State of Connecticut
Department of Public Health

2006 Legislative Analysis

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Sources of Information

The following summaries have been compiled from the Office of Legislative Research bill analyses and tailored specifically for the Department of Public Health. Only Public Acts affecting, or of interest to the Department were included in this issue.

For Further Information

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Availability on the U:/Drive

The 2006 Legislative Analysis is available on the LAN at the following site:
u:/legalert/2006legis/summary/summary.doc

Availability on the Internet

The 2006 Public Acts and reports are available through the Connecticut General Assembly's web site:
http://www.cga.state.ct.us/

Acknowledgments

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DEPARTMENT OF PUBLIC HEALTH
ADOPTED BUDGET 2006-2007
PUBLIC ACT 06-186, HOUSE BILL 5845
PUBLIC ACT 06-188, SENATE BILL 703
PUBLIC ACT 06-195, SENATE BILL 317
AS OF JULY 1, 2006

	2005-06	2006-07	2006-07	Dif	
	Estimated	Governor's	Adopted	Gov	Notes
SID number and Program Title	Expenditures	Recommended	Budget	Adopted	
	$$$	$$$	$$$	$$$	
10010 Personal Services *	27,399,217	29,187,676	30,263,394	1,075,718	Includes $850,000 general salaries deficiency; $225,718 for enhanced Lead program with 15 positions
10020 Other Expenses *	5,202,177	5,327,136	5,852,136	525,000	Includes $50,000 for med Interpreters and $125,000 for lead; $50,000 drug importation website posting; $300,000 for E Health
10050 Equipment*	4,000	1,000	5,500	4,500	Minor equipment for lead poisoning
12100 Needle and Syringe Exchange	549,495	481,306	488,526	7,220	COLA
12112 Community Srvs. Supp.-Persons with AIDS	193,402	195,280	198,210	2,930	COLA
12126 Children's Health Initiative	1,163,870	1,052,967	1,066,466	13,499	COLA
12227 Childhood Lead Poisoning*	238,414	240,729	336,840	96,111	COLA of $3,611 and $92,500 for Lead
12236 AIDS Services	4,659,821	4,597,121	4,664,690	67,569	COLA
12255 Breast & Cerv. Cancer Detection & Treatment	1,762,409	1,668,273	2,343,251	674,978	COLA of $24,978 and $650,000 program enhancement
12253 Srvs. For Children affected by AIDS	296,938	259,154	263,042	3,888	COLA
12264 Children with Spec. Hlth. Care Needs	1,672,297	1,345,644	1,365,283	19,639	COLA
12268 Medicaid Administration	1,365,283	3,462,246	3,462,246	-	
16060 Community Health Services	6,064,138	6,088,296	6,629,621	541,325	COLA of $91,325 and $250,000 by Hlth Access Prog and $200,000 United Comm & Fam Serv
16085 Emergency Medical Services Training	84,485	85,485	85,485	-	
16089 Emergency Medical Services Regional Offices	490,085	494,608	675,028	180,420	COLA of $7,420 and $173,000 for EMS Regional Offices (pick-up from PHBG)
16103 Rape Crisis	548,644	418,527	424,805	6,278	COLA
16112 X-Ray Screening and Tuberculosis Care	763,228	699,303	702,656	3,353	COLA
16121 Genetic Diseases Program	597,343	635,126	892,793	257,667	COLA of $7,667; $250,000 for adults with congenital

					blood disorders; $124,000 regional treatment centers
16133 Loan Repayment Program	122,620	122,620	124,460	1,840	COLA
16136 Immunization Services	7,100,000	9,044,950	9,044,950	-	$346,950 for Pertussis and $1,598,000 for Meningococcal Conjugate vaccines
17009 Local and District Departments of Health	4,195,374	4,195,374	4,331,550	136,176	COLA of $ 63,224 to FT depts. And districts and $72,952 to reflect updated population figures
17013 Venereal Disease Control	252,234	212,657	215,847	3,190	COLA
17019 School-based Health Clinics	6,743,781	6,646,760	7,676,462	1,029,702	COLA of $99,702; Greenville Elem. $75,000; Rippowam Midd. $50,000; Barnard Magnet N. Haven $100,000; Meriden $130,000; Bloomfield $75,000; Pro rate to all other SBHCs $500,000.
Total	**$71,469,255**	**$76,462,238**	**$80,813,241**	**$4,651,003**	
Notes:					
(1) Includes the $300,000 carry forward funds for E-Health					
In the Stem Cell fund $200,000 of the funding is designated for administrative support of the program for the 2007 fiscal year. (No new positions)					
Authority for retention of an additional $155,000 from the NBS fees for testing expenses SB 703 - LCO 5627					
35324 Stem Cell Research	10,000,000	10,000,000	0.00		Starting in FY 08 $10 million per year until FY 15. This is a non-lapsing account.
40001 Biomedical Research Trust Fund	4,000,000	4,000,000	4,000,000		May expend up to 50% of the funds.
Appropriation Committee Added Initiatives					Funding to be available 7/1/2006
Asthma Awareness program in Bridgeport (12126)	12,126		150,000		From the Tobacco and Health Trust Fund,
Easy Breathing; extend contract to include adults (12126)	12,126		650,000		From the Tobacco and Health Trust Fund,
Breast & Cerv. Cancer Detection & Treatment (12255)	12,255		1,000,000		From the Tobacco and Health Trust Fund,
Comprehensive Cancer Control Plan, CT Cancer Partnership			5,500,000		From the Tobacco and Health Trust Fund,
Hlth Professional Partnership, UConn			200,000		From the Tobacco and Health Trust Fund,; reflected in the UCHC budget
Total from the Tobacco and Health Trust Fund			$7,500,000		
Legislation to implement the mandatory lead screening program was not enacted. ** HB 5845 Section 49- The Commissioner of Social Services may expend up to $ 11,000,000 appropriated for Hospital Hardship in consultation with DPH Commisioner.					

Administration

Public Act 06-188 **SB 703**

SOCIAL SERVICES AND PUBLIC HEALTH BUDGET IMPLEMENTATION PROVISIONS

Effective Dates:
Upon Passage
Sections: 14, 46, 55 and 54
July 1, 2006
Sections: 1-7, 17-21, 24, 36, 38 and 49-51
October 1, 2006
Section: 34
Sections 47 and 48
Upon passage for establishing the pilot program; October 1, 2006 for the evaluation.

Summary:

Sec 1-5 — LONG-TERM CARE INSTITUTION REIMBURSEMENT RATES (NURSING HOMES, ICF-MR, AND RESIDENTIAL CARE HOMES

For FY 07, the act (1) increases reimbursement rates for nursing homes by 3% over FY 06, (2) leaves current reimbursement rates in effect until September 30, 2006 for intermediate care facilities for the mentally retarded (ICF-MRs) and then caps the increase at 3% for the rest of FY 07 starting October 1, 2006, and (3) leaves current reimbursement rates in effect until September 30, 2006 for residential care homes and then caps the increase at 4% for the rest of FY 07 starting October 1, 2006. For all three types of facilities, the act makes an exception to the increases for facilities that have interim rates; if these would have received a lower rate on the increase's effective date because of their interim rate status, they will still receive that lower rate.

The act requires the DSS commissioner, when considering an interim rate increase request from a nursing home, to consider the facility's ability to meet wage and benefit costs, in addition to existing mandatory factors. It eliminates the prohibition against considering the facility's immediate profitability. It also eliminates an existing prohibition on the commissioner's granting an interim rate increase on and after July 1, 2005.

In cases where a nursing home is in receivership and the reimbursement rate in effect for the facility at the time the receivership is imposed is greater than the median rate for the facility's peer grouping, the act allows the Secretary of the Office of Policy and Management, after review of area nursing home bed availability and other pertinent factors to authorize the DSS commissioner to set an increased interim rate. (The law contains two geographic peer groupings of nursing homes for each level of care (chronic and convalescent care homes and rest homes with nursing supervision) for the purpose of determining rates and allowable costs. One peer grouping is for Fairfield County and the other is for the rest of Connecticut.)

Sec 6-7 — NURSING HOME PROVIDER USER FEE

The act requires DSS to set the amount of the nursing home provider user fee by July 1 every two years instead of annually. The initial assessment, which was approximately $16 per bed per day, was set in 2005. Most nursing homes must pay the assessment, which is collected quarterly and is roughly 6% of their gross revenues.
The act requires the DSS commissioner, by July 1, 2007, to report to the Appropriations and Human Services committees on the detrimental effect, if any, a biennial fee adjustment has on nursing home residents who are "private payors. "

Sec 14 AND 55 — DRUG ASSISTANCE FOR PEOPLE WITH HIV OR AIDS

By law, DSS, within available appropriations, may provide assistance for people to purchase drugs that prevent or treat HIV or AIDS. Under the Connecticut AIDS Drug Assistance Program, participants' income must be less than 400% of the federal poverty level (FPL). Under current state law, the DSS commissioner determines the drugs to be covered and can implement a pharmacy lock-in for participants. The act requires her to do these things in consultation with the DPH commissioner.

Currently, the DSS commissioner, within available federal resources, must purchase new, or maintain existing, insurance policies for participants that cover treatments and related services. Under the act, she is permitted only to maintain existing policies and only if she receives federal approval to do so.

The act repeals DSS' Insurance Assistance Program for People with AIDS (CGS § 17b-255). Under this program, DSS must pay the insurance premiums for people with AIDS-related disease who, without the assistance, would be unable to obtain health insurance through an employer. The income limit for this program is 200% of the FPL and assets can be no higher than $ 10,000. The participant must have insurance that can be continued even when his, his spouse's, or his parent's employment ceases.

Starting on the date the act passes, people who previously received assistance under the insurance assistance program continue to receive assistance until that coverage expires, provided they continue to be eligible for it. By March 1, 2007 and each year thereafter, the DSS commissioner must report to the Human Services, Public Health, and Appropriations committees on the availability of funds for the drug assistance program.

The act requires program applicants and recipients, if eligible, to enroll in the Medicare Part D program. The DSS commissioner can be the authorized representative of these individuals for purposes of Medicare Part D enrollment or submitting an application to the Social Security Administration to obtain the low-income subsidy the Part D law provides.

Program applicants and recipients must have the opportunity to select a Part D plan and the DSS commissioner must notify them of this. Before choosing a plan, they must have the opportunity to consult with the commissioner or her agent so they can choose the plan that best meets their needs. If they do not choose a plan within time that the commissioner determines is reasonable, the commissioner must enroll them.

The applicants and recipients must appoint the commissioner as their representative for appealing Part D denials and for any other purpose (1) allowed under the federal Part D law and (2) the commissioner deems necessary.

The act permits the DSS commissioner to pay any Part D premiums and coinsurance for these individuals. The act adds PA for home health aide visits that exceed 14 hours per week. (Currently, DSS policy allows up to 20 hours of home health aide services per week without PA.) And it allows providers to submit PA requests no more than once a month but only if they are for the same client.

Sec 17-19 — DSS INDIGENT FUNERAL AND BURIAL ALLOWANCE

The act increases, from $1,200 to $1,800, the maximum amount DSS will pay toward funeral and burial expenses for people who are indigent or on welfare and do not have enough money to pay for their burial. The act specifically adds the state-administered general assistance (SAGA) program to the list of welfare programs covered (CGS § 17b-131). Other programs include the State Supplement and the Temporary Family Assistance (TFA) program (CGS § 17b-84). This provision currently also applies to Medicaid recipients, but the act removes CGS § 17b-84 from a list of sections that also cover Medicaid beneficiaries.

When people who are on welfare or otherwise indigent die without enough money in their estates to pay for burial, DSS currently pays up to $1,200 to cover burial expenses. But this amount is reduced by the amount of money in any revocable or irrevocable funeral fund, a prepaid funeral contract, or the face value of the person's life insurance. For welfare recipients who have some money in their estates, current law allows up to $1,200 of the estate to be used for burial expenses before the state claims remaining assets owed. The law also allows other people to make voluntary contributions to the funeral and burial costs up to $2,800 without diminishing the state's obligation to pay (CGS § 17b-84, § 17b-131). If people are only enrolled in Medicaid and not cash assistance, but do not have enough money for a funeral, the state currently pays up to the $1,200 using SAGA program funds.

Sec 20 — FUNDING FOR NEWBORN SCREENING

The act increases, from $345,000 to $500,000, the amount of money that is collected and earmarked for the Newborn Screening Account in the General Fund. By law, DPH can use funds from this account to pay for testing expenses. DPH sets a fee to charge institutions for the comprehensive testing, parent counseling, and treatment, which can be no less than $28.

