Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 11.07.18 DPH Clean Indoor Air Act

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Community, Family Health and Prevention Section
Agency Analyst/Drafter of Proposal: Barbara Walsh, Tobacco Control Program

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding The Clean Indoor Air Act
Statutory Reference: Section 1. Sec. 19a-342. Smoking prohibited. Exceptions. Signs required. Penalties. Section 2. Sec. 19a-342a. Use of electronic nicotine delivery system or vapor product prohibited. Exceptions. Signage required. Penalties. Section 3. 31-40q. Smoking in the workplace. Designation of smoking rooms.
Proposal Summary: This proposal will prevent additional tobacco use and exposure to secondhand smoke and aerosol, which would positively impact public health. Section 1. Makes the following revisions: (1) Prohibits smoking in any retail establishment, on any school property, regardless of whether school is in session or student activities are being conducted, in any dormitory, and in child care facilities, except if the facility is a home day care, in that instance smoking is prohibited only when children for whom the facility provides care are in the home; (2) Removes the exemptions for correctional facilities and designated smoking areas in psychiatric facilities; (3) Removes the exemptions for smoking in public housing projects for any new construction built on or after October 1, 2019. Includes a provision to allow the landlord of a public housing project and multifamily dwelling to include a clause in the landlord tenant agreement to prohibit smoking; (4) Prohibits use of smoking rooms provided by employers; (5) Eliminates the allowance for designated smoking rooms in hotels;

(6) Prohibits smoking inside or outside any building accessed by the general public, including its entryway;
(7) Defines "tobacco specialist" and allows for exemption from the Clean Indoor Air Act.
Section 2. Makes the following revisions:
(1) Prohibits the use of Electronic Nicotine Delivery Systems (ENDS) in any area of a retail establishment accessed by the general public, in any area of a school building or on school property, regardless of whether school is in session or student activities are being conducted, a dormitory of an institution of higher education;
(2) Removes the exemptions for vaping in public housing projects for any new construction built on or after October 1, 2019. Includes a provision to allow the landlord of a public housing project and multifamily dwelling to include a clause in the landlord tenant agreement to prohibit vaping;
(3) Eliminates the allowance for designated smoking rooms in hotels;
(4) Prohibits vaping inside or outside any building accessed by the general public, including its entryway;
(5) Clarifies that a "no vaping" sign does not need to be posted in every room of a building, but only in one conspicuous area;

Section 3. Makes the following revisions:
(1) Updates the definition of a business facility and smoking;
(2) Eliminates the language that exempts employers with less than five employees from designating a smoking area;
(3) Eliminates the language that permits smoking rooms in places of employment;
(4) Allows a business owner to prohibit smoking on the entire property on which the business is located;
(5) Includes ENDS and vapor products in the workplace prohibitions.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

- *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?*
- *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*
- *Have certain constituencies called for this action?*
- *What would happen if this was not enacted in law this session?*

This proposal addresses evidence-based policy strategies recommended by the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health, the Community Guide to Preventive Services, and the United States Surgeon General's Office. A number of studies performed by the Office of the Surgeon General have confirmed the harm of these products, and CDC has extensively documented the benefits of implementing comprehensive laws. These

recommendations have been shown to reduce the initiation of tobacco use, reduce prevalence of tobacco use and prevent tobacco-related illness and death.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Requests towards implementing a more comprehensive Clean Indoor Air Act have been introduced in the past few years, and have not passed the chambers of the legislature.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Consumer Protection
Agency Contact (*name, title, phone*): Leslie O'Brien
Date Contacted: 10/5/18

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: State Department of Education
Agency Contact (*name, title, phone*): Laura Stefon
Date Contacted: 10/5/18

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Board of Regents **Agency Contact (*name, title, phone*):** Sean Bradbury **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Office of Higher Education **Agency Contact (*name, title, phone*):** Lisa Negro **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: University of Connecticut **Agency Contact (*name, title, phone*):** Joann Lombardo **Date Contacted:** 10/5/18 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Office of Early Childhood **Agency Contact (*name, title, phone*):** Maggie Adair **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Housing **Agency Contact (*name, title, phone*):** Dan Arsenault **Date Contacted:** 10/5/18 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Corrections **Agency Contact (*name, title, phone*):** David McCluskey **Date Contacted:** 10/5/18 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Mental Health and Addiction Services **Agency Contact (*name, title, phone*):** Mary Kate Mason **Date Contacted:** 10/5/18 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: University of Connecticut Health Center / John Dempsey Hospital **Agency Contact (*name, title, phone*):** Andrea Keilty **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Labor **Agency Contact (*name, title, phone*):** Marisa Morello **Date Contacted:** 10/5/18 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

None

Insert language here

Section 1.

Section 19a-342 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) As used in this section: [, "smoke"]

(1) "Smoke" or "smoking" means the lighting or carrying of a lighted cigarette, cigar, pipe or similar device;

(2) "Any area" means the interior of the facility, building or establishment and the outside area within twenty-five feet of any doorway, operable window or air intake vent of the facility, building or establishment;

(3) "Child care facility" means a provider of child care services as defined in section 19a-77, or a person or entity required to be licensed under section 17a-145.

(b) (1) Notwithstanding the provisions of section 31-40q, as amended by this act, no person shall smoke: (A) In any area of a building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail [food store] establishment accessed by the general public; (D) in any restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor

pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22c, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of an establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, and, on and after April 1, 2004, in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building [while school is in session or student activities are being conducted] or on school property; (G) in any passenger elevator[, provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that smoking is prohibited by state law]; (H) in any area of a dormitory in any public or private institution of higher education; [or] (I) on and after April 1, 2004, in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games; (J) any public housing project, as defined in subsection (b) of section 21a-278a, constructed on or after October 1, 2019; (K) any room offered as an accommodation to guests by the operator of a hotel, motel or similar lodging; or (L) within a child care facility, except, if the child care facility is a family child care home as defined in section 19a-77, such use is prohibited only when a child enrolled in such home is present. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public.

(2) [This section] Subdivision (1) of this subsection shall not apply to [(A) correctional facilities; (B) designated smoking areas in psychiatric facilities; (C) public] the following establishments: (A) Public housing projects, as defined in subsection (b) of section 21a-278a, constructed prior to October 1, 2019; [(D)] (B) any classroom where demonstration smoking is taking place as part of a medical or scientific experiment or lesson; [(E) smoking rooms provided by employers for employees, pursuant to section 31-40q; (F)] (C) notwithstanding the provisions of subparagraph (E) of subdivision (1) of this subsection, the outdoor portion of the premises of any permittee listed in subparagraph (E) of subdivision (1) of this subsection, provided, in the case of any seating area maintained for the service of food, at least seventy-five per cent of the outdoor seating capacity is an area in which smoking is prohibited and which is clearly designated with written signage as a nonsmoking area, except that any temporary seating area established for special events and not used on a regular basis shall not be subject to the smoking prohibition or signage requirements of this subparagraph; [(G)] (D) any medical research site where smoking is integral to the tobacco control research being conducted; or [(H)] (E) any tobacco bar or tobacco specialist, provided no tobacco bar shall expand in size, [or] change its location, or change its owner from its size [or], location or owner as of December 31, 2002. For purposes of this subdivision, "outdoor" means an area which has no roof or other ceiling enclosure, "tobacco bar" means an establishment with a permit for the sale of alcoholic liquor to consumers issued pursuant to chapter 545 that, in the calendar year ending December 31, 2002, generated ten per cent or more of its total annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, "tobacco specialist" means an establishment engaged in the sale of tobacco products that generates at least seventy-five per cent of its annual gross income

from the on-site sale of tobacco products and the rental of on-site humidors, and "tobacco product" means any substance that contains tobacco, including, but not limited to, cigarettes, cigars, pipe tobacco or chewing tobacco.

(3) Any public housing project, as defined in subsection (b) of section 21a-278a, or landlord of a tenement house may include a provision in the rental agreement between the landlord and tenant of the housing project or tenement house to prohibit smoking in the dwelling unit of the housing project or tenement house. For purposes of this subdivision, "dwelling unit", "landlord", "rental agreement", "tenant" and "tenement house" have the same meaning as provided in section 47a-1.

[(c) The operator of a hotel, motel or similar lodging may allow guests to smoke in not more than twenty-five per cent of the rooms offered as accommodations to guests.]

[(d)] (c) In each room, elevator, area or building in which smoking is prohibited by this section, the person in control of the premises shall post or cause to be posted in a conspicuous place signs stating that smoking is prohibited by state law. Such signs, except in elevators, restaurants, establishments with permits to sell alcoholic liquor to consumers issued pursuant to chapter 545, hotels, motels or similar lodgings, and health care institutions, shall have letters at least four inches high with the principal strokes of letters not less than one-half inch wide.

[(e)] (d) Any person found guilty of smoking in violation of this section, failure to post signs as required by this section or the unauthorized removal of such signs shall have committed an infraction. Nothing in this section shall be construed to require the person in control of a building to post such signs in every room of a building, provided such signs are posted in a conspicuous place in such building.

[(f)] (e) Nothing in this section shall be construed to require any smoking area [in] inside or outside any building or the entryway to any building or on any property.

[(g)] (f) The provisions of this section shall supersede and preempt the provisions of any municipal law or ordinance relative to smoking effective prior to, on or after October 1, 1993.

Section 2.

Section 19a-342a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) As used in this section and section 2 of public act 15-206:

(1) "Any area" means the interior of the facility, building or establishment and the outside area within twenty-five feet of any doorway, operable window or air intake vent of the facility, building or establishment;

[(1)] (2) "Child care facility" means a provider of child care services as defined in section 19a-77, or a person or entity required to be licensed under section 17a-145;

[(2)] (3) "Electronic nicotine delivery system" means an electronic device that may be used to simulate smoking in the delivery of nicotine or other substances to a person inhaling from the device, and includes, but is not limited to, an electronic cigarette, electronic cigar, electronic cigarillo, electronic pipe or electronic hookah and any related device and any cartridge or other component of such device;

[(3)] (4) (3) “Liquid nicotine container” means a container that holds a liquid substance containing nicotine that is sold, marketed or intended for use in an electronic nicotine delivery system or vapor product, except “liquid nicotine container” does not include such a container that is prefilled and sealed by the manufacturer and not intended to be opened by the consumer; and

[(4)] (5) "Vapor product" means any product that employs a heating element, power source, electronic circuit or other electronic, chemical or mechanical means, regardless of shape or size, to produce a vapor that may or may not include nicotine, that is inhaled by the user of such product, but shall not include a medicinal or therapeutic product used by a (A) licensed health care provider to treat a patient in a health care setting, or (B) a patient, as prescribed or directed by a licensed health care provider in any setting.

(b) (1) No person shall use an electronic nicotine delivery system or vapor product: (A) In any area of a building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail [food store] establishment accessed by the public; (D) in any restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22a, 30-22c, 30-26, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building [while school is in session or student activities are being conducted] or on any school property; (G) within a child care facility, except, if the child care facility is a family child care home as defined in section 19a-77, such use is prohibited only when a child enrolled in such home is present; (H) in any passenger elevator; [, provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that such use is prohibited by state law;] (I) in any area of a dormitory in any public or private institution of higher education; [or] (J) in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games; (K) any public housing project, as defined in subsection (b) of section 21a-278a, constructed on or after October 1, 2019; or (L) any room offered as an accommodation to guests by the operator of a hotel, motel or similar lodging. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the

public to be a place where meals are regularly served to the public.

(2) [This section] Subdivision (1) of this subsection shall not apply to [(A) correctional facilities; (B) designated smoking areas in psychiatric facilities; (C) public] the following establishments: (A) Public housing projects, as defined in subsection (b) of section 21a-278a, constructed prior to October 1, 2019; [(D)] (B) any classroom where a demonstration of the use of an electronic nicotine delivery system or vapor product is taking place as part of a medical or scientific experiment or lesson; [(E)] (C) any medical research site where the use of an electronic nicotine delivery system or vapor product is integral to the tobacco control research being conducted; [(F) establishments] (D) any establishment or electronic nicotine delivery system dealer without a permit for the sale of alcoholic liquor that [sell] sells electronic nicotine delivery systems, vapor products or liquid nicotine containers on-site and [allow] allows their customers to use such systems, products or containers on-site; [(G) smoking rooms provided by employers for employees, pursuant to section 31-40q; (H)] (E) notwithstanding the provisions of subparagraph (E) of subdivision (1) of this subsection, the outdoor portion of the premises of any permittee listed in subparagraph (E) of subdivision (1) of this subsection, provided, in the case of any seating area maintained for the service of food, at least seventy-five per cent of the outdoor seating capacity is an area in which smoking is prohibited and which is clearly designated with written signage as a nonsmoking area, except that any temporary seating area established for special events and not used on a regular basis shall not be subject to the prohibition on the use of an electronic nicotine delivery system or vapor product or the signage requirements of this subparagraph; or [(I)] (F) any tobacco bar, provided no tobacco bar shall expand in size, [or] change its location, or change its owner from its size [or], location or owner as of October 1, 2015. For purposes of this subdivision, "outdoor" means an area which has no roof or other ceiling enclosure, "tobacco bar" means an establishment with a permit for the sale of alcoholic liquor to consumers issued pursuant to chapter 545 that, in the calendar year ending December 31, 2015, generated ten per cent or more of its total annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, and "tobacco product" means any substance that contains tobacco, including, but not limited to, cigarettes, cigars, pipe tobacco or chewing tobacco; and "electronic nicotine delivery system dealer " means an establishment engaged in the sale of vapor products that generates at least seventy-five per cent of its annual gross income from the on-site sale of electronic nicotine delivery systems or vapor products.

(3) Any public housing project, as defined in subsection (b) of section 21a-278, or landlord of a tenement house may include a provision in the rental agreement between the landlord and tenant of the housing project or tenement house to prohibit the use of electronic nicotine delivery systems or vapor products in the dwelling unit of the housing project or tenement house. For purposes of this subdivision, "dwelling unit", "landlord", "rental agreement", "tenant" and "tenement house" have the same meaning as provided in section 47a-1.

[(c) The operator of a hotel, motel or similar lodging may allow guests to use an electronic nicotine delivery system or vapor product in not more than twenty-five per cent of the rooms offered as

accommodations to guests.]

[(d)] (c) In each room, elevator, area or building in which the use of an electronic nicotine delivery system or vapor product is prohibited by this section, the person in control of the premises shall post or cause to be posted in a conspicuous place signs stating that such use is prohibited by state law. Such signs, except in elevators, restaurants, establishments with permits to sell alcoholic liquor to consumers issued pursuant to chapter 545, hotels, motels or similar lodgings, and health care institutions, shall have letters at least four inches high with the principal strokes of letters not less than one-half inch wide.

[(e)] (d) Any person found guilty of using an electronic nicotine delivery system or vapor product in violation of this section, failure to post signs as required by this section or the unauthorized removal of such signs shall have committed an infraction. Nothing in this subsection shall be construed to require the person in control of a building to post such signs in every room of a building, provided such signs are posted in a conspicuous place in such building.

[(f)] (e) Nothing in this section shall be construed to require the designation of any area for the use of electronic nicotine delivery system or vapor product [in] inside or outside any building or the entryway to any building or on any property.

[(g)] (f) The provisions of this section shall supersede and preempt the provisions of any municipal law or ordinance relative to the use of an electronic nicotine delivery system or vapor product effective prior to, on or after October 1, 2015.

Section 3.

Section 31-40q of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) As used in this section:

(1) "Person" means one or more individuals, partnerships, associations, corporations, limited liability companies, business trusts, legal representatives or any organized group of persons.

(2) "Employer" means a person engaged in business who has employees, including the state and any political subdivision thereof.

(3) "Employee" means any person engaged in service to an employer in the business of his employer.

(4) "Business facility" means a structurally enclosed location or portion thereof at which employees perform services for their employer. The term "business facility" does not include: (A) Facilities listed in subparagraph (A) [, (C) or (H)] or (D) of subdivision (2) of subsection (b) of section 19a-342, as

amended by this act, or subparagraph (D) of subdivision (2) of subsection (b) of section 19a-342a, as amended by this act; (B) any establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued on or before May 1, 2003; (C) for any business that is engaged in the testing or development of tobacco or tobacco products, the areas of such business designated for such testing or development; or (D) during the period from October 1, 2003, to April 1, 2004, establishments with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c.

(5) "Smoking" means the burning of a lighted cigar, cigarette, pipe or any other device [matter or substance which contains tobacco].

(6) "Electronic nicotine delivery system" has the same meaning as provided in section 19a-342a, as amended by this act.

(7) "Vapor product" has the same meaning as provided in section 19a-342a, as amended by this act.

[(b) Each employer with fewer than five employees in a business facility shall establish one or more work areas, sufficient to accommodate nonsmokers who request to utilize such an area, within each business facility under his control, where smoking is prohibited. The employer shall clearly designate the existence and boundaries of each nonsmoking area by posting signs which can be readily seen by employees and visitors. In the areas within the business facility where smoking is permitted, existing physical barriers and ventilation systems shall be used to the extent practicable to minimize the effect of smoking in adjacent nonsmoking areas.]

[(c)] (b) Each employer [with five or more employees] shall prohibit smoking and the use of electronic nicotine delivery systems and vapor products in any area of any business facility under said employer's control [, except that an employer may designate one or more smoking rooms]. For purposes of this subsection, "any area" means the interior of the facility and the outside area within twenty-five feet of any doorway, operable window or air intake vent of the facility.

[(2) Each employer that provides a smoking room pursuant to this subsection shall provide sufficient nonsmoking break rooms for nonsmoking employees.

(3) Each smoking room designated by an employer pursuant to this subsection shall meet the following requirements: (A) Air from the smoking room shall be exhausted directly to the outside by an exhaust fan, and no air from such room shall be recirculated to other parts of the building; (B) the employer shall comply with any ventilation standard adopted by (i) the Commissioner of Labor pursuant to chapter 571, (ii) the United States Secretary of Labor under the authority of the Occupational Safety and Health Act of 1970, as from time to time amended, or (iii) the federal Environmental Protection Agency; (C) such room shall be located in a nonwork area, where no employee, as part of his or her work responsibilities, is required to enter, except such work

responsibilities shall not include any custodial or maintenance work carried out in the smoking room when it is unoccupied; and (D) such room shall be for the use of employees only.]

[(d)] (c) Nothing in this section may be construed to prohibit an employer from designating an entire business facility and the real property on which the business facility is located as a nonsmoking area."

Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 10.30.18 DPH Dental Practitioners

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Commissioner's Office, Practitioner Licensing and Investigations Section and Office of Oral Health
Agency Analyst/Drafter of Proposal: Brie Wolf, Commissioner's Office; Chris Andresen, Practitioner Licensing and Investigations Section; Elizabeth Dowd, Office of Oral Health

Title of Proposal: An Act Concerning The Department of Public Health's Recommendations on Dental Practitioners
Statutory Reference: Section 1. 20-107. Application for license. Graduates of foreign dental schools. Section 2. 20-108. Examination of applicants. Alternative to practical examination. Section 3. 20-110. Licenses to out-of-state applicants. Section 4. (NEW) Section 5. (NEW) Section 6. 20-112a. Dental assistants and expanded function dental assistants. Section 7. 20-126c. Continuing education: Definitions; contact hours; attestation; record-keeping; exemptions; waivers; reinstatement of void licenses. Section 8. 20-126*l*. Definitions. Scope of practice. Limitations. Continuing education. Exceptions.
Proposal Summary: Sections 1-3 allow a dental student to obtain a license by going through a one year residency program instead of having to take what is known as the "regional exam," which consists of five clinical testing agencies that offer a test for a dental student to demonstrate their knowledge and proficiency in the practice of dentistry. Section 3 also permits the Department to issue a license to a dentist who has held a license for at least one year and is in good professional standing in another state with similar licensing requirements, without requiring the applicant for licensure to take a practical exam.

Sections 4 and 5 create a scope of practice for dental therapists, who would practice in a public health setting.

Section 6 revises the Expanded Function Dental Assistant (EFDA) scope of practice to clarify that an EFDA may apply a topical anesthetic and take alginate impressions under direct supervision. Alginate impressions are the same impressions used for study models, orthodontic appliances, whitening trays, mouth guards and to fabricate temporary crowns.

Section 7 defines a "temporary dental clinic" and allows a dentist to apply practice at a temporarily dental clinic towards their continuing educational credits required for licensure. An example of a temporary dental clinic is Mission of Mercy.

Section 8 revises the definition of a "public health facility" to include a temporary dental clinic, and allows a dental hygienist to apply practice at a temporarily dental clinic towards their continuing educational credits required for licensure.

It also revises the dental hygienist scope of practice to allow them to take alginate impressions under indirect supervision. Alginate impressions are the same impressions used for study models, orthodontic appliances, whitening trays, mouth guards and to fabricate temporary crowns.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Sections 1-3 make a post graduate year in dentistry the preferred method of licensure as the regional exam requires the use of human subjects to demonstrate knowledge. The Department has ethical concerns with the use of human subjects for this type of exam. The American Dental Association (ADA) developed the document "Ethical Considerations When Using Human Subjects/Patients in the Examination Process" to promote awareness of the potential ethical dilemmas faced by candidates during the examination process and to assist in maintaining the welfare of the patient as the profession's paramount concern. The document reflects existing ADA policy supporting the elimination of the use of human subjects in the clinical examination process; with the exception of the Curriculum Integrated Format (CIF) within dental schools. The ADA is scheduled to release a new examination that does not use human subjects by 2020. It's important to note that when a physician is going through the licensure process, they are not tested on their proficiency, but go through a residency program instead.

Additionally, this proposal allows dentists who have worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for one year to apply for licensure without examination. Section one of this proposal allows individuals trained in Connecticut to become licensed after one year of residency. One year of practice in an academic or clinical setting is comparable, and the Department does not want to discourage qualified dentists trained in other states from working in Connecticut.

Sections 4 and 5 create a midlevel dental practitioner, dental therapist, to increase the availability of affordable basic dental services and expand access to dental care. Dental therapists would be limited to practicing in public health settings. The Connecticut Dental Hygienists Association underwent a scope of practice review in 2011 to evaluate the establishment of this profession in Connecticut. It was demonstrated that dental hygienists who receive appropriate education and training can safely engage in expanded functions, and the Department recommended moving that scope expansion forward. It was not adopted in subsequent legislative sessions.

