

Connecticut Commission on
Women, Children *and* Seniors



Testimony before the Committee on Public Health of the General Assembly
Submitted by Steven Hernández, Executive Director
Commission on Women, Children and Seniors
February 17, 2017

Re: **SB 248, An Act Requiring a Certificate of Need for the Reduction of Services at a Hospital**

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bill.

SB 248, An Act Requiring a Certificate of Need for the Reduction of Services at a Hospital

CWCS supports SB 248 because it would help protect women's healthcare services. According to the Office of Legislative Research, some states, including Connecticut, require health care facilities to obtain a certificate of need (CON) before terminating specified services. However, Connecticut generally does not require CON authorization to reduce services.¹ Unchecked reductions in services can have negative consequences for women's health.

As one example, many hospitals have moved to dramatically reduce access to well-baby nurseries for new mothers. Over the past several years, hospitals in Connecticut, as well as nationally, have been pushing a "rooming in" approach for babies and their parents. This movement is led by the Baby Friendly Hospital Initiative (BFHI) as a way to increase breastfeeding rates. As hospitals seek baby-friendly hospital designations, they are reducing or even eliminating women's access to well-baby hospital nurseries.

CWCS does not support the baby-friendly hospital initiative because we believe in supporting women's choices and that includes whether they use the hospital nursery to rest and recover from childbirth or choose to room in with their baby. Unfortunately, there is anecdotal evidence that the many new mothers in Connecticut were unaware that the hospital they gave birth at had reduced access to well-baby nurseries until they asked to use the nursery and were declined.

Hospital nurseries are only one example of the negative effects on women's health due to a lack of checks-and-balances in hospital decisions to reduce services. CWCS supports efforts to provide more transparency and accountability in hospital service decisions.

¹ CT Office of Legislative Research, Certificate Of Need And Service Reductions

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Re: **HB 5564, An Act Concerning Accessibility of Medical Diagnostic Equipment**

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bill.

HB 5564, An Act Concerning Accessibility of Medical Diagnostic Equipment

Approximately 20% of U.S. females aged 18–64 live with at least one disabling condition.ⁱ According to the Centers for Disease Control and Prevention, the Americans with Disabilities Act (ADA) has made a positive difference in the lives of those who have disabilities, providing better access to buildings, transportation, and employment. However, health disparities (differences in health) between people with and without disability are still presentⁱⁱ. The Commission on Women, Children and Seniors supports legislation aimed at increasing access to the healthcare system for people with disabilities.

Women with disabilities have the same needs as women without disabilities when it comes to basic reproductive health care including pap smears, pelvic exams and mammograms. However, according to the Center for Research on Women with Disabilities,ⁱⁱⁱ women with major long-term mobility impairments have greater challenges getting access to this care and are consequently less likely to have these important examinations.

Medical equipment and technologies—especially examination tables and diagnostic tools—that do not fit or measure “nonstandard” bodies can limit access.^{iv} This includes mammography equipment.

Unfortunately this means that:

- Women with extensive functional limitations are less likely to receive breast and cervical cancer screening according to recommended guidelines than are non-disabled women;
- Women with disabilities are sometimes told that a pelvic exam is unnecessary when the real reason is it would be too difficult to perform;
- Women with disabilities are more likely to be diagnosed at later stages of breast cancer;

- Treatment is likely to be less successful when begun at a late stage, resulting in increased mortality rates; and
- Pregnant women with physical disabilities may have difficulty accessing quality prenatal care.

Increasing access to medical diagnostic equipment will help reduce health disparities and create better health outcomes for people with disabilities. For this reason, CWCS supports HB 5564, as it will increase access to medical diagnostic equipment, and thereby will help reduce health disparities and create better health outcomes for people with disabilities.

ⁱ Altman B and Bernstein A, Disability and Health in the United States, 2001–2005, Hyattsville, MD: National Center for Health Statistics (NCHS), 2008.

ⁱⁱ The Center for Disease Control and Prevention, Key Findings: Prevalence of Disability and Disability Type among Adults, United States – 2013 <<https://www.cdc.gov/ncbddd/disabilityandhealth/features/key-findings-community-prevalence.html>>

ⁱⁱⁱ <<https://www.bcm.edu/research/centers/research-on-women-with-disabilities/topics/health-care/reproductive-health-care>>

^{iv} *ibid*

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Testimony before the Committee on Public Health of the General Assembly
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Re: HB 5811, An Act Concerning the Provision of Telehealth Services

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bill.

