generic description and specify specific items and they are arsenic, radium, uranium, radon or gross alpha emitters.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

I -- I noticed arsenic because I know -- I do not believe that was a -- a radionuclide from what we talk about

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in committee.

REP. RITTER: (38th):

Right.

REP. CARTER: (2nd):

That seemed like it was something in addition. I know there was some talk about whether that would be an extra mandate on somebody with a private well and to the best of my understanding that -- and I'll ask this as a question, through you, Mr. Speaker, I believe the committee agreed that would not be a mandate on a private residential person checking out their well.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, that is correct.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you much -- very much, Mr. Speaker.

In Section 8, we were talking about the subsurface sewage disposal system installers, there's a mouthful for you, and we're talking about them needing to be licensed.

Through you, Mr. Speaker, would an apprentice permit

also count for those?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

This language does not deal with an apprenticeship program and we did not discuss the existence of such a program when we talked about this change.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you much -- very much, Mr. Speaker.

I noticed when I was reviewing the statute we did have an apprenticeship -- apprentice permit in the licensing language. I guess I would just say as we move forward in future years we might want to take a look at that just to see where they would fall out if somebody would try to -- to use an apprenticeship permit as a -- a means to be unlicensed.

Moving -- moving on to the Section 10, we were talking about youth camps and I think this is a very good section. It actually opens up the opportunity for physicians from

out-of-state to come in, practice without their license in our state for nine weeks as long as they're in good standing.

The -- the one question I did have, through you, Mr. Speaker, is is there any concern that we need to address with this language with respect to liability because I know in other parts of the statute when we refer to military physicians practicing in our state, one of the requirements is they have malpractice insurance either through the free clinic they're working at or on their own.

Through you, Mr. Speaker.

Is that something we need to address in a future bill?

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Anything can be contemplated in a future bill. I would like to point out though to the Representative that the requirement also is that that license be held in good standing and I believe that would address his concerns.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

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So, through you, Mr. Speaker, if the license is in good standing in another state, then they -- the -- the fact that the license is in good standing would mean they would have to have malpractice insurance in their own state?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I am not intimately aware of the requirements in every one of the other 49 states but that would be my interpretation of a license in good standing.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you much -- very much, Mr. Speaker.

In -- in line 287 there's been a lot of talk this afternoon about the ability to have a defibrillator at an athletic facility and we were talking about if it's on the premise, that they had to have one on the premise within --or -- or actually within a quarter mile of any of the premises used by the athletic trainers.

So the way I read this, and I want to make sure I understand this, through you, Mr. Speaker, is that we have to have a athletic trainer or somebody who's trained at each individual premise where there's training or a sport going on within that quarter mile.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

As I understand the requirements here, beginning on line 284, and I read them the last time, that would be the requirement if indeed it falls under the hours of intercollegiate sport practice, training and competition.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

Moving on to line 323, when we were talking about the dental licensing, one of the changes was, and it was addressed by one of my colleagues earlier, exactly what one hour of the training would be, what I noticed was, with respect to the topics, this seemed to expand the original

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five topics into the ability to take five of ten topics that were prescribed by I guess the commissioner.

My question, through you, Mr. Speaker, will we have any -- will we have any cognizance over that through Public Health as to what those topics may be in the future?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

That is addressed in current language. There is no change in that cognizance.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

So through you, Mr. Speaker, I -- I've been reading the bill and there's -- it - it addresses there are five topics that are listed in the current language and now it says that in the new language there would be ten mandatory topics.

So that's -- that's adding five topics that aren't here and my -- my interest in this is specifically one of the topics in current language that we address with

dentists is domestic violence including sexual abuse.

I -- I just kind of want to get some sort of picture that we will have the ability in the future to know what ten topics are being mandated by this legislation because it's not very clear.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

And I apologize for any confusion my previous answer may have given the Representative.

He -- yes there is cognizance and he will see beginning -- in lines 329 and 330 that those continuing education activities prescribed by the commissioner pursuant to this subdivision.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

I -- I would -- I would make one general comment of this section that I think over the next year or so we should take a look at this, watch it closely, find out exactly

what the commissioner is going to do because this may be somewhere we want to weigh in in -- in the future and look at making sure that we're making a few of these mandatory, specifically the sexual abuse and the domestic violence portion.

Through you, Mr. Speaker.

Moving to the -- towards the end of the bill, excuse me the amendment, in line 1168, there are some -- there are some I -- I guess I would call them protections afforded that my colleague earlier alluded to that when there are individual cases of medical disability or illness that the commissioner has the power to grant waiver of continuing education requirements.

My question, through you, Mr. Speaker, to the good chairman of Public Health is a similar option afforded other medical specialties in our legislation somewhere else?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I can't say that I have reviewed every one of those medical specialties but I can tell you that this language

was drafted with the Department of Public Health commissioner and the licensing division and my expectation is that it would be consistent with at least some of those other professions.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Carter.

REP. CARTER: (2nd):

Thank you very much, Mr. Speaker.

And my -- my sincerest thanks to the chairman of Public Health.

You know ladies and gentlemen this -- this tech bill as I see it does a -- a lot of really good things, provides for organ donation, as we've heard one of our colleagues speak about earlier. It's interesting too because it opens up the door to more recognition for the ability of nurse practitioners to do different things by statute which I think is a -- a great move forward.

It also, with respect to our pharmacy and therapeutics committee in the state, adds on ecology on to that and obviously that's an area where I think it's very important we make progress in looking at those medicines.

So all in all, I think this is a -- a great work and

my sincerest thanks again to the chairman, vice-chair and rankings in Public Health.

Thank you.

DEPUTY SPEAKER RYAN:

Thank you, sir.

The present Representative LeGeyt of the 17th.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker, appreciate the indulgence.

A few questions, if I may, to the proponent.

DEPUTY SPEAKER RYAN:

Please proceed, sir.

REP. LeGEYT: (17th):

Thank you.

Representative Ritter, I -- I'm looking through this bill and I have some questions about some of the sections, specifically to begin Section 1, fetal death certificates.

Is there a definition of a fetus in the bill or is it referenced in the bill such that we would know to what degree the pregnancy had matured such that the fetus would qualify for a death certificate? For instance, I assume that a full term stillborn baby would qualify for a death certificate. Is that correct?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I would agree with that, yes.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

In our state, there's a -- I believe it's national that there's a level of viability that's involved with issues of abortion and I believe that that is 22 weeks or five and a half months. If the fetus was deemed to be less than 22 weeks, in other words, assumed not to be viable on its own, would it still qualify for a death -- fetal death certificate?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I would direct the Representative to the lines -- language beginning on line 9 and running through line 12 where it defines -- or it states that a fetus born after a period of gestation of not less than 20 weeks in which there is no attempt at respiration, no heart action

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and no movement should be recorded as a fetal death.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you so much, Mr. Speaker.

And, through you, thank you to the chairperson of the Public Health Committee. I'm -- I'm working from the LOR summary and appreciate that.

Section -- the section on marriage licenses, which I believe is Section 2, allows for a license to be signed and sworn to by the applicants on different dates. Do they have to both be present on those different dates for the application and the marriage license to be valid?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you very much, Mr. Speaker.

And I would direct the representative's attention to the language beginning on lines 28 and 29 and 30 where it indicates the license could be sworn and sign -- signed and sworn in by applicants on different dates and that it would be the later date but there is no requirement that

those applicants be both present at the same time.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker.

To pose a hypothetical then, being a justice of the peace myself, I know that the law now allows for the marriage license to be procured in the town where either one of the applicants lives or in the town where the ceremony is suppose to take place. So following up on this Section 2 one step along the way perhaps could the license be signed on different dates and at different locations?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, the line -- language beginning on line 9 indicates a singular registrar and to my way of thinking that would imply that each of those applicants came to the singular registrar.

Through you, Mr. Speaker.

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Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker, appreciate that.

The section regarding permission for minors to marry, Section 3, noncustodial parents, under this bill, would not have the authority to consent to a minor's marriage and by eliminating the authority I'm assuming that that makes it more difficult for a minor to get permission. He would have to go to the pro -- he or she would have to go to the probate court. That would be the next level of relief. Would -- would that be true?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, I would correct the Representative. We are looking at LCO Number 5017. I believe the discussion that he has initiated came from a previous LCO Number and that section is not present in LCO 5017.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker, I appreciate that. I'll withdraw my question.

With regard to the Section 4, the tumor registry, reports to the tumor registry include various things and I'm wondering if any of those procedures that result in specimens or tumors or partial tumors that would go to pathology and therefore incur a cost which could be borne by insurance, would there be an opportunity for the patient if he or she so chose to maintain some privacy with respect to the reporting of the information about the patient as a result of incurring insurance expense for those procedures relative to tumor registry?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

First, I will point out that this is in the amendment before us. I believe it is in Section 3 and not Section 4, for the benefit of the Chamber.

But, secondly, the requirement that we have here only is that the report of the pathology be filed in the tumor registry. There is no requirement for any additional information. The representative may remember questions

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in discussion in the committee at the hearing about additional costs or expenses and it was indicated that none were anticipated.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker.

I appreciate that answer. Regarding the section about tuberculosis patients and allowing a reciprocal agreement with other states for transportation and treatment of patients, does that mean that there would be a restriction on travel, absent a reciprocal agreement, and is -- does this bill reference -- or amendment reference anything relative to that or is it silent on it?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

Mr. Speaker, what the language in this amendment does is it allows the Department to enter into these reciprocal agreements so that we can transport and treat these patients when the required care and expertise is not

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available in Connecticut and it doesn't address any other restrictions that I'm aware of.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you, Mr. Speaker.

Would the need for these reciprocal agreements suggest that there is some restriction on travel for tuberculosis patients between or out-of-state and because of the contagious nature of the disease?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, that would be my understanding.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you.

Section 11 has to do with the medical personnel at youth camps and summer camps and licenses during the summer for those people to perform their duties and -- and

be -- provide appropriate coverage at a youth camp and it also talks about licensing -- if -- if a health professional -- a -- a physician is licensed in good standing in another state that there could be some reciprocity such that the physician would not have to be licensed in Connecticut.

I have to say that I wasn't -- I don't remember the public hearing nor the discussion about this particular section in the Public Health Committee and so was there any discussion about -- or concern about reciprocity for states whose standards are lower than they would be in Connecticut and, therefore, was there any discussion about setting up a list of states that -- whose standards are high enough that we would offer reciprocity?

I know in my teaching career there are states that Connecticut won't allow reciprocity for and so I'm wondering if that's applicable in this situation.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

I do not recall any discussion along those lines.

Through you.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you.

I'm looking at references in the OLR summary to Sections 12 to 14, specifically certified homeless youth, and this summary talks about defining a certified homeless youth as a 15- to 17-year-old person and I'm wondering what happens to the 14-year-old person who would like to be certified as well.

So I would pose that to the chairperson of the Public Health Committee.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, once again I would like to point out that the amendment that we are speaking to is LCO Number 5017. And I believe -- or I know the sections that the Representative is referring to were in a previous LCO and do not appear in this amendment.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you, Representative.

Representative, I -- is that the second time that we've seen that you might be working from a different LCO. Do you want to take a moment to get the one we're all working off of?

Do you think that will be helpful?

REP. LeGEYT: (17th):

I'll -- I apologize and -- and appreciate the Chamber's indulgence in my mistake, sir.

DEPUTY SPEAKER RYAN:

Okay.

