MEMORANDUM

DATE: November 1, 2013

TO: Office of Policy Management Legislative Staff
Governor's Office Legislative Staff

FROM: Jewel Mullen, MD, MPH, MPA, Commissioner
Department of Public Health

RE: Legislative Proposals for the Year 2014 Session

Please find enclosed, for your review a copy of the Department of Public Health's 2013 Legislative Proposals.

My staff and I have carefully analyzed the enclosed proposals and feel that these initiatives, if passed by the General Assembly, will allow the Department to better ensure the quality and delivery of services to the public. The bills we are submitting in order of priority are:

1. An Act Concerning Various Revisions to the Public Health Statutes
2. An Act Amending the Sovereign Immunity Waiver Regarding the Department of Public Health
3. An Act Enabling the Department of Public Health to Contract with Other States
4. An Act Concerning Online Applications and License Renewal
5. An Act Concerning Meningococcal Vaccines for College Students Residing on Campus
6. An Act Concerning The Inspection Of Ambulances
7. An Act Concerning Advanced Emergency Medical Technicians
8. An Act Concerning Streamlining the Takeover Proceedings and Certificates of Public Convenience and Necessity
9. An Act Concerning Medical Orders for Life Sustaining Treatment
10. An Concerning Return of Unexpended Local Health Per-Capita Funds and Proration of Local Health Per-Capita Funds When Towns Join Health Districts
11. An Act Concerning Nursing Facility Management Services
12. An Act Concerning On-Site Breastfeeding In Day Care Facilities
13. An Act Concerning Genealogists' Access to Vital Records Vaults
14. An Act Concerning Reporting Requirements For Radon-Related Disciplines
15. An Act Concerning Electronic Physician Signatures
16. An Act Concerning Penalties for Failure To Comply With A Recall Of Shellfish.
17. An Act Concerning The Freedom of Information Act.

We have forwarded our legislative initiatives to the appropriate administrative agencies. Please let me know if you have any questions or if I can provide you with additional information. I look forward to working with you on this agenda.

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Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Various
Agency Analyst/Drafter of Proposal: Various

Title of Proposal **An Act Concerning Various Revisions To The Public Health Statutes**
Statutory Reference **Sec 1. 19a-493b - Definition of outpatient surgical facility. Licensure and exceptions. Compliance with certificate of need requirements. Dental clinics not subject to section. Waiver of certain licensure regulation requirements.** **Sec 2. 19a-42 - Amendment of vital records.** **Sec 3. 46b-172 - Acknowledgment of paternity and agreement to support; judgment. Review of acknowledgment of paternity.** **Sec 4. 19a-7h - Childhood immunization registry. Regulations.** **Sec 5. 19a-4j - Office of Multicultural Health.** **Sec 6. NEW** **Sec 7. NEW** **Sec 8. 20-482 - Penalty.** **Sec 9. 19a-110 - Report of lead poisoning. Parental notification. Availability of information regarding lead poisoning.** **Sec 10. 19a-111 - Investigation. Preventive measures. Relocation of families. Reports. Regulations.** **Sec 11. 19a-111g - Pediatric screening and risk assessment for lead poisoning. Duties of primary care provider. Exemption.** **Sec 12. 19a-111j - Financial assistance to local health departments for lead poisoning prevention and control.** **Sec 13. 19a-77 - "Child day care services" defined. Exclusions. Additional license.** **Sec 14. 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.** **Sec 15. NEW (Suggest 19a-522g)** **Sec 16. 19a-535a - Transfer or discharge of residents. Notice. Plan required. Appeal. Hearing.** **Sec 17. 19a-494a - Emergency summary orders.** **Sec 18. 19a-495 - Regulations re licensed institutions. Implementation of policies and procedures re medications.** **Sec 19. 19a-175 - Definitions.**

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Sec 21. 19a-180 - Licensure and certification of emergency medical service organizations. Suspension or revocation. Records. Penalties. Advertisement. Medical control by sponsor hospital. New or expanded emergency medical services.
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Sec 40. 19a-490k - Administration of care and vaccinations to patients by hospital without physician's order. Permitted activities. Regulations.
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Sec 42 19a-72 Connecticut Tumor Registry. Definitions. Duties of Department of Public Health. Reporting requirements.
Sec 43 - 19a-175 – Definitions
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Sec 45. 19a-29a. - Environmental Laboratories
Sec 46. 20-10b – Continuing medical education: Definitions; contact hours; attestation; record-keeping; exemptions, waivers and extensions; reinstatement of void licenses.
Sec 47. 20-146 – Licensed opticians; examinations, continuing education requirements. Licensure without examination.
Sec 48. 20-188 – Examination; qualifications
Sec 49. 20-195dd – Qualifications
Sec 50. 20-195n – Licensure requirements. License by endorsement.
Sec 51. 20-252 – Licenses. Examinations.
Sec 52. 20-413 – Permitted activities

Repealers:
Sec 53. 19a-179a - Scope of practice of emergency medical technicians and paramedics.

Sec 54. 19a-179d - Implementation of policies and procedures re training, recertification and reinstatement of certification or licensure of emergency medical service personnel.
Sec 55. 19a-195a - Regulations re recertification and state-wide standardization of certification.
Sec 56. 19a-195b - Reinstatement of expired certification. Validity of expired certificate
Sec 57. 19a-197a - Administration of epinephrine.
Sec 58. 19a-121e - AIDS: Task force.
Sec 59. 19a-121f - Grants for programs established for the study or treatment of HIV or AIDS.
Sec 60. 19a-121g - Program of services for AIDS-affected children and youths.
Sec 61. 19a-691 - Anesthesia accreditation.

Proposal Summary - See proposal background.

Please attach a copy of fully drafted bill (required for review)

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. The revision deletes certain statutory references in subsection (c) of section 19a-493b to resolve a conflict with subsection (c) of section 19a-654. The revision also deletes certain statutory references which have been repealed. As currently written, subsection (c) of section 19a-493b exempts outpatient surgical facilities from the reporting requirements outlined in subsection (c) of section 19a-654. However, the data submission requirement contained in subsection (c) of section 19a-654 is necessary for OHCA to complete the state-wide health care facilities and services plan as statutorily mandated by section 19a-634. Additionally, as currently written, subsection (c) of section 19a-493b makes reference to certain statutes that have been repealed.

Sections 2 and 3. This revision will allow parents to voluntarily acknowledge paternity for children who have reached adulthood when there is no other father listed on the birth certificate. At present there is no legal mechanism to establish paternity and list a father on a birth certificate when the registrant named on the certificate has reached the age of 18. Neither Superior Court nor Probate Court has jurisdiction over these matters, and the voluntary process of establishing paternity does not apply to persons over 18. Connecticut General Statute § 46b-160 allows a mother to petition the Superior Court to establish paternity of her child, but only until the child's eighteenth birthday. This proposal will add language to allow the establishment of paternity through a voluntary process.

Section 4. The section would amend the childhood immunization registry statute to allow school nurses "view only" access to Connecticut Immunization Registry Tracking System (CIRTS) that

will enable them to access student immunization records to monitor student compliance to school immunization requirements for school entry. Parents or guardians must provide proof of vaccinations for student entering school for the first time. This includes those entering Kindergarten/first grade as well as students new to the school. Schools are required to report this information to the Department of Public Health Immunization Program. Connecticut school vaccination laws require children who attend public or private schools to be vaccinated for several vaccine preventable diseases. Every year school nurses across the state struggle to meet reporting regulations around school immunization requirements for school entry. They spend countless hours calling parents and health care providers trying to locate immunization record for their students. By having access to CIRTS, the ability to retrieve student immunization records will greatly reduce the amount of time schools nurses spend in following up with health care providers and parents to verify student immunization status and ensure student compliance to school immunization requirements. The National Association of School Nurses (NASN), the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), and the American Immunization Registry Association (AIRA) support school nurse access to state immunization registries as a way to facilitate immunization compliance.

Section 5 - This section makes technical changes to the Office of Multicultural Health Statutes. States have a variety of titles for equivalent state offices. Given the recent emphasis on health equity rather than health disparities at the federal and state levels, several states have changed the title of this office to reflect an emphasis on "outcomes" – that is, health equity, rather than "problems," or health disparities. Within the Department of Public Health, the strategic mapping "Health Equity Definitions" staff working group recommended a name change for the Office in its 2012 final report. The concept of health equity incorporates recognition of social and economic structures that underlie health disparities, whereas the concept of multicultural focuses solely on cultural diversity but not underlying inequality. Health equity more appropriately characterizes the current public health – and social determinants – approach to addressing widespread health disparities in our state. This section changes the name of renamed the current Office of Multicultural Health to the "Office of Health Equity." Also proposed are revisions to other language in the 1998 Public Act to make it consistent with current federal data collection policies and initiatives within the Department of Public Health.

Sections 6 and 7. During the 2012 legislative session, the sections concerning depth of burials, and burial proximity to dwellings that were repealed, removing safeguards for standardized burial practices. This legislative proposal seeks to re-codify sections 53-332 (Burials, proximity to dwelling) and 53-333a (Depth of burial) that were repealed in 2012. The Department recommends restoring these sections, instead to Title 19a, Chapter 368j ("Cemeteries"). Section 6 prohibits burying the body of a deceased person within 350 feet from a house and Section 7 requires that the body of deceased person be buried at least two and a half feet below the surface of the ground, unless the body is buried in a container of impermeable material, in which case it must be buried at least one and a half feet below the surface of the ground.

Burials in cemeteries require sufficient cover to ensure nuisance conditions are avoided and to prevent grave disruptions by animals. Minimum cover requirements for burials have been in statute since they were codified in 1949.

Section 8 – This section increases the penalty for a violation of the lead licensure and

certification statutes from $1,000 penalty per violation to $5,000 penalty per violation per day in accordance with EPA authorization requirements. Connecticut has been authorized by the EPA to administer and enforce a lead-based paint program since June 23, 1998. Lead licensure and certification penalty language needs to revised to reflect a $5,000 penalty per day per violation according to the EPA. We were provided with notice of this minimal fine requirement by the US EPA office. Several consent orders have exceeded the $1,000 limit, because we have authority to issue penalties and fines for practitioners up to $25,000 under CGS 19a-17. The language is outdated and needs to meet the minimal requirements of EPA authorization.

Section 9 - This section revises language associated with 10 ug/dL blood lead levels to reflect new Childhood Lead Poisoning Prevention Screening Advisory Committee guidelines established in March/April 2013 and already being implemented.

Section 10 – This sentence deletes a reference "quarterly reports" which was part of the paper-based system that is no longer used.

Section 11 – This section revises language To clarify "testing" (an actual blood draw) versus "risk assessment" (evaluating the patient's risk by asking questions).

Section 12 - This section adds a paragraph enabling DPH to use unspent funds allocated to local health departments for lead poisoning prevention purposes. The Department intends to use these funds to print materials, develop materials, and assist local health with prevention activities. This will also assist the Department in providing its annual report to the legislature.

Section 13 – This section clarifies that a family day care home falls within the scope of the term "child day care services" as used in section 19a-87a. 19a-77 defines child day care services "(a) As used in sections 19a-77 to 19a-80, inclusive, and sections 19a-82 to 19a-87, inclusive,…" as including family day care. It does not include the use of the term in Conn. General Statutes section 19a-873. This technical change will clarify that a family day care home falls within the scope of the term "child day care services" as used in section 19a-87e.

Section 14 – This section removes the requirement that when Class II land is being sold, leased or assigned that it contain land in Class III.

Section 15 – This section removes the requirement for an annual urinalysis for residents in the nursing home setting. The Department recommends adding this language under new section 19a-522g. Obtaining an annual urinalysis is no longer consistent with the standards of care for residents in the nursing homes. This requirement is located in section 19-13-D8t(n)(1)(A)(ii) of the Department's regulations pertaining to nursing homes. The Department is in the process of reviewing all regulations but until such time as the regulation can be updated, the statute will supersede the regulation.

Section 16 - This proposal would codify the requirements for discharge plans issued by residential care home facilities. The proposed requirements are existing informal guidelines in the Department of Public Health. This proposal specifies the necessary elements of a discharge plan. The proposal would also codify a requirement for the facility to obtain signatures from all relevant parties with regard to discharge planning. In many involuntary discharge cases undertaken in the past years by the Department's Public Health Hearing Office, hearing officers

have had to continually advise facility owners and managers about the details needed to make required discharge plans legally adequate according to 19a-535 and 535a. It is unclear from the current language of 19a-535a what the specifics of the discharge plan should include in order to be legally adequate. Additionally, the Department's Hearing Office has noted confusion over the processes for locating potential placements for residents and how facility administrators are expected to assist the resident during this process. Statutorily clarifying the elements of the discharge plan and its procedures in 19a-535a would assist facility administrators and owners, as well as the appellants and their families, to determine the necessary elements required for discharge.

Section 17 - Current law only allows for the Department to issue summary orders on home health care agencies and homemaker-home health agencies and nursing homes (19a-534). This change will allow the Department to issue emergency summary orders in all institutional settings as defined in 19a-490.

Section 18 - This language will permit waiver authority in all licensed institutions as defined in 19a-490. As healthcare evolves towards a patient-centered model, the Department has identified with some frequency that regulations can be a barrier in support of this model. Currently, statutorily or in regulation, nursing homes and residential care homes have the ability to waive regulation, however other levels of care that include outpatient surgical facilities, home health agencies, or alcohol and drug treatment facilities do not. For example, 19-13-D71. Personnel policies (a) (5)" Physical examination, including tuberculin test and a physician's or his/her designee's statement that the employee is free from communicable diseases, must be prior to assignment to patient care activities". Free from communicable disease is no longer a contemporaneously recognized term and on occasion has caused difficulty for employees to obtain, therefore a waiver from this requirement could be requested. Any facility requesting a waiver would be required to apply in writing to the department. Such application shall include: (A) The specific regulations for which the waiver is requested; (B) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations; (C) The specific relief requested; and (D) Any documentation which supports the application for waiver. In consideration of any application for waiver, the commissioner or his/her designee may consider the following: (A) The level of care provided; (B) The impact of a waiver on care provided; (C) Alternative policies or procedures proposed. The Department reserves the right to request additional information before processing an application for waiver. Additionally, there cannot be any impact to life safety. For example, the Department is currently working on a project with home health agencies and the provision of continuous skilled nursing. The regulations require that each supervisor of clinical services (SCS) provide oversight to 15 Full Time Equivalent (FTE) positions. In a continuous skilled nursing case, there may be five to six FTE's caring for that one individual. In continuous skilled cases it may not be a realistic SCS to FTE ratio. Waiver authority does not exist in the home health regulations. Providing waiver authority to the Department will allow discretion to regulations that may be outdated until they are revised.

Sections 19 through 29 - This proposal will revise chapters 368d (Emergency Medical Services) and chapter 384d (Paramedic licensing). The sections pertaining to the licensing of emergency medical services personnel such as Emergency Medical Technicians, Emergency Medical Services Instructors, Advanced Emergency medical Technicians and Emergency Medical Responders will be removed from chapter 368d and placed into chapter 384d for consistency in

licensing and certification. The language will be updated to coincide with other health care practitioner licensing statutes. Discipline for EMS providers will be added to mirror that of other practitioners. This proposal also repeals the EMS definitions section and alphabetizes them along with creating a new definition for paramedic intercept service. This proposal will also remove the Department's authority to certify management service organizations. The Department is in the process of completing regulations regarding EMS services. When reviewing statutes during the regulation process and the 2013 legislative session the Department realized that the statutes pertaining to the certification of EMS personnel is very fragmented. The proposal takes the language pertaining to licensing emergency medical responders, emergency medical technicians and emergency medical service instructors was taken from different sections in chapter 368d and placed into chapter 384d and updates it to conform with current practice of licensing these entities. This proposal will also conform with current practice for paramedic intercept service by creating a definition for a certified paramedic intercept services and specifically allowing for billing of these services. A certified paramedic intercept service is a non-transport paramedic service that typically "intercepts" with basic level ambulance services to provide advanced level care. The statute 19a-177(9)(A) currently contains language requiring the Commissioner to establish emergency rates for certified ambulance services. The Department has interpreted the legislative intent to include certified paramedic intercept service providers, but requests the language to clearly include these providers. This proposal will also remove the Department's authority to certify management service organizations. Management service organizations are staffing agencies for emergency medical services personnel. They do not provide any regulated EMS service other than to provide personnel, i.e. they are not an emergency response or transport service. The Department does not regulate other healthcare professions' temporary employment or staffing agencies. The healthcare organizations that are contracting with staffing agencies are held responsible for their employees meeting minimum standards and statutory compliance, regardless of their origin, including employees of EMS services. This proposal will eliminate statutory redundancy. The Department also recommends adding the following to the heading of Chapter 384(d) Paramedics: Emergency Medical Responders, Emergency Medical Technicians and Emergency Medical Services Instructor.

Section 30 - This proposal will provide for a definition of Inter-facility Critical Care Transport and "Emergency". The ambulance industry practice of interfacility transfers has evolved with the improvement and advancement of EMS medical training. Due to the advanced and sometimes specialized medical needs of patients, the primary service area responder may not be equipped or trained to a level capable of assuming patient care responsibility. This proposal allows for the selection of interfacility transportation services by the most medically appropriate provider, modernizing the statute and reflecting current industry practice. The proposal also allows limited, local emergency resources to remain within their emergency service area if there is another appropriately trained and equipped ambulance provider available. (Examples: neonatal, balloon pumps, aero-medical transport)

Section 31 - This proposal will mandate ambulance services to have a contingency plan for potential strike activities. The language is similar to section 19a-497 which mandates health care institutions to provide the Department with documentation pertaining to strikes.

Section 32 - This proposal will allow the Department to set rates to allow for the non-emergency transport during a disaster. The EMS in CT is divided into 2 categories: licensed and certified EMS organizations. Current law only allows for the Department to set rates for certified EMS

organizations to bill for an emergency transport only. Some examples of non-emergency transport include: transport of patients from a hospital being evacuated to nursing homes and other hospitals or from a nursing home without power to another nursing home or shelter. The authorization for non-emergency transport will fall under the Department's Forward Movement of Patients Plan and be limited to 7 days at which the certified EMS organization will need to reapply.

Section 33 - This proposal will add a minimum of one hour of mandatory training annually in oral health and oral hygiene techniques for all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents. Oral Health is a vital component to overall health and well-being throughout the lifespan; however it is often an overlooked aspect of an older adult's general health. Advancing age, limited access to routine dental care, inability to maintain good oral hygiene and medications that cause dry mouth put older adults at risk for a number of oral health problems including pain, infection, loose teeth, ill-fitting dentures, severe tooth decay, gum disease and oral cancer. Unfortunately, these problems can result in changes in chewing ability, which can make it more difficult for older adults to consume a healthy diet. Dental caries and periodontal diseases are chronic, progressive bacterial infections and when present, can profoundly diminish quality of life and have an adverse impact on general health. Severe gum disease is associated with chronic disease and other health conditions including diabetes, heart disease, stroke and respiratory disease. However, with routine daily mouth care, these diseases can be prevented and/or controlled. These oral health problems are amplified in older adults residing in nursing home facilities, as physical and cognitive impairments make oral self-care difficult or impossible. Residents of LTC facilities often have difficulty accessing dental treatment services within the nursing home or in the community. Many older adults and their care givers lack the understanding of the importance of good oral health and the impact that poor oral health has on over-all health and well-being. In addition, many care givers have not received adequate training in proper oral hygiene techniques to care for the mouths of others. Failure to prevent or control the progression of oral disease can increase the risk of adverse health outcomes. Data collected during the 2012 oral health status survey of residents of long term care facilities reveal untreated tooth decay is a significant problem for residents of nursing home facilities. Fifty-three percent (53%) of the residents screened had untreated dental decay, which is 2.5 times higher when compared to the national average for adults aged 75 or older. Four percent (4%) required urgent dental care because of pain or infection.

There are two existing statutes in the Connecticut General Statutes which reference the in-service training requirements for nursing home facility staff. These are Sec. 19a -522c, which states nursing home administrators shall ensure staff receives annual in-service training in an area specific to the needs of the patient population at such facility, including patient's fear of retaliation from employees and others; and Sec. 19a-562a, which references training for all licensed and registered direct care staff and nurse's aides to include a minimum of two (2) hours of training in pain recognition and administration of pain management techniques, as well as specific training for Alzheimer's special care units. In addition, a minimum of twelve (12) annual in-service training hours in areas such abuse; fire and safety; infection control and others based on the needs of the facility, is industry standard and that which is assessed during DPH inspections.