Section 6 clarifies the scope of practice for EFDAs to conform to national best practices.

Section 7 allows a dentist to earn CEUs while practicing in a public health facility. This will expand access to dental care for vulnerable populations.

Section 8 expands public health facility definition to include a temporary dental clinic. Dental hygienists may earn CEUs while practicing in a public health facility. This will expand access to dental care for vulnerable populations. This section also expands the dental hygienist scope of practice to conform to national best practices.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected age)*

Agency Name: University of Connecticut Health Center/ John Dempsey Hospital **Agency Contact (*name, title, phone*):** Andrea Keilty **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

DPH's Practitioner Licensing and Investigations Section would have to update the practitioner licensing information on their website. New staff is not needed as eligible applicants are licensed hygienists (an existing licensure category) who must demonstrate that they have received a national certification.

Insert language here

Section 1.

Section 20-107 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) Each application for a license to practice dentistry shall be [in writing and signed by] submitted by the applicant and no license shall be issued to any person unless he or she presents (1) a diploma or

other certificate of graduation from [some reputable] a dental college or from a department of dentistry of a medical college conferring a dental degree accredited by the American Dental Association's Commission on Dental Accreditation or its successor organization, (2) evidence of having passed a written examination or examinations given by the Joint Commission on National Dental Examinations, subject to such conditions as the Dental Commission, with the consent of the Commissioner of Public Health, may prescribe, and (3) evidence of having satisfactorily completed a clinically-based postdoctoral general practice or specialty dental residency program that (A) was of at least one year's duration, and (B) is accredited by the Commission on Dental Accreditation. [or unless he or she is practicing as a legally qualified dentist in another state having requirements for admission determined by the department to be similar to or higher than the requirements of this state.

(b) The Dental Commission may, with the consent of the Commissioner of Public Health, determine the colleges which shall be considered reputable dental or medical colleges for the purposes of this chapter. The commission shall consult when possible with nationally recognized accrediting agencies when making such determinations.]

(b) [(c)] Notwithstanding the provisions of subsection[s] (a) [and (b)] of this section, the department may issue a license to practice dentistry to any applicant holding a diploma from a foreign dental school, provided the applicant (1) is a graduate of a dental school located outside the United States and has received the degree of doctor of dental medicine or surgery, or its equivalent; (2) has passed the written and practical examination or examinations required in subsection (a) [section 20-108]; (3) has successfully completed not less than two years of graduate dental training as a resident dentist in a program accredited by the Commission on Dental Accreditation; and (4) has successfully completed, at a level greater than the second postgraduate year, not less than three years of a residency or fellowship training program accredited by the Commission on Dental Accreditation in a school of dentistry in this state, or has served as a full-time faculty member of a school of dentistry in this state pursuant to the provisions of section 20-120 for not less than three years.

Section 2.

Section 20-108 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) [Except as provided in section 20-110 and subsection (b) of this section, each applicant for a license to practice dental medicine or dental surgery shall be examined by the Department of Public Health, under the supervision of the Dental Commission as to his or her professional knowledge and skill before such license is granted. Such examination shall be conducted in the English language.] In lieu of the clinically-based postdoctoral general practice or specialty dental residency program required pursuant to subsection (a) of section 20-107, the [The] Dental Commission may, with the consent of the Commissioner of Public Health, accept and approve [in lieu of the written examination

required by this section, the results of an examination given by the Joint Commission on National Dental Examinations subject to such conditions as the commission may prescribe, and the Dental Commission with the consent of the Commissioner of Public health, may accept and approve, in lieu of the written and practical examination required by this section,] the results of [regional testing agencies as to written and] clinical or practical examinations, subject to such conditions as the commission, with the consent of the Commissioner of Public Health, may prescribe. Effective January 1, 2024, such examinations shall not include examinations which require the participation of human patients. Passing scores shall be established by the department with the consent of the commission.

[(b) In lieu of the practical examination required by subsection (a) of this section, an applicant for licensure may submit evidence of having successfully completed not less than one year of graduate dental training as a resident dentist in a program accredited by the Commission on Dental Accreditation, provided the director of the dental residency program at the facility in which the applicant completed the residency training provides documentation satisfactory to the Department of Public Health attesting to the resident dentist's competency in all areas tested on the practical examination required by subsection (a) of this section. Not later than December 1, 2005, the Dental Commission, in consultation with the Department of Public Health, shall develop a form upon which such documentation shall be provided.]

Section 3.

Section 20-110 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

The Department of Public Health may, upon receipt of an application and a fee of five hundred sixty-five dollars, issue a license without examination to a practicing dentist in another state or territory who (1) holds a current valid license in good professional standing issued after examination by another state or territory that maintains licensing standards which, except for the practical examination, are commensurate with the state's standards, and (2) has worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for a period of not less than [five] one year[s] immediately preceding the application for licensure without examination. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. The department shall inform the Dental Commission annually of the number of applications it receives for licensure under this section.

Section 4.

(NEW) (*Effective January 1, 2020*):

(a) The practice of “dental therapy” means the performance of educational, preventive and therapeutic services including: (1) identification of oral and systemic conditions requiring evaluation

or treatment by dentists, physicians or other healthcare providers, and management of referrals; (2) diagnosis of and treatment for oral diseases and conditions within the dental therapist scope of practice, limited to the procedures in this section; (3) comprehensive charting of the oral cavity; (4) oral health instruction and disease prevention education, including nutritional counseling and dietary analysis; (5) dispensing and administering non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider; except schedules II, III or IV controlled substances; (6) applying topical preventive or prophylactic agents, including fluoride varnish, antimicrobial agents, and pit and fissure sealants; (7) pulp vitality testing; (8) applying desensitizing medication or resin; (9) interim therapeutic restorations; (10) fabricating athletic mouthguards; (11) changing periodontal dressings; (12) administering local anesthetic under general supervision of a dentist; (13) simple extraction of erupted primary teeth; (14) nonsurgical extractions of periodontal diseased permanent teeth with tooth mobility of +3 or greater, however a dental therapist shall not extract a tooth if it is unerupted, impacted, fractured, or needs to be sectioned for removal; (15) emergency palliative treatment of dental pain, limited to the procedures in this section; (16) preparation and placement of direct restoration in primary and permanent teeth, not requiring the fabrication of crowns, bridges, veneers, or dentures; (17) fabrication and placement of single-tooth temporary crowns; (18) preparation and placement of preformed crowns on primary teeth; (19) indirect and direct pulp capping on permanent teeth; (20) indirect pulp capping on primary teeth; (21) suture removal; (22) minor adjustments and repairs on removable prostheses; (23) placement and removal of space maintainers; and (24) recementing permanent crowns.

(b) "Dental therapist" means a person authorized to perform all services set forth in subsection (a) of this section under a collaborative agreement with a licensed dentist.

(c) No person shall engage in dental therapy unless such person holds and maintains a dental hygiene license according to chapter 379a and a certification issued by an institution of higher education accredited by the Commission on Dental Accreditation for dental therapy.

(d) A dental therapist shall practice in a public health facility, as defined in section 20-126*l*, under the general supervision of a licensed dentist.

(e) Each dental therapist certification shall be in writing on forms issued by the graduating institution, signed by the applicant and the dental therapy program director. The certification documentation must be made available to the Department of Public Health upon request. An applicant shall have successfully completed a course of instruction from an institution of higher learning accredited by the Commission on Dental Accreditation for dental therapy. Such curriculum shall, in accordance with the Commission on Dental Accreditation Dental Therapy Standards, include full-time instruction, or its equivalent, at the postsecondary college-level and incorporate all dental therapy practice competencies.

(f) An applicant for a dental therapist certification shall be examined prior to the granting of such certification through a comprehensive examination prescribed by the Commission on Dental Competency Assessments, or its equivalent, and administered independently of any institution of higher education that offers a program in dental therapy.

Section 5.

(NEW) (*Effective January 1, 2020*):

(a) "Collaborative agreement" means a written agreement between a dental therapist and a dentist, licensed in accordance with the provisions of chapter 379, that outlines a mutually agreed upon relationship in which the dental therapist and the dentist agree to the parameters of practice provided by such dental therapist.

(b) "Public health facility" has the same meaning as provided in section 20-126*l*.

(c) Prior to entering the first collaborative agreement, a dental therapist shall: (1) complete 1,000 hours of direct patient care using dental therapy procedures under the direct supervision of a dentist; and (2) receive a certificate of completion signed by the supervising dentist that verifies completion of the requirements provided in subsection (d) of this section.

(d) In order to practice as a dental therapist, a dental therapist shall enter into a written collaborative agreement with a dentist. The agreement shall include: (1) identification of public health facility practice settings where services may be provided and the populations to be served; (2) any limitations on the services that may be provided by the dental therapist; (3) age- and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency; (4) a procedure for creating and maintaining dental records for the patients that are treated by the dental therapist; (5) a plan to manage medical emergencies in each public health practice setting where the dental therapist provides care; (6) a quality assurance plan for monitoring care provided by the dental therapist, including patient care review, referral follow-up, and a quality assurance chart review; (7) protocols for prescribing, administering, and dispensing medications, including the specific conditions and circumstances under which these medications may be prescribed, dispensed, and administered; (8) criteria relating to the provision of care to patients with specific medical conditions or complex medication histories, including requirements for consultation prior to the initiation of care; (9) criteria for the supervision of dental assistants and dental hygienists; and (10) a plan for the provision of clinical resources and referrals in situations that are beyond the capabilities of the dental therapist.

(e) The supervising dentist shall be professionally responsible and legally liable for all services authorized and performed by the dental therapist pursuant to the collaborative agreement.

(f) A supervising dentist shall be licensed in accordance with the provisions of chapter 379 and practicing in Connecticut.

(g) A supervising dentist is limited to entering into a collaborative agreement with no more than two dental therapists at any one time.

(h) A collaborative agreement shall be signed and maintained by the supervising dentist and the dental therapist.

(i) A collaborative agreement shall be reviewed, updated, and kept on file at the location where such dental therapist is employed. It shall be reviewed by the dentist and dental therapist on an annual basis and updated as soon as a change is made to the agreement. It shall be available for inspection upon the request of the Department of Public Health.

(j) Nothing in this chapter shall be construed to require a dentist to enter into a collaborative agreement with a dental therapist.

(k) A dental therapist may directly supervise no more than two dental assistants or expanded function dental assistants as defined in chapter 379, and two dental hygienists as defined in chapter 379a, to the extent permitted in the collaborative agreement.

(*l*) Upon renewal of the dental hygiene license according to chapter 379a, and prior to the start of the collaborative agreement, each dental therapist shall complete an additional six hours of continuing education for a total of twenty hours within the preceding twenty-four-month period.

(m) Each licensee applying for license renewal pursuant to section 19a-88, except a licensee applying for a license renewal for the first time, shall sign a statement attesting that he or she has satisfied the continuing education requirements described in subsection (l) of this section on a form prescribed by the department. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements described in subsection (l) of this section for not less than two years following the date on which the continuing education was completed or the license was renewed. Each licensee shall submit such records to the department for inspection not later than forty-five days after a request by the department for such records. A licensee who fails to comply with the provisions of this section may be subject to disciplinary action pursuant to section 20-126o

Section 6.

Section 20-112a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) As used in this section:

(1) “Direct supervision” means a licensed dentist has authorized certain procedures to be performed on a patient by a dental assistant or an expanded function dental assistant with such dentist remaining on-site in the dental office or treatment facility while such procedures are being performed by the dental assistant or expanded function dental assistant and that, prior to the patient's departure from the dental office, such dentist reviews and approves the treatment performed by the dental assistant or expanded function dental assistant;

(2) “Indirect supervision” means a licensed dentist is in the dental office or treatment facility, has personally diagnosed the condition, planned the treatment, authorized the procedures to be performed and remains in the dental office or treatment facility while the procedures are being performed by the dental assistant or expanded function dental assistant and evaluates the performance of the dental assistant or expanded function dental assistant;

(3) “Dental assistant” means a person who: (A) Has (i) completed on-the-job training in dental assisting under direct supervision, (ii) successfully completed a dental assistant education program accredited by the American Dental Association's Commission on Dental Accreditation, or (iii) successfully completed a dental assistant education program that is accredited or recognized by the New England Association of Schools and Colleges; and (B) meets any requirements established by the Commissioner of Public Health in regulations adopted pursuant to subsection (f) of this section; and

(4) “Expanded function dental assistant” means a dental assistant who has passed the Dental Assisting National Board's certified dental assistant or certified orthodontic assistant examination and then successfully completed: (A) An expanded function dental assistant program at an institution of higher education that is accredited by the Commission on Dental Accreditation of the American Dental Association that includes (i) educational courses relating to didactic and laboratory preclinical objectives for skills used by an expanded function dental assistant and that requires demonstration of such skills prior to advancing to clinical practice, (ii) not less than four hours of education in the area of ethics and professional standards for dental professionals, and (iii) a comprehensive clinical examination administered by the institution of higher education at the conclusion of such program; and (B) a comprehensive written examination concerning certified preventive functions and certified restorative functions administered by the Dental Assisting National Board.

(b) Each expanded function dental assistant shall: (1) Maintain dental assistant or orthodontic assistant certification from the Dental Assisting National Board; (2) conspicuously display his or her dental assistant or orthodontic assistant certificate at his or her place of employment or place where he or she provides expanded function dental assistant services; (3) maintain professional liability insurance or other indemnity against liability for professional malpractice in an amount not less than five hundred thousand dollars for one person, per occurrence, with an aggregate liability of not less

than one million five hundred thousand dollars while employed as an expanded function dental assistant; (4) provide expanded function dental assistant services only under direct or indirect supervision; and (5) meet any requirements established by the Commissioner of Public Health in regulations adopted pursuant to subsection (f) of this section.

(c) (1) A licensed dentist may delegate to dental assistants such dental procedures as the dentist may deem advisable, including: (A) The taking of dental x-rays if the dental assistant can demonstrate successful completion of the dental radiation health and safety examination administered by the Dental Assisting National Board; and (B) the taking of impressions of teeth for study models. Such procedures shall be performed under direct supervision and the dentist providing direct supervision shall assume responsibility for such procedures.

(2) A licensed dentist may delegate to an expanded function dental assistant such dental procedures as the dentist may deem advisable, including: (A) The placing, finishing and adjustment of temporary restorations and long-term individual fillings, capping materials and cement bases; (B) oral health education for patients; (C) dental sealants; [and] (D) coronal polishing, provided the procedure is not represented or billed as prophylaxis; (E) administration of topical anesthetic under the direct supervision of a dentist prior to the administration of local anesthetic by a dentist or dental hygienist; and (F) taking alginate impressions of teeth under the direct supervision of a dentist used for study models, orthodontic appliances, whitening trays, mouth guards, or fabrication of temporary crowns. Such procedures shall be performed under the direct or indirect supervision and the dentist providing such supervision shall assume responsibility for such procedures.

(3) On or after January 1, 2018, (A) no licensed dentist may delegate dental procedures to a dental assistant or expanded function dental assistant unless the dental assistant or expanded function dental assistant provides records demonstrating successful completion of the Dental Assisting National Board's infection control examination, except as provided in subdivision (2) of this subsection, (B) a dental assistant may receive not more than nine months of on-the-job training by a licensed dentist for purposes of preparing the dental assistant for the Dental Assisting National Board's infection control examination, and (C) any licensed dentist who delegates dental procedures to a dental assistant shall retain and make such records available for inspection upon request of the Department of Public Health.

(4) On and after January 1, 2018, upon successful completion of the Dental Assisting National Board's infection control examination, each dental assistant or expanded function dental assistant shall complete not less than one hour of training or education in infection control in a dental setting every two years, including, but not limited to, courses, including online courses, offered or approved by a dental school or another institution of higher education that is accredited or recognized by the Commission on Dental Accreditation, a regional accrediting organization, the American Dental

Association or a state, district or local dental association or society affiliated with the American Dental Association or the American Dental Assistants Association.

(d) Under no circumstances may a dental assistant or expanded function dental assistant engage in: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medications that require the written or oral order of a licensed dentist or physician; (4) the administration of local, parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; (5) the taking of any final impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis or (6) the practice of dental hygiene as defined in section 20-126*l*.

(e) Each licensed dentist employing or otherwise engaging the services of an expanded function dental assistant shall: (1) Prior to hiring or otherwise engaging the services of the expanded function dental assistant, verify that the expanded function dental assistant meets the requirements described in subdivision (4) of subsection (a) and subdivisions (1) and (3) of subsection (b) of this section; (2) maintain documentation verifying that the expanded function dental assistant meets such requirements on the premises where the expanded function dental assistant provides services; (3) make such documentation available to the Department of Public Health upon request; and (4) provide direct or indirect supervision to not more than two expanded function dental assistants who are providing services at one time or, if the dentist's practice is limited to orthodontics, provide direct or indirect supervision to not more than four expanded function dental assistants who are providing services at one time.

(f) The Commissioner of Public Health, in consultation with the State Dental Commission, established pursuant to section 20-103a, may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section. Such regulations, if adopted, shall include, but need not be limited to, identification of the: (1) Specific types of procedures that may be performed by a dental assistant and an expanded function dental assistant, consistent with the provisions of this section; (2) appropriate number of didactic, preclinical and clinical hours or number of procedures to be evaluated for clinical competency for each skill employed by an expanded function dental assistant; and (3) the level of supervision, that may include direct or indirect supervision, that is required for each procedure to be performed by an expanded function dental assistant.

Section 7.

Section 20-126c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020)*:

(a) As used in this section:

(1) “Commissioner” means the Commissioner of Public Health;

(2) “Contact hour” means a minimum of fifty minutes of continuing education activity;

(3) “Department” means the Department of Public Health;

(4) “Licensee” means any person who receives a license from the department pursuant to this chapter; [and]

(5) “Registration period” means the one-year period for which a license renewed in accordance with section 19a-88 is current and valid[.]; and

(6) “Temporary clinic” means a dental clinic that provides dental care services at no cost to uninsured or underinsured individuals and operates for no longer than seventy two consecutive hours.

(b) Except as otherwise provided in this section, a licensee applying for license renewal shall earn a minimum of twenty-five contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include not less than one contact hour of training or education in (A) any three of the ten mandatory topics for continuing education activities prescribed by the commissioner pursuant to this subdivision, (B) for registration periods beginning on and after October 1, 2016, infection control in a dental setting, and (C) prescribing controlled substances and pain management. For registration periods beginning on and after October 1, 2011, the Commissioner of Public Health, in consultation with the Dental Commission, shall on or before October 1, 2010, and biennially thereafter, issue a list that includes ten mandatory topics for continuing education activities that will be required for the following two-year registration period. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Dental Association or state, district or local dental associations and societies affiliated with the American Dental Association; national, state, district or local dental specialty organizations or the American Academy of General Dentistry; a hospital or other health care institution; dental schools and other schools of higher education accredited or recognized by the Council on Dental Accreditation or a regional accrediting organization; agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation; local, state or national medical associations; a state or local health department; or the Accreditation Council for Graduate Medical Education. Eight hours of volunteer dental practice at a public health facility, as defined in section 20-126*l*, or a temporary clinic as defined in this section, may be substituted for one contact hour of continuing education, up to a maximum of ten contact hours in one twenty-four-month period.

(c) Each licensee applying for license renewal pursuant to section 19a-88 shall sign a statement attesting that he or she has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the department. Each licensee shall retain records of attendance or

certificates of completion that demonstrate compliance with the continuing education requirements of said subsection (b) for a minimum of three years following the year in which the continuing education activities were completed and shall submit such records to the department for inspection not later than forty-five days after a request by the department for such records.

(d) A licensee applying for the first time for license renewal pursuant to section 19a-88 is exempt from the continuing education requirements of this section.

(e) A licensee who is not engaged in active professional practice in any form during a registration period shall be exempt from the continuing education requirements of this section, provided the licensee submits to the department, prior to the expiration of the registration period, a notarized application for exemption on a form prescribed by the department and such other documentation as may be required by the department. The application for exemption pursuant to this subsection shall contain a statement that the licensee may not engage in professional practice until the licensee has met the continuing education requirements of this section.

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

(g) Any licensee whose license has become void pursuant to section 19a-88 and who applies to the department for reinstatement of such license pursuant to section 19a-14 shall submit evidence documenting successful completion of twelve contact hours of continuing education within the one-year period immediately preceding application for reinstatement.

Section 8.

Section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) As used in this section:

(1) “General supervision of a licensed dentist” means supervision that authorizes dental hygiene procedures to be performed with the knowledge of said licensed dentist, whether or not the dentist is on the premises when such procedures are being performed;

(2) "Public health facility" means an institution, as defined in section 19a-490, a community health center, a group home, a school, a preschool operated by a local or regional board of education, a head start program or a program offered or sponsored by the federal Special Supplemental Food Program for Women, Infants and Children, a senior center or a managed residential community, as defined in section 19a-693[;], or a temporary dental clinic as defined in section 20-126c;

(3) The “practice of dental hygiene” means the performance of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcerous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; the administration of local anesthesia in accordance with the provisions of subsection (d) of this section; taking alginate impressions of teeth under the indirect supervision of a dentist used for study models, orthodontic appliances, whitening trays, mouth guards, and fabrication of temporary crowns; and collaboration in the implementation of the oral health care regimen.

(b) No person shall engage in the practice of dental hygiene unless such person (1) has a dental hygiene license issued by the Department of Public Health and (A) is practicing under the general supervision of a licensed dentist, or (B) has been practicing as a licensed dental hygienist for at least two years, is practicing in a public health facility and complies with the requirements of subsection (e) of this section, or (2) has a dental license.

(c) A dental hygienist licensed under sections 20-126h to 20-126w, inclusive, shall be known as a “dental hygienist” and no other person shall assume such title or use the abbreviation “R.D.H.” or any other words, letters or figures which indicate that the person using such words, letters or figures is a licensed dental hygienist. Any person who employs or permits any other person except a licensed dental hygienist to practice dental hygiene shall be subject to the penalties provided in section 20-126t.

