Agency Legislative Proposal - 2017 Session

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DPH 1104 2017 Various Revisions.doc

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State Agency: Department of Public Health

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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:
Section 1. 19a-491. License and certificate required. Application. Assessment of civil penalties or a consent order. Fees. Minimum service quality standards. Regulations. Professional liability insurance. Prohibition.
Section 2. 19a-490. Licensing of institutions. Definitions.
Sections 3 & 4. 20-126*l.* Definitions. Scope of practice. Limitations. Continuing education. Exceptions.
Section 5. 10-206. Health assessments.
Section 6. 19a-580d. "Do not resuscitate" orders. Regulations.
Section 7. (NEW)
Section 8. 19a-17. Disciplinary action by department, boards and commissions.
Section 9. 20-110. Licenses to out-of-state applicants.
Section 10. 20-74a. Definitions.
Section 11. 20-195. Exempted activities and employment.
Section 12. 20-195bb. Practice restricted to licensed persons. Exemptions. Title protection.
Section 13. 20-195f. When license as marital and family therapist not required. Advertising.
Section 14. 19a-52. Purchase of equipment for handicapped children.
Section 15. 19a-53. Reports of physical defects of children.
Section 16. 19a-55. Newborn infant health screening. Testing required. Fees. Exemptions. Regulations.
Section 17. 19a-37. Regulation of water supply wells and spring. Information and requirements re testing of private residential wells.
Section 18. 20-278h. Licensure. Fee. Qualifications. Renewal. Disciplinary action. Penalty.
Section 19. Sec. 19a-320. Erection and Maintenance of Crematories.
Section 20. 19a-127*l*. Quality of Care Program. Quality of Care Advisory Committee.
Section 21. 19a-131g. Public Health Preparedness Advisory Committee. Report.
Section 22. 19a-491c. Criminal history and patient abuse background search program.

Regulations.
Section 23. **(Repealers)**
19a-6j. Interagency and Partnership Advisory Panel on Lupus. Membership.
19a-6n. Advisory council on pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. Report.
19a-59c. Administration of federal Special Supplemental Food Program For Women, Infants and Children in the state. Advisory Council.

Proposal Summary:
See below.

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: This proposal will revise the statutes pertaining to fees for facility licensure applications. The revision will ensure that a facility has provided the appropriate documentation and licensure fee prior to the Department reviewing such documentation for accuracy. Currently a facility, in particular home health agencies, applying for licensure will request the Department review their documentation prior to submission. There have been several instances where staff members have spent many hours (on average 60 hours) with the applicants and discovered they are not qualified to operate a home health facility. The Department hopes that by mandating that the licensure fee be submitted along with application documentation it will deter frivolous submissions.

Section 2: This proposal will revise the section of statute that pertains to outpatient dialysis units to include a definition of these entities. Currently, there are only regulations that pertain to the licensing and inspection of these facilities. The Department would like to codify the definition in statute for clarification of our role in licensing and inspecting these facilities to protect the safety of patients.

Sections 3 and 4: This proposal mandates a dental hygienist to have at least one contact hour in cultural competency prior to the renewal of their license. The Department of Public Health has made a commitment to health equity by adopting Cultural Linguistically Appropriate Standards a basis for addressing the needs of a diverse population. Cultural competence is defined as having a defined set of values and principles; and to demonstrate behaviors, attitudes, policies, and structures that enable individuals to work effectively cross-culturally. As a health care provider, dental hygienists should be aware of and understand the culture of the different populations that they serve to provide appropriate, person-centered care. In addition, this proposal includes a definition of a “contact hour” to clarify that the training or education

requirement are for registration periods on or after October 1, 2017 and that a "contact hour" means a minimum of 50 continuous minutes.

Section 5: This proposal revises a reporting requirement regarding the incidence of asthma diagnosis for Boards of Education from annual to triennial. Since 2004, school nurses across the state have been mandated to report on students with a diagnosis of asthma to DPH on an annual basis. Although no funding was allocated to DPH to administer and analyze data per this mandate, the Asthma Program has been utilizing a state-funded Health Program Assistant position to handle the majority of administrative duties for this reporting system. In 2016, the DPH Asthma Program permanently lost the state-funded position and hence its capacity to handle over 20,000 records reported annually. DPH Asthma Program felt it is prudent to move the reporting frequency to a triennial basis. This will lessen the burden on school nurses reporting; lessen the demand on DPH Asthma Program staff; and without compromising the information that can be derived from the reporting.

Section 6: Revises current statute to allow for an APRN to issue a Do Not Resuscitate (DNR) order and provides for clarifying language as to what constitutes a DNR. The proposal will make clear that measures included in a DNR reflect the current standards of care.

Section 7: This proposal will provide the Department with immediate notification should there be a major failure in a health care institution as defined in section 19a-490. This notification will allow the Department to assess vulnerabilities in the health care industry. A major systems failure includes: loss of water, heat, or electricity. Or if the electricity is being provided by an alternative source such as a generator. Section 5 of House Bill 6887 from the 2015 session did not pass due to a the industry's opposition to the other provision within the bill regarding civil penalties and administrator responsibilities. There was not opposition to this section of the bill.

Section 8: This proposal revises the statute to expand the action that may be taken against a licensed health care practitioner to include action taken by a Federal Agency. Currently the statute does not include consideration of disciplinary actions taken at the Federal level against a practitioner, which could include revocation of a permit or establishing a settlement by Agencies such as the Office of the Inspector General or Drug Enforcement Agency.

Section 9: Revises the statue to allow the Department to accept at least 5 years of licensed work experience from another state in lieu of the regional board examination to become licensed as a dentist. Department receives several applications on a yearly basis from dentists who have been in the practice of dentistry in other states for many years, hold unencumbered licenses, and have never been subject to disciplinary action. Pursuant to section 20-107, in order for a dentist to obtain a CT license by endorsement from another state, the requirements from the state they are currently licensed in must be equal to or greater than CT's requirements. CT licensure requires dentists to complete the ADEX exam. Those states that require a regional board examinations other than ADEX are not eligible for CT licensure without

completing the diagnostics component of the ADEX.

Section 10: This proposal clarifies the definition of occupational therapy assistant to include a definition of supervision. Current statute does not have a clear definition of what is considered "supervision" for occupational therapy assistants. The revisions to the statute will assure an occupational therapy assistant is working under the appropriate supervision.

Section 11: This proposal will prohibit an applicant for psychology licensure from continuing to provide unlicensed psychological services to clients after completing the work experience necessary for licensure, if they have either failed the test or failed to take the exam necessary to obtain licensure. Currently an unlicensed individual can provide psychological services if those services are part of a supervised course of study and they hold a doctoral degree in psychology. The completion of such supervised work experience is necessary for licensure. However, the statute is silent on how long they can provide such services under the auspice of the supervised work experience. This proposal will clarify the statute to ensure the unlicensed individual will no longer be able to continue to provide the psychological care if they haven't passed the exam or they haven't taken the exam within 6 months of graduating from their program.

Section 12: This proposal will prohibit an applicant for a professional counselor license from continuing to provide unlicensed professional counseling services to clients after completing the work experience necessary for licensure, if they have either failed the test or failed to take the exam necessary to obtain licensure. Currently an unlicensed individual can provide counseling services if the services are provided as part of their requirement to acquire 3000 hours of post graduate supervised work experience. However, the statute is silent on how long they can provide such services under the auspice of these post graduate supervised work experience. This proposal will clarify the statute to ensure the unlicensed individual will no longer be able to continue to provide the counseling services if they haven't passed the exam or they haven't taken the exam within 6 months of the work experience.

Section 13: This proposal will prohibit an applicant for licensure as a marital and family therapist from continuing to provide unlicensed marriage and family therapy services to clients after completing the work experience necessary for licensure, if they have either failed the test or failed to take the exam necessary to obtain licensure. Currently an unlicensed individual can provide marriage and family therapist services if the services are provided as part of their requirement to acquire 1000 hours of relevant postgraduate work experience. However, the statute is silent on how long they can provide such services under the auspice of the post graduate work experience. This proposal will clarify the statute to ensure the unlicensed individual will no longer be able to continue to provide the counseling services if they haven't passed the exam or they haven't taken the exam within 6 months of completing their postgraduate work experience.

Section 14: The Department is making technical changes to the language to ensure that it is

person centered. The proposal also updates statutory language to reflect the current practice of purchasing medically necessary and appropriate durable medical equipment for children with special health care needs. The purchase of this equipment must be covered under the CT Medicaid and HUSKY programs and not exceed the CT Medicaid payment rate. The proposal also mandates the hospitals that perform the tests for critical congenital heart disease on infants to report the results into the birth defects registry. This proposal codifies current practice for program staff. However, the program will now receiving the data electronically vs a paper copy which will allow them to streamline the collection of and analyze information provided on birth defects. This program has always approached it's work through the lens of health equity. Every child born in Connecticut starts with a screening for birth defects and they cannot be denied this screening based on gender race, ethnicity, socio economic status.

Sections 15 and 16: Updates several sections of statute as follows: (1) the Department's birth defects registry to codify current practice and include people first language and (2) updates the statute that pertain to "purchase of equipment for handicapped children" to reflect the current practice within the Children with Special Health Care Needs Program and (3) updates the section of statute that pertains to the reporting of critical congenital heart disease. The Department received a CDC grant to track birth defects that may present in children whose parents have contracted the Zika virus, including microcephaly. Based on this funding, the Department completed a review of the section of statute that pertains to the birth defects registry and determined that the statute was outdated and did not reflect the current reporting mechanism for hospitals and physician offices.

Section 17: The proposal eliminates language with contradictory time periods. The current law currently requires a laboratory or firm to submit results within 30 days, but also allows for the reporting of results to not be required when the laboratory or firm is informed that results are from samples collected within 6 months of a real estate transaction. The proposal also puts the statutory language in the affirmative and clarifies the law to require submittal of test results collected for a real estate transaction. If the proposal were not to go forward, a scenario exists where a laboratory or firm may submit results within the 30 day timeframe but is informed up to 5 months later that the submittal of the results is no longer required because the sale of the property did not actually occur making the next home buyer repeat the testing. Samples for a real estate transaction are typically collected during the home inspection by a potential buyer once an offer has been accepted by the seller. Mortgage companies also typically require water samples results before approval of the mortgage application to demonstrate the water supply for the home is supplied with potable water. As current written, the law requires a laboratory or firm to submit results within 30 days of the tests. In most cases, the closing for the sale of the property may not occur within 30 days from date the samples are collected. In some cases the closing of the sale of a property may not take place for months after due to Hubbard Law clauses or if the sales contract requires substantial improvements to be made to the property as a condition of the sale.

Section 18: Revises the language pertaining to bulk water haulers to ensure they are delivering water to private well and semipublic well users from an approved source of supply and a licensed bulk water hauler. This legislative proposal ensures that private well and semipublic well users that may need to rely on the delivery of bulk water haulers receive the same water quality from an approved source of supply and from such licensed bulk water hauler. This proposal clarifies the form and manner which the testing for public and semi-public wells needs to be completed. **Health Equity:** This proposal will help reduce health disparities by ensuring that all persons receive quality water regardless of the type of water system they have. It is common for more rural and some suburban residents obtain water from a well vs a public water system. The water in a public water system is treated before it comes out of the tap, which is not the case in a well or semi-public well. This proposal allows for users of well water to obtain the same quality of water if a delivery is needed as a person on a public water system.

Section 19: The proposal revises section 19a-320 which pertains to crematories to ensure a crematory is not located within 500 feet of any residential structure or land used for residential purposes. In 1998 section 19a-320 was updated to reflect a 500 feet setback to ensure crematories were not built near any residential structure or land used for residential purposes. During the 2009 session, legislation was passed to allow a municipality jurisdiction to exercise discretion over local zoning laws that pertain to crematories. As it currently stands, the separating distance of 500 feet would not apply to municipalities with zoning regulations that are silent on crematories. This proposal will clarify that all crematories must be 500 feet from residential structures or land regardless of local ordinances. The primary purpose of this legislative proposal is to codify language concerning setback distances for new crematories relative to residential buildings/land. This is a prudent avoidance measure to address a health concern.

Section 20: This proposal will revise the statute pertaining to the Quality in Healthcare Advisory Committee. The statutes that pertain to the Quality of Care Advisory Committee mandates the Department to meet on a semi-annual basis since 2002. The Department feels that the Committee has completed its statutory mission and the need for semi-annual meetings is no longer needed. This proposal recommends changing the “shall” to a “may” in the section of statute that mandates the frequency of Committee meetings. Which will allow the Commissioner to convene a meeting if necessary.

Section 21: This proposal will revise the statute pertaining the Public Health Preparedness Advisory Committee. The statue that pertains to the Public Health Preparedness Advisory Committee was created in 2003 to develop a plan to respond to a public health emergency including notification services. The plan has been developed and is in place. There is no longer a need for the advisory committee to continue to “develop the plan”. The revisions to this proposal maintains the public health preparedness committee, and allows the commissioner to

convene a meeting as necessary to support the Department in our efforts to maintain public health preparedness.

Section 22: This proposal permits long term care facilities to continue to employee applicants on a conditional, supervised basis pending the determination of an applicant's request for a waiver of a disqualifying offense. Currently the statute mandates any individual providing direct patient care in a long term care setting submit to a background check that includes fingerprinting. If the results of the applicant's background check are reported to the department with a disqualifying offense as outlined in statute, the applicant has the opportunity to seek a waiver. Applicants may be hired on a conditional basis for a period not to exceed 60 days while waiting for the results of the fingerprinting, but the 60 days does not include time for the review of any waiver request submitted. The proposal will allow for the applicant to be hired provisionally while waiting for the results of the department's determination of their waiver request.

Section 23. Repealers:

This proposal repeals the mandate for the Department to participate on the Interagency and Partnership Advisory Panel on Lupus, pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome council, and the WIC advisory council. Section 19a-6j established the Interagency and Partnership Advisory Panel on Lupus. This statue was created in 2011 to analyze education efforts regarding lupus and identify gaps in the current lupus education modalities in the state; and evaluate materials and resources currently available from government agencies, hospitals and lupus advocacy organizations. The Advisory Panel has fulfilled its obligation and created a complete needs assessment through private funding. Any further work of this group would require additional funding and resources that are not available at this time for activities such as conducting workshops and creating a directory of lupus-related health resources. The Department recommends repealing this statute as the advisory panel has not met since 2012.

Section 19a-6n established the pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome council. The Department was mandated to provide administrative support to the Council, and the Council also elected the DPH representative to serve as co-chair of the council. Since 2013 the Department has held the required meetings and has found that the Advisory Council rarely has a quorum. No major new advances on this condition have been identified in the last three years that would help create an evidence-informed basis for advancing the recommendations or furthering the work of the committee. The Department has limited resources and recommends that the Advisory Council be repealed.

Section 19a-59c established the Women, Infants and Children Advisory Council. The Council was created in 1988 to advise the Department on issues pertaining to increased participation and access to services under the federal Special Supplemental Food Program for Women, Infants and Children. The Department currently has policies and procedures in place to

maximize participation and access to these services and has been compliant with the federal mandates. The Council stopped meeting at least three years ago and the Department feels that the council is no longer necessary as it has fulfilled its purpose.

◊ **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*)

Section 5.
Agency Name: Department of Education
Agency Contact (*name, title, phone*): Laura Stefon
Date Contacted: 10/3/2016

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

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

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

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

Section 6.
Agency Name: Department of Aging
Agency Contact (*name, title, phone*): Pam Toohey
Date Contacted: 11/3/2016

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

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

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

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

Sections 14, 15 and 16:
Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Krista Ostaszewski
Date Contacted: 11/2/2016

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

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

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

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

Section 19
Agency Name: Department of Energy and Environmental Protection
Agency Contact (*name, title, phone*): Rob LaFrance, Liz McAullife
Date Contacted: 11/3/2016

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

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

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

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

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

State: None

Federal: None

Additional notes on fiscal impact
Click here to enter text.

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

Various

Section 1. Subsection (a) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person acting individually or jointly with any other person shall establish, conduct, operate or maintain an institution in this state without a license as required by this chapter, except for persons issued a license by the Commissioner of Children and Families pursuant to section 17a-145 for the operation of (1) a substance abuse treatment facility, or (2) a facility for the purpose of caring for women during pregnancies and for women and their infants following such pregnancies. Application for such license shall be: (1) made to the Department of Public Health upon forms provided by it; (2) accompanied by such fee as outlined in subsections (c), (d) and (e) of this section; and [shall] (3) contain such information as the department requires, which may include affirmative evidence of ability to comply with reasonable standards and regulations prescribed under the provisions of this chapter. The commissioner may require as a condition of licensure that an applicant sign a consent order providing reasonable assurances of compliance with the Public Health Code. The commissioner may issue more than one chronic disease hospital license to a single institution until such time as the state offers a rehabilitation hospital license.

Sec. 2. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, outpatient clinic, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability;

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

(c) "Residential care home", "nursing home" or "rest home" means an establishment that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy

or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

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

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

(g) “Mental health facility” means any facility for the care or treatment of mentally ill or emotionally disturbed persons, or any mental health outpatient treatment facility that provides treatment to persons sixteen years of age or older who are receiving services from the Department of Mental Health and Addiction Services, but does not include family care homes for the mentally ill;

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

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

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

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

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

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

(n) “Multicare institution” means a hospital, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric

disabilities, as defined in section 17a-495, or a general acute care hospital that provides outpatient behavioral health services that (A) is licensed in accordance with this chapter, (B) has more than one facility or one or more satellite units owned and operated by a single licensee, and (C) offers complex patient health care services at each facility or satellite unit.

(o) “Outpatient Dialysis Unit” means an out-of-hospital out-patient dialysis unit that is a licensed facility which provides services on an out-patient basis to persons requiring dialysis on a short term basis or for a chronic condition or training for home dialysis; or An in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to offer dialysis therapy on an out-patient basis, and to provide training for home dialysis and renal transplantation as appropriate.

Sec. 3. Subsection (a) of section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof:

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

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

(3) The "practice of dental hygiene" means the performance of educational, preventive and therapeutic services including: Complete prophylaxis; the removal of calcerous deposits, accretions and stains from the supragingival and subgingival surfaces of the teeth by scaling, root planing and polishing; the application of pit and fissure sealants and topical solutions to exposed portions of the teeth; dental hygiene examinations and the charting of oral conditions; dental hygiene assessment, treatment planning and evaluation; the administration of local anesthesia in accordance with the provisions of subsection (d) of this section; and collaboration in the implementation of the oral health care regimen; and

(4) "Contact hour" means a minimum of fifty minutes of continuing education activity.

Sec. 4. Subsection (g) of section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(g) Each licensed dental hygienist applying for license renewal shall earn a minimum of sixteen hours of continuing education within the preceding twenty-four-month period, including, for registration periods beginning on and after October 1, 2017, at least one contact hour of training or education in cultural competency. The subject matter for continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public. Continuing education activities shall provide significant theoretical or practical content directly related to clinical or scientific aspects of

dental hygiene. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, that are offered or approved by dental schools and other institutions of higher education that are accredited or recognized by the Council on Dental Accreditation, a regional accrediting organization, the American Dental Association, a state, district or local dental association or society affiliated with the American Dental Association, the National Dental Association, the American Dental Hygienists Association or a state, district or local dental hygiene association or society affiliated with the American Dental Hygienists Association, the Academy of General Dentistry, the Academy of Dental Hygiene, the American Red Cross or the American Heart Association when sponsoring programs in cardiopulmonary resuscitation or cardiac life support, the United States Department of Veterans Affairs and armed forces of the United States when conducting programs at United States governmental facilities, a hospital or other health care institution, agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation, local, state or national medical associations, or a state or local health department. Eight hours of volunteer dental practice at a public health facility, as defined in subsection (a) of this section, may be substituted for one hour of continuing education, up to a maximum of five hours in one two-year period. Activities that do not qualify toward meeting these requirements include professional organizational business meetings, speeches delivered at luncheons or banquets, and the reading of books, articles, or professional journals. Not more than four hours of continuing education may be earned through an on-line or other distance learning program.

Sec. 5. Subsection (f) of section 10-206 of the general statutes is repealed and the following is substituted in lieu thereof:

(f) On and after [February 1, 2004] <u>October 1, 2017</u>, each local or regional board of education shall report to the local health department and the Department of Public Health, on an [annual] <u>triennial</u> basis, the total number of pupils per school and per school district having a diagnosis of asthma (1) at the time of public school enrollment, (2) in grade six or seven, and (3) in grade ten or eleven. The report shall contain the asthma information collected as required under subsections (b) and (c) of this section and shall include pupil age, gender, race, ethnicity and school. Beginning on October 1, 2004, and every three years thereafter, the Department of Public Health shall review the asthma screening information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning asthma trends and distributions among pupils enrolled in the public schools. The report shall be submitted in accordance with the provisions of section 11-4a and shall include, but not be limited to, trends and findings based on pupil age, gender, race, ethnicity, school and the education reference group, as determined by the Department of Education for the town or regional school district in which such school is located.

Sec. 6. Section 19a-580d of the general statutes as revised in public act 16-39 is repealed and the following is substituted in lieu thereof:

<u>For the purposes of this section, Do not resuscitate order or ‘DNR order’’ means an order written by a Connecticut licensed physician or advanced practice registered nurse to withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive</u>

or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient. The Department of Public Health shall adopt regulations, in accordance with chapter 54, to provide for a system governing the recognition and transfer of "do not resuscitate" orders between health care institutions licensed pursuant to chapter 368v and upon intervention by emergency medical services providers certified or licensed pursuant to chapter 368d. The regulations shall include, but not be limited to, procedures concerning the use of "do not resuscitate" bracelets. The regulations shall specify that, upon request of the patient or his or her authorized representative, the physician or advanced practice registered nurse who issued the "do not resuscitate" order shall assist the patient or his or her authorized representative in utilizing the system. The regulations shall not limit the authority of the Commissioner of Developmental Services under subsection (g) of section 17a-238 concerning orders applied to persons receiving services under the direction of the Commissioner of Developmental Services.

Sec. 7. (NEW)

(NEW) Establishment of mandatory reporting of any major failures in an institution. All healthcare institutions as defined in section 19a-490 shall report to the Department of Public Health any major system failures, that shall include but not be limited to loss of water, loss of heat, loss of electricity and any incident that causes an activation of the institution's emergency preparedness plan. Failure to comply with such reporting may result in the imposition of a fine, not to exceed one hundred dollars per day pursuant to the event until compliance with such reporting has been achieved.

Section 8. Subsection (a) of Section 19a-17 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each board or commission established under chapters 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive, and the Department of Public Health with respect to professions under its jurisdiction that have no board or commission may take any of the following actions, singly or in combination, based on conduct that occurred prior or subsequent to the issuance of a permit or a license upon finding the existence of good cause:

(1) Revoke a practitioner's license or permit;

(2) Suspend a practitioner's license or permit;

(3) Censure a practitioner or permittee;

(4) Issue a letter of reprimand to a practitioner or permittee;

(5) Place a practitioner or permittee on probationary status and require the practitioner or permittee to:

(A) Report regularly to such board, commission or department upon the matters which are the basis of probation;

(B) Limit practice to those areas prescribed by such board, commission or department;

(C) Continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation;

(6) Assess a civil penalty of up to twenty-five thousand dollars;

(7) In those cases involving persons or entities licensed or certified pursuant to sections 20-341d, 20-435, 20-436, 20-437, 20-438, 20-475 and 20-476, require that restitution be made to an injured property owner; or

(8) Summarily take any action specified in this subsection against a practitioner's license or permit upon receipt of proof that such practitioner has been:

(A) Found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law, or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state; or

(B) Subject to disciplinary action similar to that specified in this subsection by a duly authorized professional agency of any state, federal agency, the District of Columbia, a United States possession or territory or a foreign jurisdiction. The applicable board or commission, or the department shall promptly notify the practitioner or permittee that his license or permit has been summarily acted upon pursuant to this subsection and shall institute formal proceedings for revocation within ninety days after such notification.

Sec. 9. Section 20-110 of the general statutes is repealed and the following is substituted in lieu thereof (Effective upon passage):

Licenses to out-of-state applicants. [The Department of Public Health may without examination, issue a license to any dentist who is licensed in some other state or territory, if such other state or territory has requirements for admission determined by the department to be similar to or higher than the requirements of this state, upon certification from the board of examiners or like board of the state or territory in which such dentist was a practitioner certifying to his competency and upon payment of a fee of five hundred sixty-five dollars to said department.] Notwithstanding the provisions of section 20-108a, the Department of Public Health may, upon payment of a fee of five hundred sixty five dollars, issue a license without examination to a currently practicing, competent dentist in another state or territory who (1) holds a current valid license in good professional standing issued after examination by another state or territory that maintains licensing standards which, except for the practical examination, are commensurate with this state's standards, and (2) has worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for a period of not less than five years immediately preceding the application for licensure without examination. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. The department shall inform the Dental Commission annually of the number of applications it receives for licensure under this section.

Sec. 10. Section 20-74a of the general statutes is repealed and the following is substituted in lieu thereof:

(1) "Occupational therapy" means the evaluation, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental [deficits] disabilities, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated [disfunction] dysfunction, using (A) such treatment techniques as task-oriented activities to prevent or correct physical or emotional [deficits] disabilities or to minimize the disabling effect of these [deficits] disabilities in the life of the individual, (B) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the [handicapped] disabled, (C) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in groups or through social systems. Occupational therapy also includes the establishment and modification of peer review.

(2) "Occupational therapist" means a person licensed to practice occupational therapy as defined in this chapter and whose license is in good standing.

(3) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist, and whose license is in good standing.

(4) "Commissioner" means the Commissioner of Public Health or the Commissioner's designee.

(5) "Department" means the Department of Public Health.

(6) "Supervision" means the overseeing of or the participation in the work of a occupational therapist assistant by a licensed occupational therapist, including, but not limited to: (A) Continuous availability of direct communication between the occupational therapist assistant and a licensed occupational therapist; (B) availability of a licensed occupational therapist on a regularly scheduled basis to (i) review the practice of the occupational therapist assistant, and (ii) support the occupational therapist assistant in the performance of the occupational therapist assistant's services; and (C) a predetermined plan for emergency situations, including the designation of an alternate licensed occupational therapist in the absence of the regular licensed occupational therapist;

Sec. 11. Section 20-195 of the general statutes is repealed and the following is substituted in lieu thereof (Effective upon passage):

(a) Nothing in this chapter shall be construed to limit the activities and services of a graduate student, intern or resident in psychology, pursuing a course of study in an educational institution under the provisions of section 20-189, if such activities constitute a part of a supervised course of study. No license as a psychologist shall be required of a person holding a doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved under the provisions of section 20-189, provided such activities and services are necessary to satisfy the work experience as required by section 20-188. Such privilege shall cease upon notification that the person did not successfully complete the licensing examination or after six months following completion of such work experience. The provisions of this chapter shall not apply to any person in the salaried employ of any person, firm, corporation, educational institution or governmental agency when acting within the person's own organization. Nothing in this chapter shall be construed to prevent the giving of accurate information concerning education and experience by any person in any application for employment. Nothing in this chapter shall be construed to prevent physicians, optometrists, chiropractors, members of the clergy, attorneys-at-law or social workers from doing work of a psychological nature consistent with accepted standards in their respective professions.

Sec. 12. Subsection (c) of section 20-195bb of the general statutes is repealed and the following is substituted in lieu thereof (Effective upon passage):

(c) No license as a professional counselor shall be required of the following: (1) A person who furnishes uncompensated assistance in an emergency; (2) a clergyman, priest, minister, rabbi or practitioner of any religious denomination accredited by the religious body to which the person belongs and settled in the work of the ministry, provided the activities that would otherwise require a license as a professional counselor are within the scope of ministerial duties; (3) a sexual assault counselor, as defined in section 52-146k; (4) a person participating in uncompensated group or individual counseling; (5) a person with a master's degree in a health-related or human services-related field employed by a hospital, as defined in subsection (b) of section 19a-490, performing services in accordance with section 20-195aa under the supervision of a person licensed by the state in one of the professions identified in subparagraphs (A) to (F), inclusive, of subdivision (2) of subsection (a) of section 20-195dd; (6) a person licensed or certified by any agency of this state and performing services within the scope of practice for which licensed or certified; (7) a student, intern or trainee pursuing a course of study in counseling in a regionally accredited institution of higher education, provided the activities that would otherwise require a license as a professional counselor are performed under supervision and constitute a part of a supervised course of study; (8) a person employed by an institution of higher education to provide academic counseling in conjunction with the institution's programs and services; [or] (9) a vocational rehabilitation counselor, job counselor, credit counselor, consumer counselor or any other counselor or psychoanalyst who does not purport to be a counselor whose primary service is the application of established principles of psycho-social development and behavioral science to the evaluation, assessment, analysis and treatment of emotional, behavioral or interpersonal dysfunction or difficulties that interfere with mental health and human development; (10)

person holding a degree that meets the requirements of subdivision (2) of subsection (a) of Section 20-195dd, provided such activities and services constitute a part of the supervised work experience required for licensure. Such privilege shall cease upon notification that the person did not successfully complete the licensing examination or after six months following completion of such work experience.

Sec. 13. Subsection (a) of section 20-195f of the general statutes is repealed and the following is substituted in lieu thereof (Effective Upon Passage):

(a) No license as a marital and family therapist shall be required of: (1) A student pursuing a course of study in an educational institution meeting the requirements of section 20-195c if such activities constitute a part of his supervised course of study; (2) a faculty member within an institution of higher learning performing duties consistent with his position; (3) [a person holding a graduate degree in marriage and family therapy or a certificate of completion of a postdegree program for marriage and family therapy education, provided such activities and services constitute a part of his supervised work experience required for licensure;] a person holding a graduate degree in marriage and family therapy, provided such activities and services constitute a part of the supervised work experience required for licensure. Such privilege shall cease after completion of the supervised work experience and upon notification that the person did not successfully complete the licensing examination or if the person has not taken the licensing examination, after three months following completion of such work experience; or (4) a person licensed or certified in this state in a field other than marital and family therapy practicing within the scope of such license or certification.

Sec. 14. Section 19a-52 of the general statutes is repealed and the following is substituted in lieu thereof:

Purchase of equipment for [handicapped] children and youth with special health care needs. Notwithstanding any other provision of the general statutes, the Department of Public Health and it's contractors, in carrying out its powers and duties under section 19a-50, may, within the limits of appropriations, purchase [wheelchairs and placement equipment directly and without the issuance of a purchase order, provided such purchases shall not be in excess of six thousand five hundred dollars per unit purchased. All such purchases shall be made in the open market, but shall, when possible, be based on at least three competitive bids. Such bids shall be solicited by sending notice to prospective suppliers and by posting notice on a public bulletin board within said Department of Public Health. Each bid shall be opened publicly at the time stated in the notice soliciting such bid. Acceptance of a bid by said Department of Public Health shall be based on standard specifications as may be adopted by said department] medically necessary and appropriate durable medical equipment and other department approved goods and services. Such services shall be identical to goods and services that are covered under the Connecticut Medicaid and HUSKY Programs and the payment for such goods and services shall not exceed the Connecticut Medicaid payment rate for the same goods and services.

Sec. 15. Section 19a-53 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Definitions. As used in this section:

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

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

(3) "Licensed health care professional" means a physician licensed pursuant to chapter 370; a physician assistant licensed pursuant to chapter 370; an advanced practice registered nurse or a registered nurse licensed pursuant to chapter 378; or a nurse midwife licensed pursuant to chapter 377; and

(4) "Newborn screening system" means the department's tracking system for the screening of newborns pursuant to section 19a-55.

(b) The Department of Public Health may, within available appropriations, establish a birth defects surveillance program. Such program shall monitor the frequency, distribution and type of birth defects occurring in Connecticut.

(c) [Each person licensed to practice medicine, surgery, midwifery, chiropractic, naturopathy, podiatry or nursing or to use any other means or agencies to treat, prescribe for, heal or otherwise alleviate deformity, ailment, disease or any other form of human ills, who has professional knowledge that any child under five years of age has any physical defect shall, within forty-eight hours from the time of acquiring such knowledge, mail to the Department of Public Health a report, stating the name and address of the child, the name and address of the child's parents or guardians,] Each child that is born in the state of Connecticut shall have a birth defect screening completed by a licensed health care professional prior to discharge from the hospital. The administrative officer or other person in charge of each institution shall enter the results of such birth defects screening into the birth defects registry located within the department's newborn screening system in a form and manner as prescribed by the Commissioner.

(d) Any child born in the state of Connecticut that is seen by a licensed health care professional in Connecticut who has knowledge that any child up to age one has a birth defect shall within forty eight hours from the time of acquiring such knowledge, submit a birth defects reporting form to the department in a form and manner as prescribed by the Commissioner. Such reporting form shall contain, but not be limited to, the nature of the [physical] birth defect and such other information as may reasonably be required by the department. The department shall [prepare and furnish suitable blanks in duplicate for such reports] post such form to the Department's website and, shall keep each report on file for at least six years from the date of the receipt. [thereof and shall furnish a copy thereof to the State Board of Education within ten days.]