REP. LeGEYT: (17th):

I -- I would like to move on to a different section that I'm pretty sure is in the amendment and this will be the last one that I speak about.

The -- the AEDs at higher education institutions, my reference here says that that's Section 20. I don't know if that's the section that is referenced in the amendment but in that section I'm wondering if there are --

A VOICE:

Section 16.

REP. LeGEYT: (17th):

Okay.

I know that there are some general parameters about having an AED available on the premises in some central

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location and so I'm wondering what would happen in the event of a -- a track meet away from -- an away -- an away meet -- track meet. Would we be relying on the AED at another school or would we take one with us? Where would it be placed? If I could be enlightened in that situation.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

Mr. Speaker, this requirement does not deal with athletic events that are not on the premises.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative LeGeyt.

REP. LeGEYT: (17th):

Thank you.

Mr. Speaker, I have appreciated the indulgence of the Chamber through these various questions and also the indulgence of the Chairperson for the Public Health Committee and I thank the -- I thank the Speaker for the opportunity to ask these questions.

Thank you, sir.

DEPUTY SPEAKER RYAN:

Thank you, sir.

Representative Miller of the 122nd -- okay we'll come back to Representative Miller.

We'll go to Representative Betts of the 78th.

REP. BETTS: (78th):

Thank you very much, Mr. Speaker. Good afternoon.

Just a couple of questions I'd like to ask, if I could, through you, to the proponent.

DEPUTY SPEAKER RYAN:

Please proceed, sir.

REP. BETTS: (78th):

Under Section 6, line 77 and 78, there is deleted language that says -- relating to the rape crisis centers which meets the Department of Public Health criteria of service provision for such centers, and I apologize if this question has been asked before, but could you enlighten me or the Chamber as to what the criteria was that's being deleted as a result of that?

Through you.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Mr. Speaker.

Mr. Speaker, current language mandates that the

Department of Public Health complete regulations to define criteria for the operation of rape crisis centers. The Department of Public Health does not have the statutory authority over rape crisis centers and without this statutory authority the Department has no way of identifying the rape crisis centers and enforcing the regulations.

Therefore, the proposal that you have before us is to eliminate the requirement for the Department of Public Health to be the agency that develops that criteria. This request came to us from the agency.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Betts.

REP. BETTS: (78th):

Thank you very much, and it's very helpful. I appreciate it.

To the good lady, I'd also like to have you refer to Section 12 dealing with the Nursing Home Financial Advisory Committee. On line 173, it says that this committee is going to examine the financial solvency of nursing homes on an ongoing basis.

Could you please clarify or explain to the Chamber what an ongoing basis is and is this something that's going

to be done annually?

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker, and I believe the -- the Representative is referring to language beginning in line 172 that is in current law and is not changed by this amendment. What this amendment does do, Mr. Speaker, is to remove language specifying an organization formerly known as the Connecticut Association of Not-for-Profit Providers for the Agency -- for the Aging and replacing it with the current name of the organization LeadingAge Connecticut as having a seat on that advisory committee. That's all that is contemplated in this amendment.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Thank you.

Representative Betts.

REP. BETTS: (78th):

Yes, I thank you for that answer. And I -- and I saw the change. I was just looking for information, even though it's not a change, as to what an ongoing basis was. We may have covered this in the committee but I was just

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looking to find out is this -- if this is done on an ongoing basis. Is this annual, because obviously we want to make sure we clearly understand the financial capacity and solvency of nursing homes.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. Speaker.

Mr. Speaker, I think the Representative can find some clearer elucidation beginning on lines about 174 through 177 in the current law.

Through you, Mr. Speaker.

DEPUTY SPEAKER RYAN:

Representative Betts.

REP. BETTS: (78th):

Okay. Thank you very much. And my final question, through you, Mr. Speaker, relates to Section 16, and I believe you may have answered it with the previous Representative, but it deals with the automatic external defibrillator. And I know you said it does not deal with -- necessarily with sporting events, but I'm wondering, if summer camps take place at these colleges, whether -- whether it be hosting tournaments or summer

camps, if these defibrillators are required to be made known to the people who are using these facilities.

Through you, Mr. Speaker.

(Deputy Speaker Orange in the Chair.)

DEPUTY SPEAKER ORANGE:

That would be madam now.

REP. BETTS: (78th):

Oh, Madam Speaker (inaudible).

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Good evening -- or good afternoon, Madam Speaker.

We're not quite into the evening yet.

Yeah, the answer to that is specified in lines 283 to 284, that the sport practice, training or competition must be intercollegiate in nature and that is the extent of the activities covered under this portion of the amendment.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Betts.

REP. BETTS: (78th):

Okay. And I thank the gentlelady and thank you very much for all your help and leadership this session. And that's the list of question I had, and I thank you very much.

DEPUTY SPEAKER ORANGE:

Thank you.

Will you care to remark further?

Representative Wood.

REP. WOOD: (141st):

Thank you, Madam Speaker.

I don't have any questions for the proponent of the bill but I do have a statement. I also stand in support of the organ donation, which is Section 19 of the bill, and also the agreement they have with Donate Life. I think it makes a lot of sense. It's something we need to be doing more of creating the education and the awareness. It's a small bill but I think it will have a big impact on the state and I'm very happy that it's in this bill.

Thank you very much.

DEPUTY SPEAKER ORANGE:

Thank you, Madam.

Will you care to remark further? Will you care to remark further?

Representative Candelaria -- Representative

Candelaria.

Okey doke.

Representative Lawrence Miller of the 122nd. Good evening, sir, you have the floor.

REP. MILLER: (122nd):

Thank you, Madam Speaker.

I have one short question for Representative Ritter.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. MILLER: (122nd):

I don't want to burn her out. She's been doing an awfully good job so far.

I looked through this long, long bill and I wondered why tattoo parlors were not included.

Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Through you, Madam Speaker.

The Representative is correct. I don't believe there are any portions of this bill that deal with tattoo parlors. And as I'd indicated earlier, there's no limit on legislation that we may be considering in the future and that very well may be something that we do.

DEPUTY SPEAKER ORANGE:

Representative Miller.

REP. MILLER: (122nd):

Thank you.

And again, through you, Madam Speaker.

While there's probably a better -- it was a comment rather than a question but people do get allergic reactions to tattoos. Sometimes they get infections. They get all sorts of little problems that pop up in Hepatitis B, Hepatitis C that kind of thing when they're not using clean needles.

So I just think that it's something that should be looked at from -- from our standpoint because more important -- more and more people are getting tattoos and I certainly don't have any but even elderly people are getting out there and having tattoos put on their bodies. So, again, I just think it might be a -- a good idea to look into it (inaudible) some later date and maybe even adjust this bill later on for it.

I wouldn't ask if you had a tattoo, Madam Speaker, I don't think so. Thank you.

DEPUTY SPEAKER ORANGE:

Thank you, Representative Miller.

Will you care to remark further on the amendment

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before us? Will you care to remark further on the amendment before us? Care to remark on the amendment, House Amendment Schedule "A"?

If not, let me try your minds.

All those in favor please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

All those opposed nay.

The ayes have it. The amendment is adopted.

Will you care to remark further on the bill as amended?

Will you care to remark?

Representative Ritter.

REP. RITTER: (38th):

Thank you very much, Madam Speaker.

Madam Speaker, the Clerk has an amendment, LCO 5454.

I would ask the Clerk please call the amendment and that

I be granted leave of the Chamber to summarize.

DEPUTY SPEAKER ORANGE:

Will the Clerk please call LCO Number 5454 which will be designated as House Amendment Schedule "B".

THE CLERK:

LCO 5454, House "B", offered by Representative Ritter and Perillo, et al.

DEPUTY SPEAKER ORANGE:

The Representative seeks leave of the Chamber to summarize.

Is there objection? Objection?

Seeing none, hearing none, Representative Ritter.

REP. RITTER: (38th):

Thank you very much, Madam Speaker.

Madam Speaker, this is a much shorter amendment than the amendment that we just discussed. In Sections 501 to 504 of this amendment, it codifies current practice regarding certain workers employed by the Department of Developmental Services as self-advocates making it clear that they are eligible for prorated sick leave and Section 505 clarifies what qualifies as an amendment in the -- to the vital records.

Madam, I urge its adoption.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on adoption.

Will you care to remark further on House Amendment Schedule "B"?

Representative Perillo.

REP. PERILLO: (113th):

Madam Speaker, thank you very, very much.

If I may, through you, a few questions to the

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proponent of the amendment.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. PERILLO: (113th):

If -- if I could get a better handle, how many individuals would this amendment apply to within DSS -- or DDS rather, sorry?

Through you, Madam.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Thank you.

Madam Speaker, I believe that number is 11.

DEPUTY SPEAKER ORANGE:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much.

I knew that was the number to which it could not exceed. I didn't know if there were actually 11 in place right now. What do -- if -- if I could get some sort of sense what exactly do self-advocates do within DDS?

Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Through --- thank you, Madam Speaker.

Through you, self-advocates fulfill a role in the agency to -- to promote self-advocacy, advocate themselves for individuals with intellectual disabilities, advise the Commissioner by weighing in on departmental policy decisions as self-advocates, that is individuals with developmental disabilities and I -- I also would also like to correct. It's my understanding that currently there are 10 people affected by this amendment although it could affect up to 11.

Through you.

DEPUTY SPEAKER ORANGE:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much and I appreciate it.

And -- and just to clarify, as -- as I read this, this seems to only apply to holidays. It wouldn't -- this -- this isn't -- would this apply to days where perhaps the Department closes because of extended snowfall or something like that or, you know, personal days, you know, a family member, you know, goes to the hospital, has quintuplets, you name it? Is this just rel -- relevant to holidays or is it relevant to other days

as well?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Through you, Mr. -- Madam Speaker, I caught myself, thank you, Madam Speaker.

Through you, Madam Speaker.

If the Representative would want to look at the language beginning on lines 38 to 42 he would see that this would indeed could affect sick leave, prorated sick leave, and in lines -- starting on line 61 we would be discussing legal holidays.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Perillo.

REP. PERILLO: (113th):

Thank you, Madam Speaker.

And -- and just another hopefully simple question. Where exactly do these individuals work? Do they work within the Department? Do they work offsite at -- at satellite locations in the -- in the course of their advocacy? Just to get a better understanding of exactly what these folks do.

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Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Through you, Madam Speaker.

They work through the district offices around the state.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Perillo.

REP. PERILLO: (113th):

Thank you very much, Madam Speaker.

And I thank the Chair of the Public Health Committee for her answers to the questions.

This -- this is an amendment that again as I said before in the previous amendment is something that was worked on on a bipartisan basis. It is something that, as you can see by the individuals who are offering this, that it is something that -- that everybody seems to agree on within the committee leadership and I would urge adoption of this amendment.

DEPUTY SPEAKER ORANGE:

Thank you, sir.

Will you care to remark further on House Amendment

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"B"? Will you care to remark further on House "B"?

If not, let me try your minds. All those in favor of House Amendment Schedule "B" please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

All those opposed nay.

The ayes have it. Amendment "B" is adopted.

Will you care to remark further on the bill as amended? Will you care to remark further on the bill as amended? Will you care to remark further on the bill as amended?

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

THE CLERK:

The House of Representatives is voting by roll call.
Members to the Chamber. The House is taking a roll call vote. Members to the Chamber, please.