(d) A licensed dental hygienist may administer local anesthesia, limited to infiltration and mandibular blocks, under the indirect supervision of a licensed dentist, provided the dental hygienist can demonstrate successful completion of a course of instruction containing basic and current concepts of local anesthesia and pain control in a program accredited by the Commission on Dental Accreditation, or its successor organization, that includes: (1) Twenty hours of didactic training, including, but not limited to, the psychology of pain management; a review of anatomy, physiology,

pharmacology of anesthetic agents, emergency precautions and management, and client management; instruction on the safe and effective administration of anesthetic agents; and (2) eight hours of clinical training which includes the direct observation of the performance of procedures. For purposes of this subsection, “indirect supervision” means a licensed dentist authorizes and prescribes the use of local anesthesia for a patient and remains in the dental office or other location where the services are being performed by the dental hygienist.

(e) A licensed dental hygienist shall not perform the following dental services: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medication which require the written or oral order of a licensed dentist or physician; (4) the administration of parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; (5) the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; (6) the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases.

(f) Each dental hygienist practicing in a public health facility shall (1) refer for treatment any patient with needs outside the dental hygienist's scope of practice, and (2) coordinate such referral for treatment to dentists licensed pursuant to chapter 379.

(g) Each licensed dental hygienist applying for license renewal shall earn a minimum of sixteen contact hours of continuing education within the preceding twenty-four-month period, including, for registration periods beginning on and after October 1, 2016, at least one contact hour of training or education in infection control in a dental setting and, for registration periods beginning on and after October 1, 2017, at least one contact hour of training or education in cultural competency. The subject matter for continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public. Continuing education activities shall provide significant theoretical or practical content directly related to clinical or scientific aspects of dental hygiene. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, that are offered or approved by dental schools and other institutions of higher education that are accredited or recognized by the Council on Dental Accreditation, a regional accrediting organization, the American Dental Association, a state, district or local dental association or society affiliated with the American Dental Association, the National Dental Association, the American Dental Hygienists Association or a state, district or local dental hygiene association or society affiliated with the American Dental Hygienists Association, the Academy of General Dentistry, the Academy of Dental Hygiene, the American Red Cross or the American Heart Association when sponsoring programs in cardiopulmonary resuscitation or cardiac life support, the United States Department of Veterans Affairs and armed forces of the United States when conducting programs at United States governmental facilities, a hospital or other health care institution, agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation, local, state or national

medical associations, or a state or local health department. Eight hours of volunteer dental practice at a public health facility, as defined in subsection (a) of this section, may be substituted for one contact hour of continuing education, up to a maximum of five contact hours in one two-year period. Activities that do not qualify toward meeting these requirements include professional organizational business meetings, speeches delivered at luncheons or banquets, and the reading of books, articles, or professional journals. [Not more than four contact hours of continuing education may be earned through an on-line or other distance learning program.]

(h) Each licensee applying for license renewal pursuant to section 19a-88, except a licensee applying for a license renewal for the first time, shall sign a statement attesting that he or she has satisfied the continuing education requirements described in subsection (g) of this section on a form prescribed by the department. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements described in subsection (g) of this section for not less than three years following the date on which the continuing education was completed or the license was renewed. Each licensee shall submit such records to the department for inspection not later than forty-five days after a request by the department for such records. A licensee who fails to comply with the provisions of this section may be subject to disciplinary action pursuant to section 20-126o.

(i) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this subsection to any licensee, provided the licensee submits to the Department of Public Health an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

(j) A licensee who is not engaged in active professional practice, in any form, during a registration period shall be exempt from the continuing education requirements, provided the licensee submits a notarized application for exemption on a form prescribed by the commissioner prior to the end of the registration period. A licensee who is exempt under the provisions of this subsection may not engage in professional practice until the licensee has met the continuing education requirements of this section.

(k) A licensee whose license has become void pursuant to section 19a-88 and who applies to the department for reinstatement of such license, shall: (1) Submit evidence of completion of a minimum of twenty-four contact hours of qualifying continuing education, as described in subsection (g) of this

section, during the two-year period immediately preceding the application for reinstatement; or (2) for an applicant who has not been in the active practice of dental hygiene for more than two years, submit evidence of successful completion of the National Board Dental Hygiene Examination, the North East Regional Board of Dental Examiners Examination in Dental Hygiene or a refresher course approved by the department during the one-year period immediately preceding the application for reinstatement.

Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 10.01.18 DPH Drinking Water

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Drinking Water Section
Agency Analyst/Drafter of Proposal: Lori J. Mathieu, Public Health Section Chief

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding Public Drinking Water
Statutory Reference: Section 1. 22a-483f. Public water system improvement program. Section 2. 25-32. Department of Public Health jurisdiction over and duties concerning water supplies, water companies and operators of water treatment plants and water distribution systems.
Proposal Summary: Section 1. Modifies the definition of "eligible public water system" so that public service companies may be eligible for the grants provided by the Public Water System Improvement Program. The grant is for eligible project costs of an eligible drinking water project and must only be used for such costs. Section 2. Provides the Department with the statutory authority to approve third parties to administer certification examinations to operators of water treatment plants, water distribution systems and small water systems who want to be certified. Also provides the Department with the statutory authority to approve course providers and courses of study as they relate to certified operators of water treatment plants, water distribution systems and small water systems and certified persons who test backflow prevention devices or perform cross connection surveys for initial and renewal applications.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable: *(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* *(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?*

(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Section 1. Currently, the definition of "eligible public water system" does not include public service companies. "Public service companies" are those that offer electric distribution, gas, telephone, pipeline, sewage, water and community antenna television, etc. Changing the definition of "eligible public water system" to include public service companies would allow private water companies, such as Aquarion Water Company of Connecticut and Connecticut Water Company, to be eligible for the state grants provided by the Public Water System Improvement Program. These public service companies are often requested to takeover other public water systems or to interconnect with other water systems when there is a public health issue, such as a contaminated water supply. Since this amendment would only make a public service company eligible for state grant money, if such grant money is used to offset the costs of the project, the costs of the project would not be passed on to the company's customers as such costs currently are. Therfore, the customers of public service companies would benefit from the Public Water System Improvement Program just as customers of other publicly-owned water companies, such as municipal water companies, that are currently eligible under existing law.

Section 2. Many operators of smaller water systems struggle to comply with the federal and state statutes and regulations that govern the functions of public water systems. The Department would like to ensure that operators are receiving the appropriate training and education on water system operations. This may lead to better compliance with the law, and less staff time dedicated to explaining laws to smaller system operators.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:
(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Public Utilities Regulatory Authority (PURA)
Agency Contact (*name, title, phone*): Nick Neeley
Date Contacted: 10/5/18

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Section 1. This would provide a benefit to the customers of public service companies. There are currently over one million people in Connecticut served water by public service companies. In addition, by providing this grant money to public service companies, these companies would be in a better position to address public health concerns by, for example, interconnecting with another system that has water quality and quantity issues. The Water Utility Coordinating Committee (WUCC) process identified areas in Connecticut where interconnections and other improvements are needed to fix poor quantity and quality of water as well as aging infrastructure issues at public water systems. Public water companies, such as Aquarion Water Company of Connecticut and Connecticut Water Company, are located within many communities in Connecticut and are therefore in a position to assist with public health and public drinking water quality and quantity issues. Finally, the Department hopes this proposed amendment would promote more public private partnerships for investment in public drinking water infrastructure.

Section 2. This amendment would strengthen and streamline the operator certification process by requiring Department-approval of course providers and courses of study for initial

applications for certification. It would also save staff time by authorizing the Department to approve such course providers and courses of study, and by authorizing the Department to approve other entities to administer examinations required for initial certification.

RCSA Sec. 25-32-14 requires certified operators of water treatment plants, water distribution systems and small water systems, as well as certified persons who perform tests of backflow prevention devices and cross connection surveys, to renew their certification every three years by utilizing training that is acceptable to the Department. The Department has a list of approved training program coursework for such renewals. We would like to mirror the renewal process for initial certification.

Section 1. Section 22a-483f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) For the purposes described in subsection (b) of this section, the State Bond Commission shall have the power from time to time to authorize the issuance of bonds of the state in one or more series and in principal amounts not exceeding in the aggregate twenty million dollars.

(b) The proceeds of the sale of said bonds, to the extent of the amount stated in subsection (a) of this section, shall be used by the Department of Public Health for the purpose of providing grants-in-aid, which may be provided in the form of principal forgiveness, to eligible public water systems for eligible drinking water projects for which a project funding agreement is made on or after July 1, 2014, between the Commissioner of Public Health and the eligible public water system pursuant to sections 22a-475 to 22a-483, inclusive, under the public water system improvement program established in subsection (c) of this section.

(c) (1) For purposes of the public water system improvement program established pursuant to this section:

(A) "Eligible drinking water project" has the same meaning as provided in section 22a-475;

(B) "Eligible project costs" has the same meaning as provided in section 22a-475;

(C) "Eligible public water system" has the same meaning as provided in section 22a-475[, except "eligible public water system" does not include eligible public water systems that are public service companies, as defined in section 16-1]; and

(D) "Public service company" has the same meaning as provided in section 16-1.

(2) All provisions applicable to drinking water projects under sections 22a-475 to 22a-483, inclusive, shall be applicable to the public water system improvement program, including eligibility of public water systems, eligible project costs, application procedures for financial assistance, and procedures for approving and awarding such financial assistance. The department shall comply with all allocation goals for smaller eligible public water systems and with the priorities for awarding financial assistance, as provided in sections 22a-475 to 22a-483, inclusive.

(3) An eligible public water system applying for financial assistance pursuant to this section shall submit to the department, along with the application submitted under sections 22a-475 to 22a-483, inclusive, a fiscal and asset management plan. The department shall provide financial assistance as follows:

(A) Eligible public water systems that serve ten thousand or fewer persons may receive financial assistance pursuant to this section for up to fifty per cent of eligible project costs;

(B) Eligible public water systems that serve more than ten thousand persons may receive financial assistance pursuant to this section for up to thirty per cent of eligible project costs; [and]

(C) Eligible public water systems that are for-profit companies, other than for-profit companies that are public service companies, may not receive additional financial assistance pursuant to this section; [.] and

(D) Eligible public water systems that are public service companies may not receive financial assistance pursuant to this section, unless such financial assistance is for eligible project costs of an eligible drinking water project and only used for such eligible drinking water project.

(d) All provisions of section 3-20, or the exercise of any right or power granted thereby, which are not inconsistent with the provisions of this section are hereby adopted and shall apply to all bonds authorized by the State Bond Commission pursuant to this section, and temporary notes in anticipation of the money to be derived from the sale of any such bonds so authorized may be issued in accordance with section 3-20 and from time to time renewed. Such bonds shall mature at such time or times not exceeding twenty years from their respective dates as may be provided in or pursuant to the resolution or resolutions of the State Bond Commission authorizing such bonds. None of said bonds shall be authorized except upon a finding by the State Bond Commission that there has been filed with it a request for such authorization which is signed by or on behalf of the Secretary of the Office of Policy and Management and states such terms and conditions as said commission, in its discretion, may require. Said bonds issued pursuant to this section shall be general obligations of the state and the full faith and credit of the state of Connecticut are pledged for the payment of the principal of and interest on said bonds as the same become due, and accordingly and as part of the contract of the state with the holders of said bonds, appropriation of all amounts necessary for

punctual payment of such principal and interest is hereby made, and the State Treasurer shall pay such principal and interest as the same become due.

Section 2.

Subsection (n) of section 25-32 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019)*:

(n) (1) On and after the effective date of regulations adopted under this subsection, no person may operate any water treatment plant, water distribution system or small water system that treats or supplies water used or intended for use by the public, test any backflow prevention device, or perform a cross connection survey without a certificate issued by the commissioner under this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to provide: (A) Standards for the operation of such water treatment plants, water distribution systems and small water systems; (B) standards and procedures for the issuance of certificates to operators of such water treatment plants, water distribution systems and small water systems, including standards and procedures for the department's approval of third parties to administer certification examinations to such operators; (C) procedures for the renewal of such certificates every three years; (D) standards for training required for the issuance or renewal of a certificate; (E) standards and procedures for the department's approval of course providers and courses of study as they relate to certified operators of water treatment plants, water distribution systems and small water systems and certified persons who test backflow prevention devices or perform cross connection surveys for initial and renewal applications; and [(E)] (F) standards and procedures for the issuance and renewal of certificates to persons who test backflow prevention devices or perform cross connection surveys. Such regulations shall be consistent with applicable federal law and guidelines for operator certification programs promulgated by the United States Environmental Protection Agency. For purposes of this subsection, "small water system" means a public water system, as defined in section 25-33d, that serves less than one thousand persons and has no treatment or has only treatment that does not require any chemical treatment, process adjustment, backwashing or media regeneration by an operator.

(2) The commissioner may take any disciplinary action set forth in section 19a-17, except for the assessment of a civil penalty under subdivision (7) of subsection (a) of section 19a-17, against an operator, a person who tests backflow prevention devices or a person who performs cross connection surveys holding a certificate issued under this subsection for any of the following reasons: (A) Fraud or material deception in procuring a certificate, the renewal of a certificate or the reinstatement of a certificate; (B) fraud or material deception in the performance of the certified operator's professional activities; (C) incompetent, negligent or illegal performance of the certified operator's professional activities; (D) conviction of the certified operator for a felony; or (E) failure of the certified operator to complete the training required under subdivision (1) of this subsection.

(3) The commissioner may issue an initial certificate to perform a function set forth in subdivision (1) of this subsection upon receipt of a completed application, in a form prescribed by the commissioner, together with an application fee as follows: (A) For a water treatment plant, water distribution system or small water system operator certificate, two hundred twenty-four dollars, except there shall be no such application fee required for a student enrolled in an accredited high school small water system operator certification course; (B) for a backflow prevention device tester certificate, one hundred fifty-four dollars; and (C) for a cross-connection survey inspector certificate, one hundred fifty-four dollars. A certificate issued pursuant to this subdivision shall expire three years from the date of issuance unless renewed by the certificate holder prior to such expiration date. The commissioner may renew a certificate for an additional three years upon receipt of a completed renewal application, in a form prescribed by the commissioner, together with a renewal application fee as follows: (i) For a water treatment plant, water distribution system or small water system operator certificate, ninety-eight dollars; (ii) for a backflow prevention device tester certificate, sixty-nine dollars; and (iii) for a cross-connection survey inspector certificate, sixty-nine dollars.

Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 10.19.18 DPH Electronic Medical Records Access

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Infectious Diseases Section
Agency Analyst/Drafter of Proposal: Matthew Cartter, MD, MPG

Title of Proposal: An Act Concerning Remote Access to Electronic Medical Records at Hospitals
Statutory Reference: 19a-215. Commissioner's lists of reportable diseases, emergency illnesses and health conditions and reportable laboratory findings. Reporting requirements. Confidentiality. Fines. Subsection (c) of 19a-215 grants authority to the Department of Public Health or their authorized personnel to contact the reporting health care provider to obtain medical information for the purposes of disease control. RCSA §19a-36-A1 defines medical information as "recorded health information on an individual who has a reportable disease" including medical record information.
Proposal Summary: To allow the Department of Public Health to have access to electronic medical records, including remote access, that involve "Reportable Diseases, Emergency Illnesses and Health Conditions" and "Reportable Laboratory Findings" when information is requested for disease control and prevention. Any information collected though the electronic medical record shall be protected under the Department's confidentiality statute, CGS 19a-25.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

To protect public health, the Connecticut Department of Public Health conducts surveillance for reportable diseases and emergency syndromes. The Department maintains, and annually updates, the list of "Reportable Diseases, Emergency Illnesses and Health Conditions" and the list of "Reportable Laboratory Findings."

Medical records are reviewed to collect data related to patient demographics, disease severity, and risk factors for disease. Accurate and complete data is essential to inform prevention measures. Historically, conducting medical record reviews has always been a time consuming

effort for Epidemiology Program staff; in part due to the travel time required to go to all hospitals statewide.

Hospitals have been slowly transitioning to web-based electronic medical records systems. Many use "Epic Systems Software" also known as "Epic." The Yale Healthcare system is currently the only network that has allowed DPH staff remote access to electronic medical records. We provide a list of patients for whom we need to do record reviews to a contact in medical records at Yale. Our contact adds these patients to a queue associated with our user identifications. When agency staff log into Epic from DPH we are then restricted to those patients' records. This has benefited DPH in several ways.

First, staff no longer have to travel to network hospitals (Yale, Saint Raphael's, Bridgeport, Greenwich, Lawrence and Memorial, and Westerly (RI)). Several of these hospitals require visits up to twice a month and travel typically occurs during peak traffic hours. Eliminating travel equates to a gain of ten hours or more per month of productive work time, in addition to cost savings on reimbursements for mileage.

Second, the Yale Epic system allows us to navigate through a patient's record in much the same way a clinician would. There are separate tabs for various parts of the records (e.g., demographics, lab results, surgical reports, medications administered, dictated reports, etc.) that allow us to easily compile the data we need. It allows us to see a patient's history prior to the culture date, because we often need to collect risk factor information (e.g., hospitalization and surgery dates in the prior year, facility residence in prior year, prior positive laboratory cultures). If we were restricted in Epic to the admission during which the culture was collected, this risk factor data would likely be incomplete and result in misclassification of cases.

The other state hospitals that use Epic (Hartford Healthcare, including Connecticut Children Medical Center, and Trinity Health) require us to go on-site. These facilities pull PDFs from their Epic systems which we can then view. Depending upon the length of hospitalization, these PDFs could be hundreds of pages long. Often PDFs have no logical subsections - making it necessary to look at each and every page in order to find what we need. This lack of chart organization has greatly increased the time it takes to do reviews. Needed data, such as MRSA risk factor data, is often not present in the PDFs and likely impacts data quality as it relates to identification of risk factors for disease.

Third, during the Lean process the Department underwent pursuant to Special Act 17-21, we learned that many nonprofit providers would prefer to afford facility licensing staff remote access to specific patient medical records so that a portion of the licensure survey may be completed through a desk audit rather than spending a full day at the facility. This alleviates the facility from designation a staff person to sit with the surveyor that work day. We believe this same efficiency can be achieved for hospital staff.

Fourth, the Department is upgrading the way we conduct business by making processes electronic. Apart from efficiencies gained by moving away from paper processes, this also allows the Department to prepare for the onset of the Health Information Exchange.

Of note, Section 164.512(b) of the HIPAA Privacy regulations permits providers to release personal health information to public health authorities such as the Department of Public Health for public health activities authorized by law to prevent and control diseases, injuries and disabilities. This provision permits the reporting of diseases, injuries, and vital events to the Department of Public Health as part of its legally mandated health surveillance, investigation and intervention activities.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: University of Connecticut Health Center/John Dempsey Hospital
Agency Contact (*name, title, phone*): Andrea Keilty
Date Contacted: Click here to enter text.

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
None

State

This will result in a savings for the State of Connecticut because DPH epidemiologists will no longer have to physically travel to licensed health care facilities to review medical records onsite.
Federal This will result in a savings of federal cooperative agreement funds, because the federally-funded DPH epidemiologists who do this work will no longer have to physically travel to licensed health care facilities to review medical records onsite. This will also make DPH more competitive in applying for these federal funds.
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Being able to remotely access electronic medical records at licensed health care facilities will improve the timeliness and efficiency of the Department's public health surveillance activities, and result in a more rapid and efficient response to outbreaks and epidemics.

Insert language here

Section 1.

Section 19a-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(1) "Clinical laboratory" means 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, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances.

(2) "Commissioner's list of reportable diseases, emergency illnesses and health conditions" and "commissioner's list of reportable laboratory findings" means the lists developed pursuant to section 19a-2a.

(3) "Confidential" means confidentiality of information pursuant to section 19a-25.

(4) “Health care provider” means a person who has direct or supervisory responsibility for the delivery of health care or medical services, including licensed physicians, nurse practitioners, nurse midwives, physician assistants, nurses, dentists, medical examiners and administrators, superintendents and managers of health care facilities.

(5) “Reportable diseases, emergency illnesses and health conditions” means the diseases, illnesses, conditions or syndromes designated by the Commissioner of Public Health on the list required pursuant to section 19a-2a.

(b) A health care provider shall report each case occurring in such provider's practice, of any disease on the commissioner's list of reportable diseases, emergency illnesses and health conditions to the director of health of the town, city or borough in which such case resides and to the Department of Public Health, no later than twelve hours after such provider's recognition of the disease. Such reports shall be in writing, by telephone or in an electronic format approved by the commissioner. [Such reports of disease shall be confidential and not open to public inspection except as provided for in section 19a-25.]

(c) A clinical laboratory shall report each finding identified by such laboratory of any disease identified on the commissioner's list of reportable laboratory findings to the Department of Public Health not later than forty-eight hours after such laboratory's finding. A clinical laboratory that reports an average of more than thirty findings per month shall make such reports electronically in a format approved by the commissioner. Any clinical laboratory that reports an average of less than thirty findings per month shall submit such reports, in writing, by telephone or in an electronic format approved by the commissioner. [All such reports shall be confidential and not open to public inspection except as provided for in section 19a-25.] The Department of Public Health shall provide a copy of all such reports to the director of health of the town, city or borough in which the affected person resides or, in the absence of such information, the town where the specimen originated.

(d) When a local director of health, the local director's authorized agent or the Department of Public Health receives a report of a disease or laboratory finding on the commissioner's lists of reportable diseases, emergency illnesses and health conditions and laboratory findings, the local director of health, the local director's authorized agent or the Department of Public Health may contact first the reporting health care provider and then the person with the reportable finding to obtain such information as may be necessary to lead to the effective control of further spread of such disease. In the case of reportable communicable diseases and laboratory findings, this information may include obtaining the identification of persons who may be the source or subsequent contacts of such infection.

(e) The Department of Public Health shall have access, including remote access, to electronic medical records that involve reportable diseases, emergency illnesses and health conditions published by the

commissioner of public health pursuant to subdivision (9) of section19a-2a that occur at an institution licensed pursuant to subsection (b) of section 19a-490 in a manner approved by the commissioner.