The addition of a minimum of one (1) hour of mandatory annual in-service training in oral health and oral hygiene technique would not represent a hardship, but will enhance the personal care

required to be delivered to the residents in these facilities.

Sections 34 – 39 – This proposal would require a license to be obtained by bulk water haulers that supply water to any public water system. Water hauled to a public water system for the purposes of temporarily supplying public water or supplementing a regulated public water system must meet water quality standards of the DPH. Water hauling is not seen as a permanent solution to solving a water supply issue; however the practice does take place across Connecticut for a variety of reasons which include emergency response due to power outage, system mechanical failure, etc. Due to this temporary practice, water hauled to a public water system must be clean and pure in order to protect the public health of the people that will consume the hauled water. The Department has estimated approximately 30 bulk water haulers will be applying for licensure.

Section 40 – This section will delete the word "polysaccharide" from the statutes regarding pneumococcal vaccine administration in a hospital setting. This change will reflect the latest CDC ACIP recommendations issued in October 2012 regarding use of Pneumococcal vaccines for high risk adults that include both the Pneumococcal polysaccharide and the new conjugate vaccine (PCV-13) to protect patients from invasive pneumococcal disease (IPD). By deleting the word polysaccharide, hospitals can vaccinate patients with both pneumococcal vaccines without a physician's order.

Section 41 – This proposal would revise Section 19a-89b(a) by adding a sentence referencing the CT Public Swimming Pool Design Guide as the document to be adhered to when constructing or substantially altering or renovating a public pool in Connecticut. This will ensure standardized design and construction requirements for public pools in order to protect the health and safety of people using the public pool.

Section 42 - The proposal is needed in order to ascertain all pathologic and related testing and diagnostic information required to accession and adequately code reportable tumors. A recent expansion to the required diagnostic and staging information in order to consider a case complete has made the submission of pathology reports critical to cancer surveillance and reporting standards of the National Cancer Institute's SEER Program, which is the primary funding source of the Connecticut Tumor Registry. Several states currently require pathology reports, including Louisiana, New Jersey and New Mexico.

Sections 43 & 44 - This language expressly includes state agencies within the Office of Emergency Medical Services' jurisdiction for certification and licensure. This language will clarify the issue of whether DPH can regulate state agency ambulance services and will provide certainty about the process and substantive requirements for state agencies that operate and maintain such ambulance services.

Section 45 – This section revises section 19a-29a by expanding the meaning of environmental laboratory based on the testing performed, adding to the section the terms analyte and matrix and their corresponding definitions as they pertain to laboratory testing, assigning individual responsibility with regard to environmental laboratory registration and certification for testing, including a public notice clause to identify all the matrices and analytes requiring certification from the Department, and adding new subsections for the Department to have the authority to impose civil penalties. These revisions are necessary to update the statute so as to align it with

the current administration of the Environmental Laboratory Certification Program. The proposal to revise 19a-29a deletes the testing parameters in which certification has no longer been granted and provides the Department with flexibility to certify and regulate additional testing parameters in the future. Additionally, the proposal authorizes the Program to impose a civil penalty for violations associated with Section 19a-29a, or the regulations adopted thereunder.

Section 46 – Physicians who serve on the Connecticut Medical Examining Board or as a medical hearing panelist, or who assist the Department by serving as an expert consultant in reviewing cases are eligible for a waiver of up to ten contact hours of mandatory continuing education. This proposal would allow a designated DPH staff person to grant a waiver in lieu of the Commissioner needing to review and approve each of these individual requests.

Section 47 - Applicants for licensure as an optician who have completed apprenticeship hours outside of CT are currently required to complete additional apprenticeship hours prior to being eligible to sit for the CT licensing examination. This proposal would allow the Department to accept apprenticeship hours completed in another state toward meeting the licensure requirements in CT. If this proposal is not enacted this session, qualified opticians may be unable to obtain a license in CT or would continue to be required to complete additional apprenticeship hours prior to becoming licensed in CT.

Sections 48-50. Out-of-state applicants for licensure as a social worker, marital and family therapist, professional counselor or clinical psychologist who have been in practice in another state without incident for a number of years often have difficulty documenting the required hours of supervised experience required for initial license. This proposal would allow substitution of licensed work experience for individuals with no disciplinary history toward meeting the practice requirements for licensure. Education and examination requirements would remain the same. If this proposal is not enacted this session, qualified mental health practitioners may be unable to obtain a CT license.

Section 51. For the purposes of licensing hairdressers, Sections 20-250 defines a hairdressing student as "any person …who has successfully completed the ninth grade…" Section 20-252 requires that in addition to meeting education, training and examination requirements for licensure, an applicant for a hairdresser license must have "successfully completed the eighth grade." This proposal would amend the requirements to be consistent.

Section 52. This proposal would amend the exemptions from licensure as a speech pathologist to include certain behavioral analysts who are working in the school system to be consistent with other provisions within the General Statutes.

Sections 53-57. 19a-179a, 19a-179d, 19a-195a, 19a-195b, 19a-197a are the EMS personnel statutes that are being moved into Chapter 368d

Section 58. Sec. 19a-121e. AIDS: Task force - There is no longer a need for a Task Force to work with the Department of Public Health in the planning of programs and services for People Living with HIV/AIDS and their families who are affected by it. The task Force was created in the early years of the Epidemic when other planning groups did not exist.

Section 59. 19a-121f. Grants for programs established for the study or treatment of HIV or

AIDS - The Department of Public Health HIV Prevention and Health Care and Support Services Units, develop Requests for Proposals (RFP) approximately every three years to procure HIV Care and Prevention Services based on the availability of state and federal funds. There is not additional funding that can be applied for at the will of programs in need.

Section 60. Sec.19a-121g. Program of services for AIDS-affected children and youths - In 2010, as an outcome of Connecticut's economic situation and budgetary concerns, continued funding for the Program of Services for AIDS-Affected Children and Youth was not approved. Because of the difficult financial limitations confronting the state, this program was officially discontinued effective June 30, 2010 and was not anticipated to be re-funded in the future.

Section 61. Section 19a-691 of the general statutes suggests that it is permissive to administer moderate/deep or general anesthesia in a doctor's office. However, this is not permitted as stated in section 19a-493(b) which only allows an outpatient surgical facility or hospital to perform such procedures. Section 19a-493(b) allows doctor's offices to perform minor surgical procedures using light or moderate sedation.

- **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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Sections 2 and 3:
Agency Name: **Judicial Branch**
Agency Contact (name, title, phone): **Deb Fuller/Stephen Ment**
Date Contacted: October 16, 2013
Approve of Proposal ___ YES ___NO _X_Talks Ongoing

Agency Name: **Probate Administration**
Agency Contact (name, title, phone): **Vincent Russo**
Date Contacted: October 16, 2013
Approve of Proposal ___ YES ___NO _X_Talks Ongoing

Section 4:
Agency Name: **Department of Education**
Agency Contact (name, title, phone): **Sarah Hemingway**
Date Contacted: October 10, 2013

Approve of Proposal _X_ YES ___NO ___Talks Ongoing

Section 13:

Agency Name: **Office of Early Childhood**
Agency Contact (name, title, phone): **Myra Jones-Taylor**
Date Contacted:
Approve of Proposal ___ YES ___NO __X_Talks Ongoing

Section 14:
Agency Name: **Department of Energy and Environmental Protection**
Agency Contact (name, title, phone): **Rob LaFrance**
Date Contacted:
Approve of Proposal ___ YES ___NO __X_Talks Ongoing

Section 14:
Agency Name: **Water Planning Council**
Agency Contact (name, title, phone):
Date Contacted: 08/12/13
Approve of Proposal __X_ YES ___NO ___Talks Ongoing
This proposal originated with the Water Planning Council.

Section 15:
Agency Name: **Department of Social Services**
Agency Contact (name, title, phone): **Heather Rossi**
Date Contacted:
Approve of Proposal _X_ YES ___NO __Talks Ongoing

Sections 43 and 44:
Agency Name: **University of Connecticut Health Center**
Agency Contact (name, title, phone): **Joann Lombardo**
Date Contacted:

Approve of Proposal ___ YES ___NO _X_Talks Ongoing

Sections 43 and 44:
Agency Name: **University of Connecticut**
Agency Contact (name, title, phone): **Gail Garber**
Date Contacted:

Approve of Proposal ___ YES ___NO _X__Talks Ongoing

Sections 43 and 44:
Agency Name: **Department of Developmental Services**
Agency Contact (name, title, phone): Christine Pollio/Rod O'Conner
Date Contacted:

Approve of Proposal ___ YES ___NO _X__Talks Ongoing

Summary of Affected Agency's Comments

- **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)
State: Sections 6 and 7: May have a minor revenue gain if fines are imposed, however previously the statutes had a sufficient deterrent effect so that the fines and jail time have not been necessary. Section 8 – Potential minimal revenue gain. Sections 34-39 – Potential minimal revenue gain. Section 41 – Potential minimal revenue gain.
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 1. Subsection (c) of Section 19a-493b of the general statutes is repealed and the following is substituted in lieu thereof:

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, 19a-632, 19a-644, 19a-645, 19a-646, 19a-649, [19a-654 to 19a-660,

inclusive,] 19a-664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, 19a-678, 19a-681 or 19a-683. Each outpatient surgical facility shall continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638 if the Office of Health Care Access division of the Department of Public Health determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13 or chapter 375, either directly or through a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13 or chapter 375, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13 or chapter 375, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

Section 2. Subsection (d) of section 19a-42 of the general statutes is repealed and the following is substituted in lieu thereof:

(d) (1) Upon receipt of (A) an acknowledgment of paternity executed in accordance with the provisions of subsection (a) of section 46b-172 by both parents of a child born out of wedlock, or (B) a certified copy of an order of a court of competent jurisdiction establishing the paternity of a child born out of wedlock, the commissioner shall include on or amend, as appropriate, such child's birth certificate to show such paternity if paternity is not already shown on such birth certificate, and to change the name of the child under 18 years of age, if so indicated on the acknowledgment of paternity form or within the certified court order as part of the paternity action. If the person subject to a voluntary acknowledgement of paternity is at least eighteen years of age, the department shall also obtain a notarized affidavit from such person, affirming that he or she agrees to the amendments related to the acknowledgment of paternity. To change the name on the birth certificate for an adult child, a certified copy of a court ordered legal name change is required.

Section 3. Subsection (a) of section 46b-172 of the general statutes is repealed and the following is substituted in lieu thereof:

(a)(1) In lieu of or in conclusion of proceedings under section 46b-160, a written acknowledgment of paternity executed and sworn to by the putative father of the child when accompanied by (A) an attested waiver of the right to a blood test, the right to a trial and the right to an attorney, [and] (B) a written affirmation of paternity executed and sworn to by the mother of the child, and (C) if the person subject to the acknowledgment of paternity is at least eighteen years of age, a notarized affidavit affirming consent to the acknowledgment of paternity, shall have the same force and effect as a judgment of the Superior Court. It shall be considered a legal finding of paternity without requiring or permitting judicial ratification, and shall be binding on the person executing the same whether such person is an adult or a minor, subject to subdivision (2) of this subsection. Such acknowledgment shall not be binding unless, prior to the signing of any affirmation or

acknowledgment of paternity, the mother and the putative father are given oral and written notice of the alternatives to, the legal consequences of, and the rights and responsibilities that arise from signing such affirmation or acknowledgment. The notice to the mother shall include, but shall not be limited to, notice that the affirmation of paternity may result in rights of custody and visitation, as well as a duty of support, in the person named as father. The notice to the putative father shall include, but not be limited to, notice that such father has the right to contest paternity, including the right to appointment of counsel, a genetic test to determine paternity and a trial by the Superior Court or a family support magistrate and that acknowledgment of paternity will make such father liable for the financial support of the child until the child's eighteenth birthday. In addition, the notice shall inform the mother and the father that DNA testing may be able to establish paternity with a high degree of accuracy and may, under certain circumstances, be available at state expense. The notices shall also explain the right to rescind the acknowledgment, as set forth in subdivision (2) of this subsection, including the address where such notice of rescission should be sent, and shall explain that the acknowledgment cannot be challenged after sixty days, except in court upon a showing of fraud, duress or material mistake of fact.

Section 4. Subsection (b) of section 19a-7h of the general statutes is repealed and the following is substituted in lieu thereof:

(b) For purposes of this section, "health care provider" means a person who has direct or supervisory responsibility for the delivery of immunization including licensed physicians, nurse practitioners, nurse midwives, school nurses as used in section 10-212, physician assistants and nurses. Each health care provider who has provided health care to a child listed in the registry shall report to the commissioner or his designee sufficient information to identify the child and the name and date of each vaccine dose given to that child or when appropriate, contraindications or exemptions to administration of each vaccine dose. Reports shall be made by such means determined by the commissioner to result in timely reporting. Each health care provider intending to administer vaccines to any child listed on the registry and each parent or guardian of such child shall be provided current information as contained in the registry on the immunization status of the child for the purposes of determining whether additional doses of recommended routine childhood immunizations are needed, or to officially document immunization status to meet state day care or school immunization entry requirements pursuant to sections 10-204a, 19a-79 and 19a-87b and regulations adopted thereunder. Each director of health of any town, city or health district and each school nurse who is required to verify the immunization status for children enrolled in grades Pre-Kindergarten through grade 12 at both public and private schools of any town, city or school district shall be provided with sufficient information on the children who live in his jurisdiction and who are listed on the registry to enable determination of which children are out of compliance with state mandates for immunization for school entry and overdue for scheduled immunizations and to enable provision of outreach to assist in getting each such child vaccinated.

Section 5. Sec. 19a-4j of the general statutes is repealed and the following is substituted in lieu thereof:

(a) There is established, within the Department of Public Health, an Office of [Multicultural Health] Health Equity. The responsibility of the office is to improve the health of all Connecticut residents by [eliminating] working to eliminate differences in disease, disability and death rates among ethnic, racial and [cultural populations] other population groups with adverse health status or outcome. Groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant

status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence.
(b) The department may apply for, accept and expend such funds as may be available from federal, state or other sources and may enter into contracts to carry out the responsibilities of the office.
(c) The office shall support and inform Department of Public Health efforts to:
(1) [With regard to health status:] (A) Monitor the health status of [African Americans; Latinos/Hispanics; Native Americans/Alaskan Natives; and Asians, Native Hawaiians and other Pacific Islanders] Hispanics or Latinos, American Indian or Alaska Natives, Asians, Blacks or African Americans, Native Hawaiians or other Pacific Islanders.; (B) compare the results of the health status monitoring with the health status of [non-Hispanic Caucasians/whites] white, non-Hispanics; and (C) assess the effectiveness of state programs in eliminating differences in health status;
(2) Assess the health education and health resource needs of ethnic, racial and cultural populations listed in subdivision (1) of this subsection; and
(3) [Maintain a directory of, and assist] Assist in development and promotion of[, multicultural and multiethnic] culturally and linguistically appropriate health resources in Connecticut.
(d) The office may:
(1) Provide grants for culturally and linguistically appropriate health [education] demonstration projects and may apply for, accept and expend public and private funding for such projects; and
(2) Recommend policies, procedures, activities and resource allocations to improve health among racial, ethnic and [cultural] other health disparity populations in Connecticut.

Sec 6. (NEW) No person shall bury the body of any deceased person within a distance of three hundred and fifty feet from any dwelling house unless a public highway intervenes between such place of burial and such dwelling house, or unless such body is encased in a lined vault, except in a cemetery established on or before November 1, 1911, or in a plot of land adjacent to such cemetery which has been made a part thereof with the approval in writing of the Commissioner of Public Health. Such approval shall contain a detailed description of the land so annexed and shall be recorded in the land records of the town in which such cemetery is situated. The provisions of this section shall not apply to any cemetery which, when established, was more than three hundred and fifty feet from any dwelling house. Any person who violates any provision of this section shall be fined not more than one hundred dollars per day.

Sec 7. (NEW) No corpse shall be buried in such manner that the top of the outside container within which such corpse is placed is less than two and one-half feet below the surface of the ground, except that, if such container is made of steel, bronze, concrete or other impermeable material, the top of such container shall be not less than one and one-half feet below the surface. Any person who violates the provisions of this section shall be fined not more than one hundred dollars per day.

Sec 8. Section 20-482 of the General Statutes is repealed and the following is substituted in lieu thereof:

Any person or entity who knowingly violates any provision of sections 20-474 to 20-481, including subsections (e) and (f), of section 19a-88 or any regulation adopted thereunder, shall be fined not more than [one] five thousand dollars per violation per day or pursuant to section 19a-17.

Sec 9. Subsection (d) of Section 19a-110 of the general statutes is repealed and the following is substituted in lieu thereof:

(d) The director of health of the town, city or borough shall provide or cause to be provided, to the parent or guardian of a child who is known to have a confirmed venous blood lead level of five micrograms per deciliter or more, or reported[,] pursuant to subsection (a) of this section, with information describing the dangers of lead poisoning, precautions to reduce the risk of lead poisoning, information about potential eligible city for services for children from birth to three years of age pursuant to sections 17a-248 to 17a-248g, inclusive, and laws and regulations concerning lead abatement. The information provided by the health director to the parent or guardian need only be provided after receipt of the initial report of an abnormal body burden of lead in the blood that requires such action, and not repeatedly thereafter. Said information shall be developed by the Department of Public Health and provided to each local and district director of health. With respect to the child reported, the director shall conduct an on-site inspection to identify the source of the lead causing a confirmed venous blood lead level equal to or greater than fifteen micrograms per deciliter but less than twenty micrograms per deciliter in two tests taken at least three months apart and order remediation of such sources by the appropriate persons responsible for the conditions at such source. On and after January 1, 2012, if one per cent or more of children in this state under the age of six report blood lead levels equal to or greater than ten micrograms per deciliter, the director shall conduct such on-site inspection and order such remediation for any child having a confirmed venous blood lead level equal to or greater than ten micrograms per deciliter in two tests taken at least three months apart.

Sec 10. Section 19a-111 of the general statutes is repealed and the following is substituted in lieu thereof:

Upon receipt of each report of confirmed venous blood lead level equal to or greater than twenty micrograms per deciliter of blood, the local director of health shall make or cause to be made an epidemiological investigation of the source of the lead causing the increased lead level or abnormal body burden and shall order action to be taken by the appropriate person or persons responsible for the condition or conditions which brought about such lead poisoning as may be necessary to prevent further exposure of persons to such poisoning. In the case of any residential unit where such action will not result in removal of the hazard within a reasonable time, the local director of health shall utilize such community resources as are available to effect relocation of any family occupying such unit. The local director of health may permit occupancy in said residential unit during abatement if, in his judgment, occupancy would not threaten the health and well-being of the occupants. The local director of health shall, within thirty days of the conclusion of his investigation, report to the Commissioner of Public Health the result of such investigation and the action taken to insure against further lead poisoning from the same source, including any measures taken to effect relocation of families. Such report shall include information relevant to the identification and location of the source of lead poisoning and such other information as the commissioner may require pursuant to regulations adopted in accordance with the provisions of chapter 54. The commissioner shall maintain comprehensive records of all reports submitted pursuant to this section and section 19a-110. Such records shall be geographically indexed in order to determine the location of areas of relatively high incidence of lead poisoning. [The commissioner shall prepare a quarterly summary of such records which he shall keep on file and release upon request.] The commissioner shall establish, in conjunction with recognized professional medical groups, guidelines consistent with the National Centers for Disease Control for assessment of the risk of lead poisoning, screening for lead poisoning and treatment and follow-up care of individuals including children with lead poisoning, women who are pregnant and women who are planning pregnancy. Nothing in this

section shall be construed to prohibit a local building official from requiring abatement of sources of lead.