DEPUTY SPEAKER ORANGE:

Have all the members voted? Have all the members voted? Have all members voted? Have all members voted?

Please check the board to determine if your vote has

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been properly cast.

If your vote has been properly cast, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

House Bill 5514 as amended by House "A" and "B".

Total Number Voting	150
Necessary for Passage	76
Those Voting Yea	150
Those Voting Nay	0
Those Absent and Not Voting	1

DEPUTY SPEAKER ORANGE:

The bill as amended passes.

(Speaker Donovan in the Chair.)

SPEAKER DONOVAN:

Representative Sharkey.

REP. SHARKEY: (88th):

Thank you, Mr. Speaker.

Mr. Speaker, I move that we immediately transmit the foregoing item to the Senate for further action.

SPEAKER DONOVAN:

The motion is for immediate transmittal of all items

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Senate Agenda Number 3, Substitute House Bill 5514, Madam President, would move to place that item on the consent calendar and immediately call for a vote on that consent calendar.

THE CHAIR:

Seeing no objection, so ordered, sir.

Mr. Clerk, will you please call -- hold it one second.

Senator Looney.

SENATOR LOONEY:

If we might stand at ease.

THE CHAIR:

Standing at ease.

(Chamber at ease.)

Senator Looney.

SENATOR LOONEY:

Yes, Madam President, would move to put -- place the -- the House Joint Resolution Number 85 on the -- on the consent calendar.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Yes. Thank you, Madam President.

THE CHAIR:

Mr. Clerk, will you call the --

SENATOR LOONEY:

**JOINT
STANDING
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HEARINGS**

**PUBLIC
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RAJA FATTALEH: It would immensely help patient care. I have to take staff out of clinical time and with patients and answering questions and answering forms -- I mean answering phones to be able to handle the deluge of prior authorizations. It has quadrupled just in the last four years. You can't even imagine how many people it takes to do these forms because, like you mentioned, there's 600, if not more, and you submit a form just to get another form back. Now that is extremely inefficient. That is a burden. There are offices that refuse to do it. So it is by simplifying the process and starting out with this pilot program, all of you on the committee will be able to assist to improve care in the State of Connecticut.

REP. CARTER: Thank you very much for your testimony and your time, Doctor.

SENATOR GERRATANA: Thank you, Representative, and thank you for coming today, Doctor --

RAJA FATTALEH: You're welcome. Thank you.

SENATOR GERRATANA: -- and your testimony. Next we'll go on to House Bill 5514 -- not yet? Okay. There's Kristin Granatek, I think, followed by Joe Moore followed by Michele Ciancola. Kristin? Is Kristin here? That's not Kristin. Are you giving testimony for Kristin?

DAVID BOOMER: For Joe Moore.

SENATOR GERRATANA: Oh, for Joe Moore, okay, I see. He had to leave? Kristin left, Joe Moore, but Dave Boomer is going to give testimony, and then you're up, Michele. Thank you.

DAVID BOOMER: Very briefly. David Boomer with the Kowalski Group. We represent international

health, Racket and Support Club Association which are health clubs. They have 72 members in Connecticut. And we're commenting on Section 23 of the bill which, as you know, would require every health club to have an automatic external defibrillator on site. It would require that all of the staff be trained in its use and that at least one staff member is on site during staff hours who would be able to operate it. And you have a statement from Joe Moore on that.

The fundamental point we would like to make is this is a duty and a mandate that would be now placed on the health clubs, and about a quarter of them have AEDs. They are marvelous devices and so forth. You are putting a mandate on them. They would like to have liability protection. And the Good Samaritan Law does kick in when someone uses the AEDs, so there is protection there, but if it's not used -- and I can give you several scenarios where an incident occurs and maybe the staff member doesn't use it, they are wide open to be sued. And two years ago a bill was JF from the general law committee to the floor on this very issue, Senate Bill 168, that had this protection that I'm referring to. It's called nonuse, and we'll submit this to you. We'd like to have liability protection added in if you're going to place this mandate on health clubs. Thank you very much.

SENATOR GERRATANA: Thank you very much. Are there any questions or comments? If not, thank you.

Next is Michele Ciancola followed by Louis Iannotti. Sure. Would Louis like to come up also with you, Michele?

MICHELE CIANCOLA: That's fine.

SENATOR GERRATANA: Okay.

MICHELE CIANCOLA: Co-chairs --

SENATOR GERRATANA: Welcome.

MICHELE CIANCOLA: Thank you. Co-chairs Gerratana and Ritter, Vice Chairs Slossberg and Lyddy, and all distinguished members of the Public Health Committee. My name is Michele Ciancola. I am an Orange, Connecticut resident. I am here in strong support of Bill HB 5514, AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTE. I am specifically in support of Section 22 which deals with increasing access to AEDs on college campuses. I need your help in passing legislation which would require immediate point of care defibrillators to be on site at any state or private college/university within the State of Connecticut and also a provision that any athlete collapsing from apparent heat exertion or sports related collapse should be taken to a hospital with a trauma unit. The center for disease control estimated as recent as 2003 an annual average of 688 deaths occurred due to heat exertion in athletes, a number that continues to grow. Despite the National Athletic Trainers Association position statement on exertional heat illnesses, untimely preventable deaths continue to occur in young athletes. Some of these deaths are cardiac related, and yet despite state laws on cardiac arrest and defibrillators which place automated external defibrillator devices in public domains, colleges and universities, athletic facilities may not have the these AEDs readily available. This omission may be due to the misconception that young athletes are not susceptible to sudden life threatening events. This notion however suggests discrimination of sorts due to age and athletic prowess.

Currently the NCAA states that exertional heat stroke is the third leading cause of on the field deaths in athletes.

To give you some background, on October 24, 2011, my twenty-year-old son, Joseph Paul Ciancola, collapsed on a University of Rhode Island athletic field during strength and conditioning practice. He suffered what appeared to be initial heat stroke. Emergency first responders, including university emergency responders, had no AED or thermistor. My son was taken to a local county hospital geographically closer to URI regardless of the severity of this life threatening event. Once there the decision was made to transport him to Rhode Island Hospital as they were equipped with a trauma unit. By this time and delay in emergency treatment his temperature was 107.9 and rhabdomyolysis, which is a breakdown of muscle fibers that lead to kidney failure, had ensued. During this time Joey was resuscitated five times, required 394 units of blood product due to anticoagulation and bleeding. He had compartmental syndrome which required fasciotomy of his arms and his legs, a laparotomy and right lung removal. This horrific chain of events provides you with a description of the pain and suffering that my young healthy son endured. Joey was strong and fought hard but lost his battle three days later at Rhode Island Hospital, an untimely death that could have been prevented if proper protocol and equipment were in place.

Aside from the tragic loss of life and emotional impact a loss of this severity will have on family, community and institution, there is a fiscal opportunity in legislation of this nature. The average retail cost of an AED is approximately \$1,200. To properly equip the University of Rhode Island athletic campus to

allow for an AED to be available for athletes is approximately \$30,000. The opportunity for an investment of this nature is to reduce the tremendous emotional and financial impact an incident of this nature has on a public institution and supporting health care facilities. Additionally, the training for use of the AED for athletic coaches and trainers will raise the level of sensitivity and proper response to tragic events like the one that took my son's life.

My hope is that no mother or athlete will ever have to bear what I have been through. Would you be willing to discuss the possibility of making this hope of sponsoring legislation, "Joey's Law" to address this national public health concern that afflicts young athletes in the United States?

SENATOR GERRATANA: Thank you so much for your testimony and I'm terribly sorry for your loss and what happened. I do have a question. Can you tell me what a thermistor is?

MICHELE CIANCOLA: A thermistor is a rectal thermometer which gives you the core body temperature, and that is the only way that they can actually tell what your temperature is for heat stroke.

SENATOR GERRATANA: So it has nothing to do with the AED device, per se?

MICHELE CIANCOLA: Correct.

SENATOR GERRATANA: It's just an additional --

MICHELE CIANCOLA: Correct.

SENATOR GERRATANA: I see. All right. Are there any other questions? Would Mr. -- oh, yes,

Senator Slossberg would like to ask you some questions.

SENATOR SLOSSBERG: I really don't have any questions. I just wanted to say thank you for coming today. I know how difficult this is for you. I think it's hard for us to even hear your testimony. We're just very impressed with your courage and your commitment to try to make something so difficult and make something a little bit better and hopefully save another family from the incredibly difficult tragedy that you have had to suffer. So it's a good effort, and I just wanted to say thank you. Congratulations for your courage so --

MICHELE CIANCOLA: Thanks for your support.

SENATOR GERRATANA: Thank you. If you would just hold on for a minute, Mr. Iannotti.

LOUIS IANNOTTI: Certainly.

SENATOR GERRATANA: We just had a little glitch here. I'm terribly sorry. Okay, Mr. Iannotti.

LOUIS IANNOTTI: Thank you. I'm sure it's been a long day and Michele and I certainly do appreciate the opportunity. Co-chairs Gerratana and Ritter, Vice-chairs Slossberg and Lyddy, and all distinguished members of the Public Health Committee. My name is Louis Iannotti, and I'm a North Haven, Connecticut resident. I am here in very strong support of HB 5515, AN ACT CONCERNING VARIOUS REVISIONS TO ~~THE~~ PUBLIC HEALTH STATUTES. I am specifically in support of Section 22, which deals with increasing access to AEDs on college campuses.

HB 5514

I have been involved in the defibrillator industry for the past ten years. Automated external defibrillators, AEDs, have been

developed to save lives by treating out of hospital cardiac arrest. Any cardiac arrest that would obviously happen out of hospitals and public buildings, theaters, athletic fields and so on and so forth. SCA is an electrical malfunction of the heart and is not a heart attack. SCA does not discriminate. It can affect anyone regardless of age, gender or race. There is a misconception that sudden cardiac arrest only affects the elderly. Please find attached a memoriam page from the Sudden Cardiac Arrest Association web site. There are seven memorials on this page, five of the seven are as follows, and I believe we had submitted that earlier in the week, the testimony, and it's just to prove a point that there's a fifteen-year-old on the list, a twenty-nine-year-old, a twenty-two-year-old, a twenty-four-year-old, and a thirty-year-old, again, just making the point that it just doesn't only affect the elderly, but it also affects young relatively healthy people as well.

Just some of the facts on sudden cardiac arrest, if you would indulge me. Sudden cardiac arrest kills more than 350,000 people a year. It's the number one killer in the United States. If you add up cancer and handguns and fires and accidents, it doesn't equate to 325,000 people per year. And currently only 5 percent of people that are suffering sudden cardiac arrest will survive. It's a serial killer. For every minute that someone is in sudden cardiac arrest, the chance of survival decreases by 10 percent. The average EMS facility in the United States takes about 8 and a half minutes to get to a victim's side. The average is 6 to 12 minutes throughout the United States. So if we do a simple math and we say 8 and a half minutes or 9 minutes if we can round it off, chance of survival decreases

dramatically. So having AEDs within a 3 minute period of time the American Heart Association suggests that an AED be by a victim's side within 3 minutes. And if that is the case, we can actually increase that 5 percent to between about 70 and 90 percent. And that's by either laypeople using the device or trained individuals using the device. Now we all know that --

SENATOR GERRATANA: Mr. Iannotti.

LOUIS IANNOTTI: Yes.

SENATOR GERRATANA: Could you summarize your testimony. We thank you for your testimony, if you'd be so kind.

LOUIS IANNOTTI: Yes, absolutely.