[(e)] (f) All reports and [personal] information obtained under this section [from disease prevention and control investigations as performed in subsections (c) and (d) of this section including the health care provider's name and the identity of the reported case of disease and suspected source persons and contacts shall not be divulged to anyone and] shall be held strictly confidential pursuant to section 19a-25, by the local director of health and the director's authorized agent and by the Department of Public Health.

[(f)] (g) Any person who violates any reporting or confidentiality provision of this section shall be fined not more than five hundred dollars. No provision of this section shall be deemed to supersede section 19a-584.

Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 10.01.18 DPH Emergency Medical Services Definitions and Certification

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Health Care, Quality and Safety Branch, Office of Emergency Medical Services
Agency Analyst/Drafter of Proposal: Ralf Coler and Jill Kennedy

Title of Proposal: An Act Concerning Revisions to Emergency Medical Services Definitions, Certification and Continuing Education Requirements
Statutory Reference Section 1. 19a-175. Definitions. Section 2. 19a-177. Duties of commissioner. Section 3. 19a-178a. Emergency Medical Services Advisory Board established; appointment; responsibilities. Section 4. 19a-180. Licensure and certification of ambulance service, paramedic intercept service or rescue service. Exception. Suspension or revocation. Penalty. Duties of emergency medical service organization. Additional emergency vehicles. Change of address of principal or branch location. Section 5. 19a-180b. Certificate of authorization for supplemental first responder. Suspension or revocation. Section 6. 19a-180d. Responsibility for decision-making on scene of emergency medical call. Section 7. 19a-181b. Local emergency medical services plan. Section 8. 19a-182. Emergency medical services councils. Plans for delivery of services. Section 9. 19a-183. Regional emergency medical services councils. Section 10. 20-206kk. Practice restricted to licensed persons. Exceptions. Title protection. Section 11. 20-206jj. Definitions. Section 12. 20-206mm. Qualifications for licensure and certification. Licensure and certification by endorsement. License and certificate renewal.
Proposal Summary: Sections 1-10 make technical revisions to the terms “Provider” and “Emergency Medical Service (EMS) Organization”. These terms are used interchangeably through the statutes. This technical amendment will revise the term “EMS Organization” to capture the meaning included

in both “Provider” and “EMS Organization”. It will remove the term “Provider” and replace it with “EMS Organization”.

This proposal also allows any volunteer, hospital-based or municipal ambulance service to add a branch location to their primary service area, and requires that emergency medical services data be submitted to the Department electronically.

Sections 11 and 12 require an emergency medical responder, emergency medical technician, advanced emergency medical technician and emergency medical services instructor to initiate, renew and maintain their certification using national curriculum and testing requirements through the National Registry of Emergency Medical Technicians.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

This proposal will clarify EMS definitions and ensure public health and safety by requiring future EMS personnel to meet a national level of testing and all EMS personnel to meet an increased requirement of continued education. Adopting national certification and continuing education unit (CEU) requirements will also streamline processing and achieve cost savings by eliminating the need for the Department to develop EMS exams and approve licensure and certifications. The Department will be able to track certifications and CEU’s on the National Registry internet database, allowing for more efficient certification of EMS personnel.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration’s package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Emergency Services and Public Protection **Agency Contact (*name, title, phone*):** Scott Devico **Date Contacted:** Click here to enter text. Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* Certification through the National Registry may result in a minimal cost to municipalities who directly employ such first responders. There is a $20 fee per applicant for the national registry where certification services are provided for free by DPH.
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

This will make revisions to the EMS regulations more clear, and will permit the Department to track certifications and CEU's on the National Registry internet database, removing workload burden and allowing for more efficient certification of EMS personnel.

Section 1.

Section 19a-175 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(1) “Emergency medical service system” means a system which provides for the arrangement of personnel, facilities and equipment for the efficient, effective and coordinated delivery of health care services under emergency conditions;

(2) “Patient” means an injured, ill or physically handicapped person requiring assistance and transportation;

(3) “Ambulance” means a motor vehicle specifically designed to carry patients;

(4) “Ambulance service” means an organization which transports patients;

(5) “Emergency medical technician” means a person who is certified pursuant to chapter 384d;

(6) “Ambulance driver” means a person whose primary function is driving an ambulance;

(7) “Emergency medical services instructor” means a person who is certified pursuant to chapter 384d;

(8) “Communications facility” means any facility housing the personnel and equipment for handling the emergency communications needs of a particular geographic area;

(9) “Life saving equipment” means equipment used by emergency medical personnel for the stabilization and treatment of patients;

(10) “Emergency medical service organization” means any corporation or organization whether public, private or voluntary that has been certified or licensed by the Department to offer services under the emergency medical services system that include, but are not limited to, treatment to patients [offers transportation or treatment services to patients primarily] under emergency conditions, sudden illness or injury, or during transportation by an authorized emergency medical services vehicle;

(11) “Invalid coach” means a vehicle used exclusively for the transportation of nonambulatory patients, who are not confined to stretchers, to or from either a medical facility or the patient's home in nonemergency situations or utilized in emergency situations as a backup vehicle when insufficient emergency vehicles exist;

(12) “Rescue service” means any organization, whether for-profit or nonprofit, whose primary purpose is to search for persons who have become lost or to render emergency service to persons who are in dangerous or perilous circumstances;

[(13) “Provider” means any person, corporation or organization, whether profit or nonprofit, whose primary purpose is to deliver medical care or services, including such related medical care services as ambulance transportation;]

[(14)] (13) “Commissioner” means the Commissioner of Public Health;

[(15)] (14) “Paramedic” means a person licensed pursuant to chapter 384d;

[(16)] (15) “Commercial ambulance service” means an ambulance service which primarily operates for profit;

[(17)] (16) “Licensed ambulance service” means a commercial ambulance service or a volunteer or municipal ambulance service issued a license by the commissioner;

[(18)] (17) “Certified ambulance service” means a municipal, volunteer or nonprofit ambulance service issued a certificate by the commissioner;

[(19)] (18) “Automatic external defibrillator” means a device that: (A) Is used to administer an electric shock through the chest wall to the heart; (B) contains internal decision-making electronics, microcomputers or special software that allows it to interpret physiologic signals, make medical diagnosis and, if necessary, apply therapy; (C) guides the user through the process of using the device by audible or visual prompts; and (D) does not require the user to employ any discretion or judgment in its use;

[(20)] (19) “Mutual aid call” means a call for emergency medical services that, pursuant to the terms of a written agreement, is responded to by a secondary or alternate emergency medical services provider if the primary or designated emergency medical services provider is unable to respond because such primary or designated provider is responding to another call for emergency medical services or the ambulance or nontransport emergency vehicle operated by such primary or designated provider is out of service. For purposes of this subdivision, “nontransport emergency vehicle” means a vehicle used by emergency medical technicians or paramedics in responding to emergency calls that is not used to carry patients;

[(21)] (20) “Municipality” means the legislative body of a municipality or the board of selectmen in the case of a municipality in which the legislative body is a town meeting;

[(22)] (21) “Primary service area” means a specific geographic area to which one designated emergency medical services provider is assigned for each category of emergency medical response services;

[(23)] (22) “Primary service area responder” means an emergency medical services provider who is designated to respond to a victim of sudden illness or injury in a primary service area;

[(24)] (23) “Interfacility critical care transport” means the interfacility transport of a patient between licensed health care institutions;

[(25)] (24) “Advanced emergency medical technician” means an individual who is certified as an advanced emergency medical technician pursuant to chapter 384d;

[(26)] (25) “Emergency medical responder” means an individual who is certified pursuant to chapter 384d;

[(27)] (26) “Medical oversight” means the active surveillance by physicians of the provision of emergency medical services sufficient for the assessment of overall emergency medical service practice levels, as defined by state-wide protocols;

[(28)] (27) “Office of Emergency Medical Services” means the office established within the Department of Public Health pursuant to section 19a-178;

[(29)] (28) “Sponsor hospital” means a hospital that has agreed to maintain staff for the provision of medical oversight, supervision and direction to an emergency medical service organization and its personnel and has been approved for such activity by the Department of Public Health;

[(30)] (29) “Paramedic intercept service” means paramedic treatment services provided by an entity that does not provide the ground ambulance transport; [and]

[(31)] (30) “Authorized emergency medical services vehicle” means an ambulance, invalid coach or advanced emergency technician-staffed intercept vehicle or a paramedic-staffed intercept vehicle licensed or certified by the Department of Public Health for purposes of providing emergency medical care to patients[.]; and

(31) “Emergency Medical Services Personnel” means an individual certified to practice as an emergency medical responder, emergency medical technician, advanced emergency medical technician, emergency medical services instructor or an individual licensed as a paramedic.

Section 2.

Section 19a-177 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

The commissioner shall:

(1) With the advice of the Office of Emergency Medical Services established pursuant to section 19a-178 and of an advisory committee on emergency medical services and with the benefit of meetings held pursuant to subsection (b) of section 19a-184, adopt every five years a state-wide plan for the coordinated delivery of emergency medical services;

(2) License or certify the following: (A) Ambulance operations, ambulance drivers, emergency medical services personnel and communications personnel; (B) emergency room facilities and communications facilities; and (C) transportation equipment, including land, sea and air vehicles used for transportation of patients to emergency facilities and periodically inspect life saving equipment, emergency facilities and emergency transportation vehicles to ensure state standards are maintained;

(3) Annually inventory emergency medical services resources within the state, including facilities, equipment, and personnel, for the purposes of determining the need for additional services and the effectiveness of existing services;

(4) Review and evaluate all area-wide plans developed by the emergency medical services councils pursuant to section 19a-182 in order to insure conformity with standards issued by the commissioner;

(5) Not later than thirty days after their receipt, review all grant and contract applications for federal or state funds concerning emergency medical services or related activities for conformity to policy guidelines and forward such application to the appropriate agency, when required;

(6) Establish such minimum standards and adopt such regulations in accordance with the provisions of chapter 54, as may be necessary to develop the following components of an emergency medical service system: (A) Communications, which shall include, but not be limited to, equipment, radio frequencies and operational procedures; (B) transportation services, which shall include, but not be limited to, vehicle type, design, condition and maintenance, and operational procedures; (C) training, which shall include, but not be limited to, emergency medical services personnel [emergency medical technicians], communications personnel, paraprofessionals associated with emergency medical services, firefighters and state and local police; and (D) emergency medical service facilities, which shall include, but not be limited to, categorization of emergency departments as to their treatment capabilities and ancillary services;

(7) Coordinate training of all emergency medical services personnel [related to emergency medical services];

(8) (A) Develop an emergency medical services data collection system. Each emergency medical service organization licensed or certified pursuant to chapter 386d shall submit data to the commissioner, on a quarterly basis, from each licensed ambulance service, certified ambulance service or paramedic intercept service that provides emergency medical services. Such submitted data shall include, but not be limited to: (i) The total number of calls for emergency medical services received by such licensed ambulance service, certified ambulance service or paramedic intercept service through the 9-1-1 system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, required for each such call; (iii) the response time for each licensed ambulance service, certified ambulance service or paramedic intercept service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls, both made and received, during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The data required under this subdivision may be submitted in [any written or] electronic form selected by such licensed ambulance service, certified ambulance service or paramedic intercept service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service, certified ambulance service or paramedic intercept service in approving such [written or] electronic form. The commissioner may conduct an audit of any such licensed ambulance service, certified ambulance service or paramedic intercept service as the commissioner deems necessary in order to verify the accuracy of such reported data.

(B) On or before December 31, 2018, and annually thereafter, the commissioner shall prepare a report to the Emergency Medical Services Advisory Board, established pursuant to section 19a-178a, that shall include, but not be limited to, the following data: (i) The total number of calls for emergency medical services received during the reporting year by each licensed ambulance service, certified ambulance service or paramedic intercept service; (ii) the level of emergency medical services required for each such call; (iii) the name of the [provider] emergency medical service organizations for [of] each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service, certified ambulance service or paramedic intercept service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179; and (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year. The commissioner shall prepare such report in a format that categorizes such data for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications.

(C) If any licensed ambulance service, certified ambulance service or paramedic intercept service does not submit the data required under subparagraph (A) of this subdivision for a period of six consecutive months, or if the commissioner believes that such licensed ambulance service, certified ambulance service or paramedic intercept service knowingly or intentionally submitted incomplete or

false data, the commissioner shall issue a written order directing such licensed ambulance service, certified ambulance service or paramedic intercept service to comply with the provisions of subparagraph (A) of this subdivision and submit all missing data or such corrected data as the commissioner may require. If such licensed ambulance service, certified ambulance service or paramedic intercept service fails to fully comply with such order not later than three months from the date such order is issued, the commissioner (i) shall conduct a hearing, in accordance with chapter 54, at which such licensed ambulance service, certified ambulance service or paramedic intercept service shall be required to show cause why the primary service area assignment of such licensed ambulance service, certified ambulance service or paramedic intercept service should not be revoked, and (ii) may take such disciplinary action under section 19a-17 as the commissioner deems appropriate.

(D) The commissioner shall collect the data required by subparagraph (A) of this subdivision, in the manner provided in said subparagraph, from each emergency medical service organization licensed or certified pursuant to this chapter. Any such emergency medical service organization that fails to comply with the provisions of this section shall be liable for a civil penalty not to exceed one hundred dollars per day for each failure to report the required data regarding emergency medical services provided to a patient, as determined by the commissioner. The civil penalties set forth in this subparagraph shall be assessed only after the department provides a written notice of deficiency and the organization is afforded the opportunity to respond to such notice. An organization shall have not more than fifteen business days after the date of receiving such notice to provide a written response to the department. The commissioner may adopt regulations, in accordance with chapter 54, concerning the development, implementation, monitoring and collection of emergency medical service system data. All state agencies licensed or certified as emergency medical service organizations shall be exempt from the civil penalties set forth in this subparagraph;

(E) The commissioner shall, with the recommendation of the Connecticut Emergency Medical Services Advisory Board established pursuant to Section 19a-178a, adopt for use in trauma data collection the most recent version of the National Trauma Data Bank's National Trauma Data Standards and Data Dictionary and nationally recognized guidelines for field triage of injured patients.

(9) (A) Establish rates for the conveyance and treatment of patients by licensed ambulance services and invalid coaches and establish emergency service rates for certified ambulance services and paramedic intercept services, provided (i) the present rates established for such services and vehicles shall remain in effect until such time as the commissioner establishes a new rate schedule as provided in this subdivision, and (ii) any rate increase not in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, filed in accordance with subparagraph (B)(iii) of this subdivision shall be deemed approved by the commissioner. For purposes of this subdivision, licensed ambulance service shall not include emergency air transport services.

(B) Adopt regulations, in accordance with the provisions of chapter 54, establishing methods for setting rates and conditions for charging such rates. Such regulations shall include, but not be limited to, provisions requiring that on and after July 1, 2000: (i) Requests for rate increases may be filed no more frequently than once a year, except that, in any case where an agency's schedule of maximum allowable rates falls below that of the Medicare allowable rates for that agency, the commissioner shall immediately amend such schedule so that the rates are at or above the Medicare allowable rates; (ii) only licensed ambulance services, certified ambulance services and paramedic intercept services that apply for a rate increase in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, and do not accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall be required to file detailed financial information with the commissioner, provided any hearing that the commissioner may hold concerning such application shall be conducted as a contested case in accordance with chapter 54; (iii) licensed ambulance services, certified ambulance services and paramedic intercept services that do not apply for a rate increase in any year in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, or that accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall, not later than the last business day in August of such year, file with the commissioner a statement of emergency and nonemergency call volume, and, in the case of a licensed ambulance service, certified ambulance service or paramedic intercept service that is not applying for a rate increase, a written declaration by such licensed ambulance service, certified ambulance service or paramedic intercept service that no change in its currently approved maximum allowable rates will occur for the rate application year; and (iv) detailed financial and operational information filed by licensed ambulance services, certified ambulance services and paramedic intercept services to support a request for a rate increase in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, shall cover the time period pertaining to the most recently completed fiscal year and the rate application year of the licensed ambulance service, certified ambulance service or paramedic intercept service.

(C) Establish rates for licensed ambulance services, certified ambulance services or paramedic intercept services for the following services and conditions: (i) “Advanced life support assessment” and “specialty care transports”, which terms have the meanings provided in 42 CFR 414.605; and (ii) mileage, which may include mileage for an ambulance transport when the point of origin and final destination for a transport is within the boundaries of the same municipality. The rates established by the commissioner for each such service or condition shall be equal to (I) the ambulance service's base rate plus its established advanced life support/paramedic surcharge when advanced life support assessment services are performed; (II) two hundred twenty-five per cent of the ambulance service's established base rate for specialty care transports; and (III) “loaded mileage”, as the term is defined in 42 CFR 414.605, multiplied by the ambulance service's established rate for mileage. Such rates shall

remain in effect until such time as the commissioner establishes a new rate schedule as provided in this subdivision;

(10) Research, develop, track and report on appropriate quantifiable outcome measures for the state's emergency medical service system and submit to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on or before July 1, 2002, and annually thereafter, a report on the progress toward the development of such outcome measures and, after such outcome measures are developed, an analysis of emergency medical services system outcomes;

(11) Establish primary service areas and assign in writing a primary service area responder for each primary service area. Each state-owned campus having an acute care hospital on the premises shall be designated as the primary service area responder for that campus;

(12) Revoke primary service area assignments upon determination by the commissioner that it is in the best interests of patient care to do so; and

(13) Annually issue a list of minimum equipment requirements for ambulances and rescue vehicles based upon current national standards. The commissioner shall distribute such list to all emergency medical service organizations and sponsor hospital medical directors and make such list available to other interested stakeholders. Emergency medical service organizations shall have one year from the date of issuance of such list to comply with the minimum equipment requirements.

Section 3.

Section 19a-178a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) There is established within the Department of Public Health an Emergency Medical Services Advisory Board.

(b) The advisory board shall consist of members appointed in accordance with the provisions of this subsection and shall include the Commissioner of Public Health, the department's emergency medical services medical director and the president of each of the regional emergency medical services councils, or their designees. The Governor shall appoint the following members: (1) One person from the Connecticut Association of Directors of Health; (2) three persons from the Connecticut College of Emergency Physicians; (3) one person from the Connecticut Committee on Trauma of the American College of Surgeons; (4) one person from the Connecticut Medical Advisory Committee; (5) one person from the Emergency Nurses Association; (6) one person from the Connecticut Association of Emergency Medical Services Instructors; (7) one person from the Connecticut Hospital Association;

(8) two persons representing commercial ambulance [providers]services; (9) one person from the Connecticut State Firefighters Association; (10) one person from the Connecticut Fire Chiefs Association; (11) one person from the Connecticut Police Chiefs Association; (12) one person from the Connecticut State Police; and (13) one person from the Connecticut Commission on Fire Prevention and Control. An additional eighteen members shall be appointed as follows: (A) Three by the president pro tempore of the Senate; (B) three by the majority leader of the Senate; (C) four by the minority leader of the Senate; (D) three by the speaker of the House of Representatives; (E) two by the majority leader of the House of Representatives; and (F) three by the minority leader of the House of Representatives. The appointees shall include a person with experience in municipal ambulance services; a person with experience in for-profit ambulance services; three persons with experience in volunteer ambulance services; a paramedic; an emergency medical technician; an advanced emergency medical technician; three consumers and four persons from state-wide organizations with interests in emergency medical services as well as any other areas of expertise that may be deemed necessary for the proper functioning of the advisory board.

(c) The Commissioner of Public Health shall appoint a chairperson from among the members of the advisory board who shall serve for a term of one year. The advisory board shall elect a vice-chairperson and secretary. The advisory board shall have committees made up of such members as the chairperson shall appoint and such other interested persons as the committee members shall elect to membership. The advisory board may, from time to time, appoint nonmembers to serve on such ad hoc committees as it deems necessary to assist with its functions. The advisory board shall develop bylaws. The advisory board shall establish a Connecticut Emergency Medical Services Medical Advisory Committee as a standing committee. The standing committee shall provide the commissioner, the advisory board and other ad hoc committees with advice and comment regarding the medical aspects of their projects. The standing committee may submit reports directly to the commissioner regarding medically-related concerns that have not, in the standing committee's opinion, been satisfactorily addressed by the advisory board.

(d) The term for each appointed member of the advisory board shall be coterminous with the appointing authority. Appointees shall serve without compensation.

(e) The advisory board, in addition to other power conferred and in addition to functioning in a general advisory capacity, shall assist in coordinating the efforts of all persons and agencies in the state concerned with the emergency medical service system, and shall render advice on the development of the emergency medical service system where needed. The advisory board shall make an annual report to the commissioner.

(f) The advisory board shall be provided a reasonable opportunity to review and make recommendations on all regulations, medical guidelines and policies affecting emergency medical services before the department establishes such regulations, medical guidelines or policies. The

advisory board shall make recommendations to the Governor and to the General Assembly concerning legislation which, in the advisory board's judgment, will improve the delivery of emergency medical services.

Section 4.

