Agency Legislative Proposal - 2020 Session

Document Name: 11.26.19 DPH Clean Indoor Air Act

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

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Community, Family Health and Prevention Section, Tobacco Control Program
Agency Analyst/Drafter of Proposal: Barbara Walsh

Title of Proposal: An Act Concerning The Department of Public Health's Recommendations Regarding The Clean Indoor Air Act
Statutory Reference: Section 1. Sec. 19a-342. Smoking prohibited. Exceptions. Signs required. Penalties. Section 2. Sec. 19a-342a. Use of electronic nicotine delivery system or vapor product prohibited. Exceptions. Signage required. Penalties. Section 3. 31-40q. Smoking in the workplace. Designation of smoking rooms.
Proposal Summary: This proposal will prevent additional tobacco and electronic nicotine delivery systems (ENDS) use as well as exposure to secondhand smoke and aerosol, which would positively impact public health. Section 1. Makes the following revisions: (1) Prohibits smoking in any retail establishment, on any school property, in any dormitory; (2) Removes the exemptions for correctional facilities and designated smoking areas in psychiatric facilities; (3) Removes the exemptions for smoking in public housing projects for any new construction built on or after October 1, 2020. Includes a provision to allow the landlord of a public housing project and multifamily dwelling to include a clause in the landlord tenant agreement to prohibit smoking; (4) Prohibits use of smoking rooms provided by employers; (5) Eliminates the allowance for designated smoking rooms in hotels or motels; (6) Prohibits smoking inside or outside any building accessed by the general public, including its entryway; (7) Defines “tobacco specialist” and allows for exemption from the Clean Indoor Air Act;

(8) Allows municipal ordinances on smoking policies to preempt state law if they are more stringent.

Section 2. Makes the following revisions:
(1) Prohibits the use of ENDS in any area of a retail establishment accessed by the general public or in a dormitory of an institution of higher education;
(2) Removes the exemptions for vaping in public housing projects for any new construction built on or after October 1, 2020. Includes a provision to allow the landlord of a public housing project and multifamily dwelling to include a clause in the landlord tenant agreement to prohibit vaping;
(3) Eliminates the allowance for designated smoking rooms in hotels and motels;
(4) Prohibits vaping inside or outside any building accessed by the general public, including its entryway;
(5) Clarifies that a "no vaping" sign does not need to be posted in every room of a building, but only in one conspicuous area;
(6) Allows municipal ordinances on ENDS use to preempt state law if they are more stringent.

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

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

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

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

Additionally, the provisions that remove exemptions for correctional facilities and psychiatric hospitals from the Clean Indoor Air Act will help clear up confusion, since both state agencies have already implemented smoke free policies.

◊ **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 has submitted this proposal to the Governor's Office and Office of Policy and Management every year for the last five years. A few elements of past Clean Indoor Air Act proposals have moved forward in other bills.

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: 11/20/19

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

Summary of Affected Agency's Comments

- Narrowing the medical research exemption exclusively to "tobacco control" research, would prohibit research and development of marijuana products that utilize vaporization as a route of administration, and it may also prevent any research into the use of vaping and the current lung disease that has been linked to vaping;
- The removal of the public housing and apartment exemption would also be a problem for medical marijuana patients who are unable to ingest the medicine through other methods because their conditions;
- Restricting the exemption at vape shops should that it would only apply to those shops where 75% of total sales are for said products would require DCP, to do more enforcement. We know that with respect to similar provisions in the Liquor Control Act, this sort of enforcement is quite extensive and requires thorough investigation, which would need to include auditing financial records. We would need additional investigative resources in order to implement the additional restriction. Also, there doesn't appear to be a penalty for the violation, which would also make enforcement more challenging.
- With regard to the additional prohibition on smoking in entryways of public access buildings, presuming that also applies to bars and restaurants, the Liquor Control Division is

concerned about this resulting in larger numbers of people taking drinks with them beyond designated permitted areas such as patios to smoke.
Will there need to be further negotiation? ☒ **YES** ☐**NO**

Agency Name: State Department of Education **Agency Contact (*name, title, phone*):** Laura Stefon **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Board of Regents **Agency Contact (*name, title, phone*):** Alexandra Beaudoin **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Office of Higher Education **Agency Contact (*name, title, phone*):** Noele Kidney **Date Contacted:** 11/20/19 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments Office of Higher Education asked for the definition of a private institute of higher education as it relates to DPH's legislative 2020 Clean Indoor Air Act. There is no definition of "private institution of higher education". In the DPH legislative proposal "private institution of higher education" means private college or university. OHE does not have any issues with the proposal at this point – as the ban only addresses dormitory rooms.

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

Agency Name: University of Connecticut **Agency Contact (*name, title, phone*):** Joann Lombardo and Gail Garber **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Housing **Agency Contact (*name, title, phone*):** Aaron Turner **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Corrections **Agency Contact (*name, title, phone*):** David McCluskey **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Mental Health and Addiction Services **Agency Contact (*name, title, phone*):** Mary Kate Mason **Date Contacted:** 11/20/19 Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: University of Connecticut Health Center / John Dempsey Hospital **Agency Contact (*name, title, phone*):** Joann Lombardo and Kelly Sinko **Date Contacted:** 11/20/19 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Labor **Agency Contact (*name, title, phone*):** Marisa Morello **Date Contacted:** 11/20/19 Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

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

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

Federal None
Additional notes on fiscal impact None

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

None

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

The harm caused by exposure to secondhand smoke is extensive and well-documented, and the US Surgeon General has determined that there is no safe level of exposure to secondhand smoke.[1, 2] Comprehensive Clean Indoor Air Laws are one of the most effective interventions to protect non-smokers from the health effects of secondhand smoke.[3] Smoke-free environments also help to prevent youth and young adults from starting to use tobacco, and support smokers who are trying to quit. Establishing smoke-free environments is the only proven way to prevent exposure, as research has shown that secondhand smoke cannot be controlled by ventilation, and creating separate areas does not eliminate the hazard of exposure to secondhand smoke.[4,5]

Most ENDS products contain and emit numerous potentially toxic substances[6]. The aerosol produced by ENDS can contain ingredients such as nicotine, ultrafine particles, volatile organic compounds such as benzene and heavy metals such as lead[7]. Many of the elements identified in ENDS aerosol have been known to cause respiratory distress and disease. Aerosol tested contained particles >1 µm comprised of tin, silver, iron, nickel, aluminum, and silicate and nanoparticles (<100 nm) of tin, chromium and nickel; the concentrations of nine of eleven elements in ENDS aerosol were higher than or equal to the corresponding concentrations in conventional cigarette smoke[8].

The World Health Organization (WHO) recommends that ENDS not be used indoors, especially in smokefree environments, in order to minimize the risk to bystanders of breathing in the aerosol emitted by the devices, and to avoid undermining the enforcement of smokefree laws[9]. The National Institute for Occupational Safety and Health (NIOSH) recommends that employers establish and maintain smoke-free workplaces that protect those in workplaces from involuntary, secondhand exposure to tobacco smoke and airborne emissions from ENDS[10].

The American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) also concluded that ENDS and vapor products emit harmful chemicals into the air and need to be

regulated in the same manner as tobacco smoking. "E-cigarettes do not produce a vapor (gas), but rather a dense visible aerosol of liquid sub-micron droplets consisting of glycols, nicotine, and other chemicals, some of which are carcinogenic (e.g., formaldehyde, metals like cadmium, lead, & nickel, and nitrosamines)".[11]

Prohibiting smoking and ENDS use will protect more Connecticut residents from the health effects of secondhand smoke and also support those who are trying to quit. Nonsmokers who breathe secondhand smoke are exposed to many of the same toxins and carcinogens as smokers, and 48% of nonsmoking Connecticut middle and high school students reported breathing secondhand smoke during the past week through the Connecticut School Health Survey. Reducing exposure to tobacco use is another step towards prevention of youth tobacco use, as it denormalizes tobacco use[12]. The less often youth see someone smoking or vaping the less likely they are to start.