SENATOR GERRATANA: Thank you.

LOUIS IANNOTTI: So in summarization, AEDs are very easy to use, they're relatively inexpensive and they save lives, and that's pretty much the bottom line. For a college or university in the State of Connecticut not to have one, in my opinion, is bordering on gross negligence.

SENATOR GERRATANA: Thank you so much for that. I do have a question regarding your testimony. And I'm sorry, I have to look at my screen. Sudden cardiac arrest, do you know what the causes of sudden cardiac arrest are, or is there many causes?

LOUIS IANNOTTI: There's many causes. Dehydration is a cause, mineral deficiencies, a blow to the chest at the correct rhythm of the heart can cause sudden cardiac arrest, and generally speaking there are no symptoms. A heart attack, which is a blockage in the artery, will

generally have symptoms such as chest pain, nausea, vomiting, that type of thing. With sudden cardiac arrest it's pretty -- it's instantaneous and the person is just dropping and is a victim in a short period of time.

SENATOR GERRATANA: Thank you for that very much. Are there any other comments or questions? Representative Miller.

REP. MILLER: Thank you, Madam Chair and thank you, Mr. Iannotti, for your testimony. My question is have you spoken to the Red Cross or the Heart Association? The reason I'm asking is throughout the state, particularly in the spring, there's a number of places that run like aquatic schools for camps and youth groups and they get a lot of good smart young people and they put them through a 7 or 8 day day-and-night course where they get Red Cross certification and life guard training and first aid and CPR. Could you comment on how practical it would be to include this in like a CPR, First Aid course regimen? I'm thinking we've got a lot of bright young people especially that we're teaching these skills to, and would it be all that difficult to add these to their curriculum perhaps?

LOUIS IANNOTTI: Absolutely not. I'll just give you a brief story. My son when he was in grammar school he was in seventh grade it was during a science month they asked me to come in and do a presentation and we had seventh graders that were actually using an AED on a manikin that had never seen it before. So there's no question. And I believe I'm not sure if it's in the State of Connecticut, but in certain schools there are individuals in middle school or grammar schools that are taking some type of courses like that that are teaching them how to use an AED and CPR as well. So the earlier we

can get them accustomed to using a device or performing CPR, it would just obviously speak volumes to being able to save lives.

REP. MILLER: And the reason I'm asking also, if I may have a second question, where I used to work there was one that was brought in and it was brought in because one of the people working there was also a credentialed fire marshal and had the complete training and it was his own -- he made the request to bring this into work and to keep it there so that while he's there if he would ever need to use such a piece of equipment it would be available and the request was okayed certainly, but it brought to mind the question what's the training all about. Can you give us an idea of what currently the training standards are for this?

LOUIS IANNOTTI: Yes. The FDA requires that at least one person in a facility go through either an AHA class, which is generally a two-year accreditation class, or the Red Cross class which is generally one year, and that's an AED slash CPR class which is renewed every one year with the Red Cross or every two years. And really that I think it's a two or three hour class that they would go through that would teach them the basics on how to do CPR as well as how to administer an AED. And generally speaking it's not always the same AED that's hanging on your wall. Their training, let's say for example might be training with a different manufacturer and then your device, although they operate similarly, there are some slight subtle differences, but it would give that person going through training the general idea of how to use the device.

REP. MILLER: Thank you very much.

LOUIS IANNOTTI: Thank you.

REP. RITTER: Thank you. Are there any other comments or questions from the committee? Thank you very much for your testimony.

LOUIS IANNOTTI: Thank you.

REP. RITTER: Next we'll hear from Stacey Cote followed by Susan Israel.

STACEY VIOLANTE COTE: Good evening, Representative Ritter, members of the committee, it's been a long day for you. I am here to testify in support of 5514, particularly Sections 14 and 15.

I am a lawyer at the Center for Children's Advocacy where I direct the center's teen legal advocacy clinic, and we represent low income teenagers in the Hartford area and the Bridgeport area. We do individual representation of teenagers and we do systemic advocacy. I chair a statewide group of professionals looking at issues related to homeless youth in the state, and we do advocacy to try to remove some of the barriers that homeless youth in our state face.

We are here because Sections 14 and 15 would be tremendously helpful to homeless youths in our state. These sections of the bill would allow homeless youths to get direct access to their birth certificates, and this is particularly important for homeless youths who are living on their own. I get asked quite a lot about who are these homeless youths, does Connecticut have homeless youths. Well, I'm here to tell you that we do. You do have testimony from two providers who were not able to stay to speak to you, but their written testimony talks about the stories of the kids that they work with. I

have also provided written testimony, and attached to my written testimony on the back is some of the data that we have in Connecticut related to homeless youths, and I'd be happy to answer any questions about it. What we know is these youths are victims of abuse and neglect. They are youths who have run away from the care of the Department of Children and Families. They may be gay, lesbian, bisexual or transgender teens who have been kicked out of their homes or rejected for coming out, and they also may be youth who have been separated from their family because their family is homeless and perhaps they can't stay where their family is staying. And because they cannot access their birth certificates, they cannot get employment, job training programs, it delays their access -- I'll finish up. It delays their access to health insurance and then mental health and medical care as well. So this is a no cost way to provide direct access to a vulnerable population in our state. I'm happy to answer any questions.

REP. RITTER: Are there questions from the committee?

Representative Carter.

REP. CARTER: Thank you, Madam Chair. One of the problems they were talking about the younger child or minor child not having access to parental information or things that somebody would want -- they may not be capable of dealing with I think is how we said it. Is there a way as an attorney, I mean, is there a way to provide a birth certificate and redact information regarding to a judge or a court to say you're not allowed to know who the parental information is or anything like that, is there a legal way to do something like that?

STACEY VIOLANTE COTE: So what you're proposing I think would add an additional step of a court process before somebody would be able to access their birth certificate.

REP. CARTER: The question is if the objection is they don't want the kids to have access to that information as a minor, then is there a way we could give them the ability to get a job to, you know, have a birth certificate for identification or all those things you mentioned and maybe it would be a court process or a judge would have to certify it, I'm just asking if there's a plausible way to do it.

STACEY VIOLANTE COTE: A couple of thoughts in response to your question. First of all, I am not aware of an alternate type of birth certificate. So in direct answer to your question, I'm not aware of any. Also, I would have concerns about adding another step because what we know is that these kids are generally on their own. Most of them are living from couch to couch at a friend's house or relative's house and the time that it takes to get access to needed services, whether that's mental health care, whether that's health insurance, whether that's gaining employment, all of the time that it takes then increases the amount of time that they would likely be remaining homeless. The quicker that they can get access to identity documents and to get access to those support services, the idea is that then we can decrease the amount of time that they're in these temporary placements moving from place to place.

REP. CARTER: Thank you very much.

STACEY VIOLANTE COTE: You're welcome.

REP. CARTER: Thank you, Madam Chair.

REP. RITTER: Thank you very much. And I will admit to not hearing everything in your response, but I am curious if you heard way way back hours and hours and hours ago at the very beginning of this meeting we had some discussion over this particular section of the bill. I don't know if you were here and heard it. Some of that discussion concerned the age range that we were talking about and the potential that it was a really different situation for younger children who perhaps -- the employment issues weren't there for them but instead there might be a different kind of sensitivity around some of the information in the birth certificate. And I think there also was testimony several -- I believe from the Department of Public Health seeking a different kind of a definition or clarity around a definition of precisely who would be helped by this. So I want to let you know that and encourage you to pursue those discussions because I think that's what's probably going to have to happen, we're going to see some different language here around those points. And you can comment now if you wish.

STACEY VIOLANTE COTE: Thank you. So two thoughts. One is that the process that is outlined in the statute is one that is also followed under the federal law for minors who are seeking federal financial assistance and are unaccompanied and on their own, and federal law certifies these same exact people that we have put into this language to certify them as homeless and those are HUD providers, those are runaway and homeless youth act providers and those are statewide school homeless liaisons, three groups of professionals who work with this population on a regular basis who can certify. And what has happened is forms have been developed to allow them to certify that a

person is homeless and unaccompanied and then that is given so that they can apply for federal financial aid. So this process is not new. This is one that's done federally as well, and these same professionals are already doing it.

And then in answer to the question about age, we'd be open to talking about an age. I know last year when this bill was discussed there was an age of fifteen that was put out there. We'd be open to talking about that. I would not want the younger children and youth to be kept or delayed access to medical or mental health care because they don't have access to identity documents, but I understand the concerns. And if the age of fifteen was more amenable, I think that that would be an improvement.

REP. RITTER: Fair enough. And thank you, and thank you also for the background on the other areas where really essentially we're already doing this because I think that was maybe less than clear at the time this morning, at least not clear in our minds. So thank you for that. Is there anything else? Any other questions? It's getting quieter and quieter. Thank you very much for your testimony.

STACEY VIOLANTE COTE: Thank you.

REP. RITTER: Our next person to speak and at least appears to be the last speaker will be Susan Israel.

SUSAN ISRAEL: Hi, everybody. I'm Susan Israel. I'm a physician who's been following privacy issues. After all of this it may seem trivial, but I think it speaks to a bigger problem in terms of some of the laws of the state.

HB 5514

HB 5038

HB 5514

I'm going to address Section 5, subsection (b) in reference to the Connecticut Tumor Registry. And I would hope that it would specifically state that only unidentifiable patient data as it is being taken without patient consent be sent to the Department of Public Health, that no DNA testing be done on the issue without patient consent and only aggregated data be released to the public to further protect patient privacy. Subsection (b) mandates that tissue of tumors may be sent to the DPH, along with demographic and treatment information, and that the commissioner of public health shall promulgate a list of required data items. So the commissioner, as I understand it, has open-ended authority to delve into your medical record without your consent. It seems that the intention must be to have the name of the patient as per the testimony of the commissioner on 5038 about the All-Payer Claims Data Tumor Registry and to quote, "The C T R conducts followup on all cancer patients for vital status. The CTR uses data sources such as driver's license renewal date or hospital discharge date to ascertain that a patient was alive at a certain date. All all-payer claims database, extending to outpatient care and prescriptions, would improve the completeness of the followup." So to me this means that the Connecticut CTR will receive our cancer information and our hospital information and that bill I believe is HB 5652, Public Act 11-61, Section 43(b) -- just two more sentences. Anyway it's attached. So I just wanted to point out that it sounds kind of extreme but let's say you had cervical cancer and the commissioner wants to know your sexually transmitted disease and whether you had HPV which can cause cervical cancer, but it seems to me that hopefully we won't have someone who has an invasive tumor also has an invasive state. So I would ask the committee

to please look at this. Thank you very much.

REP. RITTER: Thank you for your testimony and your extreme patience. Are there questions from the committee? Seeing none, I guess I might ask is there anyone else that wishes to testify? There is someone that would wish to testify. One moment. It's my understanding that Keith Carter -- are you Keith Carter -- would like to testify, and we're looking back at Senate Bill 425, a basic health program. Mr. Carter. Thank you.

KEITH CARTER: Thank you for taking me. I apologize because I had to take off and go back to class. I kind of like didn't want to miss it because I had to go home for my mother's home going, and I missed the other opportunities so I just wanted to make sure I got this done, but I want to thank you for the opportunity.