Section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) No person shall operate any ambulance service, paramedic intercept service or rescue service without either a license or a certificate issued by the commissioner. No person shall operate a commercial ambulance service or commercial rescue service without a license issued by the commissioner. A certificate shall be issued to any volunteer or municipal ambulance service or any ambulance service or paramedic intercept service that is operated and maintained by a state agency and that shows proof satisfactory to the commissioner that it meets the minimum standards of the commissioner in the areas of training, equipment and personnel. No license or certificate shall be issued to any volunteer, municipal or commercial ambulance service, paramedic intercept service or rescue service or any ambulance service or paramedic intercept service that is operated and maintained by a state agency, unless it meets the requirements of subsection (e) of section 14-100a. Applicants for a license shall use the forms prescribed by the commissioner and shall submit such application to the commissioner accompanied by an annual fee of two hundred dollars. In considering requests for approval of permits for new or expanded emergency medical services in any region, the commissioner shall consult with the Office of Emergency Medical Services and the emergency medical services council of such region and shall hold a public hearing to determine the necessity for such services. Written notice of such hearing shall be given to current [providers]emergency medical service organizations in the geographic region where such new or expanded services would be implemented, provided, any volunteer ambulance service which elects not to levy charges for services rendered under this chapter shall be exempt from the provisions concerning requests for approval of permits for new or expanded emergency medical services set forth in this subsection. A primary service area responder that operates in the service area identified in the application shall, upon request, be granted intervenor status with opportunity for cross-examination. Each applicant for licensure shall furnish proof of financial responsibility which the commissioner deems sufficient to satisfy any claim. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish satisfactory kinds of coverage and limits of insurance for each applicant for either licensure or certification. Until such regulations are adopted, the following shall be the required limits for licensure: (1) For damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident, at least one million dollars, (2) for damage to property at least fifty thousand dollars, and (3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars. In lieu of

the limits set forth in subdivisions (1) to (3), inclusive, of this subsection, a single limit of liability shall be allowed as follows: (A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and (B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars. A certificate of such proof shall be filed with the commissioner. Upon determination by the commissioner that an applicant is financially responsible, properly certified and otherwise qualified to operate a commercial ambulance service, paramedic intercept service or rescue service, the commissioner shall issue the appropriate license effective for one year to such applicant. If the commissioner determines that an applicant for either a certificate or license is not so qualified, the commissioner shall notify such applicant of the denial of the application with a statement of the reasons for such denial. Such applicant shall have thirty days to request a hearing on the denial of the application.

(b) Any person or emergency medical service organization that does not maintain standards or violates regulations adopted under any section of this chapter applicable to such person or organization may have such person's or organization's license or certification suspended or revoked or may be subject to any other disciplinary action specified in section 19a-17 after notice by certified mail to such person or organization of the facts or conduct that warrant the intended action. Such person or emergency medical service organization shall have an opportunity to show compliance with all requirements for the retention of such certificate or license. In the conduct of any investigation by the commissioner of alleged violations of the standards or regulations adopted under the provisions of this chapter, the commissioner may issue subpoenas requiring the attendance of witnesses and the production by any medical service organization or person of reports, records, tapes or other documents that concern the allegations under investigation. All records obtained by the commissioner in connection with any such investigation shall not be subject to the provisions of section 1-210 for a period of six months from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A complaint, as defined in subdivision (6) of section 19a-13, shall be subject to the provisions of section 1-210 from the time that it is served or mailed to the respondent. Records that are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this chapter.

(c) Any person or emergency medical service organization aggrieved by an act or decision of the commissioner regarding certification or licensure may appeal in the manner provided by chapter 54.

(d) Any person who commits any of the following acts shall be guilty of a class C misdemeanor: (1) In any application to the commissioner or in any proceeding before or investigation made by the commissioner, knowingly making any false statement or representation, or, with knowledge of its falsity, filing or causing to be filed any false statement or representation in a required application or statement; (2) issuing, circulating or publishing or causing to be issued, circulated or published any

form of advertisement or circular for the purpose of soliciting business which contains any statement that is false or misleading, or otherwise likely to deceive a reader thereof, with knowledge that it contains such false, misleading or deceptive statement; (3) giving or offering to give anything of value to any person for the purpose of promoting or securing ambulance, invalid coach, paramedic intercept vehicle or rescue service business or obtaining favors relating thereto; (4) administering or causing to be administered, while serving in the capacity of an employee of any licensed ambulance or rescue service, any alcoholic liquor to any patient in such employee's care, except under the supervision and direction of a licensed physician; (5) in any respect wilfully violating or failing to comply with any provision of this chapter or wilfully violating, failing, omitting or neglecting to obey or comply with any regulation, order, decision or license, or any part or provisions thereof; or (6) with one or more other persons, conspiring to violate any license or order issued by the commissioner or any provision of this chapter.

(e) No person shall place any advertisement or produce any printed matter that holds that person out to be an ambulance service unless such person is licensed or certified pursuant to this section. Any such advertisement or printed matter shall include the license or certificate number issued by the commissioner.

(f) Each licensed or certified emergency medical service organization shall: (1) Ensure that its emergency medical personnel, whether such personnel are employees or contracted through an employment agency or personnel pool, are appropriately licensed or certified by the Department of Public Health to perform their job duties and that such licenses or certifications remain valid; (2) ensure that any employment agency or personnel pool, from which the emergency medical service organization obtains personnel meets the required general liability and professional liability insurance limits described in subsection (a) of this section and that all persons performing work or volunteering for the medical service organization are covered by such insurance; and (3) secure and maintain medical oversight, as defined in section 19a-175, by a sponsor hospital, as defined in section 19a-175.

(g) Each applicant whose request for new or expanded emergency medical services is approved shall, not later than six months after the date of such approval, acquire the necessary resources, equipment and other material necessary to comply with the terms of the approval and operate in the service area identified in the application. If the applicant fails to do so, the approval for new or expanded medical services shall be void and the commissioner shall rescind the approval.

(h) Notwithstanding the provisions of subsection (a) of this section, any volunteer, hospital-based or municipal ambulance service or any ambulance service or paramedic intercept service operated and maintained by a state agency that is licensed or certified and is a primary service area responder may apply to the commissioner to add one emergency vehicle to its existing fleet every three years, on a short form application prescribed by the commissioner. No such volunteer, hospital-based or municipal ambulance service or any ambulance service or paramedic intercept service operated and

maintained by a state agency may add more than one emergency vehicle to its existing fleet pursuant to this subsection regardless of the number of municipalities served by such volunteer, hospital-based or municipal ambulance service. Upon making such application, the applicant shall notify in writing all other primary service area responders in any municipality or abutting municipality in which the applicant proposes to add the additional emergency vehicle. Except in the case where a primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner not later than fifteen calendar days after receiving such notice, the application shall be deemed approved thirty calendar days after filing. If any such primary service area responder files an objection with the commissioner within the fifteen-calendar-day time period and requests a hearing, the applicant shall be required to demonstrate need at a public hearing as required under subsection (a) of this section.

(i) The commissioner shall develop a short form application for primary service area responders seeking to add an emergency vehicle to their existing fleets pursuant to subsection (h) of this section. The application shall require an applicant to provide such information as the commissioner deems necessary, including, but not limited to, (1) the applicant's name and address, (2) the primary service area where the additional vehicle is proposed to be used, (3) an explanation as to why the additional vehicle is necessary and its proposed use, (4) proof of insurance, (5) a list of the [providers]emergency medical service organizations to whom notice was sent pursuant to subsection (h) of this section and proof of such notification, and (6) total call volume, response time and calls passed within the primary service area for the one-year period preceding the date of the application.

(j) Notwithstanding the provisions of subsection (a) of this section, any ambulance service or paramedic intercept service operated and maintained by a state agency on or before October 1, 2014, that notifies the Department of Public Health's Office of Emergency Medical Services, in writing, not later than September 1, 2014, of such operation and attests to the ambulance service or paramedic intercept service being in compliance with all statutes and regulations concerning such operation (1) shall be deemed certified by the Commissioner of Public Health, or (2) shall be deemed licensed by the Commissioner of Public Health if such ambulance service or paramedic intercept service levies charges for emergency and nonemergency services.

(k) Notwithstanding the provisions of subsection (a) of this section, any volunteer, hospital-based or municipal ambulance service that is licensed or certified and a primary service area responder may apply to the commissioner, on a short form application prescribed by the commissioner, to change the address of a principal or branch location or add a branch location within its primary service area. Upon making such application, the applicant shall notify in writing all other primary service area responders in any municipality or abutting municipality in which the applicant proposes to change principal or branch locations. Unless a primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner and requests a hearing on such application not later than fifteen calendar days after receiving such notice, the application shall be

deemed approved thirty calendar days after filing. If any such primary service area responder files an objection with the commissioner within the fifteen-calendar-day time period and requests a hearing, the applicant shall be required to demonstrate need to change the address of a principal or branch location within its primary service area at a public hearing as required under subsection (a) of this section.

(l) The commissioner shall develop a short form application pursuant to subsection (k) of this section for primary service area responders seeking to change the following:

(A) The address of a principal location; [or]

(B) The branch location [pursuant to subsection (k) of this section]; or

(C) The addition of a branch location.

(2) The application shall require an applicant to provide such information as the commissioner deems necessary, including, but not limited to, (1) the applicant's name and address, (2) the new address where the principal or branch is to be located, (3) an explanation as to why the principal or branch location is being moved, and (4) a list of the [providers]emergency medical service organizations to whom notice was sent pursuant to subsection (k) of this section and proof of such notification.

Section 5.

Section 19a-180b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

Sec. 19a-180b. Certificate of authorization for supplemental first responder. Suspension or revocation. (a) For the purposes of this section, "supplemental first responder" means an emergency medical [services provider] service organization who holds a certificate of authorization by the Commissioner of Public Health and responds to a victim of sudden illness or injury when available and only when called upon, but does not offer transportation to patients or operate an ambulance service or paramedic intercept service, "emergency medical services personnel" means an individual certified pursuant to chapter 384d to practice as an emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor or an individual licensed pursuant to chapter 384d as a paramedic, and "patient", "ambulance service", "[provider]emergency medical service organization", "paramedic intercept service" and "emergency medical technician" have the same meanings as provided in section 19a-175.

(b) Notwithstanding the provisions of subsection (a) of section 19a-180, the Commissioner of Public Health may issue a certificate of authorization for a supplemental first responder to an emergency medical [services provider] service organization who operates only in a municipality with a population

of at least one hundred five thousand, but not more than one hundred fifteen thousand, as determined by the most recent population estimate by the Department of Public Health. A certificate of authorization shall be issued to an emergency medical [services provider] service organization that shows proof satisfactory to the commissioner that such emergency medical [services provider] service organization (1) meets the minimum standards of the commissioner in the areas of training, equipment and emergency medical services personnel, and (2) maintains liability insurance in an amount not less than one million dollars. Applications for such certificate of authorization shall be made in the form and manner prescribed by the commissioner. Upon determination by the commissioner that an applicant is qualified to be a supplemental first responder, the commissioner shall issue a certificate of authorization effective for two years to such applicant. Such certificate of authorization shall be renewable biennially. If the commissioner determines that an applicant for such license is not so qualified, the commissioner shall provide such applicant with written notice of the denial of the application with a statement of the reasons for such denial. Such applicant shall have thirty days to request a hearing concerning the denial of the application. Any hearing conducted pursuant to this subsection shall be conducted in accordance with the provisions of chapter 54. If the commissioner's denial of a certificate of authorization is sustained after such hearing, an applicant may make new application not less than one year after the date on which such denial was sustained.

(c) The commissioner may suspend or revoke a holder's certificate of authorization for a supplemental first responder if such holder does not maintain the minimum standards of the commissioner pursuant to subdivisions (1) and (2) of subsection (b) of this section or violates any provision of this chapter. Such holder shall have an opportunity to show compliance with all requirements for the retention of such certificate of authorization.

Section 6.

Section 19a-180d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

[A provider]Emergency medical services personnel, as defined in section 19a-175, who holds the highest classification of licensure or certification from the Department of Public Health under this chapter and chapter 384d shall be responsible for making decisions concerning patient care on the scene of an emergency medical call. If two or more [providers]emergency medical service organizations on such scene hold the same licensure or certification classification, the [provider] emergency medical service organization for the primary service area responder, as defined in said section, shall be responsible for making such decisions. If all [providers]emergency medical services personnel on such scene are emergency medical technicians or emergency medical responders, as defined in said section, the emergency medical service organization providing transportation services shall be responsible for making such decisions. [A provider]An emergency medical service organization on the scene of an emergency medical call who has undertaken decision-making

responsibility for patient care shall transfer patient care to a provider with a higher classification of licensure or certification upon such provider's arrival on the scene. All [providers]emergency medical services personnel with patient care responsibilities on the scene shall ensure such transfer takes place in a timely and orderly manner. For purposes of this section, the classification of licensure or certification from highest to lowest is: Paramedic, advanced emergency medical technician, emergency medical technician and emergency medical responder. Nothing in this section shall be construed to limit the authority of a fire chief or fire officer-in-charge under section 7-313e to control and direct emergency activities at the scene of an emergency.

Section 7.

Section 19a-181b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Not later than July 1, 2002, each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical [services providers] service organizations and the public safety answering point, as defined in section 28-25, that covers the municipality. The plan shall also include, but not be limited to, the following:

(1) The identification of levels of emergency medical services, including, but not limited to: (A) The public safety answering point responsible for receiving emergency calls and notifying and assigning the appropriate provider to a call for emergency medical services; (B) the emergency medical [services provider] service organization that is notified for initial response; (C) basic ambulance service; (D) advanced life support level; and (E) mutual aid call arrangements;

(2) The name of the person or entity responsible for carrying out each level of emergency medical services that the plan identifies;

(3) The establishment of performance standards for each segment of the municipality's emergency medical services system; and

(4) Any subcontracts, written agreements or mutual aid call agreements that emergency medical [services providers] service organizations may have with other entities to provide services identified in the plan.

(b) In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional emergency medical services council established pursuant to section 19a-183, its regional emergency medical services coordinator appointed pursuant to section 19a-186a, its regional emergency medical services medical advisory committees and any

sponsor hospital, as defined in regulations adopted pursuant to section 19a-179, located in the area identified in the plan; and (2) shall submit the plan to its regional emergency medical services council for the council's review and comment.

(c) Each municipality shall update the plan required by subsection (a) of this section as the municipality determines is necessary. The municipality shall consult with the municipality's primary service area responder concerning any updates to the plan. The Department of Public Health shall, upon request, assist each municipality in the process of updating the plan by providing technical assistance and helping to resolve any disagreements concerning the provisions of the plan.

(d) Not less than once every five years, said department shall review a municipality's plan and the primary service area responder's provision of services under the plan. Such review shall include an evaluation of such responder's compliance with applicable laws and regulations. Upon the conclusion of such evaluation, the department shall assign a rating of “meets performance standards”, “exceeds performance standards” or “fails to comply with performance standards” for the primary service area responder. The Commissioner of Public Health may require any primary service area responder that is assigned a rating of “fails to comply with performance standards” to meet the requirements of a performance improvement plan developed by the department. Such primary service area responder may be subject to subsequent performance reviews or removal as the municipality's primary service area responder for a failure to improve performance in accordance with section 19a-181c.

Section 8.

Section 19a-182 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The emergency medical services councils shall advise the commissioner on area-wide planning and coordination of agencies for emergency medical services for each region and shall provide continuous evaluation of emergency medical services for their respective geographic areas. A regional emergency medical services coordinator, in consultation with the commissioner, shall assist the emergency medical services council for the respective region in carrying out the duties prescribed in subsection (b) of this section. As directed by the commissioner, the regional emergency medical services coordinator for each region shall facilitate the work of each respective emergency medical services council including, but not limited to, representing the Department of Public Health at any Council of Regional Presidents meetings.

(b) Each emergency medical services council shall develop and revise every five years a plan for the delivery of emergency medical services in its area, using a format established by the Office of Emergency Medical Services. Each council shall submit an annual update for each regional plan to the Office of Emergency Medical Services detailing accomplishments made toward plan implementation.

Such plan shall include an evaluation of the current effectiveness of emergency medical services and detail the needs for the future, and shall contain specific goals for the delivery of emergency medical services within their respective geographic areas, a time frame for achievement of such goals, cost data for the development of such goals, and performance standards for the evaluation of such goals. Special emphasis in such plan shall be placed upon coordinating the existing services into a comprehensive system. Such plan shall contain provisions for, but shall not be limited to, the following: (1) Clearly defined geographic regions to be serviced by each [provider] emergency medical service organization including cooperative arrangements with other [providers] organizations, personnel and backup services; (2) an adequate number of trained personnel for staffing of ambulances, communications facilities and hospital emergency rooms, with emphasis on former military personnel trained in allied health fields; (3) a communications system that includes a central dispatch center, two-way radio communication between the ambulance and the receiving hospital and a universal emergency telephone number; and (4) a public education program that stresses the need for adequate training in basic lifesaving techniques and cardiopulmonary resuscitation. Such plan shall be submitted to the Commissioner of Public Health no later than June thirtieth each year the plan is due.

Section 9.

Section 19a-183 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

There shall be established an emergency medical services council in each region. A region shall be composed of the towns so designated by the commissioner. Opportunity for membership shall be available to all appropriate representatives of emergency medical services including, but not limited to, one representative from each of the following: (1) Local governments; (2) fire and law enforcement officials; (3) medical and nursing professions, including mental health, paraprofessional and other allied health professionals; (4) [providers of]emergency medical service organizations that provide ambulance services, at least one of which shall be a member of a volunteer ambulance association; (5) institutions of higher education; (6) federal agencies involved in the delivery of health care; and (7) consumers. All emergency medical services councils[, including those in existence on July 1, 1974,] shall submit to the commissioner information concerning the organizational structure and council bylaws for the commissioner's approval. Such bylaws shall include the process by which each council shall elect a president. The commissioner shall foster the development of emergency medical services councils in each region.

Section 10.

Subsection (c) of Section 20-206kk of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(c) No license as a paramedic or certificate as an emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall be required of (1) a person performing services within the scope of practice for which he or she is licensed or certified by any agency of this state, or (2) a student, intern or trainee pursuing a course of study in emergency medical services in an accredited institution of education or within an emergency medical services program approved by the commissioner, provided the activities that would otherwise require a license or certificate as an emergency medical services [provider] personnel are performed under supervision and constitute a part of a supervised course of study.

Section 11.

Section 20-206jj of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

Definitions. As used in this section and sections 20-206kk to 20-206oo, inclusive:

(1) "Advanced emergency medical technician" means an individual who is certified as an advanced emergency medical technician by the Department of Public Health;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "Emergency medical services instructor" means a person who is certified under the provisions of section 20-206*ll* or 20-206mm by the Department of Public Health to teach courses, the completion of which is required in order to become an emergency medical technician;

(4) "Emergency medical responder" means an individual who is certified to practice as an emergency medical responder under the provisions of section 20-206*ll* or 20-206mm;

(5) "Emergency medical services personnel" means an individual certified to practice as an emergency medical responder, emergency medical technician, advanced emergency medical technician, emergency medical services instructor or an individual licensed as a paramedic;

(6) "Emergency medical technician" means a person who is certified to practice as an emergency medical technician under the provisions of section 20-206*ll* or 20-206mm;

(7) "National Registry of Emergency Medical Technicians" means the national organization, or its successor organization, that tests and provides certification to emergency medical responders, emergency medical technicians, advanced emergency medical technicians, and paramedics;

[(7)] (8) "Office of Emergency Medical Services" means the office established within the Department of Public Health pursuant to section 19a-178;

[(8)] (9) “Paramedicine” means the carrying out of (A) all phases of cardiopulmonary resuscitation and defibrillation, (B) the administration of drugs and intravenous solutions under written or oral authorization from a licensed physician or a licensed advanced practice registered nurse, and (C) the administration of controlled substances, as defined in section 21a-240, in accordance with written protocols or standing orders of a licensed physician or a licensed advanced practice registered nurse; and

[(9)] (10) “Paramedic” means a person licensed to practice as a paramedic under the provisions of section 20-206*ll*.

Section 12.

Section 20-206mm of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Except as provided in subsections (b) and (c) of this section, an applicant for a license as a paramedic shall submit evidence satisfactory to the Commissioner of Public Health that the applicant has successfully (1) completed a paramedic training program approved by the commissioner, and (2) passed an examination prescribed by the commissioner.

(b) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a paramedic in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that the applicant has no pending disciplinary action or unresolved complaint against him or her, or (2) (A) is currently licensed or certified as a paramedic in good standing in any New England state, New York or New Jersey, (B) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the paramedic scope of practice model conducted by an organization offering a program that is recognized by the national emergency medical services program accrediting organization, and (C) has no pending disciplinary action or unresolved complaint against him or her.

(c) Any person who is certified as an emergency medical technician-paramedic by the Department of Public Health on October 1, 1997, shall be deemed a licensed paramedic. Any person so deemed shall renew his license pursuant to section 19a-88 for a fee of one hundred fifty-five dollars.

(d) [The commissioner may issue an emergency medical technician certificate,] On or after January 1, 2020, each person seeking certification as an emergency medical responder [certificate or advanced emergency medical technician certificate to an applicant who presents] shall apply to the Department

on forms prescribed by the Commissioner. Such persons shall comply with the following requirements:

(1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant [(1) is currently certified as an emergency medical technician, emergency medical responder, or advanced emergency medical technician in good standing in any New England state, New York or New Jersey, (2)] (A) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the [emergency medical technician,] emergency medical responder curriculum[, or advanced emergency medical technician, and (3) has no pending disciplinary action or unresolved complaint against him or her.] and (B) has passed the emergency medical responder examination administered by the National Registry of Emergency Medical Technicians or an examination approved by the Department.

(2) For renewal certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education for an emergency medical responder as required by the National Registry of Emergency Medical Technicians or as approved by the Department or (B) presents a current certification as an emergency medical responder from the National Registry of Emergency Medical Technicians.

(3) For certification by endorsement from another state, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified as an emergency medical responder in good standing by a state that maintains certification or licensing requirements that the commissioner determines are equal to or greater than those in this state or (B) holds a current certification as an emergency medical responder from the National Registry of Emergency Medical Technicians.

(e) [An emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall be recertified every three years. For the purpose of maintaining an acceptable level of proficiency, each emergency medical technician who is recertified for a three-year period shall complete thirty hours of refresher training approved by the commissioner or meet such other requirements as may be prescribed by the commissioner. The refresher training or other requirements shall include, but not be limited to, training in Alzheimer's disease and dementia symptoms and care.] On or after January 1, 2020, each person seeking certification as an emergency medical technician shall apply to the Department on forms prescribed by the Commissioner. Such persons shall comply with the following requirements:

(1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety

Administration for the emergency medical technician curriculum and (B) has passed the emergency medical technician examination administered by the National Registry of Emergency Medical Technicians or an examination approved by the Department.

(2) For renewal certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education for an emergency medical technician as required by the National Registry of Emergency Medical Technicians or as approved by the Department or (B) presents a current certification as an emergency medical technician from the National Registry of Emergency Medical Technicians.