Economic evidence indicates that smoke-free policies can reduce healthcare costs substantially. In addition, the evidence shows smoke-free policies do not have an adverse economic impact on businesses, including bars and restaurants[13]. Healthcare costs related to tobacco use in Connecticut are over $2.0 billion each year[14].

[1] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. 2010.

[2] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *STATE System Smoke Free Indoor Air Fact Sheet.* September 30, 2016.

[3] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report to the Surgeon General.* 2006.

[4] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *STATE System Smoke Free Indoor Air Fact Sheet.* September 30, 2016.

[5] American Society of Heating, Refrigeration and Air Conditioning Engineers, Inc. *ASHRAE Position Document on Environmental Tobacco Smoke.* 2010. Reaffirmed June 29, 2019.

[6] National Academies of Sciences, Engineering, and Medicine. 2018. *Public Health Consequences of E-Cigarettes*. Washington, DC: The National Academies Press. doi: 10.17226/24952.

[7] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General.* 2016

[8] Williams, etal. *Metal and silicate particles including nanoparticles are present in electronic cigarette cartomizer fluid and aerosol*" PLoS ONE 8(3): e57987, 2013.

[9] World Health Organization. WHO Framework Convention on Tobacco Control. *Electronic Nicotine Delivery Systems and Electronic Non-Nicotine Delivery Systems (ENDS/ENNDS*). 2016

[10] Centers for Disease Control and Prevention. The National Institute for Occupational Safety and Health (NIOSH). *Current Intelligence Bulletin 67: Promoting Health and Preventing Disease and Injury Through Workplace Tobacco Policies*. April, 2015.

[11] Offermann, Francis B. *The Hazards of E-Cigarettes*. *ASHRAE Journal*, June 2014.

[12] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. *Preventing Tobacco Use Among Youth and Young Adults. A Report of the Surgeon General*. 2012.

Insert language here:

Section 1.

Section 19a-342 of the general statutes as amended by section 17 of Public Act 19-13 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

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

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

(b) (1) Notwithstanding the provisions of section 31-40q, as amended by this act, no person shall smoke: (A) In any area of a building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail [food store] establishment accessed by the general public; (D) in any restaurant; (E) in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22c, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of an establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, and, on and after April 1, 2004, in any area of an establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building or on the grounds of such school; (G) within a child care facility or on the grounds of such child care facility, except, if the child care facility is a family child care home, as defined in section 19a-77, such smoking 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 smoking is prohibited by state law]; (I) in any area of a dormitory in any public or private institution of higher education; or (J) 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; (K) any public housing project, as defined in subsection (b) of section 21a-278a, constructed on or after October 1, 2020; (L) any room offered as an accommodation

to guests by the operator of a hotel, motel or similar lodging. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public, "school" has the same meaning as provided in section 10-154a and "child care facility" has the same meaning as provided in section 19a-342a.

(2) [This section] Subdivision (1) of this subsection shall not apply to [(A) correctional facilities; (B) designated smoking areas in psychiatric facilities; (C) public] the following establishments: (A) Public housing projects, as defined in subsection (b) of section 21a-278a, constructed prior to October 1, 2020; [(D)] (B) any classroom where demonstration smoking is taking place as part of a medical or scientific experiment or lesson; [(E) smoking rooms provided by employers for employees, pursuant to section 31-40q; (F)] (C) notwithstanding the provisions of subparagraph (E) of subdivision (1) of this subsection, the outdoor portion of the premises of any permittee listed in subparagraph (E) of subdivision (1) of this subsection, provided, in the case of any seating area maintained for the service of food, at least seventy-five per cent of the outdoor seating capacity is an area in which smoking is prohibited and which is clearly designated with written signage as a nonsmoking area, except that any temporary seating area established for special events and not used on a regular basis shall not be subject to the smoking prohibition or signage requirements of this subparagraph; [(G)] (D) any medical research site where smoking is integral to the research being conducted; or [(H)] (E) any tobacco bar or tobacco specialist, provided no tobacco bar shall expand in size or change its location from its size and 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, "tobacco specialist" means an establishment engaged in the sale of tobacco products that generates at least seventy-five per cent of its annual gross income from the on-site sale of tobacco products and the rental of on-site humidors, and "tobacco product" means any substance that contains tobacco, including, but not limited to, cigarettes, cigars, pipe tobacco or chewing tobacco.

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

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

[(d)] (c) In each room, elevator, area or building in which smoking is prohibited by this section, the person in control of the premises shall post or cause to be posted in a conspicuous place signs stating

that smoking is prohibited by state law. Such signs, except in elevators, restaurants, establishments with permits to sell alcoholic liquor to consumers issued pursuant to chapter 545, hotels, motels or similar lodgings, and health care institutions, shall have letters at least four inches high with the principal strokes of letters not less than one-half inch wide.

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

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

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

Section 2.

Section 19a-342a of the general statutes as amended by sections 18 and 22 of Public Act 19-13 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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

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

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

[(2)] (3) "Electronic nicotine delivery system" has the same meaning as provided in section 21a-415;

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

[(4)] (5) "Vapor product" has the same meaning as provided in section 21a-415.

(b) (1) No person shall use an electronic nicotine delivery system or vapor product: (A) In any area of a building or portion of a building owned and operated or leased and operated by the state or any political subdivision thereof; (B) in any area of a health care institution; (C) in any area of a retail [food store] establishment accessed by the public; (D) in any restaurant; (E) in any area of an establishment

with a permit issued for the sale of alcoholic liquor pursuant to section 30-20a, 30-21, 30-21b, 30-22, 30-22a, 30-22c, 30-26, 30-28, 30-28a, 30-33a, 30-33b, 30-35a, 30-37a, 30-37e or 30-37f, in any area of establishment with a permit issued for the sale of alcoholic liquor pursuant to section 30-23 issued after May 1, 2003, or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c; (F) [within] in any area of a school building or on the grounds of such school; (G) within a child care facility, or on the grounds of such child care facility, except, if the child care facility is a family child care home as defined in section 19a-77, such use is prohibited only when a child enrolled in such home is present; (H) in any passenger elevator; [, provided no person shall be arrested for violating this subsection unless there is posted in such elevator a sign which indicates that such use is prohibited by state law;] (I) in any area of a dormitory in any public or private institution of higher education; [or] (J) in any area of a dog race track or a facility equipped with screens for the simulcasting of off-track betting race programs or jai alai games; (K) any public housing project, as defined in subsection (b) of section 21a-278a, constructed on or after October 1, 2020; or (L) any room offered as an accommodation to guests by the operator of a hotel, motel or similar lodging. For purposes of this subsection, "restaurant" means space, in a suitable and permanent building, kept, used, maintained, advertised and held out to the public to be a place where meals are regularly served to the public, and "school" has the same meaning as provided in section 10-154a.