My name is Keith Carter. I'm a student at the School of Social Work here at the University of Connecticut. I would like to first thank you for the opportunity again to appear before you to testify in support of the basic health plan bill. I would also like to thank you for raising this bill because I feel affordable health care is important to everyone. This is especially true for the over 100,000 individuals that are working hard to survive without health insurance in an uncertain job market, a job market that is in most cases either will not pay health insurance or enough for the employee to purchase health insurance. A neighbor of my inlaws is a good solitary example of those individuals experiencing life without health insurance. David suffered a broken ankle ten years ago and was unable to receive the proper medical care due to a lack of health insurance and now walks with a permanent limp. Just think if his minimum wage

**JOINT
STANDING
COMMITTEE
HEARINGS**

**PUBLIC
HEALTH
PART 7
1989 - 2282**

2012



The Council of Churches of Greater Bridgeport, Inc.

Testimony in Support of Bill No. 5514, section 15 (RAISED) AN ACT PROVIDING HOMELESS YOUTHS AND EMANCIPATED MINORS ACCESS TO BIRTH CERTIFICATES.

March 19, 2012

My name is John Cottrell. I am the Chief Operating Officer for the Council of Churches of Greater Bridgeport. Since 1978, the year I began working at The Council, the Janus Center for Youth in Crisis has served children and families in the Greater Bridgeport area. A major focus of the Center is on serving runaway and homeless youth. Our primary goal is not only to assist these youth to obtain stability, but to also keep children out of state systems and maintain families.

Our Basic Center Program consists of four main components: 24 hour mobile crisis response, immediate intervention and support, temporary respite care in one of our host homes, and aftercare support once the young person leaves our care. These cover four of the five service components outlined in the bill.

The Janus Center for Youth in Crisis strives to ensure easy access to services needed by youth who "live" on the streets due to extenuating circumstances, do not attend school on a regular basis, and are not involved with any traditional services or who are resistant or don't know how to access traditional services.

I feel it is important to point out the while The Council of Churches is licensed by DCF as a Child Placing Agency, we currently receive no state funding for our services. Our revenue comes from federal grants, local municipalities, foundations, churches and individual donors.

Our staff process approximately four hundred referrals each year. The majority of these calls involve families who are experiencing serious conflicts which if left unattended would likely result in the young person leaving the home. In most cases, with early and immediate intervention, separation can be avoided. The most difficult cases are those where the young person has already left the home.

Runaway and homeless youth often face many barriers that block them from having stable lives. Most often if a youth runs away from home, they leave with very few belongings, as they rush to get away from the current situation that they are in. One of these barriers for runaway and homeless youth is access to their birth certificate. In our experience in working with this vulnerable population, the parent usually is the one who holds the birth certificate of the youth in fear that the child may lose it if it is in their possession. When the child leaves the home, they often leave without having any type of identification. There have been situations in our work with runaway and homeless youth where the parent refused to give the child their birth certificate as a way of blocking their independence. This is especially relevant when a youth seeks emancipation from their parent or legal guardian.

Obtaining a birth certificate is the first step in receiving permanent identification which includes: passport, driver's license, and Social Security card. To apply for benefits the youth would need at

Bridge Building Ministry • CO-OP Center • Hunger Outreach • Janus Center for Youth in Crisis • Project Learn

1100 Boston Avenue; Bldg. 5A • Bridgeport, Connecticut 06610-2654 Tel: 203.334.1121 • Fax: 203.367.8113 • www.ccgbo.org

minimum a birth certificate and Social Security card. If the youth is not able to return home and is eligible for employment, you cannot be legally employed without having proper identification, which might cause the youth to get money in ways that might jeopardize their health and safety.

This bill would provide youth with the opportunity to take advantage of available options legally. This is a vital step in there attempts to have a stable and productive life.

Respectfully submitted,

John R. Cottrell

John R. Cottrell,
Chief Operating Officer

Testimony of Women and Families Center
In Support of HB #5514 An Act Concerning Various Revisions to Public Health Statutes
Kristen Granatek, Director of Project R.E.A.C.H. and Shelter Services, Women & Families Center
Public Health Committee, March 21, 2012

My name is Kristen Granatek and I am the Director of Project R.E.A.C.H. and Shelter Services for Women & Families Center. WFC is a multi-faceted human service agency providing services throughout Middlesex County and the Greater New Haven area. Included in our services is Project R.E.A.C.H., a program for runaway and homeless youth. Project R.E.A.C.H. supports this vulnerable population through Street Outreach and Shelter Services. Street Outreach seeks out runaway, homeless and at-risk youth in neighborhoods, parks and other areas where they congregate to provide survival aid, individual counseling, case management and referrals to community services including emergency shelter. Shelter Services, set to open in late March, will be a 6 bed short term emergency shelter for youth ages 13-17. Sheltered Youth will receive daily supervision and support, as well as extensive Case Management to help them move from homelessness to a stable long term living arrangement.

The runaway and homeless youth that we serve face many barriers. One of the most common ones is having access to identification, including their birth certificate. Youth who are on their own have left home for many reasons. They may have been kicked out of their home after "coming out" to their parents as gay, lesbian or bisexual. They may be running from abuse or neglect. Or they may have been separated from their family who is also experiencing homelessness. Many of them have no identification at all. It is our experience that parents or guardians often hold their child's birth certificate. The parent or guardian may refuse to turn it over to the youth, particularly in situations in which the youth is seeking emancipation. In some circumstances, the parent or guardian cannot be located.

Youth who do not have access to their birth certificate are unable to obtain permanent identification, including a social security card, passport or driver's license. This hinders the process of enrolling in school, getting a job and getting access to needed entitlements. The changes proposed under HB 5514: An Act Concerning Various Revisions to Public Health Statutes will provide runaway and homeless youth with a legal mechanism for obtaining a birth certificate without the consent of their parent or guardian. This is an important step toward eliminating some of the barriers that they face.

We urge you to support Section 15 of HB 5514 as it is critical to effectively supporting Connecticut's runaway and homeless youth in their quest for stability.

Thank you very much for your consideration.

Kristen Granatek, Director of Project R.E.A.C.H. and Shelter Services

Women & Families Center
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**Testimony
Elizabeth Gara
Executive Director
Connecticut Water Works Association (CWWA)
Before the Public Health Committee
March 21, 2012**

RE: HB-5514 - AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

The Connecticut Water Works Association (CWWA) opposes Section 12 of HB-5514, as currently drafted.

This section imposes a \$10,000 fine for any violation of the Public Health Code. While certain violations may warrant a \$10,000 fine, other violations may involve relatively minor issues.

We believe this section should be revised to authorize excessive fines only if the violations is egregious, willful and has the potential to result in harm to public health.

The Connecticut Water Works Association, Inc. (CWWA) is an association of private, municipal and regional public water supply utilities serving more than 500,000 customers, or population of about 2½ million people, located throughout Connecticut.

March 16, 2012

Testimony before the Public Health Committee

Bill# HB05514 An Act Concerning Various Revisions to the Public Health Statutes and Bill# SB0277, An Act Concerning a Council to Promote Collaboration between Local Health Departments and the Department of Public Health.

Shannon Wiggins, University of Connecticut School of Social Work, Chrysalis Center-Soromundi Commons Shelter

Greetings honorable senators and representatives!

I am honored to be allowed to share my testimony today. My name is Shannon Wiggins. I am a student at the University of Connecticut School of Social Work program. I am employed at a state social service agency as well as being placed in my internship at a shelter for women in Hartford, CT. I have several years of experience working with an impoverished population. Many of them have faced the issue of lack of adequate healthcare.

My purpose for coming here today is to help advocate towards adequate health care for all, and to ensure that rehabilitation needs such as mental health and substance abuse treatment, be covered thoroughly through healthcare coverage plans. I am here today to testify on Bill# HB05514, An Act Concerning Various Revisions to the Public Health Statutes and Bill# SB0277, An Act Concerning a Council to Promote Collaboration between Local Health Departments and the Department of Public Health.

I am hopeful that through the revisions to the public health statutes and collaborations between local health departments and the Department of Public Health, that a suitable basic health plan for those who are working class and who are less fortunate to be able to afford and receive a good quality of health care. This issue continues to be a significant issue as many are afraid to be vigilant about the quality of care regarding their health due to the costs associated with the maintenance of care. I have personally observed this in working with women with children, who may be qualified for health care as it relates to their children's health care, however, they themselves are covered via spend down accounts, where the cost of their medical care cannot exceed the amount of income they bring in per month. Everyone should be given the opportunity for adequate health care, as this should be viewed as a basic need to human rights.

I would also hope that a collaboration between local health departments and the department of public health to come to a resolution on the quality of health care as it relates to health care clinics in poorer neighborhoods vs. those of the wealthier neighborhoods. I would only hope that everyone could be given an equal opportunity at quality health care. In addition to the quality of health care, I am advocating that this also extend to the benefit of the needs of both mental health and substance abuse. Too often have I seen where clients who suffer from both mental health and substance abuse issues being denied access to treatment due to having reaching the limit of treatment visits that is covered through their insurance, often leading them into going into a step down program, or leaving treatment all together.

Implementing a plan that addresses the above concerns would be beneficial, as it would provide low income citizens a basic health care plan to be able to meet their basic health, preventative health, mental health and substance abuse needs. It would alleviate many of the issues of homelessness if part of the issue could be resolved through addressing their mental health and substance abuse needs appropriately. As well as saving the state of Connecticut money by implementing rehabilitation programs to actually correct behaviors rather than incarceration.

In essence, making revisions to the public health statutes and building a collaboration between local health facilities and the department of public health, would only help the state financially rather than hurt. In addition to benefiting the state, it would help rehabilitate someone who is qualified as low income to enhance their health to becoming a healthy and productive citizen.

Thank you for giving me the opportunity to testify on such an important issue. If there are any questions, I will be very happy to answer.



March 21, 2012

Members of the Joint Committee on Public Health,

My name is Joe Moore, President of the International Health, Racquet and Sportsclub Association (IHRSA). IHRSA is the health club and fitness industry's leading trade association, representing 72 businesses located throughout Connecticut.

Thank you for the opportunity to comment on HOUSE BILL 5514 and address an important issue: the nationwide trend to require businesses — not just health clubs — to install automated external defibrillators (AEDs) in their facilities. I am concerned, however, that the bill, as currently written, fails to adequately address two critical issues:

1) House Bill 5514 does not provide necessary liability protections for Connecticut small business owners and employees

As currently written, this legislation would enable harsh punishment of well-intentioned employees who either: misdiagnose a health club member's condition, and therefore choose not to use an AED; or panic in an emergency and are unable to use the device. Such a result would be in stark contrast to Good Samaritan statutes that protect and encourage well-intentioned responders. I hope that the legislature is not determined to create tremendous legal liability for health club employees and employers who may be thrust into life threatening medical situations.

2) House Bill 5514 may adversely impact the response of a trained employee during a cardiac emergency

As currently written, House Bill 5514 creates a legal jeopardy that incentivizes the use of an AED despite circumstances that call for other treatment. For example, in the event of a member with a blocked airway, a club employee may waste valuable time retrieving the AED when the Heimlich maneuver would be the appropriate treatment. In this case, the employee would know that he/she is more likely to be liable for failure to use an AED than failure to perform the Heimlich maneuver, therefore distorting the traditional analysis of an emergency responder.

In order to increase public access to defibrillation and protect well-intentioned emergency responders, I respectfully request that the following language be added to HB 6266:

Section 21a-223(e) Absent an act or omission constituting gross, willful or wanton negligence, no cause of action shall exist relating to the use or non-use of an automated external defibrillator.