HB 5811, An Act Concerning the Provision of Telehealth Services

In 2015, [PA 15-88](#) established standards for health care providers who provide telehealth services and required certain health insurance policies to cover medical services provided through telehealth to the extent they cover the services through in-person visits. Additionally last year PA [16-198](#) built upon the previous year's legislation in providing coverage for Telehealth services under the Medicaid program. Telehealth services are cost effective, increase access, have the potential to improve outcomes, and particularly benefit those limited by mobility or transportation. Using telehealth to address mobility limitations, major distance or time barriers, and transportation limitations will become increasingly important as Connecticut prepares for longer-lived, growing numbers of older adults. However, they must be administered with consideration to the risks and benefits for the patient. In the absence of an existing physician patient relationship, a face to face physical exam prior to receiving telehealth services is the best practice to ensure patient safety.ⁱ The physician patient relationship builds upon trust as the foundation for safe, effective care. A physician and patient develop a collaborative relationship, both working toward mutually agreed upon health outcomes for the patient. Telehealth, while having many advantages, can depersonalize the patient experience. Additionally, certain challenges exist with telehealth exams, such as physical assessments that require touch, detect tenderness, pressure, and smell. Other states, such as Delaware and Arkansas require in person physical exams prior to establishing a telehealth relationship. We support ongoing expansion of telehealth services and recognize the importance of protecting the patient and following a person-centered model to ensure the best health outcomes.

ⁱ Sourced from <http://annals.org/aim/article/2434625/policy-recommendations-guide-use-telemedicine-primary-care-settings-american-college>

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Testimony before the Committee on Public Health of the General Assembly
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Re: HB 6021, An Act Concerning Homeless and Unaccompanied Minor Consent to Primary Care

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bills.

HB 6021, An Act Concerning Homeless and Unaccompanied Minor Consent to Primary Care

CWCS testifies today in support of the concept of providing greater access to primary care services for homeless and unaccompanied minors. To the extent a lack of parental consent might bar access to such services, in particular to the full array of wellness services recommended by pediatricians for all children, the proposed statute would fill a void in the state's current statutory framework providing protections for homeless children and youth. The Commission does have some concern about the specific language of the bill, and some details of coverage, that are detailed below.

Poverty, and associated homelessness among families with children under 6, continues to grow in Connecticut. Families with young children are the fastest growing segment of the homeless population in the United States, accounting for nearly 40% of the homeless.¹ In 2015, there were an estimated 3,000 to 9,000 families with young children who were homeless in the state of Connecticut, according to the Federal McKinney-Vento definition. Inadequate housing and the accompanying instability is traumatic for a family, but particularly detrimental for the long-term health and development of children. While there are many interventions that have been considered in the state to quickly meet the broad range of needs facing homeless citizens while they are in crisis, it seems the height of simplicity to address the health care needs of those minors who, through no fault of theirs, find themselves without home or parents to take charge of their ongoing medical needs. Addressing those needs as and when they arise, as we would for all

¹ http://center.serve.org/nche/downloads/briefs/who_is_homeless.pdf

children, would do much to prevent irreparable damage to unaccompanied minors, and their potential development of lifelong health and developmental challenges.

Connecticut has enacted law addressing parental consent for emergency care, and the right of homeless persons to receive emergency care; we feel the provisions of Section 17a-81 are sufficient to address the emergency treatment of homeless minors, in the absence of parental consent, when a physician concludes that treatment is necessary to prevent serious harm to the child. Similarly, outpatient mental health treatment is available to minors without prior parental consent under Section 19a-14c, and this provision would apply to homeless minors who seek treatment, so long as they have themselves consented to treatment as provided in the statute; that statute does not go far enough, however, to protect the needs of unaccompanied and homeless minors, because a consent requirement arises after six sessions of treatment, and after every six sessions thereafter, requiring a reappraisal of the case, with the potential result that treatment will be terminated. (See Section 19a-14c, Subsection (c)). Such interruption in treatment, once begun, could have unpredictable and perhaps disastrous effects. The Commission therefore recommends that the proposed bill include language expanding its coverage to mental health treatment, to extend the protections for homeless minors receiving mental health care under existing legislation.