(2) [This section] Subdivision (1) of this subsection shall not apply to [(A) correctional facilities; (B) designated smoking areas in psychiatric facilities; (C) public] the following establishments: (A) Public housing projects, as defined in subsection (b) of section 21a-278a, constructed prior to October 1, 2020; [(D)] (B) any classroom where a demonstration of the use of an electronic nicotine delivery system or vapor product is taking place as part of a medical or scientific experiment or lesson; [(E)] (C) any medical research site where the use of an electronic nicotine delivery system or vapor product is integral to the research being conducted; [(F)] (D) establishments without a permit for the sale of alcoholic liquor that sell electronic nicotine delivery systems, vapor products or liquid nicotine containers on-site allow their customers to use such systems, products or containers on-site; [(G) smoking rooms provided by employers for employees, pursuant to section 31-40q; (H)] (E) notwithstanding the provisions of subparagraph (E) of subdivision (1) of this subsection, the outdoor portion of the premises of any permittee listed in subparagraph (E) of subdivision (1) of this subsection, provided, in the case of any seating area maintained for the service of food, at least seventy-five per cent of the outdoor seating capacity is an area in which smoking is prohibited and which is clearly designated with written signage as a nonsmoking area, except that any temporary seating area established for special events and not used on a regular basis shall not be subject to the prohibition on the use of an electronic nicotine delivery system or vapor product or the signage requirements of this subparagraph; or [(I)] (F) any tobacco bar, provided no tobacco bar shall expand in size or change its location 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; authorized owner, business entity and dealer registration has the same meaning as provided in section 21a-415.

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

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

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

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

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

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

Section 3.

Section 31-40q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) As used in this section:

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

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

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

(4) "Business facility" means a structurally enclosed location or portion thereof at which employees perform services for their employer. The term "business facility" does not include: (A) Facilities listed in [subparagraph (A) , (C) or (H) of] subdivision (2) of subsection (b) of section 19a-342, as amended by this act, or subdivision (2) of subsection (b) of section 19a-342a, as amended by this act; (B) any establishment with a permit for the sale of alcoholic liquor pursuant to section 30-23 issued on or before May 1, 2003; (C) for any business that is engaged in the testing or development of tobacco or tobacco products, the areas of such business designated for such testing or development; or (D) during the period from October 1, 2003, to April 1, 2004, establishments with a permit issued for the sale of alcoholic liquor pursuant to section 30-22a or 30-26 or the bar area of a bowling establishment holding a permit pursuant to subsection (a) of section 30-37c.

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

(6) “Electronic nicotine delivery system" has the same meaning as provided in section 21a-415.

(7) "Vapor product" has the same meaning as provided in section 21a-415.

(8) "Any area" means the interior of the facility, building or establishment and the outside area within fifty feet of any doorway, operable window or air intake vent of the facility, building or establishment.

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

[(c)] (b) Each employer [with five or more employees] shall prohibit smoking and the use of electronic nicotine delivery systems and vapor products in any area of any business facility under said employer's control [, except that an employer may designate one or more smoking rooms].

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

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

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

Agency Legislative Proposal - 2020 Session

Document Name: 11.26.19 DPH Tobacco and Electronic Nicotine Delivery Systems (ENDS) Flavor Restrictions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Community, Family Health, and Prevention Section, Tobacco Control Program
Agency Analyst/Drafter of Proposal: Barbara Walsh

Title of Proposal: An Act Restricting Flavor in Tobacco and Electronic Nicotine Delivery Systems Products
Statutory Reference: NEW
Proposal Summary: This proposal will prevent the sale of flavored tobacco products throughout the State of Connecticut in order to reduce youth use of tobacco products; including the use of vaping liquids and devices.

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)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?
(5) What would happen if this was not enacted in law this session?

A lung injury outbreak was identified beginning in August 2019 and is ongoing. The skyrocketing youth and young adult use of vaping products throughout the country has now resulted in nearly 80% (79%) of these lung injuries occurring in those under age 35[1]. Although in many cases the long term effects on lung function for these patients are not known, at least some of these patients will develop chronic lung issues.

The 2017 youth tobacco survey showed that 24.4% of high school seniors in Connecticut were vaping[2], and is it anticipated that the 2019 figure will be even higher. Nationally, the rate increased 78% between 2017 and 2018[3]. With the current estimated trajectory of youth tobacco

use and the severity of the lung injuries that are occurring, the costs for tobacco use will continue to climb. Based on a 20 percent adult and youth tobacco usage rate, it is estimated that tobacco costs Connecticut over $2 billion a year[4].

Flavored tobacco products were developed by the tobacco industry as a way to mask the harsh taste of tobacco, and make the product more appealing to children and youth[5].

After the 2009 passage of the Tobacco Prevention and Control Act, companies renamed cigarettes as cigars in order to retain flavors to continue to attract additional users[6].

Eliminating flavors in all tobacco products, including ENDS and vapor devices, will help to prevent additional and future youth initiation[7].

Data from the 2013-2014 Population Assessment of Tobacco and Health (PATH) study found that 80.8% of 12-17 year olds who had used a tobacco product initiated utilizing a flavored product. At least two-thirds of youth reported using that product "because they come in flavors I like.[8]"

Menthol facilitates early initiation of tobacco products, increases the risks of addiction, and makes cessation more difficult, especially among black smokers.[9]

As stated by the American Academy of Pediatrics "…any regulatory policy that effectively limits youth exposure to flavored e-cigarettes is likely to improve pediatric population health."[10]

[1] Centers for Disease Control and Prevention. *Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Product.* Accessed November 6, 2019, Data as of October 29, 2019.

[2] Connecticut Department of Public Health. Data from the Connecticut School Health Survey, Youth Tobacco Component. 2017.

[3] United States Public Health Service. *Surgeon General's Advisory on E-Cigarette Use Among Youth*. 2018.

[4] U.S. Department of Health and Human Services, Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) System. *Smoking-Attributable Expenditures for Connecticut* (SAE) 2009. Accessible via cdc.gov/oshdata.

[5] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention "Preventing Tobacco Use among Youth and Young Adults: A Report of the Surgeon General". 2012.

[6] Kostygina etal. Tobacco Control Journal: *Tobacco industry use of flavours to recruit new users of little cigars and cigarillos*. 2016; 25: 66–74.

[7] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, "VitalSigns: Tobacco Use by Youth is Rising; E-Cigarettes are the main reason", February 2019. Available at www.cdc.gov/vitalsigns/youth-tobacco-use

[8] Ambrose, etal. Journal of the American Medical Association. Research Letter: *Flavored Tobacco Product Use Among U.S. Youth Aged 12-17 Years, 2013-2014*. November 2015.

[9] Center on Addiction. CASA Columbia White Paper: *Time to Ban Menthol*. 2014.

[10] American Academy of Pediatrics. E-Cigarettes and Similar Devices: Policy Statement. 2019.

◊ **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 Consumer Protection
Agency Contact (*name, title, phone*): Leslie O'Brien
Date Contacted:

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

Summary of Affected Agency's Comments

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

Agency Name: Department of Mental Health and Addiction Services
Agency Contact (*name, title, phone*): Mary Kate Mason
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
Potentially significant costs for enforcement. Please see fiscal note for House Bill 6404 from the 2019 regular session: https://www.cga.ct.gov/2019/FN/pdf/2019HB-06404-R000118-FN.pdf.

Potentially significant sales tax revenue loss from banning products that are currently sold in Connecticut.

Federal None
Additional notes on fiscal impact According to the U.S. Department of Health and Human Services, Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) System, based on a 20 percent adult and youth tobacco usage rate, it is estimated that tobacco costs Connecticut over $2 billion a year. This estimate was issued was prior to the lung injury outbreak of 2019, from which additional long term or chronic conditions are anticipated to result. In order to prevent this cost from continuing to increase each year, stemming the use of tobacco and ENDS products by Connecticut's youth will help to hold these costs to the current level instead of continuing to increase. We know through program evaluations that Connecticut saves $8,595 in health care and lost productivity costs each year for every smoker that quits. Ensuring that additional youth do not start is even more cost effective.

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

None

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. Although flavor restrictions are fairly new, the Centers for Disease Control and Prevention published a study in 2019 that adds flavor restrictions to their best practices for tobacco control programs. Flavors are one of the major reasons that youth use tobacco products, especially since the flavorings hide the harshness of the tobacco and byproducts.