(e) The Commissioner shall have access to identifying information in hospital discharge records upon request. Such identifying information shall be used solely for purposes of the program. A hospital as defined in 19a-490 shall make available to the department upon request the medical records of a

patient diagnosed with a birth defect or other adverse reproductive outcomes for purposes of research and verification of data.

(f) The commissioner shall use the information collected pursuant to this section and information available from other sources to conduct routine analyses to determine associations that may be related to preventable causes of birth defects.
(g) All information including but not limited to personal data collected and analyzed from a health care practitioner or a hospital pursuant to this section shall be considered confidential. Such personal data shall be considered confidential as prescribed in chapter 55 and section 19a-25 and shall be used solely for the purposes of the birth defects surveillance program. Access to such information shall be limited to the Department of Public Health and persons with a valid scientific interest and qualifications as determined by the Commissioner of Public Health, provided the department and such persons are engaged in demographic, epidemiologic or other similar studies related to health and agree, in writing, to maintain confidentiality as prescribed in this section and section 19a-25.

(h) The commissioner shall prepare detailed policies and procedures for maintaining confidentiality of program information.

(i) The commissioner shall maintain an accurate record of all persons who are given access to the information in the system. The record shall include: The name, title and organizational affiliation of persons given access; dates of access; and the specific purpose for which information is to be used. The record of access shall be open to public inspection during the department's normal operating hours.

(j) All research proposed to be conducted using identifying information in the system established pursuant to this section or requiring contact with affected individuals shall be reviewed and approved in advance by the commissioner.

(k) The commissioner may publish statistical compilations relating to birth defects or other adverse reproductive outcomes which do not in any way identify individual cases or individual sources of information.

(l) Any person who, in violation of a written agreement to maintain confidentiality, discloses any information provided pursuant to this section, or who uses information provided pursuant to this section in a manner other than that approved by the department, may be denied further access to any confidential information maintained by the program. This denial of access shall not be construed as restricting any remedy, provisional or otherwise, provided by law for the benefit of the department or person.

Sec. 16. Subsection (b) of section 19a-55 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) In addition to the testing requirements prescribed in subsection (a) of this section, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to (1) every such infant in its care a screening test for (A) cystic fibrosis,

(B) severe combined immunodeficiency disease, and (C) critical congenital heart disease, and (2) any newborn infant who fails a newborn hearing screening, as described in section 19a-59, a screening test for cytomegalovirus, provided such screening test shall be administered within available appropriations on and after January 1, 2016. On or after January 1, 2018, the administrative officer or other person in charge of each institution caring for newborn infants who performs the testing for critical congenital heart disease shall report the results of such test to the to the newborn screening system pursuant to section 19a-53. Such screening tests shall be administered as soon after birth as is medically appropriate.

Sec. 17. Section 19a-37 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Definitions. As used in this section.

(1) "laboratory or firm" means an environmental laboratory registered by the Department of Public Health pursuant to section 19a-29a;
(2) "Private well" means a water supply well that meets all of the following criteria:
(A) is not a public well;
(B) supplies a population of less than 25 people; and
(C) is owned or controlled through an easement, by the same entity as the building or parcel that are served;
(3) "Public well" means a water supply well that supplies a public water system;
(4) "Semipublic well" means a water supply well that does not meet the definition of a private well or public well, and provides water for drinking and other domestic purposes; and
(5) "Water supply well'' means an artificial excavation, constructed by any method, for the purpose of getting water for drinking or other domestic use.

(b) The Commissioner of Public Health may adopt regulations in the Public Health Code for the preservation of the public health pertaining to (1) protection and location of new water supply wells or springs for residential construction or for public or semipublic use, and (2) inspection for compliance with the provisions of municipal regulations adopted pursuant to section 22a-354p.

[(b)] (c) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, for the testing of water quality in private residential wells and wells for semipublic use. Any laboratory or firm which conducts a water quality test on a private well serving a residential property or well for semipublic use shall, not later than thirty days after the completion of such test, report the results of such test to (1) the public health authority of the municipality where the property is located, and (2) the Department of Public Health in a format specified by the department, provided such report shall [not] only be required if the party for whom the laboratory or firm conducted such test informs the laboratory or firm that the test was [not conducted within six months of] for the sale of such property. No regulation may require such a test to be conducted as a consequence or a condition of the sale, exchange, transfer, purchase or rental of the real property on which the private residential well or well for semipublic use is located. [For purposes of this section, "laboratory or firm" means an environmental laboratory registered by the Department of Public Health pursuant to section 19a-29a.]

[(c)] (d) Prior to the sale, exchange, purchase, transfer or rental of real property on which a residential well is located, the owner shall provide the buyer or tenant notice that educational material concerning private well testing is available on the Department of Public Health web site. Failure to provide such notice shall not invalidate any sale, exchange, purchase, transfer or rental of real property. If the seller or landlord provides such notice in writing, the seller or landlord and any real estate licensee shall be deemed to have fully satisfied any duty to notify the buyer or tenant that the subject real property is located in an area for which there are reasonable grounds for testing under subsection [(f)] (g) or [(i)] (j) of this section.

[(d)] (e) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to clarify the criteria under which the commissioner may issue a well permit exception and to describe the terms and conditions that shall be imposed when a well is allowed at a premises (1) that is connected to a public water supply system, or (2) whose boundary is located within two hundred feet of an approved community water supply system, measured along a street, alley or easement. Such regulations shall (A) provide for notification of the permit to the public water supplier, (B) address the quality of the water supplied from the well, the means and extent to which the well shall not be interconnected with the public water supply, the need for a physical separation, and the installation of a reduced pressure device for backflow prevention, the inspection and testing requirements of any such reduced pressure device, and (C) identify the extent and frequency of water quality testing required for the well supply.

[(e)] (f) No regulation may require that a certificate of occupancy for a dwelling unit on such residential property be withheld or revoked on the basis of a water quality test performed on a private residential well pursuant to this section, unless such test results indicate that any maximum contaminant level applicable to public water supply systems for any contaminant listed in the public health code has been exceeded. No administrative agency, health district or municipal health officer may withhold or cause to be withheld such a certificate of occupancy except as provided in this section.

[(f)] (g) The local director of health may require a private residential well or well for semipublic use to be tested for arsenic, radium, uranium, radon or gross alpha emitters, when there are reasonable grounds to suspect that such contaminants are present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the existence of a geological area known to have naturally occurring arsenic, radium, uranium, radon or gross alpha emitter deposits in the bedrock; or (2) the well is located in an area in which it is known that arsenic, radium, uranium, radon or gross alpha emitters are present in the groundwater.

[(g)] (h) Except as provided in subsection (h) of this section, the collection of samples for determining the water quality of private residential wells and wells for semipublic use may be made only by (1) employees of a laboratory or firm certified or approved by the Department of Public Health to test drinking water, if such employees have been trained in sample collection techniques, (2) certified water operators, (3) local health departments and state employees trained in sample collection techniques, or (4) individuals with training and experience that the Department of Public Health deems sufficient.

[(h)] (i) Any owner of a residential construction, including, but not limited to, a homeowner, on which a private residential well is located or any general contractor of a new residential construction on which a private residential well is located may collect samples of well water for submission to a laboratory or firm for the purposes of testing water quality pursuant to this section, provided (1) such laboratory or firm has provided instructions to said owner or general contractor on how to collect such samples, and (2) such owner or general contractor is identified to the subsequent owner on a form to be prescribed by the Department of Public Health. No regulation may prohibit or impede such collection or analysis.

[(i)] (j) The local director of health may require private residential wells and wells for semipublic use to be tested for pesticides, herbicides or organic chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the presence of nitrate-nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (2) that the private residential well or well for semipublic use is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.

Sec. 18. Subsection (a) of section 20-278h of the general statutes is repealed and the following is substituted in lieu thereof:

(a) On and after October 1, 2014, no person shall act as a bulk water hauler unless such person has obtained a license issued by the Department of Public Health in accordance with this section. For purposes of this section: (1) “Bulk water hauling” means transporting water in bulk by any means to a water company, [or] a consumer of a water company, or any building currently supplied by a private well or semipublic well [in bulk by any means], where such water is to be used for private, semipublic or public drinking water supply purposes; (2) “bulk” means two hundred fifty gallons of water or more; (3) “consumer” has the same meaning as in section 25-32a; (4) “water company” has the same meaning as in section 25-32a; [and] (5) “commissioner” means the Commissioner of Public Health or the commissioner’s designee; and (6) for purposes of this section, “private well” and “semipublic well” has the same meaning as in section 19a-37.

Sec. 19. Subsection (a) of section 19a-320 of the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2017):

(a) Any resident of this state, or any corporation formed under the law of this state, may erect, maintain and conduct a crematory in this state and provide the necessary appliances and facilities for the disposal by incineration of the bodies of the dead, in accordance with the provisions of this section. The location of such crematory shall be within the confines of an established cemetery containing not less than twenty acres, which cemetery shall have been in existence and operation for at least five years immediately preceding the time of the erection of such crematory, or shall be within the confines of a plot of land approved for the location of a crematory by the selectmen of any town, the mayor and council or board of aldermen of any city and the warden and burgesses of any borough; provided, in any town, city or borough having a zoning commission, such commission shall have the authority to grant such approval. No crematory shall be located within five hundred feet of any residential structure

or land used for residential purposes not owned by the owner of the crematory. These provisions shall not apply to any crematory currently operating within five hundred feet of any residential structure or land used for residential purposes not owned by the owner of the crematory on or before July 1, 2017. **[**This section shall not apply to any resident of this state or any corporation formed under the law of this state that was issued an air quality permit by the Department of Environmental Protection prior to October 1, 1998.**]**

Sec. 20. Subsection (c)(1) of section 19a-127*l* of the general statutes is repealed and the following is substituted in lieu thereof:

(c) (1) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee [shall] may meet [at least] semiannually.

Sec. 21. Section 19a-131g of the general statutes is repealed and the following is substituted in lieu thereof:

The Commissioner of Public Health shall establish a Public Health Preparedness Advisory Committee for purposes of advising the Commissioner of Public Health on matters concerning emergency responses to a public health emergency. The advisory committee shall consist of the Commissioner of Public Health, the Commissioner of Emergency Services and Public Protection, the president pro tempore of the Senate, the speaker of the House of Representatives, the majority and minority leaders of both houses of the General Assembly and the chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, public safety and the judiciary, and representatives of town, city, borough and district directors of health, as appointed by the commissioner, and any other organization or persons that the commissioner deems relevant to the issues of public health preparedness. Upon the request of the Commissioner, [The] the Public Health Preparedness Advisory Committee [shall develop] may meet to review the plan for emergency responses to a public health emergency and other matters as deemed necessary by the commissioner. [Such plan may include an emergency notification service. Not later than January 1, 2004, and annually thereafter, the committee shall submit a report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and public safety, on the status of a public health emergency plan and the resources needed for implementation of such plan].

Sec 22. Subsection (f) of section 19a-491c of the general statutes is repealed and the following is substituted in lieu thereof:

(f) (1) Except as provided in subdivision (2) of this subsection, a long-term care facility shall not employ, enter into a contract with or allow to volunteer any individual required to submit to a background search until the long-term care facility receives notice from the Department of Public Health pursuant to subdivision (4) of subsection (d) of this section.

(2) A long-term care facility may employ, enter into a contract with or allow to volunteer an individual required to submit to a background search on a conditional basis before the long-term care facility receives notice from the department that such individual does not have a disqualifying offense, provided: (A) The employment or contractual or volunteer period on a conditional basis shall last not more than sixty days, except that the sixty day time period may be extended by the department to allow for the filing and consideration of a waiver request of a disqualifying offense filed by an individual pursuant to subsection (d), (B) the long-term care facility has begun the review required under subsection (c) of this section and the individual has submitted to checks pursuant to subsection (c) of this section, (C) the individual is subject to direct, on-site supervision during the course of such conditional employment or contractual or volunteer period, and (D) the individual, in a signed statement (i) affirms that the individual has not committed a disqualifying offense, and (ii) acknowledges that a disqualifying offense reported in the background search required by subsection (c) of this section shall constitute good cause for termination and a long-term care facility may terminate the individual if a disqualifying offense is reported in said background search.

Sec. 23. Sections 19a-6j, 19a-6n and 19a-59c of the general statutes are repealed.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
DPH 1104 Clean Indoor Air Act

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

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Community Family and Health Equity Section, Tobacco Control Program
Agency Analyst/Drafter of Proposal: Barbara Walsh

Title of Proposal: An Act Concerning Enhancements in Tobacco Control
Statutory Reference: **Section 1.** 19a-342 Smoking Prohibited. Exemptions. Signs required. Penalties. **Section 2.** 19a-342a. Use of electronic nicotine delivery system or vapor product prohibited. Exceptions. Signage required. Penalties. **Sections 3 and 4.** 31-40q Smoking in the workplace. Designation of smoking rooms. **Section 5.** 53-344 Sale or delivery of Tobacco to minors. Purchase or misrepresentation of age to purchase tobacco or possession of tobacco in public place by persons under eighteen. Transaction Scans. Affirmative defense. **Section 6.** 53-344a Sale of tobacco. Proof of age. **Section 7.** 53-344b Sale or delivery of electronic delivery system or vapor product to minors. Purchase or misrepresentation of age by persons under eighteen. Transaction scans. Affirmative defense.
Proposal Summary: Section 1. Prohibits smoking: on any school property, regardless of whether school is in session or student activities are being conducted and outdoor dining areas of restaurants; Deletes the exemptions for correctional facilities, designated smoking areas in psychiatric facilities, and public housing projects; Incorporates clearer language to allow for research studies to be conducted in both the Clean Indoor Air Act and within the statute for possession by minors; Includes electronic nicotine delivery systems (ENDS) or vapor products into the language for workplaces and eliminates the allowance for designated smoking rooms in hotels; Allows for signage to be posted in one conspicuous place rather than in every room; Prohibits smoking inside or outside any building including its entryway; Removes the preemptive language that restricts municipalities from implementing stronger indoor air laws; Eliminates the language that exempts employers with less than five employees; Eliminates the language that permits

smoking rooms in places of employment; Incorporates the definition of hookah tobacco into the definition of smoking.

Section 2. Clarifies that a vapor product as defined in section 19a-342a does not include medicinal or therapeutic treatment; Prohibits use of ENDS in any area of a school building or on school property, regardless of whether school is in session or student activities are being conducted; Removes the preemptive language that restricts municipalities from implementing stronger indoor air laws.

Section 3. Technical correction to clarify that a business facility does not include a correctional facility, public housing project and outdoor dining areas of restaurants and further clarifies that hookah and ENDS are considered "smoking".

Section 4. Allows a business owner to prohibit smoking on the entire property in which the business is located; and allows entities that are participating in scientific studies being conducted to include persons under age 18. This section also includes a technical change requested by DMHAS to increase the criminal infraction schedule (violation time period) to mirror the schedule established in the civil statute Section 12-285 from 18 months to 24 months.

Section 5. Increase the age for the sale of tobacco products to those 21 and older; and incorporates clearer language to allow for research studies to be conducted.

Section 6. Incorporates the definition of electronic nicotine delivery systems into the definition of smoking for purposes of the clean indoor air act.

Section 7. Makes technical changes and incorporates clearer language to allow for research studies to be conducted regarding ENDS; and allows entities that are participating in scientific studies being conducted to include persons under age 18. This section also includes a technical change requested by DMHAS to increase the criminal infraction schedule (violation time period) to mirror the schedule established in the civil statute Section 12-285 from 18 months to 24 months.

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 addresses evidence-based policy strategies recommended by the Centers for

Disease Control and Prevention (CDC) Office on Smoking and Health, the CDC Guide to Community Preventive Services, and the US Surgeon General's Office. These recommendations have been shown to reduce the initiation of tobacco use, reduce prevalence of tobacco use and prevent tobacco-related illness and death.

Comprehensive Clean Indoor Air Laws are one of the most effective interventions to protect non-smokers from the health effects of secondhand smoke. The US Surgeon General has determined that there is no safe level of exposure to secondhand smoke. Smoke-free environments also prevent tobacco use initiation and support smokers who are trying to quit. The proposal will protect the vast majority of employees from the health effects of secondhand smoke and ENDs at their worksites. Prohibiting smoking and ENDs use within 25 feet of doors, windows and intake vents of buildings where smoking is prohibited protects persons entering and exiting the buildings, as well as persons inside. Extending smoking and ENDs restrictions to all school property at all times will protect staff and visitors as well as students from exposure to secondhand smoke and help to prevent initiation. The less often youth see someone smoking or vaping the less likely that they are to start. Removing the preemption language from the Clean Indoor Air Law will allow cities and towns to protect their residents by implementing progressive and sustainable tobacco free policies. Prohibiting smoking and ENDS use in private clubs and disallowing bars to be classified as tobacco bars will protect workers and patrons of these venues from exposure to secondhand smoke. Requiring hotels and motels to make 100% of their rooms smoke and ENDS free will also protect workers and guests from secondhand smoke and aerosol. Removing the language that the Clean Indoor Air Law does not apply to public housing will remove confusion that public housing authorities are prohibited from adopting their own smoke free policies which they are legally able to do. Removing the language that the law does not apply to "designated smoking areas in psychiatric facilities" protects staff and patients and assists smokers in quitting. (Persons with mental illness are more likely to die from conditions related to smoking than to their mental illness). The research language clarification is added to assure that necessary research can be conducted to inform tobacco use prevention activities and guide decisions made by the Food and Drug Administration.

The Institute of Medicine reports that "Raising the tobacco sale age will significantly reduce the number of adolescents and young adults who start smoking; reduce smoking caused deaths; and immediately improve the health of adolescents, young adults, and young mothers who would be deterred from smoking as well as their children." Nearly nine out of ten smokers start smoking by the time they are 18 years old. A legal age of 21 will lessen the likelihood of adolescents receiving tobacco products from friends who can purchase tobacco legally.
The proposal will incorporate the definition of ENDS into the definitions of smoking and tobacco products rather than addressing it in a separate section of the Statutes and will also include Hookah tobacco. This will align Connecticut's definition of tobacco products with the

US Food and Drug Administration's definition in the recently published "Deeming Regulation" that became effective on August 8, 2016.

According to the US Surgeon General and the Institute of Medicine, increasing tobacco taxes is one of the most effective interventions to reduce tobacco use especially among youth and young adults, prevent initiation, and increase tobacco use cessation. Currently there is no tax on ENDS products in CT and cigars and other tobacco products are taxed at rates which often result in lower costs than the cost of cigarettes. This can result in cigarette smokers switching to other tobacco products, and youth to start smoking using less expensive products such as little cigars. ENDS are the most prevalent form of tobacco use among CT high school and middle school students (2015) and high school boys smoke cigars at a higher rate than cigarettes (2015). The use of ENDS among students has tripled between 2011 and 2015.
The World Health Organization recommends that the sale of Hookah products and hookah bar/lounges be regulated in the same manner as other forms of tobacco. Hookah is associated with many of the same health risks as cigarettes and other tobacco products and secondhand hookah smoke can pose a higher risk to nonsmokers than cigarette smoke.

◊ **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?

The comprehensive clean indoor air act proposal was forwarded previously but ultimately did not pass.

PROPOSAL IMPACT

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

Agency Name: Department of Mental Health and Addiction Services
Agency Contact (*name, title, phone*): Mary Kate Mason
Date Contacted: 11/3/2016

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

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation)* Click here to enter text.
State Click here to enter text.
Federal Click here to enter text.
Additional notes on fiscal impact Click here to enter text.

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

Click here to enter text.

Section 1. Section 19a-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section, "smoke" or "smoking" means the lighting or carrying of a lighted cigarette, cigar, pipe or similar device.

(b) (1) Notwithstanding the provisions of section 31-40q, as amended by this act, no person shall smoke: (A) In any building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail food store or other retail establishment accessed by the general public; (D) in any area of a restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22c, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of an establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, and, on and after April 1, 2004, in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building on school property; **[**while school is in session or student activities are being conducted;**]** (G) in any passenger elevator, provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that smoking is prohibited by state law; (H) in any area of a dormitory in any public or private institution of

higher education; or (I) on and after April 1, 2004, in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public, including outdoor areas; and "any area" means the interior of the building or facility and the area within twenty-five feet of the outside of any doorway, operable window, or air intake vent of the building or facility.

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

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

[(d)] (c) **[**In each room, elevator, area or building in which smoking is prohibited by this section, the person in control of the premises shall post or cause to be posted in a conspicuous place signs stating that smoking is prohibited by state law. Such signs, except in elevators, restaurants, establishments with permits to sell alcoholic liquor to consumers issued pursuant to chapter 545, hotels, motels or similar lodgings, and health care institutions, shall have letters at least four inches high with the principal strokes of letters not less than one-half inch wide.]Nothing in this subsection shall be construed to require the person in control of a building to post such signs in every room of a building, provided such signs are posted in a conspicuous place in such building.

[(e)] (d) Any person found guilty of smoking in violation of this section, [failure to post signs as required by this section or the unauthorized removal of such signs] shall have committed an infraction.

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

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

Sec. 2. Section 19a-342a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

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

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

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

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

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

(b) (1) No person shall use an electronic nicotine delivery system or vapor product: (A) In any building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail food store or other retail establishment accessed by the general public; (D) in any restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22a, 30-22c, 30-26, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, or the bar area of a bowling establishment holding a permit

pursuant to subsection (a) of section 30-37c; (F) **[**within**]** in any area of a school building on any school property; **[**while school is in session or student activities are being conducted;**]** (G) within a child care facility, except, if the child care facility is a family child care home as defined in section 19a-77, such use is prohibited only when a child enrolled in such home is present; (H) in any passenger elevator, [provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that such use is prohibited by state law]; (I) in any area of a dormitory in any public or private institution of higher education; or (J) in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building or outdoor area, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public.

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

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

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

(e) Any person found guilty of using an electronic nicotine delivery system or vapor product in violation of this section, [failure to post signs as required by this section or the unauthorized removal of such signs] shall have committed an infraction.

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

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

Sec. 3. Section 31-40q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section:

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

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

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

(4) "Business facility" means a structurally enclosed location or portion thereof at which employees perform services for their employer. The term "business facility" does not include: (A) Facilities listed in subparagraph (A), (C) or (G) of subdivision (2) of subsection (b) of section 19a-342, as amended by this act, or subparagraph (A), (C) or (I) of subdivision (2) of subsection (b) of section 19a-342a, as amended by this act; (B) any establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued on or before May 1, 2003; (C) for any business that is engaged in the testing or development of tobacco or tobacco products, the areas of such business designated for such testing or development; or (D) during the period from October 1, 2003, to April 1, 2004, establishments with a

permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c.

(5) “Smoking” means the burning of a lighted cigar, cigarette, pipe, hookah or electronic nicotine delivery system or any other matter or substance which contains tobacco.

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

[(c)] (b) (1) Each employer [with five or more employees] shall prohibit smoking in any business facility under said employer’s control[,except that an employer may designate one or more smoking rooms].

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

(3) Each smoking room designated by an employer pursuant to this subsection shall meet the following requirements: (A) Air from the smoking room shall be exhausted directly to the outside by an exhaust fan, and no air from such room shall be recirculated to other parts of the building; (B) the employer shall comply with any ventilation standard adopted by (i) the Commissioner of Labor pursuant to chapter 571, (ii) the United States Secretary of Labor under the authority of the Occupational Safety and Health Act of 1970, as from time to time amended, or (iii) the federal Environmental Protection Agency; (C) such room shall be located in a nonwork area, where no employee, as part of his or her work responsibilities, is required to enter, except such work responsibilities shall not include any custodial or maintenance work carried out in the smoking room when it is unoccupied; and (D) such room shall be for the use of employees only.]

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

Sec. 4. Section 53-344 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) As used in this section:

(1) "Cardholder" means any person who presents a driver's license or an identity card to a seller or seller's agent or employee, to purchase or receive tobacco from such seller or seller's agent or employee;

(2) "Identity card" means an identification card issued in accordance with the provisions of section 1-1h;

(3) "Transaction scan" means the process by which a seller or seller's agent or employee checks, by means of a transaction scan device, the validity of a driver's license or an identity card; and

(4) "Transaction scan device" means any commercial device or combination of devices used at a point of sale that is capable of deciphering in an electronically readable format the information encoded on the magnetic strip or bar code of a driver's license or an identity card.

(b) Any person who sells, gives or delivers to any [minor] person under [eighteen]twenty-one years of age tobacco[, unless the minor is delivering or accepting delivery in such person's capacity as an employee,] in any form shall be fined not more than two hundred dollars for the first offense, not more than three hundred fifty dollars for a second offense within [an eighteen-month] twenty four month period and not more than five hundred dollars for each subsequent offense within [an eighteen-month] twenty four month period. The provisions of this subsection shall not apply to a person under eighteen years of age who is delivering or accepting delivery (1) in such person's capacity as an employee, or (2) as part of a scientific study being conducted for the purpose of medical research to further efforts in tobacco use prevention and cessation, provided such medical research has been approved by the institution's independent review board.

(c) Any person under [eighteen] twenty-one years of age who purchases or misrepresents such person's age to purchase tobacco in any form or possesses tobacco in any form in any public place shall be fined not more than fifty dollars for the first offense and not less than fifty dollars or more than one hundred dollars for each subsequent offense. For purposes of this subsection, "public place" means any area that is used or held out for use by the public whether owned or operated by public or private interests.

(d) (1) A seller or seller's agent or employee may perform a transaction scan to check the validity of a driver's license or identity card presented by a cardholder as a condition for selling, giving away or otherwise distributing tobacco to the cardholder.

(2) If the information deciphered by the transaction scan performed under subdivision (1) of this subsection fails to match the information printed on the driver's license or identity card presented by the cardholder, or if the transaction scan indicates that the information so printed is false or fraudulent, neither the seller nor any seller's agent or employee shall sell, give away or otherwise distribute any tobacco to the cardholder.

(3) Subdivision (1) of this subsection does not preclude a seller or seller's agent or employee from using a transaction scan device to check the validity of a document other than a driver's license or an identity card, if the document includes a bar code or magnetic strip that may be scanned by the device, as a condition for selling, giving away or otherwise distributing tobacco to the person presenting the document.

(e) (1) No seller or seller's agent or employee shall electronically or mechanically record or maintain any information derived from a transaction scan, except the following: (A) The name and date of birth of the person listed on the driver's license or identity card presented by a cardholder; (B) the expiration date and identification number of the driver's license or identity card presented by a cardholder.

(2) No seller or seller's agent or employee shall use a transaction scan device for a purpose other than the purposes specified in subsection (e) of section 53-344b, subsection (d) of this section or subsection (c) of section 30-86.

(3) No seller or seller's agent or employee shall sell or otherwise disseminate the information derived from a transaction scan to any third party, including, but not limited to, selling or otherwise disseminating that information for any marketing, advertising or promotional activities, but a seller or seller's agent or employee may release that information pursuant to a court order.

(4) Nothing in subsection (d) of this section or this subsection relieves a seller or seller's agent or employee of any responsibility to comply with any other applicable state or federal laws or rules governing the sale, giving away or other distribution of tobacco.

(5) Any person who violates this subsection shall be subject to a civil penalty of not more than one thousand dollars.

(f) (1) In any prosecution of a seller or seller's agent or employee for a violation of subsection (b) of this section, it shall be an affirmative defense that all of the following occurred: (A) A cardholder attempting to purchase or receive tobacco presented a driver's license or an identity card; (B) a transaction scan of the driver's license or identity card that the cardholder presented indicated that the license or card was valid; and (C) the tobacco was sold, given away or otherwise distributed to the cardholder in reasonable reliance upon the identification presented and the completed transaction scan.

(2) In determining whether a seller or seller's agent or employee has proven the affirmative defense provided by subdivision (1) of this section, the trier of fact in such prosecution shall consider that reasonable reliance upon the identification presented and the completed transaction scan may require a seller or seller's agent or employee to exercise reasonable diligence and that the use of a transaction scan device does not excuse a seller or seller's agent or employee from exercising such reasonable diligence to determine the following: (A) Whether a person to whom the seller or seller's agent or employee sells, gives away or otherwise distributes tobacco is [eighteen] twenty-one years of age or older; and (B) whether the description and picture appearing on the driver's license or identity card presented by a cardholder is that of the cardholder.

Sec. 5. Section 53-344a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Each retailer of cigarettes, [or] tobacco products, electronic nicotine delivery systems or vapor products or employee of such retailer shall require a person who is purchasing or attempting to purchase cigarettes or tobacco products, whose age is in question, to exhibit proper proof of age. If a person fails to provide such proof of age, such retailer or employee shall not sell cigarettes or tobacco products to the person. As used in this section, “proper proof” means a motor vehicle operator’s license, a valid passport or an identity card issued in accordance with the provisions of section 1-1h.

Sec. 7. Subsection (b) of section 53-344b of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(b) Any person who sells, gives or delivers to any [minor] person under [eighteen] twenty-one years of age an electronic nicotine delivery system or vapor product[, unless the minor is delivering or

accepting delivery in such person’s capacity as an employee,] in any form shall be fined not more than two hundred dollars for the first offense, not more than three hundred fifty dollars for a second offense within [an eighteen-month period] twenty four month and not more than five hundred dollars for each subsequent offense within [an eighteen-month] twenty four month period. The provisions of this subsection shall not apply to a person under twenty-one years of age who is delivering or accepting delivery (1) in such person's capacity as an employee, or (2) as part of a scientific study being conducted for the purpose of medical research to further efforts in tobacco use prevention and cessation, provided such medical research has been approved by the institution's independent review board.

Agency Legislative Proposal – 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DPH 1104 FGI Guidelines.doc

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch (HCQS), Facilities Licensing and Investigations Section (FLIS)
Agency Analyst/Drafter of Proposal: Barbara Cass, FLIS Chief

Title of Proposal: An Act Concerning The Inclusion Of The Facilities Guidelines Institute Publication For Technical Review Of Facility Construction And Renovations
Statutory Reference: 19a-491. License and certificate required. Application. Assessment of civil penalties or a consent order. Fees. Minimum service quality standards. Regulations. Professional liability insurance. Prohibition. Maintenance of medical records.
Proposal Summary: This proposal will revise the section of statute that pertains to the Department's review of construction, renovation, or building alteration of institutions to include the Facilities Guidelines Institute Publication (FGI) as part of the design review process.

PROPOSAL BACKGROUND

- **Reason for Proposal**

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

The FGI is the industry's recognized standard and authority for health care planning, design and construction. This will require healthcare institutions to utilize this set of guidelines as another element in protecting the health and safety of Connecticut's healthcare beneficiaries. This will codify current practice.

- **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
Agency Contact (name, title, phone): Terrence Tulloch-Reid
Date Contacted: 11/3/2016

Approve of Proposal _X_ YES ___NO ___Talks Ongoing

Summary of Affected Agency's Comments:

Response from the State Building Inspector I don't see any State Building Code impacts. This is really a best practices design guide. This review would not take the place of SBC review by the local Building Officials.

One thing I did notice was that the guide allows the staff toilet rooms to be unisex. This is ok with the SBC as long as those fixtures are not part of the required count. Not a big deal usually for hospitals, rehabs, etc.

Will there need to be further negotiation? ___ YES _X_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)

Facilities Licensing and Investigations Section (FLIS) staff will verify that new construction and renovation of health care institutions will comply with FGI guidelines.

Subsection (f) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof:

(f) The commissioner shall charge a fee of five hundred sixty-five dollars for the technical assistance provided for the design, review and development of an institution's construction, renovation, building alteration, sale or change in ownership when the cost of such project is one million dollars or less and shall charge a fee of one-quarter of one per cent of the total project cost when the cost of such project is more than one million dollars. Such fee shall include all department reviews and on-site inspections. For purposes of this subsection, "institution" does not include a facility owned by the state. Such review shall meet the most current requirements with the Facility Guidelines Institute publication of "Guidelines for the Design and Construction of Healthcare Facilities" specific to the area that is subject to construction, renovation or building alteration.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DPH 1104 HIV Revisions.doc

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

State Agency: Department of Public Health
Liaison: Brie Wolf /Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov / jill.kennedy@ct.gov
Lead agency division requesting this proposal: Infectious Disease Section, TB, HIV, STD, & Viral Hepatitis Program – HIV Prevention
Agency Analyst/Drafter of Proposal: Gina D'Angelo

Title of Proposal An Act Concerning Revisions to the Statutes Pertaining to the Human Immunodeficiency Virus.
Statutory Reference Section 1. Sec. 19a-90. Blood testing of pregnant women for syphilis and AIDS. Section 2. Sec. 19a-124. Needle and syringe exchange programs. Section 3. Sec. 19a-582. General consent required for HIV-related testing. Counseling requirements. Exceptions.
Proposal Summary Section 1. Revises section 19a-90 to update the timeframes for testing pregnant women for Syphilis and AIDS. The language will separate syphilis and Human Immunodeficiency Virus (HIV) testing by specifying ideal times for pregnant women to be tested for each disease individually to ensure women testing positive for either are able to receive adequate treatment prior to delivery. Section 2. Expands the needle exchange program to increase access to clean syringes for people who inject drugs by allowing for secondary exchange within drug using networks. Section 3. Removes the requirement for community-based HIV testing providers in non-clinical or outreach settings to obtain written consent for an HIV test. This proposal will allow for informed verbal consent to documented HIV testing. All information about the person being tested, including their consent to test, will be documented on one form (The HIV Test Form) eliminating the need for a separate HIV specific consent form. Having all information related to the person being tested on one form results in a leaner process. This change will benefit individuals being tested by eliminating a barrier to testing and it will benefit community-based HIV testing providers by reducing paperwork in the field.