(3) For certification by endorsement from another state, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified as an emergency medical technician in good standing by a state that maintains certification or licensing requirements that the commissioner determines are equal to or greater than those in this state or (B) holds a current certification as an emergency medical technician from the National Registry of Emergency Medical Technicians.

(f) On or after January 1, 2020, each person seeking certification as an advanced emergency medical technician shall apply to the Department on forms prescribed by the Commissioner. Such persons shall comply with the following requirements:

(1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the advanced emergency medical technician curriculum and (B) has passed the advanced emergency medical technician examination administered by the National Registry of Emergency Medical Technicians or an examination approved by the Department.

(2) For renewal certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education for an advanced emergency medical technician as required by the National Registry of Emergency Medical Technicians or as approved by the Department or (B) present a current certification as an advanced emergency medical technician from the National Registry of Emergency Medical Technicians.

(3) For certification by endorsement from another state, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified as an advanced emergency medical technician in good standing by a state that maintains certification or licensing requirements that the commissioner determines are equal to or greater than those in this state or (B) holds a current certification as an advanced emergency medical technician from the National Registry of Emergency Medical Technicians.

(g) On or after January 1, 2020, each person seeking certification as an emergency medical services instructor shall apply to the Department on forms prescribed by the Commissioner. Such persons shall comply with the following requirements:

(1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified by the Department as an emergency medical technician or advanced emergency medical technician, or licensed by the Department as a paramedic; (B) has completed a program of training as an emergency medical instructor based on current national education standards within the prior two years; (C) has completed twenty-five hours of teaching activity under the supervision of a currently certified emergency medical services instructor; (D) has completed written and practical examinations as prescribed by the commissioner; (E) has no pending disciplinary action or unresolved complaints against the applicant; and (F) effective on a date as prescribed by the Commissioner, presents documentation satisfactory to the Commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the National Registry of Emergency Medical Technicians.

(2) For renewal certification, that applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed the continuing education and teaching activity as required by the Department; (B) maintains current certification by the Department as an emergency medical technician, advanced emergency medical technician or licensure by the Department as a paramedic; and (C) effective on a date as prescribed by the Commissioner, presents documentation satisfactory to the Commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the National Registry of Emergency Medical Technicians.

(h) A certified emergency medical responder, emergency medical technician, advanced emergency medical technician, or emergency medical services instructor shall enter and administer their continuing educational requirements through the continuing education platform internet website as prescribed by the Commissioner.

[(f)] (i) The commissioner may issue a temporary emergency medical technician certificate to an applicant who presents evidence satisfactory to the commissioner that (1) the applicant was certified by the department as an emergency medical technician prior to becoming licensed as a paramedic pursuant to section 20-206*ll*, or (2) the applicant's certification as an emergency medical technician has expired and the applicant's license as a paramedic has become void pursuant to section 19a-88. Such temporary certificate shall be valid for a period not to exceed one year and shall not be renewable.

[(g)] (j) An applicant who is issued a temporary emergency medical technician certificate pursuant to subsection [(f)] (i) of this section may, prior to the expiration of such temporary certificate, apply to

the department for: (1) Renewal of such person's paramedic license, giving such person's name in full, such person's residence and business address and such other information as the department requests, provided the application for license renewal is accompanied by evidence satisfactory to the commissioner that the applicant was under the medical oversight of a sponsor hospital, as those terms are defined in section 19a-175, on the date the applicant's paramedic license became void for nonrenewal; or (2) recertification as an emergency medical technician, provided the application for recertification is accompanied by evidence satisfactory to the commissioner that the applicant completed emergency medical technician refresher training approved by the commissioner not later than one year after issuance of the temporary emergency medical technician certificate. The department shall recertify such person as an emergency medical technician without the examination required for initial certification specified in regulations adopted by the commissioner pursuant to section 20-206oo.

[(h) The commissioner may issue an emergency medical responder, emergency medical technician or advanced emergency medical technician certificate to an applicant for certification by endorsement who presents evidence satisfactory to the commissioner that the applicant (1) is currently certified as an emergency medical responder, emergency medical technician or advanced emergency medical technician in good standing by a state that maintains licensing requirements that the commissioner determines are equal to, or greater than, those in this state, (2) has completed an initial department-approved emergency medical responder, emergency medical technician or advanced emergency medical technician training program that includes written and practical examinations at the completion of the course, or a program outside the state that adheres to national education standards for the emergency medical responder, emergency medical technician or advanced emergency medical technician scope of practice and that includes an examination, and (3) has no pending disciplinary action or unresolved complaint against him or her.]

[(i) The commissioner may issue an emergency medical service instructor certificate to an applicant who presents (1) evidence satisfactory to the commissioner that the applicant is currently certified as an emergency medical technician in good standing, (2) documentation satisfactory to the commissioner, with reference to national education standards, regarding qualifications as an emergency medical service instructor, (3) a letter of endorsement signed by two instructors holding current emergency medical service instructor certification, (4) documentation of having completed written and practical examinations as prescribed by the commissioner, and (5) evidence satisfactory to the commissioner that the applicant has no pending disciplinary action or unresolved complaints against him or her.]

[(j)] (k) Any person certified as an emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor pursuant to this chapter and the regulations adopted pursuant to section 20-206oo whose certification has expired may apply to the Department of Public Health for reinstatement of such certification as follows: (1) If

such certification has expired [one year] two years or less [from the date of the application for reinstatement,] such person shall complete the requirements for recertification specified in regulations adopted pursuant to section 20-206oo; or (2) [if such recertification expired more than one year but less than three years from the date of application for reinstatement, such person shall complete the training required for recertification and the examination required for initial certification specified in regulations adopted pursuant to section 20-206oo; or (3)] if such certification has expired [three] greater than two years [or more years from the date of application for reinstatement,] such person shall complete the requirements for initial certification set forth in this section. Any certificate issued pursuant to this section shall remain valid for ninety days after the expiration date of such certificate and become void upon the expiration of such ninety-day period.

[(k)] (*l*) The Commissioner of Public Health shall issue an emergency medical technician certification to an applicant who is a member of the armed forces or the National Guard or a veteran and who (1) presents evidence satisfactory to the commissioner that such applicant holds a current certification as a person entitled to perform similar services under a different designation by the National Registry of Emergency Medical Technicians, or (2) satisfies the regulations promulgated pursuant to subdivision [(4)] (3) of subsection (a) of section 19a-179. Such applicant shall be exempt from any written or practical examination requirement for certification.

[(l)] (m) For the purposes of this section, “veteran” means any person who was discharged or released under conditions other than dishonorable from active service in the armed forces and “armed forces” has the same meaning as provided in section 27-103.

Agency Legislative Proposal - 2018 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
10.01.18 DPH Seat Belts in All Positions

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Commissioner's Office
Agency Analyst/Drafter of Proposal: Brie Wolf

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding Seat Belts
Statutory Reference: Section 1. 14-100a. Seat safety belts. Child restraint systems. Wheelchair transportation devices. Section 2. 54-33m. Failure to wear seat belt not probable cause for vehicle search.
Proposal Summary: To revise section 14-100a to require persons to wear seat belts in all positions of the vehicle.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The Centers for Disease Control and Prevention's (CDC) guidelines for passenger safety recommend that seat belts are worn by every person in the vehicle, on every trip. Statistics show that motor vehicle crashes are **the leading** cause of death for people ages 5-34, and that more than half of those killed in car crashes were not wearing seat belts at the time of the crash.

According to Connecticut Department of Transportation, National Highway Traffic Safety Administration (NHTSA) statistics show that among young adults ages 18 to 34 killed in crashes in 2016, more than half (57%) were completely unrestrained – one of the highest percentages for all age groups.

Men make up the majority of those killed in motor vehicle traffic crashes. In 2016, 65 percent of the 23,714 passenger vehicle occupants who were killed were men. Men wear their seat belts at a lower rate than women do – 52 percent of men in fatal crashes were unrestrained, compared to 40 percent of women. Forty-seven percent of all front-seat passenger vehicle occupants killed in crashes in 2016 were unrestrained, but 57 percent of those killed in back seats were unrestrained.

According to the National Transportation Safety Board, although opponents to strong seat belt laws claim that nonuse is a personal choice and affects only the individual, the fact is that motor vehicle injuries and fatalities have a significant societal cost. The National Highway Traffic Safety Administration (NHTSA) calculated that the lifetime cost to society for each motor vehicle fatality is over $977,000. More than 80 percent of these costs were attributed to lost workplace and household productivity.

Adult seat belt use is the single most effective way to save lives and reduce injuries in crashes. The Department is recommending a revision to section 14-100a to require persons wear a seatbelt in all positions of the vehicle.

Additionally, the Department is including language that would exclude busses and vehicles manufactured before January 1, 1968 from the requirements of this section. On January 1, 1968, Title 49 of the United States Code, Chapter 301, Motor Vehicle Safety Standard mandated all vehicles, except busses, be fitted with a safety belt in designated seating positions.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

This proposal died in the House Chamber during the 2018 session due to a fight it caused between members. DOT put forward this proposal during the 2017 session, but it failed to move forward because it was included in a larger bill that spoke about helmet laws and other items.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Transportation **Agency Contact (*name, title, phone*):** CJ Strand **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Motor Vehicles **Agency Contact (*name, title, phone*):** Jim Carson **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

None

Insert language here

Section 1.

Subdivision (1) of subsection (c) of section 14-100a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(c) (1) The operator of and any [front seat] passenger in any motor vehicle or fire fighting apparatus originally equipped with seat safety belts complying with the provisions of 49 CFR 571.209, as amended from time to time, shall wear such seat safety belt while the vehicle is being operated on any highway, except as follows:

(A) A child under eight years of age shall be restrained as provided in subsection (d) of this section;

(B) The operator of such vehicle shall secure or cause to be secured in a seat safety belt any passenger eight years of age or older and under sixteen years of age; and

(C) **[**If the operator of such vehicle is under eighteen years of age, such operator and each passenger in such vehicle shall wear such seat safety belt while the vehicle is being operated on any highway.] Nothing in this subsection shall be construed to require passengers to wear seat safety belts while on a bus having a tonnage rating of one ton or more.

Section 2.

Section 54-33m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

The failure of an operator of, or [front seat] passenger in, a private passenger motor vehicle or vanpool vehicle to wear a seat safety belt as required by section 14-100a shall not constitute probable cause for a law enforcement official to conduct a search of such vehicle and its contents.

Agency Legislative Proposal - 2019 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. 10.30.18 DPH Various Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092611_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf **Phone:** (860) 509-7246 **E-mail:** brie.wolf@ct.gov
Lead agency division requesting this proposal: Various
Agency Analyst/Drafter of Proposal: Brie Wolf

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding Various Revisions To The Public Health Statutes
Statutory Reference: Section 1. 19a-6i. School-based health center advisory committee. Members. Duties. Report. Section 2. 22a-478. Eligible water quality projects. Eligible drinking water projects. Project grants. Grant account loans. Section 3. 19a-36g. Food code. Definitions. Section 4. 19a-36l. Inspection violations. Appeal process. Section 5. 19a-493. Initial license and renewal. Prior approval for change in ownership. Multicare institution. Regulations. Section 6. 19a-490. Licensing of institutions. Definitions. Section 7. 20-73a. Charges against licensee, verification, hearing. Grounds for disciplinary action. Appeal. Section 8. 19a-17. Disciplinary action by department, boards and commissions. Section 9. 17b-256. Prescription drug and insurance assistance program for persons with acquired immunodeficiency syndrome or human immunodeficiency virus. Annual report. Enrollment in Medicare Part D. Section 10. 17b-274a. Maximum allowable costs for generic prescription drugs. Implementation of maximum allowable cost list. Section 11. 17b-274c. Voluntary mail order option for maintenance prescription drugs and drugs covered under the Medicare Part D program. Section 12. 17b-274e. Prescription drugs. Utilization of cost-efficient dosages. Section 13. 17b-491c. Rebates for prescription drugs covered under Connecticut AIDS drug assistance program and state medical assistance programs. Calculation of unit rebate amounts. Contracts for supplemental rebates. Pharmaceutical manufacturers' participation in program. Rebates for new drugs. Payment for medically necessary drugs.

Section 14. (NEW)
Section 15. 19a-14b. Radon mitigators, diagnosticians and testing companies. Regulations.
Section 16. 19a-37b. Regulations establishing radon measurement requirements and procedures for evaluating radon in indoor air and reducing radon in public schools.
Section 17. 19a-495a. Unlicensed assistive personnel in residential care homes. Certification re administration of medication. Regulations. Nonnursing duties.
Section 18. 19a-562b. Staff training and education on Alzheimer's disease and dementia symptoms and care.
Section 19. 19a-902. Dual licensure program for providers of mental health services and substance abuse services. Drug testing at facilities licensed by Department of Public Health. Regulations.
Section 20. 20-262. Schools for instruction. Approval. Change of location or ownership. Minimum curriculum requirements.
Section 21. 19a-177. Duties of commissioner.
Section 22. 4-67x. Child Poverty and Prevention Council established. Duties. Ten-year plan. Prevention goals, recommendations and outcome measures. Protocol for state contracts. Agency reports. Council report to General Assembly. Termination of council.
Section 23. 19a-6q. Chronic disease plan. Report.
Section 24. Repealers.

Proposal Summary:

Section 1. Transfers the authority for appointing School Based Health Center Advisory Committee members to the Commissioner of Public Health if a seat is vacant for one year. Additionally, the report of the Advisory Committee will be filed every other year instead of annually.

Section 2. Removes the requirement that the Commissioner of Public Health declare a public drinking water supply emergency in order for the Commissioner to make a Drinking Water State Revolving Fund (DWSRF) loan without regard to the priority list. Instead, it authorizes the Commissioner to make a DWSRF loan if there is an emergency including, but not limited to, an unanticipated infrastructure failure, a contamination of water or a shortage of water, which requires that the eligible drinking water project be undertaken immediately to protect the public health and safety.

Sections 3 and 4. Make technical corrections to model food code.

Section 5. Extends the timeframe from 90 to 120 days for a nursing home to submit to background check when there is a change in ownership.

Section 6. Defines “satellite” units that are referenced within a multicare institution license.

Section 7. Modifies the grounds for disciplinary action to be taken against physical therapists to better conform to disciplinary statutes for other healthcare professions.

Section 8. Includes the voluntary surrender of a license in another state as grounds for reciprocal disciplinary action in Connecticut.

Sections 9-14. Codify the transition of the Connecticut Aids Drug Assistance Program (CADAP) from DSS to DPH.

Sections 15-20. Make adoption of regulations permissive or repeal the need to adopt regualtions.

Sections 21 and 22. Repeal outdated reporting requirements.

Section 23. Modifies a reporting requirement.

Section 24. Repealers.

PROPOSAL BACKGROUND

- ◊ **Reason for Proposal**

Section 1. Long standing seat vacancies on the School Based Health Center Advisory Committee have existed for several years, and have been cited by the Auditors of Public Accounts in their annual report of findings. These seats were to be appointed by specific legislative authorities. Due to the diminished membership, there has been difficulty in obtaining a quorum for meetings; resulting in rescheduling. This proposal will allow the Commissioner of Public Health to make the appointment if the seat is vacant for one year or more. The Advisory Committee meets quarterly, making an annual report based on four meetings impractical. The annual report has been filed late in the last two years, and has contained some of the same information for several years in a row. The proposal will make the report more meaningful, and will give the Advisory Committee more time to address the issues with which it is charged.

Section 2. This proposal will enable the Commissioner of Public Health to act more quickly to address emergency situations. This spring, private wells in a community in Glastonbury were found to have extremely high levels of uranium. Staff from the Drinking Water Section and Private Wells Program met with a legislator, the impacted constituents and the towns of Glastonbury and Manchester to devise a solution, which involved connecting into an existing public water system. The Commissioner would have had to declare a public drinking water supply emergency in order for DWSRF funds to be used for this new project. Residents would

have had to wait until the 2019 legislative session for bonding money to be appropriated to the DWSRF for use for this project.

Sections 3 and 4. In Section 20 of Public Act 18-168, the Department amended CGS 19a-36g to change the definition of classes 1, 2, 3, and 4 food establishments. This proposal offers technical corrections to the definition of a class 2 food establishment. Discrepancies were noted when local health departments reclassified the food establishments within their jurisdiction. If not revised, there would be inconsistencies in the way local health departments classify their food establishments, and may create issues for chain food establishments.

The Department failed to amend CGS 19a-36/ in Public Act 18-168 to address food inspections and appeals. This proposal offers a technical correction to change the term "food service establishment" to "food establishment". This modification will allow all food establishments to appeal an order.

Section 5. Notice of any proposed change of ownership for nursing homes must be given to the Department at least ninety days prior to the effective date of the change. The change of ownership process involves many elements including criminal background checks. In accordance with CGS 19a491b(c), the statute requires each initial applicant to submit to state and national criminal history record checks. Such record check is accomplished through fingerprint checks. The process is done either with live scan or ink and roll and can take up to four months for the results to be returned to the DPH. Extending the time frame from 90 days to 120 days will better align with the average processing time that the required fingerprinting is taking and will prepare the potential owners for any unanticipated delays with the criminal background check process which may lead to the delay.

Section 6. Hospitals and behavioral health facilities are classified as multicare institutions and as such are permitted by regulation to add a satellite to their license. Often times, a multicare institution will not list all satellites on their license application, and the Department does not have a good inventory of the physical locations where they provide services. For example, several hospitals have ambulatory surgical centers that could be independently licensed, but because they are a provider based entity using the hospital's billing number, they elect to list the entity as a satellite of the hospital. This change will allow the Department to have a better idea of where services are bring provided, and may increase transparency around billing fees for the patient when services are rendered.

Section 7. It was discovered that reasons for disciplinary action to be taken for a physical therapist were not aligned with other professions. The basis for discipline fails to acknowledge, in part, potential impairment by a practitioner. The proposed technical amendment better

aligns the disciplinary language for physical therapists with that almost uniformly provided for in other healthcare professions and will better protect the public health and safety.

Section 8. This revision would include the voluntary surrender of a license in another state among the actions for which the Department and/or a Board in Connecticut could take reciprocal disciplinary action.

Sections 9-14. Section 72 of Public Act 18-168 allowed the Department of Public Health to select another contractor to implement the Connecticut AIDS Drug Assistance Program (CADAP) program and Connecticut Insurance Premium Assistance Program (CIPA). The Department's contractor for this program was the Department of Social Services who subcontracted the services. The CADAP is a pharmaceutical assistance program that pays for medications approved by the U.S. Food and Drug Administration to treat HIV and HIV-related conditions. The CIPA is a health insurance premium assistance program for eligible CADAP clients with private insurance obtained through the Affordable Care Act (ACA), an employer, or COBRA. Health insurance plans must offer drug coverage that is comparable to the CADAP formulary and must provide comprehensive primary care services. Both of the federally-funded programs have substantial, detailed reporting and auditing requirements, which DPH is responsible for meeting. The obligations created by these requirements were increasingly challenging to manage through the DPH-DSS model. These sections formalize the change made last session.

Sections 15-20. The Auditors of Public Accounts' Report for SFYs 16-17 outlined a series of statutorily mandated regulations that have not yet been adopted. Many of these regulations are still in the drafting phase. These sections make the adoption of the regulations permissive so that the Department is not cited for, "Lack of Adoption of State Regulations". Section 20 repeals the regulation requirement since a curriculum has been adopted by the Department and Board.

Sections 21 and 22. Subparagraph (B) of subdivision (8) of CGS 19a-177 requires the Commissioner of Public Health to report on a number of emergency medical services data. Subdivision 10 of 19a-177 requires a report to be submitted on many of the same items, and is no longer necessary because of the language in subparagraph (B) of subdivision (8).

Additionally, CGS 4-67x requires budgeted state agencies that provide prevention services to children to report the following on at least two prevention services: (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) a description of performance-based standards and outcomes included in relevant contracts, and (D) any performance-based vendor accountability protocols. These reports were statutorily created when the Child Poverty and Prevention Council was still in existence. Since

the Council terminated on June 30, 2015, we do not see the need to provide such reports; particularly with a dwindling staff and resources.

Section 23. The Auditors of Public Accounts cited the Department for not submitting the report required pursuant to CGS 19a-6q. Instead of repealing the reporting requirement entirely, the Department proposes to amend the statute to align the reporting with the Centers for Disease Control and Prevention (CDC) 6/18 Initiative. This initiative has identified the six top high-burden health conditions that have effective interventions that can improve health and control health care costs.

Section 24. Repeals the following statutes:

19a-89d, which requires the Department to create a report card on nurse staffing and patient care data. The Department no longer has the staff to complete this task and recommends repeal.

19a-7b, which establishes a Health Care Access Commission to develop the design, administrative, actuarial and financing details of program initiatives necessary to assure the availability of appropriate health care to all Connecticut residents, regardless of their ability to pay. Such a program has been designed through the health insurance exchange and is monitored by the Lieutenant Governor's Health Care Cabinet. Therefore, the Department recommends repeal.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

Click here to enter text.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Mike Carone
Date Contacted: 10/5/18

Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: State Department of Education **Agency Contact (*name, title, phone*):** Laura Stefon **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Mental Health and Addiction Services **Agency Contact (*name, title, phone*):** Mary Kate Mason **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Children and Families **Agency Contact (*name, title, phone*):** Josh Howroyd **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.

Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Consumer Protection **Agency Contact (*name, title, phone*):** Leslie O'Brien **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Public Utilities Regulatory Authority **Agency Contact (*name, title, phone*):** Nick Neeley **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: University of Connecticut Health Center / John Dempsey Hospital **Agency Contact (*name, title, phone*):** Andrea Keilty **Date Contacted:** 10/5/18 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact None

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Section 1. Ensures compliance with existing statute and with state auditing. Ensures quorum needed for meetings.

Section 2. Allows staff to quickly address pressing issues such as contamination of drinking water supplies.

Sections 3 and 4. The Food Protection Program will be able to provide standardized training and guidance documents regarding classification of food establishments resulting in consistent application of the statute by local health departments and consistent regulatory requirements for the food industry.

Section 5. Streamlines nursing home change of ownership application processing for staff.

Section 6. Provides clarity to facilities licensing staff on where health care services are being provided.