Insert language here:

Section 1.

(NEW) (*Effective July 1, 2020*) (a) As used in this section:

(1) "Cigarette" has the same meaning as provided in section 12-285 of the general statutes;

(2) "Electronic cigarette liquid" has the same meaning as provided in section 53-344b of the general statutes;

(3) "Flavoring agent" has the same meaning as provided in section 20-617a of the general statutes;

(4) "Retail establishment" has the same meaning as provided in section 19a-106a of the general statutes; and

(5) “Tobacco product” has the same meaning as provided in section 12-330a of the general statutes.

(b) On and after January 1, 2021, no retail establishment may sell or offer for sale: (1) electronic cigarette liquid to which a flavoring agent or other extract, compound or concentrate has been added for the purpose of flavoring such liquid; (2) a cigarette that contains menthol; and (3) a tobacco product that contains menthol or any other flavoring agent.

(c) Any retail establishment that violates subsection (b) of this section shall be fined not more than two hundred dollars for the first offense, not more than three hundred fifty dollars for a second offense and not more than five hundred dollars for each subsequent offense. For a third infraction on or before thirty-six months after the date of the first infraction, the commissioner shall revoke any license or registration held by the dealer, distributor, or registrant.

(d) The Commissioner of Mental Health and Addiction Services shall have the power to enforce the provisions of this section.

Agency Legislative Proposal - 2020 Session

Document Name: 12.12.19 DPH Various Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Multiple
Agency Analyst/Drafter of Proposal: Brie Wolf and Jill Kennedy

Title of Proposal: An Act Concerning The Department Of Public Health's Recommendations Regarding Various Revisions To The Public Health Statutes
Statutory Reference: Section 1. Section 73 of Public Act 19-117 Section 2. Section 74 of Public Act 19-117 Section 3. Sec. 8-3i. Notice to water company re projects within aquifer protection area or watershed of water company. Section 4. Sec. 22a-42f. Notice of application to water company re conduct of regulated activities within watershed of water company. Section 5. Sec. 19a-111. Investigation. Preventive measures. Relocation of families. Reports. Regulations. Section 6. Sec. 19a-37. Regulation of water supply wells and springs. Definitions. Information and requirements re testing of private residential wells or wells for semipublic use. Transportation of water in bulk by bulk water hauler. Section 7. Sec. 19a-524. Citations issued for certain violations. Section 8. Sec. 19a-491c. Criminal history and patient abuse background search program. Regulations. Section 9. Sec. 19a-177. Duties of commissioner. Section 10. Sec. 20-207. Definitions. Section 11. Sec. 20-212. Embalming, care and disposal of bodies restricted. Section 12. Sec. 20-213. Embalmer's license. Examination. Fee. Out-of-state licensees. Section 13. Sec. 20-215. Affidavit re preparation or embalming of body. Section 14. Sec. 20-217. Funeral director's license. Examination. Fee. Out-of-state licensees. Section 15. Sec. 20-224. Employment of assistants and students. Apprentice registration. Section 16. Sec. 20-226. Lists of licensees and students to be filed with town clerks. Section 17. Sec. 20-195dd. Qualifications. Section 18. Sec. 20-195c. Qualification for licensure. Fees.

Section 19. Sec. 20-266n. Definitions.
Section 20. Sec. 20-266o. Licenses. Qualifications. Renewal. Exceptions. Regulations.
Section 21. Sec. 19a-14. Powers of department concerning regulated professions.
Section 22. Sec. 20-204a. Allegations of wrongdoing, investigation by department. Owner of animal not third party to investigation for purposes of disclosure of investigation.
Section 23. Sec. 7-62b. Death certificates; filing and registration; responsibilities of funeral directors and licensed embalmers; medical certification; burial of person who died from communicable disease; "presumptive" death certificates; regulations.
Section 24. Sec. 19a-200. City, borough and town directors of health. Sanitarians. Authorized agents.
Section 25. 19a-202a. Requirements re municipality designating itself as having a part-time health department. Regulations.
Section 26. 19a-244. Qualifications, term and duties of the director of health. Employees.
Section 27. 19a-12a. Professional assistance program for regulated professions. Definitions. Program requirements. Referrals to Department of Public Health. Notification of disciplinary action against program participants. Annual reporting requirements. Confidentiality. Annual audit.
Section 28. 19a-12d. Commissioner of Public Health to transfer certain revenue to professional assistance program account.
Section 29. 19a-12e. Petition re inability of health care professional to practice with reasonable skill or safety. Report re arrest or disciplinary action. Investigation. Disclosure. Procedure.
Section 30. 20-185k. Behavior analysts. License applications. Renewals.
Section 31. Sec. 17a-412. Report of suspected abuse, neglect, exploitation or abandonment. Penalty for failure to report. Confidentiality. Immunity and protection from retaliation. Notification requirements. Registry.
Section 32. Sec. 17b-451. Report of suspected abuse, neglect, exploitation or abandonment or need for protective services. Penalty for failure to report. Immunity and protection from retaliation. Training program.
Section 33. Sec. 19a-6o. Palliative Care Advisory Council. Duties. Members. Report.
Section 34. Sec. 19a-6q. Chronic disease plan. Report.
Section 35. Sec. 19a-493. Initial license and renewal. Prior approval for change in ownership. Multicare institution. Regulations.
Section 36. (NEW)
Section 37. Sec. 19a-343. State action to abate public nuisance. Offenses.
Section 38. Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care.
Section 39. Sec. 19a-131g. Public Health Preparedness Advisory Committee.

Proposal Summary:
Sections 1 and 2. Amend Sections 73 and 74 of Public Act 19-117 to remove the population requirements for the replacement of an existing well.

Sections 3 and 4. Streamline and reduce the receipt of notifications for projects in public drinking water watersheds and aquifer protection areas.

Section 5. Requires that local health departments and districts to use the MAVEN surveillance system to electronically report lead home inspection findings and follow up activities that address elevated blood lead levels.

Section 6. Revises the definition of “private well” to add specificity to the population type served by a private well to reflect that it pertains to residential settings, and replace the term “private residential well” with the newly-defined term “private well” throughout the section.

Section 7. Allows the Department to submit citations to nursing home facilities and residential care homes electronically, as well as by certified mail.

Section 8. Makes a technical change to allow, when necessary, a temporary suspension of a long-term care facility’s requirement to process individuals through the background search program, ABCMS, as a result of a significant disruption to internet capabilities, ABCMS functionality or state or long-term care facility workforce.

Section 9. Allows the Department to waive certain statutes and regulations pertaining to Emergency Medical Services (EMS) organizations when the health, safety and welfare of Connecticut’s residents would not be jeopardized.

Sections 10 through 16. Change the title of "student embalmer and "student funeral director" to “registered apprentice embalmer” or a “registered funeral director embalmer” to make clear that such person may register with Department as an apprentice.

Section 17. Amends the professional counselor statutes to ensure all persons eligible for either a professional counselor license or professional counselor associate license are able to apply and obtain their license.

Section 18. Amends the statute regarding renewal of marriage and family therapist license by revising the educational requirement for marriage and family therapy associates for consistency purposes.

Sections 19 and 20. Amend the statute regarding licensure of tattoo technicians to require supervised practical training and completion of Connecticut’s infection prevention and control plan guidelines.

Sections 21 and 22. Provide a pet owner who files a complaint on a veterinarian access to the investigation file when the case is closed with no findings.

Section 23. Requires several licensed practitioners to use Connecticut's electronic death registry when certifying a death certificate.

Sections 24 through 26. Make revisions to the statutes pertaining to local health departments and districts.