Sec 11. Section 19a-111g of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each primary care provider giving pediatric care in this state, excluding a hospital emergency department and its staff: (1) Shall conduct lead [screening] testing at least annually for each child nine to thirty-five months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee recommendations for childhood lead screening in Connecticut; (2) shall conduct lead [screening] testing for any child thirty-six to seventy-two months of age, inclusive, who has not been previously [screened] tested or for any child under seventy-two months of age, if clinically indicated as determined by the primary care provider in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee recommendations for childhood lead screening in Connecticut; (3) During the medical appointment at which a child under 72 months of age must be tested for lead, the primary care provider shall also provide educational materials or anticipatory guidance on lead poisoning prevention to the parent or guardian of the child in accordance with the Childhood Lead Poisoning Prevention Screening Advisory recommendations for childhood lead screening in Connecticut; [(3)] (4) shall conduct a medical risk assessment at least annually for each child thirty-six to seventy-one months of age, inclusive, in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee recommendations for childhood lead screening in Connecticut; [(4)] (5) may conduct a medical risk assessment at any time for any child thirty-six months of age or younger who is determined by the primary care provider to be in need of such risk assessment in accordance with the Childhood Lead Poisoning Prevention Screening Advisory Committee recommendations for childhood lead screening in Connecticut.

(b) The requirements of this section do not apply to any child whose parents or guardians object to blood testing as being in conflict with their religious tenets and practice.

Sec 12. Subsection (e) of section 19a-111j of the general statutes is repealed and the following is substituted in lieu thereof:

(e) The Department of Public Health shall disburse program funds to the local health department on an annual basis. After approving a local health department's application for program funding, the funding period shall begin on July first each year. The amount of such funding shall be determined by the Department of Public Health based on the number of confirmed childhood lead poisoning cases reported in the local health department's geographic coverage area during the previous calendar year. The director of any local health department that applies for program funding shall submit, not later than September thirtieth, annually, to the Department of Public Health a report concerning the local health department's lead poisoning and prevention control program. Such report shall contain: (1) A proposed budget for the expenditure of program funds for the new fiscal year; (2) a summary of planned program activities for the new fiscal year; and (3) a summary of program expenditures, services provided and operational activities during the previous fiscal year. The Department of Public Health shall approve a local health department's proposed budget prior to disbursing program funds to the local health department. When a local health department elects to not accept such funding, the allocated funding for that health department, calculated as described above, shall be made available to the Department of Public Health under a designated lead poisoning prevention account, to be used to for lead poisoning prevention activities.

Sec 13. Subsection (a) of Section 19a-77 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in sections 19a-77 to 19a-80, inclusive, and sections 19a-82 to [19a-87] 19a-87e, inclusive, "child day care services" shall include:

Sec 14. Subsection (e) of Section 25-32 of the general statutes is repealed and the following is substituted in lieu thereof:

(e) The commissioner shall not grant a permit for the sale, lease, assignment or change in use of any land in class II unless (1)**[**the land in class II is being sold, leased or assigned as part of a larger parcel of land also containing land in class III and**]** use restrictions applicable to the land in class II will prevent the land in class II from being developed, (2) the applicant demonstrates that the proposed sale, lease, assignment or change in use will not have a significant adverse impact upon the purity and adequacy of the public drinking water supply and that any use restrictions which the commissioner requires as a condition of granting a permit can be enforced against subsequent owners, lessees and assignees, (3) the commissioner determines, after giving effect to any use restrictions which may be required as a condition of granting the permit, that such proposed sale, lease, assignment or change in use will not have a significant adverse effect on the public drinking water supply, whether or not similar permits have been granted, and (4) on or after January 1, 2003, as a condition to the sale, lease or assignment of any class II lands, a permanent conservation easement on the land is entered into to preserve the land in perpetuity predominantly in its natural scenic and open condition for the protection of natural resources and public water supplies while allowing for recreation consistent with such protection and improvements necessary for the protection or provision of safe and adequate potable water, except in cases where the class II land is deemed necessary to provide access or egress to a parcel of class III land, as defined in section 25-37c, that is approved for sale. Preservation in perpetuity shall not include permission for the land to be developed for any commercial, residential or industrial uses, nor shall it include permission for recreational purposes requiring intense development, including, but not limited to golf courses, driving ranges, tennis courts, ballfields, swimming pools and uses by motorized vehicles other than vehicles needed by water companies to carry out their purposes, provided trails or pathways for pedestrians, motorized wheelchairs or nonmotorized vehicles shall not be considered intense development.

Sec 15. (NEW) Chronic and convalescent nursing homes and rest homes with nursing supervision: Urinalysis requirement.

A chronic and convalescent nursing home or a rest home with nursing supervision may elect not to obtain an annual urinalysis, including determination of qualitative protein glucose and microscopic examination of the urine sediment. In accordance with section 19a-36, the Commissioner of Public Health shall amend the Public Health Code in conformity with the provisions of this section.

Sec 16. Section 19a-535a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, a "facility" means a residential care home, as defined in section 19a-490.

(b) A facility shall not transfer or discharge a resident from the facility unless (1) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility, (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, (3) the health or safety of individuals in the facility is endangered, (4) the resident has failed, after reasonable and appropriate notice, to pay for a stay or a requested service, at the facility or (5) the facility ceases to operate. In the case of an involuntary transfer or discharge the resident and, if known, his legally liable relative, guardian or conservator shall be given a thirty-day written notification which includes the reason for the transfer or discharge and notice of the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection (d) of this section. No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge presents imminent danger of death.

(c) The facility shall be responsible for assisting the resident in finding appropriate placement. A discharge plan, prepared by the facility, which indicates the resident's individual needs shall accompany the patient.

(d) (1) For transfers or discharges effected on or after October 1, 1989, a resident or his legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection (b) of this section, that he will be transferred or discharged from the facility may appeal such transfer or discharge to the Commissioner of Public Health by filing a request for a hearing with the commissioner within ten days of receipt of such notice. Upon receipt of any such request, the commissioner or his designee shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. Such a hearing shall be held within seven business days of receipt of such request and a determination made by the commissioner or his designee within twenty days of the termination of the hearing. The hearing shall be conducted in accordance with chapter 54.

(2) In an emergency the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident. Before making such a determination, the commissioner shall notify the resident and, if known, his legally liable relative, guardian or conservator. The commissioner shall issue such a determination no later than seven days after receipt of the request for such determination. If, as a result of such a request, the commissioner or his designee determines that a failure to effect an immediate transfer or discharge would endanger the health, safety or welfare of the resident or other residents, the commissioner or his designee shall order the immediate transfer or discharge of the resident from the facility. A hearing shall be held in accordance with the requirements of subdivision (1) of this subsection within seven business days of the issuance of any determination issued pursuant to this subdivision.

(3) Any involuntary transfer or discharge shall be stayed pending a determination by the commissioner or his designee. Notwithstanding any provision of the general statutes, the determination of the commissioner or his designee after a hearing shall be final and binding upon all parties and not subject to any further appeal.

(e) All discharge plans for residents transferred or discharged from a facility shall be in writing and shall be signed by the person assigned to prepare the plan or by the facility administrator. The discharge plan must include, at a minimum, the following information: (1) the name and address of the facility and the resident; (2) a description of the resident's current medical condition(s); (3) a complete list of medications the resident is currently taking and a complete list of all medical providers the resident uses; (4) a detailed explanation of any social or emotional conditions of the resident that might impact his or her placement in a particular level of facility; and, (5) the type of facility that is most appropriate for the resident. The discharge plan shall be marked as confidential.

(f) The facility shall be permitted to discharge a resident only after: (1) the facility has assisted the resident in finding appropriate placement. Such assistance shall include obtaining and providing to the resident a list of all appropriate facilities within the geographical area of interest to the resident; (2) the facility has permitted the resident reasonable use of its facilities, including its telephones and computers, to contact potential placement facilities; and, (3) the facility has assisted the resident in completing applications for potential placement facilities, including obtaining all necessary medical forms and information; and, (4) the facility shall make efforts to obtain the resident's, the resident's legally liable relative's, guardian's or conservator's signature as acknowledgement of receipt of the discharge plan, and also acknowledgement of consultation with respect thereto.

Sec 17. Section 19a-494(a) of the general statutes is repealed and the following is substituted in lieu thereof:

If the Commissioner of Public Health finds that the health, safety or welfare of any patient or patients served by an institution as defined in [subsections (d) and (e) of] section 19a-490, imperatively requires emergency action and incorporates a finding to that effect in [his] the order, [he] the Commissioner of Public Health may issue a summary order to the holder of a license issued pursuant to section 19a-493 pending completion of any proceedings conducted pursuant to section 19a-494. These proceedings shall be promptly instituted and determined. The orders which the Commissioner of Public Health may issue shall include, but not be limited to: (1) Revoking or suspending the license; (2) prohibiting such facility from contracting with new patients or terminating its relationship with current patients; (3) limiting the license of such institution in any respect, including reducing the patient capacity, or services which may be provided by such institution.; and (4) compelling compliance with the applicable statutes or regulations of the department.

Sec 18. Subsection (c) of section 19a-495 is repealed and the following is substituted in lieu thereof:

(c) The commissioner may waive any provisions of the regulations affecting the physical plant requirements of an institution as defined in section 19a-490 [residential care homes] if the commissioner determines that such waiver would not endanger the health, safety or welfare of any resident. The commissioner may impose conditions, upon granting the waiver, that assure the health, safety and welfare of residents, and may revoke the waiver upon a finding that the health, safety or welfare of any resident has been jeopardized. The commissioner shall not grant a waiver that would result in a violation of the State Fire Safety Code or State Building Code. The commissioner may adopt regulations, in accordance with chapter 54, establishing procedures for an application for a waiver pursuant to this subsection.

Sec 19. Section 19a-175 of the general statutes is repealed and the following is substituted in lieu thereof:

(1) "Ambulance" means a motor vehicle specifically designed to carry patients;
(2) "Ambulance driver" means a person whose primary function is driving an ambulance;
(3) "Ambulance service" means an organization which transports patients;
(4) "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;
(5) "Certified ambulance service" means a municipal, volunteer or nonprofit ambulance service issued a certificate by the commissioner;
(6) "Commercial ambulance service" means an ambulance service which primarily operates for profit;
(7) "Commissioner" means the Commissioner of Public Health;
(8) "Communications facility" means any facility housing the personnel and equipment for handling the emergency communications needs of a particular geographic area;
(9) "Emergency medical responder" means an individual who is pursuant to chapter 384e;
(10) "Emergency medical services instructor" means a person who is certified pursuant to chapter 384e;
(11) "Emergency medical service organization" means any organization whether public, private or voluntary which offers transportation or treatment services to patients primarily under emergency conditions;
(12) "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;
(13) "Emergency medical technician" means a person who is certified pursuant to chapter 384e;
(14) "Interfacility critical care transport" means the interfacility transport of a patient between licensed health care institutions;
(15) "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;
(16) "Licensed ambulance service" means a commercial ambulance service or a volunteer or municipal ambulance service issued a license by the commissioner;
(17) "Life saving equipment" means equipment used by emergency medical personnel for the stabilization and treatment of patients;
(19) "Medical oversight" means the active surveillance by physicians of emergency medical service sufficient for the assessment of overall emergency medical service practice levels, as defined by protocols;
(20) "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) "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) "Office of Emergency Medical Services" means the office established within the Department of Public Health pursuant to section 19a-178; and
(23) "Patient" means an injured, ill, crippled or physically handicapped person requiring assistance and transportation;

(24) "Paramedic" means a person licensed pursuant to section 20-206*ll*;
(25) "Paramedic intercept service" means paramedic treatment services provided by an entity that does not provide the ground ambulance transport.
(26) "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;
(27) "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;
(28) "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;
(29) "Rescue service" means any organization, whether 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;
(30) "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.

Sec 20. Subsection (9)(A) of section 19a-177 of the general statutes is repealed and the following is substituted in lieu thereof:

(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.

Sec 21. Section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person shall operate any ambulance service, paramedic intercept service, or rescue service [, management service] without either a license or a certificate issued by the commissioner. No person shall operate a commercial ambulance service or commercial rescue service [or a management service] without a license issued by the commissioner. A certificate shall be issued to any volunteer or municipal ambulance service which 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 management service], as defined in subdivision (19) of section 19a-175, 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 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[,] <u>paramedic intercept service or</u> rescue service [or management 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[, management service organization] or emergency medical service organization which 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 which 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 which 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 which 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[, management service organization] 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 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; (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 [ambulance service] emergency medical services organization shall assure the following for all its emergency medical personnel, whether such personnel are employed by the emergency medical services organization or through a temporary employment or staffing agency, or personnel pool: (1) Are covered by, but not limited to the following, worker's compensation, general liability, and professional liability insurance minimum limits pursuant to subsection (a); (2) Are licensed or certified by the Commissioner at, or above, the level the person is employed; and [secure] (3) Secure and maintain medical oversight, as defined in section 19a-175, by a sponsor hospital, as defined in section 19a-175[, for all its emergency medical personnel, whether such personnel are employed by the ambulance service or a management service].

Sec 22. Section 19a-179 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner shall adopt regulations, in accordance with chapter 54, concerning [(1) the methods and conditions for the issuance, renewal and reinstatement of licensure and certification or recertification of emergency medical service personnel, (2)] (1) the methods and conditions for licensure and certification of the operations, facilities and equipment enumerated in section 19a-177, and [(3)] (2) complaint procedures for the public and any emergency medical service organization. Such regulations shall be in conformity with the policies and standards established by the commissioner. Such regulations shall require that, as an express condition of the purchase of any business holding a primary service area, the purchaser shall agree to abide by any performance standards to which the purchased business was obligated pursuant to its agreement with the municipality.

[(b) The commissioner may issue an emergency medical technician certificate to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is currently certified as an emergency medical technician in good standing in any New England state, New York or New Jersey, (2) has completed an initial training program consistent with the United States Department of Transportation, National Highway Traffic Safety Administration emergency medical technician curriculum, and (3) has no pending disciplinary action or unresolved complaint against him or her.

(c) 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*, and (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.

(d) An applicant who is issued a temporary emergency medical technician certificate pursuant to subsection (c) 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 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 this section.

(e) For purposes of subsection (d) of this section, "medical oversight" means the active surveillance by physicians of mobile intensive care sufficient for the assessment of overall practice levels, as defined by state-wide protocols, and "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, as defined in section 19a-175, and its personnel and has been approved for such activity by the Office of Emergency Medical Services.]

Sec 23. Section 20-206mm of the general statutes is repealed and the following is substituted in lieu thereof:

(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, as defined in section 19a-175, that the applicant has successfully (1) completed a [mobile intensive care] <u>paramedic</u> 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 [United States Department of Transportation, National Highway Traffic Safety Administration paramedic curriculum] national education standards for the paramedic scope of practice model conducted by a program 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 dollars.

(d) The commissioner may issue an emergency medical technician or emergency medical responder certificate to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is currently certified as an emergency medical technician emergency medical responder or in good standing in any New England state, New York or New Jersey, (2) has completed an initial training program consistent with the national education standards for the emergency medical technician or emergency medical responder curriculum, and (3) has no pending disciplinary action or unresolved complaint against him or her.

(e) 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*, and (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.

(f) An applicant who is issued a temporary emergency medical technician certificate pursuant to subsection (c) 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 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 this section.

(g) The commissioner may issue an emergency medical responder certificate to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is currently certified as an emergency medical responder in good standing by a state that maintains licensing requirements equal to or higher than those in this state (2) has completed an initial Department approved emergency medical responder training program that included written and practical examinations at the completion of the course, or if outside of Connecticut a program which adhered national education standards for the emergency medical responder scope of practice, and which included an examination, and (3) has no pending disciplinary action or unresolved complaint against him or her.

(h) The commissioner may issue an emergency medical services instructor certificate to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is currently certified as an emergency medical technician in good standing, (2) has submitted documentation to the to the Department regarding qualifications as an emergency medical service instructor as set by the

Department with reference to national standards, (3) provides a letter of endorsement signed by two instructors holding current emergency medical service instructor certification, (4) has completed the written and practical examinations as prescribed by the Department, and (5) has no pending disciplinary action or unresolved complaints against him or her.

Sec 24. Section 20-206oo of the general statutes is repealed and the following is substituted in lieu thereof:

The Commissioner of Public Health may adopt regulations in accordance with the provisions of chapter 54 to carry out the provisions of subdivision [(18)] 24 of subsection (c) of section 19a-14, subsection (e) of section 19a-88, subdivision (15) of section 19a-175, subsection (b) of section 20-9, subsection (c) of section 20-195c, sections 20-195aa to 20-195ff, inclusive, and sections 20-206jj to 20-206oo, inclusive.

Sec 25. The general statutes are amended by adding section 20-206pp:

(NEW) Notwithstanding any provision of the general statutes or any regulation adopted pursuant to this chapter, the scope of practice of any person certified or licensed as an emergency medical responder, emergency medical technician, advanced emergency medical technician, emergency medical services instructor or a paramedic under regulations adopted pursuant to section 20-206tt may include treatment modalities not specified in the regulations of Connecticut state agencies, provided such treatment modalities are (1) approved by the Connecticut Emergency Medical Services Medical Advisory Committee established pursuant to section 19a-178a and the Commissioner of Public Health, and (2) administered at the medical oversight and direction of a sponsor hospital, as defined in section 28-8b.

Sec 26. The general statutes are amended by adding section 20-206qq:

(NEW) (a) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to provide that emergency medical technicians 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. (b) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) provide for state-wide standardization of certification for each class of (A) emergency medical technicians, including, but not limited to, paramedics, (B) emergency medical services instructors, and (C) medical response technicians, (2) allow course work for such certification to be taken state-wide, and (3) allow persons so certified to perform within their scope of certification state-wide.

Sec 27. The general statutes are amended by adding section 20-206rr:

(NEW) (a) Any person certified as an emergency medical technician, advanced emergency medical technician, emergency medical responder or emergency medical services instructor pursuant to this chapter and the regulations adopted pursuant to section 19a-179 whose certification has expired may apply to the Department of Public Health for reinstatement of such certification as follows: (1) If such certification expired one year or less from the date of application for reinstatement, such person shall complete the requirements for recertification specified in regulations adopted pursuant

to section 19a-179, as such recertification regulations may be from time to time amended; (2) if such certification 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 19a-179, as such training and examination regulations may be from time to time amended; or (3) if such certification expired three or more years from the date of application for reinstatement, such person shall complete the requirements for initial certification specified in regulations adopted pursuant to section 19a-179, as such initial certification regulations may be from time to time amended. (b) Any certificate issued pursuant to this chapter and the regulations adopted pursuant to section 19a-179 which expires on or after January 1, 2001, shall remain valid for ninety days after the expiration date of such certificate. Any such certificate shall become void upon the expiration of such ninety-day period.

Sec 28. The general statutes are amended by adding section 20-206ss:

(NEW) (a) As used in this section, "emergency medical technician" means (1) any class of emergency medical technician certified under regulations adopted pursuant to section 19a-179, including, but not limited to, any advanced emergency medical technician, and (2) any paramedic licensed pursuant to section 20-206*ll*.
(b) Any emergency medical technician who has been trained, in accordance with national standards recognized by the Commissioner of Public Health, in the administration of epinephrine using automatic prefilled cartridge injectors or similar automatic injectable equipment and who functions in accordance with written protocols and the standing orders of a licensed physician serving as an emergency department director may administer epinephrine using such injectors or equipment. All emergency medical technicians shall receive such training. All licensed or certified ambulances shall be equipped with epinephrine in such injectors or equipment which may be administered in accordance with written protocols and standing orders of a licensed physician serving as an emergency department director.

Sec 29. The general statutes are amended by adding section 20-206tt:

(NEW) (a) The commissioner shall adopt regulations, in accordance with chapter 54, concerning (1) the methods and conditions for the issuance, renewal and reinstatement of licensure and certification or recertification of emergency medical responders, emergency medical technicians and emergency medical service instructors

Sec 30. Section 19a-179c of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Any ambulance used for interfacility critical care transport shall meet the requirements for a basic level ambulance, as prescribed in regulations adopted pursuant to section 19a-179, including requirements concerning medically necessary supplies and services, and may be supplemented by a licensed registered nurse, advanced practice registered nurse, physician assistant or respiratory care practitioner, provided such licensed professionals shall have current training and certification in pediatric or adult advanced life support, or from the Neonatal Resuscitation Program of the American Academy of Pediatrics, as appropriate, based on the patient's condition. (b) A general hospital, or children's general hospital, licensed under Section 19a-490 of the Connecticut General Statutes, may utilize an ambulance service, whether ground or air, other than the primary service

area responder for emergency interfacility transports of patients when 1) the primary service area responder is not authorized to the level of care required for the patient, 2) the primary service area responder does not have the equipment necessary to transport the patient safely, or 3) if the transport takes the primary service area responder out of their service area for an extended period of time and there is another ambulance service with the appropriate level of medical authorization and proper equipment available. The decision to utilize the primary service area responder or other ambulance service shall be made by the attending physician to provide for an expeditious and medically appropriate transfer.