Section 7. Provides uniformity in DPH disciplinary actions, and simplifies DPH's investigative processes.

Section 8. Allows regulatory staff to avoid investigation into misconduct when licensee surrenders license in another state to avoid additional discipline.

Sections 9-14. Makes statutory authority over these programs clear.

Sections 15-20. Provides staff more to time get regulations approved.

Sections 21 and 22. Alleviate staff from performing unnecessary reporting requirement.

Section 23. Makes achieving tis reporting requirement feasible.

Section 24. Alleviates staff from performing tasks that we are unable to accomplish within existing resources or that are outdated.

Insert language here

Section 1.

Section 19a-6i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) There is established a school-based health center advisory committee for the purpose of advising the Commissioner of Public Health, on matters relating to (1) statutory and regulatory changes to improve health care through access to school-based health centers and expanded school health sites, (2) minimum standards for the provision of services in school-based health centers and expanded school health sites to ensure that high quality health care services are provided in school-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, and (3) other topics of relevance to the school-based health centers and expanded school sites, as requested by the commissioner.

(b) The committee shall be composed of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall be a family advocate or a parent whose child utilizes school-based health center services;

(2) One appointed by the president pro tempore of the Senate, who shall be a school nurse;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of a school-based health center that is sponsored by a community health center;

(4) One appointed by the majority leader of the Senate, who shall be a representative of a school-based health center that is sponsored by a nonprofit health care agency;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of a school-based health center that is sponsored by a school or school system;

(6) One appointed by the minority leader of the Senate, who shall be a representative of a school-based health center that does not receive state funds;

(7) Two appointed by the Governor, one each of whom shall be a representative of the Connecticut Chapter of the American Academy of Pediatrics and a representative of a school-based health center that is sponsored by a hospital;

(8) Three appointed by the Commissioner of Public Health, one of whom shall be a representative of a school-based health center that is sponsored by a local health department, one of whom shall be from a municipality that has a population of at least fifty thousand but less than one hundred thousand and that operates a school-based health center and one of whom shall be from a municipality that has a population of at least one hundred thousand and that operates a school-based health center;

(9) The Commissioner of Public Health, or the commissioner's designee;

(10) The Commissioner of Social Services, or the commissioner's designee;

(11) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(12) The Commissioner of Education, or the commissioner's designee;

(13) The Commissioner of Children and Families, or the commissioner's designee;

(14) The executive director of the Commission on Women, Children and Seniors, or the executive director's designee; and

(15) Three school-based health center providers, one of whom shall be the executive director of the Connecticut Association of School-Based Health Centers and two of whom shall be appointed by the board of directors of the Connecticut Association of School-Based Health Centers.

(c) Any appointment that is vacant for at least one year shall be filled by the Commissioner of Public Health. The Commissioner of Public Health shall notify the appointing authority not less than 30 days before making such appointment.

[(c)] (d) The committee shall meet not less than quarterly. On or before January 1, 2014, and [annually] biennially thereafter, the committee shall report, in accordance with the provisions of section 11-4a, on its activities to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education.

[(d)] (e) Administrative support for the activities of the committee may be provided by the Department of Public Health.

Section 2.

Subsection (n) of section 22a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(n) Notwithstanding any provision of sections 22a-475 to 22a-483, inclusive, to the contrary, the Commissioner of Public Health may make a project loan or loans in accordance with the provisions of subsection (j) of this section with respect to an eligible drinking water project without regard to the priority list of eligible drinking water projects if [a public drinking water supply] an emergency exists, [pursuant to section 25-32b,] including, but not limited to, an unanticipated infrastructure failure, a contamination of water, or a shortage of water, which requires that the eligible drinking water project be undertaken immediately to protect the public health and safety.

Section 3.

Section 19a-36g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(1) "Catering food service establishment" means a business that is involved in the (A) sale or distribution of food and drink prepared in bulk in one geographic location for retail service in individual portions in another location, or (B) preparation and service of food in a public or private venue that is not under the ownership or control of the operator of such business;

(2) "Certified food protection manager" means a food employee that has supervisory and management responsibility and the authority to direct and control food preparation and service;

(3) "Class 1 food establishment" means a retail food establishment that does not serve a population that is highly susceptible to food borne illnesses and only offers (A) commercially packaged food in its original commercial package that is time or temperature controlled for safety, or (B) commercially prepackaged, precooked food that is time or temperature controlled for safety and heated, hot held and served in its original commercial package not later than four hours after heating, or (C) food prepared in the establishment that is not time or temperature controlled for safety;

(4) “Class 2 food establishment” means a retail food establishment that does not serve a population that is highly susceptible to food-borne illnesses and offers a limited menu of food that is prepared [,] or cooked and served immediately, or that prepares [and] or cooks food that is time or temperature controlled for safety and may require hot or cold holding, but that does not involve cooling;

(5) "Class 3 food establishment" means a retail food establishment that (A) does not serve a population that is highly susceptible to food-borne illnesses, and (B) offers food that is time or temperature controlled for safety and requires complex preparation, including, but not limited to, handling of raw ingredients, cooking, cooling and reheating for hot holding;

(6) "Class 4 food establishment" means a retail food establishment that serves a population that is highly susceptible to food-borne illnesses, including, but not limited to, preschool students, hospital patients and nursing home patients or residents, or that conducts specialized food processes, including, but not limited to, smoking, curing or reduced oxygen packaging for the purposes of extending the shelf life of the food;

(7) "Cold holding" means maintained at a temperature of forty-one degrees Fahrenheit or below;

(8) "Commissioner" means the Commissioner of Public Health or the commissioner's designee;

(9) "Contact hour" means a minimum of fifty minutes of a training activity;

(10) "Department" means the Department of Public Health;

(11) "Director of health" means the director of a local health department or district health department appointed pursuant to section 19a-200, as amended by this act, or 19a-242, as amended by this act;

(12) "Food code" means the food code administered under section 19a-36h, as amended by this act;

(13) "Food establishment" means an operation that (A) stores, prepares, packages, serves, vends directly to the consumer or otherwise provides food for human consumption, including, but not limited to, a restaurant, catering food service establishment, food service establishment, temporary food service establishment, itinerant food vending establishment, market, conveyance used to transport people, institution or food bank, or (B) relinquishes possession of food to a consumer directly, or indirectly through a delivery service, including, but not limited to, home delivery of grocery orders or restaurant takeout orders or a delivery service that is provided by common carriers. "Food establishment" does not include a vending machine, as defined in section 21a-34, a private residential dwelling in which food is prepared under section 21a-62a or a food manufacturing establishment, as defined in section 21a-151;

(14) "Food inspector" means a director of health, or his or her authorized agent, or a registered sanitarian who has been certified as a food inspector by the commissioner;

(15) "Food inspection training officer" means a certified food inspector who has received training developed or approved by the commissioner and been authorized by the commissioner to train candidates for food inspector certification;

(16) "Food-borne illness" means illness, including, but not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens intoxication and hepatitis A, acquired through the ingestion of a common-source food or water contaminated with a chemical, infectious agent or the toxic products of a chemical or infectious agent;

(17) "Food-borne outbreak" means illness, including, but not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens intoxication and hepatitis A, in two or more individuals, acquired through the ingestion of common-source food or water contaminated with a chemical, infectious agent or the toxic products of a chemical or infectious agent;

(18) "Hot holding" means maintained at a temperature of one hundred thirty-five degrees Fahrenheit or above;

(19) "Itinerant food vending establishment" means a vehicle-mounted, self-contained, mobile food establishment;

(20) "Permit" means a written document issued by a director of health that authorizes a person to operate a food establishment;

(21) "Temporary food service establishment" means a food establishment that operates for a period of not more than fourteen consecutive days in conjunction with a single event or celebration;

(22) "Time or temperature controlled for safety" means maintained at a certain temperature or maintained for a certain length of time, or both, to prevent microbial growth and toxin production; and

(23) "Variance" means a written document issued by the commissioner that authorizes a modification or waiver of one or more requirements of the food code.

Section 4.

Section 19a-36*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

The owner or operator of a food establishment aggrieved by an order to correct any inspection violations identified by the food inspector or to hold, destroy or dispose of unsafe food may appeal such order to the director of health not later than forty-eight hours after issuance of such order. The director of health shall review the request for an appeal and, upon conclusion of the review, may vacate, modify or affirm such order. If affirmed by the director of health, the corrective actions specified by the food inspector shall be so ordered by the director of health. An owner or operator of a food [service] establishment who is aggrieved by the affirmation or modification of an order by the director of health, including, but not limited to, an order to suspend the permit or license to operate the food [service] establishment, may appeal to the department pursuant to section 19a-229. During such appeal, the order shall remain in effect unless the commissioner orders otherwise.

Section 5.

Section 19a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Upon receipt of an application for an initial license, the Department of Public Health, subject to the provisions of section 19a-491a, shall issue such license if, upon conducting a scheduled inspection and investigation, the department finds that the applicant and facilities meet the requirements established under section 19a-495, provided a license shall be issued to or renewed for an institution, as defined in section 19a-490, only if such institution is not otherwise required to be licensed by the state. If an institution, as defined in subsections (b), (d), (e) and (f) of section 19a-490, applies for license renewal and has been certified as a provider of services by the United States Department of Health and Human Services under Medicare or Medicaid programs within the immediately preceding twelve-month period, or if an institution, as defined in subsection (b) of section 19a-490, is currently certified, the commissioner or the commissioner's designee may waive on renewal the inspection and investigation of such facility required by this section and, in such event, any such facility shall be deemed to have satisfied the requirements of section 19a-495 for the purposes of licensure. Such license shall be valid for two years or a fraction thereof and shall terminate on March thirty-first, June thirtieth, September thirtieth or December thirty-first of the appropriate year. A license issued pursuant to this chapter, unless sooner suspended or revoked, shall be renewable biennially (1) after an unscheduled inspection is conducted by the department, and (2) upon the filing by the licensee, and approval by the department, of a report upon such date and containing such information in such form as the department prescribes and satisfactory evidence of continuing compliance with requirements established under section 19a-495. In the case of an institution, as defined in subsection (d) of section 19a-490, that is also certified as a provider under the Medicare program, the license shall be issued for a period not to exceed three years, to run concurrently with the certification period. Except in the case of a multicare institution, each license shall be issued only for the premises and persons named in the application. Such license shall not be transferable or assignable. Licenses shall be posted in a conspicuous place in the licensed premises.

(b) (1) A nursing home license may be renewed biennially after (A) an unscheduled inspection conducted by the department, (B) submission of the information required by section 19a-491a, and (C) submission of evidence satisfactory to the department that the nursing home is in compliance with the provisions of this chapter, the Public Health Code and licensing regulations.

(2) Any change in the ownership of a facility or institution, as defined in subsection [(c)] (o) of section 19a-490, owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten per cent or more of the stock of a corporation which owns, conducts, operates or maintains such facility or institution, shall be subject to prior approval of the department after a scheduled inspection of such facility or institution is conducted by the department, provided such approval shall be conditioned upon a showing by such facility or institution to the commissioner that it has complied with all requirements of this chapter, the regulations relating to licensure and all applicable requirements of the Public Health Code. Any such change in ownership or beneficial ownership resulting in a transfer to a person related by blood or marriage to such an owner or beneficial owner shall not be subject to prior approval of the department unless: (A) Ownership or beneficial ownership of ten per cent or more of the stock of a corporation, partnership or association which owns, conducts, operates or maintains more than one facility or institution is transferred; (B) ownership or beneficial ownership is transferred in more than one facility or institution; or (C) the facility or institution is the subject of a pending complaint, investigation or licensure action. If the facility or institution is not in compliance, the commissioner may require the new owner to sign a consent order providing reasonable assurances that the violations shall be corrected within a specified period of time. Notice of any such proposed change of ownership shall be given to the department at least [ninety] one hundred and twenty days prior to the effective date of such proposed change. For the purposes of this subdivision, "a person related by blood or marriage" means a parent, spouse, child, brother, sister, aunt, uncle, niece or nephew. For the purposes of this subdivision, a change in the legal form of the ownership entity, including, but not limited to, changes from a corporation to a limited liability company, a partnership to a limited liability partnership, a sole proprietorship to a corporation and similar changes, shall not be considered a change of ownership if the beneficial ownership remains unchanged and the owner provides such information regarding the change to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution. For the purposes of this subdivision, a public offering of the stock of any corporation that owns, conducts, operates or maintains any such facility or institution shall not be considered a change in ownership or beneficial ownership of such facility or institution if the licensee and the officers and directors of such corporation remain unchanged, such public offering cannot result in an individual or entity owning ten per cent or more of the stock of such corporation, and the owner provides such information to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution.

(c) (1) A multicare institution may, under the terms of its existing license, provide behavioral health services or substance use disorder treatment services on the premises of more than one facility, at a satellite unit or at another location outside of its facilities or satellite units that is acceptable to the patient receiving services and is consistent with the patient's assessment and treatment plan.

(2) Any multicare institution that intends to offer services at a satellite unit or other location outside of its facilities or satellite units shall submit an application for approval to offer services at such location to the Department of Public Health. Such application shall be submitted on a form and in the manner prescribed by the Commissioner of Public Health. Not later than forty-five days after receipt of such application, the commissioner shall notify the multicare institution of the approval or denial of such application. If the satellite unit or other location is approved, that satellite unit or location shall be deemed to be licensed in accordance with this section and shall comply with the applicable requirements of this chapter and regulations adopted under this chapter.

(3) A multicare institution that is a hospital providing outpatient behavioral health services or other health care services shall provide the Department a list of satellite locations when completing the initial or renewal licensure application.

[(3)] (4) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this subsection. The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this subsection while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Section 6.

Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, health care facility for the handicapped, nursing home facility, home health care agency, homemaker-home health aide agency, behavioral health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, outpatient clinic, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for persons with intellectual disability licensed pursuant to section

17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability;

(b) “Hospital” means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(c) “Residential care home” or “rest home” means a community residence that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry and may qualify as a setting that allows residents to receive home and community-based services funded by state and federal programs;

(d) “Home health care agency” means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

(e) “Homemaker-home health aide agency” means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

(f) “Homemaker-home health aide services” as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state of Connecticut;

(g) “Behavioral health facility” means any facility that provides mental health services to persons eighteen years of age or older or substance use disorder services to persons of any age in an outpatient treatment or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues;

(h) “Alcohol or drug treatment facility” means any facility for the care or treatment of persons suffering from alcoholism or other drug addiction;

(i) “Person” means any individual, firm, partnership, corporation, limited liability company or association;

(j) “Commissioner” means the Commissioner of Public Health or the commissioner's designee;

(k) “Home health agency” means an agency licensed as a home health care agency or a homemaker-home health aide agency;

(l) “Assisted living services agency” means an agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable;

(m) “Outpatient clinic” means an organization operated by a municipality or a corporation, other than a hospital, that provides (1) ambulatory medical care, including preventive and health promotion services, (2) dental care, or (3) mental health services in conjunction with medical or dental care for the purpose of diagnosing or treating a health condition that does not require the patient's overnight care;

(n) “Multicare institution” means a hospital that provides outpatient behavioral health services or other health care services, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric disabilities, as defined in section 17a-495, or a general acute care hospital that provides outpatient behavioral health services that (1) is licensed in accordance with this chapter, (2) has more than one facility or one or more satellite units owned and operated by a single licensee, and (3) offers complex patient health care services at each facility or satellite unit[;]. For purposes of this subsection, “Satellite” means a location where a segregated unit of services is provided by the multi care institution; and

(o) “Nursing home” or “nursing home facility” means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries.

Section 7.

Subsection (a) of section 20-73a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The Board of Examiners for Physical Therapists shall have jurisdiction to hear all charges of conduct that fails to conform to the accepted standards of the practice of physical therapy brought against any person licensed as a physical therapist or physical therapist assistant and, after holding a

hearing, written notice of which shall be given to the person complained of, the board, if it finds such person to be guilty, may revoke or suspend such person's license or take any of the actions set forth in section 19a-17. [Any proceedings relative to such action may be begun by the filing of written charges with the Commissioner of Public Health. The causes for which such action may be taken are as follows] Conduct which fails to conform to the accepted standards of the practice of physical therapy includes, but is not limited to, the following: (1) Conviction in a court of competent jurisdiction, either within or without this state, of any crime in the practice of such person's profession; (2) illegal, incompetent or negligent conduct in the practice of physical therapy or in the supervision of a physical therapist assistant; (3) aiding or abetting the unlawful practice of physical therapy; (4) treating human ailments by physical therapy without the oral or written referral by a person licensed in this state or in a state having licensing requirements meeting the approval of the appropriate examining board in this state to practice medicine and surgery, podiatry, naturopathy, chiropractic or dentistry if such referral is required pursuant to section 20-73; (5) failure to register with the Department of Public Health as required by law; (6) fraud or deception in obtaining a license; (7) engaging in fraud or material deception in the course of professional services or activities; (8) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (9) emotional disorder or mental illness; [(8)] (10) failure to comply with the continuing education requirements of section 20-73b; [(9)] (11) violation of any provision of this chapter, or any regulation adopted under this chapter; or [(10)] (12) failure to provide information to the Department of Public Health required to complete a health care provider profile, as set forth in section 20-13j.

Section 8.

Subsection (f) of section 19a-17 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(f) Such board or commission or the department may take disciplinary action against a practitioner's license or permit as a result of the practitioner having been subject to disciplinary action similar to an action specified in subsection (a) or (d) of this section by a duly authorized professional disciplinary agency of any state, a federal governmental agency, the District of Columbia, a United States possession or territory or a foreign jurisdiction. Such board or commission or the department may rely upon the findings and conclusions made by a duly authorized professional disciplinary agency of any state, a federal governmental agency, the District of Columbia, a United States possession or territory or foreign jurisdiction in taking such disciplinary action.

Section 9.

Section 17b-256 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) [The Commissioner of Social Services may administer, within available appropriations, a program providing payment for the cost of drugs prescribed by a physician for the treatment of acquired immunodeficiency syndrome or human immunodeficiency virus. The commissioner, in consultation with the Commissioner of Public Health, shall determine specific drugs to be covered and may implement a pharmacy lock-in procedure for the program. The Commissioner of Social Services shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of this section. The Commissioner of Social Services may implement the program while in the process of adopting regulations, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days of implementation. The regulations may include eligibility for all persons with acquired immunodeficiency syndrome or human immunodeficiency virus whose income is below four hundred per cent of the federal poverty level. Subject to federal approval, the Commissioner of Social Services may, within available federal resources, maintain insurance policies for eligible clients, including, but not limited to, coverage of costs associated with such policies, that provide a full range of human immunodeficiency virus treatments and access to comprehensive primary care services as determined by the commissioner and as provided by federal law, and may provide payment, determined by the commissioner, for (1) drugs and nutritional supplements prescribed by a physician that prevent or treat opportunistic diseases and conditions associated with acquired immunodeficiency syndrome or human immunodeficiency virus; (2) ancillary supplies related to the administration of such drugs; and (3) laboratory tests ordered by a physician. On and after May 26, 2006, any person who previously received insurance assistance under the program established pursuant to section 17b-255 of the general statutes, revision of 1958, revised to 2005, shall continue to receive such assistance until the expiration of the insurance coverage, provided such person continues to meet program eligibility requirements established in accordance with this subsection. On or before March 1, 2007, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations and the budgets of state agencies on the projected availability of funds for the program established pursuant to this section.]

[(b)] Applicants for and recipients of benefits under the Connecticut AIDS drug assistance program [established pursuant to subsection (a) of this section] shall, if eligible, enroll in Medicare Part D. The Commissioner of Social Services may be the authorized representative of such an applicant or recipient for purposes of enrolling in a Medicare Part D plan or submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. The applicant or recipient, prior to selecting a Medicare Part D plan, shall have the opportunity to consult with the commissioner, or the commissioner's designated agent, concerning the selection of a Medicare Part D plan that best meets the prescription drug needs of such applicant or recipient. In the event that such applicant or recipient does not select a Medicare Part D plan within

a reasonable period of time, as determined by the commissioner, the commissioner shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner as such applicant's or recipient's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner. The commissioner may pay the premium and coinsurance costs of Medicare Part D coverage for eligible applicants or recipients.

Section 10.

Section 17b-274a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

The Commissioner of Social Services may establish maximum allowable costs to be paid under the Medicaid [and Connecticut AIDS drug assistance] program[s] for generic prescription drugs based on, but not limited to, actual acquisition costs. The department shall implement and maintain a procedure to review and update the maximum allowable cost list at least annually, and shall report annually to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies on its activities pursuant to this section.

Section 11.

Section 17b-274c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The Commissioner of Social Services may establish a voluntary mail order option for any maintenance prescription drug covered under the Medicaid [or Connecticut AIDS drug assistance] program[s].

(b) Notwithstanding any provision of the general statutes or regulations adopted pursuant thereto, the Commissioner of Social Services may provide a voluntary mail order option, regardless of a mail order pharmacy's location, for any prescription drug covered under the Medicare Part D program established pursuant to Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Section 12.

Section 17b-274e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

A pharmacist, when filling a prescription under the Medicaid [or Connecticut AIDS drug assistance p]Program[s], shall fill such prescription utilizing the most cost-efficient dosage, consistent with the prescription of a prescribing practitioner as defined in section 20-571, unless such pharmacist receives permission to do otherwise pursuant to the prior authorization requirements set forth in sections 17b-274 and 17b-491a.

Section 13.

Section 17b-491c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) On and after February 1, 2008, any pharmaceutical manufacturer of a prescription drug covered by the Department of Social Services under [the Connecticut AIDS drug assistance program or] a state medical assistance program administered by the department that is a federally qualified state pharmacy assistance program shall provide rebates to the department for prescription drugs paid for by the department under such program in unit rebate amounts equal to the unit rebate amounts paid under the Medicaid program.

(b) On and after February 1, 2008, any pharmaceutical manufacturer of a prescription drug covered by the department under a state medical assistance program that is not a federally qualified state pharmacy assistance program shall provide rebates to the department. The unit rebate amount shall be calculated as follows: (1) For noninnovator multiple source drugs, the average manufacturer's price multiplied by eleven per cent, and (2) for single source or innovator drugs, the greater of the average manufacturer's price multiplied by fifteen and one-tenth per cent or the average manufacturer's price minus best price. In the event the calculated rebate would establish a new Medicaid best price, the unit rebate amount will be capped at the average manufacturer's price minus best price.