PROPOSAL BACKGROUND

- **Reason for Proposal**

Section 1. Currently, 19a-90 requires that physicians giving prenatal care to pregnant women in Connecticut obtain a blood sample within thirty days from the date of the first examination and during the final trimester between 26 to 28 weeks gestation or shortly thereafter to be submitted to an approved laboratory for a standard serological test for syphilis and an HIV-related test, as defined in section 19a-581, provided consent is given for the HIV-related test consistent with section 19a-582. Since the passing of this law, Connecticut has seen a reduction in perinatal transmission of HIV resulting in only 7 cases after the passing of the law in 1999 through 2007 and no new cases between 2007 and 2015. However, in January 2016, an infant was diagnosed with HIV. This transmission may have been prevented if the mother was tested later in the pregnancy. The expectant mother tested negative during the first and second trimester however, the second test was done earlier than recommended at 23 weeks. Eighteen months after birth, both mother and infant tested positive for HIV. Somewhere between the time of the second HIV test and eighteen months after birth the mother seroconverted and infected the child either during delivery or through breastfeeding. Therefore, the HIV Prevention and Surveillance programs propose changing the time frame of the second HIV test to be done at 32 to 36 weeks gestation with a caveat that expectant mothers who present for labor prior to the second HIV test must be tested during the admission for delivery. In addition, this statute requires pregnant women to be tested for syphilis as well as HIV; however the recommended timeframes for testing of HIV and syphilis differ. CDC guidelines recommend testing for syphilis between 28 to 32 weeks gestation in order to give enough time to get the result and treat if necessary. Therefore, the HIV and STD programs recommend differentiating timeframes for the testing of HIV and Syphilis in the statute.

Section 2. Currently 19a-124 requires that program participants receive an equal number of needles and syringes for those returned. The State Department of Public Health supports three operating Syringe Service Programs (SSP) and two community-based programs that integrate SSP services. In 2014, DPH funded SSPs served 2,905 people, up 39% from 2013. SSPs collected 257,174 used syringes and exchanged 258,505 new ones. SSPs served 27 people who inject drugs and reported living with HIV, and 105 clients (3.6% of SSP clients) who reported experiencing at least one drug overdose. This harm reduction strategy makes a case for the effectiveness of SSPs. From 2002 to 2014, the number of newly diagnosed HIV cases in Connecticut with an identified risk of intravenous drug use (IDU) fell 93% (from 325 to 22).

Secondary exchange is an important but underemphasized component of HIV and hepatitis C prevention for people who inject drugs. Secondary exchange refers to a range of formal and informal practices through which syringe exchange participants redistribute sterile syringes to peers within social and drug-using networks. Despite their remarkable success in disease prevention, syringe exchange programs only directly reach between 5-10% of active injection drug users. With changing communities, gentrification, and shifting drug trends, it is clear that

public health policies must respond by promoting practices that reach the most at-risk communities. Secondary exchange therefore facilitates access to sterile syringes for a far greater number of drug users. Based on a recent nationwide survey of syringe exchange programs, 90% of programs encourage secondary exchange and the vast majority of people who inject drugs supply syringes to others.

Data on opioid poisonings suggests increases in drug abuse and injection drug use in suburbs. Residents in these areas would benefit from Syringe Services Programs including secondary exchange. Between 1997 and 2007, 794 overdose deaths attributed to heroin or other opioids were reported in Fairfield and New Haven Counties. Approximately 40 % of these occurred among residents in 35 small cities and towns, with particularly high rates (>30 per 100,000 residents) in several smaller communities. This data reveals an ongoing need for expansion to non-urban areas of a broad range of programs, especially those that incorporate harm reduction approaches to promote safe injection, hepatitis testing and vaccination against HBV, and overdose prevention and response trainings.

A study conducted by Dr. Heimer at Yale, found that injectors' knowledge about HIV is poor and statistically no better than it is regarding either hepatitis or overdose, which differs from findings from studies of urban injectors in Connecticut. This suggests that the HIV-centric prevention messages targeted to urban injectors have failed to reach their suburban counterparts. Furthermore, individuals seem to have limited awareness of their HIV or hepatitis infection status. For Hepatitis C, serological testing revealed that almost half of those tested in the study had been infected. For Hepatitis B, one-fifth of those infected with remained carriers, and two in five injectors remained susceptible. Given the ease of Hepatitis transmission further epidemic spread is likely. Drug overdoses, another major cause of morbidity and mortality among drug injectors, have been commonplace. According to data from the Office of the Chief Medical Examiner, accidental overdoses more than doubled between 2012 and 2015 from 359 deaths to 729.

The New York City Department of Public Health and Mental Hygiene convened a group of experts on syringe exchange and published a report on best practices that confirmed the importance of not placing caps or limiting the number of syringes distributed through Syringe Service Programs. Expanded access to syringes allows more injectors to obtain sterile equipment and lessens the opportunities for disease transmission, such as HIV and hepatitis C. One study out of Beth Israel Medical Center in New York found that 89% of the 131 Syringe Exchange Programs in the US that are known to the North American Syringe Exchange Network, allowed secondary exchange and 69% gave extra supplies to clients in 2007. (Des Jarlais DC, McKnight C, Eigo K, Friedmann, P. (2000). Unites States Syringe Exchange Program Survey. North American Syringe Exchange Convention.)

Section 3. Currently, 19a-582 requires individuals who are tested for HIV in community or non-

clinical settings to sign a separate consent form specific to HIV. In 2009, Connecticut changed the law so that a separate HIV consent form would no longer be necessary however it applied only to clinical settings (e.g. hospitals, community health centers or other medical facilities). Therefore, if an individual signs a general consent for medical care which includes testing and or treatment, HIV consent is covered. This statute change was supported by the Centers for Disease Control and Prevention's recommendations for the routine testing of all people ages 13-64 that was announced in 2001. However, in non-clinical or outreach settings (e.g. bars, parks, vans or other public venues) where an average 13,000 tests are conducted annually by funded contractors alone, currently a separate signed informed consent form is still required for HIV testing. The separate signed consent for HIV is in no way connected to an individual's test result nor does it contain any identifying information about the individual. In most cases, the form is signed and kept on file until it is shredded by the agency funded to provide HIV testing. The extra paperwork in the field is a barrier to testing for some people and extra work for the community-based HIV testing provider conducting HIV testing.

Many states including Massachusetts, Rhode Island and New York have already changed their consent law to allow for documented verbal consent in outreach and non-clinical settings where there is no general consent to cover. Therefore, the HIV Prevention Program proposes that community-based HIV testing providers conducting HIV testing in the field be allowed to get verbal informed consent from individuals they test for HIV. Community-based HIV testing providers will be required to document the verbal informed consent on the HIV Test Form that is used to collect all other information related to the person being tested. This information includes demographics and risk history information. The HIV Test Form can also be traced back to the person being tested and the client's test results because each individual is assigned a unique identifier. This practice will create a more streamlined process where all information regarding the person being tested will be documented on one form.

- **Origin of Proposal _x__ 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?

Public Act 16-87, the Department's HIV bill from 2016, passed the chambers without the language that removes HIV consent in non-clinical settings. The Department feels that there

was not a clear understanding about what purpose this document serves. We believe that the consent form was associated with the actual testing form. The consent form is in no way connected to the testing of individuals. DPH HIV Prevention staff will develop a fact sheet to share with legislators and others to inform them about the process and how the change will positively impact how HIV testing services are delivered and documented. There is a field in the testing form that the Department will modify in order to capture the patient's consent.

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)

Sec. 19a-90. Blood testing of pregnant women for syphilis and AIDS.
The impact will be that pregnant women will be screened for syphilis and HIV at designated times based on current recommendations. Another impact will be averting perinatal transmission of syphilis and or HIV. The HIV and STD Programs will work with the American Congress of Obstetricians and Gynecologists and other partners to educate Connecticut physicians on the new recommendations for testing if passed.

Sec. 19a-124. Needle and syringe exchange programs. Secondary exchange will allow for clients of Syringe Service Programs to exchange syringes for other drug users in their drug using networks that do not access the services on their own. The impact will be that more people who inject drugs will have access to clean syringes and will be less likely to contract HIV or Hepatitis C. Averting new HIV and Hepatitis C infections improves quality of life and is a cost effective measure.

Sec. 19a-582. ***General consent required for HIV-related testing. Counseling requirements. Exceptions.***
Documented verbal consent to HIV testing will allow for a leaner process by eliminating unnecessary paperwork in the field for Outreach, Testing and Linkage staff and allowing for all client information to be documented on one form. The impact for clients being tested will be eliminating a barrier to testing while helping to de-stigmatize HIV.

Section 1. Section 19a-90 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each physician giving prenatal care to a pregnant woman [in this state during gestation] shall take or cause to be taken [a] an initial blood sample of each such woman within thirty days from the date of the first examination and a second blood sample during the [final] third trimester. The [final] third trimester blood sample shall be taken at 28-32 weeks gestation for syphilis testing and 32-36 weeks gestation for HIV testing,[between the twenty-sixth and twenty-eighth week of gestation or shortly thereafter] subject to the provisions of this section, and shall submit such sample to an approved laboratory for [a] standard serological tests for syphilis and [an] HIV[-related test], as defined in section 19a-581, provided consent is given for the HIV[-related] test consistent with section 19a-582. Each other person permitted by law to attend upon pregnant women [in the state,] but not permitted by law to take blood tests, shall cause a blood sample of each pregnant woman so attended to be taken by a licensed physician in accordance with the time schedule and requirements of this section and such sample shall be submitted to an approved laboratory for [a] standard serological tests for syphilis and HIV[-related test], provided consent is given for the HIV[-related] test consistent with section 19a-582. If a pregnant woman presents to labor and delivery without documentation of the required third trimester tests for syphilis and/or HIV, a blood sample shall be taken at the time of delivery.[A blood sample taken at the time of delivery shall not meet the requirement for a blood sample

during the final trimester. The term “approved laboratory” means a laboratory approved for this purpose by the Department of Public Health. A standard serological test for syphilis is a test recognized as such by the Department of Public Health. The laboratory tests required by this section shall be made on request without charge by the Department of Public Health.]

(b) The provisions of this section shall not apply to any woman who objects to a blood test as being in conflict with her religious tenets and practices.

Sec. 2. Section 19a-124 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Department of Public Health shall establish, within available appropriations, [needle and] syringe [exchange] services programs in order to enhance health outcomes of people who inject drugs in any community impacted by the human immunodeficiency virus or hepatitis C. The department shall establish protocols in accordance with the provisions of subsection (b) of this section. [The department may authorize programs, as determined by the commissioner, through local health departments or other local organizations.]

(b) The programs shall: (1) Be incorporated into existing human immunodeficiency virus and hepatitis C outreach and prevention programs in the selected communities; (2) provide [for] access to free and confidential exchanges of needles and syringes and [(A) provide that program participants receive an equal number of needles and syringes for those returned; and] (3) provide for safe disposal or exchange of syringes; [(B)] (4) provide that first-time applicants to the program receive an initial packet of needles and syringes, educational material and a list of drug counseling services; [(3)] (5) offer education on the human immunodeficiency virus, hepatitis C, harm reduction, and drug overdose prevention measures and assist program participants in obtaining drug treatment services; (4) provide referrals for substance abuse counseling or treatment; and (5) provide referrals for medical or mental health care.

(c) The department shall require programs to include an annual evaluation component to monitor (1) the number of syringes distributed and collected, (2) program participation rates, (3) behavioral change of program participants, (4) the number of participants who are referred to treatment, and (5) the incidence of human immunodeficiency virus from injection drug use to determine if there is a reduction as a result of the syringe access program.

(d) The local health department or community-based organization of each community conducting a **[**Any organization conducting a needle and] syringe service [exchange] program shall submit a report evaluating the effectiveness of the program to the Department of Public Health.

Sec. 3. Section 19a-582 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Except as required pursuant to section 19a-586, a person who has provided general consent as described in this section for the performance of medical procedures and tests is not required to also sign or be presented with a specific informed consent form relating to medical procedures or tests to determine human immunodeficiency virus infection or antibodies to human immunodeficiency virus. General consent shall include instruction to the patient that: (1) As part of the medical procedures or tests, the patient may be tested for human immunodeficiency virus, and (2) such testing is voluntary and that the patient can choose not to be tested for human immunodeficiency virus or antibodies to human immunodeficiency virus. General consent that includes HIV-related testing shall be obtained without undue inducement or any element of compulsion, fraud, deceit, duress or other form of constraint or coercion. If a patient declines an HIV-related test, such decision by the patient shall be documented in the medical record. The consent of a parent or guardian shall not be a prerequisite to testing of a minor. The laboratory shall report the test result to the person who orders the performance of the test.

(b) A person ordering the performance of an HIV-related test shall not be held liable for ordering a test without specific informed consent if a good faith effort is made to convey the instruction required pursuant to subsection (a) of this section.

(c) At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV-related test shall provide the subject of the test or the person authorized to consent to health care for the subject with counseling or referrals for counseling, as needed: [(1) For coping with the emotional consequences of learning the result; (2) regarding the discrimination problems that disclosure of the result could cause; (3) for behavior change to prevent transmission or contraction of HIV infection;][(4)] (1) to inform such person of available medical treatments and medical services; [(5)] (2) regarding local or community-based HIV/AIDS support services agencies; [(6)] (3) to work towards the goal of involving a minor's parents or legal guardian in the decision to seek and in the ongoing provision of medical treatment; and [(7)] (4) regarding the need of the test subject to notify his partners and, as appropriate, provide assistance or referrals for assistance in notifying partners; except that if the subject of the test is a minor who was tested without the consent of his parents or guardian, such counseling shall be provided to such minor at the time of communicating such test result to such minor. A health care provider or health facility shall not withhold test results from the protected individual. [The protected individual may refuse to receive his test result but the person ordering the performance of the test shall encourage him to receive the result and to adopt behavior changes that will allow him to protect himself and others from infection.]

(d) The provisions of this section shall not apply to the performance of an HIV-related test:

(1) By licensed medical personnel when the subject is unable to grant or withhold consent and no other person is available who is authorized to consent to health care for the individual and the test results are needed for diagnostic purposes to provide appropriate urgent care, except that in such cases the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided as soon as practical;

(2) By a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals, provided if the test results are communicated to the subject, the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided;

(3) For the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher;

(4) On a deceased person when such test is conducted to determine the cause or circumstances of death or for epidemiological purposes;

(5) In cases where a health care provider or other person, including volunteer emergency medical services, fire and public safety personnel, in the course of his occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician or, if the patient or person does not have a personal physician or if the patient's or person's physician is unavailable, another physician or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an HIV test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the HIV testing of a patient or other person, nor the health facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's determination and performs that test shall have any liability as a result of his action carried out pursuant to this section, unless such person acted in bad faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known, which could not otherwise be

taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an HIV test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (c) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the HIV test shall be borne by the employer of the potentially exposed worker;

(6) In facilities operated by the Department of Correction if the facility physician determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to subdivisions (6) and (7) of this subsection until reasonable effort has been made to secure informed consent. When testing without consent takes place pursuant to subdivisions (6) and (7) of this subsection, the counseling referrals and notification of test results described in subsection (c) of this section shall, nonetheless be provided;

(8) Under a court order which is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the HIV-related test result which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for a test result against the privacy interests of the test subject and the public interest which may be disserved by involuntary testing, (B) pleadings pertaining to the request for an involuntary test shall substitute a pseudonym for the true name of the subject to be tested. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court, (C) before granting any such order, the court shall provide the individual on whom a test result is being sought with notice and a reasonable opportunity to participate in the proceeding if he is not already a party, (D) court proceedings as to involuntary testing shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice;

(9) When the test is conducted by any life or health insurer or health care center for purposes of assessing a person's fitness for insurance coverage offered by such insurer or health care center; or

(10) When the test is subsequent to a prior confirmed test and the subsequent test is part of a series of repeated testing for the purposes of medical monitoring and treatment, provided (A) the patient has previously given general consent that includes HIV-related tests, (B) the patient, after consultation with the health care provider, has declined reiteration of the general consent, counseling and education requirements of this section, and (C) a notation to that effect has been entered into the patient's medical record.

(11) When the test is conducted by community-based HIV testing providers in non-clinical and/or outreach settings when they have received and documented verbal consent on the HIV Test Form.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DPH 1104 HPV Immunization.doc

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

State Agency: Department of Public Health
Liaison: Jill Kennedy/Brie Wolf **Phone:** 7280/7246 **E-mail:** Jill.Kennedy@ct.gov; Brie.Wolf@ct.gov
Lead agency division requesting this proposal: Commissioner/Infectious Diseases Section, Immunization Program
Agency Analyst/Drafter of Proposal: Kathy Kudish

Title of Proposal: An Act Concerning Cancer Prevention
Statutory Reference: 10-204a. Required immunizations. Temporary waiver.
Proposal Summary: To require that children begin the human papillomavirus (HPV) vaccination regimen before entry into the seventh grade.

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 part of a recommendation from the CDC, it is important for children age 11 or 12 to be vaccinated against HPV so they are protected before even being exposed to the virus. The HPV vaccine produces a more robust immune response during the preteen years. HPV infection can cause cervical, vaginal and vulvar cancers in women; penile cancer in men; and anal cancer, throat cancer and genital warts in both women and men. To minimize exposure to the virus and maximize effectiveness, children age 11 or 12 get the 2 dose series of HPV vaccine. Women can get the vaccine through age 26 and men can get vaccinated through age 21. The American Academy of Pediatrics has taken a position that 11 and 12 year-old girls should be vaccinated. Should this vaccine be incorporated into the Connecticut vaccine Program, it is anticipated that insurers would save $36.10 per dose per child or $72.20 per child for a completed 2 dose series. Incorporating this into the Connecticut Vaccine Program will also help ensure that providers are limiting their expenditure on this vaccine, which could potentially expire before both doses are administered.

◊ **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: Insurance Department
Agency Contact (*name, title, phone*): Eric Weinstein, Director of Legislative Affairs, 860.297.3864
Date Contacted: 11/3/2016

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

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation):*
This may require a municipality, based on recommendations made from the local school board, to pay for the HPV vaccine in the event a family cannot afford it.

State: This vaccine would be incorporated into the State's Connecticut Vaccine Program. We anticipate a savings of up to $2,580,493 to insurance companies for the two dose series.

Federal: The HPV vaccine is also eligible to be administered to youth through the federal Vaccines For Children (VFC) Program. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP), of which HPV is one.

Additional notes on fiscal impact
Click here to enter text.

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

Section 1. Subsection (a) of section 10-204a of the general statutes is repealed and the following is substituted in lieu thereof: (*Effective August 1, 2018*)

(a) Each local or regional board of education, or similar body governing a nonpublic school or schools, shall require each child to be protected by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, hemophilus influenzae type B, human papillomavirus and any other vaccine required by the schedule for active immunization adopted pursuant to section 19a-7f before being permitted to enroll in any program operated by a public or nonpublic school under its jurisdiction. Before being permitted to enter seventh grade, a child shall receive a second immunization against measles. Any such child who (1) presents a certificate from a physician, physician assistant, advanced practice registered nurse or local health agency stating that initial immunizations have been given to such child and additional immunizations are in process under guidelines and schedules specified by the Commissioner of Public Health; or (2) presents a certificate from a physician, physician assistant or advanced practice registered nurse stating that in the opinion of such physician, physician assistant or advanced practice registered nurse such immunization is medically contraindicated because of the physical condition of such child; or (3) presents a statement from the parents or guardian of such child that such immunization would be contrary to the religious beliefs of such child or the parents or guardian of such child, which statement shall be acknowledged, in accordance with the provisions of sections 1-32, 1-34 and 1-35, by (A) a judge of a court of record or a family support magistrate, (B) a clerk or deputy clerk of a court having a seal, (C) a town clerk, (D) a notary public, (E) a justice of the peace, (F) an attorney admitted to the bar of this state, or (G) notwithstanding any provision of chapter 6, a school nurse; or (4) in the case of measles, mumps or rubella, presents a certificate from a physician, physician assistant or advanced practice registered nurse or from the director of health in such child's present or previous town of residence, stating that the child has had a confirmed case of such disease; or (5) in the case of hemophilus influenzae type B has passed his fifth birthday; or (6) in the case of pertussis, has passed his sixth birthday, shall be exempt from the appropriate provisions of this section. If the parents or guardians of any child are unable to pay for such immunizations, the expense of such immunizations shall, on the recommendations of such board of education, be paid by the town. Before being permitted to enter seventh grade, the parents or guardian of any child who is exempt on religious grounds from the immunization requirements of this section, pursuant to subdivision (3) of this subsection, shall present to such school a statement that such immunization requirements are contrary to the religious beliefs of such child or the parents or guardian of such child, which statement shall be acknowledged, in accordance with the provisions of sections 1-32, 1-34 and 1-35, by (A) a judge of a court of record or a family support magistrate, (B) a clerk or deputy clerk of a court having a seal, (C) a town clerk, (D) a notary public, (E) a justice of the peace, (F) an attorney admitted to the bar of this state, or (G) notwithstanding any provision of chapter 6, a school nurse.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Immunization Rates.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Infectious Diseases Section, Immunization Program

Agency Analyst/Drafter of Proposal: Kathy Kudish

Title of Proposal: An Act Concerning Immunization Rates

Statutory Reference: 10-204a. Required Immunizations. Temporary Waiver.

Proposal Summary: This proposal will allow the Department to release aggregate data regarding the immunizations for each school in Connecticut.

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?

Schools are responsible for ensuring that all students are immunized according to state regulations. The school immunization survey provides aggregated data by school to the Department of Public Health and affords some assurance that the student population is in compliance with these regulations. The public should also have access to the aggregated immunization data for each school. Parents of school children and the media have requested, and continue to request, information about school-specific immunization rates. We must process a freedom of information request to release this information. Other states have begun to release and publicly post school-specific immunization rates on websites. Since this data is aggregate, no students would be specifically identified.

◊ **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 Education
Agency Contact (*name, title, phone*): Laura Stefon, Legislative Liaison
Date Contacted: 10/18/2016

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

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

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

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

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

State
None

Federal
None

Additional notes on fiscal impact
Click here to enter text.

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

The Immunization Program would be responsible for posting aggregated immunization data by school on the Department's website.

Section 1. Subsection (b) of section 10-204a. of the general statutes is repealed and the following is substituted in lieu thereof:

(b) The definitions of adequate immunization shall reflect the schedule for active immunization adopted pursuant to section 19a-7f and be established by regulation adopted in accordance with the provisions of chapter 54 by the Commissioner of Public Health, who shall also be responsible for providing procedures under which said boards and said similar governing bodies shall collect and report immunization data on each child to the Department of Public Health for compilation and analysis and release by [said] the department of annual immunization rates for each public and private schools in Connecticut.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): DPH 1104 Lead Prevention Initiatives.doc

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

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** 860-509-7246/860-509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Environmental Health Section, Lead Poisoning Prevention and Control Program
Agency Analyst/Drafter of Proposal: Krista Veneziano

Title of Proposal: An Act Concerning Lead Prevention Initiatives
Statutory Reference: Section 1. 20-474. Definitions. Section 2. 20-476. Lead consultants, lead abatement supervisors or lead abatement workers. Certifications; fee; renewal. Section 3. 20-477. Training courses. Regulations. Section 4. 20-479. Limited exemption for code enforcement officials. Section 5. 20-480. Exemption for certain state and federal employees performing duties under occupational safety and health laws. Section 6. 20-481. Disciplinary action. Section 7. 19a-14. Powers of department concerning regulated professions. Section 8. 19a-88. License renewal by certain health care providers. On-line license renewal system Section 9. 20-439. Training programs. Approval. Fees. Periodic reviews.
Proposal Summary: Section 1. Creates a definition of a lead risk assessor and updates the definitions of a lead consultant and lead consultant contractor. This proposal also makes technical revisions to allow for gender neutral language. Section 2. Adds lead training provider to the list of entities that need certification from the Department. Section 3. Provides the Department with the authority to certify the lead inspector training courses. Sections 4, 5 and 6. Make technical revisions to allow for gender neutral language. Section 7. Adds lead training provider to the list of licensed and certified professions that the department can take action against. Section 8. Makes a technical change to include lead training providers as one of the professions listed in the statute that pertains to renewal licenses for lead abatement consultants,

contractor and workers.
Section 9. Makes a technical change to create the title "asbestos training provider" for the individuals who provide asbestos abatement or asbestos consultation training programs.

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 to rectify missing or unclear information within Chapter 400c of the general statutes. The Department of Public Health currently certifies a lead inspector risk assessor discipline but has no definition for it within Section 20-474. Taking enforcement actions against individuals who have not followed the law is difficult when there is no corresponding definition within Section 20-474. The Department must ensure that its statutes will cover any disciplinary action needed to protect the citizens of Connecticut.

The Department currently reviews and approves training courses submitted by training providers but has never certified them. Without the authority to require these training providers to obtain a certification, the Department is unable to take any regulatory action against them. Currently, there are two Connecticut based training providers under Federal indictment for selling training certificates. Without a mechanism to take disciplinary action and withdraw a certificate the Department is unable to stop these training providers from conducting business in Connecticut. The proposal also updates the definitions section to include lead risk assessor, and update the definitions pertaining to lead consultant and lead consultant contractor to comply with current practice.

The individuals who take these trainings, and ultimately become certified, deal with vulnerable populations: property owners and parents who require lead inspections or risk assessment because of a lead poisoned child, require a lead abatement plan developed, or need lead abatement work performed on their home. The average property owner or parent will not have the knowledge or expertise to know if the certified individuals are actually following the requirements of the general statues and corresponding regulations. They have faith that the certified individuals have received quality training that ensures compliance with all applicable statutes and regulations. The safety of their children and other occupants of the home are at risk should a training provider not offer the best training possible.

The Department currently reviews and approves training courses for risk assessors, but said discipline is not referenced in Section 20-477. If the statute is not updated, training providers could call into question the Department's authority to request submission of the training course

materials for review and approval and collect the fees associated with such review. If the Department is unable to review the course materials there would be no way to know if the individuals seeking certification have actually been taught the necessary information to hold the certification. As noted above, these individuals are working with inexperienced property owners who rely on the training and certification that the individual has received to ensure that the work they are paying for is completed correctly and that their children are safe within their own home. This proposal will update Sec. 20-477 to include risk assessor.

Also missing from Section 20-477 is the licensed discipline lead consultant contractor. The lead consultant contractor must also "seek instruction" because they employ inspectors, risk assessors, planner-project designers, lead abatement supervisors and lead abatement workers; all of which are referenced within Section 20-477. Without this revision, the licensed lead consultant contractors could call into question the Department's authority to require them to "seek instruction" thus allowing a licensed discipline to forgo needed training; placing their clients, especially children, at risk. This proposal updates Section 20-477 to include the missing licensed discipline of lead consultant contractor.

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

If this is a resubmission, please share:

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

Click here to enter text.

PROPOSAL IMPACT

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

Agency Name: Department of Housing
Agency Contact (*name, title, phone*): Dan Arsenault, Legislative Program Manager, 860.270.8103
Date Contacted: 11/4/16

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

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact Click here to enter text.

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

The Lead Poisoning Prevention and Control Program must exercise oversight of lead risk assessors, lead inspector training providers and programs, as well as asbestos training providers.

Section 1. Section 20-474 of the general statutes is repealed and the following is substituted in lieu thereof:

(1) "Abatement" means any set of measures designed to eliminate lead hazards in accordance with standards established pursuant to sections 20-474 to 20-482, inclusive, and subsections (e) and (f) of section 19a-88 and regulations adopted thereunder, including, but not limited to, the encapsulation, replacement, removal, enclosure or covering of paint, plaster, soil or other material containing toxic levels of lead and all preparation, clean-up, disposal and reoccupancy clearance testing;

(2) "Certificate" means a document issued by the department indicating successful completion of an approved training course;

(3) "Code enforcement official" means the director of health or a person authorized by [him] the director to act on [his] the director's behalf, the local housing code official or a person authorized by [him] the local housing code official to act on [his] their behalf, or an agent of the commissioner;

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

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

(6) “Director of health” means a municipal health director or a district director of health as defined in chapters 368e and 368f;

(7) “Dwelling” means every building or shelter used or intended for human habitation, including exterior surfaces and all common areas thereof, and the exterior of any other structure located within the same lot, even if not used for human habitation;

(8) “Dwelling unit” means a room or group of rooms within a dwelling arranged for use as a single household by one or more individuals living together who share living and sleeping facilities;

(9) “Entity” means any person, partnership, firm, association, corporation, limited liability company, sole proprietorship or any other business concern, state or local government agency or political subdivision or authority thereof, or any religious, social or union organization, whether operated for profit or otherwise;

(10) “Inspection” means an investigation to determine the presence of lead in paint, lead in other surface coverings, lead in dust, lead in soil or lead in drinking water, and the provision of a report explaining the results of the investigation;

(11) “Inspector” means an individual who performs inspections solely for the purpose of determining the presence of lead-based paint and surface coverings and lead in soil, dust and drinking water through the use of on-site testing including, but not limited to, x-ray fluorescence (XRF) analysis with portable analytical instruments, and the collection of samples for laboratory analysis and who collects information designed to assess the level of risk;

(12) “Lead abatement contractor” means any entity which contracts to perform lead hazard reduction by means of abatement including, but not limited to, the encapsulation, replacement, removal, enclosure or covering of paint, plaster, soil or other material containing toxic levels of lead;

(13) “Lead abatement supervisor” means an individual who oversees lead abatement activities;

(14) “Lead abatement worker” means an individual who performs lead abatement activities;

(15) “Lead consultant” means any person who performs lead detection, risk assessment, abatement design or related services in disciplines including inspector, risk assessor, and planner-project designer;

(16) “Lead consultant contractor” means any entity which contracts to perform lead hazard reduction consultation work utilizing an inspector, risk assessor or planner-project designer;

(17) “License” means the whole or part of any department permit, approval or similar form of permission required by the general statutes and which further requires: (A) Practice of the profession by licensed persons or entities only; (B) that a person or entity demonstrate competence to practice

through an examination or other means and meet certain minimum standards; and (C) enforcement of standards by the department;

(18) “Planner-project designer” means an individual who designs lead abatement and management activities;

(19) “Premises” means the area immediately surrounding a dwelling;

(20) “Refresher training course” means an annual, supplemental training course for personnel engaged in lead abatement or lead consultation services;

(21) “Risk assessor” means an individual who performs lead risk assessments for the purpose of determining the presence, type, severity and location of lead-based paint hazards, including lead hazards in paint, dust, drinking water and soil, through the use of on-site testing, including, but not limited to x-ray florescence analysis with portable instruments, and the collection of samples for laboratory analysis and provides suggested ways to control hazards identified;

[(21)] (22) “Training course” means an approved training course offered by a training provider for persons seeking instruction in lead abatement or lead consultation services; and

[(22)] (23) “[Training] Lead training provider” means an entity which offers an approved training course or refresher training course in lead abatement or lead consultation services.

Section 2. Section 20-476 of the general statutes is repealed and the following is substituted in lieu thereof:

On and after the effective date of regulations adopted pursuant to section 20-478, no person shall hold [himself] themselves out as a lead training provider, lead consultant, lead abatement supervisor or a lead abatement worker as defined in regulations adopted pursuant to section 20-478, in this state without a certificate issued by the Commissioner of Public Health. Applications for such certificate shall be made to the department on forms provided by it and shall be accompanied by a fee of fifty dollars, and shall contain such information regarding the applicant’s qualifications as the department may require in regulations adopted pursuant to said section 20-478. No person shall be issued a certificate to act as a lead training provider, lead consultant, lead abatement supervisor or lead abatement worker unless such person obtains such approval. The commissioner may issue a certificate under this section to any person who is licensed or certified in another state under a law which provides standards which are equal to or higher than those of Connecticut and is not subject to any unresolved complaints or pending disciplinary actions. Certificates issued pursuant to this section shall be renewed annually in accordance with the provisions of section 19a-88 upon payment of a fee of fifty dollars.

Section 3. Section 20-477 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [On and after July 1, 1994, all] All training courses and refresher training courses offered by lead training providers for persons seeking instruction as a lead consultant or lead consultant contractor, including inspector, risk assessor or planner-project designer, lead abatement supervisor and lead abatement worker, shall be approved by the department and shall be conducted in accordance with the requirements of this section. Each application for approval of each training course offered by a lead training provider shall be accompanied by a fee of one thousand two hundred fifty dollars. Each application for approval of each refresher training course offered by a training provider shall be accompanied by a fee of three hundred fifteen dollars. Each training course shall be reapproved by the department every three years. Each lead training provider shall pay a fee of one thousand two hundred fifty dollars for application for reapproval of each training course in accordance with this section. Each refresher training course shall be reapproved by the department every three years. Each refresher lead training provider shall pay a fee of three hundred fifteen dollars for application for reapproval of each refresher training course in accordance with this section. No fee shall be imposed upon training courses or refresher training courses operated and provided by the state, municipalities or nonprofit agencies. In order to facilitate uniformity among states in regulatory programs for lead abatement and lead consultant personnel and reciprocity of licensure and certification programs, the commissioner may establish liaisons with other states having state certification or licensure programs.