Sections 27 through 30. Add licensed behavior analysts to the list of health care providers who contribute to the professional assistance program, and increase the annual license renewal fee by $5.00.

Sections 31 and 32. Add licensed behavior analysts to the list of health care providers that are mandated reporters.

Section 33. Transfers the authority for appointing Palliative Care Advisory Council members to the Commissioner of Public Health if a seat is vacant for one year, and adjusts the annual reporting requirement to a biennial basis.

Section 34. Removes the chronic disease reporting requirement.

Section 35. Offers a technical revision to make clear when a change of ownership takes place in a facility.

Section 36. Removes the regulatory requirements for persons who provide direct patient care in home health and hospice, assisted living, infirmaries, recovery care centers and in-hospital recovery care centers settings to have an annual screening for Tuberculosis.

Section 37. Inserts new Fire Prevention Code references to the public nuisance statute. The repealed sections were in fact deleted from (19a-343 (c) (11)), but were not replaced with new references.

Section 38. Adds a definition of sexual assault nurse examiner and expands the definition of health care facility.

Section 39. Provides members of the Public Health Preparedness Advisory Committee with the authority to appoint a designee.

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)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

Sections 1 and 2.

This proposal amends Sections 73 and 74 of Public Act 19-117 to remove the population requirements for the replacement of an existing well. Currently, only a town in southeastern Connecticut with a population between fifteen thousand and fifteen thousand three hundred, as enumerated by the 2010 federal decennial census, is eligible for such replacement well. The proposal expands this replacement well provision to include other wells in Connecticut. This would permit the installation of a replacement well that does not meet the sanitary radius and minimum setback requirements as specified in the regulations of Connecticut state agencies when such well is necessary for the water company to maintain and provide to its consumers a safe and adequate water supply.

Sections 3 and 4.

This proposal will ensure that the Commissioner of Public Health receives notification of 1) projects to change the regulations, boundaries or zoning district classifications that may have an impact on a public drinking water watershed or aquifer protection area only for those projects on five or more acres; 2) regulated activity upon an inland wetland or watercourse within the watershed of a water company that may have an impact on a public drinking water watershed or aquifer protection area only for those projects on five or more acres or is for commercial or industrial use.

Currently, the Commissioner receives notification on all projects. This proposal will streamline the notification process to ensure that DPH receives only notification of those projects that may have a potential impact to public drinking water sources. This will focus DPH's limited staff and resources on the projects that could be a concern for public drinking water sources, and will also save time and money in local planning and zoning commission proceedings by removing the mandate to notify the Department of every project.

Section 5.

This proposal would require that local health departments and districts to use the MAVEN surveillance system to electronically report lead home inspection findings and follow up activities

that address elevated blood lead levels. A centralized collection mechanism will allow DPH staff to better track incidents of elevated blood lead levels, monitor lead abatement activities, confirm patient follow up and analyze data trends for epidemiological purposes. It will also bolster communication among Lead Poisoning Prevention and Radon Program and local health departments and districts on enforcement of the regulations governing lead abatement. The Department of Public Health will work with local health directors and recognized professional medical groups to develop guidelines consistent with the National Centers for Disease Control and Prevention for assessment of the risk of lead poisoning, screening for lead poisoning and treatment, and follow up care of individuals.

Section 6.

This proposal would revise the definition of "private well" to add specificity to the population type served by a private well and reflect that it pertains to residential settings. This proposal will also replace the term "private residential well" with the newly-defined term "private well" throughout the section. The term "private well" is terminology that has been used by DPH, local health departments and other state agencies for several years. The proposal will align terminology in statute with common vernacular.

Section 7.

Allows the Department to submit citations to nursing home facilities and residential care homes electronically, as well as by certified mail. The Department issues citations by certified mail only, but has been transitioning to automated systems that will generate and issue the violations through an electronic platform when non-compliance with the Regulations of the Connecticut State Agencies has been identified. This proposal will modernize current practice, will promote greater efficiencies and will generate a cost saving as the expenses associated with certified mail will be significantly reduced. All nursing home facilities have the ability to receive electronic communications from the Department, while only some residential care homes are able to receive electronic information. Therefore, the process of corresponding through certified mail must be maintained until such time that all facilities have the capability to receive electronic notice from the Department.

Section 8.

This proposal makes a technical change to 19a-491c to allow, when necessary, a temporary suspension of a long-term care facility's requirement to process individuals through the background search program, ABCMS, as a result of a significant disruption to internet capabilities, ABCMS functionality or state or long-term care facility workforce.

The ABCMS is currently operating under policies and procedures, absent regulations. Regulations to govern the program have been drafted and are undergoing review. The DPH policies and procedures for this long-term care background check program contain a provision for the temporary suspension of the web-based long-term care background search program in limited emergency circumstances. The "emergency suspension" language contained within ABCMS policies and procedures allows for a sixty-day "grace period" for processing background checks in certain emergency circumstances, if determined by the DPH. This policy was crafted with input and approval by the Office of Policy and Management, Governor's Office (prior administration) and long-term care industry. It is viewed as an important provision to address possible widespread internet system crashes, natural disasters, pandemics or other significant workforce disruptions that may, temporarily, hinder the ability to conduct full fingerprint-based background searches.

The Office of the Attorney General, in reviewing the program's established policies and procedures for adoption as regulation, recently suggested that section 19a-491c contain some express statutory language allowing for such temporary suspension in regulation.

Section 9.

This proposal allows the Department to waive certain statutes and regulations that pertain to EMS organizations when the health, safety and welfare of Connecticut's residents would not be jeopardized. Section 19a-495 allows the Department to waive regulations pertaining to licensed health care facilities when we determine that such request will not jeopardize the health, safety and welfare of the patients. This proposal will afford the same opportunity to EMS organizations.

There have been several instances where the Department is required by law to take an ambulance off line for something minor, such as a decal not being replaced correctly, or an issue with an older ambulance needing to be retrofitted. The Department does not want to prohibit an EMS organization from their life saving activities because of such minor outstanding issues.

The Department has been made aware of another pressing issue pertaining to national drug shortages. Ambulances are required to have certain medications, which may not be available due to a national shortage. For example, section 19a-197a requires all EMS personnel to be trained and all ambulances be equipped with automatic prefilled cartridge injectors for epinephrine. However, there is a national shortage of these automatic prefilled cartridge injectors, so the Department would like the ability to waive this requirement and create protocols and training on the use of either a prefilled syringe or non-prefilled syringe of epinephrine for EMS personnel. The ambulances that cannot obtain these products are considered out of compliance with regulations and are unable to operate.

Sections 10 through 16.

This proposal revises the title given to students enrolled in a program studying the funeral service business by replacing "student embalmer and "student funeral director" with “registered apprentice embalmer” or a “registered funeral director embalmer” to clarify that such person may register with Department as an apprentice. Additionally the proposal delineates that a student enrolled in an embalming program can perform up to ten embalmings under the supervision of a licensed embalmer. This is common practice and a requirement to graduate from an accredited embalming program.

During a recent prosecution of a complaint regarding funeral directors and embalmers, it became clear that there are inconsistencies within the statutory language as it relates to apprentices and students. For example, “student embalmer” and “student funeral directors” are defined as “a person studying the funeral service business and registered with the Department of Public Health as an apprentice…” However, in order to be an apprentice, one must have already graduated from a program. Due to the current language in the statute, there is confusion as to whether a “student” is someone in school, or someone eligible to be an apprentice.

These revisions will create clear and consistent terminology in statute for embalming and funeral directing apprentices and will clarify that students enrolled in an accredited embalming school are able to gain embalming experience while enrolled in school.

Section 17.