Sec 31. The general statutes are amended by adding the following:

(NEW) (a) Each emergency medical services organization licensed or certified by the Commissioner shall, upon receipt of a notice of intention to strike by a labor organization representing the employees of such institution, in accordance with the provisions of the National Labor Relations Act, 29 USC 158, file a strike contingency plan with the commissioner not later than five days before the date indicated for the strike.

(b) The commissioner may issue a summary order to any emergency medical services organization, as defined in section 19a-175, that fails to file a strike contingency plan that complies with the provisions of this section and the regulations adopted by the commissioner pursuant to this section within the specified time period. Such order shall require the emergency medical services organization to immediately file a strike contingency plan that complies with the provisions of this section and the regulations adopted by the commissioner pursuant to this section.

(c) Any emergency medical services organization that is in noncompliance with this section shall be subject to a civil penalty of not more than ten thousand dollars for each day of noncompliance.

(d) (1) If the commissioner determines that an emergency medical services organization is in noncompliance with this section or the regulations adopted pursuant to this section, for which a civil penalty is authorized by subsection (c) of this section, the commissioner may send to an authorized officer or agent of the emergency medical services organization, by certified mail, return receipt requested, or personally serve upon such officer or agent, a notice that includes: (A) A reference to this section or the section or sections of the regulations involved; (B) a short and plain statement of the matters asserted or charged; (C) a statement of the maximum civil penalty that may be imposed for such noncompliance; and (D) a statement of the party's right to request a hearing to contest the imposition of the civil penalty.

(2) An emergency medical services organization may make written application for a hearing to contest the imposition of a civil penalty pursuant to this section not later than twenty days after the date such notice is mailed or served. All hearings under this section shall be conducted in accordance with the provisions of chapter 54. If an emergency medical services organization fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the emergency medical services organization is in noncompliance, the commissioner may, in the commissioner's discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the emergency medical services organization named in such order.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54: (1) Establishing requirements for a strike contingency plan, which shall include, but not be limited to, a requirement that the plan contain documentation that the institution has arranged for adequate staffing and security, fuel, pharmaceuticals and other essential supplies and services necessary to

meet the needs of the patient population served by the emergency medical services organization in the event of a strike; and (2) for purposes of the imposition of a civil penalty upon an emergency medical services organization pursuant to subsections (c) and (d) of this section.
(f) Such plan shall be deemed a statement of strategy or negotiation with respect to collective bargaining for the purpose of subdivision (9) of subsection (b) of section 1-210.

Sec 32. The general statutes are amended by adding the following:

(NEW) (a) The Commissioner of Public Health shall develop and implement the Forward Movement of Patients Plan to mobilize Connecticut emergency medical service assets to aid areas where local emergency medical services and ordinary mutual aid resources have been overwhelmed. The plan shall include, but not be limited to, a procedure for the request of resources, authority for plan activation, the typing of resources, resource command and control and logistical considerations.
(b) When authorized by and functioning as part of the Forward Movement of Patients Plan, as amended from time to time, emergency rates previously established by the Commissioner for a certified emergency medical service shall also apply for the conveyance of patients by such service. When authorized by the Commissioner to meet the temporary transportation needs of a specified event or incident, rates previously established by the Commissioner for a certified emergency medical service shall also apply for the conveyance of patients by such service. Each such authorization shall be limited to not more than seven days, except that the Commissioner may reissue any such authorization at the expiration of the previous authorization.

Sec 33. Subsection (a) of Section 19a-562a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each nursing home facility that is not a residential care home or an Alzheimer's special care unit or program shall annually provide a minimum of two hours of training in pain recognition and administration of pain management techniques, and a minimum of one hour in oral health and oral hygiene techniques, to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents.

Sec. 34. The general statutes are amended by adding the following:

(NEW) No person shall engage in the act of bulk water hauling to a public water system without a license issued pursuant to the requirements of and by the Department of Public Health. "Bulk water hauler for Public Water Systems" means any person who hauls water in bulk by any mean of transportation if the water is to be used for drinking, culinary, or other purposes involving a likelihood of the water being ingested by humans as part of a public water system. "Bulk" means containers having a capacity of 250 gallons or greater. Bulk water hauling to a public water system is seem as a temporary and non-permanent measure to resolve a short-term water supply issue for a public water system. Bulk water supplied and used by a public water system shall meet the water quality requirements of the Department of Public Health.

Sec. 35. The general statutes are amended by adding the following:

(NEW) (a) Any person who desires to be granted a license as a bulk water hauler for public water system shall apply to the Department of Public Health on forms provided by the department under oath which sets forth:

(1) Person who is applying for the license, which shall include a description of the entity if the person is other than an individual;

(2) License applied for;

(3) Source from which the drinking water is to be drawn;

(4) Methods to be employed to maintain the drinking water as suitable for human consumption;

(5) any other information deemed relevant by the Department to protect the public health; and

(b) Such application shall be accompanied by the payment of an application fee of $100.

Sec. 36. The general statutes are amended by adding the following:

(NEW) (a) The Department of Public Health may issue a license to an applicant after determining the applicant has the expertise and qualifications necessary to perform the functions of the license for which the applicant applied. The department shall adopt regulations in accordance with the provisions of Chapter 54 setting forth the qualifications necessary for each license applied for and minimum standards of performance for each license to ensure that the drinking water shall be fit for human consumption, and any other provisions to implement this act.

(b) The department shall have all the powers set forth in section 19a-14 to administer the provisions of this section. Upon a determination that a licensee has committed fraud or deceit in obtaining or renewing the license, fraud or deceit in rendering services under the license, acted negligently, incompetently, or wrongfully in rendering services under the license, failed to comply with any of the provisions of this act or the regulations adopted thereunder, the department may take any action set forth in section 19a-17 after providing notice and an opportunity for a hearing.

Sec. 37. The general statutes are amended by adding the following:

(NEW) Licenses issued under this chapter shall be subject to renewal once every two years for a fee of $100 and shall expire unless renewed in a manner prescribed by regulation.

Sec. 38. The general statutes are amended by adding the following:

(NEW) The Department of Public Health may enter or inspect any equipment, material, or land to determine whether any violation of the statute or the regulations adopted thereunder have been violated and may issue any orders necessary to the licensee when it determines that there is a threat to the public health in accordance with the provisions of section 25-34. Any order issued under this provision shall not be stayed upon any appeal by the licensee under section 25-34 or section 25-36.

Sec. 39. The general statutes are amended by adding the following:

(NEW) Any person who violates any provision of this act shall for each offense be guilty of a class C misdemeanor.

Section 40. Subsection (c) of section 19a-490k is repealed and the following is substituted in lieu thereof:

(c) A hospital may administer influenza and pneumococcal [polysaccharide] vaccines to patients, after an assessment for contraindications, without a physician's order, in accordance with a physician-approved hospital policy. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this subsection.

Section 41. Section 19a-89b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Commissioner of Public Health may establish Public Swimming Pool Design Guidelines, without adopting such Design Guidelines as regulations pursuant to Chapter 368a, to establish minimum standards for the proper construction and maintenance of public pools. The Department of Public Health shall charge a fee of fifteen dollars for a copy of its pool design guidelines.

Section 42. Subsection (d) of section 19a-72 of the general statutes is repealed and the following is substituted in lieu thereof :

(d) The Department of Public Health may enter into a contract for the storage, holding and maintenance of the data, files, and tissue samples under its control and management.

Section 43. Subsections (17) and (18) of Section 19a-175 of the general statutes is repealed and the following is substituted in lieu thereof:

(17) "Licensed ambulance service" means a commercial ambulance service, [or] a volunteer or municipal ambulance service, or ambulance service operated and maintained by any state agency issued a license by the commissioner.

(18) "Certified ambulance service" means a municipal or volunteer ambulance service or ambulance service operated and maintained by any state agency issued a certificate by the commissioner.

Section 44. Section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person shall operate any ambulance service, rescue service [or management service] or otherwise transport in a motor vehicle a patient on a stretcher without either a license or a certificate issued by the commissioner. No person shall operate a commercial ambulance service or commercial rescue service or a management service without a license issued by the commissioner. A certificate shall be issued to any volunteer or municipal ambulance service or any ambulance service operated and maintained by any state agency which 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, rescue service or [management service, as defined in subdivision (19) of section 19a-175] any ambulance service operated and maintained by any 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….

(h) Notwithstanding the provisions of subsection (a) of this section, any volunteer, hospital-based or municipal ambulance service, or any ambulance service operated and maintained by any 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 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.

Section 45. Section 19a-26a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, "environmental laboratory" means any facility, entity or other area used for [biological] microbiological, chemical, [physical] radiological, or other [examination] analyte testing of drinking waters, ground waters, sea waters, rivers, streams and surface waters, recreational waters, fresh water sources, wastewaters, swimming pools, [air] construction, renovation and demolition building materials, soil, solid waste, [hazardous waste, food, food utensils] animal and plant tissues, sewage, sewage effluent, [or] sewage sludge or any other matrix for the purpose of providing information on the sanitary quality or the amount of pollution [and] or any substance prejudicial to health or the environment. For the purposes of this section, "analyte" means a microbiological, chemical, radiological or other component of a matrix being measured by an analytical test and "matrix" means the substance or medium, such as drinking water, wastewater or a physical item, in which an analyte is contained.

(b) The Department of Public Health shall, in its Public Health Code, adopt regulations and reasonable standards governing environmental laboratory operations and facilities, personnel qualifications, [and] certification for testing, levels of acceptable proficiency in testing programs approved by the department, the collection, acceptance and suitability of samples for analysis, [and] such other pertinent laboratory functions, including the establishment of advisory committees, as may be necessary to insure environmental quality, public health and safety, and establishing a schedule or schedules of the amounts, or ranges of the amounts, of civil penalties that may be imposed under this section. Each registered environmental laboratory shall comply with all standards for environmental laboratories set forth in the Public Health Code and shall be subject to inspection by said department, including inspection of all records necessary to carry out the purposes of this section. The failure of a registered environmental laboratory to comply with the provision of this section and to regulations adopted thereunder may result in the registration being revoked or otherwise limited.

(c) The department may determine whether a test for an analyte in a matrix performed by an environmental laboratory requires the environmental laboratory to be registered and to have a certification for testing to test such analyte to protect the public health or the environment. No person shall operate, manage or control an environmental laboratory that tests for analytes for the purpose of providing information on the sanitary quality or the amount of pollution or any substance prejudicial to health or the environment for which a certification for testing is required under this provision unless such environmental laboratory is registered and has a certification for testing to test such analytes.

(d) The department shall annually publish a list setting forth all matrices and analytes for which a certification for testing is required.

[(c)] (e) Each application for registration of an environmental laboratory [or application for approval] and for a certification for testing of any analyte shall be made on forms provided by said department, shall be accompanied by a fee of one thousand two hundred fifty dollars and shall be executed by the owner or owners or by a responsible officer [of] authorized to do so by the agency, firm or corporation owning the environmental laboratory. Upon receipt of any such application, the department shall make such inspections and investigations as are necessary and shall deny registration [or approval] when operation of the environmental laboratory would be prejudicial to the health of the public. Registration [or approval] shall not be in force until notice of its effective date and term has been sent to the applicant.

[(d)] (f) Each registration [or certificate of approval] shall be issued for a period of not less than twenty-four or more than twenty-seven months [from the deadline for applications]. Renewal applications shall be made (1) biennially within the twenty-fourth month of the current registration [or certificate of approval]; (2) before any change in ownership [or change in director] is made; and (3) prior to any major expansion or alteration in, or moving of quarters.

[(e)] (g) This section shall not apply to any environmental laboratory that only provides laboratory services or information for the agency, person, firm or corporation which owns or operates such laboratory [and the fee required under subsection (c) of this section shall not be required of laboratories operated by a state agency].

(h) If upon review, investigation or inspection the Commissioner of Public Health determines a registered environmental laboratory has violated any provision of this section or regulations adopted thereunder, the commissioner may impose a civil penalty not to exceed five thousand dollars per violation per day upon such environmental laboratory and issue such other orders as it determines necessary to protect the public health. Upon notice of imposition of the civil penalty the commissioner shall provide the environmental laboratory with an opportunity for a hearing. Governmental immunity shall not be a defense against the imposition of any civil penalty imposed pursuant to this section. In determining the amount of the civil penalty to be imposed on an environmental laboratory, the commissioner shall consider the degree of the threat to public health or the environment, the amount necessary to achieve compliance, and the history of compliance of the environmental laboratory. Any order issued under this provision may be appealed in accordance with the provisions of section 4-183.

(i) The failure to pay a civil penalty to the department shall be a ground for revocation of the environmental laboratory's registration and certification for testing.

(j) The commissioner may order an unregistered environmental laboratory to cease operation.

(k) The commissioner may request the Attorney General to petition the Superior Court for an order to aid in enforcement of any provision of this section.

Section 46. Subsection (b) of Section 20-10b of the general statutes as amended by Public Act 13-217 is repealed and the following is substituted in lieu thereof: ***(effective upon passage)***

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) during the first renewal period in which continuing medical education is required and not less than once every six years thereafter, include at least one contact hour of training or education in each of the following topics: (A) Infectious diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, (B) risk management, (C) sexual assault, (D) domestic violence, (E) cultural competency, and (F) behavioral health. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Medical Association, Connecticut Hospital Association, Connecticut State Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department. The **[**commissioner**]** **department** may grant a waiver for not more than ten contact hours of continuing medical education for a physician who: (i) Engages in activities related to the physician's service as a member of the Connecticut Medical Examining Board, established pursuant to section 20-8a; (ii) engages in activities related to the physician's service as a member of a medical hearing panel, pursuant to section 20-8a; or (iii) assists the department with its duties to boards and commissions as described in section 19a-14.

Section 47. Section 20-146 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as provided in section 20-146a, no person shall produce or reproduce ophthalmic lenses and similar products or mount the same to supporting materials or fit the same by mechanical manipulation, molding techniques or other related functions, unless such person is licensed by the Department of Public Health. Said department may issue license certificates as licensed optician to all persons who lawfully apply for the same, upon their submitting to the commission an acceptable written application, and after they have passed examinations as hereinafter provided: Any person shall be admitted to take the examinations for a license to practice as a licensed optician who has satisfied the department that he is a person of good professional character, has served as a registered apprentice in Connecticut or in another state for not less than four calendar years' full-time employment under the supervision of a licensed optician in an optical establishment, office,

department, store, shop or laboratory where prescriptions for optical glasses from given formulas have been filled, and has acquired experience in the producing and reproducing of ophthalmic lenses, mounting the same to supporting materials, of which one year, at least, shall have been acquired within the five years last preceding the date of such application and who has acquired experience in the fitting of ophthalmic lenses to the eyes by mechanical manipulation, molding technique or other related functions, of which one year, at least, shall have been acquired within the five years last preceding the date of such application, under the supervision of a licensed optician. Any person who is licensed to perform optical services in any other state or territory with licensure requirements similar to or higher than those required in this state shall be eligible for licensure without examination. Successful completion of a two-year educational program approved by the board with the consent of the Commissioner of Public Health may be substituted for the four-year work experience requirement.

(b) All examinations shall be conducted in the English language and shall be written and oral as well as by practical demonstration. The examinations for licensed optician shall include inquiry into the theory and practice of the fundamentals of mechanical and technical knowledge, optics, mathematics, physics, chemistry and physiology as they pertain to the functional knowledge and application of producing and reproducing ophthalmic lenses and the mounting of the same to supporting materials and shall also include further examination into the theory and practice of fitting, adapting and designing of optical glasses from given formulas, or kindred products, to the ultimate wearer by mechanical manipulation, molding techniques or other related functions. Such examinations shall be conducted at least once each year by the Department of Public Health, under the supervision of the board. The examinations shall be prescribed by the department with the advice and consent of the board.

(c) Each licensed optician shall meet such continuing education requirements as the Commissioner of Public Health may establish. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth continuing education requirements for licensed opticians.

Section 48. Section 20-188 of the general statutes is repealed and the following is substituted in lieu thereof:

Before granting a license to a psychologist, the department shall, except as provided in section 20-190, require any applicant therefor to pass an examination in psychology prescribed by the department with the advice and consent of the board. Each applicant shall pay a fee of five hundred sixty-five dollars, and shall satisfy the department that such applicant (1) has received the doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved in accordance with section 20-189; and (2) has had at least one year's experience that meets the requirements established in regulations adopted by the department, in consultation with the board, in accordance with the provisions of chapter 54. The department shall establish a passing score with the consent of the board. Any certificate granted by the board of examiners prior to June 24, 1969, shall be deemed a valid license permitting continuance of profession subject to the provisions of this chapter. <u>An applicant who is currently licensed or certified as a psychologist in another state, territory or commonwealth of the United States may substitute two years of licensed or certified work experience in the practice of psychology, as defined in section 20-187a, in lieu of the requirements of subdivision (2) of this section.</u>

Section 49. Section 20-195dd of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as provided in subsections (b) and (c) of this section, an applicant for a license as a professional counselor shall submit evidence satisfactory to the Commissioner of Public Health of having: (1) Completed sixty graduate semester hours in or related to the discipline of counseling at a regionally accredited institution of higher education, which included coursework in each of the following areas: (A) human growth and development, (B) social and cultural foundations, (C) counseling theories and techniques or helping relationships, (D) group dynamics, (E) processing and counseling, (F) career and lifestyle development, (G) appraisals or tests and measurements for individuals and groups, (H) research and evaluation, and (I) professional orientation to counseling; (2) earned, from a regionally accredited institution of higher education a master's or doctoral degree in social work, marriage and family therapy, counseling, psychology or a related mental health field (3) acquired three thousand hours of postgraduate-degree-supervised experience in the practice of professional counseling, performed over a period of not less than one year, that included a minimum of one hundred hours of direct supervision by (A) a physician licensed pursuant to chapter 370 who has obtained certification in psychiatry from the American Board of Psychiatry and Neurology, (B) a psychologist licensed pursuant to chapter 383, (C) an advanced practice registered nurse licensed pursuant to chapter 378 and certified as a clinical specialist in adult psychiatric and mental health nursing with the American Nurses Credentialing Center, (D) a marital and family therapist licensed pursuant to chapter 383a, (E) a clinical social worker licensed pursuant to chapter 383b, (F) a professional counselor licensed, or prior to October 1, 1998, eligible for licensure, pursuant to section 20-195cc, or (G) a physician certified in psychiatry by the American Board of Psychiatry and Neurology, psychologist, advanced practice registered nurse certified as a clinical specialist in adult psychiatric and mental health nursing with the American Nurses Credentialing Center, marital and family therapist, clinical social worker or professional counselor licensed or certified as such or as a person entitled to perform similar services, under a different designation, in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state; and (4) passed an examination prescribed by the commissioner.

[(b) Prior to December 30, 2001, an applicant for a license as a professional counselor may, in lieu of the requirements set forth in subsection (a) of this section, submit evidence satisfactory to the commissioner of having: (A) Earned at least a thirty-hour master's degree, sixth-year degree or doctoral degree from a regionally accredited institution of higher education with a major in social work, marriage and family therapy, counseling, psychology or forensic psychology; (B) practiced professional counseling for a minimum of two years within a five-year period immediately preceding application; and (C) passed an examination prescribed by the commissioner.**]**

(b) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant is licensed or certified as a professional counselor, or as a person entitled to perform similar services under a different designation, 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 there are no disciplinary actions or unresolved complaints pending.

(c) Notwithstanding the provisions of this section, an applicant who is currently licensed or certified as a professional counselor or its equivalent in another state, territory or commonwealth of the United States may substitute three years of licensed or certified work experience in the practice

of counseling, as defined in section 20-195aa, in lieu of the requirements of subdivision (3) of subsection (a) of this section.

Section 50. Section 20-195n of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person shall practice clinical social work unless such person has obtained a license pursuant to this section.

(b) An applicant for licensure as a master social worker shall: (1) Hold a master's degree from a social work program accredited by the Council on Social Work Education or, if educated outside the United States or its territories, have completed an educational program deemed equivalent by the council; and (2) pass the masters level examination of the Association of Social Work Boards or any other examination prescribed by the commissioner.