(b) (1) A lead training provider seeking approval of a training course or a refresher training course shall submit to the department completed application forms provided by the department and other associated material and such information as the department shall require to establish compliance with the requirements of this section.

(2) A lead training provider may offer any training course or refresher training course as desired, provided each course is approved by the department. Only lead training providers who have already received approval for a training course in a particular discipline, or are concurrently seeking such approval, may seek approval for a refresher training course in that discipline.

(3) Training course curricula shall encompass topics and materials as established by the commissioner. These curricula shall conform to standards or guidance for such course as established by the federal Environmental Protection Agency or such other federal agencies as may have jurisdiction.

(4) Training courses and refresher training courses shall utilize staff and faculty who comply with educational and experience standards as established by the commissioner. These standards shall conform to standards or guidance for such personnel qualifications as established by the federal Environmental Protection Agency or such other federal agencies as may have jurisdiction.

(c) Refresher training courses for each training course shall include the following: (1) An overview of key safety practices; (2) an update on new federal, state and local laws and regulations; and (3) an update on new technologies. Each refresher course shall consist of a minimum of seven training hours.

(d) Each lead training provider shall administer a closed book objective examination at the completion of each training or refresher training course. Such examination shall be an evaluation of the knowledge and skills acquired by each student. The course examination shall cover the course curriculum taught in each course. Training providers shall establish a passing standard for each course examination, provided such standard shall not be lower than seventy per cent correct.

(e) The department may conduct an audit of any training course or refresher training course prior to reapproval. The lead training provider shall submit an application for reapproval not earlier than one hundred eighty days or later than ninety days before the current course approval expires. In the event an audit is performed, the following elements may be examined: (1) Course materials; (2) instructor competency; (3) validity and security of the course examination; (4) the conduct of hands-on skills assessments; (5) adequacy of the facility and equipment; and (6) the training course quality control plan.

(f) Each lead training provider shall retain the following information: (1) Records of staff and faculty qualifications; (2) curriculum and course materials; (3) course examination or pool of examination questions; (4) information on how hands-on skills assessments were conducted; and (5) student files grouped alphabetically by class and year. Each student file shall contain results of the hands-on skills assessment and the examination and copies of any course completion certificate issued. The training provider shall retain these records at the location specified on the training provider's approved application for a minimum of three years.

(g) The department may, after opportunity for hearing, suspend, revoke or withdraw approval of a training or refresher training course upon a finding that a training course provider has committed any of the following acts: (1) Misrepresentation or concealment of a material fact in the obtaining of approval or reapproval of a training or a refresher training course; (2) failure to submit required information or notifications in a timely manner; (3) failure to maintain requisite records; (4) falsification of records, instructor qualifications or other approval information; (5) failure to adhere to the training standards and requirements of this section; (6) failure on the part of the training manager or other person with supervisory authority over the delivery of training to comply with federal, state or local lead statutes or regulations; or (7) fraudulent issuance of a course completion document to a person who has failed to successfully complete the course or course examination. Notice of any contemplated action under this subsection, the cause of action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54. The commissioner may petition the superior court for the judicial district of Hartford to enforce any order or action taken pursuant to this subsection. The provisions of this subsection shall not apply to applications for approval or reapproval filed pursuant to this section.

(h) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, requiring that applicants successfully complete an examination prescribed by the department, for certification in the following professions: Inspector, risk assessor, and lead abatement supervisor.

Section 4. Section 20-479 of the general statutes is repealed and the following is substituted in lieu thereof:

The provisions of section 20-476 shall not apply to a code enforcement official acting within the scope of [his] their duties, provided, within one year of July 1, 1994, no code enforcement official shall perform the duties of a lead consultant unless [he has] they have successfully completed an appropriate approved training course and an annual refresher training as specified in section 20-477 or complies with the standards established in regulations adopted pursuant to section 20-478.

Section 5. Section 20-480 of the general statutes is repealed and the following is substituted in lieu thereof:

The provisions of sections 20-475 to 20-477, inclusive, shall not apply to an employee of the Labor Department performing [his] their duties in accordance with chapter 571 nor to a federal employee of the Occupational Safety and Health Administration performing [his] their duties, in accordance with the federal Occupational Safety and Health Act.

Section 6. Section 20-481 of the general statutes is repealed and the following is substituted in lieu thereof:

The department may take any action set forth in section 19a-17 against a person or entity issued a license or certificate pursuant to sections 20-474 to 20-482, inclusive, and subsections (e) and (f) of section 19a-88 for reasons including, but not limited to, the following: Conviction of a felony; fraud or deceit in the practice of [his] their profession; negligent, incompetent or wrongful conduct in professional activities; misrepresentation or concealment of a material fact in the obtaining, reinstatement or renewal of a license; or violation of any provision of sections 20-474 to 20-482, inclusive, and subsections (e) and (f) of section 19a-88 or any regulation adopted thereunder. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to said section 19a-17. Notice of any contemplated action under said section 19a-17, the cause of action and the date of a hearing on the action shall be given and an opportunity for hearing afforded in accordance with the provisions of chapter 54.

Section 7. Subsection (c) of Section 19a-14 of the general statutes is repealed and the following is substituted in lieu thereof:

(c) No board shall exist for the following professions that are licensed or otherwise regulated by the Department of Public Health:

(1) Speech and language pathologist and audiologist;

(2) Hearing instrument specialist;

(3) Nursing home administrator;

(4) Sanitarian;

(5) Subsurface sewage system installer or cleaner;

(6) Marital and family therapist;

(7) Nurse-midwife;

(8) Licensed clinical social worker;

(9) Respiratory care practitioner;

(10) Asbestos contractor [and] asbestos consultant, and asbestos training provider;

(11) Massage therapist;

(12) Registered nurse’s aide;

(13) Radiographer;

(14) Dental hygienist;

(15) Dietitian-Nutritionist;

(16) Asbestos abatement worker;

(17) Asbestos abatement site supervisor;

(18) Licensed or certified alcohol and drug counselor;

(19) Professional counselor;

(20) Acupuncturist;

(21) Occupational therapist and occupational therapist assistant;

(22) Lead abatement contractor, lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, lead training provider, inspector and planner-project designer;

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

(24) Paramedic;

(25) Athletic trainer;

(26) Perfusionist;

(27) Master social worker subject to the provisions of section 20-195v;

(28) Radiologist assistant, subject to the provisions of section 20-74tt;

(29) Homeopathic physician;

(30) Certified water treatment plant operator, certified distribution system operator, certified small water system operator, certified backflow prevention device tester and certified cross connection survey inspector, including certified limited operators, certified conditional operators and certified operators in training; and

(31) Tattoo technician.

The department shall assume all powers and duties normally vested with a board in administering regulatory jurisdiction over such professions. The uniform provisions of this chapter and chapters 368v, 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c, including, but not limited to, standards for entry and renewal; grounds for professional discipline; receiving and processing complaints; and disciplinary sanctions, shall apply, except as otherwise provided by law, to the professions listed in this subsection.

Section 8. Subsection (e) of Section 19a-88 is repealed and the following is substituted in lieu thereof:

(e) (1) Each person holding a license or certificate issued under section 19a-514, 20-65k, 20-74s, 20-195cc or 20-206*ll* and chapters 370 to 373, inclusive, 375, 378 to 381a, inclusive, 383 to 383c, inclusive, 384, 384a, 384b, 384d, 385, 393a, 395, 399 or 400a and section 20-206n or 20-206o shall, annually, during the month of such person's birth, apply for renewal of such license or certificate to the Department of Public Health, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(2) Each person holding a license or certificate issued under section 19a-514, section 20-266o and chapters 384a, 384c, 386, 387, 388 and 398 shall apply for renewal of such license or certificate once every two years, during the month of such person's birth, giving such person's name in full, such person's residence and business address and such other information as the department requests.

(3) Each person holding a license or certificate issued pursuant to section [20-475 or 20-476] chapter 400c shall, annually, during the month of such person's birth, apply for renewal of such license or certificate to the department.

(4) Each entity holding a license issued pursuant to section 20-475 shall, annually, during the anniversary month of initial licensure, apply for renewal of such license or certificate to the department.

(5) Each person holding a license issued pursuant to section 20-162bb shall, annually, during the month of such person's birth, apply for renewal of such license to the Department of Public Health, upon payment of a fee of three hundred fifteen dollars, giving such person's name in full, such person's residence and business address and such other information as the department requests.

Section 9 of Section 20-439 of the general statutes is repealed and the following is substituted in lieu thereof:

On and after the effective date of regulations adopted pursuant to section 20-440, an asbestos training provider who provides asbestos abatement or asbestos consultation training programs serving to qualify asbestos abatement workers and asbestos abatement site supervisors for certification and asbestos consultants for certification shall be approved by the department. The department shall approve a training program upon determination that such program complies with such requirements as may be established in regulations adopted pursuant to section 20-440. Each application or reapplication for approval of a training program shall be accompanied by a fee of five hundred dollars. Each application for approval or reapproval of a refresher training program as required by section 20-441 shall be accompanied by a fee of two hundred fifty dollars. Each [person] asbestos training provider offering an asbestos abatement or asbestos consultation training program shall furnish the department

with a list of the persons who have successfully completed the course within thirty days of such completion. The department shall conduct periodic reviews of approved training courses and may revoke approval at any time it determines that the course fails to meet the requirements established in such regulations.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Local Health Integration.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Commissioner's office and Office of Local Health

Agency Analyst/Drafter of Proposal: Juanita Estrada/Shawn Rutchick

Title of Proposal: An Act Concerning the Integration of Local Health Departments into Districts

Statutory Reference:
Section 1. 19a-206
Section 2. 19a-207
Section 3. 19a-207a
Section 4. 19a-208
Section 5. 19a-209
Section 6. 19a-209a
Section 7. 19a-210
Section 8. 19a-211
Section 9. 19a-212
Section 10. 19a-213
Section 11. 19a-214
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Section 31. (NEW)
Section 32. (NEW)
Section 33. (Repealers)

Proposal Summary:
This proposal will integrate 73 local health departments and districts into regional health districts. The proposal will incorporate changes to the municipal payment structure along with standardizing the operations of the departments and services they provide to members of the community.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

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

Sections 1-32. Will improve governmental efficiencies at the state and local level, standardize public health practices and provide consistency in the delivery of the ten essential public health services to all the citizens of CT, the 73 local health departments and districts (LHDs) will be reorganized into regional health districts using (1) the Council of Government planning regions or (2) the 8 county boundaries. Each municipality in CT will be required to contribute a percentage of their budget to fund the regional health districts. This contribution may be offset by the revenue the regional health district receives such as state and federal grants and fees for permits, licenses, inspections or clinical services. The regionalization of LHDs will ensure that all the citizens of CT have access to full time local public health services. In CT, there is significant variability of types of services provided among LHDs even though there is a statutory requirement for a Basic Health Program. LHDs' staffing also varies across the state and ranges from less than 1 FTE to 60 FTEs. Regionalization of LHDs will pool resources therefore improving staffing numbers, the delivery of public health services, and the capacity to respond to public health threats in the event of an emergency. Regionalization will also provide governmental efficiencies. The Department of Public Health (DPH) will be able to provide better oversight and technical assistance to fewer LHDs. The DPH will be able to save time and money reducing the number of contracts and payments to LHDs.

Section 33. Repeals the sections of statute that pertain directly to part time and full time

municipal health districts.

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

If this is a resubmission, please share:

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

Click here to enter text.

PROPOSAL IMPACT

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

Agency Name: Click here to enter text.
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

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

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation)*
This will require municipalities to pay 1.5% of their operating budget into the local health district that they are joining.

State
See associated budget option

Federal
None

Additional notes on fiscal impact
Click here to enter text.

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

The Office of Local Health will have better oversight over the activities of Directors of Health

Section 1. Section 19a-206 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) [Town, city and borough] District directors of health or their authorized agents shall, within their respective jurisdictions, examine all nuisances and sources of filth injurious to the public health, cause such nuisances to be abated or remediated and cause to be removed all filth which in their judgment may endanger the health of the inhabitants. Any owner or occupant of any property who maintains such property, whether real or personal, or any part thereof, in a manner which violates the provisions of the Public Health Code enacted pursuant to the authority of sections 19a-36 and 19a-37 shall be deemed to be maintaining a nuisance or source of filth injurious to the public health. Any [local] district director of health or his authorized agent or a sanitarian authorized by such director may enter all places within [his] the director's jurisdiction where there is just cause to suspect any nuisance or source of filth exists, and abate or remediate or cause to be abated or remediated such nuisance and remove or cause to be removed such filth.

(b) When any such nuisance or source of filth is found on private property, such director of health shall order the owner or occupant of such property, or both, to remove, abate or remediate the same within such time as the director directs. If the owner of such property is a registrant, such director may deliver the order in accordance with section 7-148ii, provided nothing in this section shall preclude a director from providing notice in another manner permitted by applicable law. If such order is not complied with within the time fixed by such director: (1) Such director, or any official [of such town, city or borough] authorized to institute actions on behalf of such district [town, city or borough], may institute and maintain a civil action for injunctive relief in any court of competent jurisdiction to require the abatement or remediation of such nuisance, the removal of such filth and the restraining and prohibiting of acts which caused such nuisance or filth, and such court shall have power to grant such injunctive relief upon notice and hearing; (2) (A) the owner or occupant of such property, or both, shall be subject to a civil penalty of two hundred fifty dollars per day for each day such nuisance is maintained or such filth is allowed to remain after the time fixed by the director in his order has expired, except that the owner or occupant of such property or any part thereof on which a public eating place is conducted shall not be subject to the provisions of this subdivision, but shall be subject to the provisions of subdivision (3) of this subsection, and (B) such civil penalty may be collected in a civil proceeding by the director of health or any official of such [town, city or borough] district authorized to institute civil actions and shall be payable to the treasurer of such city, town or borough; and (3) the owner or occupant of such property, or both, shall be subject to the provisions of sections 19a-36, 19a-220 and 19a-230.

(c) If the director institutes an action for injunctive relief seeking the abatement or remediation of a nuisance or the removal of filth, the maintenance of which is of so serious a nature as to constitute an

immediate hazard to the health of persons other than the persons maintaining such nuisance or filth, [he] the director may, upon a verified complaint stating the facts which show such immediate hazard, apply for an ex parte injunction requiring the abatement or remediation of such nuisance or the removal of such filth and restraining and prohibiting the acts which caused such nuisance or filth to occur, and for a hearing on an order to show cause why such ex parte injunction should not be continued pending final determination on the merits of such action. If the court finds that an immediate hazard to the health of persons other than those persons maintaining such nuisance or source of filth exists, such ex parte injunction shall be issued, provided a hearing on its continuance pending final judgment is ordered held within seven days thereafter and provided further that any persons so enjoined may make a written request to the court or judge issuing such injunction for a hearing to vacate such injunction, in which event such hearing shall be held within three days after such request is filed.

(d) In each [town, except in a town having a city or borough within its limits] district, the [town] director of health shall have and exercise all the power for preserving the public health and preventing the spread of diseases[; and, in any town within which there exists a city or borough, the limits of which are not coterminous with the limits of such town, such town director of health shall exercise the powers and duties of his office only in such part of such town as is outside the limits of such city or borough, except that when such city or borough has not appointed a director of health, the town director of health shall, for the purposes of this section, exercise the powers and duties of his office throughout the town, including such city or borough, until such city or borough appoints a director of health].

(e) When such nuisance is abated or remediated or the source of filth is removed from private property, such abatement, remediation or removal shall be at the expense of the owner or, where applicable, the occupant of such property, or both, and damages and costs for such abatement, remediation or removal may be recovered against the owner or, where applicable, the occupant, or both, by the [town, city or borough] district in a civil action as provided in subsection (b) of this section or in a separate civil action brought by the director of health or any official of such [city, town or borough] district authorized to institute civil actions.

(f) If the order of a district department of health, formed pursuant to section 19a-241, causes the displacement of any occupant of a residential dwelling unit, the municipality in which such dwelling unit is located shall be responsible for any relocation assistance afforded to such occupant pursuant to chapter 135. The district department of health shall provide written notification to the occupant of the occupant's rights under chapter 135 at the time an order causing displacement is issued. The written notification shall include the name, address and telephone number of the person authorized by the municipality to process applications for relocation assistance afforded pursuant to chapter 135.

Section 2. Section 19a-207 of the general statutes is repealed and the following is substituted in lieu thereof:

The [local] district director of health or [his] the director's authorized agent or the board of health shall enforce or assist in the enforcement of the [Public Health Code] statutes and [such] regulations as may

be adopted by the Commissioner of Public Health. Towns, cities and boroughs may retain the power to adopt, by ordinance, sanitary rules and regulations, but no such rule or regulation shall be inconsistent with the [Public Health Code] statutes and regulations as adopted by said commissioner. In any emergency when the health of any locality is menaced or when any [local board of health or] district director of health fails to comply with recommendations of the Department of Public Health, said department may enforce such regulations as may be required for the protection of the public health.

Section 3. Section 19a-207a of the general statutes is repealed and the following is substituted in lieu thereof:

Each district department of health [and municipal health department] shall ensure the provision of a basic health program that includes, but is not limited to, the following services for each community served by the district department of health [and municipal health department]: (1) Monitoring of health status to identify and solve community health problems; (2) investigating and diagnosing health problems and health hazards in the community; (3) informing, educating and empowering persons in the community concerning health issues; (4) mobilizing community partnerships and action to identify and solve health problems for persons in the community; (5) developing policies and plans that support individual and community health efforts; (6) enforcing laws and regulations that protect health and ensure safety; (7) connecting persons in the community to needed health care services when appropriate; (8) assuring a competent public health and personal care workforce; (9) evaluating effectiveness, accessibility and quality of personal and population-based health services; and (10) researching to find innovative solutions to health problems.

Section 4. Section 19a-208 of the general statutes is repealed and the following is substituted in lieu thereof:

[Town, city, borough and district] District directors of health shall attend conferences called by the Department of Public Health to consider matters relating to public health, and the necessary expenses incident to such attendance shall be paid by the [town, city, borough or] district represented by the director[, provided said department shall not call more than two such conferences in any year].

Section 5. Section 19a-209 of the general statutes is repealed and the following is substituted in lieu thereof:

The director of health of a [town, city or borough] district contiguous to any stream or body of water which is not wholly within the limits of such [town, city or borough] district shall, in the enforcement of the laws, rules and regulations relating to public health, have jurisdiction over such stream or body of water and the islands situated therein.

Section 6. Section 19a-209a of the general statutes is repealed and the following is substituted in lieu thereof:

The director of health of a [town, city, or borough or of a] district health department may issue a permit for the installation or replacement of a water supply well at residential premises on property whose boundary is located within two hundred feet of an approved community water supply system, measured along a street, alley or easement, where (1) the water from the water supply well is only used for irrigation or other outside use and is not used for human consumption, (2) a reduced pressure device is installed to protect against a cross connection with the public water supply, (3) no connection exists between the water supply well and the community water system, and (4) the use of the water supply well will not affect the purity or adequacy of the supply or service to the customers of the community water supply system. Any well installed pursuant to this subsection, except a well used for irrigation, shall be subject to water quality testing that demonstrates the supply meets the water quality standards established in section 19a-37 at the time of installation and at least every ten years thereafter or as requested by the [local] district director of health. Upon a determination by the [local] district director of health that an irrigation well creates an unacceptable risk of injury to the health or safety of persons using the water, to the general public, or to any public water supply, the [local] district director of health may issue an order requiring the immediate implementation of mitigation measures, up to and including permanent abandonment of the well, in accordance with the provisions of the Connecticut Well Drilling Code adopted pursuant to section 25-128. In the event a cross connection with the public water system is found, the owner of the system may terminate service to the premises.

Section 7. Section 19a-210 of the general statutes is repealed and the following is substituted in lieu thereof:

Any [board of health or borough or town] district director of health may, upon the written complaint of any person having an interest in any land, cause the removal of refuse and rubbish from such land and shall apportion the expenses of such removal among the co-owners; provided the cost of removal of any refuse and rubbish caused by the alteration or erection of any structure on such land shall be charged to the owner or owners causing such alteration or erection.

Section 8. Section 19a-211 of the general statutes is repealed and the following is substituted in lieu thereof:

Any owner or person having the care, custody or control of any building, room or premises maintained for or used by the public, who allows any toilet in any such building, room or premises or connected therewith to be in an insanitary condition, shall be fined not more than one hundred dollars for each offense. [The] Each district director of health [of each town, city or borough] shall inspect each such toilet and cause the same to be maintained in a sanitary condition and shall make complaint of any failure to maintain any such toilet in such condition to a prosecuting officer having jurisdiction. The failure of any director of health to perform his duty under the provisions of this section shall be cause for [his] the director's removal.

Section 9. Section 19a-212 of the general statutes is repealed and the following is substituted in lieu thereof:

When there exist upon any premises swampy or wet places or depressions in which a foul and unhealthy condition, arising from natural causes, permanently exists, the director of health of the district [town or the health committee, director of health or board of health of any city or borough], in which such places or depressions exist, upon the written complaint of any person and upon finding that such places or depressions are a source of danger to the public health, may cause such places or depressions to be filled with suitable material or drained. When caused to be done in any town outside the limits of a city or borough, it shall be under the direction of the selectmen of such town, and the expenses incurred thereby shall be paid by the treasurer of the town upon the orders of the selectmen, and, when caused to be done within the limits of any city or borough, the expense thereof shall be borne by such city or borough, provided such director of health[, health committee or board of health] shall not cause to be expended in any year under the provisions of this section a sum in excess of three hundred dollars, unless expressly authorized by such town, city or borough to expend a greater amount. Any resident or taxpayer of such town, city or borough may appeal from such order of any director of health[, health committee or board of health] in the manner provided in section 19a-229. If the owner of such premises, or [his] the owner's agent in charge thereof, has been notified in writing by such director of health[, health committee or board of health] to cause such places to be filled in or drained and has failed to do so, the owner of such premises filled in or drained under the provisions of this section shall pay to the community performing such work the benefits accruing to him therefrom, to be determined in the same manner as benefits are assessed in the layout of streets and highways.

Section 10. Section 19a-213 of the general statutes is repealed and the following is substituted in lieu thereof:

When it has been brought to the attention of a director of health [or board of health] that rain water barrels, tin cans, bottles or other receptacles or pools near human habitations are breeding mosquitoes, such director of health [or board of health] shall investigate and cause any such breeding places to be abolished, screened or treated in such manner as to prevent the breeding of mosquitoes. The director of health, or any inspector or agent employed by [him] the director, may enter any premises in the performance of [his] their duties under this section.

Section 11. Section 19a-214 of the general statutes is repealed and the following is substituted in lieu thereof:

No person, firm, corporation or partnership supplying fuel oil or bottled gas for the purpose of heating to a residential building which such person, firm, corporation or partnership knows, or reasonably should know, is occupied by any person other than the owner or any other party legally liable to the supplier for such fuel oil or bottled gas shall fail to provide such fuel oil or bottled gas in quantities sufficient to maintain the interior of such building at sixty-five degrees Fahrenheit, unless such supplier notifies, at least three days or, in the situation where such supplier has a contract providing for automatic delivery, at least ten days prior to the time such building is reasonably expected to require an additional supply of fuel oil or bottled gas to continue to maintain the interior of the building at such temperature, the owner or any other party legally liable to the supplier for such fuel oil or bottled gas, the Secretary of the Office of Policy and Management and [the chief health officer] district health director of the [municipality, town, city or borough] district in which such building is located of [his]

their intention to discontinue such supply of fuel oil or bottled gas. Such notice shall include: (1) The address of the residential building affected; (2) the name and if known to the supplier of fuel oil or bottled gas, the address and telephone number of the person, firm, corporation, or partnership or its agent financially responsible for the supply of fuel oil or bottled gas; (3) the date on which the building is reasonably expected to require additional supplies of fuel oil or bottled gas to maintain the interior of the building at sixty-five degrees Fahrenheit; and (4) the reason for the refusal to provide fuel oil or bottled gas to the residential building. Such notice shall be given by telephone or in person during normal business hours of the [municipality, town, city, or borough] district in which such building is located. The person, firm, corporation, or partnership supplying fuel oil or bottled gas shall maintain adequate records at its principal place of business of such notice including the date, time, and person to whom such notice is given. A copy of such record shall be mailed to the district health director [officer], the owner or party legally liable to the supplier for such fuel oil or bottled gas and the Secretary of the Office of Policy and Management on the same day as the notice is given. Within twenty-four hours after such notice is received from the fuel oil or bottled gas supplier, (A) the district health director [officer] shall contact the owner, agent, lessor, or manager of such building and advise [him] them of [his] their responsibilities pursuant to section 19a-109, and shall post notices in conspicuous places on the premises that service may be discontinued; and (B) the district health director [officer], or an agent designated by the chief executive officer of the municipality, shall take reasonable steps to notify each tenant that he may have rights and remedies under sections 47a-13 and 47a-14a. A copy of such notice shall also be delivered to each dwelling unit within the premises. The name of the supplier shall not be mentioned in such notice. The supplier of fuel oil or bottled gas shall not be liable to such person, firm, corporation, or partnership financially responsible to such supplier for the supply of fuel oil or bottled gas or its agent for any damages whatsoever caused by the negligence of such supplier in making the notification required by the provisions of this section.

Section 12. Section 19a-215 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For the purposes of this section:

(1) “Clinical laboratory” means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances.

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

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

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

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

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

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

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

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

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

Section 13. Section 19a-216 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Any [municipal] district health department, state institution or facility, licensed physician or public or private hospital or clinic, may examine or provide treatment for venereal disease for a minor, if the physician or facility is qualified to provide such examination or treatment. The consent of the parents or guardian of the minor shall not be a prerequisite to the examination or treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for the minor. The fact of consultation, examination or treatment of a minor under the provisions of this section shall be confidential and shall not be divulged by the facility or physician, including the sending of a bill for the services to any person other than the minor, except for purposes of reports under section 19a-215, and except that, if the minor is not more than twelve years of age, the facility or physician shall report the name, age and address of that minor to the Commissioner of Children and Families or the commissioner's designee who shall proceed thereon as in reports under section 17a-101g.

(b) A minor shall be personally liable for all costs and expenses for services afforded such minor at his or her request under this section.

Section 14. Section 19a-216a of the general statutes is repealed and the following is substituted in lieu thereof:

(a) For the purposes of this section: (1) "Communicable disease control clinic" means a state or local health department funded clinic established for the purpose of providing readily accessible treatment of persons with possible sexually-transmitted diseases and their sexual contacts or persons with possible tuberculosis and their contacts. (2) "Epidemiologic information" means the names of possible human sources of infection or subsequent transmission from a person with a sexually-transmitted disease or tuberculosis.

(b) The personal medical records of persons examined or treated in a communicable disease control clinic shall be held strictly confidential by the [local] district director of health and [his] their authorized agents and shall not be released or made public or be subject to discovery proceedings, except release may be made of personal medical information, excluding epidemiologic information under the following circumstances:

(1) For statistical purposes in such form that no individual person can be identified;

(2) With the informed consent of all persons identified in the records;

(3) To health care providers in a medical emergency to the extent necessary to protect the health or life of the person who is the subject;

(4) To health care providers and public health officials in the states or localities authorized to receive such information by other state statute or regulation to the extent necessary to protect the public health or safety by permitting the continuation of service or public health efforts directed to disease prevention and control;

(5) To any agency authorized to receive reports of abuse or neglect of minors not more than twelve years of age pursuant to section 19a-216. If any information is required to be disclosed in a court proceeding involving abuse or neglect, the information shall be disclosed in camera and sealed by the court upon conclusion of the proceeding; or

(6) By court order as necessary to enforce any provision of the general statutes or state regulations or local ordinances pertaining to public health and safety provided the order explicitly finds each of the following: (A) The information sought is material, relevant and reasonably calculated to be admissible evidence during the legal proceeding; (B) the probative value of the evidence outweighs the individual's and the public's interest in maintaining its confidentiality; (C) the merits of the litigation cannot be fairly resolved without the disclosure; and (D) the evidence is necessary to avoid substantial injustice to the party seeking it and the disclosure will result in no significant harm to the person examined or treated. Before making such findings, the court may examine the information in camera. If the information meets the test of necessary evidence as listed in this subdivision, it shall be disclosed only in camera and shall be sealed by the court on conclusion of the proceeding.

(c) Except as provided in subsection (b) of this section, no [local] district health department official or employee shall be examined in any court proceeding, civil or criminal, or before any other tribunal, board, agency or person as to the existence or contents of pertinent records, reports or information of a person examined or treated for a sexually-transmitted disease by a state or [local] district health department, or as to the existence or contents of such records, reports or information received by such department from a private physician or private health facility, without the written consent of the individual who is the subject of the records, reports or information.

(d) Information released under the provisions of this section shall not be rereleased unless the rerelease is made in accordance with the provisions of this section.

(e) Any person who violates any provision of this section shall be fined not more than one thousand dollars. No provision of this section shall be deemed to supersede section 19a-584.

Section 15. Section 19a-220 of the general statutes is repealed and the following is substituted in lieu thereof:

When any person refuses to obey a legal order given by a director of health[, health committee or board of health,] or endeavors to prevent it from being carried into effect, a judge of the Superior Court

may issue [his] a warrant to a proper officer or to an indifferent person, therein stating such order and requiring [him] such person to carry it into effect, and such officer or indifferent person shall execute the same.

Section 16. Section 19a-221 as amended by public act 15-217 of the general statutes is repealed and the following is substituted in lieu thereof:

Order of quarantine or isolation of certain persons. Appeal of order. Hearing. (a) Any [town, city, borough or] district director of health may order any person isolated or quarantined whom such director has reasonable grounds to believe to be infected with a communicable disease or to be contaminated, if such director determines such person poses a substantial threat to the public health and isolation or quarantine is necessary to protect or preserve the public health, except that in the event the Governor declares a public health emergency, pursuant to section 19a-131a, each [town, city, borough and] district director of health shall comply with and carry out any order the Commissioner of Public Health issues in furtherance of the Governor's order pursuant to the declaration of the public health emergency.

(b) (1) The director shall adhere to the following conditions and principles when isolating or quarantining persons: (A) Isolation and quarantine shall be by the least restrictive means necessary to prevent the spread of a communicable disease or contamination to others and may include, but not be limited to, confinement to private homes or other private or public premises; (B) quarantined persons shall be confined separately from isolated persons; (C) the health status of isolated or quarantined persons shall be monitored frequently to determine if they continue to require isolation or quarantine; (D) if a quarantined person subsequently becomes infected or contaminated or is reasonably believed to have become infected with a communicable disease or contaminated, such person shall be promptly moved to isolation; (E) isolated or quarantined persons shall be immediately released when they are no longer infectious or capable of contaminating others or upon the order of a court of competent jurisdiction; (F) the needs of persons isolated or quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in isolation or quarantine and outside those settings, medication and competent medical care; (G) premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to individuals isolated or quarantined; (H) to the extent possible without jeopardizing the public health, family members and members of a household shall be kept together, and guardians shall stay with their minor wards; and (I) to the extent possible, cultural and religious beliefs shall be considered in addressing the needs of persons and establishing and maintaining premises used for quarantine and isolation.

(2) The order by the director shall be in writing setting forth: (A) The name of the person to be isolated or quarantined, (B) the basis for the director's belief that the person has a communicable disease or has been contaminated and poses a substantial threat to the public health and that isolation or quarantine is necessary to protect or preserve the public health, (C) the period of time during which the order shall remain effective, (D) the place of isolation or quarantine that may include, but need not be limited to, private homes or other private or public premises, as designated by the director, and (E) such other

terms and conditions as may be necessary to protect and preserve the public health. Such order shall also inform the person isolated or quarantined that such person has the right to consult an attorney, the right to a hearing under this section, and that if such a hearing is requested, he has the right to be represented by counsel, and that counsel will be provided at the state's expense if he is unable to pay for such counsel. A copy of the order shall be given to such person. In determining the duration of the order, the director shall consider, to the extent known, the length of incubation of the communicable disease or contamination, the date of the person's exposure and the person's medical risk of exposing others to such communicable disease or contamination. Within twenty-four hours of the issuance of the order, the director of health shall notify the Commissioner of Public Health that such an order has been issued. The order shall be effective for not more than twenty days, provided further orders of confinement pursuant to this section may be issued as to any respondent for successive periods of not more than twenty days if issued before the last business day of the preceding period of isolation or quarantine.

(c) A person ordered isolated or quarantined under this section shall be isolated or quarantined in a place designated by the director of health until such time as such director determines such person no longer poses a substantial threat to the public health or is released by order of a Probate Court for the district in which such person is isolated or quarantined. Any person who desires treatment by prayer or spiritual means without the use of any drugs or material remedies, but through the use of the principles, tenets or teachings of any church incorporated under chapter 598, may be so treated during such person's isolation or quarantine in such place.