Sec 21 — STATE PAYMENTS TO HOSPITALS

Starting July 1, 2006, the act requires the DSS commissioner, within available appropriations, to increase the Medicaid fees it pays for hospital outpatient services, which can include clinics, emergency room, magnetic resonance imaging, and computerized axial tomography.

The act also changes the minimum amount of money DSS pays hospitals for inpatient services they provide to Medicaid recipients. Under current law, any hospital with a target amount per discharge less than $4,000 has its target amount set at $4,000, beginning October 1, 2006. This floor rises to $4,250 on October 1, 2007. Under the act, and subject to available appropriations, the DSS commissioner instead (1) must establish a target amount of at least $4,000 for hospitals with lower target amounts for the rate period ending September 30, 2006 and (2) can adjust the target amounts for those hospitals whose target rates do not increase as a result of the floor. As a corollary, the act shortens the moratorium on annual adjustments for inpatient services from March 31, 2008 to September 30, 2006.

By October 1, 2006, the DSS commissioner must submit a report to the Public Health, Human Services, and Appropriations committees identifying increased outpatient fees target amounts and their impact on DSS' budget.

Sec 24 — USE OF MEDICAID FUNDS TO PAY DENTAL LAWSUIT SETTLEMENT

The act authorizes DSS, with General Assembly approval, to use money in its Medicaid FY 07 appropriation to pay for any settlement agreement in the Mary Carr et. al v. Patricia Wilson-Coker lawsuit. DSS must report to the Appropriations, Human Services, and Public Health committees within six months of the settlement date on a plan to achieve compliance. By law, any lawsuit settlement resulting in more than $ 2. 5 million in General Fund expenditures must receive General Assembly approval.

In 2000, legal aid lawyers sued DSS, alleging that its failure to comply with the Medicaid law resulted in a critical shortage of dental providers willing or able to service children and adults receiving Medicaid. In January 2006, the court granted DSS summary judgment on some of the counts on limited legal and

technical grounds. It denied other counts concerning the Medicaid law's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Sec 28-29 — BEHAVIORAL HEALTH PARTNERSHIP (BHP) OVERSIGHT COUNCIL

The act adds at least four nonvoting, ex-officio members to the council: one representative each from the State Department of Education and the Comptroller's Office, appointed by the heads of those agencies, a representative from the Office of Health Care Access (no appointing authority is designated), and one or more consumers appointed by the council chairmen.

Sec 34 — MANAGED CARE REPORT CARDS

The law requires the insurance commissioner, in consultation with the public health commissioner, to develop and annually distribute a consumer report card on managed care companies. The act requires the report card to contain information or measures about the percentage of enrollees who receive mental health services, the utilization of mental health and chemical dependency services, inpatient and outpatient admissions, discharge rates, and average lengths of stay. The data collection must be consistent with Health Plan Employer Data and Information Set measures.

Sec 36 — USES FOR COMMUNITY MENTAL HEALTH STRATEGY BOARD FUNDS

The act permits DMHAS to use its FY 07 appropriations for the Community Mental Health Strategy Board to reach certain goals if the board recommends this and the secretary of Policy and Management approves. It can use the money for programs and services that both maximize federal Medicaid reimbursement for community-based care and reduce inappropriate emergency hospitalization, inpatient psychiatric care, nursing home admissions, incarceration or referral to juvenile justice, and other institutionalization of adults and children with serious mental illness. The specific services and programs DMHAS can fund include (1) housing services for those receiving the home- and community-based services for which the act directs DSS to seek Medicaid funding (see § 33) and (2) day care and education providers' consultations with mental health professionals.

Sec 37 — AUTISM SPECTRUM DISORDER PILOT PROGRAM

The act requires the Department of Mental Retardation (DMR) commissioner to establish a pilot program to provide coordinated services and support to people with autism spectrum disorders who do not also have mental retardation. The program must serve up to 50 people who are not eligible for DMR services.

The pilot program must begin by October 1, 2006 and must end by October 1, 2008. When establishing the program, the DMR commissioner must consult with the DSS and DMHAS commissioners and any other commissioner he believes appropriate. He must establish eligibility requirements for program participation, identify appropriate services and supports for each participant and his or her family, and coordinate the provision of those services and supports. He may designate someone to perform the indentification and coordination components.

The act requires the commissioner to report to the Public Health Committee on the pilot program's results by January 1, 2009. The report must contain recommendations about a system to address this population's needs, including (1) creating an independent council to advise DMR on system design, implementation, and quality enhancement; (2) establishing procedural safeguards; (3) designing and implementing a quality enhancement and improvement process; and (4) designing and implementing an interagency data and information management system.

Sec 38 — LONG-TERM CARE COMPREHENSIVE NEEDS ASSESSMENT

The act transfers the existing duty to conduct a comprehensive needs assessment of unmet long-term care (LTC) needs and project future demand for such services from the Office of Policy and Management to the General Assembly. It requires the General Assembly to contract for the assessment, rather than conduct it,

and to do so after consulting with the Commission on Aging, the Long-Term Care Advisory Council, and the Long-Term Care Planning Committee. It specifies numerous items, which the assessment must include.

Areas to be Included in Comprehensive Needs Assessment
The act requires the comprehensive needs assessment to include:

1. The number of people (a) presently at risk for having unmet LTC needs and (b) potentially at risk for having LTC needs over the next 30 years;
2. Both costs and public and private resources available to meet the LTC needs, including adequacy of current resources, projected costs, and projected resources needed to address LTC needs over the next 30 years;
3. The existing services available to people with LTC needs;
4. Existing and potential future models of public and private service delivery systems for people with LTC needs;
5. State government's programmatic structure in meeting the needs of people requiring LTC;
6. Strategies that may assist families in providing for their own LTC needs at reasonable cost; and
7. The service needs of the state's elderly population with long-term care needs with emphasis on healthcare, housing, transportation, nutrition, employment, prevention, and recreation services; and
8. Recommendations on qualitative and quantitative changes that should be made to existing programs or service delivery systems, including recommendations on new programs or service delivery systems to better serve persons with LTC needs. The act removes a requirement of current law that the assessment specifically include a review of the Department of Mental Retardation's waiting list.

Sec 46 — ADDED RESPONSIBILITY AND NEW MEMBERS FOR MEDICAID MANAGED CARE COUNCIL

The act expands the Medicaid Managed Care Council's scope to include recommendations on the managed care portion of the State-Administered General Assistance (SAGA) program. It also adds the Appropriations Committee's chairmen and ranking members to the council.
The Medicaid Managed Care Council, first established in 1994 to help develop Medicaid managed care, continuously monitors the implementation of the program and advises DSS on its further development. Its members include legislators, Medicaid consumers, advocates, health care providers, insurers, and state agencies.

Sec 47-48 — MEDICAL HOME PILOT PROGRAM

The act permits the DSS commissioner, in consultation with the managed care organization administering the HUSKY A program, to establish a medical home pilot program in on Connecticut region on or after January 1, 2007 and within any available federal or private funds. The program is to enhance the health outcome of children, including those with special needs, by ensuring that each child has a primary care physician (PCP) to provide continuous comprehensive health care services.
The DSS and public health commissioner must, no later than one year after beginning the pilot program, evaluate the pilot program to determine improved health outcomes and any cost efficiencies. Within 30 days of the evaluation the public health commissioner must report to the Public Health and Appropriations committees on the evaluation.

Sec 49 — EPSDT

The act requires the DSS commissioner to provide people under age 21 and eligible for Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (including medical, vision, dental, and hearing services), which are required under federal law.

Under federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, state Medicaid programs (HUSKY A in Connecticut) must provide comprehensive health and developmental assessments and vision, dental, and hearing services to children and youth up to age 21.

The medical screen must include a comprehensive physical and mental health and development assessment and history; a comprehensive unclothed medical examination; appropriate immunizations; laboratory tests, including lead blood testing; and health guidance.

Other EPSDT services include eye examinations and eye glasses; teeth restoration and maintenance of dental health; and diagnosis and treatment of hearing problems, including hearing aids.

Sec 50 — MEDICAID PAYMENTS FOR HOME HEALTH AIDES IN NON-HOME SETTINGS

The act requires the DSS commissioner to provide Medicaid reimbursement for children's home health care services provided in the Medicaid recipient's home or a "substantially equivalent environment. " The act specifies that the latter setting can include, at a minimum, licensed child day care facilities and after-school programs. It is not clear whether federal Medicaid matching funds would be available for services provided outside the recipient's home since the regulations (42 CFR § 440. 70) define home health services for Medicaid reimbursement purposes as those services provided at the place of residence.

As a result of a recent court case, DSS has been paying for skilled nursing services provided outside of the home. The agreement says nothing about home health aide services.

Sec 51 — COMMUNITY HEALTH SERVICES TRANSFER

The sum of $50,000 appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2007, for community health services, shall be transferred to other expenses.

Sec 54 — DEPARTMENT ON AGING

This act postpones the effective date of the 2005 law that requires establishment of a Department on Aging by six months, from January 1, 2007 to July 1, 2007.

Required Action:

Section 34 requires the insurance commissioner, in consultation with the public health commissioner, to develop and annually distribute a consumer report card on managed care companies.

Laboratory Branch: Section 20 requires coding of revenue.

Planning Branch: Section 51 appropriates funding to publish Drug Importation recommendations.

Public Act 06-32 **HB 5738**

Reconsidered Agency Decisions and Appeals Under the Uniform Administrative Procedure Act

Effective Date: October 1, 2006

Summary:

This act caps, at 90 days, the maximum time a state agency has to issue a new decision in a contested case it decides to reconsider. By law, agencies can decide to reconsider a final decision in a contested case on their own or pursuant to a petition from a party to the case.

With one exception, the act provides that a decision an agency issues in a contested case on reconsideration replaces its original decision as the final decision from which an appeal may be taken. The exception applies if an agency fails to render a decision on reconsideration within the 90-day period the act establishes. In this case, the original decision is the final decision for purpose of an appeal. By law, an appeal may be based on a number of issues, including issues the agency (1) decided in its original final decision that were not the subject of the reconsideration; (2) was requested, but declined, to address on reconsideration; and (3) reconsidered but did not modify.

Lastly, the act establishes a deadline for filing an appeal after a petition for reconsideration is filed. The deadline is 45 days after (1) the petition is denied, (2) a decision made after reconsideration is mailed or personally delivered, or (3) the 90-day deadline for the decision.

Analysis of Agency Proposals

Incorporated in SB 317 **SB 309**

CONCERNING EMERGENCY AND NONEMERGENCY MEDICAL SERVICES AND THE CERTIFICATE OF NEED PROCESS

Summary: Incorporated in SB 317

To allow certified or licensed emergency medical service providers to add one emergency vehicle to their service every three years without undergoing a needs assessment by the Office of Emergency Medical Services, to clarify the Commissioner of Public Health's responsibilities with respect to establishing methods for setting emergency service rates for certified ambulance services and to protect patients from the dangers of secondhand smoke while being transported to or from nonemergency medical services.

Required Action:

See section 34 and 35 of Senate Bill 317.

Failed **SB 310**

WATER COMPANIES AND WATER RESOURCES

Summary: Failed

To streamline the application process for non-community public water supplies, to better link this application process with the drinking water supply planning process and to improve and streamline the operations of the water utility coordinating committee's water planning process.

Public Act 06-53 **SB 313**

PROTECTION OF PUBLIC WATER SUPPLY SOURCES

Effective Date: The DPH commissioner notification and regulation provisions take effect October 1, 2006; the ethanol study and technical changes take effect upon passage.

Summary:

This act requires the public health (DPH) commissioner to receive notice of applications submitted to local agencies about activities on public water supply watersheds. It allows the DPH commissioner to adopt regulations that incorporate by reference federal drinking water regulations.

The act requires the public health and environmental protection (DEP) commissioners to study the use of ethanol as a gasoline additive in the state as a means of meeting federal Clean Air Act requirements.

NOTIFICATION OF PUBLIC HEALTH COMMISSIONER
By law, anyone filing an application, petition, request, or plan with the local zoning or zoning appeals authority for any site within a water company's watershed or aquifer protection area must notify the water company if the company has filed a watershed map with the municipality or map of the aquifer protection area. The act adds a filing made with a local planning commission.

The act requires that the applicant also notify the DPH commissioner, in a format he approves, when DPH has filed such a map. The applicant must send the notice by certified mail, return receipt requested, within seven days after the application date. The commissioner has the right to be heard at any hearing on the application.

The law establishes an exemption from the notice requirements in towns that allow zoning agents to approve applications, if the agent determines that a proposed activity will not adversely affect the public water supply. Existing law exempts notice to water companies in such towns. The act correspondingly exempts notice to the DPH commissioner in such towns.