(c) An applicant for licensure as a clinical social worker shall: (1) Hold a doctorate or master's degree from a social work program accredited by the Council on Social Work Education or, if educated outside the United States or its territories, have completed an educational program deemed equivalent by the council; (2) have three thousand hours post-master's social work experience which shall include not less than one hundred hours of work under professional supervision by a licensed clinical or certified independent social worker, provided on and after October 1, 2011, such hours completed in this state shall be as a licensed master social worker; and (3) pass the clinical level examination of the Association of Social Work Boards or any other examination prescribed by the commissioner. On and after October 1, 1995, any person certified as an independent social worker prior to October 1, 1995, shall be deemed licensed as a clinical social worker pursuant to this section, except a person certified as an independent social worker on and after October 1, 1990, shall not be deemed licensed as a clinical social worker pursuant to this chapter unless such person has satisfied the requirements of subdivision (3) of this subsection.

(d) Notwithstanding the provisions of subsection (b) of this section, the commissioner may grant a license by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a master social worker or clinical social worker in good standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state, and (2) has successfully completed the master level examination of the Association of Social Work Boards, or its successor organization, or any other examination prescribed by the commissioner. No license shall be issued under this subsection to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(e) Notwithstanding the provisions of subsection (c) of this section, the commissioner may grant a license by endorsement to an applicant who presents evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a clinical social worker in good standing in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state, and (2) has successfully completed the clinical level examination of the Association of Social Work Boards, or its successor organization, or any other examination prescribed by the commissioner. No license shall be issued under this subsection to any applicant

against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(f) Notwithstanding the provisions of this section, an applicant who is currently licensed or certified as a clinical social worker or its equivalent in another state, territory or commonwealth of the United States may substitute three years of licensed or certified work experience in the practice of clinical social work, as defined in section 20-195a, in lieu of the requirements of subdivision (2) of subsection (c) of this section.

Section 51. Section 20-252 of the general statutes is repealed and the following is substituted in lieu thereof: (*effective upon passage)*

No person shall engage in the occupation of registered hairdresser and cosmetician without having obtained a license from the department. Persons desiring such licenses shall apply in writing on forms furnished by the department. No license shall be issued, except a renewal of a license, to a registered hairdresser and cosmetician unless the applicant has shown to the satisfaction of the department that the applicant has complied with the laws and the regulations administered or adopted by the department. No applicant shall be licensed as a registered hairdresser and cosmetician, except by renewal of a license, until the applicant has made written application to the department, setting forth by affidavit that the applicant has successfully completed the **[**eighth**]** **ninth** grade and that the applicant has completed a course of not less than fifteen hundred hours of study in a school approved in accordance with the provisions of this chapter, in a school teaching hairdressing and cosmetology under the supervision of the State Board of Education, or, if trained outside of Connecticut, in a school teaching hairdressing and cosmetology whose requirements are equivalent to those of a Connecticut school and until the applicant has passed a written examination satisfactory to the department. Examinations required for licensure under this chapter shall be prescribed by the department with the advice and assistance of the board. The department shall establish a passing score for examinations with the advice and assistance of the board which shall be the same as the passing score established in section 20-236.

Section 52. Section 20-413 of the general statutes is repealed and the following is substituted in lieu thereof: *(effective upon passage)*

Nothing in this chapter shall be construed as prohibiting:

(1) Consulting with or disseminating research findings and scientific information to accredited academic institutions or governmental agencies or offering lectures to the public for a fee, monetary or otherwise;

(2) The activities and services of a graduate student or speech and language pathology intern in speech and language pathology pursuing a course of study leading to a graduate degree in speech and language pathology at an accredited or approved college or university or a clinical training facility approved by the department, provided these activities and services constitute a part of his supervised course of study and that such person is designated as "Speech and Language Pathology Intern", "Speech and Language Pathology Trainee", or other such title clearly indicating the training status appropriate to his level of training;

(3) (A) A person from another state offering speech and language pathology services in this state, provided such services are performed for no more than five days in any calendar year and provided such person meets the qualifications and requirements for licensing in this state; or (B) a person from another state who is licensed or certified as a speech and language pathologist by a similar authority of another state, or territory of the United States, or of a foreign country or province whose standards are equivalent to or higher than, at the date of his certification or licensure, the requirements of this chapter and regulations adopted hereunder, or a person who meets such qualifications and requirements and resides in a state or territory of the United States, or a foreign country or province which does not grant certification or license to speech and language pathologists, from offering speech and language pathology services in this state for a total of not more than thirty days in any calendar year;

(4) The activities and services of a person who meets the requirements of subdivisions (1) and (2) of subsection (a) of section 20-411, while such person is engaged in full or part-time employment in fulfillment of the professional employment requirement of subdivision (3) of said subsection (a);

(5) The use of supervised support personnel to assist licensed speech and language pathologists with tasks that are (A) designed by the licensed speech and language pathologists being assisted, (B) routine, and (C) related to maintenance of assistive and prosthetic devices, recording and charting or implementation of evaluation or intervention plans. For purposes of this subdivision, "supervised" means (i) not more than three support personnel are assisting one licensed speech and language pathologist, (ii) in-person communication between the licensed speech and language pathologist and support personnel is available at all times, and (iii) the licensed speech and language pathologist provides the support personnel with regularly scheduled direct observation, guidance, direction and conferencing for not less than thirty per cent of client contact time for the support personnel's first ninety workdays and for not less than twenty per cent of client contact time thereafter**[.] ; or**

(6) The provision of applied behavior analysis services in accordance with section 10-76ii.

Section 53. Section 19a-179a of the general statutes is repealed.
Section 54. Section 19a-179d of the general statutes is repealed.
Section 55. Section 19a-195a of the general statutes is repealed.
Section 56. Section 19a-195b of the general statutes is repealed.
Section 57. Section 19a-197a of the general statutes is repealed.
Section 58. Section 19a-121e of the general statutes is repealed.
Section 59. Section 19a-121f of the general statutes is repealed.
Section 60. Section 19a-121 of the general statutes is repealed.
Section 61. Section 19a-691 of the general statutes is repealed

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

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

State Agency: **Department of Public Health**
Liaison: **Elizabeth Keyes/Jill Kentfield** Phone: **(860) 509-7246/(860) 509-7280** E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Legal Office
Agency Analyst/Drafter of Proposal: Marianne Horn

Title of Proposal: An Act Amending The Sovereign Immunity Waiver Regarding The Departments Of Public Health And Developmental Services.
Statutory Reference: § 19a-24 - Claims for damages against Commissioners of Public Health and Developmental Services and certain officials, employees, council members and trustees. Immunity. Indemnification.
Proposal Summary: This proposal will require all claims against the Department of Public Health and the Department of Developmental Services to be handled in accordance with Chapter 53 of the General Statutes, Conn. Gen. Stat. § 4 – 141, et seq.
Please attach a copy of fully drafted bill (required for review)

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?

- **Origin of Proposal __ New Proposal _X_ 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?

The proposal was approved for inclusion in the Administration's package for 2013, but ultimately the Department decided not to submit it.

(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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **Department of Developmental Services** Agency Contact (name, title, phone): **Christine Pollio Cooney/Rod O'Connor** Date Contacted: 10/16/2013 Approve of Proposal _X__ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments: **DDS approves of the proposal and has requested proposing this change jointly to reflect a repeal of the whole statute.**
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)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The proposal deletes any heretofore present waiver of sovereign immunity regarding the Departments of Public Health and Developmental Services and the ability to bring a direct action against them. This provision was enacted when the Department of Public Health was involved in the operation of chronic disease hospitals. As there are no longer any chronic disease hospitals in the state, this provision should be deleted. Instead, any claim against it shall be governed Chapter 53 of the General Statutes.

Section 19a-24 of the general statutes is repealed.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: **Department of Public Health**
Liaison: **Elizabeth Keyes/Jill Kentfield** Phone: **(860) 509-7246/(860) 509-7280** E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Legal Office
Agency Analyst/Drafter of Proposal: Marianne Horn

Title of Proposal: An Act Enabling The Department Of Public Health To Contract With Other States.
Statutory Reference: Sec 1. 19a-2a - Powers and duties Sec 2. 19a-32- Department authorized to receive gifts.
Proposal Summary: This proposal would enable the Department of Public Health to contract with other states to carry out its statutory obligations and permit it to receive gifts from other states.
Please attach a copy of fully drafted bill (required for review)

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?

DPH has encountered an increasing number of instances in which it was highly desirable for it to enter into an agreement with another state but it was unable to do so. In addition, DPH has encountered cases where it was offered a monetary donation to provide information that it was statutorily permitted to provide but it could not accept the donation.

This proposal will align DPH's goals and statutory obligations regarding public health with its authority to contract to satisfy those obligations and achieve those goals. Currently, DPH can contract with the Federal government and private persons and entities, but it cannot enter into an agreement with or receive money from another state.

As recognized in Conn. Gen. Stat. § 19a-2a(8), among other statutes, Public Health issues concerning Connecticut residents are intertwined with public health issues concerning non-Connecticut residents.

As a geographically small state nestled amongst three bordering states, Connecticut has many residents who live in towns that touch towns in other states or are otherwise in close proximity to towns in other states. To effectively deal with public health issues affecting those residents, among others, DPH needs to be able to enter into agreements with sister states that permit it to contract for services and receive and pay money.

- **Origin of Proposal _X_ 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?
A version of this proposal, applicable only to contracts to advance stem cell research, was part of DPH's package in 2012. The bill was approved by the Public Health Committee and the House but was never called in the Senate.
(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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:
Agency Contact (name, title, phone):
Date Contacted:

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)

State
Potential minor revenue gain

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec. 1. Section 19a-2a of the general statutes is repealed and the following is substituted in lieu thereof:

The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. The commissioner shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) contract for facilities, services and programs to implement the purposes of the department as established by statute <u>including contracts with another state</u>; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases, emergency illnesses and health conditions and a list of reportable laboratory findings and amend such lists as the commissioner deems necessary and distribute such lists as well as any necessary forms to each licensed physician and clinical laboratory in this state. The commissioner shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health, boards of health and registrars of vital statistics; (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of

treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section 17a-688 and regulations adopted thereunder. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. The commissioner shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. The commissioner shall assist and advise local directors of health in the performance of their duties, and may require the enforcement of any law, regulation or ordinance relating to public health. When requested by local directors of health, the commissioner shall consult with them and investigate and advise concerning any condition affecting public health within their jurisdiction. The commissioner shall investigate nuisances and conditions affecting, or that he or she has reason to suspect may affect, the security of life and health in any locality and, for that purpose, the commissioner, or any person authorized by the commissioner, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by the commissioner shall have the authority conferred by law upon constables. Whenever the commissioner determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department, he or she shall forthwith take such measures, including the performance of any act required of the local health department, to ensure enforcement of such statute or regulation and shall inform the local health department of such measures. In September of each year the commissioner shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government, the state or any political subdivision thereof, <u>another state</u> or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may establish state-wide and regional advisory councils.

Sec 2. Section 19a-32 of the general statutes is repealed and the following is substituted in lieu thereof:

Department authorized to receive gifts. The Department of Public Health is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government<u>, another state</u> or by any person, corporation or association, provided such real estate, money, securities, supplies or equipment shall be used only for the purposes designated by the federal government or such <u>state,</u> person, corporation or association. Said department shall include in its annual report an account of the property so received, the names of its donors, its location, the use made thereof and the amount of unexpended balances on hand.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch, Practitioner Licensing and Investigations Section
Agency Analyst/Drafter of Proposal: Jennifer Filippone

Title of Proposal: An Act Concerning Online Applications And License Renewal
Statutory Reference **19a-88 - License renewal by certain health care providers. On-line license renewal system.**
Proposal Summary To allow the Department of Public Health to expand the use of the eLicense system.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

Pursuant to Section 139 of PA 13-234, effective with licenses that expire on and after October 1, 2013, all physicians, dentists and nurses will be required to renew their licenses on-line through the State's eLicense system. Section 139 of PA 13-234 also extended a $5 license fee increase to cover the costs associated with on-line transactions. This proposal would allow the Department to charge a fee to cover transaction costs and offer on-line initial applications and renewals as an option for other licensed professions/entities.

Licensed professions/entities include all other licensed health and health related practitioners (including but not limited to physician assistants, mental health professionals, dental practitioners and barbers and hairdressers), day care providers, youth camps and certified water operators.

A corresponding budget option was submitted.

- **Origin of Proposal** **___ New Proposal** **X 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? This concept was submitted last year but was not pursued as it did not request authorization to pass a transaction fee onto the applicant.* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? DPH is proposing to pass the transaction cost onto the applicant/licensee in order to make the proposal cost neutral.* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? Legislation was not pursued in the past.* *(4) What was the last action taken during the past legislative session? Drafting of concept at the agency level.*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: 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)
State
Federal
Additional notes on fiscal impact No anticipated fiscal impact.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

(NEW) (effective from passage and for license renewals applicable to registration periods beginning on and after October 1, 2014)

The Department of Public Health shall allow persons applying for or holding a license issued pursuant to chapters 372 through 378, inclusive, chapters 379 through 381b, inclusive, chapters 383 through 388, inclusive, chapter 393a, chapter 395, chapters 397a through 399, chapter 400a, chapter 400c, Section 19a-515 and Section 132 of Public Act 13-234 to apply for or renew any such license utilizing the Department's secure on-line license renewal system to pay his or her professional service fee on-line by means of a credit card or electronic transfer of funds from a bank or credit union account and shall charge such person a fee of five dollars for any such online payment made by credit card or electronic funds transfer.

(NEW) (*effective July 1, 2014*) The Department of Public Health shall allow persons or entities applying for or holding a license issued pursuant to sections 19a-80, 19a-87b or 19a-421 and sections 25-32-9, 25-32-11 and 25-31-11a of the Regulations of Connecticut State Agencies to apply for or renew any such license utilizing the Department's secure on-line license renewal system to pay the required license application or renewal fee on-line by means of a credit card or electronic transfer of funds from a bank or credit union account and shall charge such person a fee of five dollars for any such online payment made by credit card or electronic funds transfer.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Infectious Diseases Section
Agency Analyst/Drafter of Proposal: Vincent Sacco

Title of Proposal: An Act Concerning Meningococcal Vaccines For College Students Residing On Campus.
Statutory Reference **10a-155b - Meningitis vaccination for residents of on-campus housing. Meningitis information and records.**
Proposal Summary: To require that each college student who resides in on-campus housing have received a meningococcal conjugate vaccine not more than 5 years before enrollment.
Please attach a copy of fully drafted bill (required for review)

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?

Connecticut mandates one meningococcal vaccine for college freshmen living in dormitories. The vaccine is recommended at age 11-12. In March of 2013, the Advisory Committee on Immunization Practices (ACIP) voted to recommend that first-year college students living in residence halls should receive at least 1 dose of MenACWY not more than 5 years before college entry. The preferred timing of the most recent dose is on or after their 16th birthday. If only 1 dose of vaccine was administered before the 16th birthday, a booster dose should be administered before enrollment.

This proposal would amend CGS Section 10a-155b, which requires that each student who resides in on-campus housing be vaccinated against meningitis as a condition of such residence, to require that the students have received the vaccine not more than 5 years before enrollment.

- **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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **University of Connecticut**
Agency Contact (name, title, phone): **Gail Garber**
Date Contacted:
Approve of Proposal _X_ YES ___NO __Talks Ongoing

Agency Name: **Board of Regents for Higher Education**
Agency Contact (name, title, phone): **Kyle Thomas**
Date Contacted:
Approve of Proposal ___ YES ___NO _X_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)

State
Anticipated costs of administering the program on state campuses include purchase of educational materials to send to parents of all accepted students, personnel cost for the required

record-keeping and the potential costs for purchasing vaccines to catch-up students who arrive on campus who are not yet vaccinated.
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

To update the college immunization requirements to be consistent with recently revised national recommendations established by the Advisory Committee on Immunization Practices (ACIP), and CGS Section 10a-155 by including language requiring first year college students have documentation of receipt of meningococcal conjugate vaccine not more than 5 years before enrollment beginning in August of 2014.

Section 1. Subsection (a) of section 10-155b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For the [2002-2003] 2014-2015 school year, and each school year thereafter, each public or private college or university in this state shall require that each student who resides in on-campus housing be vaccinated against meningitis and have documentation of receipt of meningococcal conjugate vaccine not more than 5 years before enrollment as a condition of such residence. The provisions of this subsection shall not apply to any such student who (1) presents a certificate from a physician or an advanced practice registered nurse stating that, in the opinion of such physician or advanced practice registered nurse, such vaccination is medically contraindicated because of the physical condition of such student, or (2) presents a statement that such vaccination would be contrary to the religious beliefs of such student.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Healthcare Quality and Safety Branch, Office of Emergency Medical Services
Agency Analyst/Drafter of Proposal: Ray Barishansky

Title of Proposal: An Act Concerning The Inspection Of Ambulances
Statutory Reference: **19a-181 Registration of ambulance or rescue vehicles. Suspension or revocation of registration certificates.**
Proposal Summary Currently, authorized EMS vehicles (Ambulances, Non-Transport, and Invalid Coaches) need to be inspected by both the Department of Motor Vehicles and Department of Public Health. The DPH and DMV inspections overlap in content with DMV only inspecting about 5 items that DPH does not. The Department is proposing allowing these ambulances to be inspected by a certified dealer and present this certification to the Department during our inspection. This is the same procedure the fire departments need to follow when their apparatus is inspected. This will relieve the burden of DMV inspections during their busy times and create a more efficient procedure that does not duplicate the inspection process and will allow ambulance companies the convenience of a local inspection which should equate to less time the ambulance spends off line.
Please attach a copy of fully drafted bill (required for review)

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?

- **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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **Department of Motor Vehicles**
Agency Contact (name, title, phone): Mike Bzdyra
Date Contacted:

Approve of Proposal __X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments

DMV is very supportive of the concept and offered some comments. There is no statutory mandate for DMV to inspect the ambulances, it was an agreement made between DPH & DMV. The form used is partially in memo format from DPH & DMV and some inspection components are overlapped. All ambulances, except for those owned by the state, pay a $20 inspection fee. In 2012 DMV inspected 443 ambulances; 2011 – 471; 2010 – 404. Average annual revenue is $8,780. A summary of recent inspections of ambulances, most passed inspection and the few that didn't were for minor items such as a light being out. DMV does occasionally go out to inspect ambulances at a central location to inspect a region's ambulances.

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)

State

Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-181 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each ambulance, invalid coach, and intermediate or paramedic intercept vehicle [or rescue vehicle] used by an [ambulance or rescue service] emergency medical service organization shall be registered with the Department of Motor Vehicles pursuant to chapter 246. Said Department of Motor Vehicles shall not issue a certificate of registration for any such ambulance, invalid coach, and intermediate or paramedic intercept vehicle [or rescue vehicle] unless the applicant for such certificate of registration presents to said department a safety certificate from the Commissioner of Public Health certifying that said ambulance, invalid coach, and intermediate or paramedic intercept vehicle [or rescue vehicle] has been inspected and has met the minimum standards prescribed by the commissioner. Each vehicle so registered with the Department of Motor Vehicles shall be inspected once every two years thereafter by the Commissioner of Public Health on or before the anniversary date of the issuance of the certificate of registration. Each inspector, upon determining that such ambulance, invalid coach, and intermediate or paramedic intercept vehicle [or rescue vehicle] meets the standards of safety and equipment prescribed by the Commissioner of Public Health, shall affix a safety certificate to such vehicle in such manner and form as the commissioner designates, and such sticker shall be so placed as to be readily visible to any person in the rear compartment of such vehicle.

(b) Such inspection shall be performed by personnel qualified in accordance with the Code of Federal Regulations, Title 49, Parts 396.19 and 396.25, as from time to time amended, and employed by a facility operated by the state of Connecticut, a Connecticut municipality, or a dealer or repair facility that has been issued a license by the Connecticut Department of Motor Vehicles, Dealer and Repairs Division authorizing general repairs and new or used car dealers. The results of such inspection shall be recorded on a report that meets the record keeping requirements as prescribed in the Code of Federal Regulations, Title 49, Part 396.21.

(c) Standards and procedures for inspection of an authorized EMS vehicle, as provided in subsection (a) of this section, shall be in accordance with Code of Federal Regulations, Title 49, Part 396.17, as from time to time amended.