(d) A person isolated or quarantined under this section shall have the right to a hearing in Probate Court and, if such person or such person's representative requests a hearing in writing, such hearing shall be held not later than seventy-two hours after receipt of such request, excluding Saturdays, Sundays and legal holidays. A request for a hearing shall not stay the order of isolation or quarantine issued by the director of health under this section. The hearing shall be held to determine if (1) the person ordered isolated or quarantined is infected with a communicable disease or is contaminated, (2) the person poses a substantial threat to the public health, and (3) isolation or quarantine of the person is necessary and the least restrictive alternative to protect and preserve the public health. The commissioner shall have the right to be made a party to the proceedings.

(e) Jurisdiction shall be vested in the Probate Court for the district in which such person resides or is isolated or quarantined.

(f) Notice of the hearing shall be given the respondent and shall inform the respondent that his or her representative has a right to be present at the hearing; that the respondent has a right to counsel; that the respondent, if indigent or otherwise unable to pay for or obtain counsel, has a right to have counsel appointed to represent the respondent; and that the respondent has a right to cross-examine witnesses testifying at the hearing. If the court finds such respondent is indigent or otherwise unable to pay for counsel, the court shall appoint counsel for such respondent, unless such respondent refuses counsel and the court finds that the respondent understands the nature of his or her refusal. The court shall provide such respondent a reasonable opportunity to select his or her own counsel to be appointed by the court. If the respondent does not select counsel or if counsel selected by the respondent refuses to

represent such respondent or is not available for such representation, the court shall appoint counsel for the respondent from a panel of attorneys admitted to practice in this state provided by the Probate Court Administrator. The reasonable compensation of appointed counsel shall be established by and paid from funds appropriated to, the Judicial Department, but, if funds have not been included in the budget of the Judicial Department for such purposes, such compensation shall be established by the Probate Court Administrator and paid from the Probate Court Administration Fund.

(g) Prior to such hearing, such respondent or respondent's counsel shall be afforded access to all records including, without limitation, hospital records if such respondent is hospitalized. If such respondent is hospitalized at the time of the hearing, the hospital shall make available at such hearing for use by the respondent or the respondent's counsel all records in its possession relating to the condition of the respondent. Nothing in this subsection shall prevent timely objection to the admissibility of evidence in accordance with the rules of civil procedure.

(h) At such hearing, the director of health who ordered the isolation or quarantine of the respondent shall have the burden of showing by a preponderance of the evidence that the respondent is infected with a communicable disease or is contaminated and poses a substantial threat to the public health and that isolation or quarantine of the respondent is necessary and the least restrictive alternative to protect and preserve the public health.

(i) If the court, at such hearing, finds by a preponderance of the evidence that the respondent is infected with a communicable disease or is contaminated and poses a substantial threat to the public health and that isolation or quarantine of the respondent is necessary and the least restrictive alternative to protect and preserve the public health, it shall order (1) the continued isolation or quarantine of the respondent under such terms and conditions as it deems appropriate until such time as it is determined that the respondent's release would not constitute a reasonable threat to the public health, or (2) the release of the respondent under such terms and conditions as it deems appropriate to protect the public health.

(j) If the court, at such hearing, fails to find that the conditions required for an order for isolation or quarantine have been proven, it shall order the immediate release of the respondent.

(k) A respondent may, at any time, move the court to terminate or modify an order made under subsection (i) of this section, in which case a hearing shall be held in accordance with this section. The court shall annually, upon its own motion, hold a hearing to determine if the conditions which required the isolation or quarantine of the respondent still exist. If the court, at a hearing held upon motion of the respondent or its own motion, fails to find that the conditions which required isolation or quarantine still exist, it shall order the immediate release of the respondent. If the court finds that such conditions still exist but that a different remedy is appropriate under this section, the court shall modify its order accordingly.

(l) Any person aggrieved by an order of the Probate Court under this section may appeal to the Superior Court.

Section 17. Section 19a-222 of the general statutes is repealed and the following is substituted in lieu thereof:

Directors of health [and boards of health] may adopt such measures for the general vaccination of the inhabitants of their respective districts [towns, cities or boroughs] as they deem reasonable and necessary in order to prevent the introduction or arrest the progress of smallpox, and the expenses in whole or in part of such general vaccination shall, upon their order, be paid out of the town, city or borough treasury of the person's residence, as the case may be. Any person who refuses to be vaccinated, or who prevents a person under [his] the person's care and control from being vaccinated, on application being made by the director of health [or board of health] or by a physician employed by the director of health [or board of health] for that purpose, unless, in the opinion of another physician, it would not be prudent on account of sickness, shall be fined not more than five dollars.

Section 18. Section 19a-223 of the general statutes is repealed and the following is substituted in lieu thereof:

[Municipalities] Districts may contract for health services. (a) Any [municipal departments of health, pursuant to municipal charter or ordinance, and] health [districts] district may contract among themselves for the joint use or benefit of the [municipality] district for services, personnel, facilities, equipment or any other property or resources for matters affecting public health. Any officer or employee of a [municipality] district furnishing such services under such an agreement shall have, in the [municipality or] district to which the services are furnished, the same authority, responsibilities and duties as to public health as the officer or employee has in the [municipality or] district employing [him] that person.

(b) When necessary to protect and preserve the public health and prevent the spread of disease and injury, any [municipal department of health, pursuant to any municipal charter or ordinance and with the approval of the chief executive officer of the municipality, or any] health district may request emergency assistance and the use of resources from any other [municipal department of health or] health district. Any officer or employee of a [municipality or] health district, while acting in response to such a request, shall have, in the [municipality or] district to which the services are furnished, the same powers, duties, privileges and immunities as are conferred on public health officers and employees of the [municipality or] district requesting assistance.

Section 19. Section 19a-226 of the general statutes is repealed and the following is substituted in lieu thereof:

Unless otherwise provided, [city and borough] directors of health shall have power to make orders and regulations controlling the time during which, and the manner in which, manure and other fertilizers may be unloaded from vessels or cars and transported upon the highways in their several jurisdictions.

Section 20. Section 19a-227 of the general statutes is repealed and the following is substituted in lieu thereof:

[The] A director of health of any [town, city or borough] may designate limits within the navigable waters of the state, outside the channel and adjacent to any public or private bathing beach or bathing house, within which limits houseboats or other vessels used by the owners or possessors thereof as dwelling places shall not, while so used and occupied as dwelling places, be anchored or moored; and such [town, city or borough] director of health shall, upon the written application of five or more persons owning property adjoining any bathing beach or bathing house within such navigable waters, designate such limits. After limits have been designated as aforesaid, no person having immediate charge of any such houseboat or other vessel, while used and occupied as a dwelling place, shall anchor or moor the same or keep the same anchored or moored within the limits so designated.

Section 21. Section 19a-229 of the general statutes is repealed and the following is substituted in lieu thereof:

Any person aggrieved by an order issued by a [town, city or borough] director of health may appeal to the Commissioner of Public Health not later than three business days after the date of such person's receipt of such order, who shall thereupon immediately notify the authority from whose order the appeal was taken, and examine into the merits of such case, and may vacate, modify or affirm such order.

Section 22. Section 19a-230 of the general statutes is repealed and the following is substituted in lieu thereof:

Any person who violates any provision of this chapter or any legal order of a director of health [or board of health], for which no other penalty is provided, shall be guilty of a class C misdemeanor.

Section 23. Section 19a-231 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Salon" includes any shop, store, day spa or other commercial establishment at which the practice of barbering, as described in section 20-234, hairdressing and cosmetology, as defined in section 20-250, or the services of a nail technician, or any combination thereof, is offered and provided; and

(2) "Nail technician" means a person who, for compensation, cuts, shapes, polishes or enhances the appearance of the nails of the hands or feet, including, but not limited to, the application and removal of sculptured or artificial nails.

(b) The director of health for any [town, city, borough or] district department of health, or the director's authorized representative, shall, on an annual basis, inspect all salons within the director's jurisdiction regarding their sanitary condition. The director of health, or the director's authorized representative, shall have full power to enter and inspect any such salon during usual business hours. If any salon, upon such inspection, is found to be in an unsanitary condition, the director of health shall

make written order that such salon be placed in a sanitary condition. The director of health may collect from the operator of any such salon a reasonable fee, not to exceed one hundred dollars, for the cost of conducting any annual inspection of such salon pursuant to this section. Notwithstanding any municipal charter, home rule ordinance or special act, any fee collected by the director of health pursuant to this section shall be used by the [town, city, borough or] district department of health for conducting inspections pursuant to this section.

Section 24. Section 19a-232 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) "Consumer" means any individual who (A) is provided access to a tanning facility in exchange for a fee or other compensation, or (B) in exchange for a fee or other compensation, is afforded use of a tanning device as a condition or benefit of membership or access;

(2) "Operator" means an individual designated by the tanning facility to control operation of the tanning facility and to instruct and assist the consumer in the proper operation of the tanning device;

(3) "Tanning device" means any equipment that emits radiation used for tanning of the skin, such as a sunlamp, tanning booth or tanning bed that emits ultraviolet radiation, and includes any accompanying equipment, such as timers or handrails; and

(4) "Tanning facility" means any place where a tanning device is used for a fee, membership dues or other compensation.

(b) An operator shall not allow any person under seventeen years of age to use a tanning device. Any operator who, knowing that a person is under seventeen years of age or under circumstances where such operator should know that a person is under seventeen years of age, allows such person to use a tanning device shall be fined not more than one hundred dollars. Such fine shall be payable to the municipal health department or health district for the municipality in which the tanning facility is located.

(c) Any [municipal health department established under this chapter and any] district department of health established under chapter 368f may, within its available resources, enforce the provisions of this section.

Section 25. Section 19a-240 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in this chapter, unless the context otherwise requires, ["board" means a board of a district department of health created as provided in section 19a-241] <u>(1) "County" means a county specified in section 6-1 of the General Statutes; (2) Executive board means the executive board of a health district;</u>

(3) “Governing board” means the board of health district; and (4) “Health district” means a health district created under section 19a-241 of the General Statutes.

Section 26. Section 19a-241 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each county shall have a district health department that shall be comprised of the [Towns] towns, cities and boroughs, [by vote of their respective legislative bodies, after a public hearing, may unite to form district departments of health,]. The district health department [which] shall be [instrumentalities] an instrumentality of [their] its constituent municipalities. The affairs of any such district department of health shall be managed by [a] an executive board, which shall have all the duties exercised or performed immediately prior to the effective date of the creation of such district by directors of health, [or] boards of health of the municipalities or districts and which shall exercise all the authority as to public health required of or conferred upon the constituent municipalities by law and shall have the powers of the district set forth in section 19a-243. [Towns, cities and boroughs may, in like manner, join a district department of health previously formed with the approval of the board of such district.]

(b) Each town, city and borough within each county[, which has so voted to become a part of any such district,] shall, by its board of selectmen, city council or board of burgesses, appoint one person to be a member of such the district’s governing board. Any town, city or borough having a population of more than [ten] fifty thousand inhabitants, as annually estimated by the Department of Public Health by a method comparable or similar to that used by the United States Bureau of the Census, shall be entitled to one additional representative [for each additional ten thousand population or part thereof, provided no such municipality shall have more than five representatives on a district] on the governing board of health.

(c) The governing board of health shall appoint at least ten people to be members of the executive board. At least one member shall be from each of the following categories (1) a licensed physician or surgeon; (2) a licensed advance practice registered nurse; (3) a licensed oral health professional; (4) a licensed mental health professional; and (5) a public member. Members may not serve in more than one capacity to satisfy the category requirements.

(d) The term of office for members of the governing and executive [district board] boards of health shall be three years, except that[: (1) A district board of health containing only one town may elect to have one-year or three-year terms of office, and (2)] during the initial formation of a board [with three-year appointments,] appointments shall be so made that approximately one-third of the board shall be appointed for one year, approximately one-third appointed for two years and approximately one-third appointed for three years. Members of the [district board] governing and executive boards of health shall serve without compensation but shall receive their necessary expenses while in the performance of their official duties.

Section 27. Section 19a-242 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The executive board shall, after approval of the Commissioner of Public Health, appoint some discreet person, possessing the qualifications specified in section 19a-244, to be director of health for such district for a period of not more than two years, and if [he] the person is not selected within sixty days from the formation of any such district, or if a vacancy in said office continues to exist for sixty days, such director shall then be appointed by said commissioner. The executive board may, after approval of the Commissioner of Public Health, appoint a person to serve as the acting director of health during such time as the director of health is absent or a vacancy exists, provided such acting director shall meet the qualifications for directors of health in section 19a-244, or such other qualifications as may be approved by said commissioner. Upon the appointment of a director of health under the provisions of this section, the terms of office of the directors of health of the towns, cities or boroughs forming such district shall terminate.

(b) Such director of health may be removed as provided in section 19a-244 or whenever a majority of the [directors of such health district find] the executive board finds that such director of health is guilty of misconduct, material neglect of duty, [or] incompetence in the conduct of [his] the director's office, or violating any provisions in such director's written agreement under section 19a-244.

(c) On and after July 1, 1988, each district health department shall provide for the services of a sanitarian certified under chapter 395 to work under the direction of the district director of health. Where practical, the district director of health may act as the sanitarian.

(d) As used in this chapter, "authorized agent" means a sanitarian certified under chapter 395 and any individual certified for a specific program of environmental health by the Commissioner of Public Health in accordance with the Public Health Code.

(e) Each director of health shall, annually, at the end of the fiscal year of the district, file with the Department of Public Health a report of the activities of the basic health program as prescribed in section 19a-207a and other such information as prescribed by the commissioner.

Section 28. Section 19a-243 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each governing board shall meet at least annually. The governing board shall [may] make and modify, as necessary or desirable, district bylaws and may [make] and may adopt other reasonable rules and regulations for the promotion of general health within the district not in conflict with [law or with the Public Health Code] the statutes or regulations. The powers of each district shall include but not be limited to the following enumerated powers: (1) To sue and be sued; (2) to make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the health district; (3) to make and from time to time amend and repeal bylaws, rules and regulations; (4) to acquire real estate; (5) to provide for the financing of the programs, projects or other functions of the district in the manner described in subsection (b) of this section; and (6) to have such other powers as are necessary to properly carry out its powers as an independent entity of government.

(b) A district may, without limiting its authority under other provisions of law, borrow money for the purpose of carrying out or administering a district project, program or other function authorized under this chapter, or for the purpose of refinancing existing indebtedness, or temporarily in anticipation of receipt of current revenues, and provided the governing board shall hold a public hearing on any such proposed borrowing which is estimated by the board to increase the annual apportionment of district expenses made pursuant to subsection (c) of this section by more than seven per cent over levels currently established. The board shall give one week's notice of such hearing in a newspaper having a circulation in each constituent municipality of the district. The district may enter into note, loan or other agreements providing that such borrowings shall be payable from or secured by one or more of the following: (1) A pledge, lien, mortgage or other security interest in any or all of the income, proceeds, revenues and property, real or personal, of its projects, assets, programs or other functions, including the proceeds of payments, grants, loans, advances, guarantees or contributions from the federal government, the state of Connecticut, the constituent municipalities of the district or any other source; or (2) a pledge, lien, mortgage or other security interest in the property, real or personal, of projects to be financed by the borrowing. Such borrowings and obligations shall not constitute an indebtedness within the meaning of any debt limitation or restrictions on, and shall not be obligations of, the state of Connecticut or any municipality. No constituent municipality of a district shall be liable for any such borrowing or obligation of the district upon default. Neither members of the board nor any person executing on behalf of the district any note, mortgage, pledge, loan, security or other agreement in connection with the borrowing of money by a district shall be personally liable on the obligations thereunder or be subject to any personal liability or accountability by reason of the entrance into such agreements. Each pledge, agreement or assignment made for the benefit or security of any such borrowing entered into pursuant to this subsection shall be in effect until the principal and interest on such borrowing for the benefit of which the same were made have been fully paid, or until provision is made for the payment in the manner provided therein. Any pledge or assignment made in respect of such borrowing secured thereby shall be valid and binding from the time when the pledge or assignment is made; any income, proceeds, revenues or property so pledged or assigned and thereafter received by the district shall immediately be subject to the lien of such pledge, without any physical delivery thereof or further act; and the lien of any such pledge or assignment shall be valid and binding as against parties having claims of any kind in tort, contract or otherwise against the district irrespective of whether such parties have notice thereof. Neither the resolution, trust indenture, agreement, assignment [or] nor other instrument by which a pledge is created need be recorded or filed, except for the recording of any mortgage or lien on real property or on any interest in real property.

(c) The executive board shall meet at least quarterly and at other times determined by the chairperson or the Commissioner of Public Health. At its September meeting it shall elect a chairperson and it shall furnish the necessary offices and equipment to enable it to carry out its duties. The executive board may elect an executive committee, consisting of the chairperson and two other members, and the director of health, who shall serve without a vote, and such executive committee shall have power to act when the board is not in session. The fiscal year of each district department of health shall be from July first to June thirtieth, and, by June thirtieth in each year, the executive board shall estimate the amount of money required to pay the costs and expenses of the district during the ensuing fiscal year, provided, if any municipality within the district has a fiscal year which begins on July first, such

estimate shall be made by April thirtieth of each year. Such executive board shall hold a public hearing on its proposed budget, two weeks' notice of which shall be given in a newspaper having a circulation in each constituent municipality of such district. From time to time the executive board shall draw upon the treasurer of each town, city or borough within the district a proportionate share of the expenses of such district, from such funds as may have been appropriated by each, to pay the cost of operating the district, including debt service on borrowings of the district, such apportionment to be made equitable on a per capita basis as established by the last annual population estimate by the Department of Public Health for each participating town, city or borough.

Section 29. Section 19a-244 as amended by public act 16-66 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

[On and after October 1, 2010, any] Any person nominated to be the director of health shall (1) be a licensed physician and hold a degree in public health from an accredited school, college, university or institution, or (2) hold a graduate degree in public health from an accredited school, college or institution. [The educational requirements of this section shall not apply to any director of health nominated or otherwise appointed as director of health prior to October 1, 2010.] The executive board may specify in a written agreement with such director the term of office, which shall not exceed [three] two years, salary and duties required of and responsibilities assigned to such director in addition to those required by the general statutes or the [Public Health Code] regulations, if any. Such director shall be removed during the term of such written agreement only for cause after a public hearing by the board on charges preferred, of which reasonable notice shall have been given. No director shall, during such director's term of office, have any financial interest in or engage in any employment, transaction or professional activity that is in substantial conflict with the proper discharge of the duties required of directors of health by the general statutes or the [Public Health Code] regulations or specified by the executive board in its written agreement with such director. Such director shall serve in a full-time capacity and act as secretary and treasurer of the executive board, without the right to vote. Such director shall give to the district a bond with a surety company authorized to transact business in the state, for the faithful performance of such director's duties as treasurer, in such sum and upon such conditions as the executive board requires. Such director shall be the executive officer of the district department of health. Full-time employees of a [city, town or borough] district health department at the time such district city, town or borough [votes to form or join] joins a district department of health shall become employees of such district department of health. Such employees may retain their rights and benefits in the pension system of the district, town, city or borough by which they were employed and shall continue to retain their active participating membership therein until retired. Such employees shall pay into such pension system the contributions required of them for their class and membership. Any additional employees to be hired by the district or any vacancies to be filled shall be filled in accordance with the rules and regulations of the merit system of the state of Connecticut and the employees who are employees of district, cities, towns or boroughs which have adopted a local civil service or merit system shall be included in their comparable grade with fully attained seniority in the state merit system. Such employees shall perform such duties as are prescribed by the director of health. [In the event of the withdrawal of a town, city or borough from the district department, or in the event of a dissolution of any district department, the employees thereof, originally employed therein, shall automatically become employees of the appropriate town, city or borough's board of health.]

Section 30. 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 Commissioner of Public Health approves the public health program and budget of such health district, (2) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one and one half percent of their previous fiscal year's annual operating budgets [dollar per capita from the annual tax receipts], and (3) the health district meets the requirements of section 19a-207a, within available appropriations. Each town, city, and boroughs one and a half percent contribution may be offset on a pro rata basis by its district's previous fiscal year's revenues from state and federal grants, fees, permits, licenses, inspections, and clinical services. 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. 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.

Section 31 (NEW)

New (Effective July 1, 2017) The Commissioner of the Department of Public Health shall appoint a local health organization for each "county" who shall be responsible for leading the transition to the county district health department model contemplated by foregoing sections of this Public Act. Such director of health shall be appointed for a term of three years, which term may be renewed.

Section 32 (NEW)

New (Effective July 1, 2017) A county health district may operate under the provisions of this Public Act before January 1, 2020 in which case the provisions of this Public Act shall be effective as of the date on which such health district first operates with respect to such county health district.

Section 33 Repealers
Sections 19a-200, 19a-202, 19a-202b, 19a-204, 19a-205 and 19a-246 are repealed.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. DPH 1104 Model Food Code

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

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Environmental Health Section, Food Protection Program
Agency Analyst/Drafter of Proposal: Tracey Weeks/Shawn Rutchick/Suzanne Blancaflor

Title of Proposal: An Act Concerning the Adoption of the FDA Model Food Code
Statutory Reference: Section 1. 19a-36; Section 2. (New); Section 3. Repeal Sections 19a-36c, 19a-36d, 19a-36e and 19a-36f
Proposal Summary: Section 1. Removes the sections of 19a-36 that pertain to food service. Section 2. Creates definitions for the model food code adoption; provides language that allows the adoption of the FDA model food code; describes the certification of persons that can inspect food establishments to ensure the model food code is being applied appropriately; describes the processes for the prevention and control of foodborne diseases; describes the process for permitting a food establishment; describes the inspections that will take place at food establishments; penalties for impeding an investigation of a foodborne outbreak; provides for due process to appeal an order issued by a food inspector; incorporates the exemption language from section 19a-36. Section 3. Repeals the sections of statute that pertain to food service regulated by the Department and Local Health Department. These sections were incorporated into the section 1.

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 provides the Department with the authority to adopt the Federal Food and Drug Administration's Model Food Code. This change would align Connecticut with the majority of other states that have moved towards a national, uniform regulatory system that provides a scientific foundation and legal framework for regulating the foodservice industry. Adoption of the Code will provide consistency with federal performance standards currently established and implemented in Connecticut, as well as consistency with foodservice industry practices. Mandating these federal standards alleviates the burden of local and state agencies of having to develop and update the Connecticut food regulations and instead provides the opportunity to focus resources on the implementation and enforcement of the Code

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

If this is a resubmission, please share:

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

Click here to enter text.

PROPOSAL IMPACT

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

Agency Name: Department of Agriculture
Agency Contact (*name, title, phone*): George Krivda
Date Contacted: 11/4/2016

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

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

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

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

Agency Name: Department of Consumer Protection **Agency Contact (*name, title, phone*):** Leslie O'Brien **Date Contacted:** 11/4/2016 Approve of Proposal ☐ **YES** ☐ **NO** X **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

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

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact Click here to enter text.

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

Mandating these federal standards alleviates the burden to local and state agencies of having to develop and update the Connecticut food regulations and training and provides the opportunity to focus resources on the implementation and enforcement of the Code.

Section 1. Section 19a-36 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Commissioner of Public Health shall establish a Public Health Code and, from time to time, amend the same. The Public Health Code may provide for the preservation and improvement of the public health.

[(1) Said code may include regulations pertaining to retail food establishments, including, but not limited to, food service establishments, catering food service establishments and itinerant food vending establishments and the required permitting from local health departments or districts to operate such establishments.]
[(2)] (1) Drainage and toilet systems to be installed in any house or building arranged or designed for human habitation, or field sanitation provided for agricultural workers or migratory farm laborers, shall conform to minimum requirements prescribed in said code.
[(3)] (2) Said code may include regulations requiring toilets and handwashing facilities in large stores, as defined in such regulations, in shopping centers and in places dispensing food or drink for consumption on the premises, for the use of patrons of such establishments, except that the provisions of such regulations shall not apply to such establishments constructed or altered pursuant to plans and specifications approved or building permits issued prior to October 1, 1977.
[(4) The provisions of such regulations (A) with respect to the requirement of employing a qualified food operator and any reporting requirements relative to such operator, shall not apply to an owner or operator of a soup kitchen who relies exclusively on services provided by volunteers, and (B) shall not prohibit the sale or distribution of food at a noncommercial function such as an educational, religious, political or charitable organization's bake sale or potluck supper provided the seller or person distributing such food maintains such food under the temperature, pH level and water activity level conditions that will inhibit the rapid and progressive growth of infectious or toxigenic microorganisms. For the purposes of this section, a "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the for profit business of selling such food.]
[(5) The provisions of such regulations with respect to qualified food operators shall require that the contents of the test administered to qualified food operators include elements testing the qualified food operator's knowledge of food allergies.]
[(6)] (3) Each regulation adopted by the Commissioner of Public Health shall state the date on which it shall take effect, and a copy of the regulation, signed by the Commissioner of Public Health, shall be filed in the office of the Secretary of the State and a copy sent by said commissioner to each director of health, and such regulation shall be published in such manner as the Commissioner of Public Health may determine.
[(7)] (4) Any person who violates any provision of the Public Health Code shall be guilty of a class C misdemeanor.

(b) The Commissioner of Public Health shall charge the following fees for the following services: (1) Review of each small flow plan for subsurface sewage disposal, two hundred dollars; and (2) review of each large flow plan for subsurface sewage disposal, six hundred twenty-five dollars. The commissioner shall amend the regulations adopted pursuant to this section as necessary to implement the provisions of this subsection.

(c) (1) For purposes of this subsection, "public pool" means an artificial basin constructed of concrete, steel, fiberglass or other impervious material and equipped with a controlled water supply that is intended for recreational bathing, swimming, diving or therapeutic purposes and includes, but is not limited to, any related equipment, structure, area or enclosure intended for the use of any person using or staffing such pool. "Public pool" does not include an artificial basin

provided with a controlled water supply that is intended for use at a single-family residence, except when such basin is used for commercial or business purposes at such residence.

(2) The Department of Public Health shall classify public pools into one of the following categories:

(A) Public swimming pool, which is a pool used or intended to be used for recreational bathing, swimming or water recreation activities;

(B) Public wading pool, which is a pool principally used or intended to be used for wading and recreational bathing by small children;

(C) Public spa, which is a pool used for recreational bathing in conjunction with a high-velocity air system, a high-velocity water recirculation system, hot water, cold water, a mineral bath or any combination thereof;

(D) Public diving pool, which is a pool used solely for diving or the instruction and practicing of diving techniques; or

(E) Special purpose public pool, which is a pool used for a specialized purpose, including, but not limited to, a splash pad or spray park where the water is recirculated, water flume, pool used for scuba diving instruction, therapeutic pool, hydrotherapy pool or a pool used in an aquatics program for handicapped persons. Special purpose public pool does not include a flotation vessel, which shall not be subject to review by the Department of Public Health. For purposes of this subparagraph, "flotation vessel" means a tank devoid of light and sound and containing salt water in which a person floats for purposes including, but not limited to, meditation, relaxation and alternative medicine.

(3) The commissioner shall charge the following fees for the following services: (A) Review of plans for a public pool, seven hundred fifty dollars; (B) review of a resubmitted plan for a public pool, two hundred fifty dollars; (C) initial inspection of a public pool, two hundred dollars; and (D) any subsequent inspection of a public pool, one hundred fifty dollars. The commissioner shall amend the regulations adopted pursuant to this section as necessary to implement the provisions of this subsection.

(4) Notwithstanding subsection (a) of this section, regulations governing the safety of public pools shall not require fences around naturally formed ponds subsequently converted to public pool use, provided the converted ponds (A) retain sloping sides common to natural ponds, and (B) are on property surrounded by a fence.

(d) The local director of health may authorize the use of an existing private well, consistent with all applicable sections of the regulations of Connecticut state agencies, the installation of a replacement well at a single-family residential premises on property whose boundary is located

within two hundred feet of an approved community water supply system, measured along a street, alley or easement, where (1) a premises that is not connected to the public water supply may replace a well used for domestic purposes if water quality testing is performed at the time of the installation, and for at least every ten years thereafter, or for such time as requested by the local director of health, that demonstrates that the replacement well meets the water quality standards for private wells established in the Public Health Code, and provided there is no service to the premises by a public water supply, or (2) a premises served by a public water supply may utilize or replace an existing well or install a new well solely for irrigation purposes or other outdoor water uses provided such well is permanently and physically separated from the internal plumbing system of the premises and a reduced pressure device is installed to protect against a cross connection with the public water supply. Upon a determination by the local director of health that an irrigation well creates an unacceptable risk of injury to the health or safety of persons using the water, to the general public, or to any public water supply, the local director of health may issue an order requiring the immediate implementation of mitigation measures, up to and including permanent abandonment of the well, in accordance with the provisions of the Connecticut Well Drilling Code adopted pursuant to section 25-128. In the event a cross connection with the public water system is found, the owner of the system may terminate service to the premises.

Section 2.
(NEW) (a): Definitions. As used in this Chapter:

(1) “Authorized agent” means any individual certified by the commissioner to inspect food establishments and enforce the provisions of this section;

(2) “Catering food service establishment” means a business involved in the sale or distribution of food and drink prepared in bulk in one geographic location for service in individual portions at another or which involves preparation and service of food on public or private premises not under the ownership or control of the operator of such service;

(3) “Certified food protection manager” means a food employee that has supervisory and management responsibility with authority to direct and control food preparation and service;

(4) "Class 1 food establishment" means a food establishment that offers only pre-packaged non-time temperature controlled for safety foods, prepares only non-temperature controlled for safety foods, heats only commercially processed, time temperature controlled for safety foods for hot holding, and do not cool time temperature controlled for safety foods;

(5) "Class 2 food establishment" means a food establishment that does not serve a highly susceptible population and offers a limited menu of foods that are prepared/cooked and served immediately, or prepares/cooks time temperature controlled for safety foods that may involve hot or cold holding but do not involve cooling;

(6) "Class 3 food establishment" means a food establishment that has an extensive menu and handling of raw ingredients, complex preparation including cooking, cooling, and reheating for hot holding that involves many time temperature controlled for safety foods;

(7) "Class 4 food establishment" means a food establishment that serves a highly susceptible population such as preschools, hospitals, and nursing homes or that conducts specialized processes such as smoking, curing, reduced oxygen packaging or others for the purposes of extending shelf-life;

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

(9) "Core item" means a provision in the Food Code that is not designated as a priority item or a priority foundation item;

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

(11) "Director of Health" means the director of a local health department or district health department appointed pursuant to section 19a-200 or 19a-242 of the General Statutes;

(12) "Food code" means the model food code adopted under this Chapter;

(13) "Food establishment" means an operation that: stores, prepares, packages, serves, vends food directly to the consumer, or otherwise provides food for human consumption such as a restaurant; satellite or catered feeding location; catering operation if the operation provides food directly to a consumer or to a conveyance used to transport people; market; vending location; conveyance used to transport people; institution; or food bank; and relinquishes possession of food to a consumer directly, or indirectly through a delivery service such as home delivery of grocery orders or restaurant takeout orders, or delivery service that is provided by common carriers. A food establishment includes a catering food service establishment, food service establishment, a temporary food service establishment, and an itinerant food vending establishment;

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

(15) "Food inspection training officer" means a certified food inspector who has received training from the Commissioner and been approved to train candidates for food inspector certification;

(16) "Foodborne illness" means illness acquired through the ingestion of common-source food or water contaminated with chemicals, infectious agents or their toxic products. Foodborne illness includes, but is not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens intoxication and hepatitis A;

(17) "Foodborne outbreak" means illness in two or more individuals acquired through the ingestion of common-source food or water contaminated with chemicals, infectious agents or their toxic products.

Foodborne outbreak includes, but is not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens intoxication and hepatitis A;

(18) “Food service establishment” means a food establishment where food is prepared and intended for individual portion and includes the site at which individual portions are served;

(19) “HACCP plan” means a written document that delineates the formal procedures for following the Hazard Analysis and Critical Control Point Principles developed by the National Advisory Committee on Microbiological Criteria for Foods;

(20) “Itinerant food vending establishment” is a mobile food establishment;

(21) “Mobile food establishment” means a vehicle mounted self-contained food establishment;

(22) “Permit” means a document which includes a license or permit issued by a director of health that authorizes a person to operate a food establishment;

(23) “Permit holder” means the entity that is legally responsible for the operation of the food establishment such as the owner, the owner’s agent, or other person who possesses a valid permit to operate a food establishment;

(24) “Priority item” means a provision in the food code whose application contributes directly to the elimination, prevention or reduction to an acceptable level, hazards associated with foodborne illness or injury and there is no other provision that more directly controls the hazard;

(25) “Priority foundation item” means a provision in the food code whose application supports, facilitates or enables one or more priority items;

(26) “Temporary food service establishment” means a food establishment that operates for a period of no more than fourteen consecutive days in conjunction with a single event or celebration;

(27) “Qualified food operator” has the same meaning as certified food protection manager; and

(28) “Variance” means a written document issued by the Commissioner that authorizes a modification or waiver of one or more requirements of the food code.