This proposal amends the professional counselor statutes to ensure all persons eligible for either a professional counselor license or professional counselor associate license are able to apply and obtain their license. Public Act 19-117 established a licensure category for professional counselor associates. The Act repeals grandfathering language that allowed applicants for a professional counselor license, who matriculated in a master’s program on or before July 1, 2017, to apply for licensure without completing a 100 hour practicum and a six-hundred-hour internship. The Department agreed to this carve out for students who began a graduate program that did not meet the new standards for licensure that were enacted in 2017. As written, these applicants will not qualify for either professional counselor or professional counselor associate license because they have not completed the practicum and internship. The Department would like to afford all graduates of licensed professional counselor programs with the opportunity to gain licensure and work experience so they can be employed.

Additionally, the Connecticut Nonprofit Alliance, Clifford Beers, Wellmore, and several legislators reached out to the Department to highlight that some of the staff they employ do not meet the qualifications for LPCA or LPC licensure. Some providers have been working in perpetuity under the supervision of a LPC. These unlicensed providers completed their master's degree before 2007, prior to passage of Section 47 of Public Act 07-252, which increased the number of required graduate semester hours from 42 to 60. Other unlicensed providers graduated from masters programs that require less than sixty semester hours to graduate. This section removes the sixty semester hour requirement for a LPCA. It also removes the 100 hour practicum, a six-hundred-hour internship requirement and additional coursework requirements that came to fruition in 2017 through Public Act 17-94.

Section 18.

This proposal seeks to revise the educational requirement for marriage and family therapy associates (MFTA) for consistency purposes. Public Act 19-117 established a MFTA licensure category. The statutory language was written so that educational requirements for a MFTA and MFT are inconsistent.

An applicant for a MFTA needs a master's degree and verification from a supervising licensed marital and family therapist that the applicant is working toward completing the postgraduate experience to become a MFTA. An applicant for a MFT needs a master's degree, supervised practicum, postgraduate experience provided by a licensed MFT and must have passed the exam. As a result, a person could be issued a MFTA license, but then not be eligible for a MFT license because they had not completed the practicum.

Sections 19 and 20.

This proposal would revise the tattoo technician license and temporary permit requirements as follows:
(1) Require an applicant for an initial license to complete at least 2000 hours of practical training and experience as a student tattoo technician under the supervision of a licensed tattoo technician with at least five years' experience;
(2) Prohibit a supervising tattoo technician from overseeing more than 2 students;
(3) Incorporate minimum standards for a supervising tattoo technician and require the supervising tattoo technician to maintain records on each student for a period of 3 years; and
(4) Require individuals applying for initial or renewed licensure or licensure by endorsement (i.e., those licensed in other states) comply with DPH's infection prevention and control plan guidelines and sign a form attesting to their adherence.

The Department always felt that the statute was very vague and difficult to enforce. This proposal will provide clarification for tattoo technicians, local health departments, and DPH in our shared efforts to promote public health and safety in the tattoo industry. The Department was grateful to collaborate with members of the Connecticut Association of Professional Tattooers on these revisions.

In 2019, Senate Bill 1058 incorporated these revisions and was introduced on behalf of the industry. It passed the Senate chamber as amended by Senate Amendment A, but did not pass the House. Discussions with members of the House during the last few days of session showed support for the bill. The Department is unclear as to why the bill did not move forward. We are very supportive of this initiative.

Sections 21 and 22.

This proposal will make it possible for a pet owner who files a complaint on a veterinarian to have access to the investigation file when the case is closed with no findings. This would align the rights of a petitioner in closed veterinary cases with those of petitioners in closed physician cases.

Typically, when someone files a complaint against a licensed practitioner, and an investigation concludes with no findings, the statutes allow the individual who filed the complaint permission to review the file to learn why the case was closed without any findings or without proceeding to licensure discipline. Closed cases on veterinarians are the only exception to this rule. The Department believes that pet owners who file a complaint against a veterinarian should have at least the same access to closed case files as individuals who file complaints against other practitioners such as physicians, dentists, psychologists, etc.
The complainants in these veterinary cases are understandably frustrated that they filed a complaint worthy enough for an investigation, but are unable to obtain any follow up information without the permission of the veterinarian when the case was closed with no findings.

The legislature recently passed Public Act 17-168 with the intention of providing access to the records of closed veterinary cases to pet owners. The Department had the opportunity to review the language and provide feedback during the 2017 session. The Department recognized that the draft language did not have the intended effect and provided alternative language. The DPH's suggestion was not adopted and the Act continued to leave pet owners without the ability to review closed veterinary case records.

Section 23.

This proposal will require health care practitioners and funeral directors to use Connecticut's electronic death registry when certifying a death certificate. Birth, marriage, death and fetal death data is used by the National Center for Health Statistics, the Department of Public Health,

local health departments and other independent researchers to conduct health related studies and to guide public policy in improving the health of our citizens. The data is shared at no cost with several DPH programs (Immunization Registry, Tumor Registry, Maternal Mortality Review Committee and opioid overdose syndrome surveillance (SWORD) as well as numerous state and federal agencies (Department of Social Services, Department of Children and Families, Department of Developmental Services, Department of Mental Health ad Addiction Services, Department of Aging and Disability Services, Department of Emergency Services and Public Protection, US and CT Departments of Labor, Comptroller, Treasurer, Judicial Department, Auditors of Public Accounts, Teacher's Retirement Board, Office of the Chief Medical Examiner, US Department of State, US Office of Personnel Management, et al.). Given the significant role that vital statistics plays in the public health arena and providing support data to other state agencies, it is critical that the state of Connecticut continue to modernize its vital records systems to produce accurate and timely data.

In addition to improving timely data for medical and public health research, modern electronic registries will also assist in combatting fraud related to misuse of birth certificates of deceased persons by allowing a timely birth-death match, and assist in the prevention and detection of marriage fraud crimes.

Sections 24 through 26.

Make technical revisions to the statutes pertaining to local health departments and districts. The proposal will
(1) reorganize the language of the section into subsections to clarify intent;
(2) insert language on approval of municipal director of health appointments consistent with district health departments (CGS 19a-242);
(3) include a clause requiring a municipality that hires a director of health to also submit the required written employment agreement to the DPH; and
(4) revise the statute to include the requirement that district health departments submit an annual report to ensure consistency with the requirement for municipal health departments.

Sections 27 through 30.

Add licensed behavior analysts to the list of health care providers eligible for the professional assistance program outlined in statute, and increase the annual license renewal fee by $5.00, which will be deposited into the professional assistance program account. This process mirrors that for all other professions eligible for the professional assistance program. Senate Bill 923, was introduced during the 2019 session and would have required behavioral analysts to contribute five dollars to the health professional assistance program (HAVEN) during their licensure renewal. This bill died in the House Chamber.

Sections 31 and 32.

Add licensed behavior analysts to the list of health care providers that are mandated reporters. The behavior analysts were inadvertently omitted from the language that passed on Public Act 19-120.

Section 33.

This proposal would allow the Commissioner to appoint a position to the Palliative Care Advisory Council if such position has been vacant for more than one year. Due to long term vacancies, the council has difficulty achieving a quorum at their meetings. The proposal also revises the annual reporting requirements to a biennial basis, as the council does not have enough activity to report on a yearly basis. Similar revisions were made to the School Based Health Center Advisory Council through Section 1 of Public Act 19-118.

Section 34.

In 2018 the Auditors of Public Accounts cited the Department for not submitting the report required pursuant to CGS 19a-6q. During the 2019 session the Department worked to amend the statute to align the reporting with the Centers for Disease Control and Prevention (CDC) 6/18 Initiative. The hope was that staff would have the opportunity to craft this report if the data given to the federal government could be used to generate this state required report. Staffing issues have remained unchanged and reporting is not feasible, therefore we are requesting repeal of this requirement.