[(b)](d) The Department of Motor Vehicles shall suspend or revoke the certificate of registration of any vehicle inspected under the provisions of this section upon certification from the Commissioner of Public Health that such ambulance or rescue vehicle has failed to meet the minimum standards prescribed by said commissioner.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Healthcare Quality and Safety Branch, Office of Emergency Medical Services
Agency Analyst/Drafter of Proposal: Ray Barishansky

Title of Proposal: An Act Concerning Advanced Emergency Medical Technicians
Statutory Reference: **Sec 1. 19a-14 - Powers of department concerning regulated professions.** **Sec 2. 19a-178a - Emergency Medical Services Advisory Board established; appointment; responsibilities.** **Sec 3. 19a-179a - Scope of practice of emergency medical technicians and paramedics.** **Sec 4. 19a-179d - Implementation of policies and procedures re training, recertification and reinstatement of certification or licensure of emergency medical service personnel.** **Sec 5. 19a-195b - Reinstatement of expired certification. Validity of expired certificate.** **Sec 6. 19a-197a - Administration of epinephrine.** **Sec 7. 20-206nn - Disciplinary action. Grounds.**
Proposal Summary This proposal eliminates the category of Advanced Emergency Medical Technician (AEMT). The Department is putting this request forward based upon the advice and recommendation of the Connecticut Emergency Medical Services Advisory Board (legislatively appointed board) and the Connecticut Emergency Medical Services Medical Advisory Committee (EMS medical director physicians from the sponsor hospitals). The currently certified AEMTs in Connecticut are trained to 1985 National DOT curriculum. The training program is antiquated and the Department sought advice from industry experts on upgrading the level to the 2009 National Education Standards. As an aside, there are far fewer AEMTs than any other level of EMS provider in the State – out of the 24,000 licensed and certified EMS personnel in Connecticut, only 900 are AEMTs. The EMS medical directors from the sponsor hospitals, as well as the EMS training program directors, have advised the Department that they do not have the infrastructure to support the upgraded training level for AEMT providers as the increase in training requirements and continuous maintenance of skill competencies is significant. As the determination has been made that the 1985 standards have limited clinical value, the elimination of the level will result in a savings of OEMS personnel time processing the more complex

education and certification paperwork.

Please attach a copy of fully drafted bill (required for review)

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?

- **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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name:

Agency Contact (name, title, phone):

Date Contacted:

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)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec 1. Subdivision (23) of subsection (c) of section 19a-14 of the general statutes is repealed and the following is substituted in lieu thereof:

(23) Emergency medical technician, [advanced emergency medical technician,] emergency medical responder and emergency medical services instructor;

Sec 2. Section 19a-178a of the general statutes is repealed and the following is substituted in lieu thereof:

(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 and the department's emergency medical services medical director, or their designees. The Governor shall appoint the following members: One person from each of the regional emergency medical services councils; one person from the Connecticut Association of Directors of Health; three persons from the Connecticut College of Emergency Physicians; one person from the Connecticut Committee on Trauma of the American College of Surgeons; one person from the Connecticut Medical Advisory Committee; one person from the Emergency Department Nurses Association; one person from the Connecticut Association of Emergency Medical Services Instructors; one person from the Connecticut Hospital Association; two persons representing commercial ambulance providers; one person from the Connecticut Firefighters Association; one person from the Connecticut Fire Chiefs Association; one person from the Connecticut Chiefs of Police Association; one person from the Connecticut State Police; and one person from the Connecticut Commission on Fire Prevention and Control. An additional eighteen members shall be appointed as follows: Three by the president pro tempore of the Senate; three by the majority leader of the Senate; four by the minority leader of the Senate; three by the speaker of the House of Representatives; two by the majority leader of the House of Representatives and 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.

Sec 3. Section 19a-179a of the general statutes is repealed and the following is substituted in lieu thereof:

Notwithstanding any provision of the general statutes or any regulation adopted pursuant to this chapter, the scope of practice of any person certified or licensed as an emergency medical [technician] <u>responder</u>, [advanced] emergency medical technician or a paramedic under regulations adopted pursuant to section 19a-179 may include treatment modalities not specified in the regulations of Connecticut state agencies, provided such treatment modalities are (1) approved by the Connecticut Emergency Medical Services Medical Advisory Committee established pursuant to section 19a-178a and the Commissioner of Public Health, and (2) administered at the medical oversight and direction of a sponsor hospital, as defined in section 28-8b.

Sec 4. Section 19a-179d of the general statutes is repealed and the following is substituted in lieu thereof:

Notwithstanding the provisions of subdivision (1) of subsection (a) of section 19a-179 and section 19a-195b, the Commissioner of Public Health may implement policies and procedures concerning training, recertification and reinstatement of certification or licensure of emergency medical responders, emergency medical technicians[, advanced emergency medical technicians] and paramedics, while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt regulations in the Connecticut Law Journal not later than thirty days after the date of implementation of such policies and procedures.

Policies implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec 5. Section 19a-195b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Any person certified as an emergency medical technician, [advanced emergency medical technician,] emergency medical responder or emergency medical services instructor pursuant to this chapter and the regulations adopted pursuant to section 19a-179 whose certification has expired may apply to the Department of Public Health for reinstatement of such certification as follows: (1) If such certification expired one year or less from the date of application for reinstatement, such person shall complete the requirements for recertification specified in regulations adopted pursuant to section 19a-179, as such recertification regulations may be from time to time amended; (2) if such certification 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 19a-179, as such training and examination regulations may be from time to time amended; or (3) if such certification expired three or more years from the date of application for reinstatement, such person shall complete the requirements for initial certification specified in regulations adopted pursuant to section 19a-179, as such initial certification regulations may be from time to time amended.

(b) Any certificate issued pursuant to this chapter and the regulations adopted pursuant to section 19a-179 which expires on or after January 1, 2001, shall remain valid for ninety days after the expiration date of such certificate. An such certificate shall become void upon the expiration of such ninety-day period.

Sec 6. Section 19a-197a of the general statutes is repealed and the following is substituted in lieu thereof:

[(a) As used in this section, "emergency medical technician" means (1) any class of emergency medical technician certified under regulations adopted pursuant to section 19a-179, including, but not limited to, any advanced emergency medical technician, and (2) any paramedic licensed pursuant to section 20-206*ll*. (b)] Any emergency medical technician <u>or paramedic</u> who has been trained, in accordance with national standards recognized by the Commissioner of Public Health, in the administration of epinephrine using automatic prefilled cartridge injectors or similar automatic injectable equipment and who functions in accordance with written protocols and the standing orders of a licensed physician serving as an emergency department director may administer epinephrine using such injectors or equipment. All emergency medical technicians <u>and paramedics</u> shall receive such training. All licensed or certified ambulances shall be equipped with epinephrine in such injectors or equipment which may be administered [in accordance with written protocols and standing orders of a licensed physician serving as an emergency department director] <u>under the medical oversight and direction of a sponsor hospital, as defined in section 28-8b</u>.

Sec 7. Section 20-206nn of the general statutes is repealed and the following is substituted in lieu thereof:

The Commissioner of Public Health may take any disciplinary action set forth in section 19a-17 against a paramedic, emergency medical technician, emergency medical responder[, advanced emergency medical technician] or emergency medical services instructor for any of the following reasons: (1) Failure to conform to the accepted standards of the profession; (2) conviction of a felony, in accordance with the provisions of section 46a-80; (3) fraud or deceit in obtaining or seeking reinstatement of a license to practice paramedicine or a certificate to practice as an emergency medical technician, emergency medical responder[, advanced emergency medical technician] or emergency medical services instructor; (4) fraud or deceit in the practice of paramedicine, the provision of emergency medical services or the provision of emergency medical services education; (5) negligent, incompetent or wrongful conduct in professional activities; (6) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession; (7) alcohol or substance abuse; or (8) wilful falsification of entries in any hospital, patient or other health record. The commissioner may take any such disciplinary action against a paramedic for violation of any provision of section 20-206jj or any regulations adopted pursuant to section 20-206oo. The commissioner may order a license or certificate holder to submit to a reasonable physical or mental examination if his or her physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17. The commissioner shall give notice and an opportunity to be heard on any contemplated action under said section 19a-17.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

State Agency: Connecticut Department of Public Health

Liaison: Elizabeth Keyes/Jill Kentfield
Phone: (860) 509-7246/(860) 509-7280
E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov

Lead agency division requesting this proposal: Regulatory Services Branch, Drinking Water Section

Agency Analyst/Drafter of Proposal: Lori Mathieu

Title of Proposal: An Act Concerning Streamlining The Takeover Proceedings And Certificates Of Public Convenience And Necessity.

Statutory Reference:
16-46 - Dissolution or termination of public service company. Cessation of public service operations.
16-262n - Definition. Economic viability of water companies. Reviews. Failure to comply with orders.

Proposal Summary

Option 1:

* The water company selling and the acquiring water company would submit an application to the Department of Public Health (DPH) and the Public Utilities Regulatory Authority (PURA) (together, Departments). The application would require information regarding whether the acquiring entity has the financial, managerial and technical resources to operate the water company in a reliable and efficient manner and to provide continuous, adequate service to the persons served by the water company, the status of the water company, and the rates the acquiring entity proposes to charge the customers of the water company.

* A hearing may be held, but would not be required.

* The Departments would issue a final decision that would set forth the actions the acquiring entity and the water company would be required to take to ensure a continuous supply of potable water at adequate volume and pressures and at a reasonable cost.

Option 2:

* The water company selling and the acquiring water company would submit a capacity review application to the DPH, as well as a water company land permit application. Additional applications may also be required depending on the transaction proposed.

* The DPH would conduct a capacity review and review any other applications submitted, including applications regarding the transfer of water company land.

* After DPH completes its reviews and the water companies obtain any necessary permits and approvals from DPH, the water companies would then proceed to PURA for any reviews, approvals and decisions required by PURA for such acquisitions.

Please attach a copy of fully drafted bill (required for review)

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?*

- **Origin of Proposal _X__ 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?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: DEEP/PURA Agency Contact (name, title, phone): **Rob LaFrance** Date Contacted: Approve of Proposal ___ YES ___NO _X__Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? _X__ 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) No known impact
State No known impact
Federal No known impact
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The current process as specified in Sections 16-46, 16-262n, 16-262o, and 16-262m of the Connecticut General Statutes requires DPH and Public Utilities Regulatory Authority (PURA) of DEEP to concurrently review applications, hold hearings in many cases and render joint decisions when an entity acquires the holdings/assets of another water company, voluntarily or involuntarily, or when a new water company is created and constructed. This concurrent review seems to be considerably bogged down by duplicate and repetitive reviews by technical staff on both sides, and in some cases conflicting jurisdictional interest and concerns. Statutes will have to be modified to streamline the review, eliminate duplications, recognize jurisdictions and shorten the acquisition process without jeopardizing its integrity.

OPTION 1:

Section 1. Section 16-46 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No public service company shall cease operations as a public service company, dissolve or terminate its corporate existence without the consent of the Public Utilities Regulatory Authority.[, except a]

(b) A water company, as defined in section 16-262n, shall not cease its operations, or unilaterally discontinue the provision of water service to customers without the consent of both the Public Utilities Regulatory Authority and the Department of Public Health. (1) Upon receipt of a request from a water company to cease its operations or discontinue the provision of water service when such water company has not found an entity to voluntarily acquire it, the Public Utilities Regulatory Authority, in conjunction with the Department of Public Health, shall , [hold a public hearing and] after an opportunity for a hearing, issue a final decision setting forth the actions the water company shall take to ensure a continuous supply of potable water at adequate volume and pressures, in accordance with the procedures and criteria set forth in sections 16-262n to 16-262q, inclusive.

(2) In the case of a voluntary acquisition, the acquiring entity and the water company requesting to cease its operations shall file an application on a form and in a manner prescribed by the Public Utilities Regulatory Authority and the Department of Public Health. Such application shall include, but not be limited to, information regarding whether the acquiring entity has the financial, managerial and technical resources to operate the water company in a reliable and efficient manner and to provide continuous, adequate service to the persons served by the water company, the status of the water company, and the rates the acquiring entity proposes to charge the customers of the water company. The Public Utilities Regulatory Authority and the Department of Public Health shall, after an opportunity for a hearing, make a determination regarding the completeness of the application within X days of the filing of the application, unless the Public Utilities Regulatory Authority or the Department of Public Health determine in their discretion that additional time is needed within which to render a determination regarding the completeness of the application, and issue a final decision on said application within 45 days of the Public Utilities Regulatory Authority and the Department of Public Health determination that the application filed is complete, unless the Public Utilities Regulatory Authority or the Department of Public Health determine in their

discretion that additional time is needed within which to render a decision. Such final decision shall set forth the actions the acquiring entity and the water company shall take to ensure a continuous supply of potable water at adequate volume and pressures and at a reasonable cost.

[(b)] (c) Any public service company may, with such consent, or in the case of a water company, as defined in section 16-262n, for which a decision has been issued pursuant to section 16-262o, such water company shall, dissolve and terminate its corporate existence in the manner provided for dissolution and termination by such company's charter or certificate of incorporation, provided, if such charter or certificate requires stockholder approval, such approval shall be by not less than two-thirds of the voting power of the shares entitled to vote thereon. If there is no provision for dissolution and termination in such charter or certificate, such company may, with the consent of the Public Utilities Regulatory Authority, or in the case of a water company, the consent of both the Public Utilities Regulatory Authority and the Department of Public Health, dissolve and terminate its corporate existence in any manner provided in part XIV of chapter 601 in the case of a company organized with capital stock or part XI of chapter 602 in the case of a company organized without capital stock. Such dissolution and termination shall take effect upon (1) for a corporation, the filing with the Secretary of the State of a certificate of dissolution, and (2) for an unincorporated entity, the filing of a certificate of dissolution with the Public Utilities Regulatory Authority and the Department of Public Health. In the event of such cessation, dissolution or termination, all claims and rights of creditors shall constitute liens upon the property and franchises of the company and shall continue in existence as long as may be necessary to preserve the same.

Section 2. Section 16-262n of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, sections 16-262o to 16-262q, inclusive, and section 16-262s, "water company" means a corporation, company, association, joint stock association, partnership, municipality, other entity or person, or lessee thereof, owning, leasing, maintaining, operating, managing or controlling any pond, lake, reservoir, stream, well or distributing plant or system employed for the purpose of supplying water to not less than two service connections or twenty-five persons.

(b) The Public Utilities Regulatory Authority, in consultation with the Department of Public Health and the Department of Energy and Environmental Protection, may review the economic viability of a water company, except a municipal water company, based upon performance measures of the company's stability and financial condition, technical and managerial expertise and efficiency, and physical condition and capacity of plant. The Public Utilities Regulatory Authority shall make recommendations for improvement or provide counseling to a reviewed water company to assist in improving the company's economic viability.

(c) Whenever any water company fails to comply with an order issued pursuant to section 16-11, 25-32, 25-33 or 25-34, concerning the availability or potability of water or the provision of water at adequate volume and pressure, or if the Public Utilities Regulatory Authority determines a water company does not possess economic viability pursuant to subsection (b) of this section, the Public

Utilities Regulatory Authority, the Department of Public Health and, when its participation is required, the Department of Energy and Environmental Protection, may, or following a request from a water company filed pursuant to section 16-46, shall, after an opportunity for a hearing, and after notice to public and private water companies, municipal utilities furnishing water service, municipalities or other appropriate governmental agencies in the service area of the water company, and any municipality in which the water company's source or sources of supply are located, [conduct a hearing in accordance with the provisions of sections 4-176e, 4-177, 4-177c and 4-180 to] determine the actions that may be taken and the expenditures that may be required, including the acquisition of the water company by a suitable public or private entity, to assure the availability and potability of water and the provision of water at adequate volume and pressure to the persons served by the water company at a reasonable cost.

OPTION 2

(NEW) The general statutes are amended by adding the following:

Whenever an entity seeks to voluntarily acquire a water company, as defined in section 16-262n, the acquiring entity and the water company shall file an application on a form and in a manner prescribed by the Public Utilities Regulatory Authority and the Department of Public Health. Such application shall include, but not be limited to, information regarding whether the acquiring entity has the financial, managerial and technical resources to operate the water company in a reliable and efficient manner and to provide continuous, adequate service to the persons served by the water company, the status of the water company, and the rates the acquiring entity proposes to charge the customers of the water company. The Public Utilities Regulatory Authority and the Department of Public Health shall, after an opportunity for a hearing, make a determination regarding the completeness of the application within X days of the filing of the application, unless the Public Utilities Regulatory Authority or the Department of Public Health determine in their discretion that additional time is needed within which to render a determination regarding the completeness of the application, and issue a final decision on said application within 45 days of the Public Utilities Regulatory Authority and the Department of Public Health determination that the application filed is complete, unless the Public Utilities Regulatory Authority or the Department of Public Health determine in their discretion that additional time is needed within which to render a decision. Such final decision shall set forth the actions the acquiring entity and the water company shall take to ensure a continuous supply of potable water at adequate volume and pressures and at a reasonable cost.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch
Agency Analyst/Drafter of Proposal: Suzanne Blancaflor

Title of Proposal **An Act Concerning Medical Orders for Life Sustaining Treatment**
Statutory Reference: NEW
Proposal Summary: This language will allow the Department to establish a pilot program to implement Medical Orders for Life Sustaining Treatment.
Please attach a copy of fully drafted bill (required for review)

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?
Yes outcomes in other states has been positive
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The MOLST Program:

- Offers terminally ill or frail elderly patients the opportunity to learn about the benefits and drawbacks of all treatment options, and to make their wishes known.
- Assists health care professionals in discussing and developing treatment plans that reflect patient wishes.
- Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining treatments.

MOLST is intended for patients with life-threatening health conditions who:

- Choose to continue treatment, including any or all life-sustaining interventions;
- Choose to decline any or all life-sustaining interventions when death is imminent as

determined by an appropriate health care provider;

- Wish to have health care services provided that would allow for a natural dying process which includes medications and treatments to provide comfort and relieve pain

MOLST is for the frail elderly or terminally ill patients who can be expected to die in 6-12 months with or without treatment.

MOLST is an adjunct to an advanced directive in that it provides a form that is an actual medical order which can be transferred across all settings.

In 1990, under Title 42 U.S.C. 1395 cc (a) of the Omnibus Reconciliation Act, Congress passed an amendment known as the Patient Self Determination Act which gives individuals the right to make their own heath care decisions and to prepare advance directives (ADs). MOLST is an adjunct to a formal written advance directive and will benefit Connecticut residents with life limiting illnesses or residents of an advanced age who wish to make their choices known, in exercising their rights and articulating their choices about the medical life sustaining treatments they will accept at the end of life. The MOLST paradigm is an advanced care planning tool that uses a structured process of decision-making so providers can elicit patient preferences about probable medical interventions. The patient's preferences are then translated into an actionable medical order on a highly visible standardized form that travels with the patient across all care settings to ensure continuity of care. MOLST reflects the patient's current goals for medical decisions that s/he will likely confront within the near future. Currently there are 15 states with approved MOLST programs, 32 states including Connecticut with developing programs and three states without a program. The bill gives the Department the authority to pilot test MOLST through a voluntary program that involves health care professionals and institutions in designated areas of the state. A pilot program will provide the opportunity to collect and analyze data on the use, effectiveness and limitations of MOLST. If the program is successful, the legislature may elect to implement the program statewide, through a comprehensive educational program that targets specific groups of health care provider.

- **Origin of Proposal ___ New Proposal _X__ 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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Department of Developmental Services Agency Contact (name, title, phone): Christine Pollio, Rod O'Conner Date Contacted: Approve of Proposal ___ YES ___NO _X__Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? ___ YES ___NO
Agency Name: Office of Protection and Advocacy Agency Contact (name, title, phone): Beth Leslie Date Contacted: Approve of Proposal ___ YES ___NO _X__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

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

1. Clarity regarding patient's wishes for medical treatment at the end of life
2. Transferability of patient wishes across all settings

The general statutes are amended by adding the following:

(NEW) (a) The Commissioner of Public Health may, within available appropriations, establish a pilot program in one or more geographic areas in the state to implement the use of medical orders for life-sustaining treatment by health care providers. For purposes of this section: (1) "Medical order for life-sustaining treatment" means a written medical order by a physician, advanced practice registered nurse, or physician assistant to effectuate a patient's request for life-sustaining treatment; and (2) "health care provider" means any person, corporation, limited liability company, facility or institution operated, owned or licensed by this state to provide health care or professional services, or an officer, employee or agent thereof acting in the course and scope of his or her employment.