I sincerely hope that we can work with the members of this Committee to ensure that this language or language similar to it is added in the form of an amendment to HB 6266.

We appreciate the liability protection currently found within § 52-557b of Connecticut's General Statute ("Good Samaritan Law"), and believe that our proposed amendment will simply strengthen the effectiveness of this legislation. I should note that our proposed language is similar to language adopted in several other states. This very approach was enacted into law in 2006 in the Commonwealth of Massachusetts. In fact, nine of the eleven states (including Massachusetts and also Rhode Island) that currently require an AED to be placed in health clubs provide explicit liability protection for the use and non-use of an AED.

Thank you for the opportunity to weigh in on this important matter. If the committee would like any information about AEDs in Connecticut health clubs, please contact Tim Sullivan in our office at ts@ihrsa.org or (617) 951-0055.

Sincerely,

Joe Moore
IHRSA CEO & President

Co-Chairs Gerretana and Ritter, Vice-Chairs Slossberg and Lyddy, and all distinguished members of the Public Health Committee:

My name is Michele Ciancola. I am an Orange, Connecticut resident. I am here in *strong support* of HB 5514, an Act Concerning Various Revisions to the Public Health Statutes. I am specifically in support of Sec 22 which deals with increasing access to AEDs on college campuses.

I need your help in passing legislation which would require immediate point of care defibrillators to be on site at any state or private college/university within the state of Connecticut; and also a provision that any athlete collapsing from "apparent" heat exertion or sports related collapse should be taken to a hospital with a trauma unit. The Center for Disease Control estimated, as recent as 2003, an annual average of 688 deaths occurred due to heat exertion in athletes, a number that continues to grow. Despite the National Athletic Trainer's Association position statement on exertional heat illnesses, untimely preventable deaths continue to occur in young athletes. Some of these deaths are cardiac related and yet despite state laws on cardiac arrest and defibrillators, which place automated external defibrillator (AED), devices in public domains, colleges and university athletic facilities may not have these AEDs readily available. This omission may be due to the misconception that young athletes are not susceptible to sudden life threatening events. This notion however suggests discrimination of sorts due to age and athletic prowess. Currently the NCAA states that exertional heat stroke is the third leading cause of on the field death in athletes.

To give you some background, on October 24th 2011, my 20 year old son, Joseph Paul Ciancola, collapsed on a University of Rhode Island athletic field during strength and conditioning practice. He suffered what appeared to be initial heat stroke. Emergency first responders, including university emergency responders had no AED or thermistor. My son was taken to a local county hospital geographically closer to URI regardless of the severity of the life threatening event. Once there, the decision was made to transport him to Rhode Island Hospital, as they were equipped with a trauma unit. By this time and delay in emergency treatment, his temperature was 107.9 and rhabdomyolysis (breakdown of muscle fibers that leads to kidney failure) had ensued. During this time Joey was resuscitated five times, required 394 units of blood product due to anticoagulation and bleeding had compartmental syndrome with fasciotomy, laparotomy and right lung removal. This horrific chain of events provides you with a description of the pain and suffering that my young healthy son endured. Joey was strong and fought hard, but lost his battle three days later at Rhode Island Hospital; an untimely death that could have been prevented if proper protocol and equipment (AED and thermistor) were in place.

Aside from the tragic loss of life and emotional impact a loss of this severity will have on family, community and institution there is a fiscal opportunity in legislation of this nature. The average retail cost of an AED is approximately \$1200. To properly equip the University of Rhode Athletic campus to allow for an AED to be available for athletes is approximately \$30,000. The opportunity for an investment of this nature is to reduce the tremendous emotional and financial impact an incident of this nature has on a public institution and supporting healthcare facilities. Additionally, the training for use of the AED for athletic coaches and trainers will raise the level of sensitivity and proper response to tragic events like the one that took my son's life.

My hope is that no mother or athlete will ever have to bear what I have been through. Would you be willing to discuss the possibility of making this hope of sponsoring legislation, "Joey's Law" to address this national public health concern that afflicts young athletes in the United States?

Thank you, in advance, for your time and consideration. I look forward to your reply.

Sincerely,

Michele Ciancola

Michele Ciancola
813 Taft Road
Orange, CT 06477
Michele_ciancola@covidien.com
203.710 3495

Co-Chairs Gerretana and Ritter, Vice-Chairs Slossberg and Lyddy, and all distinguished members of the Public Health Committee:

My name is Louis Iannotti. I am a North Haven, Connecticut resident. I am here in *strong support* of HB 5514, an Act Concerning Various Revisions to the Public Health Statutes. I am specifically in support of Sec 22 which deals with increasing access to AEDs on college campuses.

I have been involved in the Defibrillator industry for the past 10 years. Automated External Defibrillators (AED's) have been developed to save lives by treating out of hospital Sudden Cardiac Arrest (SCA). SCA is an electrical malfunction of the heart and is not a heart attack. SCA does not discriminate. It can affect anyone regardless of age, gender or race. There is a misconception that SCA only affects the elderly. Please find attached a Memoriam page from the Sudden Cardiac Arrest Association website. There are seven memorials on this page. Five of the seven are as follows:

Olivia Hoff, 15 yrs old – Cause of death SCA

Jorge Herrera, 29 yrs old – Cause of death SCA

Jimmy & Crissy Renfrow, 22 & 24 yrs old – Cause of death SCA

Ryan Clarke, 30 yrs old – Cause of death SCA

SCA Facts:

- Sudden Cardiac Arrest kills more than 325,000 Americans each year-more than car wrecks, cancer, handguns, house fires and AIDS...COMBINED!
- Currently only 5% of people survive Sudden Cardiac Arrest
- Every minute that passes without defibrillation lowers a person's chances of survival by an estimated 10%
- National EMS response time is 8.5 minutes to respond to ANY emergency
- The American Heart Association recommends that defibrillation from an AED should occur within 3 minutes to have the greatest chance to resuscitate a victim of SCA
- Survival rates can increase to as high as 90% if treatment is initiated with an AED within the first minutes following the arrest.

AED's are easy to use, are relatively inexpensive (\$1000-\$1200) and save lives. For a college or university in the state of Connecticut not to have them, is bordering on a case of gross negligence.

TIME

Monday, May. 07, 2007

Saving Athletes from Cardiac Arrest

By Carolyn Sayre

It happens all too often; every three days to be exact. In the middle of throwing a curveball or catching a pass, a young athlete dies of sudden cardiac arrest — an abrupt loss of heart function that affects more than 400,000 people in the U.S. and is the leading cause of death in competitive athletes.

Every so often, we hear about it on the news. A young man or woman who appears to be the picture of health and vigor has their life tragically cut short. But in reality, these incidents happen more than we realize and are possibly preventable.

For years, the medical community has thought that only about 20 fatal cases of sudden cardiac arrest occurred each year in the U.S. among young athletes. But new research presented in November 2006 by Dr. Barry Maron, director of the Hypertrophic Cardiomyopathy Center at the Minneapolis Heart Institute Foundation, at the American Heart Association conference shows that the number of deaths among those athletes under 35 is nearly six times higher. "This is still an underestimate," Maron says. "It is real public health problem." And those are just the cases we know about: the ones that are picked up by local TV stations and printed in the newspaper. In the absence of a government subsidized national registry, there is no telling just how high the number really is. ([See pictures of the college dorm's evolution.](#))

The disease itself is as mysterious as its incidence. Unlike many heart problems indicated by symptoms or murmurs, the conditions that cause sudden cardiac arrest usually do not show up during a physical or an athletic screening. That was certainly the case for Davis Nwankwo, a basketball player from Vanderbilt University who collapsed suddenly last year during practice and was found later to have hypertrophic cardiomyopathy, a condition that causes the heart muscles to thicken. "There were no warning signs at all," says Michael

Meyer, an athletic trainer who saved Nwankwo's life using an automatic external defibrillator (AED), a portable electronic device that stops cardiac arrhythmia by shocking the heart.

In the absence of symptoms, 95% of all sudden cardiac arrest victims will die on the scene. You can try to call for help, but in these dire cases, there isn't much time. It takes the average Emergency Medical Service team approximately 6 to 12 minutes to respond to any type of call, but with every minute that passes the chance of survival of sudden cardiac arrest decreases by 7 to 10%, according to the American Heart Association. (See pictures of college mascots.)

As a result, the U.S. National Athletic Trainer's Association and the Inter-Association Task Force recently recommended in the *Journal of Athletic Training* that every school in the country, public and private, have an AED on site. "We all wear life vests in the water, just in case something crazy does happen," says Chuck Kimmel, the President of the National Athletic Trainers' Association. "The AED is the cardiac life vest."

And it works. More than 70% of all sudden cardiac arrest victims are saved by defibrillators. Laura Friend, the cofounder of Parent Heart Watch, an advocacy group that helps to raise awareness and protect children from sudden cardiac death, knows that percentage all too well. Three years ago, she lost her 12-year-old daughter Sarah at a water park in Texas from the same condition as Nwankwo's. An AED might have saved Sarah's life. "It is an epidemic," Friend says. "When are we going to realize we are losing too many kids?"

Only nine states have laws in place that require an AED in any type of school. And most of those laws only apply to high schools, not colleges or universities. Struck by the deaths of four children in only two months last September and a total 15 deaths that same year, Texas recently passed the most comprehensive AED bill in the country, requiring every private, elementary, middle and high school in the state to have a defibrillator and a staff member trained to use it. "When the sixteenth child was saved by a defibrillator, the Governor finally woke up and said we do have a problem," Friend says. (See pictures of eighth-graders being recruited for college basketball.)

More importantly, the Texas bill also requires that the AED be available in a reasonable amount of time and be within reach of the athletes. "An AED only answers half of the problem if it is locked away in the nurse's office," says Dr. Jonathan Drezner, co-chair of the

Inter-Association Task Force Consensus Statement. "I see cases all the time where an athlete collapses and the school doesn't know where the AED is."

So what's the holdup? Like most problems, it boils down to simple dollars and cents. Schools just don't want to pay the money. The average AED now costs about \$1,500 and some are even available for less than a grand. But buying the equipment isn't the only hurdle, they also need to train someone to use it. "Money is a big problem," says Vanderbilt's Meyer, whose college has since bought ten additional defibrillators.

In Nwankwo's case, it was a small price to pay. The Vanderbilt junior, who still plays on the team and helps coach, says: "It could happen anytime to anyone."

Olivia Hoff

June 27, 1989 – Olivia Corinne Hoff was born into this world.

April 22, 2004 – Olivia died from sudden cardiac arrest.

Olivia was the perfect picture of health, so I thought. She was always involved in sports and cheerleading; so of course there could be nothing wrong with my daughter. She was so outgoing, always wanted to ride the fastest roller coaster, never afraid of anything. My daughter was looking forward to the future. She was thinking about becoming a foreign exchange student. She was also learning how to play the guitar because she wanted to be in an "all girl band". After Olivia's death, I found some songs she had written. My daughter was so full of life and had so many plans; but her life ended too soon. Little did I know that Easter Sunday, April 11, 2004, would be Olivia's last day alive. As I look back, I can remember what a wonderful day we had with all of our family. Olivia looked so pretty. I can still see her smile.