By law, an applicant for a regulated activity on an inland wetland or watercourse must notify the water company of the application if it affects the company's watershed and the company has filed a map with the municipality. The act extends the notice requirement to include the health commissioner in a format he approves. The applicant must send the notice by certified mail, return receipt requested, within seven days of the date of the application. The commissioner can appear and be heard at the hearing on the application.

REGULATIONS
The act authorizes DPH to adopt regulations that incorporate by reference the provisions of the federal National Primary Drinking Water regulations (40 CFR, Parts 141, 142) if they (1) are consistent with other regulations adopted by the state and (2) explicitly incorporate any future amendments to the federal regulations.

ETHANOL STUDY
The act requires the DEP and DPH commissioners to study the costs and benefits of using ethanol as a gas additive to meet the federal Clean Air Act requirements. The study must address (1) public health implications of exposure to unsafe ethanol levels and other toxics unique to ethanol-blended gasoline, (2) how using ethanol affects motor vehicle emissions and affects the state's implementation plan under the federal act, and (3) health risks associated with chronic exposure to ethanol or ethanol-blended gas.

DEP must, within available appropriations, report the study findings to the Public Health and Environment committees by December 31, 2006. Additionally, the report must include an analysis of (1) any reports or recommendations made by Northeast States for Coordinated Air Use Management and the New England Institute Water Pollution Control Commission; (2) whether Connecticut should continue to use ethanol as a gas additive and if not, an analysis of the waiver process from the federal Environmental Protection Agency to discontinue its use; and (3) the effect of ethanol on the state's air quality.

The report must also include (1) an update on other states' use of ethanol as a gas additive, (2) recommendations for new ethanol exposure standards for gas-related occupations and sensitive population subgroups, and (3) specific recommendations on alternative or supplemental air pollution reduction programs (e. g. , alternative motor vehicle fuel incentives, mass transit, and employee commuter programs).

Required Action:

Regulatory Services Branch: Sections 1 and 2 requires the department to prescribe the format for applicants to provide notification to the department of proposed projects on watersheds.

Regulatory Services Branch: Section 6 requires the department to conduct risk assessment on the effects of ethanol in gasoline and to report the study findings to the Public Health and Environment committees by December 31, 2006.

Public Act 06-195 SB 317

REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES

Effective Dates:

Upon Passage:

Sections: 4, 5, 14-16, 18, 19, 30–35, 40, 42, 43, 45-47, 49-51, 53, 56-58, 86

July 1, 2006

Sections: 6, 23, 84,

October 1, 2006

Sections: 1-3, 7-13, 17, 20 – 29, 36-39, 41, 44, 48, 52, 54, 55, 59, 60 – 83, 85, 87

Summary:

This act makes numerous substantive and technical changes to Department of Public Health (DPH) and other related statutes concerning various health care professionals, health care facilities, programs, and activities.

Sec. 1 - LOCAL REGISTRARS AND VITAL RECORDS

The act deletes obsolete language providing a $2 fee to the local registrar for completing each birth, marriage, death, or fetal death record. Registrars are compensated by salary, not by this fee structure.

Sec. 2, 7 - DIALYSIS PATIENT CARE TECHNICIANS

Public Act 05-66, which allows dialysis patient care technicians employed in outpatient dialysis units to administer certain medications, did not require DPH to license or certify the technicians. The act repeals references to dialysis patient care technicians in a statute (CGS § 19a-14) that identifies those health professions for which there are no boards or commissions and provides DPH with regulatory oversight over them. The act allows technicians to administer limited medications in hospital dialysis units, as well as outpatient dialysis units, under the supervision of a registered nurse as necessary to initiate or conclude hemodialysis treatment. The act also makes a technical change to recognize that technicians must be certified as such by an organization approved by DPH.

Sec. 3, 11, 12 - RESPIRATORY CARE PRACTITIONERS

The act allows respiratory care practitioners on active duty in the armed forces to renew their licenses when they become void for up to one year from the date of discharge, once they complete six contact hours of continuing education. A “contact hour” is a minimum of 50 minutes of continuing education. A licensee applying for renewal must submit an application on a DPH-prescribed form and other documentation the department may require.

Under the act, a licensee applying for renewal for registration periods beginning on and after October 1, 2007, must maintain either (1) credentialing as a respiratory therapist (which presumably is the same as a respiratory care practitioner) from the National Board for Respiratory Care, or its successor, or (2) earn a minimum of six contact hours of continuing education within the preceding registration period. (A registration period is the one-year period for which a renewed license is current and valid.) The continuing education must be directly related to respiratory therapy and reflect the licensee's professional needs in

order to meet the public's health care needs. Qualifying continuing education includes courses (including on-line courses) offered or approved by the American Association for Respiratory Care, regionally accredited higher education institutions, or a state or local health department.

Each license renewal applicant must sign a statement attesting that he has maintained credentialing as a respiratory therapist, issued by the national board, or has met the continuing education requirements. Licensees must keep credentialing records, records of attendance, or certificates of completion showing compliance with the continuing education requirements. These must be kept for a minimum of five years following the year in which the licensee was recredentialed or completed the continuing education. The licensee must submit the records within 45 days after DPH requests them. A first-time applicant for license renewal is exempt from the continuing education requirements.

In his discretion, the DPH commissioner may waive the continuing education requirements or grant an extension to fulfill them in cases of medical disability or illness. The licensee must submit a waiver or extension application to DPH on a department form, along with a physician's certification of his disability or illness and other documentation DPH may require. DPH can grant a waiver or extension for up to one registration period and can grant additional waivers or extensions if the disability or illness continues beyond the initial period and the licensee reapplies.

A licensee whose license expires and who applies to DPH for reinstatement must provide documentation showing successful completion of the six contact hours of continuing education within the one-year period immediately preceding his application.

DPH can take disciplinary action against a respiratory care practitioner failing to comply with the continuing education requirements. This can include license revocation or suspension, censure, letter of reprimand, probation, and civil penalties.

Sec. 4, 15, 16 - NEEDLE AND SYRINGE EXCHANGE

The act eliminates the existing cap of 30 needles and syringes that may be exchanged at any one time under DPH's needle and syringe exchange program. It makes corresponding changes to the laws on drug paraphernalia reflecting the cap's removal. By law, unchanged by the act, first-time needle exchange program applicants are subject to a 30 needle and syringe cap.

Sec. 5, 6, 52 - BREAST AND CERVICAL CANCER PROGRAMS AND COMPREHENSIVE CANCER PLAN

Breast and Cervical Cancer Programs
Under existing law, DPH can apply for and receive money from public and private sources and the federal government to fund a breast and cervical cancer early detection and treatment referral program. The act expands the use of this money to allow for the funding of a comprehensive cancer program.

Previously, if the state received a payment according to a court settlement for use for women's health it had to be deposited in a DPH account for breast and cervical cancer treatment services. Under the act, any such funds must be deposited in a DPH account for comprehensive cancer initiatives.

The act defines “breast cancer screening and referral services,” instead of “breast cancer treatment services,” as necessary breast cancer screening services and referral services for a procedure to treat breast cancer. Similarly, it defines “cervical cancer screening and referral services,” instead of “cervical cancer treatment services, “as necessary cervical cancer screening services and referral services for a procedure to treat cancer of the cervix.

The act expands the breast cancer program’s current public education and outreach initiative to include publicizing the benefits of early detection and the recommended frequency of screening services, including clinical breast examinations and mammography.

Under prior law, DPH had to provide, within existing appropriations and through contracts with health care providers, unserved or underserved populations with: (1) an annual mammogram for those aged 45 to 65; (2) an annual mammogram for those aged 35 to 44 with a first degree female relative who has had breast cancer or with other equal risk factors; (3) one annual pap test for cervical cancer for those aged 19 to 64 who have had a positive finding, otherwise one every three years or more frequently as directed by a physician; (4) a 60 day follow-up pap test for sexual assault victims; and (5) a pap test every six months for women who have tested HIV positive.

This act instead substitutes the provision of clinical breast examinations, screening mammograms, and pap tests as recommended in the most current breast and cervical cancer screening guidelines of the U.S. Preventive Services Task Force, for the woman's age and medical history. It retains the 60-day Pap test follow-up for sexual assault victims and the every six-month test for HIV positive women.

Sec. 8, 9, 10 - YOUTH CAMPS

Staff Training and Safety Issues

The act requires licensed youth camps to provide training to staff on the camp's policies and procedures on behavioral management and supervision; emergency health and safety procedures; and recognizing, preventing, and reporting child abuse and neglect.

It requires that DPH, and the state or local fire marshal certify each of the camp's dwelling units, buildings, and structures as presenting no health or fire hazard. This must be indicated by a current fire marshal certificate dated within the past year and available on-site when the camp is operating. Previously, such certification had to be received within 90 days of applying for the license.

Disciplinary Action Against a Youth Camp License and Hearing Process
The act expands the list of disciplinary actions that DPH may take against youth camp licensees. Under existing law, DPH can suspend, revoke, or refuse to renew a youth camp license if the licensee:

1. is convicted of any offense of moral turpitude,
2. is legally found insane or mentally incompetent,
3. uses any narcotic or controlled drug that impairs his ability to care for children,
4. consistently fails to meet DPH standards,
5. provides misleading or false statements or reports to DPH,
6. refuses to provide DPH with reports or records necessary for licensure investigation,
7. fails or refuses to submit to a DPH investigation,
8. fails to maintain safe and sanitary premises, or
9. willfully or deliberately violates any provisions of the youth camp law.

The act amends the fourth standard above to "failure to comply with the statutes and regulations for licensing youth camps."

This act allows DPH, after a contested case hearing, to take any of the following action, when it finds that the youth camp licensee has substantially failed to comply with the law or regulations:

1. revoke or suspend a license,
2. impose a civil penalty of up to $100 per violation for each day of occurrence,
3. place the licensee on probation and require regular reporting to DPH on those matters that are the basis of the probation, or
4. restrict the licensee's acquisition of other facilities for a set period.

The act requires DPH to notify the licensee in writing of its intent to take action. The licensee, if aggrieved, can apply in writing for a hearing, stating why he is aggrieved. DPH must receive the application within 30 days of the licensee getting DPH's notice of intended action. The commissioner must hold a hearing within 60 days of receiving the application and mail a notice to the licensee at least 10 days before the hearing

date, giving its place and time. The commissioner or a hearing officer can conduct the hearing and may issue subpoenas requiring witnesses to attend. The licensee can be represented by counsel and must receive a hearing transcript. (The act uses the term "entitled" to be represented by counsel but presumably does not guarantee the right to counsel.) The hearing officer must state his findings and make a license action recommendation to the commissioner.

Under the act, the commissioner must make his written decision on whether to suspend, revoke, or continue the license or take other action against the licensee. A decision to revoke or suspend a license is effective 30 days after mailing the licensee by certified or registered mail. The licensee can appeal the commissioner's decision to Superior Court.

The act specifies that the hearing and appeal provisions do not apply to the denial of an initial license application if DPH notifies the applicant of the denial and the reasons for it in a written notice mailed to the applicant.

Reports or Complaints About a Camp
The act allows anyone with reasonable cause to believe that a youth camp is operating (1) without a current and valid license; (2) in violation of regulations; or (3) in a manner posing a potential danger to a camper's health, welfare, and safety to report that information to DPH, which must investigate. It authorizes the DPH commissioner or his authorized agent, concerning any youth camp investigation, to administer oaths; issue subpoenas; compel testimony; and order that books, records, and documents be produced. If a person refuses to appear, testify, or produce any documents when ordered, a Superior Court judge can make an appropriate enforcement order.

The act specifies that the name of the person making the report or complaint must not be disclosed unless (1) the person consents, (2) a judicial or administrative proceeding results from the report or complaint, or (3) a license action against the camp results from the complaint or report.

All records DPH obtains of these investigations are not subject to disclosure under the freedom of information laws for 30 days from the date the investigation is initiated, until the investigation is terminated because of a withdrawal or other informal disposition, or until a hearing is convened, whichever is earlier. A formal statement of DPH charges is subject to disclosure from the time that it is served or mailed to the respondent. Records that are otherwise public records cannot be deemed confidential just because they have been obtained in connection with these investigations.

Sec. 13 - FUNERAL SERVICE CONTRACTS

The act requires every funeral home to maintain at its address of record for inspection purposes copies of all records relating to funeral service contracts, prepaid funeral contracts, or escrow accounts for at least three years after the death of the person for whom the funeral services were provided.

Sec. 14 - CREMATED REMAINS

Prior law required the funeral director to provide notice to the local registrar of vital records who issued the cremation permit about the method of disposition of unclaimed cremated remains. The act instead requires that the funeral director give notice to the registrar of the town where the person died.