(b) The Commissioner of Public Health may establish an advisory group of health care providers to make recommendations concerning the pilot program described in this section. The members of such advisory group may include one or more: (1) Physicians, (2) advanced practice registered nurses, (3) physician assistants, (4) emergency medical service providers, (5) patient advocates, (6) hospital representatives, or (7) long-term care facility representatives.

(c) Prior to commencement of a pilot program pursuant to this section, said commissioner may contact a representative of each health care institution, as defined in section 19a-490 of the general statutes, a representative of each emergency medical service organization, as defined in section 19a-175 of the general statutes, any physician licensed under chapter 370 of the general statutes, any advanced practice registered nurse licensed under chapter 378 of the general statutes, and any physician assistant licensed under chapter 370 of the general statutes in the geographic area in which the commissioner intends to establish the pilot program to request such institution's, organization's, physician's or advanced practice registered nurse's participation in the pilot program. Participation by each institution, organization, physician and advanced practice registered nurse shall be voluntary.

(d) Patient participation in the pilot program shall be voluntary. Any such agreement to participate in the pilot program shall be made in writing, signed by the patient or the patient's legally-authorized representative. Such agreement shall be maintained by the health care institution, emergency medical services organization, physician, advanced practice registered nurse, or physician assistant that presented such agreement to the patient and shall be made available to the commissioner upon request.

(e) Notwithstanding the provisions of sections 19a-495 and 19a-580d of the general statutes, and regulations adopted thereunder, the commissioner may implement policies and procedures for the pilot program to ensure that medical orders for life-sustaining treatment are transferrable among, and recognized by, various health care institutions.

(f) After the termination of the pilot program, said commissioner may submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning the pilot program.

(g) Said commissioner may implement policies and procedures necessary to implement the pilot program while in the process of adopting such policies and procedures in regulation form, provided the commissioner holds a public hearing prior to implementing such policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation of such policies and procedures. Policies implemented pursuant to this section shall be valid until the time final regulations are adopted or until the pilot program terminates, whichever occurs earlier.

(h) Any pilot program established in accordance with this section shall terminate not later than October 1, 2015.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Local Health Administration
Agency Analyst/Drafter of Proposal: Juanita Estrada/Sue Walden
Title of Proposal **Return Of Unexpended Local Health Per-Capita Funds And Proration Of Local Health Per-Capita Funds When Towns Join Health Districts.**
Statutory Reference **Sec 1. 19a-245 Reimbursement by state.** **Sec 2. 19a-202 Payments to municipalities.**
Proposal Summary: Per this proposal, local health departments and districts would no longer be allowed to carryover per-capita funds as currently allowed in Sec. 19a-245. Also, per-capita funds would be pro-rated when a town or towns joins and or forms a health district effective from the date of forming and/or joining the health district.
Please attach a copy of fully drafted bill (required for review)

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?

Local health departments and districts are currently able to carryover unexpended per-capita funds from year to year. By deleting the language to carryover funding, this will require local health departments to better plan and utilize the state funds in a timely manner for necessary public health services or return the unspent funds to DPH. The returned funds would be deposited into a separate non lapsing account within the general fund and support local health department and district programs and initiatives, based on department priorities and local health agency needs with the approval of the Commissioner.

When a town joins a health district or a health district forms at any time during the fiscal year, the district receives 100% of the per-capita funding, regardless of the date of joining and/or

forming. To decrease the burden of the State and to increase better planning at the local level in regards to districting, language will be added to disperse the per-capita funds on a pro-rated basis effective the date of the joining and/or forming the health district.

- **Origin of Proposal X 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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: NONE
Agency Contact (name, title, phone):
Date Contacted:

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)

Possible municipal fiscal impact if per-capita funds are not fully expended during the state fiscal year or poor planning for towns joining a health district.

State

Federal

Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Sec 1. Section 19a-245 of the general statutes is repealed and the following is substituted in lieu thereof:

Upon application to the Department of Public Health, each health district that has a total population of fifty thousand or more, or serves three or more municipalities irrespective of the combined total population of such municipalities, shall annually receive from the state an amount equal to one dollar and eighty-five cents per capita for each town, city and borough of such district, provided (1) the district employs a full-time director of health, except of a vacancy exists in the office of the director of health or the office is occupied by an acting director of health for more than ninety days, such district shall not be eligible for funding unless the Commissioner of Public Health waives this requirement, (2) [(1)] the Commissioner of Public Health approves the public health program and budget of such health district, and (3) [(2)] the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts, provided any appropriation for the maintenance of a health district formed during the fiscal year as provided in subsection (4) shall be pro-rated effective from the date of formation of the health district, and (4) any town, city or borough joining or forming a health district during a fiscal year shall receive per capita funding on a pro-rated basis, effective the date of joining or forming the health district. Such district departments of health are authorized to use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The Comptroller shall quarterly, in July, October, January and April, upon such application and upon the voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such district department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. [Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year.] Any moneys remaining unexpended at the end of a fiscal year shall be refunded to the Department of Public Health. The Department of Public Health will establish an account to be known as the "Local Health Department and District Program Fund" which shall be a separate, non-lapsing account within the General Fund. These funds will be redistributed to local health departments and districts to support local public health programs and initiatives based on the Department's Public Health priorities and local health agency needs, subject to approval of the Commissioner. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Sec 2. Section 19a-202 of the general statutes is repealed and the following is substituted in lieu thereof:

Upon application to the Department of Public Health any municipal health department shall annually receive from the state an amount equal to one dollar and eighteen cents per capita, provided such municipality (1) employs a full-time director of health, except that if a vacancy exists in the office of director of health or the office is filled by an acting director for more than [three months] ninety days, such municipality shall not be eligible for funding unless the Commissioner of Public Health waives this requirement; (2) submits a public health program and budget which is approved by the Commissioner of Public Health; (3) appropriates not less than one dollar per capita, from the annual tax receipts, for health department services; and (4) has a population of fifty thousand or more. Such municipal department of health may use additional funds, which the Department of Public Health may secure from federal agencies or any other source and which it may allot to such municipal department of health. The money so received shall be disbursed upon warrants approved by the chief executive officer of such municipality. The Comptroller shall annually in July and upon a voucher of the Commissioner of Public Health, draw the Comptroller's order on the State Treasurer in favor of such municipal department of health for the amount due in accordance with the provisions of this section and under rules prescribed by the commissioner. [Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of such municipal department of health for the ensuing year.] Any moneys remaining unexpended at the end of a fiscal year shall be refunded to the Department of Public Health. The Department of Public Health will establish an account to be known as the "Local Health Department and District Program Fund," which shall be a separate, nonlapsing account within the General Fund. These funds with be redistributed to local health departments districts to support local public health programs and initiatives, based on the Department's public health priorities and local health agency needs, subject to the approval of the Commissioner. This aid shall be rendered from appropriations made from time to time by the General Assembly to the Department of Public Health for this purpose.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch, Facility Licensing and Investigations Section
Agency Analyst/Drafter of Proposal: Barbara Cass

Title of Proposal: **An Act Concerning Nursing Facility Management Services**
Statutory Reference **Sec 19a-561 - Nursing facility management services. Certification. Initial applications and biennial renewals. Investigation. Disciplinary action.**
Proposal Summary This act would ensure that nursing facility management services registered through DPH ensure and maintain quality of care.
Please attach a copy of fully drafted bill (required for review)

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?

In 2012, the Department identified Immediate Jeopardy (IJ) to patient health and safety in 11 nursing home facilities, 5 of the 11 facilities had nursing facility management services in place. In 2013, to date, IJ has been identified in 10 facilities and 9 of those facilities also had nursing facility management services in place. Additionally, since the revision of the CMS Special Focus Facility initiative in 2005, the majority of the homes with this additional sanction/remedy were utilizing nursing facility management services during the time period when significant care concerns were identified.

In addition to the per diem bed rate negotiated with DSS, facilities that utilize nursing facility management services are reimbursed an additional $6-8 per day, per bed. Addition of these services should promote higher quality, but that has not always been what is identified.

Codifying in statute additional obligations on the nursing facility management company that include at the very least maintaining the current star rating with Nursing Home Compare will provide assurances that there has not been a decline in services when nursing facility management company services are utilized. Nursing Home Compare measures quality indicators, staffing and inspection activities which provide a broad snapshot of a nursing home that assists consumers in decision making regarding nursing home care.

Compliance with the statute would be determined during nursing home activities and with biennial renewal of the nursing facility management certificate. The addition of subsection (l) to section 19a-561 notices management companies that quality care must be maintained.

The Department receives the star ratings from DHHS Centers for Medicare and Medicaid Services (CMS).

- **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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **Department of Social Services**
Agency Contact (name, title, phone): **Heather Rossi**
Date Contacted:

Approve of Proposal _X_ 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)

State

Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-561 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section, "nursing facility management services" means services provided in a nursing facility to manage the operations of such facility, including the provision of care and services and "nursing facility management services certificate holder" means a person or entity certified by the Department of Public Health to provide nursing facility management services.

(b) No person or entity shall provide nursing facility management services in this state without obtaining a certificate from the Department of Public Health.

(c) Any person or entity seeking a certificate to provide nursing facility management services shall apply to the department, in writing, on a form prescribed by the department. Such application shall include the following:

(1) (A) The name and business address of the applicant and whether the applicant is an individual, partnership, corporation or other legal entity; (B) if the applicant is a partnership, corporation or other legal entity, the names of the officers, directors, trustees, managing and general partners of the applicant, the names of the persons who have a ten per cent or greater beneficial ownership interest in the partnership, corporation or other legal entity, and a description of each such person's relationship to the applicant; (C) if the applicant is a corporation incorporated in another state, a certificate of good standing from the state agency with jurisdiction over corporations in such state; and (D) if the applicant currently provides nursing facility management services in another state, a certificate of good standing from the licensing agency with jurisdiction over public health for each state in which such services are provided;

(2) A description of the applicant's nursing facility management experience;

(3) An affidavit signed by the applicant and any of the persons described in subparagraph (B) of subdivision (1) of this subsection disclosing any matter in which the applicant or such person (A) has been convicted of an offense classified as a felony under section 53a-25 or pleaded nolo contendere to a felony charge, or (B) has been held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property, or (C) is subject to a currently effective injunction or restrictive or remedial order of a court of record at the time of application, or (D) within the past five years has had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, arising out of or relating to business activity or health care, including, but not limited to, actions affecting the operation of a nursing facility, residential care home or any facility subject to sections 17b-520 to 17b-535, inclusive, or a similar statute in another state or country; and

(4) The location and description of any nursing facility in this state or another state in which the applicant currently provides management services or has provided such services within the past five years.

(d) In addition to the information provided pursuant to subsection (c) of this section, the department may reasonably request to review the applicant's audited and certified financial statements, which shall remain the property of the applicant when used for either initial or renewal certification under this section.

(e) Each application for a certificate to provide nursing facility management services shall be accompanied by an application fee of three hundred dollars. The certificate shall list each location at which nursing facility management services may be provided by the holder of the certificate.

(f) The department shall base its decision on whether to issue or renew a certificate on the information presented to the department and on the compliance status of the managed entities. The department may deny certification to any applicant for the provision of nursing facility management services (1) at any specific facility or facilities where there has been a substantial failure to comply with the Public Health Code, or (2) if the applicant fails to provide the information required under subdivision (1) of subsection (c) of this section.

(g) Renewal applications shall be made biennially after (1) submission of the information required by subsection (c) of this section and any other information required by the department pursuant to subsection (d) of this section, and (2) submission of evidence satisfactory to the department that any nursing facility at which the applicant provides nursing facility management services is in substantial compliance with the provisions of this chapter, the Public Health Code and licensing regulations, and (3) payment of a three-hundred-dollar fee.

(h) In any case in which the Commissioner of Public Health finds that there has been a substantial failure to comply with the requirements established under this section, the commissioner may initiate disciplinary action against a nursing facility management services certificate holder pursuant to section 19a-494.

(i) The department may limit or restrict the provision of management services by any nursing facility management services certificate holder against whom disciplinary action has been initiated

under subsection (h) of this section.

(j) The department, in implementing the provisions of this section, may conduct any inquiry or investigation, in accordance with the provisions of section 19a-498, regarding an applicant or certificate holder.

(k) Any person or entity providing nursing facility management services without the certificate required under this section shall be subject to a civil penalty of not more than one thousand dollars for each day that the services are provided without such certificate.

(l) Shall ensure that if such nursing facility has been certified as a provider of services by the United States Department of Health and Human Services under Medicare or Medicaid programs, the overall star rating through the Medicare Nursing Home Compare is at least maintained. Should such star rating decline, the Nursing Facility Management Service's Certificate Holder shall provide a plan for immediate and sustained improvement to the Department. The plan shall specifically address staffing and quality measures, to include but not be limited to the following: (1) Assessment of patient acuity; (2) Increasing the Registered Nurse staffing hours; (3) Staff re-training; and (4) Interventions to improve quality measures that fall outside of the Connecticut average

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Community Health and Prevention (Special Supplemental Nutrition Program for Women, Infants and Children (WIC))
Agency Analyst/Drafter of Proposal: Marilyn Lonczak and Caroline Cooke

Title of Proposal: An Act Concerning On-Site Breastfeeding In Day Care Facilities
Statutory Reference: New
Proposal Summary: The legislation will require a place to nurse an infant on-site at both childcare centers and family day care homes.
Please attach a copy of fully drafted bill (required for review)

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? ***A private room or space must be provided for center employees under federal and state lactation accommodation laws.***
(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?

There are several reasons why this addition/amendment should be supported:

- Breastfeeding is the cornerstone of combatting childhood obesity.
- Breastfeeding objectives related to worksite support for lactation (ergo, child care would also need to be supportive) are included in the Maternal Child Health Section of the State Health Assessment and Health Improvement Plan.
- The Affordable Care Act and FLSA mandate worksite accommodation of pumping, again, supportive childcare centers are central to the success of worksite lactation accommodations. Being able to nurse on site would be a benefit to a mother, because it can promote the duration of breastfeeding. Commutes can be long and moms may need to express milk or feed so as not to be uncomfortable or become engorged for the remainder of the commute from the childcare facility to home. Moms may have supply

issues (i.e. reduced milk supply) if that late afternoon nursing is suppressed. Also, nursing at the drop off also could reduce the number of feeds that center employees have to do.

- Supporting research and national policy guidance on supporting environmental approaches to support breastfeeding. (See http://pediatrics.aappublications.org/content/129/3/e827.full.pdf+html and Surgeon General Breastfeeding Call to Action http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html
- The 2013 CDC Breastfeeding report card indicates that Connecticut's childcare legislation doesn't support on-site breastfeeding at childcare centers. http://www.cdc.gov/breastfeeding/pdf/2013BreastfeedingReportCard.pdf

The space for breastfeeding in a child day care center does not need to be a permanent/designated space that would limit facility space to interfere with the care of children. The "space" can be a couch, a rocking chair, a chair at the kitchen table. We do not recommend the "place" provided be bathroom or bathroom stall. It can be a private space, but it does not need to be.

Also, a mom nursing her infant will lead to promoting normalization of breastfeeding**.** There are many discreet ways to nurse an infant in public. As a best practice for a day care center, a private room or space could be provided which should be provided for center employees under federal and state lactation accommodation laws anyway. For a family day care center, you would expect it would be more difficult to designate a dedicated space**.**

Being able to nurse on site would be a benefit to a mother, because it can promote the duration of breastfeeding. Commutes can be long and moms may need to express milk or feed so as not to be uncomfortable or become engorged for the remainder of the commute from the childcare facility to home. Moms may have supply issues (i.e. reduced milk supply) if that late afternoon nursing is suppressed. Also, nursing at the drop off also could reduce the number of feeds that center employees have to do**.**

DPH has training planned for childcare centers that can help educate providers on this initiative.

- **Origin of Proposal _X__ 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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Office of Early Childhood Agency Contact (name, title, phone): Myra Jones-Taylor Date Contacted: Approve of Proposal ___ YES ___NO __X_ Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? _X__ 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)
State: DPH estimates a cost of $66,697 per year to support this proposal, as it would create a need for an additional Child Care Licensing Specialist (1FTE). This proposal increases the regulatory responsibilities of Child Care Licensing Specialists to monitor compliance and follow-up on issues of noncompliance. This appropriation would be transferred to the Office of Early Childhood (OEC).
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

The general statutes are amended by adding the following:

(NEW) Every child day care center, group day care home or family day care home shall provide a place for a breastfeeding mother to feed her infant or child on the premises of the center, group or family day care home, other than a bathroom or toilet stall, during normal business hours to support the continuation and duration of breastfeeding per the American Academy of Pediatrics policy statement on breastfeeding and use of human milk.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

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

State Agency: Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield **Phone: 860-509-7246** **E-mail: elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov**
Lead agency division requesting this proposal: Vital Records
Agency Analyst/Drafter of Proposal: Lisa Kessler

Title of Proposal: An Act Concerning Genealogists' Access to Vital Records Vaults.
Statutory Reference: 7-51a
Proposal Summary: Current statute gives genealogists access to vital records during all normal business hours. This proposal will allow vital records registrars to schedule appointments if business needs require such a scheduling system.

PROPOSAL BACKGROUND

- **Reason for Proposal**

Connecticut General Statutes section 7-51a allows genealogists access to vital records and the vital records vaults during all normal business hours, to carry out genealogical research. Connecticut genealogists have broad access to all vital records except those records that have been amended to reflect a change in parentage or gender change, or those records that contain social security numbers restricted by federal law.

In the smaller towns, genealogists are often able to show up at any time and gain access to the vaults. However, in the larger cities and towns, as well as the State Vital Records Office, genealogists are provided access to the vaults through scheduled appointments. Appointments are necessary so that multiple genealogists are not present in the vaults at the same time – such a situation would impede the workflow of the vital records office. As well, scheduled appointments give time to office staff to carry out duties related to confidential matters that cannot be performed when visitors are in the office. Examples of these confidential matters include, but are not limited to:

- Matters related to gender change, surrogacy, adoption and paternity actions. Often, circumstances arise that requires consultation between staff members, and further discussions with the person(s) to whom such confidential matters pertain to. Since genealogists are not entitled to this information, discussions with these customers and among staff must be curtailed.
- The processing of medical birth data, which is afforded the strictest

protections by law, is impeded by the presence of genealogists in the work area.

- Records containing social security numbers restricted by federal law and not accessible to genealogists, must be kept locked when genealogists are researching in the vaults. This hinders the work process of vital records staff who need access to these records to perform their work related duties.
- Matters related to possible proposals of legislation and regulations, or features of electronic systems cannot be freely discussed.

Appointments are offered a few days a week, giving genealogists access to the vaults to conduct their research, while at the same time allowing the business needs of the office to be carried out with minimal interruption. However, the scheduling system often causes issues with genealogists who show up at a vital records office expecting to be allowed to enter the vaults without any appointment. The statute is often relied upon as the grounds for immediate access to the vaults. Nevertheless, the scheduling system is a necessity, particularly for the State Vital Records Office and those located in Connecticut's larger cities, so that these offices can serve the public efficiently, and carry out duties related to confidential matters.

Based upon these reasons, the Department proposes that the language of the statute be changed to allow vital records registrars to schedule appointments for genealogists if the business needs of the office warrant such a process. Note that Connecticut is one of a handful of states that allows genealogists direct access to vital records. The proposed change to allow vital records registrars to schedule appointments will continue to provide Connecticut genealogists with one of the most liberal access policies in the nation, without compromising services offered to the public.

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? ***No***
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? ***Most states do not allow genealogists direct access to vital records vaults.***
(3) Have certain constituencies called for this action? ***No***
(4) What would happen if this was not enacted in law this session? ***Conflicting interpretation between vital records offices and genealogists will continue.***

- **Origin of Proposal** **_X_ New Proposal** **___ Resubmission**

If this is a resubmission, please share: ***N/A***

(5) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?

(6) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?

(7) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?

(8) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: 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

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Revise language so that genealogists' access to vital records offices can be effectively managed so as to not interfere with the business needs of the vital records offices.