Aside from those concerns, the Commission also wishes to raise the issue of the meaning of “primary care.” Does it include the full schedule of preventive treatment prescribed by the American Academy of Pediatrics? Would the treatment codes assigned by insurance providers for reimbursement be an appropriate source of guidance? Our research indicates the Connecticut statutory framework lacks a definition. It was, in fact, a duty of the now defunct State-wide Primary Care Access Authority, under Section 19a-6h, Subsection (e)(1), to “determine what constitutes primary care services;” perhaps a report of the findings of that authority might lend guidance. Certainly, the Commission would advocate that the bill provide for pediatrician-recommended primary medical and dental care.

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Re: HB 6951, An Act Concerning the Protection of Patients Receiving Telehealth Care or Services Provision of Telehealth Services

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bill.

HB 6951, An Act Concerning the Protection of Patients Receiving Telehealth Care or Services

In 2015, [PA 15-88](#) established standards for health care providers who provide telehealth services and required certain health insurance policies to cover medical services provided through telehealth to the extent they cover the services through in-person visits. Additionally last year PA [16-198](#) built upon the previous year's legislation in providing coverage for Telehealth services under the Medicaid program. Telehealth services are cost effective, increase access, have the potential to improve outcomes, and particularly benefit those limited by mobility or transportation. Using telehealth to address mobility limitations, major distance or time barriers, and transportation limitations will become increasingly important as Connecticut prepares for longer-lived, growing numbers of older adults. However, they must be administered with consideration to the risks and benefits for the patient. In the absence of an existing physician patient relationship, a face to face physical exam prior to receiving telehealth services is the best practice to ensure patient safety.¹ The physician patient relationship builds upon trust as the foundation for safe, effective care. A physician and patient develop a collaborative relationship, both working toward mutually agreed upon health outcomes for the patient. Telehealth, while having many advantages, can depersonalize the patient experience. Additionally, certain challenges exist with telehealth exams, such as physical assessments that require touch, detect tenderness, pressure, and smell. Other states, such as Delaware and Arkansas require in person physical exams prior to establishing a telehealth relationship. We support ongoing expansion of telehealth services and recognize the importance of protecting the patient and following a person-centered model to ensure the best health outcomes.

¹ Sourced from <http://annals.org/aim/article/2434625/policy-recommendations-guide-use-telemedicine-primary-care-settings-american-college>

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Testimony before the Committee on Public Health of the General Assembly
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Re: HB 7048, An Act Protecting Youth and Student Athletes From Concussions

Senators Gerratana and Somers, and Representative Steinberg, and distinguished members of the Public Health Committee, thank you for the opportunity to provide testimony on behalf of the Commission on Women, Children and Seniors (CWCS) on the above referenced bills.

HB 7048, An Act Protecting Youth and Student Athletes From Concussions

CWCS testifies today in strong support for expanding concussion protections for all children in the state of Connecticut.

Representing the Commission on Children, the predecessor agency to CWCS, I testified exactly one year ago on a similar measure before the Committee on Children, and at the time incorporated by reference prior testimony from 2015. Prior to the consolidation of the commissions in 2016, the Commission on Children served the Concussion Task Force in an organizing and administrative capacity, and worked side by side with the members of the task force, who brought various areas of expertise and interest to our understanding of concussions and their impact on public health. The accumulated research into the incidence of concussions, their effects and treatment, and the identification of best practices and model legislation to protect those athletes who are most frequently exposed to concussion risk, have all served to support the current position of CWCS, as it has succeeded to the original mandate designating the Commission on Children. The Co-Chairs and members of the task force are owed a debt of thanks for their leadership and service, throughout our long engagement in this work. Building upon that foundation, CWCS continues in its unequivocal support for the expansion of concussion protections.

A concussion is a traumatic brain injury. The facts about concussion injuries are clear, but they bear repeating: 3,800,000 concussions were reported in 2012, double the number reported in 2002. Most recent figures indicate that 4 to 5 million concussions occur annually, with rising numbers among middle school athletes. Whether the increase is due to better reporting, or to the spate of bills in other states that have raised awareness of the issue, or whether the increases are due to higher levels of sports activity, the incidences of concussions are growing.

In 39% of cases of cumulative concussions, the likelihood of catastrophic injury is increased, leading to permanent neurologic disability. An estimated 5.3 million Americans live with a traumatic brain injury-related disability, according to the Centers for Disease Control; enforcement of rules regarding return to play, such as those in House Bill 7048, are critical best practices which offer some hope of stemming the tide of this growing disability.

Our research tells us that 33% of all sports concussions happen at practice, and that 90% of all diagnosed concussions do *not* involve a loss of consciousness; so training in identifying symptoms and behaviors indicative of concussion is critical.