Sec. 17 - INVESTIGATION OF HEALTH CARE PRACTITIONERS AND INSURANCE RECORDS

The act gives DPH access to records maintained by insurance companies for review during the course of an investigation of a health care practitioner.

Sec. 18, 19 - VALIDATION OF MARRIAGES

The act updates current law to validate marriages performed up to the act's passage in a town other than (1) that authorized by the marriage license or (2) where either party resided at the time of the marriage license application. It also validates those marriages performed by a justice of the peace whose appointment had expired.

Sec. 20 - PROFESSIONAL LIABILITY INSURANCE FOR DENTISTS

The act requires dentists who provide direct patient care services to maintain professional liability insurance or other indemnity against liability for professional malpractice. The amount each dentist must carry against claims for injury or death for malpractice must be at least $500,000 for one person, per occurrence, with an aggregate of at least $1.5 million.

Beginning January 1, 2007, each insurance company issuing professional liability insurance must provide DPH with a true record of the names and addresses, by classification, of cancellations of, and refusals to renew, professional liability insurance policies, including the reasons for cancellation or refusal, for the year ending on the preceding December 31.

Under the act, a dentist who must carry malpractice insurance is deemed in compliance when providing dental services at a DPH-licensed, tax exempt clinic (under § 501(c)(3) of the IRS Code) if the dentist is not compensated and the clinic:

1. does not charge patients for services,
2. maintains professional liability insurance coverage in the required amounts for each aggregated 40 hours of fraction of for the dentists,
3. carries additional appropriate professional liability coverage for itself and its employees of $500,000 per occurrence with an aggregate of not less than $1.5 million, and
4. maintains total professional liability coverage of at least $1 million per occurrence with an annual aggregate of at least $3 million.

But a dentist is subject to the insurance requirements when providing direct patient care services in any setting other than the clinic. The act specifies that it does not relieve the clinic from any other insurance requirements of law.

Under the act, a person insured with a claims-made medical malpractice insurance policy does not lose the right to unlimited additional extended reporting period coverage when he permanently retires from practice if he solely provides professional services without charge at a tax-exempt clinic.

Sec. 21 – TRANSFER, SALE OR CLOSING A FUNERAL HOME

The act requires the person or entity that holds a DPH certificate to operate a funeral home to notify owners of prepaid funeral contracts, people for whom it is holding cremated remains and DPH when more than 50% of the business is transferred or the business is discontinued or terminated. The person or entity must:

1. notify each owner of a prepaid funeral contract;
2. mail a letter to anyone for whom the home is storing cremated remains; and
3. give DPH, within 10 days of the transfer, discontinuance, or termination, a list of all unclaimed cremated remains the home held at that time.

Sec. 22 - INDOOR TANNING FACILITIES

The act subjects the operator of a tanning facility to a fine up to $100 for permitting anyone under age 16 to use a tanning device without a parent or guardian's written consent if he knows or should have known the person's age. The fine is payable to the local health department or health district where the device is located. The act permits departments and districts to enforce its provisions within their available resources.

It applies to devices in tanning facilities, which it defines as any place where a device is used for a fee, membership dues, or other compensation. An operator is the person the facility designates to control its operation and help consumers use the device properly.

Sec. 23 - NURSING FACILITY MANAGEMENT SERVICES

The act requires DPH to certify nursing facility management services. It defines these as services provided in a nursing home to manage the home's operations, including providing care and services. It prohibits anyone from providing these services after January 1, 2007 without a certificate.
Anyone seeking a certificate, or to renew one, must apply to DPH on a form it prescribes. The application must include a $300 fee and:

1. the applicant's name, business address, organization type (e.g., individual, corporation, partnership, or other form) and a description of its nursing home management experience;
2. a signed criminal history affidavit disclosing whether the applicant has a history of certain crimes, civil actions, or administrative penalties;
3. the location and description of any other health care facilities in which the applicant currently provides management services or has provided them within the past five years.

The criminal history affidavit must disclose any matter in which the applicant:

1. has been convicted of, pleaded nolo contendre to, or been held liable or enjoined by final judgment in a civil action to any felony or action involving fraud, embezzlement, fraudulent conversion, or misappropriation of property;
2. is subject to a current injunction or restrictive or remedial court order; or
3. has, within the past five years, had a federal or state license or permit revoked or suspended due to a government agency's action arising out of or relating to business activity or health care, including actions affecting the operations of a nursing home, retirement or residential care home, or any continuing care facility subject to Connecticut law or similar laws of any other state or nation.

In addition to the above information, DPH may reasonably request to review the applicant's audited and certified financial statements, which remain the applicant's property when used for either initial or renewal certification. The certificate must list each location at which nursing facility management services may be provided.

DPH must base its certification decision on the information presented to it and on the managed nursing home's compliance status. DPH can deny an applicant certification for any specific facility where there has been substantial noncompliance with the Public Health Code. Renewals must be made biennially after (1) submission of the information required above and any other information DPH requires and (2) submission of satisfactory evidence that the nursing facility where the applicant provides management services substantially complies with the law on health care institution licensure and the Public Health Code, and (3) payment of $300.

If DPH finds substantial noncompliance with the act's requirements, the commissioner can initiate disciplinary action against the management services certificate holder. DPH can limit or restrict the management services provided by a certificate holder against whom it has begun disciplinary action.

Sec. 24 - HOSPITAL PERFORMANCE IMPROVEMENT PLANS

The law requires hospitals to implement performance improvement plans. The act requires them to make their plans available to DPH at its request, rather than submit them annually as a condition of licensure.

Sec. 25, 26 - ADVERSE EVENT REPORTS

The act specifies that the form the DPH commissioner prescribes for hospitals and outpatient surgical facilities to report adverse events to DPH, does not have to be adopted in regulation.

Sec. 27 - ALCOHOL AND SUBSTANCE ABUSE SCREENING PROTOCOLS

The act requires hospitals annually to send the protocols they use to screen patients for alcohol and substance abuse only to the Department of Mental Health and Addiction Services (DMHAS), rather than to both it and DPH.

Sec. 28 - EMERGENCY ACTION AGAINST NURSING HOME LICENSEES

This section is technical.

Sec. 29 - CONTINUING EDUCATION FOR RADIOGRAPHERS

Beginning October 1, 2008, the act requires radiographers, in order to renew their license, to attest in writing that they (1) are registered by a professional organization or (2) have earned at least 24 contact hours of continuing education in the previous 24 months. A contact hour is at least 50 minutes of activity. Anyone who fails to do this is subject to disciplinary action, including license revocation or suspension. An individual who does not take the continuing education path must register as a radiographer or radiation therapy technologist with the American Registry of Radiologic Technologists. Continuing education must be in the individual's practice area and reflect his professional needs in order to meet the public's health care needs.

The act specifies 10 organizations that offer or approve courses that qualify for CEU credit. On-line courses offered or approved by any of these organizations qualify, as do courses offered or approved by hospitals and other health care institutions, regionally accredited colleges and universities, and state and local health departments. Individuals must keep records for at least three years after completing their continuing education activities and submit these records to DPH within 45 days of its asking for them.

The act exempts from its continuing education requirements first-time license renewal applicants and those not engaged in active practice. The latter must submit a notarized exemption application to DPH plus any other documentation DPH requires before his license expires. The exemption application, which must be on a DPH form, must state that the individual will not practice until he has met the act's continuing education requirements.

The act permits the DPH commissioner to waive continuing education requirements or extend the time for fulfilling them for a radiographer who is ill or disabled. The individual must submit a waiver or extension application and other documentation the commissioner may require. A waiver or extension can be for up to one year, and the commissioner can grant additional waivers or extensions if the illness or disability continues and the person applies again.

A radiographer who applies to have his license reinstated after it has lapsed must show DPH that he completed 12 contact hours during the preceding year.

Sec. 30 - ADVANCED PRACTICE NURSE TEMPORARY PRACTICE

The act permits a graduate advanced practice registered nurse (APRN) to work without a license for 120 days after graduating in a hospital or other setting under the supervision of a physician or other APRN. The graduate APRN cannot prescribe or dispense drugs. The hospital or other setting must verify that the graduate has applied to take the national certification exam and must end his work if notified that the graduate failed the exam.

Sec. 31, 32 - DENTIST AND PHYSICIAN CONTINUING EDUCATION

This section is technical.

Sec. 33 - MEDICAL HEARING PANEL MEMBERSHIP

By law, a three-person panel hears allegations of malpractice against physicians and physician assistants. One panel member must be a physician or physician assistant, as appropriate. Under prior law, this person was selected from a list the DPH commissioner creates. The act permits him to be a member of the Medical Examining Board. The law already requires one of the panel's other two members to be from the examining board and permitted the other, public, panel member to be on the board, as well.

Sec. 34, 35 - EMERGENCY MEDICAL SERVICES (EMS)

Certificate of Need Process
The act grants primary service area responders (PSAR) intervenor status in DPH hearings on the need for new or expanded EMS service in their area and establishes an expedited process for certain PSARs to add ambulances to their fleets. Intervenor status, including the opportunity to cross examine witnesses, must be granted to a PSAR if the hearing deals with new or expanded service in a town it serves and the PSAR asks for this status.

The act permits a licensed or certified volunteer municipal ambulance service that is a PSAR to add one emergency vehicle every three years without having to go through the otherwise required public hearing on the request. The one vehicle limit applies to the provider's entire fleet regardless of the number of town it serves.

When it applies for this expedited review, the volunteer municipal PSAR must give written notice to all other PSARs in towns where the applicant proposes to add the vehicle and those abutting them. If one of them requests a hearing within 15 calendar days after receiving notice, DPH must hold one hearing; if none object, the application is deemed approved 30 calendar days after it is filed.

PSARs must apply for expedited review on a short form DPH develops. The form must require the applicant to provide, at least, (1) its name and address; (2) the primary service area for which the vehicle is proposed; (3) how the vehicle will be used and why it is needed; (4) proof of insurance; (5) a list of the PSARs notified and proof of this notification; (6) total call volume, response time, and calls passed within the primary service area in the year before its application; and (7) any other information the commissioner deems necessary.

The act requires an entity (which includes an ambulance, rescue, or management service), within six months after the date DPH approves the request for new or expanded services, to (1) acquire the resources, equipment, and other material needed to comply with the terms of approval and (2) operate in the area identified in its application. Failure to do so within six months will void the approval, which DPH must rescind.

EMS Management Services
The act specifies that EMS management services organizations, which provide personnel to EMS providers, are employment organizations and may not own or lease ambulance or other emergency vehicles. The law requires DPH to license these organizations, and the act explicitly subjects them to DPH disciplinary action if they violate DPH regulations or fail to maintain required standards and explicitly permits them to appeal DPH disciplinary or other licensing actions under the Uniform Administrative Procedures Act. These disciplinary actions include license or certification suspension or revocation, probation, and a civil penalty of up to $10,000.

The act also requires all ambulance services to secure and keep medical control by a sponsor hospital for all their EMS personnel, whether they or a management service employs them.

Sec. 36-39 - NURSE-MIDWIFE PRACTICE

The act revises the nurse-midwife scope of practice and their relationship with physicians. It expands their scope to include all women's health care needs; previously their scope was limited to gynecology, pregnancy, childbirth, and post-partum care of mothers and newborns. It removes the restriction that nurse-midwives care only for essentially normal newborns and women and only under an obstetrician-gynecologist's (OB-GYN) direction (which does not require the physician to be present). And it specifies that (1) their scope includes family planning and (2) they practice in collaboration with qualified ob-gyns. The act eliminates the requirement that the clinical relationship between a nurse-midwife and a physician be based on written protocols and guidelines that contain a list of the drugs, devices, and lab tests a nurse-midwife can prescribe, administer, or dispense. Instead, it requires them to practice within a health care system and have a clinical relationship with ob-gyns that provide for consultation, collaborative management, or referral as indicated by the patient's health status. It requires each nurse-midwife to provide (1) care consistent with standards the American College of Nurse Midwives establishes and (2) information about, or referral to, other providers or services, if the patient asks or requires care that is not in the nurse-midwife's scope of practice.

The act permits a graduate of a nurse-midwife program approved by the American College of Nurse Midwives to practice midwifery without a license in a hospital or other facility for up to 90 days after graduation or until they learns that they failed the licensing exam. The facility must (1) verify the graduate's successful completion of an approved program and (2) provide supervision the DPH commissioner determines is adequate.

Finally, the act requires the nurse-midwives the DPH commissioner appoints to advise him in regulating the profession be licensed and have practiced for at least five years. It prohibits any of them from being an officer in the Connecticut Chapter of the American College of Nurse Midwives.