Section 35.

Makes a technical revision, at the suggestion of the Attorney General's Office, to ensure the statute clearly captures when a change of ownership takes place in a facility.

Section 36.

This proposal would remove the regulatory requirements for persons who provide direct patient care in the home health and hospice, assisted living, infirmaries, recovery care centers and in-hospital recovery care centers settings to have an annual screening for Tuberculosis (TB).

The Centers for Disease Control and Prevention (CDC) recommendations changed in January 2019 to no longer require yearly blood tests. Instead, CDC recommends all healthcare personnel with direct patient contact be screened for TB upon their hire, based on the new CDC TB risk assessment guidelines. They are not recommending annual testing unless there is a known exposure or ongoing transmission at a healthcare facility. Healthcare personnel with untreated latent TB infection should receive an annual TB symptom screen. All healthcare facilities should follow the CDC guidelines for post-exposure screening and testing when healthcare personnel are exposed to TB.

When regulations regarding TB testing were put in place in the 1990's, the recommendation from CDC was to have every healthcare professional with direct patient contact to obtain an annual TB test to ensure any transmission of TB could be contained. However, as with most diseases, incidence of TB has been drastically reduced since this recommendation was put in place many years ago. DPH currently has five sets of regulations outlining the annual TB testing requirement for healthcare professionals, which would need to be updated.

The Department would like a statutory fix that would negate the TB testing requirements in the regulations. The Department has heard from several infirmaries, including UCONN Health Center, that the testing is expensive and time consuming. In light of the new CDC recommendations, the Department would like all licensed healthcare facilities to review their current policies regarding TB screening to ensure they are following the latest recommendations from CDC.

Section 37.

Public Act 17-80, An Act Concerning Recommendations By The Office of the State Fire Marshal Regarding The State Fire Prevention Code and Licenses for Demolition repealed sections 29-320, 29-329, and 29-337, which were referenced in 19a-343(c) (11). The sections were repealed because the statutes, which were once directives for standalone regulations on different subjects, had been amended to direct the content be included in the Fire Prevention Code. Once the subjects were included in the code, the statutes directing such inclusion were not necessary and, as a result, were repealed.

The repealed sections were in fact deleted from the public nuisance statute (19a-343 (c) (11)), but were not replaced with the appropriate Fire Prevention Code references.

The statute sections referencing the Fire Prevention Code (29-291a and 29-291c) should be included in 19a-343(c) (11). Omitting the Fire Prevention Code statutes from the list, inadvertently omits the violations for flammable or combustible liquids (29-320) from the list of offenses that could constitute a public nuisance.

Section 38.

Public Act 19-114 expanded the current Sexual Assault Forensic Examiners (SAFE) Training Program so that victims of sexual assault have greater access to a trained sexual assault forensic examiner. This revises the Act to insert a definition of sexual assault nurse examiner and expand the definition of health care facility to include the Yale University Health Services infirmary as one of the locations where emergency treatment may be given to a victim of sexual assault.

Section 39. Provides members of the Public Health Preparedness Advisory Committee with the authority to appoint a designee so that the advisory committee can achieve a quorum and meet to review plans for responses to a public health emergencies.

◊ **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?

Several sections were introduced in previous sessions.

Sections 1 and 2. Seek to amend Sections 73 and 74 of Public Act 19-117 to remove the population requirements for the replacement of an existing well.

Section 6. The definition of "water supply well" is outlined in two sections of statute (CGS 19a-37 and CGS 25-126). Section 22 of Public Act 19-118 modified the definition "water supply well" to align the terms and help DPH and DCP coordinate the drafting of the private well and geothermal well sets of regulations. We are opening the same section of statute for this revision.

Section 17. Seeks to amend Section 165 of Public Act 19-117, which established a licensure category for professional counselor associates.

Section 18. Seeks to amend Section 170 of Public Act 19-117, which established a licensure category for marriage and family therapists.

Sections 19 and 20. Modifications to the licensure qualifications for tattoo technicians was introduced by the industry last year through Senate Bill 1058 to enhance health and safety

practices in the profession. Unfortunately, this bill did not make it through both chambers before the regular session ended.

Sections 21 and 22. Revisions to the veterinarian complaint process passed in Public Act 17-168 Proponents of this law included the late Representative Eziquiel Santiago, former Representative Diana Urban, Representative Robert Sanchez and Senator Martin Looney. There have also been a number of pet owners who supported this change. Staff from the Department met with former Representative Diana Urban following passage of the Act to discuss the shortcomings.

Sections 24 through 26. The provision in Section 26 of this proposal that requires districts of health to submit a report of their activities to the Commissioner was first introduced in Section 4 of House Bill 5150 from the 2018 session. That bill did not make it back to the House Chamber after being referred to the Planning and Development Committee.

Sections 27 through 30. Senate Bill 923 was introduced during the 2019 session by the behavior analysts and would have required the professional to contribute five dollars to the health professional assistance program (HAVEN) during their licensure renewal. Unfortunately, this bill did not make it through both chambers before the regular session ended.

Section 34. Section 21 of Public Act 19-118 amended CGs 19a-6q to align the reporting with the Centers for Disease Control and Prevention (CDC) 6/18 Initiative. The hope was that staff would have the opportunity to craft this report if the data given to the federal government could be used to generate this state required report. Staffing issues have remained unchanged and reporting is not feasible, therefore we are requesting repeal of this requirement.

Section 35. Section 5 of Public Act 19-118 extended the time frame from 90 days to 120 days to process criminal background check when a change in ownership has taken place at a health care facility. The Department hope to make a technical revision, at the suggestion of the Attorney General's Office, to ensure the statute clearly captures when a change of ownership takes place in a facility.

Section 37. Public Act 17-80 repealed sections 29-320, 29-329, and 29-337, which were referenced in 19a-343(c) (11). They must now be replaced with the new Fire Prevention Code references.

Section 38. Public Act 19-114 expanded the current Sexual Assault Forensic Examiners (SAFE) Training Program so that victims of sexual assault have greater access to a trained sexual assault forensic examiner. This revises the Act to insert a definition of sexual assault nurse examiner and expand the definition of health care facility to include the Yale University Health Services

infirmary as one of the locations where emergency treatment may be given to a victim of sexual assault.

PROPOSAL IMPACT

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

Agency Name: Department of Energy and Environmental Protection – Sections 1 through 4 **Agency Contact (*name, title, phone*):** Mandi Careathers **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Consumer Protection – Section 6 **Agency Contact (*name, title, phone*):** Leslie O'Brien **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Emergency Services and Public Protection – Sections 8 and 39 **Agency Contact (*name, title, phone*):** Scott Devico **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Social Services – Sections 31 and 32 **Agency Contact (*name, title, phone*):** David Seifel **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: University of Connecticut Health Center/John Dempsey Hospital – Section 35 **Agency Contact (*name, title, phone*):** Kelly Sinko **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

Agency Name: Department of Administrative Services – Section 37 **Agency Contact (*name, title, phone*):** Erin Choquette **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments

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

Agency Name: Judicial Branch – Section 38 **Agency Contact (*name, title, phone*):** Doreen Del Bianco and Brittany Kaplan **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)* Section 5. Access to MAVEN has already been provided to all local health departments and districts to use on a voluntary basis , so this will not have a fiscal impact on municipalities. Local health staff only need access to a computer and a MAVEN account. Sections 24 through 26. Will require the mayor or chief executive official of a municipality to provided evidence that a candidate for municipal director of health fulfills the statutory criteria for such appointment. The city or town must also submit the director's written employment agreement to DPH. Districts of Health will now submit the same activity report that Departments of Health provide to DPH. Although there is no cost to implement these provisions, it would be considered a mandate on a municipality.
State Section 7. Will generate a minimal cost savings to the state as the expenses associated with sending citations through certified mail will be reduced. Sections 27 through 29. Approximately $3,840 will be transferred annually into the professional assistance account. There are currently 768 behavioral analysts licensed in Connecticut.
Federal Section 23. Improving the timeliness of reporting death data will allow the State to receive maximum reimbursement from the Social Security Administration. They reimburse states on a

sliding scale for death verification work. The faster data is reported the larger the reimbursement amount. The amount of revenue this could generate is unknown.
Additional notes on fiscal impact None.