(b): Adoption of Model Food Code. The Commissioner shall adopt and administer by reference the 2013 Food and Drug Administration model food code as amended from time to time for the purpose of regulating food establishments.

(c) Food Inspector Certification.

(1) No person shall engage in the practice of a food inspector unless such person is certified by the Commissioner.

(2) The Commissioner shall develop a training and verification program for food inspector certification, which program shall be administered by the food inspection training officer at a local health department.

(3) An applicant for certification shall:
   (A) Be sponsored by the director of health in the jurisdiction in which the applicant is employed to conduct food inspections;
   (B) Possess a bachelor's degree or three years of experience in a regulatory food protection program;
   (C) Have successfully completed the training and verification program as prescribed in subdivision (2) of this subsection, which shall be recognized by the Commissioner as valid for a period not to exceed three years upon completion;
   (D) Have successfully completed the Department of Public Health's field standardization inspection as prescribed by the Commissioner; and
   (E) Not be involved in the ownership or management of a food establishment located in the applicant's jurisdiction.

(4) The director of health sponsoring an applicant for certification shall submit to the Commissioner:
   (A) An application in a form and manner as prescribed by the Commissioner that includes documentation of the applicant's qualifications as described in subdivision (3) of this subsection;
   (B) Documentation of successful completion of the training program as prescribed in subdivision (2) of this subsection; and
   (C) A written field standardization request for the applicant to the commissioner;

(5) The Commissioner shall issue a food inspector certification to the applicant upon successful completion of the requirements of this subsection or section. Such certification shall be renewed once every three years in a form and manner as prescribed by the Commissioner. The Commissioner shall notify the applicant in writing specifying the issuance of certification and the expiration date.

(6) No certification shall be renewed until the applicant demonstrates successful completion of twenty contact hours in food protection training as approved by the Commissioner. Failure to comply with recertification requirements may result in the Commissioner taking action against the food inspector's certification, including but not limited to, not renewing the food inspector's certification.

(7) The Commissioner may take disciplinary action against a certified food inspector or anyone engaging in the practice of a food inspector under sections 19a-14 and 19a-17 of the General Statutes. The department shall notify the director of health and the chief elected official of the affected food service jurisdiction when a certification is suspended, revoked, or not renewed.

(d): Prevention and control of foodborne disease.

(1) When a director of health has reasonable cause to suspect the possibility of a foodborne illness or outbreak acquired from any food establishment or any food establishment employee, such director shall investigate and take action to control the illness or outbreak, including, but not limited to securing employee morbidity histories, or make such other investigation as may be indicated, and take appropriate action.

(2) A director of health may require one or more of the following measures:

(A) The immediate exclusion of any employee from all food establishments;

(B) The immediate closure of the food establishment concerned until, in the opinion of the director of health, no further danger of disease outbreak exists;

(C) Restriction of the employee's services to some area of the food establishment where there would be no danger of transmitting disease;

(D) Adequate medical and laboratory examinations of the employee, or other employees, and of his and their body discharges;

(E) The modification of the establishment's menu or food preparation practices; or

(F) The imposition of any other restriction or action deemed necessary by such director of health to control such illness or outbreak.

(e) Food establishment requirements. License and permit required. Application. Registration with the Department.

(1) A food establishment shall comply with the requirements of the food code as defined in subsection (a) of this section except as otherwise specified in this section.

(2) No person, firm or corporation shall operate or maintain any place where food or beverages are served or sold to the public within any town, city or borough, without obtaining a valid permit to operate from the Director of Health of such town, city or borough in a form and matter prescribed by the director of health.

(3) Each person seeking to obtain a permit or license to operate a food establishment shall be an owner or authorized representative of the food establishment or an officer of the legal entity that owns the food establishment; and shall comply with the requirements of this section.

(4) No permit to operate a food establishment shall be issued by a director of health unless the applicant has provided the director of health with proof of registration with the department, and a written application for a permit in a form and manner prescribed by the department.

(5) Temporary food establishments.

(A) No director of health shall issue a permit for a temporary food establishments for a period of time not to exceed fourteen consecutive days within a thirty day period.

(B) For such temporary food establishments, the director of health may:

(i) Implement more stringent requirements than those required under the food code to ensure the service of safe food;

(ii) Prohibit the sale of potentially hazardous food or drink that require temperature control to prevent the growth of infectious or toxigenic microorganisms;

(iii) Modify specific requirements for physical facilities when the director determines that no health hazard will result; and

(iv) Impose any other restriction or action deemed necessary by such director of health to control such illness or outbreak.

(6) Mobile food establishments.

(A) No director of health shall issue a permit for a mobile vendor unless:

(i) The menu, vehicle, and equipment have been approved in accordance with the food code;

(ii) The owner provides proof that a commissary or other regulated food establishment will be used to prepare and store food, supplies, and equipment for the mobile unit; and

(iii) The business name and phone number are on both sides of the mobile unit.

(B) The director of health may implement more stringent requirements than those required under the food code to ensure the service of safe food.

(7) Certified food protection manager.

(A) Each class 2, 3, and 4 food establishment shall employ a certified food protection manager.

(B) No person shall serve as a certified food protection manager unless such person has satisfactorily passed a test that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs;

(8) Variance.

(A) The commissioner may grant a variance for a requirement of the food code if the Commissioner determines that such variance would not result in a health hazard or a nuisance.

(B) The food establishment shall request such variance by submitting the required documentation that includes but is not limited to verification by a process control authority that the process is safe, microbiological challenge studies, HACCP plans, or other such documentation as may be required by the Commissioner to determine the safety of the variance.

(f) Food establishment inspections.

(1) A certified food inspector shall conduct a thorough and accurate inspection of a food establishments in a form and manner prescribed by the commissioner to determine compliance with the food code. The certified food inspection shall provide the owner or person in charge of the food establishment with a copy of the inspection report form within forty-eight hours of the inspection. The certified food inspector and owner or person in charge of the establishment shall sign the inspection report to acknowledge receipt. Such report shall include but not be limited to the following:

(A) A record of any findings;

(B) The on-site inspection start and end times; and

(C) Dates for correcting violations cited on the inspection report form;

(2) The Director of Health shall ensure all food establishments are inspected at a frequency determined by their risk classification. Such Director of health shall evaluate the food establishment's risk classification on an annual basis to determine accuracy. More frequent

inspections may be conducted to ensure compliance with the food code. Each food establishment classification shall be inspected pursuant to the following schedule:

(A) Class 1 establishments shall be inspected at intervals not to exceed three hundred and sixty (360) days.

(B) Class 2 establishments shall be inspected at intervals not to exceed one hundred and eighty (180) days.

(C) Class 3 establishments shall be inspected at intervals not to exceed ninety (120) days.

(D) Class 4 establishments shall be inspected at intervals not to exceed ninety (90) days.

(E) Temporary food service establishments shall be inspected prior to the issuance of a permit to operate and as often as necessary to ensure compliance with the food code

(3) No food establishment operator shall deny access to the certified food inspector.

(4) If a food establishment has one or more priority items or priority foundation items violations, or any HACCP plan deviations, the director of health or certified food inspector shall immediately upon discovering such violations order corrective action in accordance with the food code.

(5) The director of health or certified food inspector shall order a temporary food service establishment to correct any violations of priority items or priority foundation items at the time of the inspection or within twenty-four hours, as determined by the director of health.

(6) The director of health, or certified food inspector shall re-inspect food establishments to ensure timely compliance with issued orders and the code.

(7) The director of health shall take immediate steps to suspend the permit to operate and have the food establishment closed if at the time of the reinspection, priority items, priority foundation items, or HACCP plan deviations have not been corrected, or there are other priority items or priority foundation items in violation or other HACCP plan deviations.

(8) When the director of health determines that conditions at a food establishment constitute an immediate and substantial hazard to the public health, he shall immediately issue a written notice to the permit holder citing such conditions, specifying the corrective action to be taken, and specifying the time period within which such action shall be taken, indicating the intention to suspend the license or permit to operate and, if deemed necessary order immediate correction. If correction is not made in the stated time, the license or permit to operate shall be suspended and a written order shall be issued to close the food service establishment.

(9) The permit holder or operator shall immediately discontinue affected operations and notify the health authority if an imminent health hazard may exist because of an emergency such as a fire, flood, extended interruption of electrical or water service, sewage backup, misuse of poisonous or toxic materials, onset of an apparent foodborne illness outbreak, gross unsanitary occurrence or condition including ill employees, or other circumstances that may endanger public health. The permit holder or operator shall obtain approval from the director of health before resuming the affected operations. The director of health may issue an order to summarily suspend a permit to operate and require that the food service establishment discontinue affected or all operations, as warranted, immediately without prior warning, notice of hearing or a hearing, if the director of health or the authorized agent determines through inspection, or examination of employees, food, records, or other means that an imminent health hazard exists. The summary suspension shall remain in effect until the conditions cited in the suspension order no longer exist and their elimination has been confirmed by the director of health or authorized agent

through inspection and other means as appropriate. After receiving a written request from the permit holder stating that the conditions cited in the summary suspension order no longer exist, the director of health or certified food inspector shall conduct a reinspection within two business days. The suspended permit may be reinstated immediately if the director of health determines that the public health hazard or nuisance no longer exists.

(h) Penalties. A person who violates any provision of this Chapter or who provides false information during an investigation, refuses to cooperate with an investigation or who otherwise impedes an investigation under this Chapter shall be guilty of a Class C misdemeanor.

(i) Appeal of an order.

(1) The owner or operator of a food establishment aggrieved by an order issued by the director of health to correct inspection violations or to hold, destroy, or dispose of unsafe food may, within forty-eight hours after such order, appeal to the director of health, who shall thereupon immediately examine into the merits of such case and may vacate, modify or affirm such order. If affirmed by the director of health, the corrective actions specified by the authorized agent shall be so ordered by the director of health.

(2) An owner or operator of a food service establishment who is aggrieved by such action of the director of health or by other orders issued by a director of health including orders to suspend the permit or license to operate the food service establishment may appeal pursuant to section 19a-229 of the General Statutes. During such appeal, the order shall remain in effect unless the commissioner orders otherwise.

(j) Nothing in this Chapter shall limit the authority of directors of health under Chapter 368e or 368f.

(k) The provisions of the model food code with respect to the requirement of employing a certified food manager and any reporting requirements relative to such operator, shall not apply to an owner or operator of a soup kitchen that relies exclusively on services provided by volunteers, to any volunteer who serves meals from a nonprofit organization; and to any person who serves meals to individuals at registered congregate meal sites funded under Title III of the Older Americans Act of 1965, as amended which were prepared under the supervision of a certified food manager and (B) shall not prohibit the sale or distribution of food at (1) a bed and breakfast operation that prepares and offers food to guests if the home is owner occupied and the total building occupant load is not more than sixteen persons including the owner and occupants, and has no provisions for cooking or warming food in the guest rooms and breakfast is the only meal offered and the consumer is informed by statements contained in published advertisements, mailed brochures, and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director and (2) a noncommercial function such as an educational, religious, political or charitable organization's bake sale or potluck supper provided the seller or person distributing such food maintains such food under the temperature, pH level and water activity level conditions that will inhibit the

growth of infectious or toxigenic microorganisms. For the purposes of this section, a "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the for profit business of selling such food.

(*l*) Use of disposable, nonsterile or sterile natural rubber latex gloves.

(1) No person shall use or require the use of disposable, nonsterile or sterile natural rubber latex gloves at a retail food establishment, including, but not limited to, a food service establishment, catering food service establishment or itinerant food vending establishment.

(2) Any person who violates subsection (a) of this section shall be fined not less than two hundred fifty dollars nor more than five hundred dollars.

Section 3.

Sections 19a-36c, 19a-36d, 19a-36e and 19a-36f are repealed.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc):
DPH 1104 MOLST.doc

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

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@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 the Statewide Adoption of the Medical Orders for Life Sustaining Treatment Program
Statutory Reference: (NEW)
Proposal Summary: This proposal will allow the statewide adoption of the Medical Orders for Life Sustaining Treatment Program.

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?

During the 2014 legislative session, the legislature passed a pilot program that allowed the Department to move forward with the creation a program that offers persons with life limiting diseases or chronic frailty a Medical Order for Life Sustaining Treatment (MOLST). A MOLST is an adjunct to an advanced directive. It provides a form that is an actual medical order from a person's health care provider that can be transferred across all settings. This proposal will eliminate the pilot program and provide the Commissioner with the authority to implement the MOLST Program statewide. Other states have implemented this program and have had positive outcomes.

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;
- Results in the completion of the MOLST form in conjunction with the patient and the health care provider; and
- 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; and
- 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.

◊ **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?

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PROPOSAL IMPACT

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

Agency Name: Office of Protection and Advocacy
Agency Contact (name, title, phone): Beth Leslie
Date Contacted: 11/1/2016

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

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

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

Agency Name: Department of Developmental Services **Agency Contact (name, title, phone):** Christine Polio and Rod O'Connor **Date Contacted:** 11/1/2016 Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**
Agency Name: Department of Aging **Agency Contact (name, title, phone):** Pam Toohey **Date Contacted:** 11/1/2016 Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

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

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

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

The Health Care Quality and Safety Branch within the Department of Public Health will implement the program.

Section 1. (*NEW*)

(a) The Commissioner of Public Health shall establish a statewide program 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 when the patient has been determined by a physician licensed under chapter 370 or an advance practice registered nurse licensed under chapter 378 to be approaching the end stage of a serious, life-limiting illness or is in a condition of advanced, chronic progressive frailty; 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 medical services, or an officer, employee or agent thereof acting in the course and scope of his or her employment; and (3)"legally authorized representative" means a patient's parent, guardian or health care representative appointed in accordance with sections 19a-576 and 19a-577 of the general statutes.

(b) Patient participation in the program shall be voluntary. Agreement to participate in the program shall be documented by the patient or the patient's legally authorized representative's signature on the medical order for life sustaining treatment form and verified by the signature of a witness request.

(c) Notwithstanding the provisions of sections 19a-495 and 19a-580d of the general statutes, and regulations adopted thereunder or any other statute or regulation to the contrary, the Commissioner of Public Health may implement regulations in accordance with chapter 54 for the program established in accordance with this section to ensure that: (1) medical orders for life-sustaining treatment are transferrable among, and recognized by, various types of health care institutions; (2) any procedures and forms developed for recording medical orders for life-sustaining treatment require the signature of the patient or the patient's legally authorized representative on the medical order for life-sustaining treatment, the patient or the patient's legally authorized representative is given the original order immediately after signing such order and a copy of the order is immediately placed in the patient's medical record; (3) prior to requesting the signature of the patient or the patient's legally authorized representative on such order, the physician, advanced practice registered nurse or physician assistant writing the medical order discusses with the patient or the patient's legally authorized representative the patient's goals for care and treatment and the benefits and risks of various methods for documenting the patient's wishes for end-of-life treatment, including medical orders for life sustaining treatment; and (4) each physician, advanced practice registered nurse or physician assistant that intends to write a medical order for life-sustaining treatment receives training concerning: (A) The importance of talking with patients about their personal treatment goals; (B) methods for presenting choices for end-of-life care that elicit information concerning patients' preferences and respects those preferences without directing patients toward a particular option for end-of-life care; (C) the importance of fully informing patients about the benefits and risks of an immediately effective medical order for life-sustaining treatment; (D) awareness of factors that may affect the use of medical orders for life-sustaining treatment, including but not limited to: Race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence; and (E) procedures for properly completing and effectuating medical orders for life-sustaining treatment.

(d) Policies and procedures implemented pursuant to the medical orders for life sustaining treatment pilot program established pursuant to section 1 of public act 14-5, as amended, shall be valid until regulations are adopted in accordance with the provisions of chapter 54.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Newborn Screening Panel.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kentfield
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/ jill.kentfield@ct.gov

Lead agency division requesting this proposal: State Public Health Laboratory

Agency Analyst/Drafter of Proposal: Elise Kremer

Title of Proposal: AAC The Expansion and Enhancement of the Newborn Screening Program

Statutory Reference:
Section 1: 19a-55. Newborn infant health screening. Tests required. Fees. Exemptions. Regulations.
Section 2: 19a-55a. Newborn screening account.

Proposal Summary: The proposal will add the following metabolic disorders to the newborn screening panel: Cystic Fibrosis, Pompe disease, Mucopolysaccharidosis type I (MPS I), Fabry disease and Gaucher disease. With the addition of these new disorders, the Department has submitted an associated budget option.

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?

Currently hospitals are mandated to send blood spot cards to the Department for the testing of 67 different mandated disorders and to either Yale New Haven Hospital or UCONN Health Center (UCHC) for the testing of Cystic Fibrosis. Since the spots are sent to two different laboratories, the infant is pricked twice in the heel. The Laboratory is proposing to streamline testing so that all cards are sent to the Public Health Laboratory (PHL) so the baby only has to be pricked once. This will help reduce the rate of infection and medical error. In 2009 the testing was being performed on a voluntary, fee-for-service basis by UCHC and Yale. Sound public policy dictates that the newborn screening program not be outsourced and fragmented, and that the PHL carry out all screening consistent with its statutory responsibility for 67 other disorders. PHL's program is a coordinated, integrated system of testing, tracking,

diagnosis/treatment, and program evaluation. After an $82 million dollar investment, the Department's PHL is positioned to move forward with further testing to allow for a comprehensive newborn screening panel. The PHL is best positioned to deliver comprehensive, timely, and effective, state of the art services. Each process within the PHL's well-proven system adds value, contributing to an extraordinary level of quality assurance that is in the best interests of our newborns.

The Department is also proposing to expand the panel to include Pompe disease, Mucopolysaccharidosis type I (MPS I), Fabry disease and Gaucher disease, which are all characterized as lysosomal storage disorders (LSDs). The reason for adding these new disorders to the panel is both Pompe disease and MPS I have been officially added by the US Department of Health and Human Services Advisory Committee on Heritable Disorders in Newborns and Children to their Recommended Uniform Screening Panel (RUSP); therefore the addition of these disorders would bring us up-to-date with consistency with the RUSP. The inclusion of the other LSDs (Fabry disease and Gaucher disease) would benefit the overall health of the infants born in the state of Connecticut as they are also treated in the same manner as Pompe and MPS I and have shown evidence of benefit for early identification and treatment.

These disorders all have similar frequency of occurrence, clinical manifestations and treatment. For example, Pompe disease is an inherited disorder, affecting about 1 in 40,000 people in the United States, which is caused by the buildup of a complex sugar called glycogen in the body's cells. The accumulation of glycogen in certain organs and tissues, especially muscles, impairs their ability to function normally. Researchers have described three types of Pompe disease, which differ in severity and the age at which they appear. The classic form of infantile-onset Pompe disease begins within a few months of birth. Infants with this disorder typically experience muscle weakness, poor muscle tone, an enlarged liver, and heart defects. Affected infants may also have breathing problems and fail to gain weight and grow at the expected rate. If untreated, infantile-onset Pompe disease leads to death from heart failure in the first year of life. The non-classic form of infantile-onset Pompe disease usually appears by age one. It is characterized by delayed motor skills and progressive muscle weakness and possible enlarged heart. Muscle weakness leads to serious breathing problems, and most children with non-classic infantile-onset Pompe disease live only into early childhood. Late-onset Pompe disease becomes apparent later in childhood, adolescence, or adulthood. This is usually milder than the infantile-onset forms of this disorder; however, progressive muscle weakness, including in the muscles that control breathing, may lead to respiratory failure in individuals with late onset. Treatment is with Enzyme Replacement Therapy, and is effective in preventing onset and advancement of symptoms, improving outcomes, and extending lifespans.

We propose to perform an initial screening and follow-up testing of presumptive positive babies for the 39 most common mutations; this would provide a much needed uniformity to

the testing protocol. The necessary funds are already available to establish and maintain the needed infrastructure within the PHL. UCHC and Yale currently charge submitting hospitals $15 per infant tested for cystic fibrosis. DPH can provide a value-enhanced and more robust service for $12 per infant for both cystic fibrosis and testing of LSDs which includes a one-time cost for instrumentation to be purchased prior to the initiation of screening. The reduced cost will allow hospitals to save approximately $100,000 annually.

◊ **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?

The Department submitted this as a budget option in 2015 for the 2016 legislative session, however, it did not move forward.

PROPOSAL IMPACT

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

Agency Name: University of Connecticut Health Center
Agency Contact (*name, title, phone*): Joann Lombardo and Andrea Keilty
Date Contacted: 11/4/2016

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: See Department Budget Option

Federal: None

Additional notes on fiscal impact
Click here to enter text.

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

If enacted, this proposal would ensure that uniform policies and protocols are established for all NBS conducted in the PHL.

Section 1. Section 19a-55 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581, a test for phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, severe combined immunodeficiency disease, adrenoleukodystrophy, and such other tests for inborn errors of metabolism as shall be prescribed by the Department of Public Health. The tests shall be administered as soon after birth as is medically appropriate. If the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593, the person responsible for testing under this section may omit an HIV-related test. The Commissioner of Public Health shall (1) administer the newborn screening program, (2) direct persons identified through the screening program to appropriate specialty centers for treatments, consistent with any applicable confidentiality requirements, and (3) set the fees to be charged to institutions to cover all expenses of the comprehensive screening program including testing, tracking and treatment. The fees to be charged pursuant to subdivision (3) of this subsection shall be set at a minimum of ninety-eight dollars. The Commissioner of Public Health shall publish a list of all the abnormal conditions for which the department screens newborns under the newborn screening program, which shall include screening for amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD).

(b) In addition to the testing requirements prescribed in subsection (a) of this section, the administrative officer or other person in charge of each institution caring for newborn infants shall cause to have administered to (1) every such infant in its care a screening test for (A) cystic fibrosis, [(B) severe combined immunodeficiency disease,] and [(C)] (B) critical congenital heart disease, and (2) any newborn infant who fails a newborn hearing screening, as described in section 19a-59, a screening test for cytomegalovirus, provided such screening test shall be administered within available appropriations on and after January 1, 2016. Such screening tests shall be administered as soon after birth as is medically appropriate. On or after January 1, 2018, the screening test for cystic fibrosis shall be conducted by the Department of Public Health and the administrative officer or other person in charge of each institution caring for newborn infants shall send all specimens for such testing to the Department as part of the newborn screening program prescribed in subsection (a) of this section.

[(c) On or before October 1, 2015, the Commissioner of Public Health shall execute an agreement with the New York State Department of Health to conduct a screening test of newborns for adrenoleukodystrophy using dried blood spots, as well as the development of a quality assurance testing methodology for such test. The commissioner may accept private grants and donations to

defray the cost of purchasing equipment that is necessary to perform the testing described in this subsection.]

(d) The administrative officer or other person in charge of each institution caring for newborn infants shall report any case of cytomegalovirus that is confirmed as a result of a screening test administered pursuant to subdivision (2) of subsection (b) of this section to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(e) The provisions of this section shall not apply to any infant whose parents object to the test or treatment as being in conflict with their religious tenets and practice. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section.

Sec. 2. Section 19a-55a of the general statutes is repealed and the following is substituted in lieu thereof: (*Effective July 1, 2017*)

(a) There is established a newborn screening account that shall be a separate nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited into the account. Any balance remaining in said account at the end of any fiscal year shall be carried forward in the account for the next fiscal year.

(b) Five hundred thousand dollars of the amount collected pursuant to section 19a-55, in each fiscal year, shall be credited to the newborn screening account, and be available for expenditure by the Department of Public Health for the expenses of the testing required by sections 19a-55 and 19a-59.

(c) Notwithstanding subsection (b) of section 19a-55a of the general statutes, the full amount collected pursuant to said section shall be credited to the newborn screening account for use by the Department of Public Health as follows: (1) for the purchase of upgrades to newborn screening technology and for the expenses of the testing required by sections 19a-55 and 19a-59 of the general statutes; (2) to offset personnel costs associated with the newborn screening program; and (3) to support grants to newborn screening regional and sickle cell disease treatment centers.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Nursing Home Administrators.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Health Care Quality and Safety Branch, Facilities Licensing and Investigations Section (FLIS)

Agency Analyst/Drafter of Proposal: Barbara Cass, FLIS Chief

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding The Protection Of Residents In Health Care Institutions.

Statutory Reference:
Section 1: 19a-511. Nursing home administrators to supervise homes. Definitions.
Section 2: 19a-517. (Formerly Sec. 19-598). Unacceptable conduct. Notice. Hearing. Revocation or suspension of license. Appeal.

Proposal Summary: This proposal seeks to make nursing home administrators responsible for the quality and safety of all services provided in a nursing home.

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?

Currently, Public Health Code section 19-13-D8t (f) Administrator (3) includes in part, "The administrator shall be responsible for the overall management of the facility," however it does not address overall accountability of a nursing home's operation and medical responsibility to its residents. The code of federal regulations directs that "A facility must be administered a in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." Amending the statute that pertains to nursing home administrators provides for a greater and strict accountability in caring for Connecticut's vulnerable nursing home residents and ensures that each beneficiary of nursing home care is able to at the very least maintain their highest practicable physical, mental and psychosocial well-being, in accordance with the

comprehensive assessment and plan of care. Additionally, amending this section will align the expectations of the Administrator with the 42 CFR 483.75.

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

If this is a resubmission, please share:

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

This is a resubmission. House Bill 6887 from 2015 and Senate Bill 209 from 2016 did not make it through the process. The Connecticut Association of Health Care Facilities (CAHCF) and Leading Age Connecticut had concerns with the mandate. The Department met with nursing home administrators, CAHCF and Leading Age Connecticut to discuss the proposal. During our discussions we identified the main issue to be an outdated scope of practice for nursing home administrators. We will be updating the nursing home administrator statute to reflect current standards and best practices in their profession. We provided the nursing home administrators with recommended language based on conversations at our meetings and are waiting to hear back from them regarding approval of the language.

PROPOSAL IMPACT

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

Agency Name: Department of Aging
Agency Contact (*name, title, phone*): Pam Toohey
Date Contacted: 11/3/2016

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

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

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

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

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

State: None

Federal: None

Additional notes on fiscal impact

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

By clarifying the role of the nursing home administrator, the language will provide the Department's Facilities Licensing and Investigations Section and Legal Office with clear criteria for decision making on the appropriateness of taking action against a nursing home administrator's license.

Section 1. Section 19a-511 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in sections 19a-511 to 19a-520, inclusive, "nursing home" means an institution licensed under this chapter and "nursing home administrator" means the person in general administrative charge of a nursing home.

(b) All nursing homes licensed under this chapter shall be under the supervision of a licensed nursing home administrator. The nursing home administrator shall be responsible for the planning, organizing, directing, managing the operation and implementing the policies of, a nursing home, including but not limited to making operating decisions, ensuring fiscal responsibility, ongoing evaluation of care and services provided in the nursing home to ensure the health and safety of residents and the overall management of the nursing home in accordance with all applicable federal, state and local laws relating to the administration of a nursing home.

Sec. 2. Section 19a-517 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The Department of Public Health shall have jurisdiction to hear all charges of unacceptable conduct brought against any person licensed to practice as a nursing home administrator and, after holding a hearing, written notice of which shall be given to such person, said department, if it finds that any grounds for action by the department enumerated in subsection (b) of this section exist, may take any of the actions set forth in section 19a-17. Such notice shall be given, and such hearing conducted, as provided in the regulations adopted by the Commissioner of Public Health. Any person aggrieved by the finding of the department may appeal therefrom in accordance with the provisions of section 4-183, and such appeal shall have precedence over nonprivileged cases in respect to order of trial.

(b) The department may take action under section 19a-17 for any of the following reasons: (1) The license holder has employed or knowingly cooperated in fraud or material deception in order to obtain [his] a license or has engaged in fraud or material deception in the course of professional services or

activities; (2) the license holder is suffering from physical or mental illness, emotional disorder or loss of motor skill, including but not limited to, deterioration through the aging process, or is suffering from the abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (3) illegal, incompetent or negligent conduct in carrying out the license holder's responsibilities as a nursing home administrator [his practice]; (4) violation of any provision of state or federal law governing the license holder's responsibilities as a nursing home administrator [practices within a nursing home]; or (5) violation of any other provision of this chapter or any regulation adopted hereunder, including but not limited to section 19a-550 of the general statutes. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is being investigated. Said 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.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Nursing Home Citations.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Healthcare Quality and Safety Branch, Facilities Licensing and Investigations Section (FLIS)

Agency Analyst/Drafter of Proposal: Barbara Cass, FLIS Chief

Title of Proposal: An Act Concerning Revisions to the Process for Citations in Chronic and Convalescent Nursing Homes

Statutory Reference:
Section 1. 19a-524. Citations issued for certain violations.
Section 2. 19a-525. Contest of citation. Information conference. Hearing. Final order.
Section 3. 19a-527. Classification of violations. 19a-494. Disciplinary action.

Proposal Summary: Revises sections 19a-524 and 19a-525 to provide transparency regarding responsibilities of the Department and the licensee during an informal conference; amends section 19a-527 to increase fines for Class A and Class B violations in nursing home facilities; revises section 19a-494 to allow the Commissioner to appoint a temporary manager as part of the actions that can be taken against a nursing home.

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 19a-525 as currently written creates ambiguity regarding the responsibilities of both parties. The new language outlines time frames which will provide greater structure to the process.

The current threshold for Class A and B violations as provided for in Section 19a-527 have not been updated for over 20 years. Examples of a Class B violation include: failure to monitor patient condition and/or carry out patient care plan; failure to monitor patient condition and/or

patient accident/incident; failure to conformance with federal, state and local regulations and/or failure to monitor patient condition and/or patient accident/incident. These violations were taken directly from the 4th quarter of the 2014 regulatory action report which is on the department's website: http://www.ct.gov/dph/cwp/view.asp?a=4061&q=534952.

When a Class A or B violation is found, a facility is fined a civil penalty that is determined by using a special formula that includes: number of affected patients, number of occurrences of the violation; and takes into consideration if it is a repeat violation from a previous visit.

During 2015, the Department received a total of $182,235.00 in civil penalties with $124,235.00 in citations issued to nursing homes and $58,000 in enforcement consent orders. We do not anticipate many changes to our current practices, but we would like to be able to include a higher fine if the nursing home is not making the mandated corrective actions.

The proposal also removes the five day mandate to hold an informal conference if an entity requests an informal hearing. Both the Department and the nursing home staff have found this to be a difficult mandate to follow. Most informal hearings are held between 10 to 30 days of the request.

The Department has the ability to take action against a nursing home facility after a formal hearing process. Recommendations that may be a result of such hearing include: revoking a license, suspend a license, issue a letter of reprimand, place the license on probationary status, and impose a directed plan of correction. This proposal will allow the Department to also impose a temporary manager to take over the day to day operations of the facility.

◊ **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?

In 2015, House Bill 6887 did not make it out of the Public Health Committee and Senate Bill 209 did not make it out of the Senate chamber. Leading Age Connecticut had concerns about the potential for increased fines.

PROPOSAL IMPACT

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

Agency Name: Department of Aging **Agency Contact (*name, title, phone*):** Pam Toohey **Date Contacted:** 11/4/2016 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: Unsure. The Department cannot anticipate how many citations will be issued on an annual basis.
Federal: None
Additional notes on fiscal impact

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

Section 1. Section 19a-524 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

If, upon review, investigation or inspection pursuant to section 19a-498, the Commissioner of Public Health determines that a nursing home facility or residential care home has violated any provision of section 17a-411, 19a-491a to 19a-491c, inclusive, 19a-493a, 19a-521 to 19a-529, inclusive, 19a-531 to 19a-551, inclusive, or 19a-553 to 19a-555, inclusive, or any regulation in the Public Health Code or regulation relating to licensure or the Fire Safety Code relating to the operation or maintenance of a nursing home facility or residential care home, which violation has been classified in accordance with section 19a-527, as amended by this act, **[**he or she shall immediately**]** the commissioner may issue or cause to be issued a citation to the licensee of such nursing home facility or residential care home. Governmental immunity shall not be a defense to any citation issued or civil penalty imposed pursuant to sections 19a-524 to 19a-528, inclusive. Each such citation shall be in writing, shall provide notice of the nature and scope of the alleged violation or violations and shall be sent by certified mail to

the licensee at the address of the nursing home facility or residential care home in issue. A copy of such citation shall also be sent to the licensed administrator at the address of the nursing home facility or residential care home.

Sec. 2. Section 19a-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) The administrator of the nursing home facility or residential care home, or **[**his or her**]** the administrator's designee, shall, **[**within three days, excluding Saturdays, Sundays and holidays, of**]** not later than five business days after receipt of the citation by the licensee, notify the commissioner if the licensee contests the citation. If the administrator fails to so notify the commissioner **[**within such three-day period**]** not later than five business days after such receipt, the citation shall be deemed a final order of the commissioner, effective upon the expiration of said period.