Section 7-51a of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 7-51a of the Connecticut General Statutes is revised and the following is substituted in lieu thereof:

(a) Any person eighteen years of age or older may purchase certified copies of marriage and death records, and certified copies of records of births or fetal deaths which are at least one hundred years old, in the custody of any registrar of vital statistics. The department may issue uncertified copies of death certificates for deaths occurring less than one hundred years ago, and uncertified copies of birth, marriage, death and fetal death certificates for births, marriages, deaths and fetal deaths that occurred at least one hundred years ago, to researchers approved by the department pursuant to section 19a-25, and to state and federal agencies approved by the department. [During all normal business hours] For the purpose of conducting genealogical research, members of genealogical societies incorporated or authorized by the Secretary of the State to do business or conduct affairs in this state shall (1) have full access to all vital records in the custody of any registrar of vital statistics, including certificates, ledgers, record books, card files, indexes and database printouts, except for those records containing Social Security numbers protected pursuant to 42 USC 405 (c)(2)(C), and confidential files on adoptions, gender change, gestational agreements and paternity, (2) be permitted to make notes from such records, (3) be permitted to purchase certified copies of such records, and (4) be permitted to incorporate statistics derived from such records in the publications of such genealogical societies. At the discretion of the registrar, such access shall be granted either immediately upon request or by scheduled appointment. Such appointments shall be scheduled without undue delay. For all vital records containing Social Security numbers that are protected from disclosure pursuant to federal law, the Social Security numbers contained on such records shall be redacted from any certified copy of such records issued to a genealogist by a registrar of vital statistics.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Regulatory Services Branch, Environmental Health Section
Agency Analyst/Drafter of Proposal: Francesca Provenzano, Health Program Supervisor, Lead & Healthy Homes Program
Title of Proposal: An Act Concerning Reporting Requirements For Radon-Related Disciplines
Statutory Reference **19a-14b - Radon mitigators, diagnosticians and testing companies. Regulations.**
Proposal Summary: This proposal will revise 19a-14b to require analytical measurement services providers (i.e., laboratories) and approved radiological laboratories (radon in water analysis service providers) to report radon results to the CT DPH so that we can collect meaningful data. Revise 19a-14b to require residential mitigation service providers (i.e., radon mitigation contractors) to uniformly report radon mitigation system installations throughout CT for all residential mitigation systems.
Please attach a copy of fully drafted bill (required for review)

PROPOSAL BACKGROUND

- **Reason for Proposal**

The CT DPH is developing a web-based surveillance system to enable laboratory reporting and practitioner reporting of radon-related measurement and mitigation practices in CT. Currently, the CT DPH does not collect radon-related data. As a public health agency, we can change that. Radon is the leading cause of lung cancer in the US for non-smokers. Based on surveys conducted in the late 1980 and early 90s, we know that there is a high likelihood of finding elevated radon levels in the majority of CT counties. Furthermore, real estate laws and real estate transactions call for the disclosure of radon test results, but there is no government entity that actually collects this information.

- **Origin of Proposal _X__ 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?

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: **Department of Consumer Protection** Agency Contact (name, title, phone): **Gary Berner** Date Contacted: **October 28, 2013** Approve of Proposal _X_ YES ___NO ___Talks Ongoing
Summary of Affected Agency's Comments DCP has no objections.
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) No municipal mandate.
State Will utilize existing resources to carry out this additional work.
Federal May or may not receive continuing funding from the US EPA
Additional notes on fiscal impact We already paid for the development of a surveillance system to track environmental contaminants, including radon in air and water.

Section 19a-14b of the general statutes is repealed and the following is substituted in lieu thereof:

(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 and whose businesses are located in Connecticut that have been approved by the Commissioner of Public Health. Companies and individuals who do not comply with subsections (c) through (f) below, or who do not maintain registration with the Department of Consumer Protection as required under section 20-420 of the Connecticut General Statutes, shall be removed from the list.
(c) [The Department of Public Health shall adopt regulations, in accordance with chapter 54, concerning radon in drinking water that are consistent with the provisions contained in 40CFR 141 and 142.] Reports on actionable radon test results made by analytical measurement service providers. Not later than forty-eight hours after a radon in air test analysis result is found to be greater than or equal to 4.0 picocuries per liter (pCi/L) each analytical measurement service provider shall report to the Commissioner of Public Health the following information pertaining to the radon test device and result in a format prescribed by the Department: (1) the residential measurement service provider name, company, and address analyzing and reporting the radon test data; (2) the residential address of the test location including street number, street name, town, and zipcode, (3) the building level where the radon test was placed for the testing period designated as basement, first floor, second floor, etc.; (4) the purpose of the radon test such as a routine test, a real estate transaction test, a post-mitigation radon test, or a diagnostic radon test used by a residential mitigation service provider for diagnosing the source of existing high radon levels; (5) the dates and times for both deployment and retrieval of the radon test device; (6) the analytical radon test result reported in pCi/L; and (7) such other information as the Commissioner may require.

(d) Reports on all other radon test results made by analytical measurement service providers. (1) For all radon in air test results that are below 4.0 picocuries per liter, each analytical measurement service provider pursuant to subsection (a) of this section shall, at least monthly, submit to the Commissioner of Public Health a comprehensive report that includes the information as described under subsection (c)(1-7) of this section. (2) For all radon in water test results analyzed by laboratories approved under Connecticut General Statute section 19a-29a, and in accordance with the requirements of section 19a-37, the approved laboratory shall report all radon in water test results to the Commissioner monthly. The report shall include the name, address, city and state of the approved laboratory that analyzed the sample; who collected the sample designated as one of the following: analytical measurement service provider, residential measurement service provider, licensed home inspector, or homeowner; and the analysis results for the water sample in units of pCi/L. Radon in water analysis laboratories shall be responsible for collecting all of the information described in this section for Commissioner reporting purposes.

(e) Whenever a residential measurement service provider refers radon analysis services to an analytical measurement service provider for analysis, the service providers may agree as to which

measurement service provider will report to the Commissioner of Public Health to ensure compliance with subsections (c) and (d)(1) of this section, but both service providers shall be accountable to insure that reports are made. The residential and analytical measurement service provider shall insure that the requisition slip includes all of the information that is required in subsections (c) and (d) of this section and that this information is transmitted with the radon test to the analytical measurement service provider or approved radon in water analysis laboratory performing the analysis.

(f) Each residential mitigation service provider legally operating in Connecticut as described under subsection (b) of this section, that conducts radon mitigation for air or water shall, at least monthly, submit to the Commissioner of Public Health a comprehensive report that includes: (1) the name of the residential mitigation service provider company name and company address for which the residential mitigation service provider who installed each radon control system; (2) the full residential address including number, street, town and zip code where the radon mitigation system was installed; (3) the type of mitigation system installed; (4) the date the radon in air or radon in water mitigation system was installed, and (5) such other information as the Commissioner may require.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch, Facility Licensing and Investigations Section
Agency Analyst/Drafter of Proposal: Barbara Cass

Title of Proposal: **An Act Concerning Electronic Physician Signatures**
Statutory Reference **19a-522b - Chronic and convalescent nursing homes and rest homes with nursing supervision: Maintenance and preservation of patient medical records.**
Proposal Summary: This proposal will ensure facilities utilizing electronic medical records will have written policies in place to ensure patient privacy and security.
Please attach a copy of fully drafted bill (required for review)

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?

As the number of institutional settings which adopt electronic health records increases, it has become apparent that requirements should be set forth in statute. Facilities must have written policies in place to ensure that they have proper security measures to protect use of an electronic signature by anyone other than to which the electronic signature belongs. The policy must also ensure that access to a hard copy of clinical records is made available upon request.

- **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?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: 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)
State
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Section 19a-522b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) A chronic and convalescent nursing home or a rest home with nursing supervision shall preserve all patient medical records, irrespective of whether such records are in a printed or electronic format, for not less than seven years following the date of the patient's discharge from such facility or, in the case of a patient who dies at the facility, for not less than seven years following the date of death. A chronic and convalescent nursing home or rest home with nursing supervision may maintain all or any portion of a patient's medical record in an electronic format that complies with accepted professional standards for such medical records. In accordance with section 19a-36, the Commissioner of Public Health shall amend the Public Health Code in conformity with the provisions of this section. (b) Chronic and convalescent nursing homes and rest homes with nursing supervision may implement the use of electronic signatures for patient medical records. Institutions shall have written policies in place to ensure that they have proper privacy and security measures to protect use of an electronic signature by anyone other than to which the electronic signature belongs.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: Elizabeth Keyes/Jill Kentfield Phone: (860) 509-7246/(860) 509-7280 E-mail: Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov
Lead agency division requesting this proposal: Regulatory Services Branch
Agency Analyst/Drafter of Proposal:

Title of Proposal: An Act Concerning Penalties For Failure To Comply With A Recall Of Shellfish.
Statutory Reference: NEW
Proposal Summary: This proposal would create a penalty for shellfish harvesters or wholesalers who fail to initiate a recall of in accordance with the requirements the National Shellfish Sanitation Program Model Ordinance when it is determined that the failure to comply with the recall has negatively impacted public health.
Please attach a copy of fully drafted bill (required for review)

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 is being submitted in response to the increased number of Vibrio parahaemolyticus infections that occurred during the summer of 2013. Vibrio infections typically result from eating raw or undercooked shellfish, particularly oysters, that have Vibrio bacteria in them or from ingesting contaminated seawater.

- **Origin of Proposal __X_ 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?*

PROPOSAL IMPACT

- **Agencies Affected** (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted: 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)
State: Potential revenue gain from creation of new fine.
Federal
Additional notes on fiscal impact

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

(NEW) Any person, firm or corporation engaged in the harvesting or selling of shellfish who fails to initiate a recall of shellfish in accordance with the requirements of Section II, Chapter II of the National Shellfish Sanitation Program Model Ordinance, as amended from time to time, and whose failure to initiate such recall has been determined by the Department of Public Health to have negatively impacted public health and safety, such person, firm or corporation shall be fined one thousand dollars.

Agency Legislative Proposal - 2014 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): **GRE will fill in**

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

State Agency: Connecticut Department of Public Health
Liaison: **Elizabeth Keyes/Jill Kentfield** Phone: **(860) 509-7246/(860) 509-7280** E-mail: **Elizabeth.keyes@ct.gov/ jill.kentfield@ct.gov**
Lead agency division requesting this proposal: Regulatory Services Branch, Drinking Water Section
Agency Analyst/Drafter of Proposal: Lori Mathieu

Title of Proposal: An Act Concerning The Freedom Of Information Act
Statutory Reference: **1-210 - Access to public records. Exempt records**
Proposal Summary: To remove from the Department of Administrative Services' review certain records, thereby streamlining the current security risk review concerning water company records and in turn reducing the time it takes DPH to provide responsive records to Freedom of Information Act requestors.
Please attach a copy of fully drafted bill (required for review)

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?*

- **Origin of Proposal _X_ 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?*

PROPOSAL IMPACT

- **Agencies** Affected (please list for each affected agency)

Agency Name: **Department of Administrative Services (DAS)** Agency Contact (name, title, phone): **Jeffrey R. Beckham, Staff Counsel/Director of Communications** Date Contacted: **October 18, 2013** Approve of Proposal __X_ YES ___ NO __ Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? _X_ 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 Potential minimal savings - By removing certain records from the Department of Administrative Services' security risk review under *Conn. Gen. Stat.* § 210(d), there is a potential for cost reduction.

- **Policy and Programmatic Impacts** (Please specify the proposal section associated with the impact)

Conn. Gen. Stat. § 1-210(d) requires that whenever a public agency, receives a Freedom of Information act request from any person for disclosure of any records when there are reasonable grounds to believe disclosure of such records may result in a safety risk (as described in *Conn. Gen. Stat.* 1-210(b)(19), the public agency shall notify the Commissioner of Administrative Services or the Commissioner of Emergency Services and Public Protection, as applicable, of such request. If the commissioner, after consultation with the chief executive officer of the applicable agency or after consultation with the chief executive officer of the applicable water company for information related to a water company believes the requested record is exempt from disclosure pursuant to subdivision (19) of subsection (b) of this section, the commissioner may direct the agency to withhold such record from such person.

The proposal will enable the Department of Public Health (DPH) to respond more quickly to Freedom of Information Act (FOIA) requestors with respect to certain records enumerated in the proposal because such proposal will remove these records from the Department of Administrative Services' (DAS) review under *Conn. Gen. Stat.* § 1-210(d).

Section 1. Subsection (b) Section 1-210 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) Nothing in the Freedom of Information Act shall be construed to require disclosure of:

(1) Preliminary drafts or notes provided the public agency has determined that the public interest in withholding such documents clearly outweighs the public interest in disclosure;

(2) Personnel or medical files and similar files the disclosure of which would constitute an invasion of personal privacy;

(3) Records of law enforcement agencies not otherwise available to the public which records were compiled in connection with the detection or investigation of crime, if the disclosure of said records would not be in the public interest because it would result in the disclosure of (A) the identity of informants not otherwise known or the identity of witnesses not otherwise known whose safety would be endangered or who would be subject to threat or intimidation if their identity was made known, (B) signed statements of witnesses, (C) information to be used in a prospective law enforcement action if prejudicial to such action, (D) investigatory techniques not otherwise known to the general public, (E) arrest records of a juvenile, which shall also include any investigatory files, concerning the arrest of such juvenile, compiled for law enforcement purposes, (F) the name and address of the victim of a sexual assault under section 53a-70, 53a-70a, 53a-71, 53a-72a, 53a-72b or 53a-73a, or injury or risk of injury, or impairing of morals under section 53-21, or of an attempt thereof, or (G) uncorroborated allegations subject to destruction pursuant to section 1-216;

(4) Records pertaining to strategy and negotiations with respect to pending claims or pending litigation to which the public agency is a party until such litigation or claim has been finally adjudicated or otherwise settled;

(5) (A) Trade secrets, which for purposes of the Freedom of Information Act, are defined as information, including formulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, customer lists, film or television scripts or detailed production budgets that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy; and

(B) Commercial or financial information given in confidence, not required by statute;

(6) Test questions, scoring keys and other examination data used to administer a licensing examination, examination for employment or academic examinations;

(7) The contents of real estate appraisals, engineering or feasibility estimates and evaluations made for or by an agency relative to the acquisition of property or to prospective public supply and construction contracts, until such time as all of the property has been acquired or all proceedings or transactions have been terminated or abandoned, provided the law of eminent domain shall not be affected by this provision;

(8) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with such licensing agency to establish the applicant's personal qualification for the license, certificate or permit applied for;

(9) Records, reports and statements of strategy or negotiations with respect to collective bargaining;

(10) Records, tax returns, reports and statements exempted by federal law or the general statutes or communications privileged by the attorney-client relationship, marital relationship, clergy-penitent relationship, doctor-patient relationship, therapist-patient relationship or any other privilege established by the common law or the general statutes, including any such records, tax returns, reports or communications that were created or made prior to the establishment of the applicable privilege under the common law or the general statutes;

(11) Names or addresses of students enrolled in any public school or college without the consent of each student whose name or address is to be disclosed who is eighteen years of age or older and a parent or guardian of each such student who is younger than eighteen years of age, provided this subdivision shall not be construed as prohibiting the disclosure of the names or addresses of students enrolled in any public school in a regional school district to the board of selectmen or town board of finance, as the case may be, of the town wherein the student resides for the purpose of verifying tuition payments made to such school;

(12) Any information obtained by the use of illegal means;

(13) Records of an investigation or the name of an employee providing information under the provisions of section 4-61dd or sections 17b-301c to 17b-301g, inclusive;

(14) Adoption records and information provided for in sections 45a-746, 45a-750 and 45a-751;

(15) Any page of a primary petition, nominating petition, referendum petition or petition for a town meeting submitted under any provision of the general statutes or of any special act, municipal charter or ordinance, until the required processing and certification of such page has been completed by the official or officials charged with such duty after which time disclosure of such page shall be required;

(16) Records of complaints, including information compiled in the investigation thereof, brought to a municipal health authority pursuant to chapter 368e or a district department of health pursuant to chapter 368f, until such time as the investigation is concluded or thirty days from the date of receipt of the complaint, whichever occurs first;

(17) Educational records which are not subject to disclosure under the Family Educational Rights and Privacy Act, 20 USC 1232g;

(18) Records, the disclosure of which the Commissioner of Correction, or as it applies to Whiting Forensic Division facilities of the Connecticut Valley Hospital, the Commissioner of Mental Health and Addiction Services, has reasonable grounds to believe may result in a safety risk, including the risk of harm to any person or the risk of an escape from, or a disorder in, a correctional institution or facility under the supervision of the Department of Correction or Whiting Forensic Division facilities. Such records shall include, but are not limited to:

(A) Security manuals, including emergency plans contained or referred to in such security manuals;

(B) Engineering and architectural drawings of correctional institutions or facilities or Whiting Forensic Division facilities;

(C) Operational specifications of security systems utilized by the Department of Correction at any correctional institution or facility or Whiting Forensic Division facilities, except that a general description of any such security system and the cost and quality of such system may be disclosed;

(D) Training manuals prepared for correctional institutions and facilities or Whiting Forensic Division facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(E) Internal security audits of correctional institutions and facilities or Whiting Forensic Division facilities;

(F) Minutes or recordings of staff meetings of the Department of Correction or Whiting Forensic Division facilities, or portions of such minutes or recordings, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(G) Logs or other documents that contain information on the movement or assignment of inmates or staff at correctional institutions or facilities; and

(H) Records that contain information on contacts between inmates, as defined in section 18-84, and law enforcement officers;

(19) Records when there are reasonable grounds to believe disclosure may result in a safety risk, including the risk of harm to any person, any government-owned or leased institution or facility or any fixture or appurtenance and equipment attached to, or contained in, such institution or facility, except that such records shall be disclosed to a law enforcement agency upon the request of the law enforcement agency. Such reasonable grounds shall be determined (A) (i) by the Commissioner of Administrative Services, after consultation with the chief executive officer of an executive branch state agency, with respect to records concerning such agency; and (ii) by the Commissioner of Emergency Services and Public Protection, after consultation with the chief executive officer of a municipal, district or regional agency, with respect to records concerning such agency; (B) by the Chief Court Administrator with respect to records concerning the Judicial Department; and (C) by the executive director of the Joint Committee on Legislative Management, with respect to records concerning the Legislative Department. As used in this section, "government-owned or leased institution or facility" includes, but is not limited to, an institution or facility owned or leased by a public service company, as defined in section 16-1, a certified telecommunications provider, as defined in section 16-1, a water company, as defined in section 25-32a, or a municipal utility that

furnishes electric, gas or water service, but does not include an institution or facility owned or leased by the federal government, and "chief executive officer" includes, but is not limited to, an agency head, department head, executive director or chief executive officer. Such records include, but are not limited to:

(i) Security manuals or reports;

(ii) Engineering and architectural drawings of government-owned or leased institutions or facilities;

(iii) Operational specifications of security systems utilized at any government-owned or leased institution or facility, except that a general description of any such security system and the cost and quality of such system, may be disclosed;

(iv) Training manuals prepared for government-owned or leased institutions or facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(v) Internal security audits of government-owned or leased institutions or facilities;

(vi) Minutes or records of meetings, or portions of such minutes or records, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(vii) Logs or other documents that contain information on the movement or assignment of security personnel;

(viii) Emergency plans and emergency preparedness, response, recovery and mitigation plans, including plans provided by a person to a state agency or a local emergency management agency or official; and

(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, operational plans, portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection reports, technical specifications and other materials that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply. Records that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply, such as water quality reports and margin of safety information, and that only include the town or municipality in which such operating facilities, collection and distribution systems or sources of supply are located, but do not include more specific location information, such as the specific address at which such operating facilities, collection and distribution systems or sources of supply are located, may be disclosed;

(20) Records of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system;

(21) The residential, work or school address of any participant in the address confidentiality program established pursuant to sections 54-240 to 54-240o, inclusive;

(22) The electronic mail address of any person that is obtained by the Department of Transportation in connection with the implementation or administration of any plan to inform individuals about significant highway or railway incidents;

(23) The name or address of any minor enrolled in any parks and recreation program administered or sponsored by any public agency;

(24) Responses to any request for proposals or bid solicitation issued by a public agency or any record or file made by a public agency in connection with the contract award process, until such contract is executed or negotiations for the award of such contract have ended, whichever occurs earlier, provided the chief executive officer of such public agency certifies that the public interest in the disclosure of such responses, record or file is outweighed by the public interest in the confidentiality of such responses, record or file;

(25) The name, address, telephone number or electronic mail address of any person enrolled in any senior center program or any member of a senior center administered or sponsored by any public agency;

(26) All records obtained during the course of inspection, investigation, examination and audit activities of an institution, as defined in section 19a-490, that are confidential pursuant to a contract between the Department of Public Health and the United States Department of Health and Human Services relating to the Medicare and Medicaid programs.