April 12, 2004, Olivia went into sudden cardiac arrest and was on life support. Ten days later, April 22, 2004, the doctors told us that Olivia no longer had any brain activity, Olivia's body was slowly starting to shut down. It was time to take my baby girl off the breathing machine. My husband and I were faced with a decision no parent should have to make, we had to let our Olivia go. The nurses allowed me to clean Olivia for the last time. I changed and cleaned her the way I did when she was a baby. I brushed her hair, kissed her perfectly polished "pink toes" and told her it was time to go home. We watched and cried as Olivia took her last breath.

April 22, 2004, Olivia was taken off life support and became my Angel in Heaven.

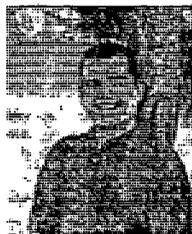
My daughter was an organ donor. On April 27, 2004, a 4-month old girl in Maryland was the recipient of Olivia's right cornea and a 29-year old man in Texas received the left cornea.

Olivia's heart valves were normal. Her heart valves were implanted into a 2-year old boy August, 2004.

Olivia's gift gave three people a chance at a better life.

Some people only dream of angels but I've held an angel, Olivia, in my arms.

Jorge Herrera



The morning of March 12, 2011 my 29 year old husband woke up with plans to buy a swing set for our then 14 month old daughter. Our sweet girl was the light of his eye. We were also six months pregnant with our first son. Jorge was beyond excited for our growing family. He was excelling in his career as an attorney and loved by countless friends and family. If I could say anything about my husband, it would be that his short life was overflowing with joyous memories. He valued experiences and great quality time with those he loved. He possessed a laugh that was very distinct and so infectious!

Our perfect world shattered in the blink of an eye that day. I will never forget his voice as he yelled out for me. I found him collapsed on our bed with our innocent baby girl tightly wrapped in his arms. I find comfort knowing he left this world hugging his princess. My husband was healthy. His death was unexpected and sudden. The autopsy did reveal some mild cardiomegaly, though not significant enough to cause his death. In honor of my husband's memory I look forward to educating others about Sudden Cardiac Death.

--

Crystal Ryan

"Be kinder than necessary, for everyone you meet is fighting some kind of battle."

Jimmy and Crissy

Jackie Renfrow

Like all parents, I worried about my children. As Jimmy and Crissy were growing up they both suffered what we thought of as seizures. I worried about them, but I knew that these seizures were part of my family's medical history. Jimmy and Crissy took the medications they were prescribed, and I thought they would live normal, productive lives. I was thrilled when Jimmy got married and had a beautiful daughter.



Jackie Renfrow's son Jimmy

My optimism was shattered by a phone call I received April 15, 2000. Jimmy was having a seizure, could I come? That call was followed by another call telling us that Jimmy had died of sudden cardiac arrest.

He was just 22 years old. He left behind a wife and a two-year-old daughter.

After that, I was so afraid for Chrissy. When she became pregnant, I was more worried than ever. My own seizures had increased after the births of my children and I was afraid this would happen to her, too.

Chrissy spoke with her doctor about my concerns, and he did an MRI, blood work, and an EEG. However, he didn't do an EKG, and it turns out that was the test that should have been done.

Chrissy gave birth to a baby girl, Jessica, Nov. 23, 2001. She was thrilled to be a mom. I still couldn't shake the feeling that something was going to go wrong. Everyone said this was because I was still suffering from Jimmy's death the year before.



Jackie Renfrow's daughter, Crissy

On July 25, 2002, I received a call saying that Crissy had passed out and her husband couldn't get her to come to. When I arrived at the hospital the doctor took us into a room and told us that Chrissy was gone. They were so sorry. Like Jimmy, she was a victim of sudden cardiac arrest.

I couldn't believe that this was happening. How could I lose both of my children to something that no one could explain?

It was about 10 months after Crissy died that my mom was rushed to the hospital for what we thought was a panic attack. In her case, all the necessary tests were done and we discovered that she has a medical condition called Long QT syndrome. It's a heart rhythm abnormality that, if left untreated or not treated properly, can cause seizures and sudden cardiac death.

Long QT syndrome is hereditary. I have it, and so do my two granddaughters. So did my Jimmy and Crissy. It turns out that a simple EKG test could have saved my children's lives.

I'm now doing everything I can to make sure that other families find out about Long QT syndrome so their children can get diagnosed and treated. And I want my community to have automated external defibrillators (AEDs) available so that when Long QT syndrome leads to sudden cardiac arrest, it doesn't have to be fatal.

I've started a chapter of the Sudden Cardiac Arrest Association in Indianapolis and am working with Cardiac Science, doctors, parents, and others to promote heart health. In memory of Jimmy and Crissy and on behalf of my grandchildren, I'm going to make sure that other families with Long QT syndrome are spared our losses.

Read about Jackie's efforts to encourage youth heart exams in [this IndyStar](#)

Ryan Clarke



The light of my life was extinguished on March 17, 2011. My son, Ryan, fell victim to sudden cardiac arrest. He was healthy, athletic and extremely active. He turned 30 on Monday and died on Thursday. My last memory of him alive was him pulling away my house in his car, birthday cake in tow, with his window down he waved to me and said "Love you Mom" The next time I saw him the EMS was doing CPR and using the AED. It was too late though at least 8 minutes had gone by without any care. My heart is so broken and I am looking so hard for a way to heal it. Ryan had been married for 1 year 9 months to the love of his life Gina. Prior to that time he worked as a firefighter and EMT and had the opportunity to save many lives. He wasn't rich or famous. He was Ryan and I am so proud of the man he became. His autopsy was completely normal, nothing abnormal at all and that makes it even harder to accept.

Center for Children's Advocacy

University of Connecticut School of Law, 65 Elizabeth Street, Hartford, CT 06105

**TESTIMONY IN SUPPORT OF RAISED BILL NO. 5514, Sections 14 and 15,
AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH
STATUTES**

March 21, 2012

This testimony is submitted on behalf of the Center for Children's Advocacy, a private, non-profit legal organization based at the University of Connecticut School of Law. The Center provides holistic legal services for poor children in Connecticut's communities through individual representation and systemic advocacy. I am an attorney at the Center and the Director of the Center's Teen Legal Advocacy Clinic, which provides legal services to teens throughout the state. In addition, I am the Chair of the Connecticut Team on Runaway and Homeless Youth,¹ a statewide group of professionals interested in improving access to services and supports for runaway and homeless youth in the state of Connecticut. The Team is comprised of state agencies including the Department of Children and Families (DCF), Court Support Services Division, and the State Department of Education, as well as private providers throughout the state including The Center for Children's Advocacy, The Council of Churches of Greater Bridgeport, RYASAP, CT Coalition to End Homelessness, True Colors, Women and Families Center, Partnership for Strong Communities, as well as others.

I am testifying today to urge you to support Raised Bill No. 5514, "An Act Concerning Various Revisions to the Public Health Statutes." Specifically, I am testifying in support of Sections 14 and 15, which amend the current statutes to allow homeless youth who are under eighteen years old to access their birth certificates. The proposed change would allow certain professionals including school district homeless liaisons and the director or designees of youth and adult shelters to certify that the youth is homeless, thus allowing the youth to directly request a copy of his/her birth certificate. This process mirrors the process outlined in the federal College Cost Reduction Act for unaccompanied homeless youth to access federal financial aid for college.



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By all accounts, the number of homeless youth has increased in CT. (Please see attached data.) The National Association for the Education of Homeless Children and Youth states that parental abuse and neglect is a primary cause of homelessness among unaccompanied youth (homeless youth who are on their own).² The National Network for Youth estimates that according to studies of a homeless youth sample, 33% had been in foster care, 51%

¹ The Connecticut Team on Runaway and Homeless Youth was convened in the summer of 2008 in response to a request by the American Bar Association's Committee on Homelessness and Poverty as well as the National Network for Youth that each state bring together advocates to affect systemic change on behalf of runaway and homeless youth.

² "Using What We Know: Supporting the Education of Unaccompanied Homeless Youth." 39, Julianelle, Patricia, The National Association for the Education of Homeless Children and Youth, February 2008, available at http://www.naehcy.org/dl/uwwk_youth.pdf.

had been physically abused, and 60% of girls and 23% of boys had been sexually abused.³ We also know that lesbian, gay, bisexual and transgender (LGBT) youth are over-represented among the homeless youth population. Multiple studies have found that one out of every five homeless youth (20 percent) is LGBT-identified. This is highly disproportionate to the estimated percentage of LGBT youth in the general population, which is approximately 10 percent.⁴

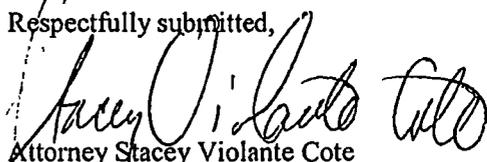
The dangers for minors who are living on their own are many. Homeless youth are targets to be lured into the life of prostitution (also called domestic minor sex trafficking), they are at risk for physical abuse, sexual abuse, illness and suicide. Removing barriers for homeless youth to access supports and services is critical.

For some homeless youth, school may be the only safe and stable environment available. Yet, without a parent or guardian to assist them, enrollment in school may be denied or delayed, particularly when the youth does not have access to required enrollment documents like a birth certificate. Connecticut State Coordinator for Education of Homeless Children and Youths has indicated that the proposed changes would help both school districts and homeless students to expedite school enrollment. The American Bar Association and the National Network for Youth recently published a book entitled "Runaway and Homeless Youth and the Law: Model State Statutes," where they emphasize the importance of homeless youth having access to identification documents, including birth certificates. The book also notes other states who have provided for flexibility in birth certificate requests (citing Pennsylvania, Maryland, Mississippi, and Texas).⁵

This bill would remove one of the many obstacles faced by unaccompanied homeless youth who are attempting to access supports to move out of homelessness. I get the calls from youth who are on their own and cannot get copies of their birth certificates in order to register in school, seek employment, get a state identification card, apply for food assistance or cash assistance, or become involved in a job training opportunity. Providers for homeless youth also tell us that youth who cannot access their birth certificates can experience delays in accessing health insurance and thus needed mental or medical health care. **Please support sections 14 and 15 of Raised Bill No. 5514. This bill provides a no-cost way to eliminate obstacles for homeless youth.**

Thank you for your time and consideration.

Respectfully submitted,


 Attorney Stacey Violante Cote
 Director, Teen Legal Advocacy Clinic
 Chair, CT Team on Runaway and Homeless Youth

³ "Unaccompanied Youth: Fast Facts" National Network for Youth, citing YouthCare, Inc., 1998, available at http://www.nn4youth.org/media/factsheets/FactSheet_Unaccompanied_Youth.pdf.

⁴ "Incidence and Vulnerability of LGBTQ Homeless Youth," National Alliance to End Homelessness, Solutions Brief, December 8, 2008.

⁵ Horton-Newell, Amy, Meyer, Katie & Trupin, Casey. "Runaway and Homeless Youth and the Law: Model State Statutes," pp 111-113 (2009).

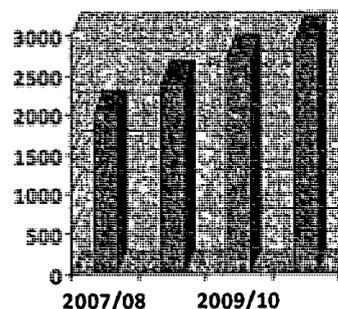
Connecticut's Invisible Population: Homeless Children and Youth

- This is the invisible population because no one knows how many unaccompanied homeless youth are in CT (youth who are on their own).
- Most youth are "couch surfing" and staying with friends or relatives for short periods of time.
- Homeless youth are counted differently by each agency, or not counted at all.
- Homeless youth are at risk for sex abuse, being lured into prostitution, physical abuse, illness and suicide.