(b) If any administrator of a nursing home facility or residential care home, or **[**his or her**]** the administrator's designee, notifies the commissioner that the licensee contests the citation, the commissioner shall provide **[**within five days of such notice, excluding Saturdays, Sundays and holidays,**]** an informal conference between the licensee and the commissioner or the commissioner's designee. Not later than five business days after the conclusion of the informal conference, the commissioner shall notify the licensee of the commissioner's conclusions resulting from the informal conference. If the licensee **[**and commissioner fail to reach an agreement at such conference, the**]** disagrees with the commissioner's conclusions, the licensee shall notify the commissioner in writing and the commissioner shall set the matter down for a hearing as a contested case in accordance with chapter 54. **[**, not more than five nor less than three days after such conference, with notice of the date of such hearing to the administrator not less than two days before such hearing, provided the minimum time requirements may be waived by agreement. The commissioner shall, not later than three days, excluding Saturdays, Sundays and holidays,**]** The commissioner shall, after the conclusion of the informal conference if an agreement is reached at, or as a result of, such conference, or after the hearing, issue a final order, based on findings of fact, affirming, modifying or vacating the citation.

Sec. 3. Section 19a-527 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

Citations issued pursuant to section 19a-524, as amended by this act, for violations of statutory or regulatory requirements shall be classified according to the nature of the violation and shall state such classification and the amount of the civil penalty to be imposed

on the face thereof. The Commissioner of Public Health shall, by regulation in accordance with chapter 54, classify violations as follows:

[(a)**]** (1) Class A violations are conditions that the Commissioner of Public Health determines present an immediate danger of death or serious harm to any patient in the nursing home facility or residential care home. For each class A violation, a civil penalty of not more than **[**five**]** ten thousand dollars may be imposed;

[(b)**]** (2) Class B violations are conditions that the Commissioner of Public Health determines present a probability of death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility or residential care home, but that he or she does not find constitute a class A violation. For each **[**such**]** class B violation, a civil penalty of not more than **[**three**]** five thousand dollars may be imposed.

Sec. 4. Subsection (a) of section 19a-494 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) The Commissioner of Public Health, after a hearing held in accordance with the provisions of chapter 54, may take any of the following actions, singly or in combination, in any case in which the commissioner finds that there has been a substantial failure to comply with the requirements established under this chapter, the Public Health Code or licensing regulations:

(1) Revoke a license or certificate;

(2) Suspend a license or certificate;

(3) Censure a licensee or certificate holder;

(4) Issue a letter of reprimand to a licensee or certificate holder;

(5) Place a licensee or certificate holder on probationary status and require him to report regularly to the department on the matters which are the basis of the probation;

(6) Restrict the acquisition of other facilities for a period of time set by the commissioner;

(7) Issue an order compelling compliance with applicable statutes or regulations of the department; **[**or**]**

(8) Impose a directed plan of correction; or

(9) Appoint temporary management for a facility in accordance with the provisions of 42 CFR 488.415, as amended from time to time, for a period of time to be determined by the commissioner.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Radon.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Regulatory Services Branch, Environmental Health Section, Radon Program

Agency Analyst/Drafter of Proposal: Krista Veneziano

Title of Proposal: An Act Concerning Reporting of Radon Test Results

Statutory Reference: 19a-14b. Radon mitigators, diagnosticians and testing companies. Regulations.

Proposal Summary: Revises 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.

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 because the Department has no current means or authority to collect residential radon testing and radon reduction activities in Connecticut. As the State's health agency, we are expected to identify health problems and provide informed answers to citizens. This proposal is being submitted to determine the scope, incidence and risk associated with the largest environmental health risk in Connecticut, radon. As the leading cause of lung cancer for non-smokers, it is imperative that we begin to collect standardized data. We have invested federal dollars in the development of a radon surveillance system, thus reducing any barriers at the Department for implementing these requirements. The burden associated with reporting is limited to analytical measurement service providers (laboratories), and residential

mitigation service providers (radon mitigation contractors). There are no reporting requirements, burdens or delays associated with this legislation for home inspectors, realtors, or home buying and selling.

Radon is the second leading cause of lung cancer in the United States and is associated with 15,000 to 22,000 lung cancer deaths each year. That is greater than the annual number of deaths for several common cancers including cancer of the ovaries, liver, brain, stomach, or melanoma (Field 2005). Most of the radon-induced lung cancer cases occur among smokers due to a strong combined effect of smoking and radon. Current or former smokers who are exposed to radon have an exponentially higher risk of developing lung cancer compared to never-smokers exposed to radon. The majority of radon related lung cancer deaths will occur among persons exposed to indoor radon concentrations below commonly used indoor radon reference levels (< 4 pCi/L) (National Cancer Institute, 2011). In view of the latest scientific data, in 2009, the World Health Organization (WHO) proposed a reference level of 100 Bq/m^3 (3.7 pCi/L) to minimize health hazards due to indoor radon exposure. Testing is the only way to know if your home has elevated radon levels. All health authorities recommend radon testing and encourage corrective action when necessary.

Originally, miner studies were relied upon to illustrate the association between radon exposure and lung cancer risk. Case-control studies are now preferred, since over 40 case-control studies have been conducted. Of note are the case-control studies that researchers have pooled; thirteen in the European Union (Darby et al. 2005, 2006) and seven in North America (Krewski, et al. 2005, 2006). Each of the individual studies is smaller, so by pooling the case-control studies researchers are able to acquire a greater number of cases, and more statistically valid risk estimates and associations (WHO, 2009).

The North American and European pooling studies indicate that radon is responsible for 10-18% of the lung cancer burden in the U.S. *The disease burden is even greater for former or current smokers.* Furthermore, recent research on radon-induced lung cancer risk among the American Cancer Society cohort (Turner, et.al., 2011) found that study participants who lived in US counties with an average radon concentration above the EPA action level of 4 pCi/L (148 Bq/m^3) experience a 34% increase in lung cancer risk relative to those that lived in counties with average radon levels below the EPA action level. This same study also found that lung cancer *mortality* risk varied depending upon where participants lived. *In the Northeast, there was a 31% increase in the risk of lung cancer mortality observed per 100 Bq/m^3 increase in radon.*

The Department has developed a web-based surveillance system to enable laboratory reporting and practitioner reporting of radon-related measurement and mitigation practices in Connecticut. We have developed a means for importing laboratory rosters for all radon measurement results, so that reporting time by private companies, and staff time is minimal.

Currently, the Department 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. 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.

Multiple states throughout the US collect radon measurement and mitigation data. We are developing a surveillance system under the Department's Consilience-Maven system and environmental public health tracking system to electronically collect this data. Without reporting requirements radon risks and risk reductions will continue to be unknown or skewed to DPH-related activities. There is no state agency that collects and provides this information to the public to make informed decisions.

◊ **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?

The Connecticut Realtors Association and Home Builders Association opposed this legislation. Comments submitted by the Connecticut Realtors Association indicated that this expense for home inspectors and cause a delay in real estate transactions. This legislation does not impact home inspection services, the time associated with buying or selling a home, or reporting on the part of regular home inspectors. The reports would be submitted monthly to the Department by analytical measurement services providers (entities that operate as laboratories and are nationally-certified). Another concern was that the information would be shared openly. Since this data is being collected to determine the risk of morbidity and mortality, it is subject to confidentiality statutes and regulations (19a-25). Revisions to the language were made, after meeting with the Realtors Association and Home Inspector groups (ASHI, and CAHI) to ensure the data is de-identified.

The Connecticut Home Builders Association opposed the bill because they believed it would impact home construction practices in the state. DPH staff contacted the Home Builders Association to alert them that the legislation does not pertain to building or home construction, but rather, to radon testing (when it occurs) in residential properties.

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

Yes. DPH staff met with the Connecticut Realtors Association, ASHI and CAHI members

to review the legislation and address concerns. The definition of Analytical Measurement Service Providers was clarified to mean only those entities that perform analytical services who are also nationally-certified. This limitation was not recognized initially by the interest groups. As such, a home inspector placing a passive radon test device (e.g., activated charcoal, or alpha-track device) would not be subject to reporting. Most home inspectors use passive devices and would not need to report to the Department. The proposed language was also revised as follows:

(a) Reporting of radon measurement results by analytical services providers was limited to monthly reporting only – former language asked for more rapid reporting of high radon test results;

(b) Language pertaining to confidentiality was included in the proposal to reduce concerns about disclosure of reported results to the general public or others.

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

The initial proposal was drafted by staff in DPH. There are no advocacy groups for radon in the state. Efforts have been made by the DPH to convene interest groups, but sustainability became an issue.

PROPOSAL IMPACT

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

Agency Name: Department of Housing
Agency Contact (*name, title, phone*): Dan Arsenault, Legislative Program Manager, 860.270.8103
Date Contacted: 11/4/2016

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

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

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

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

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

State: None. The Department of Public Health will use existing resources to carry out the

environmental risk surveillance work. The work will result in the ability of the program to target limited resources by making informed decisions.
Federal: Will utilize State Indoor Radon Grant funds to support a position within the program to conduct disease surveillance, data entry, and reporting.
Additional notes on fiscal impact: Analytical laboratories can readily provide the Department with tables containing the information described under statute; in some instances they already do report the information to the local director of health. This is not a burden to the laboratories. Home inspectors who are nationally-certified and operate as an analytical measurement service provider account for possibly 10-20 individuals statewide. Only those 10-20 individuals would report to the Department because they are nationally-certified and using devices that provide real-time field-based electronic results. This has little-to-no impact on home inspectors statewide. The information is maintained as confidential health data and would not be released to the public in any identifiable format. The information would be received on a monthly basis, and is not delaying real estate transaction, because the parties associated with the real estate transaction – home buyer/seller, realtor and inspector are not impacted by this proposal.

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

Through the data collected by the web-based surveillance system operated by the Radon Program, we will be able to measure the risk reduction effectiveness of different radon installation types and track how many radon resistant passive systems are activated. This informs the Radon Program's activities and targets where they can focus efforts to increase awareness, track morbidity, and make recommendations for reducing the effects of radon. Health disparities can exist by geographical location, this data will help us determine if there is a higher prevalence of radon in certain areas this will help determine whether there is a disproportional impact on low income populations.

Section 1. Section 19a-14b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

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

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

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

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

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

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

(b) The Department of Public Health shall maintain a list of **[**companies or individuals that are included in current lists of national radon proficiency programs that have been approved by the Commissioner of Public Health**]** analytical measurement service providers, residential measurement service providers and residential mitigation service providers who (1) are providing services in the state, (2) maintain current certification with the National Radon Safety Board or the National Radon Proficiency Program, and (3) if required, are registered with the Commissioner of Consumer Protection as a contractor performing radon mitigation, pursuant to section 20-420. Any such service provider who is determined by the Commissioner of Public Health to have failed to comply with the provisions of this section shall be removed from such 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 40 CFR 141 and 142.**]**

(c) Each analytical measurement service provider shall, not later than the fifteenth day of each month, submit to the Commissioner of Public Health, in the form and manner prescribed by the commissioner, a comprehensive report for each radon in-air test result analyzed by the analytical measurement service provider during the month prior to the month in which the report is submitted. Such report shall

include, for each such radon test conducted: (1) The analytical measurement service provider's name, such provider's company name and business address; (2) the complete street address of each test location; (3) the building level where the radon test device was placed for the testing period, to be indicated as "basement" or by floor number; (4) the purpose of the radon test, to be indicated as a "routine test", a "real estate transaction test", a "post-mitigation radon test", or a "diagnostic radon test used for diagnosing the source of existing high radon levels"; (5) the date and time of deployment and retrieval of the radon test device; (6) the date of analysis; (7) the analytical radon test result reported in picocuries per liter; and (8) such other information as the commissioner may require.

(d) Each environmental laboratory, as defined in section 19a-29a, that analyzes a radon in-water test shall report such test results, in accordance with the provisions of section 19a-37, to the commissioner not later than the fifteenth day of the month after the month in which the test was analyzed. Such report shall include: (1) The environmental laboratory's name and complete street address; (2) the complete street address of each test location; (3) the name and title or description of the individual who collected the sample that was analyzed by the environmental laboratory, to be indicated as "analytical measurement service provider", "residential measurement service provider", "licensed home inspector", or "homeowner"; and (4) the analysis results reported in units of picocuries per liter.

(e) Each residential mitigation service provider who is certified with the National Radon Safety Board or the National Radon Proficiency Program and, if required, is registered with the Commissioner of Consumer Protection as a contractor performing radon mitigation pursuant to section 20-420 shall submit to the commissioner, in the form and manner prescribed by the commissioner, a comprehensive report for each radon control system installed not later than thirty days after the date of such installation. Such report shall include: (1) The residential mitigation service provider's name, such provider's company name and such provider's business address; (2) the complete street address where the radon mitigation system was installed; (3) an indication of the type of mitigation system installed, to be designated as "air" or "water"; (4) the date the mitigation system was installed; (5) the post-mitigation radon results; and (6) such other information as the commissioner may require.

(f) Information submitted to the commissioner pursuant to this section shall be confidential, as provided in section 19a-25.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH 1104 Revisions to Local EMS Plans.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: 860-509-7246/860-509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Healthcare Quality and Safety Branch, Office of Emergency Medical Services (OEMS)

Agency Analyst/Drafter of Proposal: Raffaella Coler, Director, OEMS

Title of Proposal: An Act Concerning Revisions to Local Emergency Medical Services Plans

Statutory Reference: 19a-181b. Local emergency medical services plan.

Proposal Summary: This proposal does a variety of things: gives the Commissioner authority to approve Local Emergency Medical Services Plans; requires municipalities to submit the plans every five years for the Department's approval; defines minimum performance standards for the municipalities EMS system; and transfers the responsibility of evaluating the performance standards back to the individual municipality who submits a report of their finding to the Department's Office of Emergency Medical Services.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

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

This proposal will give the Commissioner authority to approve local EMS plans, will improve workflow management by establishing a set timeframe by which a local EMS plan must be revised and submitted to the Department, and will allow the Department to receive specific data from the local EMS system for better tracking of performance.

◊ **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?* Click here to enter text.

PROPOSAL IMPACT

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation)* Local Emergency Medical Services will have to comply with updated requirements for plan submission. No fiscal impact is anticipated since the mandate for establishing plans has been in effect for several years.
State: None
Federal: None
Additional notes on fiscal impact

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

Click here to enter text.

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

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

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

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

(3) The establishment of performance standards for each segment of the municipality's emergency medical services system. Performance standards shall include but not be limited to: percentage of first call responses met, response time standards, quality assurance standards and service area coverage patterns; and

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

(b) In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional emergency medical services council established pursuant to section 19a-183, its regional emergency medical services coordinator appointed pursuant to section 19a-186a, its regional emergency medical services medical advisory committees and any sponsor hospital, as defined in regulations adopted pursuant to section 19a-179, located in the area identified in the plan; and (2) shall submit the plan to its regional emergency medical services council for the council's review and comment.

(c) Each municipality shall update the plan required by subsection (a) of this section [as the municipality determines is necessary] not less than every five years. The municipality shall consult with the municipality's primary service area responder concerning any updates to the plan. The Department of Public Health shall, upon request, assist each municipality in the process of updating the plan by providing technical assistance and helping to resolve any disagreements concerning the provisions of the plan.

(d) Not less than once every five years, [said department] each municipality shall review [a municipality's] their plan and the primary service area responder's provision of services under the plan. [Such review shall include an evaluation of such responder's compliance with applicable laws and regulations.] Upon the conclusion of such evaluation, the department shall assign a rating of

“meets performance standards”, “exceeds performance standards” or “fails to comply with performance standards” for the primary service area responder. Within thirty days of the review completion, the municipality shall report the findings to the Department of Public Health. The Commissioner of Public Health may require any primary service area responder that is assigned a rating of “fails to comply with performance standards” to meet the requirements of a performance improvement plan developed by the department. Such primary service area responder may be subject to subsequent performance reviews or removal as the municipality’s primary service area responder for a failure to improve performance in accordance with section 19a-181c.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text. DPH Boards Commissions and Department Enforcement Provisions.doc

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

State Agency: Department of Public Health
Liaison: Brie Wolf/Jill Kennedy **Phone:** (860) 509-7246/(860) 509-7280 **E-mail:** brie.wolf@ct.gov/jill.kennedy@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch's Legal Office
Agency Analyst/Drafter of Proposal: Matthew Antonetti

Title of Proposal: An Act Concerning Enforcement Actions Taken Against a Licensed Health Care Professional by the Department of Public Health.
Statutory Reference: 19a-17. Disciplinary action by department, boards and commissions.
Proposal Summary: Section 19a-17 does not presently, and technically, permit a permanent restriction on a license. Based on the current statute, an enforcement action is subject to a probationary term only. This proposal creates a technical change to allow for permanent restrictions on a health care practitioner's license.

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?

During a recent meeting of a professional board, Section 19a-17(a)(5)(B) was reviewed and it was determined that licensure restrictions can only be placed on a practitioner license for a probationary period. This proposal will provide the Department with the ability to pose permanent restrictions on a practitioner license such as a restriction against prescribing certain narcotics, or having a chaperone in certain patient examinations, or requiring that a practitioner work in an office setting with other practitioners.

This past year, the Board of Veterinary Medicine was told that they were not able to take permanent action against a license due to the current wording of the statute, which only permits restriction of a license for a probationary period. Therefore, the Board was required to place a practitioner's license on probation for 25 years just so that the given veterinarian

couldn't administer rabies vaccinations (he was doing them improperly). The proposed amendment would clarify that the Department would be allowed to take permanent action on a license and Boards/Commissioner/Department need not place practitioners' licenses on probation for an entire career to effectuate such restrictions.

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

If this is a resubmission, please share:

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

Click here to enter text.

PROPOSAL IMPACT

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

Agency Name: Click here to enter text.
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

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

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

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

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

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

State
None

Federal
None

Additional notes on fiscal impact
Click here to enter text.

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

Will allow professional Boards/Commissions or the Department to restrict a license or permit (such as restricting ability to prescribe narcotics, etc.) outside the context of a time limited probationary status.

Subsection (a) of section 19a-17 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each board or commission established under chapters 369 to 376, inclusive, 378 to 381, inclusive, and 383 to 388, inclusive, and the Department of Public Health with respect to professions under its jurisdiction that have no board or commission may take any of the following actions, singly or in combination, based on conduct that occurred prior or subsequent to the issuance of a permit or a license upon finding the existence of good cause:

(1) Revoke a practitioner's license or permit;

(2) Suspend a practitioner's license or permit;

(3) Censure a practitioner or permittee;

(4) Issue a letter of reprimand to a practitioner or permittee;

(5) Restrict or otherwise limit practice to those areas prescribed by such board, commission or department;

[(5)] (6) Place a practitioner or permittee on probationary status and require the practitioner or permittee to:

(A) Report regularly to such board, commission or department upon the matters which are the basis of probation;

(B) Limit practice to those areas prescribed by such board, commission or department;

(C) Continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation;

[(6)] (7) Assess a civil penalty of up to twenty-five thousand dollars;

[(7)](8) In those cases involving persons or entities licensed or certified pursuant to sections 20-341d, 20-435, 20-436, 20-437, 20-438, 20-475 and 20-476, require that restitution be made to an injured property owner; or

[(8)] (9) Summarily take any action specified in this subsection against a practitioner's license or permit upon receipt of proof that such practitioner has been:

(A) Found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law, or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state; or

(B) Subject to disciplinary action similar to that specified in this subsection by a duly authorized professional agency of any state, the District of Columbia, a United States possession or territory or a foreign jurisdiction. The applicable board or commission, or the department shall promptly notify the practitioner or permittee that his license or permit has been summarily acted upon pursuant to this subsection and shall institute formal proceedings for revocation within ninety days after such notification.

Agency Legislative Proposal - 2017 Session

Document Name (e.g. OPM1015Budget.doc; OTG1015Policy.doc): Click here to enter text.
DPH Data Sharing.doc

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: (860) 509-7246/(860) 509-7280
E-mail: brie.wolf@ct.gov/jill.kennedy@ct.gov

Lead agency division requesting this proposal: Commissioner' s Office

Agency Analyst/Drafter of Proposal: Raul Pino/Shawn Rutchick

Title of Proposal: An Act Concerning Facilitating Data Sharing Between State Agencies

Statutory Reference:
19a-25. Confidentiality of records procured by the Department of Public Health or directors of health of towns, cities or boroughs.

Proposal Summary:
This proposal authorizes other state agencies to share information with DPH for specific purposes.

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 March 2016, the Department received grant funding from the CDC to provide 6 different local health departments funding to implement recommended evidence based strategies identified in the CT Opioid REsponse Initiative. The grant also requires the Department to: enhance and maximize Connecticut's PDMP; implement community health system interventions; and evaluate the impact of PA 14-61. PA 14-61 provides immunity to persons who administer an overdose reversal medication. The Department is required to collect and analyze the data regarding emergency department visits and inpatient hospitalizations for drug misuse and overdose, as well as behavioral changes of by-standers and overdose death. While applying for this grant, the Department realized that statute doesn't allow data to be shared between the agencies that are impacted by PA 14-61. This proposal will revise the Department's current confidentiality of medical records statute to allow for data to be shared under strict confidentiality requirements.

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

If this is a resubmission, please share:

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

Click here to enter text.

PROPOSAL IMPACT

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

Agency Name: Department of Consumer Protection
Agency Contact (*name, title, phone*): Leslie O'Brien
Date Contacted: 11/7/2016

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

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

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

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

Agency Name: Mary Kate Mason
Agency Contact (*name, title, phone*): Department of Mental Health and Addiction Services
Date Contacted: 11/7/2016

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

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

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

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

Agency Name: Department of Insurance
Agency Contact (*name, title, phone*): Eric Weinstein
Date Contacted: 11/7/2016

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

Summary of Affected Agency's Comments

Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

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

Agency Name: Department of Emergency Services and Public Protection **Agency Contact (*name, title, phone*):** Scott Devico **Date Contacted:** 11/7/2016 Approve of Proposal ☐ **YES** ☐ **NO** ☒ **Talks Ongoing**
Summary of Affected Agency's Comments Click here to enter text.
Will there need to be further negotiation? ☐ **YES** ☐**NO**

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

Municipal *(please include any municipal mandate that can be found within legislation)* None
State None
Federal None
Additional notes on fiscal impact Click here to enter text.

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

Will allow the Department to exchange information under strict confidentiality restrictions with sister state agencies.

Section 19a-25 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) All information, including but not limited to records of interviews, written reports, statements, notes, memoranda or other data, including personal data as defined in subdivision (9) of section 4-190, procured by the Department of Public Health or by staff committees of facilities accredited by the Department of Public Health in connection with studies of morbidity and mortality conducted by the Department of Public Health or such staff committees, or carried on by said department or such staff committees jointly with other persons, agencies or organizations, or procured by the directors of health of towns, cities or boroughs or the Department of Public Health pursuant to section 19a-215, or procured by such other persons, agencies or organizations, for the purpose of reducing the morbidity or mortality from any cause or condition, shall be confidential and shall be used solely for the purposes of medical or scientific research and, for information obtained pursuant to section 19a-215, disease prevention and control by the local director of health and the Department of Public Health. Such information, records, reports, statements, notes, memoranda or other data shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person, nor shall it be exhibited or its contents disclosed in any way, in whole or in part, by any officer or representative of the Department of Public Health or of any such facility, by any person participating in such a research project or by any other person, except as may be necessary for the purpose of furthering the research project to which it relates. Notwithstanding the provisions of chapter 55, the Department of Public Health may exchange personal data for the purpose of medical or scientific research, with any other governmental agency or private research organization; provided such state, governmental agency or private research organization shall not further disclose such personal data. The Commissioner of Public Health shall adopt regulations consistent with the purposes of this section to establish the procedures to ensure the confidentiality of such disclosures. The furnishing of such information to the Department of Public Health or its authorized representative, or to any other agency cooperating in such a research project, shall not subject any person, hospital, sanitarium, rest home, nursing home or other person or agency furnishing such information to any action for damages or other relief because of such disclosure. This section shall not be deemed to affect disclosure of regular hospital and medical records made in the course of the regular notation of the care and treatment of any patient, but only records or notations by such staff committees pursuant to their work. (b) Notwithstanding any other section of the general statutes to the contrary, any department within section 4-38c of the general statutes and any quasi-public agency within section 1-120 of the general statutes may share any information, as set forth in subsection a, with the Department of Public Health for a morbidity and mortality study or disease prevention and control.

Agency Legislative Proposal - 2017 Session

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

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

State Agency: Department of Public Health

Liaison: Brie Wolf/Jill Kennedy
Phone: 860.509.7246/7280
E-mail: brie.wolf@ct.gov/ jill.kennedy@ct.gov

Lead agency division requesting this proposal: Drinking Water Section

Agency Analyst/Drafter of Proposal: Lori Mathieu, Public Health Section Chief, Drinking Water Section

Title of Proposal: An Act Concerning Connecticut's Safe Drinking Water

Statutory Reference:
Section 1: § 22a-477r [DWSRF]
Section 2: NEW [Public Drinking Water Account]
Section 3: NEW [General Assembly blurb]
Section 4: NEW [Definitions for License to Operate]
Section 5: NEW [CWS license to operate]
Section 6: NEW [NTNC license to operate]
Section 7: NEW [TNC license to operate]
Section 8: NEW [Commissioner may authorize AG to initiate action re license to operate]
Section 9: NEW [Authority to adopt regulations for license to operate]
Section 10: NEW [Requirement re annual report for public drinking water account]
Section 11: NEW [Aging Infrastructure]
Section 12: § 25-32e [Civil penalties]
Section 13: NEW [Definitions for new receivership law]
Section 14: NEW [Appointment of receiver]
Section 15: NEW [When Court can grant application for receiver]
Section 16: NEW [Defenses to receivership]
Section 17: NEW [Powers of receiver]
Section 18: NEW [Receiver's authority re leases, mortgages, or other contract]
Section 19: NEW [Who may be receiver and removal of receiver by court]
Section 20: NEW [Removal of receiver by court]
Section 21: NEW [Receiver's authority to sell assets to pay fees]
Section 22: NEW [Requirement that receiver file accounting with the court]

Section 23: NEW [Termination of receivership]
Section 24: NEW [Temporary receivership]

Proposal Summary:

Sections 1 through 10: [DWSRF and License to Operate] To create a license to operate for the state's public drinking water systems to sustain state public drinking water program staff salaries to support their current and growing work effort to assure public drinking water primacy under the Safe Drinking Water Act and assure safe public drinking water, as well as support the various public drinking water system responsibilities under state statute. Overall the Department of Public Health (DPH) has recognized that federal funding support continues to be reduced for its Drinking Water Section staff and there is a projected need starting in calendar year 2017 to collect fees to support the DPH Drinking Water Section staff. The projected need is approximately $1.3 million annually. The legislative proposal includes methods to collect sufficient fees to be able to sustain the DPH Drinking Water Section staff. Fees are seen as necessary in order to spread costs across the programs within the Drinking Water Section. The legislation creates a biennial license to operate (LTO) fee for public water systems. LTO fees can be adjusted in future years to be able to account for cost increases over time. LTO fees are adequate to account for start-up costs of $200,000 for the e-licensing system.

Section 11: [Aging Infrastructure] The U.S. Environmental Protection Agency (EPA) considers asset management planning to be a critical part to managing public water systems to meet federal drinking water standards. If this is not enacted this session, small water companies' infrastructure would continue to degrade without a regard or recognition of the need to replace and or upgrade their systems drinking water infrastructure. Aging infrastructure can lead to public water system failure and/or water quality or water quantity problems leading to very expensive repairs. This proposed legislation would require the Connecticut's water companies to at a minimum review their small water system infrastructure's age, condition and funding needed to upgrade.

Section 12: [Civil penalties] To update the existing statute that gives the Commissioner of Public Health the authority to issue civil penalties against public water systems and eliminate the need for separate civil penalty regulations.

Section 13 to 24: [Receivership for small water companies] Authorizes DPH to request the court to appoint a receiver for a small water company, which under this proposal is a water company that is not required to prepare water supply plans pursuant to *Conn. Gen. Stat.* § 25-32d, in for

a number of reasons, after providing notice and an opportunity for a hearing, except when there is a reasonable likelihood that a condition exists at the small water company that must be remedied immediately, in which case a hearing is held after order issued.

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?

Sections 1 through 10: [DWSRF and License to Operate] Many other states have authorization to collect fees to provide support to their public drinking water programs. According to a 2014 Association of State Drinking Water Administrators' national survey of state drinking water programs, 34 (or 90%) of the 38 states programs that replied have some type of fee for service or connection fee, or a combination of both. Of the regional states that responded to the survey, Maine's program has a per capita fee assessment on public water systems; Vermont's program has a fee for services as well as a fee for gallons produced, Rhode Island's program has a connection fee and annual fees, and New Jersey's program has an annual operation fee.

The Department reached out to directly to several states that responded to the survey to collect additional information on their structure and processes. Of all the states with which we spoke, Ohio's drinking water fee program seems the most robust with an ability to adjust fees over time as needed. Ohio has an annual license to operate fee to support their public water system program services since the mid-1990s. Their public drinking water fee is based on the number of service connections and population served, and is adjusted each year. It raises $ 3.5 million annually, which is about 25% of Ohio's total drinking water program funding.

This funding is needed to sustain current costs to operate the DPH's Drinking Water Section due to the reduction in available federal funds.

If this proposal is not enacted in law this session, the state's ability to maintain primary enforcement responsibility of the federal Safe Drinking Water Act and the Connecticut General Statutes will be severely compromised. If this proposal is not enacted, DPH's Drinking Water Section staff who are responsible for overseeing public drinking water quality and quantity, as well as for responding to customer complaints, drinking water emergencies and/or chemical spills that affect public drinking water statewide, will be reduced by approximately 30%.

Further, DPH will lose any ability to be proactive and recognize potential public health problems that concern public drinking water statewide. Proactive work to be compromised and/or directly eliminated includes:

- Monitoring trends in public drinking water quality and the effects to human health,
- Tracking public water systems to assure drought tracking and heading off over use of drinking water supplies,
- Working with public water systems to assure cyanotoxin tracking and addressing the new EPA health advisory concerning toxic blue-green algae in Connecticut's 150 public drinking water reservoir systems,
- Working with public water systems and critical public health priority customers, such as hospitals and VA facilities, concerning potential waterborne disease outbreak issues such as with legionella,
- Working with public water systems to adjust to the new EPA Safe Drinking Water Act rules in order to remain in compliance with state and federal law,
- Working with public water systems to identify drinking water contamination threats prior to a contamination event,
- Working with public water systems concerning emergency response to severe weather events, such as hurricanes,
- Working to assure that consumers in Connecticut utilize high quality sources of public drinking water,
- Working with public water systems to assure the Connecticut's drinking water infrastructure meets and exceeds national water quality standards in order to assure purity of the state's drinking water supply, and
- Working with Connecticut's 330 small public drinking water community systems to address aging infrastructure and ownership issues.

Unfortunately, with a reduction of 30% of the DPH Drinking Water Section staff, public health will be compromised and the risk of waterborne disease outbreaks will increase without

adequate statewide public drinking water oversight.

Section 11. Following a 2015 explosion of a hydropneumatic tank that took place at a small water company, there is a general need for small water companies to review their aging infrastructure and move forward with needed upgrades. DPH would like to require that fiscal and asset management plans be produced by the state's community water companies serving 10,000 or less. We would like to avoid another total system failure similar to the tank explosion that took place last year. We believe that there are thousands of hydropneumatic tanks in use today in water systems across the state which have never been professionally inspected or reviewed for replacement. There have not been changes to federal law, however the EPA considers asset management planning to be a critical part to managing water systems to meet federal drinking water standards. We are not aware on another state implementing this type of a program. If this is not enacted this session, small water companies' infrastructure would continue to degrade without regard or recognition of the need to replace and or upgrade their systems drinking water infrastructure. Aging infrastructure can lead to system failure, water quality, or water quantity problems leading to very expensive repairs. This law would require the state's small water companies, at a minimum, to review their water company's infrastructure age, condition, and identify funding needed to upgrade.

Section 12. Every time a new rule comes out from EPA, the Department needs to update the regulations pertaining to civil penalties to match the new rule requirements. This section will remove the requirement for the Department to complete regulations, but instead provide for a listing on it's website with an annual review.

Section 13 through 24. The authorization to request the court to appoint a receiver for a small water company would provide the Department with the ability to ensure the public receives adequate and safe drinking water. The reasons for which a court may appoint a receiver include: a small water company's failure to have the technical, managerial and financial resources to operate the small water company in a reliable and efficient manner and to provide continuous, adequate service to the persons served by the small water company; its failure to meet the drinking water standards and such failure constitutes an immediate threat to the quality or adequacy of the drinking water; and failure to maintain the small water company's facilities, resulting in a potential threat to the quality or adequacy of the drinking water supply.

This proposal requires DPH to publish and maintain on its Internet website a list of interested and qualified individuals, corporations, associations and partnerships, with experience in the

provision of water service and a history of satisfactory operation of a water company.

It also requires the court to appoint any responsible individual, corporation, association or partnership whose name is proposed by the Commissioner of Public Health to act as receiver, unless there is no individual, corporation, association or partnership that has consented to assume operation of the small water company, in which case the court is required to appoint a receiver. It provides the Commissioner of Public Health the ability to authorize a person to temporarily manage and operate a small water company in certain situations. DPH is modeling portions of this proposal after the receivership law for nursing homes.

PROPOSAL IMPACT

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

Agency Name: Click here to enter text.
Agency Contact (*name, title, phone*): Click here to enter text.
Date Contacted: Click here to enter text.