47% of all reported sports concussions occur during high school football; 1 in 5 high school athletes will sustain a sports concussion during the season; 33% of high school athletes who have a sports concussion report two or more in the same year, again leading to caution regarding return to play and appreciation of the stakes attached to the return to play requirements of the bill.

And recent research has shown that teenage girls are more prone to concussions than boys. A 2007 study found the concussion rate among girl soccer players was 68 percent higher than among boys playing the same sport. Another 2007 study showed the concussion rate for high school basketball players was three times higher among girls than boys. This is an issue that respects no limits in age or gender, just as it respects no limits as to school time athletic activity or that taking place on public fields at other times.

The warnings drawn from these figures have not fallen on deaf ears: the state of Connecticut has enacted statutes on concussion safety. In 2010 the state mandated concussion education for high school coaches, along with remove-from-play and return-to-play protocols. The proposal in this bill would extend some of those protections to children on fields other than school premises, outside of school hours, where the authority over and ownership of the field might differ, but the dangers are still the same.

Youth concussion laws are, finally, about accountability, and in the case of this bill, best practices. This proposal would move our state one step closer to ensuring that children exposed to injury on our public playing fields, whether in school or out, are supervised and attended to by adults trained in the state of the art regarding concussion safety.

The Commission strongly supports this bill, with the few amendments outlined in the draft attached to this testimony for your consideration.

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CWCS

PROPOSED CHANGES TO LCO No.

3669

18-20 Trinity St., Hartford, CT 06106
860-240-1475 • www.ctcwcs.com



General Assembly
January Session, 2017

Raised Bill No. 7048

LCO No. 3669



Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT PROTECTING YOUTH AND STUDENT ATHLETES FROM CONCUSSIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 21a-432 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) For purposes of this section:

(1) "Youth athletic activity" means an organized athletic activity involving participants [of not less than seven years of age and not more than nineteen] under twenty years of age, who (A) (i) engage in an organized athletic game or competition against another team, club or entity or in practice or preparation for an organized game or competition against another team, club or entity, or (ii) attend an organized athletic camp or clinic the purpose of which is to train, instruct or prepare such participants to engage in an organized athletic game or competition, and (B) (i) pay a fee to participate in such organized athletic game or competition or attend such camp or clinic, or (ii) whose cost

to participate in such athletic game or competition or attend such camp or clinic is sponsored by a municipality, business or nonprofit organization. "Youth athletic activity" does not include any college or university athletic activity, or an athletic activity that is incidental to a nonathletic program or lesson; and

(2) "Operator" means any municipality, business or nonprofit organization that conducts, coordinates, organizes or otherwise oversees any youth athletic activity but shall not include any municipality, business or nonprofit organization solely providing access to, or use of, any field, court or other recreational area, whether for compensation or not.

(b) (1) Not later than July 1, ~~2016~~ 2017, and annually thereafter, each operator of a youth athletic activity shall make available a written or electronic ~~statement~~ information and consent form regarding concussions to each youth athlete participating in the youth athletic activity and to a parent or legal guardian of ~~each~~ any such youth athlete participating in the youth athletic activity under the age of eighteen. Such written or electronic ~~statement~~ information and consent form shall be (A) made available upon registration of each youth athlete, (B) substantially similar to the consent form developed or approved by the State Board of Education under subdivision (1) of subsection (e) of section 10-149b, and ~~shall be~~ (C) consistent with the most recent information provided by the National Centers for Disease Control and Prevention regarding concussions. Such written or electronic ~~statement~~ information or consent form shall include educational content addressing, at a minimum: [(1)] (i) The recognition of signs or symptoms of a concussion, [(2)] (ii) the means of obtaining proper medical treatment for a person suspected of sustaining a concussion, [(3)] (iii) the nature and risks of concussions, including the danger of continuing to engage in youth athletic activity after sustaining a concussion, and [(4)] (iv) the proper procedures for allowing a youth athlete who has sustained a concussion to return to athletic activity.

Comment [A1]: The CWCS will develop a consent for that is accessible online and downloadable.

(2) Not later than July 1, 2017, and annually thereafter, each operator of a youth athletic activity shall obtain the signature of each youth athlete eighteen years of age or older and the signature of the parent or legal guardian of each youth athlete under the age of eighteen, attesting to the fact that such youth athlete, parent or legal guardian has received a copy of the information and consent form and consents to participate in the athletic activity or authorizes the youth athlete to participate in the athletic activity.