What We Do Know:

Homeless children/youth enrolled in public school is increasing.

CT Department of Education
2010-11 School Year Total: 2942



Many children/youth run away from DCF care.

CT Department of Children and Families
2010/2011 Total Incidents: 2984

Minors are victims of prostitution.

Reported to DCF (2010-2011): 66

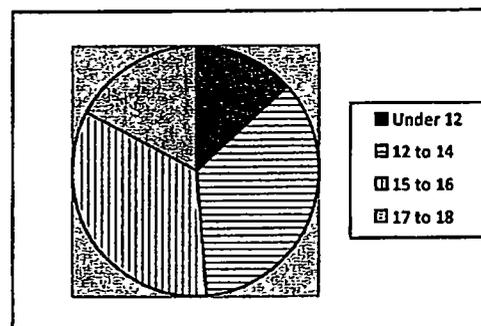
18-21 y.o.'s are in adult shelters/housing.

CT Homeless Management Information System
Fiscal Year 2011: 666

Some minors are in the few youth shelter beds in CT.

Total In Youth Shelters (Oct '10- Sept '11): 251
National Runaway and Homeless Youth Management Information System (RHYMIS)

Male:	102
Female:	149
<12 years:	33
12-14 years:	88
15-16 years:	85
17-18 years:	43
>18 years:	2



Bonhomme, Penny

From: Susan Israel [susie96@optonline.net]
Sent: Tuesday, March 20, 2012 10 15 AM
To: PHC Testimony
Subject: HB 5514 resubmission

To the Committee on Public Health

March 21, 2012

Testimony on H.B. 5514, Sec. 5, Subsection (b)

Submitted by Susan Israel, MD

I am Susan Israel, a physician. It is my hope that Sec. 5, Subsection (b) of HB 5514 will specifically state that only *unidentifiable* patient data, as it is being taken without consent, will be sent to the Dept. of Public Health, by the hospitals, labs and providers, and that no DNA testing be done on the tissue without patient consent. And only aggregated data be released to the public, to further protect patient privacy.

Subsection (b) mandates that tissue of tumors may be sent to the DPH, along with demographic and treatment information, and the "Commissioner of Public Health shall promulgate a list of required data items." So the Commissioner has open ended authority to delve into your medical record without your consent. It seems that the intention must be to have the name of the patients, as per the testimony of the Commissioner of Public Health on HB 5038, the All-Payer Claims Database, CT Tumor Registry (CTR). And to quote: "The CTR conducts follow-up on all cancer patients for vital status. The CTR uses data sources such as *driver's license* renewal date or hospital discharge date and ... status to ascertain that a patient was alive at a certain date. An all-payer claims database, extending to *outpatient care and prescriptions*, would improve the completeness of the follow-up...". So this seems to mean that the CTR will receive our cancer information and our hospital information *with* our identities attached.

So let's say a woman has cervical cancer. The state may wish to know her history of sexually transmitted infections because HPV may cause cervical cancer. But please let us have laws that would avoid a patient having an invasive tumor and an invasive state.

Thank you very much for this opportunity.

3/20/2012



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Office of the Commissioner

**TESTIMONY PRESENTED BEFORE THE PUBLIC HEALTH COMMITTEE
March 21, 2012**

Jewel Mullen, MD, MPH, MPA, Commissioner, (860) 509-7101

House Bill 5514 - An Act Concerning Various Revisions to the Public Health Statutes

The Department of Public Health supports certain sections of House Bill 5514. The Department would like to thank the Public Health Committee for raising the Department's bill.

Below is a description of each of the sections of the bill. Highlights of the Department's proposed sections 1 through 13 include technical changes to the birth and marriage certificate process, the tumor registry reporting section, tuberculosis program, and oral health program; clarifying the definition of a subsurface sewage disposal system installer and subsurface sewage disposal system cleaner, and the qualifications for a physician practicing at a youth camp. The Department has subject matter experts available who can answer any questions you might have related to each section.

Section 1. The Department supports the proposed language in section 1 of the bill, however, we respectfully request an amendment as follows: "*Amendment*" means to (A) change or enter new information on a certificate of birth, marriage, death or fetal death, more than one year after the date of the vital event recorded in such certificate, in order to accurately reflect the facts existing at the time of the recording of the event, (B) create a replacement certificate of birth for matters pertaining to parentage and gender change, or (C) change a certificate of birth, [marriage, death or fetal death to reflect facts that have changed since the time the certificate was prepared, including, but not limited to,] to reflect a legal name change in accordance with section 19a-42(f) of the Connecticut General Statutes or make a modification to a cause of death.

This change to the definition of an "amendment" will assist the Department in its mission to uphold the integrity of vital records. The information on a vital record documents the facts as they exist at the time of the vital event. This information should be preserved except in those circumstances that are specified in statute. The exceptions include matters of adoption, paternity, gestational agreements, gender change, a legal name change for a birth registrant, and a change to the cause and manner of death. These amendments to original vital records information are allowed because they serve a greater public need. Allowing other types of amendments, such as changing address information or name information for persons other than a birth registrant, do not serve a greater public need, but instead undermine the integrity of vital records.

Section 2. Revises section 7-60 by removing the statutory reference to C.G.S. section 7-50, regarding acknowledgements of paternity. By removing the statutory reference, parents of a fetus born dead will no longer have to be subject to the formal acknowledgement of paternity process. Instead, the Department and DSS would like to initiate a simpler acknowledgement process that would bypass many of the formal requirements, such as being notified of rights and responsibilities that do not apply in the case of a fetal death. The simpler process will be more sensitive to grieving families.

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Section 3 Revises section 46b-25, which concerns the expiration date of a marriage license. Under current statute, if the parties to the marriage sign the marriage license on different dates, the 60 day expiration period will be calculated from the earlier of the two dates. Local vital records registrars have requested that the calculation of the time frame be changed so that the 60 day time period begins from the later date.

Section 4. Revises section 46b-30 to clarify that only a custodial parent has the right to grant permission for a minor to marry

Section 5. Makes a technical change to section 19a-72 requiring those entities who submit information to the Department regarding the diagnosis and treatment of tumors also include a complete pathology report.

Section 6. Creates a new subsection (d) of section 19a-255 which would allow the Department of Public Health to enter into reciprocal agreements with other states so that patients with tuberculosis can be transported and treated in state run institutions when the required care and/or expertise is not available in Connecticut. The management and treatment of tuberculosis (TB) patients is often medically and socially complex. This includes patients with multi-drug resistant TB who require specialized care (e.g. surgery), as well as patients who are not willing to cooperate with public health authorities. This section would allow the Department of Public Health to take advantage of TB treatment facilities and expertise that are available at state-run institutions in both Massachusetts and New Jersey. Currently, there is no similar institution or facility for the treatment of TB patients in Connecticut. The Department of Public Health needs to be able to have the option of sending patients to other state-run institutions so that medically or socially complex patients have the best chance of having their TB disease cured and the health of the people of Connecticut can be protected.

Section 7. Makes changes to section 19a-41, regarding qualifications for the State Dental Director. The current statute requires that the director of the Office of Oral Public Health be a dental health professional with a graduate degree in public health and hold a license to practice under chapter 379 or 379a. The specificity of the requirement limits the ability of the DPH to fill the position, which is required by the federal Oral Health Infrastructure Cooperative Agreement. The CDC-funded Cooperative Agreement for State Oral Health Infrastructure requires that the state have a State Oral Health Director. The DPH has already been cited for being out of compliance with this requirement. The state risks losing this agreement (approximately \$300,000/year) and the ability to apply for further CDC funding. We are in year 4 of this 5 year agreement. In addition, since the CDC Cooperative Agreement is the core of the State Oral Health Office, losing this funding may negatively impact the opportunity to apply for funding from other sources.

Section 8. Makes revisions to section 52-146k, by deleting the reference to the Department of Public Health. Current language mandates the department to complete regulations to define the criteria for rape crisis centers. The Department does not have statutory authority over rape crisis centers. Without this statutory authority, the Department has no way of identifying the rape crisis centers and enforcing the regulations. Therefore, we are proposing to eliminate the requirement for the Department to develop criteria.

Section 9. Revises section 19a-37 to specify arsenic and specific radionuclides that are of concern in groundwater. The radionuclides of concern are radium, uranium, radon or gross alpha emitters.

Section 10. This section revises section 20-341a to strike the word "regularly" from subsurface sewage disposal system installer and cleaner definitions. This will allow the Department to take action against individuals that practice the work of a subsurface sewage disposal system (SSDS) cleaner or installer without a license.

Sections 11 and 12. This proposal would raise the maximum penalty cited in CGS Sec. 20-341 that can be pursued against individuals that practice the work of a subsurface sewage disposal system cleaner or installer without a license, and against individuals that violate other provisions of CGS Chapter 393a. The current maximum penalty is \$100 per violation, this language raises the maximum available penalty to \$10,000. Many individuals who practice without a license will choose to absorb the \$100 fine and may provide substandard work, costing the homeowner thousands of dollars to fix their mistakes.

Section 13. The Department supports this section of the bill which amends section 20-12 to allow a physician with a current license to practice as a youth camp physician. However we respectfully request an amendment to the language in lines 153 and 154 to state the following

(e) Any physician [licensed] or surgeon who holds a license in good standing in another state [who is board-certified in pediatrics or family medicine, or whose state standards for licensure are equivalent to or greater than those required in this state,] may practice as a youth camp physician in this state without a license for a period not to exceed nine weeks

The Department of Public Health has the following concerns with regards to sections 14, 15, 22 and 23 and respectfully requests amending the bill to address these concerns.

Sections 14 and 15. The Department is opposed to these sections of the bill, which contain provisions to allow emancipated minors and certified homeless youth access to birth certificates. However, please note that the Department only has concerns about the portion of the bill referring to certified homeless youths.

The definition of 'certified homeless youth' has no minimum age requirement. This means that very young children will be eligible to access birth certificates. Birth certificates often contain sensitive information -- matters of paternity, incarceration of mother at time of birth, etc -- that a young child may not be emotionally equipped to handle

Additionally, there is no mechanism in place to verify the identity of the youth. Those given the authority to certify under this bill, such as a shelter director, often have no verification of a resident's identity, and often do not inquire into the matter for fear of dissuading the person from staying and accepting help. This opens up the potential for fraud and identity theft

Finally, certified homeless youth are unlikely to meet the identification requirements that are needed to obtain a birth certificate, and without proper ID the birth certificate cannot be issued. These identification requirements are in place to protect against fraud, and for security purposes cannot be waived. To reiterate, the provisions regarding emancipated minors are not of concern, only those related to certified homeless youths

Sections 22 and 23. -- These sections mandate athletic departments of an institution of higher education and health club owners to have an automatic external defibrillator (AED) on the premises. Section 22 mandates the institutions to have at least one athletic trainer or other person trained in CPR and the use of the AED on site during all sports practices, training and competition. Section 23 mandates the health club owners to have at least one employee trained in the use of the AED during business hours. Section 23 also mandates the Department of Consumer Protection to take action against a health club if they violate any of the provisions set forth in this chapter. Please note that the Department has been informed that the Department of Consumer Protection will have a fiscal impact if section 23 were to pass

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