Sec. 40 - MOLD ABATEMENT PROTOCOL

The act requires the DPH commissioner to publish guidelines establishing mold abatement protocols that contain acceptable methods for performing abatement or remediation work. He must do by October 1, 2006. The act specifies that these guidelines are not regulations.

Sec. 41 – HOSPITALISTS

The act requires the Quality of Care Advisory Commission, which advises DPH on ways to measure health care facilities' clinical performance, to make recommendations on best practices concerning communications between patients' primary care providers and other providers involved in patient care, including specialists and hospitalists. The commission must make its recommendations to DPH by January 1, 2008. Hospitalists are physicians, mainly internists, whose primary professional focus is the general medical care of hospitalized patients.

Sec. 42 - MENTAL HEALTH FACILITY LICENSURE

The act extends DPH licensing requirements to all facilities that treat people with mental illness, not just (1) those treating adults and (2) outpatient facilities treating youths over age 15 who receive services from the Department of Mental Health and Addiction Services. It does this by revising the definition of "mental health facility."

Sec. 43-46 - ATHLETIC TRAINERS

For purposes of athletic trainer licensure, the act references certification by the Board of Certification, Inc. or its successor instead of the National Athletic Trainers' Association Board of Certification, Inc. It also specifies that the DPH commissioner, before April 30, 2007, must license as an athletic trainer an applicant providing satisfactory evidence of (1) continuously providing services as an athletic trainer since October 1, 1979 or (2) being certified as an athletic trainer by the Board of Certification.

It authorizes DPH to take various disciplinary actions against a licensed athletic trainer failing to meet the profession's accepted standards. These include license suspension or revocation; censure; issuance of a letter of reprimand; placement on probation; or assessment of a civil penalty. DPH can order a licensee to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of investigation. DPH can petition the Hartford Superior Court to enforce an order or action. The licensee must receive notice of any contemplated action, the cause of the action, and the opportunity and date for a hearing.

Sec. 47 - PHYSICAL THERAPY ASSISTANTS

The act alters two conditions under which DPH can license a physical therapy assistant (PTA) without an examination. It permits DPH to issue a license (1) before April 30, 2007, to applicants who show that they have worked for 20 years as a PTA before October 1, 1989 or (2) were registered PTAs before April 1, 2006. Under prior law, DPH could license a person without an exam who was eligible to register as a PTA when DPH notified the public that it had adopted PTA licensing regulations (it did so on April 11, 2006), had graduated from an approved physical therapy school, or had worked 20 years as a PTA by October 1, 1989. DPH continues to be able to license anyone without an exam who is licensed or registered in another state or nation with similar or higher requirements than Connecticut.

Sec. 48 - PROFESSIONAL COUNSELORS

The act changes the education criteria required for a person seeking a professional counselor's license. Under prior law, a person must have completed 60 hours of graduate school work in counseling-related areas and have earned a master's degree, a master's degree and a sixth year degree, or a doctorate. The act, instead, requires licensure candidates to have accomplished one of the following:

1. completed 60 hours of graduate school work in counseling-related areas;
2. earned (a) a master's degree with at least 42 graduate hours with a major the National Board of Certified Counselors deems to be in the discipline of counseling or (b) a master's degree with a major in social work, marriage and family therapy, counseling, psychology, or a mental health field plus a sixth year degree in a discipline deemed as counseling by the national board; or
3. a doctorate in a discipline the national board deems to be counseling.

Sec. 49, 50 - PHARMACEUTICAL EMERGENCY PREPAREDNESS

When the governor or her authorized representative declares an emergency, the act allows a hospital pharmacy, pharmacy, or registrant authorized by state or federal law to possess controlled substances to transfer or distribute drugs or controlled drugs to a licensed pharmacy, registrant, or a location authorized by the Consumer Protection Department (DCP) commissioner. This must be done according to applicable federal law, regulations, guidelines, and policy and with the commissioner's prior approval. The registrant must record the transfer accurately in compliance with all state and federal law and report the transfer in writing to the commissioner.

The act requires licensed wholesalers that distribute prescription drugs to provide the DCP commissioner with a report on the wholesaler's on-hand inventory of specifically identified prescription drugs. Licensed repackagers of the finished form of the drug must do the same.

DCP must establish a list of strategic prescription drugs that must be reported. The list must include selected vaccines and antibiotic products, and be based on priorities DCP establishes in consultation with DPH. The list, issued biannually, must be based on anticipated medication requirements for public health preparedness, pharmacological terrorism prevention or response, and medication and economic integrity.

An inventory report must include the (1) name, address, town, and state of the wholesaler and manufacturer; (2) prescription drug name; (3) quantity of the drug on hand, including the size of each container and the number of containers; and (4) report date. The information must be reported as prescribed by DCP.

Information licensed wholesalers provide is not subject under the bill to disclosure under the Freedom of Information Act. It is available to DCP, DPH, the Office of Emergency Management, and other agencies and entities determined by DCP after a request and a demonstration of need is made for public health preparedness, pharmacological-terrorism prevention or response, medication integrity, or other appropriate purpose.

DCP must adopt regulations with the assistance of the Commission on Pharmacy. Violation of these provisions results in a fine of up to $10,000, imprisonment up to one year, or both.

Sec. 51 – SCHOOL BASED HEALTH CENTER STUDY

The act requires the DPH commissioner to establish an ad hoc committee to assist him in examining statutory and regulatory changes to improve health care through access to school-based health centers, particularly by under- or uninsured people or Medicaid recipients. The committee must meet by July 15, 2006. The committee includes the DPH and DSS commissioners or their designees and the following members appointed by the DPH commissioner: (1) two DPH employees; (2) one DMHAS employee recommended by the department; (3) one OPM employee recommended by the office; and (4) three school-based health center providers recommended by the Connecticut Association of School Based Health centers. The DPH commissioner can expand membership to include representatives from related fields if he determines this is useful.

The committee must focus on improving school-based resources, facilitating access to school-based health centers, and identifying or recommending appropriate fiscal support for operational and capital activities. It must also assess the current school-based health center system, with particular emphasis on (1) expansion of existing services to achieve the school-based health center model; (2) supportive processes for such expansion, including the use of unified data systems; (3) identification of geographical areas of need; (4) financing for an expanded system; and (5) service availability under the current and expanded system. Other topics may be included at the discretion of the commissioner and the committee.

Sec. 53 - KIDNEY DISEASE TESTING

The act imposes certain requirements, beginning September 1, 2006, on licensed physicians, hospitals, and clinical laboratories concerning testing of patients age 18 and older for kidney disease.

It requires physicians to order a serum creatinine test as part of each patient's annual physical examination if the patient has not had such a test within the preceding 12 months. (Creatinine is a breakdown product of creatine, which is an important part of muscle. A serum creatinine test measures the amount of creatinine in the blood.) The physician's order must include a notification that the test is being done according to the bill's provisions.

PA 06-120 requires hospitals to order this test for each patient admitted to the hospital, at least once during the patient's stay. This act amends that act to instead require that if the test is performed on a patient admitted to a hospital as an inpatient, the ordering provider must request at least once during the patient's stay that the testing laboratory report an estimated glomerular filtration rate (eGFR). This is required if the patient has not had the test in the year preceding the hospitalization.

Under the act, a clinical laboratory, when it tests a specimen to determine a patient's serum creatinine level as ordered by a physician or provider in the hospital, must: (1) calculate the patient's eGFR using the patient's age and gender which the physician or hospital provider must provide and (2) include the patient's eGFR with its report to the physician or hospital provider. GFR is a measure of how effectively the kidneys are removing waste and excess fluid from the blood. It is calculated based on a blood test for creatinine.

Under the act, a "clinical laboratory" is any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological, or other examinations of human body fluids, secretions, excretions, or excised or exfoliated tissues, to provide information for the (1) diagnosis, prevention, or treatment of any human disease or impairment; (2) assessment of human health; or (3) presence of drugs, poisons, or other toxicological substances (CGS § 19a-30).

The act specifies that a person, firm, or corporation operating a clinical laboratory is deemed in compliance with the act's provisions if the laboratory makes available to the ordering physician or hospital provider test order codes for serum creatinine that include eGFR.

Sec. 54 - DEFIBRILLATORS AT PUBLIC GOLF COURSES

The act requires all public golf courses (a course with at least nine holes and a course length of at least 2,750 yards) to provide and maintain at least one automatic external defibrillator at a central location on the premises.

Sec. 55, 56 - ALZHEIMER'S SPECIAL CARE UNITS

The act requires Alzheimer's special care units or programs to disclose in writing to people who will live in them or their legal representative or other responsible party information about the unit's philosophy, costs, admission, and discharge procedures; care planning and assessment; staffing; physical environment; residents' activities; and family involvement. Disclosure must begin by January 1, 2007 and be signed by the patient or responsible party.

An "Alzheimer's special care unit or program" is any nursing facility, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice, or adult foster home that locks, secures, segregates, or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia, or similar disorder. The unit or program must be one that prevents or limits a resident's access outside the designated or separated area and advertises or markets itself as providing specialized care or services for those with Alzheimer's disease or dementia.

The required disclosure must explain what additional care and treatment or specialized program the Alzheimer's unit will provide that is distinct from the care and treatment required by the applicable licensing rules and regulations.

It must include:

1. a written statement of the special unit's overall philosophy and mission as it reflects the needs of residents with Alzheimer's, dementia, or similar disorders;
2. the process and criteria for placement within or discharge from the unit;
3. the process for assessing, establishing, and implementing the care plan, including how it is modified in response to changes in condition;
4. the extent and nature of staff coverage, including staff to patient ratios and staff training and continuing education;
5. the physical environment and design features appropriate for the residents' functioning;
6. the frequency and types of activities and the ratio of residents to recreation staff;
7. the role of families and family support programs; and
8. the cost of care, including any additional fees.

Each Alzheimer's special care unit program must develop a standard disclosure form for compliance with the bill and, at least once a year, review and verify the accuracy of information provided. Each unit must update any significant changes to the information reported above within 30 days of the change.

The act requires each special care unit or program to annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff who provide direct patient care to residents in these units or programs. This must include (1) at least eight hours of dementia-specific training, completed within six months after beginning employment, followed by three hours of such training annually and (2) at least two hours a year of training in pain recognition and administration of pain management techniques for direct care staff.

Sec. 57 - EMERGENCY RESPONSE INFORMATION

The act changes the information public safety answering points are required to report. Instead of reporting the calls they receive for EMS services and the 9-1-1 calls they receive involving medical services, it requires them to report all calls they receive through the 9-1-1 system for services. And, instead of reporting the time that elapsed between answering a call and dispatching services or relaying it to another public or private safety agency, they must report the elapsed time until they transfer or terminate a call. Finally, the act removes the requirement that they report this information quarterly to DPH.

Sec. 58 - USE OF THE TERM 'DOCTOR' AND RELATED TERMS

The act amends the law on use of the title "doctor" and related terms and abbreviations. It prohibits anyone engaged in any branch of the art of healing the sick or injured or claiming to do so, other than a licensed medical doctor, from using or implying the use the terms "physician," "surgeon," "medical doctor," "osteopath," or "doctor," or the initials "M.D.", "D.O.", or "Dr.," or any similar title or description of services with the intent to represent or likely have someone believe that the person (1) practices medicine in the state, (2) is licensed to practice medicine in the state, or (3) may diagnose or treat any injury, deformity, ailment or disease, actual or imaginary, of another person for compensation, gain, or reward.

Under the act, a person who has a doctor of medicine degree or doctor of osteopathy, but not licensed to practice medicine under state law, may use the initials "M.D.," or "D.O.," if they are not used with the intent to represent or induce the belief that the person (1) practices medicine in the state, (2) is licensed to practice medicine within the state, or (3) may diagnose or treat any injury, deformity, ailment, or disease of another person for compensation, gain, or reward.

Violation of these provisions or of existing law on who may legally practice medicine results in a fine of up to $500, imprisonment up to five years, or both. The act specifies that each instance of patient contact or consultation in violation of the physician practice law constitutes a separate offense. The act specifies that failure to timely renew a license is not a violation of the act.

Sec. 59-81 - HEALTH CARE DECISION- MAKING

Sec. 82 - PHYSICAL THERAPIST DIRECT ACCESS

Refer to PA 06-125 Senate Bill 164.

Sec. 83, 85 - PHYSICAL THERAPIST MALPRACTICE INSURANCE

The act requires licensed physical therapists who provide direct patient care to carry malpractice insurance of at least $500,000 per person, per occurrence with an aggregate of at least $1.5 million. It requires malpractice insurers, beginning January 1, 2007, to annually notify DPH of the names and addresses of physical therapists whose policies it cancelled or refused to renew in the previous calendar year and the reasons why.