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

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

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

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

Municipal *(please include any municipal mandate that can be found within legislation)*

Sections 1 through 10: [DWSRF and License to Operate] Throughout the legislative proposal, language is added to allow DPH to issue a LTO public water systems, which includes municipalities that own a public water supply system. This LTO will include a biennial fee that would need to be paid to the DPH and deposited into the DPH's Public Drinking Water account.

Section 11: [Aging Infrastructure]

Section 12: [Civil penalties]

Section 13 to 24: [Receivership for small water companies]

State

Sections 1 through 10: [DWSRF and License to Operate] No fiscal impact.

Section 11: [Aging Infrastructure]

Section 12: [Civil penalties]

Section 13 to 24: [Receivership for small water companies]

Federal

Sections 1 through 10: [DWSRF and License to Operate] Throughout the legislative proposal, language is added to allow DPH to issue a LTO public water systems which includes federal facilities that own a public water supply system. This LTO will include a biennial fee that would need to be paid to the DPH and deposited into the DPH's Public Drinking Water account.

Section 11: [Aging Infrastructure]

Section 12: [Civil penalties]

Section 13 to 24: [Receivership for small water companies]

Additional notes on fiscal impact

Sections 1 through 10: [DWSRF and License to Operate] Fiscal impact will include start up as well as ongoing administration costs for the LTO for public drinking water systems. It is estimated that a one-time cost of $200,000 will be needed for incorporation of the LTO for public water systems into CT's E-licensing System. Further ongoing annual software maintenance costs will range from $15,000 to $30,000. Also, the administration of the LTO will require three FTEs; one fiscal administrative officer and two processing technicians for the DPH Drinking Water Section. All costs as noted above are proposed to be covered by the LTO fee proposal.

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

Sections 1 through 10: [DWSRF and License to Operate]

Section 11: [Aging Infrastructure] This proposal includes better use of existing resources to have a more significant

and positive social impact on the state and its residents and will improve our agency's effectiveness by allowing us to monitor and be prepared for any potential problems with outdated equipment.

Section 12: [Civil penalties] This proposal will update the existing statute that gives the Commissioner of Public Health the authority to issue civil penalties against public water systems and eliminate the need for separate civil penalty regulations.

Section 13 to 24: [Receivership for small water companies]

An Act Concerning Connecticut's Safe Drinking Water

Sec. 1. Section 22a-477(r) of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(r) Within the drinking water state account there are established the following subaccounts: (1) A state bond receipts subaccount, into which shall be deposited the proceeds of notes, bonds or other obligations issued by the state for the purpose of deposit therein; (2) a General Fund receipts subaccount into which shall be deposited funds appropriated by the General Assembly for the purpose of deposit therein; [and] (3) a state loan repayment subaccount into which shall be deposited payments received from any recipient in repayment of a project loan made from any moneys deposited in the drinking water state account; and (4) a state administrative and management subaccount into which shall be deposited amounts for the administrative and management of the public water system improvement program established pursuant to section 22a-483f, which amounts shall be determined by the Commissioner of Public Health in consultation with the Secretary of the Office of Policy and Management.

Sec. 2. (NEW) *(Effective July 1, 2017)*

(NEW) (a) There is established a public drinking water account that shall be a separate nonlapsing account within the General Fund. The public drinking water account shall contain any moneys required by law to be deposited into the account. Any balance remaining in said account at the end of any fiscal year shall be carried forward in the account for the next fiscal year.

(b) All of the money collected pursuant to sections 5, 6, and 7 of this Act, in each fiscal year, shall be credited to the public drinking water account, and be available for expenditure by the Department of Public Health to defer the cost of administering the public drinking water program.

Sec. 3. (NEW) *(Effective July 1, 2017)*

(NEW) The General Assembly finds that it is a paramount policy of the state to protect the purity and adequacy of the water we drink, that the maintenance of high quality potable water is essential to safeguard the

public health, welfare, and economic wellbeing of the people of the state and that the Department of Public Health has been authorized to carry out this public purpose; that the department's mission is to protect and improve the health and safety of the people of the state; that the federal Safe Drinking Water Act provides a comprehensive framework, at a minimum, for establishing standards, providing technical assistance and for regulating the collection, treatment, monitoring, storage, and distribution of drinking water, and that it is in the best interest of the people of the state for the state through the department to maintain primary enforcement responsibility.

Sec. 4. (NEW) *(Effective July 1, 2017)*

(NEW) Definitions. As used in sections 4 through 8, inclusive, of this Act:

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

(2) "Community public water system" means a public water system that regularly serves at least twenty-five year-round residents;

(3) "Consumer" shall have the same meaning as provided in section 25-32a;

(4) "Non-community public water system" means a public water system that serves at least twenty-five persons at least sixty days out of the year and is not a community water system;

(5) "Non-transient non-community public water system" means a public water system that is not a community public water system and that regularly serves at least twenty-five of the same persons over six months per year;

(6) "Public water system" means a water company that supplies drinking water to fifteen or more consumers or twenty-five or more persons daily at least sixty days of the year;

(7) "Transient non-community public water system" means a non-community public water system that does not meet the definition of a non-transient non-community water system; and

(8) "Water company" has the same meaning as provided in section 25-32a.

Sec. 5. (NEW) *(Effective July 1, 2017)*

(NEW) Community public water systems. License required. Application. Fees. Civil penalties. Exemptions.

(a) License requirement. No community public water system may provide drinking water to the public unless the water company that owns such community public water system has obtained a community public water system license to operate from the Department of Public Health pursuant to this section.

(b) Application for the issuance of a license.

(1) On or after January 1, 2018, in accordance with the schedule published on the department's Internet web site, and every two years thereafter, an application for a community public water system license to operate shall be made by the water company that owns such community public water system to the department on a form and in the manner prescribed by the commissioner, along with the fee required in subsection (e) of this section. The department shall publish such schedule on the department's Internet web site not later than two months after the effective date of this section. Such application shall be signed under oath by the owner of the water company, or the person authorized to act on behalf of the owner, and shall contain a notice that false statements made therein are punishable in accordance with section 53a-157b of the Connecticut General Statutes.

(2) Such water company that owns the community public water system shall present evidence in its application satisfactory to the department that the water company has the qualifications necessary to own a community public water system.

(3) Such community public water system license to operate shall be in effect for two years.

(4) Notice to the public. The community public water system license to operate shall be posted in a conspicuous and publicly-accessible location at the community public water system.

(c) Renewal. The community public water system license to operate shall be renewed once every two years, in accordance with the schedule published on the department's Internet web site pursuant to subsection (b)(1) of this section. Such application for renewal shall be made by the water company that owns such community public water system to the department not less than ninety days prior to the date of renewal, in a form and manner prescribed by the commissioner, along with the fee required in subsection (e) of this section.

(d) Issuance, nonissuance, suspension and revocation.

(1) The department may deny a water company's application for a community public water system license to operate, or may suspend or revoke a water company's community public water system license to operate, for any of the following reasons, including but not limited to:

(A) A water company's failure to comply with federal or state statutes and regulations applicable to water companies;

(B) A water company's material misstatement of fact made on the initial or renewal application; or

(C) There is an imminent threat to public health with respect to such community public water system as determined by the commissioner.

(2) The department may issue a license or renewal of a water company's community public water system license to operate, if the commissioner determines that the water company is in compliance with the statutes and regulations pertaining to the water company's community public water system license to operate.

(3) The water company shall not transfer or assign the water company's community public water system license to operate. Any change in ownership of the community public water system for which the water company has a community public water system license to operate shall require a new community public water system license to operate in accordance with this section.

(e) Fees.

(1) Fee schedule.

(A) The department shall charge a water company a community public water system license to operate fee based on the number of service connections the community public water system has for which the water company is applying. The department shall publish the fee schedule on the department's Internet web site not later than two months after the effective date of this section.

(B) The department may review the community public water system license to operate fee schedule in subparagraph (A) of this subdivision biennially, or as the department deems necessary, and adjust the fee schedule by applying a percentage adjustment based on the needs of the department's public drinking water program. If the department adjusts such fee schedule, the department shall publish the adjusted fee schedule on the department's Internet web site on or before July 1.

(3) Any fee collected pursuant to this subsection shall be deposited in the department's public drinking water account in accordance with section 2 of this Act.

(4) A water company may collect such community public water system license to operate fee from the consumers of the water company's community public water system for which the water company paid such community public water system license to operate fee.

(f) Assessment of Civil Penalties. Any water company that fails to pay the community public water system license to operate fee shall be assessed a civil penalty under the provisions of section 25-32e, which will accrue daily until the appropriate amount plus interest is tendered to the department. The water company may be subject to such other orders as the department deems appropriate. The department shall provide an opportunity for a hearing upon the assessment.

(g) Exemption. Any state agency shall be exempt from the fee requirement provided in this section.

Sec. 6. (NEW) *(Effective July 1, 2017)*

(NEW) Non-transient non-community public water systems.

(a) License requirements. No non-transient non-community public water system may provide drinking water to the public unless the water company that owns such non-transient non-community public water system has obtained a non-transient non-community public water system license to operate from the Department of Public Health pursuant to this section.

(b) Application for the issuance of a license.

(1) On or after January 1, 2018, in accordance with the schedule published on the department's Internet web site, and every two years thereafter, an application for a non-transient non-community public water system license to operate shall be made by the water company that owns such non-transient non-community public water system to the department on a form and in the manner prescribed by the commissioner, along with the fee required in subsection (e) of this section. The department shall publish such schedule on the department's Internet web site not later than two months after the effective date of this section. Such application shall be signed under oath by the owner of the water company, or the person authorized to act on behalf of the owner, and shall contain a notice that false statements made therein are punishable in accordance with section 53a-157b of the Connecticut General Statutes.

(2) Such water company that owns the non-transient non-community public water system shall present evidence in its application satisfactory to the department that the water company has the qualifications necessary to own a non-transient non-community public water system.

(3) Such non-transient non-community public water system license to operate shall be in effect for two years.

(4) Notice to the public. The non-transient non-community public water system license to operate shall be posted in a conspicuous and publicly-accessible location at the non-transient non-community public water system.

(c) Renewal. The non-transient non-community public water system license to operate shall be renewed once every two years, in accordance with the schedule published on the department's Internet web site pursuant to subsection (b)(1) of this section. Such application for renewal shall be made by the water company that owns such non-transient non-community public water system to the department not less than ninety days prior to the date of renewal, in a form and manner prescribed by the commissioner, along with the fee required in subsection (e) of this section.

(d) Issuance, nonissuance, suspension and revocation.

(1) The department may deny a water company's application for a non-transient non-community public water system license to operate, or may suspend or revoke a water company's non-transient non-community public water system license to operate, for any of the following reasons, including but not limited to:

(A) A water company's failure to comply with federal or state statutes and regulations applicable to water companies;

(B) A water company's material misstatement of fact made on the initial or renewal application; or

(C) There is an imminent threat to public health with respect to such non-transient non-community public water system as determined by the commissioner.

(2) The department may issue a license or renewal of a water company's non-transient non-community public water system license to operate, if the commissioner determines that the water company is in compliance with the statutes and regulations pertaining to the water company's non-transient non-community public water system license to operate.

(3) The water company shall not transfer or assign the water company's non-transient non-community public water system license to operate. Any change in ownership of the non-transient non-community public water system for which the water company has a non-transient non-community public water system license to operate shall require a new non-transient non-community public water system license to operate in accordance with this section.

(e) Fees.

(1) Any non-transient non-community public water system applying for initial or renewal of a license shall accompany such application with fee of five hundred dollars.

(2) The department may review the non-transient non-community public water system license to operate fee in subdivision (1) of this subsection biennially, or as the department deems necessary, and adjust such fee by applying a percentage adjustment based on the needs of the department's public drinking water program. If the department adjusts such fee, the department shall publish the adjusted fee on the department's internet website on or before July 1.

(3) Any fee collected pursuant to this subsection shall be deposited in the department's public drinking water account in accordance with section 2 of this Act.

(f) Assessment of civil penalties. Any water company that fails to pay the non-transient non-community public water system license to operate fee shall be assessed a civil penalty under the provisions of section 25-32e, which will accrue daily until the appropriate amount plus interest is tendered to the department. The water company may be subject to such other orders as the department deems appropriate. The department shall provide an opportunity for a hearing upon the assessment.

(g) Exemption. Any state agency shall be exempt from the fee requirement provided in this section.

Sec. 7. (NEW) *(Effective July 1, 2017)*

(NEW) Transient non-community public water systems.

(a) License requirements. No transient non-community public water system may provide drinking water to the public unless the water company that owns such transient non-community public water system has obtained a license to operate from the Department of Public Health pursuant to this section.

(b) Application for the issuance of a license.

(1) On or after January 1, 2018, in accordance with the schedule published on the department's Internet web site, and every two years thereafter, an application for a transient non-community public water system license to operate shall be made by the water company that owns such transient non-community public water system to the department on a form and in the manner prescribed by the commissioner, along with the fee required in subsection (e) of this section. The department shall publish such schedule on the department's Internet web site not later than two months after the effective date of this section. Such application shall be signed under oath by the owner of the water company, or the person authorized to act on behalf of the owner, and shall contain a notice that false statements made therein are punishable in accordance with section 53a-157b of the Connecticut General Statutes.

(2) Such water company that owns the transient non-community public water system shall present evidence in its application satisfactory to the department that the water company has the qualifications necessary to own a transient non-community public water system.

(3) Such transient non-community public water system license to operate shall be in effect for two years.

(4) Notice to the public. The transient non-community public water system license to operate shall be posted in a conspicuous and publicly-accessible location at the transient non-community public water system.

(c) Renewal. The transient non-community public water system license to operate shall be renewed once every two years in accordance with the schedule published on the department's Internet web site pursuant to subsection (b)(1) of this section. Such application for renewal shall be made by the water company that owns such transient non-community public water system to the department not less than ninety days prior to the date of renewal, in a form and manner prescribed by the commissioner, along with the fee required in subsection (e) of this section.

(d) Issuance, nonissuance, suspension and revocation.

(1) The department may deny a water company's application for a transient non-community public water system license to operate, or may suspend or revoke a water company's transient non-community public water system license to operate, for any of the following reasons, including but not limited to:

(A) A water company's A water company's failure to comply with federal or state statutes and regulations applicable to water companies;

(B) A water company's material misstatement of fact made on the initial or renewal application; or

(C) There is an imminent threat to public health with respect to such transient non-community public water system as determined by the commissioner.

(2) The department may issue a license or renewal of a water company's transient non-community public water system license to operate, if the commissioner determines that the water company is in compliance with the statutes and regulations pertaining to the water company's transient non-community public water system license to operate.

(3) The water company shall not transfer or assign the water company's transient non-community public water system license to operate. Any change in ownership of the transient non-community public water system for which the water company has a transient non-community public water system license to operate shall require a new transient non-community public water system license to operate in accordance with this section.

(e) Fees.

(1) Any transient non-community public water system applying for initial or renewal of a license shall accompany such application with a fee of three hundred dollars.

(2) The department may review the transient non-community public water system license to operate fee in subdivision (1) of this subsection biennially, or as the department deems necessary, and adjust such fee by applying a percentage adjustment based on the needs of the department's public drinking water program. If the department adjusts such fee, the department shall publish the adjusted fee on the department's internet website on or before July 1.

(3) Any fee collected pursuant to this subsection shall be deposited in the department's public drinking water account in accordance with section 2 of this Act.

(f) Assessment of civil penalties. Any water company that fails to pay the transient non-community public water system license to operate fee shall be assessed a civil penalty under the provisions of section 25-32e, which will accrue daily until the appropriate amount plus interest is tendered to the department. The water company may be subject to such other orders as the department deems appropriate. The department shall provide an opportunity for a hearing upon the assessment.

(g) Exemptions. Any state agency shall be exempt from the fee requirement provided in this section.

Sec. 8. (NEW) *(Effective July 1, 2017)*

(NEW) The Commissioner of Public Health may request the Attorney General to initiate an action in the superior court for the judicial district of Hartford to obtain an order from the court to aid in enforcement of provisions of sections 4 through 7, inclusive, of this Act.

Sec. 9. (NEW) *(Effective July 1, 2017)*

(NEW) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 4 to 8, inclusive, of this Act.

Sec. 10. (NEW) *(Effective July 1, 2017)*

(NEW) The Commissioner of Public Health shall prepare an annual report to the Governor within six months after the completion of each fiscal year that includes the amount of funds deposited into the public drinking water account in section 2 of this Act and the how such funds were used by the Department of Public Health in administering the public drinking water program.

Sec. 11. (NEW) (*Effective October 1, 2017*).

(NEW) (a) Definitions. As used in this section:

(1) “Small community water system” means a water company that regularly serves at least twenty-five, but not more than one thousand, year-round residents; and

(2) “Water company” has the same meaning as provided in section 25-32a.

(b) Each water company shall prepare a fiscal and asset management plan for all of the capital assets that comprise each of the water company’s small community water systems. The fiscal and asset management plan shall include, but not be limited to, a list of all capital assets of the small community water system, the useful life of such capital assets, which shall be based on the current condition, the maintenance and service history and the manufacturer’s recommendation of such capital assets, and the water company’s plan for the reconditioning, refurbishment, or replacement of such capital assets. Each water company shall commence the creation of the fiscal and asset management plan with the assessment of its hydropneumatic pressure tanks as its initial priority. Each water company shall complete the fiscal and asset management plan for all of the capital assets of each of its small community water systems not later than January 1, 2020, except that each water company shall complete on a form prepared by the Department of Public Health the asset and fiscal management plan assessment review of the hydropneumatic pressure tanks at each of its small community water systems not later

than May 1, 2018. The water company shall update each of its fiscal and asset management plans annually and shall make such fiscal and asset management plans available to the Department of Public Health upon request.

(c) This section shall not apply to a water company that is a water company, as defined in section 16-1, or that is subject to the requirements in section 25-32d, or both.

(d) This section shall be deemed to relate to the purity and adequacy of water supplies for the purposes of section 25-32e with respect to the imposition of civil penalties.

(e) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

Sec. 12. Section 25-32e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) If, upon review, investigation or inspection, the Commissioner of Public Health determines that a water company has violated any provision of section 25-32, section 25-32d or any regulation adopted under section 25-32d, or any [regulation in the Public Health Code] provision of the general statutes or regulations of Connecticut state agencies relating to the regulation of the purity and adequacy of water supplies or to the testing of water supplies or any report of such testing, the commissioner may impose a civil penalty not to exceed five thousand dollars per violation per day upon such water company. Governmental immunity shall not be a defense against the imposition of any civil penalty imposed pursuant to this section. The commissioner shall [adopt regulations, in accordance with the provisions of chapter 54, establishing a schedule or schedules of the amounts, or the ranges of amounts, of civil penalties which may be imposed under this section. In adopting such regulations, the commissioner shall consider the size of or the number of persons served by the water company, the level of assessment necessary to insure immediate and continued compliance with such provision, and the character and degree of injury or impairment to or interference with or threat thereof to: (1) The purity of drinking water supplies; (2) the adequacy of drinking water supplies; and (3) the public health, safety or welfare. No such civil penalty may be imposed until the regulations required by this subsection have been adopted] annually, or as the commissioner deems necessary, publish on the Department of Public Health's Internet web site a schedule or schedules of the amounts, or the ranges of amounts, of civil penalties which may be imposed under this section.

(b) In setting a civil penalty in a particular case, the commissioner shall consider all factors which the commissioner deems relevant, including, but not limited to, the following: (1) The amount of assessment necessary to insure immediate and continued compliance with such provision; (2) the character and degree of impact of the violation on the purity and adequacy of drinking water supplies; (3) whether the water company incurring the civil penalty is taking all feasible steps or procedures necessary or appropriate to comply with such provisions or to correct the violation; (4) any prior violations by such water company of statutes, regulations, orders or permits administered, adopted or issued by the commissioner; and (5) the character and degree of injury to, or interference with, public health, safety or welfare which has been or may be caused by such violation; and (6) [after the adoption of the federal Safe Drinking Water Act Public Notification Rule pursuant

to section 5 of public act 01-185*,] whether the consumers of the water company have been notified of such violation pursuant to [such rule] section 19-13-B102 of the Regulations of Connecticut State Agencies.

(c) If the commissioner has reason to believe that a violation has occurred, the commissioner may impose a penalty if compliance is not achieved by a specified date and send to the violator, by certified mail, return receipt requested, or personal service at the address provided to the Department of Public Health by the water company as required by section 25-33(a) or, if the water company did not provide an address as required by section 25-33(a), to the last known address of the water company on file at the department, a notice which shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the [matters asserted or charged] violation; (3) a statement of the amount of the civil penalty or penalties [to be] imposed; (4) the initial date of the imposition of the penalty, when the penalty imposed is for a continuing violation, or the dates for which the penalty is imposed; and (5) a statement of the [party's] water company's right to a hearing. The commissioner shall send a copy of such notice to the local director of health in the municipality or municipalities in which such violation occurred or that utilize such water.

(d) The civil penalty shall be payable for noncompliance on the date specified in subsection (c) of this section and for each day thereafter until the water company against which the penalty was issued [notifies] demonstrates to the commissioner that the violation has been corrected for the period in which the violation occurred or has ceased to occur. [Upon receipt of such notification, the commissioner shall determine whether or not the violation has been corrected and shall notify the water company, in writing, of such determination. The water company may, within twenty days after such notice is sent by the commissioner, request a hearing to contest an adverse determination. If, after such hearing, the commissioner finds that the violation still exists, or if the water company fails to request a hearing, the penalty shall continue in force from the original date of imposition.]

(e) The water company to which the notice is addressed shall have [twenty] ten days from the date of mailing of the notice to make written application to the commissioner for a hearing to contest the imposition of the penalty, which shall set forth the reason or reasons for the appeal. The water company shall send a copy of such application to the local director of health in the municipality or municipalities in which such violation occurred or that utilize such water. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive, except that the presiding officer shall automatically grant each local director of health in the municipality or municipalities in which such violation occurred or that utilize such water the right to be heard in the proceeding. Any civil penalty may be mitigated by the commissioner upon such terms and conditions as the commissioner, in the commissioner's discretion, deems proper or necessary upon consideration of the factors set forth in subsection (b) of this section.

(f) A final order of the commissioner assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the commissioner pursuant to subsection (e) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain and shall have precedence in the order of trial as provided in section 52-191. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, notice, permit, denial or other final decision by the commissioner. The local director of health in the municipality or municipalities in which such violation occurred or that utilize such water for which the order was assessed shall have the right to be heard on such appeal.

(g) If any water company fails to pay any civil penalty, the Attorney General, upon request of the commissioner, may bring an action in the superior court for the judicial district of Hartford to obtain enforcement of the penalty by the court. All actions brought by the Attorney General pursuant to the provisions of this section shall have precedence in the order of trial as provided in section 52-191.

(h) The provisions of this section are in addition to and not in derogation of any other enforcement provisions of any statute administered by the commissioner. The powers, duties and remedies provided in such other statutes, and the existence of or exercise of any powers, duties or remedies under this section or under such other statute shall not prevent the commissioner from exercising any other powers, duties or remedies available to the commissioner at law or in equity.

Sec. 13. (NEW) (*Effective October 1, 2017*)

(NEW) As used in this section and sections 13 to 24, inclusive, of this Act:

(1) "Abandoned operations" means, but is not limited to, a small water company's:

(A) Failure to provide water to consumers of the small water company for at least five days during the preceding three months or repeated service interruptions;

(B) Failure to meet the standards adopted under section 25-32 for the quantity and quality of public drinking water and such failure to meet such standards constitutes an immediate threat to the quality or adequacy of any source of water supply;

(C) Failure to have the financial, managerial and technical resources to operate the small water company in a reliable and efficient manner and to provide continuous, adequate service to the persons served by the small water company;

(D) Failure to adequately maintain the small water company's facilities, resulting in potential threat to the quality or adequacy of the small water company's public water supply; and

(E) Failure to provide consumers adequate notice of a public health threat or potential public health threat.

(2) "Consumer" has the same meaning as provided in section 25-32a;

(3) "Small water company" means a water company that is not required to submit a water supply plan pursuant to section 25-32d; and

(4) "Water company" has the same meaning as provided in section 25-32a.

Sec. 14. (NEW) (*Effective October 1, 2017*)

(NEW) (a) An application to appoint a receiver for a small water company may be filed in the Superior Court by the Commissioner of Public Health. The court shall hold a hearing not later than ten days after the date the application is filed. Notice of such hearing shall be given to the owner of such small water company, or such owner's agent for service of process, not less than five days prior to such hearing. Such notice shall be posted by the court in conspicuous locations throughout the distribution system of the small water company for not less than three days prior to such hearing.

(b) Notwithstanding the provisions of subsection (a) of this section, the court may appoint a receiver upon an ex parte motion when affidavits, testimony or any other evidence presented indicates that there is a reasonable likelihood a condition exists at such small water company that must be remedied immediately to insure the health, safety and welfare of the consumers of such small water company. Notice of the application and order shall be served on the owner or the owner's agent for service of process and shall be posted in a conspicuous place at such small water company not later than twenty-four hours after issuance of such order. A hearing on the application shall be held not later than five days after the issuance of such order unless the owner consents to a later date.

Sec. 15. (NEW) (*Effective October 1, 2017*)

(NEW) The court shall grant an application for the appointment of a receiver for a small water company upon a finding of any of the following:

(1) Such small water company is operating without a license issued pursuant to sections 5, 6 or 7 of this Act or such small water company's license has been suspended or revoked pursuant to sections 5, 6 or 7;

(2) such small water company has abandoned operations of the small water company; or

(3) such small water company failed to comply with an order issued in response to violations under section 19a-36 to 19a-39, inclusive, or sections 25-32 to 23-53, inclusive, or any regulation or permit adopted or issued thereunder, and such violation or violations constitutes an immediate threat to the quality or adequacy of any source of water supply.

Sec. 16. (NEW) (*Effective October 1, 2017*)

(NEW) It shall be a sufficient defense to a receivership application if any owner of a small water company establishes that:

(1) The owner did not have a reasonable time in which to correct such violations; or

(2) the violations listed in the application do not, in fact, exist.

Sec. 17. (NEW) (*Effective October 1, 2017*)

(NEW) (a) A receiver appointed pursuant to the provisions of sections 13 to 22, inclusive, of this Act in operating a small water company, shall have the same powers as a receiver of a corporation under section 52-507, except as provided in subsection (c) of this section and shall exercise such powers to remedy the conditions that constituted grounds for the imposition of receivership, ensure the availability and potability of water and the provision of water at adequate volume and pressure to the consumers of the small water company and preserve the assets and property of the owner. If such small water company is placed in receivership, it shall be the duty of the receiver to notify each consumer. Such receiver may correct or eliminate any condition or violation that is prejudicial to public health while the receiver remains at such small water company, provided the total cost of correction does not exceed three thousand dollars. The court may order expenditures for this purpose in excess of three thousand dollars on application from such receiver.

(b) Not later than ninety days after the date of appointment as a receiver, such receiver shall take all necessary steps to stabilize the operation of the small water company in order to ensure the availability and potability of water and the provision of water at adequate volume and pressure to the consumers of such small water company.

(c) The court may limit the powers of a receiver appointed pursuant to the provisions of sections 14 to 22, inclusive, of this Act to those necessary to solve a specific problem.

Sec. 18. (NEW) (*Effective October 1, 2017*)

(NEW) (a) A receiver may not be required to honor any lease, mortgage, secured transaction or other contract entered into by the owner of a small water company if, upon application to the Superior Court, said court determines that:

(1) The person seeking payment under the agreement was an owner or controlling stockholder of such small water company or was an affiliate of such owner or controlling stockholder at the time the agreement was made; or

(2) the rental, price or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rental, price or rate of interest at the time the contract was entered into.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage or security interest which the receiver is permitted to avoid under subsection (a) of this section and if the real estate or goods are necessary for the continued operation of the small water company under this section, the receiver may apply to the court to set a reasonable rental, price or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing not later than fifteen days after application is made. Any known owners of the property involved shall receive notice of such application from the receiver at least ten days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease,

security interest or mortgage involved by any person who received such notice, but the payment does not relieve the owner of the small water company of any liability for the difference between the amount paid by the receiver and the amount due under such lease, security interest or mortgage involved.

(c) The provisions of this section shall not apply to a lease, mortgage, secured transaction or other contract entered into with any financial institution regulated by a state or federal agency.

Sec. 19. (NEW) (*Effective October 1, 2017*)

(NEW) (a) The Department of Public Health shall maintain and publish on the department's Internet web site a list of interested and qualified individuals, corporations, associations and partnerships, with experience in the provision of water service and a history of satisfactory operation of a water company. The court may appoint any responsible individual, corporation, association or partnership whose name is proposed by the Commissioner of Public Health to act as receiver. No state employee or owner or other person with a financial interest in the small water company may serve as a receiver for that small water company. No person appointed to act as a receiver shall be permitted to have a current financial interest in the small water company; nor shall such person appointed as a receiver be permitted to have a financial interest in the small water company for a period of five years from the date the receivership ceases. If there is no individual, corporation, association or partnership that has consented to assume operation of the small water company, the Superior Court shall appoint a receiver.

(b) The court, in its discretion, may require a bond of such receiver in accordance with section 52-506.

Sec. 20. (NEW) (*Effective October 1, 2017*)

The court may remove a receiver appointed pursuant to section 19 of this Act in accordance with section 52-513. A small water company receiver appointed pursuant to section 19 of this Act shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in the receiver's official capacity for injury to person and property by reason of the conditions of the small water company. The receiver shall not be personally liable, except for acts or omissions constituting gross, willful or wanton negligence.

Sec. 21. (NEW) (*Effective October 1, 2017*)

(NEW) The receiver may, subject to the approval of the Superior Court and the Commissioner of Public Health, sell or otherwise dispose of all or part of the real and personal property of the small water company to pay the costs incurred in the operation of the receivership. The costs include:

(1) Payment of fees to the receiver for the receiver's services;

(2) Payment of fees of attorneys, accountants, certified operators, engineers or any other person or entity that provides goods or services necessary to the operation of the receivership; and

(3) Any other fee deemed necessary by the Superior Court and the Commissioner of Public Health.

Sec. 22. (NEW) (*Effective October 1, 2017*)

(NEW) Each receiver shall, during the first week in January, April, July and October in each year, sign, swear to and file with the clerk of the court by which the receiver was appointed a full and detailed account of his or her doings as such receiver for the three months next preceding, together with a statement of all court orders passed during such three months and the present condition and prospects of the small water company in the receiver's charge, and cause a motion for a hearing and approval of the same to be placed on the short calendar.

Sec. 23. (NEW) (*Effective October 1, 2017*)

(NEW) The Superior Court, upon a motion by the receiver or the owner of the small water company, may terminate the receivership if it finds that such small water company has been rehabilitated so that the violations or other conditions complained of no longer exist. Upon such finding, the court may terminate the receivership and return such small water company to its owner. In its termination order the court may include such terms as it deems necessary to prevent the violations or other conditions complained of from recurring.

Sec. 24. (NEW) (*Effective October 1, 2017*)

(NEW) (a) The Commissioner of Public Health, after providing to the owner of the small water company notice and an opportunity for a hearing, may authorize a person to temporarily manage and operate a small water company if the small water company:

(1) Has abandoned operations of the small water company; or

(2) the commissioner has filed or is filing an application in a Superior Court for the appointment of a receiver under section 14 of this Act.

(b) The commissioner may appoint a person under this section by emergency order, and notice of the action is adequate if the notice is mailed or hand-delivered to the last known address of the small water company.

(c) A temporary manager appointed under this section has the powers and duties necessary to ensure the continued operation of the small water company and the availability and potability of water and the provision of water at adequate volume and pressure to the consumers of the small water company, including the power and duty to:

(1) Read meters;

(2) bill consumers for water services;

(3) collect revenues;

(5) disburse funds;

(6) increase rates charged to consumers, if such rate increase is necessary and approved by the commissioner;

(7) access all small water company components;

(8) conduct sampling;

(9) make necessary repairs, as determined by the temporary manager in consultation with the commissioner; and

(10) perform other acts necessary to assure continuous and adequate water service as authorized by the commissioner.

(d) Upon appointment by the commissioner, the commissioner may require a bond of such temporary manager in accordance with section 52-506.

(e) A temporary manager shall serve a term of one year, unless:

(1) Specified otherwise by the commissioner;

(2) An extension is requested by the Department of Public Health or the temporary manager and the commissioner grants such extension;

(3) The temporary manager is discharged from such temporary manager's responsibilities by the commissioner; or

(4) A receiver is appointed pursuant to the provisions of sections 14 to 23, inclusive, of this Act.

(f) Not later than sixty days after appointment, the temporary manager shall provide to the commissioner an accounting of the assets and property of the small water company received.

(g) Compensation for the temporary manager shall come from the rates collected from the consumers of the small water company. The commissioner will set the compensation at the time of appointment.

(h) The temporary manager shall report to the commissioner on a monthly basis. Such report shall include, but not be limited to:

(1) An income statement for the reporting period;

(2) A summary of small water company activities, including all repairs made; and

(3) Any other information deemed necessary by the commissioner.

(i) This section does not affect the authority of the Department of Public Health to pursue enforcement against a water company.