(c) The department may enter into contracts for supplemental rebates for drugs that are on a preferred drug list or formulary established by the department.

(d) Pharmaceutical manufacturers shall submit written confirmation of participation on a form prescribed by the Commissioner of Social Services that states the terms of participation, including, but not limited to, the process by which a manufacturer may discontinue participation. The department shall provide advance notice to participating manufacturers if a new pharmacy assistance program is established and shall provide the manufacturers with the opportunity to discontinue participation. The department shall promptly notify participating manufacturers if a state pharmacy assistance program becomes disqualified. If a program becomes disqualified and a manufacturer has paid rebates at the rate for a qualified program, the department shall reimburse the manufacturer the amount overpaid as a result of disqualification.

(e) A manufacturer shall not be required to provide a rebate for a prescription drug that is new to the marketplace until the quarter in which the manufacturer has established a Medicaid best price for the product.

(f) No payment shall be made by the department for the prescription drugs of a manufacturer that does not provide rebates to the department pursuant to this section unless a specific drug is determined by the department to be medically necessary for an individual client.

Section 14.

Section 72 of Public Act P.A. 18-168 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

[Notwithstanding the provisions of sections 17b-256, 17b-274a, 17b-274c, 17b-274e and 17b-491c, t] (a) The Department of Public Health may, within available resources, administer the Connecticut Aids drug assistance program and Connecticut Insurance Premium Assistance Program. The department may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided the department posts such policies and procedures on the eRegulations System prior to adopting them. Policies and procedures implemented pursuant to this section shall be valid until regulations are adopted in accordance with chapter 54 of the general statutes.

(b) [Notwithstanding the provisions of sections 17b-256, 17b-274a, 17b-274c, 17b-274e and 17b-491c, a] All rebates and refunds from the Connecticut AIDS drug assistance program and Connecticut Insurance Premium Assistance Program shall be paid to the Department of Public Health.

Section 15.

Section 19a-14b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) For the purposes of this section and sections 20-420 and 20-432, the following terms shall have the following meanings unless the context clearly denotes otherwise:

(1) “Radon diagnosis” means evaluating buildings found to have levels of radon gas that are higher than the guidelines promulgated by this state or the United States Environmental Protection Agency and recommending appropriate remedies to eliminate radon.

(2) “Radon mitigation” means taking steps including, but not limited to, installing ventilation systems, sealing entry routes for radon gas and installing subslab depressurization systems to reduce radon levels in buildings.

(3) “Analytical measurement service providers” means companies or individuals that have their own analysis capability for radon measurement but may or may not offer measurement services directly to the public.

(4) “Residential measurement service providers” means individuals that offer services that include, but are not limited to, detector placement and home inspection and consultation but do not have their own analysis capability and utilize the services of an analytical measurement service provider for their detector analysis.

(5) “Residential mitigation service providers” means individuals that offer services that include, but are not limited to, radon diagnosis or radon mitigation.

(b) The Department of Public Health shall maintain a list of companies or individuals that are included in current lists of national radon proficiency programs that have been approved by the Commissioner of Public Health.

(c) The Department of Public Health [shall] may adopt regulations, in accordance with chapter 54, concerning radon in drinking water that are consistent with the provisions contained in 40 CFR 141 and 142.

Section 16.

Section 19a-37b of the general statutes is repealed and the following is substituted in lieu thereof:

The Department of Public Health [shall] may adopt regulations pursuant to chapter 54 to establish radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated radon gas levels when detected in public schools.

Section 17.

Section 19a-495a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a)(1) The Commissioner of Public Health [shall] may adopt regulations, as provided in subsection (d) of this section, to require each residential care home, as defined in section 19a-490, that admits residents requiring assistance with medication administration, to (A) designate unlicensed personnel

to obtain certification for the administration of medication, and (B) ensure that such unlicensed personnel receive such certification and recertification every three years thereafter.

(2) The regulations shall establish criteria to be used by such homes in determining (A) the appropriate number of unlicensed personnel who shall obtain such certification and recertification, and (B) training requirements, including ongoing training requirements for such certification and recertification.

(3) Training requirements for initial certification and recertification shall include, but shall not be limited to: Initial orientation, resident rights, identification of the types of medication that may be administered by unlicensed personnel, behavioral management, personal care, nutrition and food safety, and health and safety in general.

(b) Each residential care home, as defined in section 19a-490, shall ensure that, on or before January 1, 2010, an appropriate number of unlicensed personnel, as determined by the residential care home, obtain certification and recertification for the administration of medication. Certification and recertification of such personnel shall be in accordance with regulations adopted pursuant to this section. Unlicensed personnel obtaining such certification and recertification may administer medications that are not administered by injection to residents of such homes, unless a resident's physician specifies that a medication only be administered by licensed personnel.

(c) On and after October 1, 2007, unlicensed assistive personnel employed in residential care homes, as defined in section 19a-490, may (1) obtain and document residents' blood pressures and temperatures with digital medical instruments that (A) contain internal decision-making electronics, microcomputers or special software that allow the instruments to interpret physiologic signals, and (B) do not require the user to employ any discretion or judgment in their use; (2) obtain and document residents' weight; and (3) assist residents in the use of glucose monitors to obtain and document their blood glucose levels.

(d) The Commissioner of Public Health [may] shall implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Section 18.

Section 19a-562b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

Each home health agency, residential care home and assisted living services agency, as those terms are defined in section 19a-490, and each licensed hospice care organization operating pursuant to section 19a-122b shall provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter. The Commissioner of Public Health [shall] may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Section 19.

Section 19a-902 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

On or before January 1, 2011, the Department of Public Health, in consultation with the Department of Mental Health and Addiction Services, [shall] may (1) amend the department's substance abuse treatment regulations; (2) implement a dual licensure program for behavioral health care providers who provide both mental health services and substance abuse services; and (3) permit the use of saliva-based drug screening or urinalysis when conducting initial and subsequent drug screenings of persons who abuse substances other than alcohol at facilities which are licensed by the Department of Public Health.

Section 20.

Section 20-262 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) Schools for instruction in hairdressing and cosmetology may be established in this state. All applicants for a license as a registered hairdresser shall have graduated from a school of hairdressing approved by the board with the consent of the Commissioner of Public Health. All hairdressing schools may be inspected regarding their sanitary conditions by the Department of Public Health whenever the department deems it necessary and any authorized representative of the department shall have full power to enter and inspect the school during usual business hours. If any school, upon inspection, is found to be in an unsanitary condition, the commissioner or his designee shall make written order that such school be placed in a sanitary condition.

(b) (1) Schools for instruction in hairdressing and cosmetology shall obtain approval pursuant to this section prior to commencing operation. In the event that an approved school undergoes a change of ownership or location, such approval shall become void and the school shall apply for a new approval pursuant to this section. Applications for such approval shall be on forms prescribed by the commissioner. In the event that a school fails to comply with the provisions of this subsection, no

credit toward the fifteen hundred hours of study required pursuant to section 20-252 shall be granted to any student for instruction received prior to the effective date of school approval.

(2) The Commissioner of Public Health, in consultation with the Connecticut Examining Board for Barbers, Hairdressers and Cosmeticians, [shall adopt regulations, in accordance with the provisions of chapter 54, to prescribe minimum curriculum requirements for hairdressing and cosmetology schools. The commissioner, in consultation with said board, may] shall adopt a curriculum and procedures for the approval of hairdressing and cosmetology schools. Such curriculum shall be posted on the Department's Internet website. [provided the commissioner prints notice of intent to adopt regulations concerning the adoption of a curriculum and procedures for the approval of hairdressing and cosmetology schools in the Connecticut Law Journal not later than thirty days after the date of implementation of such curriculum and such procedures. The curriculum and procedures implemented pursuant to this section shall be valid until such time final regulations are adopted.]

Section 21.

Section 19a-177 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

The commissioner shall: (1) With the advice of the Office of Emergency Medical Services established pursuant to section 19a-178 and of an advisory committee on emergency medical services and with the benefit of meetings held pursuant to subsection (b) of section 19a-184, adopt every five years a state-wide plan for the coordinated delivery of emergency medical services;

(2) License or certify the following: (A) Ambulance operations, ambulance drivers, emergency medical services personnel and communications personnel; (B) emergency room facilities and communications facilities; and (C) transportation equipment, including land, sea and air vehicles used for transportation of patients to emergency facilities and periodically inspect life saving equipment, emergency facilities and emergency transportation vehicles to ensure state standards are maintained;

(3) Annually inventory emergency medical services resources within the state, including facilities, equipment, and personnel, for the purposes of determining the need for additional services and the effectiveness of existing services;

(4) Review and evaluate all area-wide plans developed by the emergency medical services councils pursuant to section 19a-182 in order to insure conformity with standards issued by the commissioner;

(5) Not later than thirty days after their receipt, review all grant and contract applications for federal or state funds concerning emergency medical services or related activities for conformity to policy guidelines and forward such application to the appropriate agency, when required;

(6) Establish such minimum standards and adopt such regulations in accordance with the provisions of chapter 54, as may be necessary to develop the following components of an emergency medical service system: (A) Communications, which shall include, but not be limited to, equipment, radio frequencies and operational procedures; (B) transportation services, which shall include, but not be limited to, vehicle type, design, condition and maintenance, and operational procedures; (C) training, which shall include, but not be limited to, emergency medical technicians, communications personnel, paraprofessionals associated with emergency medical services, firefighters and state and local police; and (D) emergency medical service facilities, which shall include, but not be limited to, categorization of emergency departments as to their treatment capabilities and ancillary services;

(7) Coordinate training of all personnel related to emergency medical services;

(8) (A) Develop an emergency medical services data collection system. Each emergency medical service organization licensed or certified pursuant to chapter 386d shall submit data to the commissioner, on a quarterly basis, from each licensed ambulance service, certified ambulance service or paramedic intercept service that provides emergency medical services. Such submitted data shall include, but not be limited to: (i) The total number of calls for emergency medical services received by such licensed ambulance service, certified ambulance service or paramedic intercept service through the 9-1-1 system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, required for each such call; (iii) the response time for each licensed ambulance service, certified ambulance service or paramedic intercept service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls, both made and received, during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The data required under this subdivision may be submitted in any written or electronic form selected by such licensed ambulance service, certified ambulance service or paramedic intercept service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service, certified ambulance service or paramedic intercept service in approving such written or electronic form. The commissioner may conduct an audit of any such licensed ambulance service, certified ambulance service or paramedic intercept service as the commissioner deems necessary in order to verify the accuracy of such reported data.

(B) On or before December 31, 2018, and annually thereafter, the commissioner shall prepare a report to the Emergency Medical Services Advisory Board, established pursuant to section 19a-178a, that shall include, but not be limited to, the following data: (i) The total number of calls for

emergency medical services received during the reporting year by each licensed ambulance service, certified ambulance service or paramedic intercept service; (ii) the level of emergency medical services required for each such call; (iii) the name of the provider of each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service, certified ambulance service or paramedic intercept service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179; and (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year. The commissioner shall prepare such report in a format that categorizes such data for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications.

(C) If any licensed ambulance service, certified ambulance service or paramedic intercept service does not submit the data required under subparagraph (A) of this subdivision for a period of six consecutive months, or if the commissioner believes that such licensed ambulance service, certified ambulance service or paramedic intercept service knowingly or intentionally submitted incomplete or false data, the commissioner shall issue a written order directing such licensed ambulance service, certified ambulance service or paramedic intercept service to comply with the provisions of subparagraph (A) of this subdivision and submit all missing data or such corrected data as the commissioner may require. If such licensed ambulance service, certified ambulance service or paramedic intercept service fails to fully comply with such order not later than three months from the date such order is issued, the commissioner (i) shall conduct a hearing, in accordance with chapter 54, at which such licensed ambulance service, certified ambulance service or paramedic intercept service shall be required to show cause why the primary service area assignment of such licensed ambulance service, certified ambulance service or paramedic intercept service should not be revoked, and (ii) may take such disciplinary action under section 19a-17 as the commissioner deems appropriate.

(D) The commissioner shall collect the data required by subparagraph (A) of this subdivision, in the manner provided in said subparagraph, from each emergency medical service organization licensed or certified pursuant to this chapter. Any such emergency medical service organization that fails to comply with the provisions of this section shall be liable for a civil penalty not to exceed one hundred dollars per day for each failure to report the required data regarding emergency medical services provided to a patient, as determined by the commissioner. The civil penalties set forth in this subparagraph shall be assessed only after the department provides a written notice of deficiency and the organization is afforded the opportunity to respond to such notice. An organization shall have not more than fifteen business days after the date of receiving such notice to provide a written response to the department. The commissioner may adopt regulations, in accordance with chapter 54, concerning the development, implementation, monitoring and collection of emergency medical service system data. All state agencies licensed or certified as emergency medical service organizations shall be exempt from the civil penalties set forth in this subparagraph;

(E) The commissioner shall, with the recommendation of the Connecticut Emergency Medical Services Advisory Board established pursuant to section 19a-178a, adopt for use in trauma data collection the most recent version of the National Trauma Data Bank's National Trauma Data Standards and Data Dictionary and nationally recognized guidelines for field triage of injured patients.

(9) (A) Establish rates for the conveyance and treatment of patients by licensed ambulance services and invalid coaches and establish emergency service rates for certified ambulance services and paramedic intercept services, provided (i) the present rates established for such services and vehicles shall remain in effect until such time as the commissioner establishes a new rate schedule as provided in this subdivision, and (ii) any rate increase not in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, filed in accordance with subparagraph (B)(iii) of this subdivision shall be deemed approved by the commissioner. For purposes of this subdivision, licensed ambulance service shall not include emergency air transport services.

(B) Adopt regulations, in accordance with the provisions of chapter 54, establishing methods for setting rates and conditions for charging such rates. Such regulations shall include, but not be limited to, provisions requiring that on and after July 1, 2000: (i) Requests for rate increases may be filed no more frequently than once a year, except that, in any case where an agency's schedule of maximum allowable rates falls below that of the Medicare allowable rates for that agency, the commissioner shall immediately amend such schedule so that the rates are at or above the Medicare allowable rates; (ii) only licensed ambulance services, certified ambulance services and paramedic intercept services that apply for a rate increase in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, and do not accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall be required to file detailed financial information with the commissioner, provided any hearing that the commissioner may hold concerning such application shall be conducted as a contested case in accordance with chapter 54; (iii) licensed ambulance services, certified ambulance services and paramedic intercept services that do not apply for a rate increase in any year in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, or that accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall, not later than the last business day in August of such year, file with the commissioner a statement of emergency and nonemergency call volume, and, in the case of a licensed ambulance service, certified ambulance service or paramedic intercept service that is not applying for a rate increase, a written declaration by such licensed ambulance service, certified ambulance service or paramedic intercept service that no change in its currently approved maximum allowable rates will occur for the rate application year; and (iv) detailed financial and operational information filed by licensed ambulance services, certified ambulance services and paramedic intercept services to support a request for a

rate increase in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, shall cover the time period pertaining to the most recently completed fiscal year and the rate application year of the licensed ambulance service, certified ambulance service or paramedic intercept service.

(C) Establish rates for licensed ambulance services, certified ambulance services or paramedic intercept services for the following services and conditions: (i) “Advanced life support assessment” and “specialty care transports”, which terms have the meanings provided in 42 CFR 414.605; and (ii) mileage, which may include mileage for an ambulance transport when the point of origin and final destination for a transport is within the boundaries of the same municipality. The rates established by the commissioner for each such service or condition shall be equal to (I) the ambulance service's base rate plus its established advanced life support/paramedic surcharge when advanced life support assessment services are performed; (II) two hundred twenty-five per cent of the ambulance service's established base rate for specialty care transports; and (III) “loaded mileage”, as the term is defined in 42 CFR 414.605, multiplied by the ambulance service's established rate for mileage. Such rates shall remain in effect until such time as the commissioner establishes a new rate schedule as provided in this subdivision;

[(10) Research, develop, track and report on appropriate quantifiable outcome measures for the state's emergency medical service system and submit to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on or before July 1, 2002, and annually thereafter, a report on the progress toward the development of such outcome measures and, after such outcome measures are developed, an analysis of emergency medical services system outcomes;]

[(11)] (10) Establish primary service areas and assign in writing a primary service area responder for each primary service area. Each state-owned campus having an acute care hospital on the premises shall be designated as the primary service area responder for that campus;

[(12)] (11) Revoke primary service area assignments upon determination by the commissioner that it is in the best interests of patient care to do so; and

[(13)] (12) Annually issue a list of minimum equipment requirements for ambulances and rescue vehicles based upon current national standards. The commissioner shall distribute such list to all emergency medical service organizations and sponsor hospital medical directors and make such list available to other interested stakeholders. Emergency medical service organizations shall have one year from the date of issuance of such list to comply with the minimum equipment requirements.

Section 22.

Subsection (g) of section 4-67x of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(g) (1) On or before November first of each year from 2006 to 2014, inclusive, each budgeted state agency with membership on the council that provides prevention services to children shall, within available appropriations, report to the council in accordance with this subsection. [On or before November first of each year from 2015 to 2020, inclusive, each budgeted state agency that provides prevention services to children shall, within available appropriations, report to the joint standing committees of the General Assembly having cognizance of matters related to appropriations, human services and children in accordance with this subsection.]

(2) Each agency report shall include at least two prevention services not to exceed the actual number of prevention services provided by the agency. For each prevention service reported by the agency, the agency report shall include (A) a statement of the number of children and families served, (B) a description of the preventive purposes of the service, (C) for reports due after November 1, 2006, a description of performance-based standards and outcomes included in relevant contracts pursuant to subsection (h) of this section, and (D) any performance-based vendor accountability protocols.

Section 23.

Section 19a-6q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(a) The Commissioner of Public Health, in consultation with the Lieutenant Governor, or the Lieutenant Governor's designee, and local and regional health departments, shall, within available resources, develop a plan that is consistent with the Department of Public Health's Healthy Connecticut 2020 health improvement plan and the state healthcare innovation plan developed pursuant to the State Innovation Model Initiative by the Centers for Medicare and Medicaid Services Innovation Center. The commissioner shall develop and implement such plan to: (1) Reduce the incidence of [chronic disease, including, but not limited to, chronic cardiovascular disease, cancer, lupus, stroke, chronic lung disease, diabetes, arthritis or another chronic metabolic disease and the effects of behavioral health disorders] <u>tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy and diabetes</u>; (2) improve chronic disease care coordination in the state; and (3) reduce the incidence and effects of chronic disease and improve outcomes for conditions associated with chronic disease in the state.

(b) The commissioner shall, on or before January 15, 2015, and biennially thereafter, submit a report, in consultation with the Lieutenant Governor or the Lieutenant Governor's designee, in accordance with the provisions of section 11-4a to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning chronic disease and implementation of the

plan described in subsection (a) of this section. The commissioner shall post each report on the Department of Public Health's Internet web site not later than thirty days after submitting such report. [Each report shall include, but need not be limited to: (1) A description of the chronic diseases that are most likely to cause a person's death or disability, the approximate number of persons affected by such chronic diseases and an assessment of the financial effects of each such disease on the state and on hospitals and health care facilities; (2) a description and assessment of programs and actions that have been implemented by the department and health care providers to improve chronic disease care coordination and prevent chronic disease; (3) the sources and amounts of funding received by the department to treat persons with multiple chronic diseases and to treat or reduce the most prevalent chronic diseases in the state; (4) a description of chronic disease care coordination between the department and health care providers, to prevent and treat chronic disease; and (5) recommendations concerning actions that health care providers and persons with chronic disease may take to reduce the incidence and effects of chronic disease.]

Section 24.

Sections 19a-89d and 19a-7b of the general statutes are repealed (*Effective July 1, 2019*).

[Sec. 19a-89d. Nurse staffing and patient care data. The Department of Public Health shall: (1) Develop a single, uniform method for collecting and analyzing standardized data concerning the linkage between nurse staffing levels and the quality of acute care, long-term care and home care, including patient outcomes; (2) conduct an ongoing study of the relationship between nurse staffing patterns in hospitals and the quality of health care, including patient outcomes; (3) obtain relevant licensure and demographic data that may be available from other state agencies and make the data collected under this subsection available to the public in a standardized format; and (4) collaborate with hospitals and the nursing profession with respect to the collection of standardized data concerning patient care outcomes at such hospitals and make such data available to the public in a report card format.]

[Sec. 19a-7b. Health Care Access Commission. (a) There is established a Health Care Access Commission, within the legislative department, which shall be comprised of: (1) The Commissioner of Public Health; (2) the Commissioner of Social Services; (3) the Insurance Commissioner; (4) three members appointed by the president pro tempore of the Senate, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall represent community health centers and one of whom shall represent mental health services; (5) two members appointed by the majority leader of the Senate, one of whom shall represent commercial insurance companies and one of whom shall represent the disabled; (6) three members appointed by the minority leader of the Senate, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies, one of whom shall represent Blue Cross and Blue Shield of Connecticut, Inc. and one of whom shall represent small business; (7) three

members appointed by the speaker of the House of Representatives, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to human services, one of whom shall represent consumers and one of whom shall represent labor; (8) two members appointed by the majority leader of the House of Representatives, one of whom shall represent large business and one of whom shall represent children; and (9) three members appointed by the minority leader of the House of Representatives, one of whom shall be a member of the joint standing committee of the General Assembly having cognizance of matters relating to insurance, one of whom shall represent hospitals and one of whom shall be a pediatric primary care physician. All members of the commission may be represented by designees.

(b) The commission shall develop the design, administrative, actuarial and financing details of program initiatives necessary to attain the goal described in section 19a-7a. The commission shall make recommendations to the General Assembly on any legislation necessary to further the attainment of the goal described in section 19a-7a.

(c) The commission may request from all state agencies such information and assistance as it may require.

(d) The commission may accept any gifts, donations or bequests for any of the purposes of this section and for the achievement of the goal described in section 19a-7a.]