Sec. 84 - LOAN REPAYMENT PROGRAM

The law authorizes DPH to establish, within available appropriations, a program providing three-year grants to community-based, primary care service providers to expand access to health care for the uninsured. The grants may be awarded to recruit and retain primary care clinicians and registered nurses through salary subsidies or a loan repayment program. By law, clinicians and nurses participating in the loan repayment or salary subsidy program must provide services to the uninsured based on a sliding fee schedule, provide free care if necessary, accept Medicare assignment, and participate as a Medicaid provider. The act specifies that these providers can also provide nursing services in a school-based health center.

Sec. 86 - MUNICIPAL WATER AUTHORITIES

The act repeals a law passed last session allowing any municipality with a population greater than 100,000 to create, by ordinance, a water authority and transfer all or part of its water supply to the authority (PA 05-5, June Special Session, § 23-35; § 7-244g to 244s of the 2006 Supplement to the General Statutes.)

Sec. 87 - HEALTH CARE DECISION REPEAL

The act repeals a statutory short form power of attorney for health care decisions for consistency with the health care decision making provisions of the act above.

Required Action:

Establish an ad hoc committee for the purpose of assisting, examining and evaluating access to school based health centers.

Sections 1, 14, 18, and 19 require notification and update of local registrars. Provide materials as necessary via mail and/or website.

Sections 2, 3, 11, 12, 13, 20, 21, 22, 29, 30, 31, 32, 36, 37, 39, 43, 44, 45, 46, 47, 48, 53, 58, 82, and 83 update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Sections 4, 15, and 16 require the revision of Syringe/Needle Exchange Program protocol.

Multicultural Healthcare and Comprehensive Cancer: Sections 5, 6, and 52 requires DPH, within available appropriations, to establish a comprehensive state cancer plan. The plan must provide for (1) a statewide smoking cessation program that targets Medicaid recipients, (2) development and implementation of (a) a program that encourages people to get colorectal screenings and (b) a statewide clinical trials network, (3) identification of services for, and provision of services to, cancer survivors, and (4) identification and provision of services to organizations offering hospice or palliative care education.

Section 34 and 35 requires the development of a “short form” for emergency vehicle addition.

Section 51 requires the establishment of an ad hoc committee to examine and evaluate access to school based health centers. The committee must submit the results of its examinations with specific recommendations for statutory or regulatory changes to the governor and Public Health Committee by December 1, 2006.

Incorporated in SB 317 **HB 5244**

LICENSURE OF PUBLIC HEALTH FACILITIES

Summary: Failed – Incorporated in SB 317

Background:

To establish a certification process for persons or entities that provide nursing home management services and to make technical revisions to sections 19a-127m, 19a-127n and 19a-490h.

Healthcare Systems Branch

Public Act 06-142 **SB 160**

HOSPITAL ACQUIRED INFECTIONS

Effective Date: Upon Passage

Summary:

This act creates an 11-member "Committee on Healthcare Associated Infections" responsible for developing, operating, and monitoring a mandatory reporting system for healthcare associated infections.

There is established a Committee on Healthcare Associated Infections, which shall consist of the commissioner or the commissioner's designee, and the following members appointed by the commissioner: Two members representing the Connecticut Hospital Association; two members from organizations representing health care consumers; two members who are either hospital-based infectious disease specialists or epidemiologists with demonstrated knowledge and competence in infectious disease related issues; one representative of the Connecticut State Medical Society; one representative of a labor organization representing hospital based nurses; and two public members. All appointments to the committee shall be made no later than August 1, 2006, and the committee shall convene its first meeting no later than September 1, 2006.

The act defines a "healthcare associated infection" as any localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent or its toxin that (1) occurs in a patient in a healthcare setting; (2) was not found present or incubating at the time of admission unless the infection was related to a previous admission to the same setting; and (3) if the setting is a hospital, meets the criteria for a specific infection site, as defined by the National Centers for Disease Control.

The act requires the Department of Public Health (DPH) to implement the committee's recommendations concerning a mandatory reporting system for infections and standardized data reporting measures. It also establishes reporting requirements.

Background:

Quality of Care/Adverse Event Reporting Law

Connecticut, while not having a law specifically addressing hospital acquired infections, does require hospitals to report hospital acquired infections that result in death or serious injury as part of the quality of care/adverse event reporting law (PAs 02-125 and 04-164).

Required Action:

The Committee on Healthcare Associated Infections will advise the department with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare associated infections. Identify, evaluate and recommend to the department appropriate standardized measures, including aggregate and facility specific reporting measures for healthcare associated infections and processes designed to prevent healthcare associated infections in hospital settings and any other healthcare settings deemed appropriate by the committee. Identify, evaluate and recommend to the Department of Public Health appropriate methods for increasing public awareness about effective measures to reduce the spread of infections in communities and in hospital settings and any other healthcare settings deemed appropriate by the committee.

Public Act 06-125 **SB 164**

PATIENT ACCESS TO PHYSICAL THERAPY

Effective Date: October 1, 2006

Summary:

This act allows physical therapists meeting certain standards to treat patients without referral from another health care practitioner, except in cases involving workers' compensation injuries and a specific kind of treatment. The act establishes procedures a physical therapist must follow in treating patients without a referral.

The act specifically authorizes the Board of Examiners for Physical Therapists to take disciplinary action, including license suspension or revocation, against a physical therapist who fails to comply with continuing education requirements. The law already subjected physical therapists to disciplinary action for failure to comply. And the act modifies the process for therapists to seek a waiver from continuing education requirements.

It specifies that physical therapy does not include performing surgery; prescribing drugs; or diagnosing disease, injury, or illness. And it prohibits physical therapists and physical therapist assistants from using the terms “chiropractic adjustment or manipulation” to indicate or suggest they use these techniques in their practice.

Required Action:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 06-155 **SB 505**

THE ESTABLISHMENT OF AN ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM AND WORK GROUP AND THE RELEASE OF CONTROLLED SUBSTANCES BY PHARMACISTS

Effective Date: October 1, 2006

Summary:

This act requires the commissioner of the Department Consumer Protection (DCP), within available appropriations, to establish an electronic prescription drug monitoring program to collect prescription information from pharmacies about Schedules II, III, IV, and V controlled substances. It requires the program to be designed to provide information about the prescription of these substances to prevent their improper or illegal use. It prohibits the program from infringing on legitimate prescriptions of controlled substances made in good faith and in the course of professional practice.

The act (1) sets requirements for information reporting, (2) makes the information confidential and establishes a mechanism allowing it to be reported, and (3) establishes a prescription drug monitoring working group and sets its duties.

Required Action:

The act requires the commissioner to adopt regulations about reporting, evaluating, managing, and storing electronic controlled substance prescription information. In addition the act requires a pharmacist or his agent to require the presentation of valid photographic identification before releasing a controlled substance to anyone he does not know. It exempts from this requirement transactions taking place in an institutional or long-term care setting, including an assisted living facility or hospital.

Public Act 06-160 SB 651

PODIATRIC MEDICINE

Effective Date: October 1, 2006 for the scope of practice changes; upon passage for the panel.

Summary:

This act expands the scope of practice of podiatrists by allowing the medical and nonsurgical treatment of the ankle under certain conditions. Podiatrists' existing scope allows diagnosis and treatment of ailments of the foot, including medical and surgical treatment, and administering and prescribing drugs incidental to the care.

Required Action:

The act requires the public health (DPH) commissioner to convene a panel, directed by an arbitrator, to develop a protocol and recommendations for allowing qualified podiatrists to perform surgery on the ankle. Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 06-87 HB 5181

PREPAID FUNERAL CONTRACTS

Effective Date: October 1, 2006

Summary:

This act requires pre-need funeral service contracts to be written and include certain provisions that, among others, describe the parties, identify the goods and services to be provided, state the amount paid or to be paid, and designate an escrow agent who will hold the prepaid funeral service funds. It requires funeral homes to (1) keep copies of the contracts and (2) inform contract purchasers whenever they change majority ownership or close.

The law requires a funeral home to deposit money provided under pre-need funeral service contracts into an escrow account and sets a deadline for making the deposit. The act sets a deadline for the escrow agent to notify the purchaser that he has received the initial deposit. It also requires the agent to notify the purchaser when transferring funds in the account. It prohibits transfers to an insurance contract except under specified conditions. It also revises the restriction on investing escrow accounts in insurance contracts.

Finally, the act requires Medicaid beneficiaries to notify the social services commissioner when revoking certain pre-need funeral service contracts.

Public Act 06-107 HB 5215

SEXUAL ASSAULT BY HYPNOTISTS

Effective Date: October 1, 2006

Summary:

This act makes it sexual assault for hypnotists to have consensual sexual intercourse or contact with clients under the same circumstances that currently apply to people performing or purporting to perform psychotherapy.

This conduct is 2nd-degree sexual assault when it involves sexual intercourse

1. With a client during a treatment session for a mental or emotional illness, symptom, or condition;
2. The hypnotist represents to be for legitimate treatment purposes; or
3. With a client or former client the hypnotist has reason to know is unable to withhold consent because of her emotional dependence on him.

By law, people convicted of this crime are subject to lifetime sex offender registration. The act also makes it 4th-degree sexual assault to have sexual contact with a client or former client under the circumstances listed above.

Public Act 06-110 HB 5477

SUPERVISION OF PHYSICIAN ASSISTANTS

Effective Date: October 1, 2006

Summary:

This act revises the supervision requirements for physician assistants (PAs) by (1) making a distinction between supervision in a hospital versus other settings and (2) eliminating a requirement that the supervision in any setting be at the specific location where the PA is practicing. By law, each PA must have a clearly identified supervising physician, registered with the Department of Public Health (DPH), who has

final responsibility for patient care and the PA's performance. A physician may supervise up to six full-time PAs concurrently or the equivalent part-time number, if medically appropriate.

The law requires the supervising physician to personally review the PA's practice at least weekly or more frequently as needed to ensure quality care. In settings other than hospitals, the act requires (1) that these reviews be done through face-to-face meetings, at least weekly or more frequently as necessary to ensure quality care, at a facility or location where the PA or supervising physician practices and (2) that the supervising physician document in writing his already-required regular review of the PA's charts and records at the facility or practice location of the PA or physician.

The act also specifies that, in any setting, a physician designated as the PA's alternate supervising physician in the absence of his regular supervising physician must be registered with DPH.

Required Action:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 06-120 HB 5616

SCREENING FOR KIDNEY DISEASE

Effective Date: Upon Passage
***Updated language in section 53 of SB 317.

Summary:

This act imposes certain requirements, beginning September 1, 2006, on licensed physicians, hospitals, and clinical laboratories concerning testing of patients age 18 and older for kidney disease.
It requires physicians to order a serum creatinine test as part of the patient's annual physical examination if the patient has not had such a test within the preceding 12 months. (Creatinine is a breakdown product of creatine, which is an important part of muscle. A serum creatinine test measures the amount of creatinine in the blood.) The physician's test order must include a notification that it is being done according to the act's provisions.

The act requires hospitals to order this test for each patient admitted to the hospital, at least once during the patient's stay. The test order must include the same notification as above. (PA 06-317 amends this to instead require that if a serum creatinine test is performed on a patient admitted to a hospital as an inpatient, the ordering provider must request at least once during the patient's stay that the testing laboratory report an estimated glomerular filteration rate (eGFR)). GFR is a measure of how effectively the kidneys are removing waste and excess fluid from the blood. It is calculated based on a blood test for creatinine.

Under the act, a clinical laboratory, when it tests a specimen to determine a patient's serum creatinine level as ordered by a physician or hospital, must (1) calculate the patient's eGFR using the patient's age and gender which the physician or hospital must provide and (2) include the patient's eGFR with its report to the physician or hospital.

Required Action:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 06-169 **HB 5617**

PRESCRIPTIVE AUTHORITY OF ADVANCED PRACTICE REGISTERED NURSES

Effective Date: October 1, 2006

Summary:

This act allows advanced practice registered nurses (APRNs) to request, receive, and dispense sample medications in all health care settings. Current law allows APRNs to do this only in noninstitutional settings (i. e., a physician's office).

Local Health Administration

Public Act 06-185 **SB 389**

MUNICIPALITIES TO ESTABLISH A SPECIAL ASSESSMET ON BLIGHTED HOUSING, INCREASING THE FINES FOR VIOLATIONS OF MUNICIPAL ORDINANCES AND CONCERNING MUNICIPAL LIENS FOR ACCRUED FINES AND CODE VIOLATIONS

Effective Date: July 1, 2006 for the blight provisions, October 1, 2006 for the remaining provisions.

Summary:

This act allows municipalities that meet certain conditions to impose a special assessment on blighted housing and specifies the conditions under which they may do so. Any unpaid special assessment a municipality imposes is a lien upon the real estate against which it was imposed, running from the date of the fine. The lien may be continued, recorded, enforced, and released like a property tax lien.