(c) (1) Not later than July 1, 2017, and annually thereafter, each operator of a youth athletic activity shall ensure that any individual coaching a youth athletic activity complete an initial training course regarding concussions that is substantially similar to the initial training course developed or approved under subdivision (1) of subsection (b) of section 10-149b.

Comment [A2]: Clarify that this may include free CDC concussions course.

(2) For the school year commencing July 1, 2018, and each school year thereafter, any individual coaching a youth athletic activity who has completed the initial training course described in subdivision (1) of this subsection shall annually review current and

relevant information regarding concussions that is substantially similar to the annual review materials developed or approved under subdivision (2) of subsection (b) of section 10-149b. Such annual review shall not be required in any year when such individual coaching a youth athletic activity is required to complete the refresher course, pursuant to subdivision (3) of this subsection.

(3) For the school year commencing July 1, 2022, and each school year thereafter, an individual coaching a youth athletic activity shall complete a refresher course regarding concussion recognition and safety practices that is substantially similar to the refresher course developed or approved under subdivision (3) of subsection (b) of section 10-149b, not later than five years after completion of the initial training course required under subdivision (1) of this subsection. Such operator shall thereafter retake such refresher course at least once every five years.

~~[(c) No]~~ (d) The operator, or designee of such operator, shall be subject to civil liability for failing to make available the ~~[written or electronic statement]~~ information and consent form regarding concussions pursuant to subsection (b) of this section.

(e) Any individual coaching a youth athletic activity shall immediately remove an athlete from participating in any youth athletic activity who (A) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following an observed or suspected blow to the head or body, or (B) is diagnosed with a concussion by a licensed health care provider trained in concussion management, regardless of when such concussion may have occurred. Upon such removal, a reasonable effort shall be made to notify the parent/guardian that the athlete has exhibited such signs, symptoms or behaviors consistent with a concussion. This notification shall be made in a timely fashion and not later than twenty-four hours after such removal.

(f) An athlete who is suspected of sustaining a concussion shall not be permitted to participate in the activity/competition on that day, and may not return to any athletic activity until evaluated by a licensed health care provider trained in concussion management. The athlete shall not be permitted to return to athletic activity until he or she receives written clearance to return to athletic activity from a licensed health care provider trained in concussion management.

Sec. 2. Section 10-149c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) The coach of any intramural or interscholastic athletics shall immediately remove a student athlete from participating in any intramural or interscholastic athletic activity who (A) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following an observed or suspected blow to the head or body, or (B) is diagnosed with a concussion, regardless of when such concussion may have occurred. Upon such removal, a qualified school employee, as defined in subsection (e) of section 10-212a, shall notify the student athlete's parent or legal guardian that the student athlete has exhibited such signs, symptoms or behaviors consistent with a concussion or

has been diagnosed with a concussion. Such qualified school employee shall provide such notification not later than twenty-four hours after such removal and shall make a reasonable effort to provide such notification immediately after such removal.

(2) The coach shall not permit such student athlete to participate in any supervised team activities involving physical exertion, including, but not limited to, practices, games or competitions, until such student athlete receives written clearance to participate in such supervised team activities involving physical exertion from a licensed health care professional trained in the evaluation and management of concussions.

(3) Following clearance pursuant to subdivision (2) of this subsection, the coach shall not permit such student athlete to participate in any full, unrestricted supervised team activities without limitations on contact or physical exertion, including, but not limited to, practices, games or competitions, until such student athlete (A) no longer exhibits signs, symptoms or behaviors consistent with a concussion at rest or with exertion, and (B) receives written clearance to participate in such full, unrestricted supervised team activities from a licensed health care professional trained in the evaluation and management of concussions.

(b) The State Board of Education may revoke the coaching permit, in accordance with the provisions of subsection (i) of section 10-145b, of any coach found to be in violation of this section.

(c) For purposes of this section, "licensed health care professional" means a physician licensed pursuant to chapter 370, a physician assistant licensed pursuant to chapter 370, an advanced practice registered nurse licensed pursuant to chapter 378, [or] an athletic trainer licensed pursuant to chapter 375a or a chiropractor licensed pursuant to chapter 372.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<u>July 1, 2017</u>	21a-432
Sec. 2	<u>July 1, 2017</u>	10-149c

Statement of Purpose:

To protect youth and student athletes from concussions.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]