The act makes certain municipal housing and health related fines, expenses, charges, and penalties that remain unpaid for 60 days after they are due a lien on the violator's property if the municipality records a violation notice on its land records within 30 days after the fine, expense, service charge, and penalty are imposed. The lien takes precedence over subsequently recorded transfers and encumbrances. The act requires that a current record of all properties for which fines, expenses, charges, and penalties remain unpaid be kept in the enforcing agency's office and available for public inspection.

It requires a municipality to notify a lienholder of any notice or order to a property owner under local or state law to dispose of the real estate or make it safe and sanitary. It also requires municipalities to make reasonable efforts to send a copy of the notice by first class mail to lienholders of the property at their current or last-known address. It allows a municipality to recover its costs in making a property sanitary in the same way it can recover its costs in making it safe or secure, including making these costs a lien on the property. It adds the municipality's costs of making a property safe, secure, or sanitary to the taxes due on the property.

The act increases fines that municipalities may impose for violations of local laws, but decreases the daily maximum fine that they may impose for housing code and tenement or lodging house safety and health code violations. It allows violations of certain local laws to be handled as infractions.

Background:

Tenement, Lodging, and Boarding House

A “tenement house” means any house or building, or portion of it, rented to be occupied, or arranged or designed to be occupied, or occupied, as the home or residence of three or more families, living independently, and doing their cooking upon the premises, and having a common right in the halls, stairways, or yards. A “lodging house” or “boarding house” means any house or building or portion of it, in which six or more people stay, or any building or part of it, used as a sleeping place or lodging for six or more persons not members of the family living there (CGS § 47a-50(1)).

Required Action:

The office of Local Health would need to bring this to the attention of the Connecticut Association of Directors of Health members.

Public Act 06-81 **HB 5440**

PRESENCE OF VOLATILE ORGANIC COMPOUNDS AND NOTICE OF POLLUTING EVENTS

Effective Date: October 1, 2006

Summary:

This act tightens drinking water pollution notice requirements by requiring (1) sellers of homes that are or will be served by well water to notify prospective buyers of the results of any water test for volatile organic compounds and (2) the Department of Environmental Protection (DEP) commissioner to notify state, federal, and employee representatives about contaminated sites.

Required Action:

Notify local health departments of updated application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website

Multicultural Health and Comprehensive Cancer

Public Act 06-77 **SB 311**

DESIGNATING THE MONTH OF NOVEMBER AS LUNG CANCER AWARENESS MONTH AND CONCERNING THE ESTABLISHMENT OF A PUBLIC UMBILICAL CORD BLOOD BANK

Effective Date: Upon passage for the cord blood bank provisions; October 1, 2006 for the lung cancer awareness section.

Summary:

This act directs the public health (DPH) commissioner, in consultation with the Stem Cell Research Advisory Committee, to establish an ad hoc committee concerning a public umbilical cord blood bank in the state.

The act also requires the governor to designate November as Lung Cancer Awareness Month to heighten public awareness that lung cancer is the leading cause of cancer death of both men and women in the United States. The act specifies that suitable events must be held in the State Capitol and other places the governor designates.

Public Act 06-38 **SB 422**

HEALTH INSURANCE COVERAGE FOR BREAST CANCER SCREENING

Effective Date: October 1, 2006

Summary:

This act changes when health insurance policies must provide coverage for a comprehensive ultrasound screening of an entire breast or breasts for a woman. Under prior law, a policy had to provide coverage if a physician recommended the screening for a woman classified as category 2, 3, 4, or 5 on the American College of Radiology's Breast Imaging Reporting and Database System (BI-RADS) mammogram reading scale. The act instead requires coverage if (1) a mammogram shows heterogeneous or dense breast tissue based on BI-RADS or (2) a woman is considered at an increased breast cancer risk because of family history, her own prior breast cancer history, positive genetic testing, or other indications determined by her physician or advanced-practice registered nurse. By law, unchanged by the act, coverage for breast ultrasound screening is subject to any policy provisions applicable to other covered services and is in addition to coverage required for mammograms.

The act applies to individual and group health insurance policies that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; and (4) hospital or medical services, including those provided by HMOs. The act also applies to individual policies that cover (1) accidents only and (2) limited benefits.

Background:

BI-RADS Categories

The American College of Radiology collaborated with the National Cancer Institute, the Centers for Disease Control and Prevention, the American Medical Association, and others to develop BI-RADS, which is used to standardize mammography reporting. There are two BI-RADS scales: (1) one characterizes breast density and (2) the other characterizes a radiologist's reading of what he sees on a mammogram.

Density. The BI-RADs scale shown in Table 1 categorizes breast density.

TABLE 1

Category	***Breast Density***
1	Having no areas of tissue that could obscure cancer
2	Having at least one area of tissue that could obscure cancer
3	Having tissue that can obscure cancer in 50% to 75% of the breast
4	Having tissue that can obscure cancer in greater than 75% of the breast

Mammogram Reading. The BI-RADS scale shown in Table 2 categorizes specific findings and recommendations based on what a radiologist sees on a mammogram.

TABLE 2

Category	***Finding and Recommendation***
0	Need additional imaging evaluation
1	Negative – continue annual mammogram screening
2	Benign (non-cancerous) – continue with annual mammogram screening
3	Probably benign – six-month follow-up mammogram
4	Suspicious abnormality – biopsy should be considered
5	Highly suggestive of malignancy – appropriate action should be taken (e. g. , biopsy)

Related Law

Health insurance policies must provide coverage for mammograms at least equal to the following: one initial examination for women ages 35 to 39 and one examination every year for women age 40 and older. Coverage is subject to any policy provisions applicable to other covered services.

Public Act 06-131 **HB 5114**

DEVELOPMENTAL NEEDS OF CHILDREN AND YOUTH WITH CANCER.

Effective Date: October 1, 2006, except the HUSKY provision, which is effective on passage.

Summary:
This act requires individual and group health insurance policies to provide coverage for neuropsychological testing of children diagnosed with cancer after December 31, 1999. The mandate applies to plans delivered, issued for delivery, amended, renewed, or continued in the state on and after October 1, 2006. The act also requires the social services commissioner to amend the state's Medicaid and State Children's Health Insurance Program plans to provide this coverage under HUSKY A and B.

Under the act, insurers and the HUSKY plans must cover tests a licensed physician orders to assess the extent chemotherapy or radiation treatment has caused the child to have cognitive or developmental delays. They may not require prior authorization for the tests.

The law requires individual and group health insurance policies that cover dependents to do so through age 18 and up to age 23 if they are full-time students at an accredited school. HUSKY A and B cover children through age 18.

Operations

Public Act 06-72 **SB 72**

EMERGENCY PERSONNEL BICYCLES WITH AUDIBLE WARNING DEVICES

Effective Date: October 1, 2006

Summary:

This act exempts firefighters and emergency services personnel from state laws and local regulations governing bicycle operations on highways, under the same circumstances as police officers. Police officers are exempt when responding to emergency calls, engaged in rescue operations, or pursuing actual or suspected criminals if they (1) completed a basic bicycle patrol course certified by the Police Officer Standards and Training Council or an equivalent course and (2) wear a distinctive uniform and use an audible signal such as a siren, whistle, or bell. The act requires that the firefighter, police officer, or emergency services personnel be at least age 16.

Public Act 06-15 **HB 5085**

DEFINING "EMERGENCY" AND "MAJOR DISASTER"

Effective Date: October 1, 2006

Summary:

This act conforms the definitions of "major disaster" and "emergency" to the current federal definitions (42 USC § 5122) for purposes of the civil preparedness and emergency management statutes.

Public Act 06-22 **HB 5284**

MODEL GUIDELINES FOR VOLUNTEER EMERGENCY PERSONNEL

Effective Date: Upon Passage

Summary:

This act requires the state fire administrator, within available appropriations, to develop model guidelines by January 1, 2007, that municipalities with paid or emergency personnel may use to enter into agreements allowing people to serve as volunteer emergency personnel during their personal time.

Planning Branch

VETOED **SB 4**

PROVIDING CERTAIN ADULT ADOPTED PERSONS WITH ACCESS TO INFORMATION IN THEIR ORIGINAL BIRTH CERTIFICATES.

Effective Date: Vetoed by Governor Rell 5/30/06

Summary:

This act requires the Department of Public Health (DPH) to give adopted adults copies of their sealed original birth certificates on request. Prior law barred access without a biological parent's consent or probate court order.

The act also creates a voluntary, non-binding procedure for biological parents to complete a DPH form indicating whether they want to be contacted by their adopted children. DPH must attach completed forms to the sealed birth certificates and make them available to adult adoptees on request.

The act applies to adoptions completed on and after October 1, 2006. Disclosure is not required until these adoptees reach at age 21.

The act requires DPH to tell people permitted to get copies of an adopted child's medical history record how to do so and makes minor and conforming changes.

Background:

Sealed Birth Certificates

In most cases, DPH seals the original birth certificate when a probate court sends notification it that a child born in Connecticut has been adopted. It prepares a new certificate substituting the adoptive parents' names for those appearing on the original certificate.

Public Health Initiatives

Public Act 06-44 SB 204

PROMOTING THE PHYSICAL HEALTH NEEDS OF STUDENTS

Effective Date: Upon Passage

Summary:

This act requires the State Department of Education (SDE) to develop guidelines to comprehensively address and coordinate students' physical health needs before, after, and during the regular school day. It authorizes all boards of education to use them to develop their own comprehensive, coordinated plans. SDE must develop the guidelines by January 1, 2007; schools may implement their plans in the 2007-08 school year and each year thereafter.

Public Act 06-63 SB 373

HEALTHY FOOD AND BEVERAGES IN SCHOOLS

Effective Date: July 1, 2006

Summary:

This act (1) restricts the types of beverages that may be sold to students in school; (2) requires the State Department of Education (SDE) to set nutritional standards for food sold to students in schools; and (3) provides a financial incentive for local and regional school boards, charter school, endowed academy, and interdistrict magnet school governing authorities, and the regional vocational-technical school system (V-T system) to certify that their schools meet the SDE standards. The act supersedes the existing requirement that school boards provide nutritious and low-fat drink options whenever drinks are available for purchase by students. It extends the requirement that boards provide nutritious and low-fat food options to the governing authorities of state charter schools, interdistrict magnet schools, and endowed academies.

Required Action:

The Department of Public Health will offer assistance to the state Department of Education as needed and participate on any work groups formed to implement this law.

Public Act 06-105 **SB 411**

EXEMPTION FROM RABIES VACCINATION REQUIREMENTS

Effective Date: October 1, 2006

Summary:

This act allows the agriculture commissioner, his designee, or the state veterinarian to grant an exemption from the rabies vaccine requirement, when a licensed veterinarian determines that a cat or dog may be harmed by vaccination due to disease or other medical considerations. The exemption is valid for one year, after which it must be renewed or the animal must receive the vaccination. The act specifies the process for granting the exemption.

Required Action:

The act requires the agriculture commissioner to adopt regulations instituting measures necessary to prevent animals from transmitting rabies in public settings (e. g. , petting zoos and educational exhibits). The act also makes minor and technical changes.

Public Act 06-164 **HB 5251**

RECOMMENDATIONS OF THE CHILD POVERTY COUNCIL RELATED TO JOB TRAINING AND CHILD WELLNESS

Effective Date: July 1, 2006

Summary:

This act permits the Office of Workforce Competitiveness (OWC) to establish a pilot program giving parents access to training to develop skills they need to get and keep jobs. The program is for those with children under age 18 who qualify for, but are not receiving, federal Temporary Assistance to Needy Families (cash welfare) benefits.

Required Action:

DPH is required to work with DSS and DMHAS to jointly establish a program to inform the Healthy Start program about the availability of, and eligibility for, services provided by the Nurturing Families Network. It also requires the departments of Social Services (DSS), Public Health (DPH), and Mental Health and Addiction Services (DMHAS) to disseminate information about services provided by the state's Nurturing Family Network.

Public Act 06-179 **HB 5254**

STATE INVESTMENT IN PREVENTION AND CHILD POVERTY REDUCTION AND THE MERGER OF THE STATE PREVENTION AND CHILD POVERTY COUNCILS

Effective Date: October 1, 2006

Summary:

This act merges the state's Child Poverty and Prevention councils to create a new Child Poverty and Prevention Council. It imposes new reporting requirements on the governor, executive branch agencies, and the council. It ties the latter council's prevention services to others included in the Child Poverty Council's plan to reduce child poverty by 50% by June 30, 2014.

The new council terminates on June 30, 2015, as did the Child Poverty Council under prior law.

Required Action:

DPH is required to report by November 1,2006 and November 1, 2007 on two prevention services, such report to include (A) A statement of the number of children and families served (B) a description of the preventative purposes of the service (C) for 11/1/07, a description of performance-based standards and outcomes included in relevant contracts (D) any performance-based vendor accountability. Also (A) long term agency goals, strategies and outcomes to promote the health and well being of children and families (B)overall findings on the effectiveness of prevention within the agency, (C)A statement if whether there are methods used by the agency to reduce disparities in child performance and outcomes by race, income level and gender, and a description of such methods (D) other relevant information concerning health goals (# healthy pregnant women and newborns, # youths who adopt healthy behaviors, access to health care for children and families), education goals, safety goals (the incidence of child and youth suicide), and housing goals.

Public Act 06-113 **SB 5495**

ASSESSMENTS FOR IMMUNIZATIONS

Effective Date: July 1, 2006

Summary:

This act specifies that the health and welfare fee each Connecticut insurance company and HMO must pay annually is not capped at 25% of the expenditures of the Insurance Department and the Office of Healthcare Advocate. Thus, each company will pay an amount in proportion to its respective share of premium taxes and other charges imposed on its in-state business in the preceding calendar year. The fee, which goes to the General Fund, pays for immunization services provided in Connecticut by the Department of Public Health.

Public Act 06-182 **HB 5532**

YOUTH POLICY AND THE KINSHIP NAVIGATOR PROGRAM

Summary:

This act requires the director of the Office of Workforce Competitiveness (OWC), in consultation with the Connecticut Employment and Training Commission, to convene a 17-member youth futures committee by July 1, 2006. The committee must develop service delivery guidelines, improve communication among agencies, assess existing resources to maximize community youth services, and collaborate with partnerships to facilitate positive youth outcomes. By January 1, 2008, the OWC director must issue a progress report.

The act also requires the Department of Children and Families (DCF), in consultation with the departments of Social Services (DSS), Mental Health and Addiction Services (DMHAS), and Mental Retardation (DMR) to establish, within available appropriations, a kinship navigator program to help relative caregivers find services and become foster parents. By January 1, 2008 and annually thereafter, the act requires the DCF commissioner to report to the Human Services Committee on the new program.

Required Action:

Commissioner to appoint designee to committee.

Regulatory Service Branch

Public Act 06-52 **SB 294**

FARMER'S MARKETS

Effective Date: Upon Passage

Summary:

This act expands the types of products that can be sold at farmers' markets that participate in the Women, Infants, and Children (WIC) program. By law, WIC voucher holders can exchange the vouchers for Connecticut-grown fresh produce at participating farmers' markets. The act broadens the definition of such produce by eliminating the exclusion of nuts, popcorn, vegetable plants or seedlings, dried beans or peas, seed or grains, flowers, cider, and eggs.

Under prior law, such markets principally served as markets for farmers who sell Connecticut-grown fresh produce. The act adds "farm products," which include honey, maple syrup, flowers, meat, milk, and cheese, to the goods that can be sold at these markets. It also requires that at least two of the farmers participating in such markets sell Connecticut-grown fresh produce.

The act establishes requirements for "certified farmers' markets," which it defines as one the agriculture commissioner authorizes to operate (but not necessarily participate in the WIC program). The act requires farmers who sell products at a kiosk at a certified farmers' market to get and maintain any required license to sell the products and comply with state regulations on the sale of farm products on a farm (i. e. , sales at such a market are an extension of sales on the farm).

The act specifies that existing law concerning WIC program farmers' markets and the act's certified farmers' markets provisions do not supersede state and local health and safety laws, regulations, or ordinances.

Public Act 06-154 **SB 455**

EARLY CHILDHOOD EDUCATION WORKFORCE

Effective Date: July 1, 2006

Summary:

This act requires the higher education commissioner, within available appropriations, to develop programs for an accelerated, alternate route to initial teacher certification with an early childhood education endorsement. It also requires her to define preservice and minimum training requirements and competencies for people involved in early childhood education from birth to age five. These must include requirements for individual levels of credentialing and licensing.

In defining training requirements and competencies, the commissioner must consult with the Office of Workfore Competitiveness, the Education and Social Services departments, Charter Oak College, early

childhood education professional organizations, early childhood faculty at public and private colleges and universities, early childhood educators and advocates, and people knowledgeable in early childhood care and education career development and programs.

Public Act 06-81 **HB 5440**

PRESENCE OF VOLATILE ORGANIC COMPOUNDS AND NOTICE OF POLLUTING EVENTS

Effective Date: October 1, 2006

Summary:

This act tightens drinking water pollution notice requirements by requiring (1) sellers of homes that are or will be served by well water to notify prospective buyers of the results of any water test for volatile organic compounds and (2) the Department of Environmental Protection (DEP) commissioner to notify state, federal, and employee representatives about contaminated sites.

It sets various deadlines by which the recipient of the commissioner's order to test any private drinking well must notify the property owner, local health director, and others of findings of excessive contaminant levels.

Background:

Related Bill

sHB 5792 (File 402) requires the testing of a private water supply system when property on which there is a private residential well is sold, exchanged, transferred or purchased.

It sets various deadlines by which the recipient of the commissioner's order to test any private drinking well must notify the property owner, local health director, and others of findings of excessive contaminant levels.

Required Action:

Notify Local Health

Special Act 06-6 **HB 5470**

ESTABLISHING A DRINKING WATER QUALITY MANAGEMENT PLAN FOR THE TOWN OF GROTON, ESTABLISHING THE LITCHFIELD HILLS REGIONAL WATER AUTHORITY AND CONCERNING EXAMINATION OF BORE HOLES USED FOR THE DEVELOPMENT OF GEOTHERMAL HEAT PUMPS

Effective Date:

Upon Passage
Sections: 2-33
July 1, 2006
Sections: 1 and 34

Summary:

Sec 1.
The act establishes the development of a drinking water quality management plan for the preservation of Groton's drinking water and the Thames River Regional pipeline.

Sec. 2-33
The act establishes the Litchfield Hills Regional Water Authority for the primary purpose of providing and assuring the provision of an adequate supply of pure water at reasonable cost within the Litchfield Hills Regional Water District and such other areas as may be served pursuant to cooperative agreements and acquisitions.

Sec. 34.
(a) The Department of Public Health, in consultation with the Departments of Consumer Protection and Environmental Protection, shall review and make recommendations regarding bore holes to be used for the development of closed loop geothermal heat pumps or similar systems, and specifically the abandonment, construction of and appropriate separating distances between such bore holes.
(b) On or before January 1, 2007, the Commissioner of Public Health shall submit the department's specific recommendations and findings based on such review to the joint standing committee of the General Assembly having cognizance of matters relating to public health, for review and appropriate action, in accordance with the provisions of section 11-4a of the general statutes.

Required Action:

Section 1 – On or before January 1, 2009, the Commissioner of Public Health shall submit the department's findings and recommendations based on such review, including specific recommendations concerning necessary statutory changes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, environment, energy and technology and planning and development, in accordance with the provisions of section 11-4a of the general statutes.

Section 2-33 – No specific recommends beyond normal water company review and approval issues.

Section 34 – Staff will be required to review history and public health concerns for separation distances, well construction standards, and abandonment procedures.

Public Act 06-98 **HB 5720**

REGULATION OF DISTRIBUTION WATER MAIN INSTALLATIONS AND WELLS ON RESIDENTIAL PROPERTY

Effective Date: October 1, 2006

Summary:

This act specifically excludes certain distribution water main installations from the Department of Public Health's (DPH) review and approval. The act requires water companies to report to DPH annually on the number and location of such new installations. Reporting must be in an electronic format prescribed by DPH.

Current law prohibits the construction or expansion of a water supply system owned or used by a water company or the use of a new additional water supply source until plans for them have been submitted to and approved by DPH. Under this act, no prior review or approval is required for distribution water main installations if they are constructed according to sound engineering standards and all applicable laws and regulations.

The act defines “distribution water main installations” as installations, extensions, replacements, or repairs of public water supply system mains from which water is or will be delivered to one or more service connections and which do not require construction or expansion of pumping stations, storage facilities, treatment facilities, or supply sources.

Required Action:

Develop format for water companies to submit annual information will have to be determined and made available to water companies.

Special Act 06-9 **HB 5802**

WATER BASINS

Effective Date: July 1, 2006

Summary:

The Connecticut Institute of Water Resources at The University of Connecticut, in consultation with the advisory board of the Connecticut Institute of Water Resources, shall, within the bond allocation provided for such purposes, conduct a study of the scientific and legal structure needed to conduct effective basin level water allocation planning and any significant impediments to said planning. Such study shall to the greatest extent practicable within the bond allocation:

1. Evaluate existing basin studies, including the level of available and required data, to develop guidance for state-wide water planning, including an analysis of the transferability of such studies to other regional or subregional basins, and the costs associated with acquiring that data;

2. Integrate diversion data collected pursuant to section 22a-368a of the general statutes into geospatial and modeling formats consistent with United States Geological Survey data protocols beginning with those subregional watershed basins selected for water allocation planning studies pursuant to subdivision (3) of this subsection and, within available appropriations, other subregional watershed basins;

3. Implement water allocation planning studies for three subregional watershed basins selected by the Connecticut Institute of Water Resources to reflect a range of stream conditions, from stressed to near natural, based on available data and the range of existing and potential water use intensities. Such water allocation planning studies shall include the collection and evaluation of existing technical and scientific data and an assessment of any additional data needs to conduct effective basin planning;

4. Develop and document a water allocation planning model for a selected basin, which shall include stakeholder involvement and shall identify ways to best manage the water resource to promote ecological protection while providing for the needs and requirements of public health, flood control, industry, public utilities, water supply, public safety, agricultural and other lawful uses of such waters.

Research and Development

Public Act 06-77 **SB 311**

DESIGNATING THE MONTH OF NOVEMBER AS LUNG CANCER AWARENESS MONTH AND CONCERNING THE ESTABLISHMENT OF A PUBLIC UMBILICAL CORD BLOOD BANK

Effective Date: Upon passage for the cord blood bank provisions; October 1, 2006 for the lung cancer awareness section.

Summary:

This act directs the public health (DPH) commissioner, in consultation with the Stem Cell Research Advisory Committee, to establish an ad hoc committee concerning a public umbilical cord blood bank in the state.

The act also requires the governor to designate November as Lung Cancer Awareness Month to heighten public awareness that lung cancer is the leading cause of cancer death of both men and women in the United States. The act specifies that suitable events must be held in the State Capitol and other places the governor designates.

Background:

Umbilical Cord Blood

Following the birth of a baby, the umbilical cord usually is discarded along with the placenta. But blood retrieved from the umbilical cord is a rich source of stem cells. These are unspecialized stem cells that produce all other blood cells, including blood-clotting platelets and red and white blood cells. Like donated bone marrow, umbilical cord blood can be used to treat various genetic disorders that affect the blood and immune system.

Both private and public cord blood banks have developed in the last few years in response to the success of umbilical cord blood transplants in treating certain diseases. Private blood banking allows families to preserve their blood for their own use. For-profit private banks charge a fee to preserve a newborn's cord blood for possible use by the family later. Public banks, usually established at medical centers, accept donations for use by anyone in need. Connecticut does not have a public cord blood bank.

Public Act 06-33 **HB 5843**

STEM CELL RESEARCH ADVISORY COMMITTEE

Effective Date: Upon Passage

Summary:

This act adds eight members to the existing nine-member Stem Cell Research Advisory Committee. These additional members begin serving on or after July 1, 2006. By law, this committee is responsible for (1) establishing and administering, in consultation with the Department of Public Health (DPH) commissioner, a program to provide stem cell research grants to eligible institutions; (2) directing the commissioner on grant awards; (3) monitoring grant-funded research; (4) developing, in consultation with DPH, a donated funds program for stem cell research; and (5) reporting to the governor and General Assembly on stem cell research in the state.

The act specifies that it is not a conflict of interest for a person affiliated with an eligible institution to serve as an advisory committee member. By law, an "eligible institution" is (1) a nonprofit tax-exempt college or university, (2) a hospital conducting biomedical research, or (3) any entity conducting biomedical research or embryonic or human adult stem cell research.

Background:

Stem Cell Peer Review Committee

The five-member peer review committee must review all applications for grants and make recommendations to DPH and the advisory committee concerning the ethical and scientific merit of each application. It must establish guidelines for the rating and scoring of the applications. The DPH commissioner appoints the members (CGS § 19a-32g of the 2006 supplement to the General Statutes).

Required Action:

Assist legislators in appointing potential new members. Prepare PSA's with new members if needed, for travel expenses.

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