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

Sections 3 and 4. Streamline the notification process to ensure that DPH receives only notification of those projects that may have a potential impact to public drinking water sources. This will focus DPH's limited staff and resources on the projects that could be a concern for public drinking water sources, and will also save time and money in local planning and zoning commission proceedings by removing the mandate to notify the Department of every project.

Section 5. Requires that local health departments and districts to use the MAVEN surveillance system to electronically report lead home inspection findings and follow up activities that address elevated blood lead levels. A centralized collection mechanism will allow DPH staff to better track incidents of elevated blood lead levels, monitor lead abatement activities, confirm patient follow up and analyze data trends for epidemiological purposes.

Section 7. Submitting citations to nursing home facilities and residential care homes electronically will result in a reduction in staff processing time and will provide a more efficient delivery of information. Currently, receipt of documents by the facility is validated when the Department receives notification by the United States Postal Service (USPS). However, validation can be easily accomplished with an electronic read receipt. There will be a cost savings to the state as documents will no longer need to be processed through certified mail with the USPS.

Sections 21 and 22. Makes the veterinarian complaint and investigation process more transparent to pet owners who file a complaint. The Department often deals with angry or disappointed pet owners who are unable to see the records that determined the outcome their complaint. The perception is often that the Department is “covering something up” or didn’t conduct a thorough investigation. The staff in the investigations unit often wish they could afford these complainants the same access allowed to complainants in all other cases. It seems fair that a complainant should at least be able to review the records and report that led to the final determination.

Section 23. The registry will save staff time by eliminating dual data entry. It takes three months to receive and make death data available. Currently, both DPH staff and a contracted vendor manually key in death certificate information. Additionally, funeral directors submit a separate

form to the Social Security Administration to verify a decedent's social security number. The registry will streamline the process for all parties submitting death data.

◊ EVIDENCE BASE

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Section 8. Protracted periods where the ABCMS program is not operational, such as a result of significant internet or computer disruption, or emergency events or labor disputes that might create substantial disruptions to both state and private workforce staffing, could have a significant impact on the healthcare workforce in emergent circumstances; thereby restricting timely care provided to patients and clients.

Should an emergency suspension of the ABCMS be required, any such suspension would be entirely in the discretion of the DPH upon assessment of the particular circumstances. Any individual with access to residents during such emergency suspension would be required to have direct, on site supervision by other staff during such period. The DPH would monitor any patient abuse, neglect or misappropriation of funds, complaints or reportable events in the healthcare facilities to ensure there is not a direct correlation to a direct patient care staff member, hired without a background check.

Any such emergency suspension would be for a period not to exceed 60 calendar days. Once the program became operational after the emergency, all affected staff would be required to obtain their background check within 14 calendar days.

Section 9. As part of the Quality Assurance And Performance Improvement Program, the Department will monitor the number of waivers granted and determine if there is a cost savings to the EMS organization and the impact to health and safety of Connecticut's residents.

Sections 10 through 16. Clarifying the terminology around funeral director and embalmer apprenticeships will lead to less confusion in interpreting the statutes, and will ensure students are able to fully participate in their educational program.

Section 17. The Department has heard from several mental health provider organizations and their staff who are not eligible for the professional counselor associate license because they assumed that since they started their educational program in counseling prior to July 1, 2017, they would not have to meet the new educational requirements as were enacted pursuant to the provisions of Public Act 19-177. This proposal will ensure all qualified individuals will have the opportunity to obtain their license and provide the much needed mental health services. The

Department anticipates this will increase the number of qualified mental health providers and will allow for individuals to obtain their license and to mitigate this unintended consequence of the passage of Public Act 19-177.

Sections 19 and 20. Since the inception of licensure of tattoo artists, the department has received many complaints regarding unsanitary conditions and lack of training for tattoo technicians. The language in the current statute uses vague terms that can be left to the interpretation of each individual person. Over the past several years, the Department has not been able to take regulatory action due to this ambiguous language. These revisions will help clarify the role of the tattoo technician, supervising tattoo technician, student tattoo technician and local health departments. With this language in place, the Department will spend less time investigating allegations of misconduct because we will have clarification as to the actions that need to be taken.

There are 48 states have laws addressing some aspect of body art and tattooing, and 38 states have comprehensive body art and tattooing laws, similar to what Connecticut is proposing. Some of these states include: Alaska, California, Delaware, Florida, Maine, New Hampshire, New York, Rhode Island, the District of Columbia and many more. Information regarding other state's laws can be found on the National Conference of State Legislature's website: http://www.ncsl.org/research/health/tattooing-and-body-piercing.aspx.

Section 23. Increasing number of electronically filed death certificates will improve timeliness and accuracy of death data.

Section 35. The removal of the annual testing requirement of health care providers for Tuiberculosis will provide some relief both financially and administratively to the institutions named in the regulations. Additionally, this revision will align the requirements to meet the national benchmarks set by the Centers for Disease Control and Prevention.

Insert language here:

Section 1.

Section 73 of Public Act 19-117 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

Notwithstanding any provision of title 19a or 25 of the general statutes [and not later than March 1, 2020], a director of health of a town, city or borough or of a district department of health appointed pursuant to section 19a-200 or 19a-242 of the general statutes may issue a permit for a replacement public well if the Department of Public Health has approved such replacement public well pursuant to

subsection (b) of section 25-33 of the general statutes. For purposes of this section, "replacement public well" means a public well that (1) replaces an existing public well [in a town in southeastern Connecticut with a population between fifteen thousand and fifteen thousand three hundred, as enumerated by the 2010 federal decennial census], and (2) does not meet the sanitary radius and minimum setback requirements as specified in the regulations of Connecticut State Agencies.

Section 2.

Subsection (b) of section 25-33 of the general statutes, as amended by Section 74 of Public Act 19-117, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) No system of water supply owned or used by a water company shall be constructed or expanded or a new additional source of water supply utilized until the plans therefor have been submitted to and reviewed and approved by the department, except that no such prior review or approval is required for distribution water main installations that are constructed in accordance with sound engineering standards and all applicable laws and regulations. A plan for any proposed new source of water supply submitted to the department pursuant to this subsection shall include documentation that provides for: (1) A brief description of potential effects that the proposed new source of water supply may have on nearby water supply systems including public and private wells; and (2) the water company's ownership or control of the proposed new source of water supply's sanitary radius and minimum setback requirements as specified in the regulations of Connecticut state agencies and that such ownership or control shall continue to be maintained as specified in such regulations. If the department determines, based upon documentation provided, that the water company does not own or control the proposed new source of water supply's sanitary radius or minimum setback requirements as specified in the regulations of Connecticut state agencies, the department shall require the water company proposing a new source of water supply to supply additional documentation to the department that adequately demonstrates the alternative methods that will be utilized to assure the proposed new source of water supply's long-term purity and adequacy. In reviewing any plan for a proposed new source of water supply, the department shall consider the issues specified in this subsection. The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this subsection and subsection (c) of this section. For purposes of this subsection and subsection (c) of this section, "distribution water main installations" means installations, extensions, replacements or repairs of public water supply system mains from which water is or will be delivered to one or more service connections and which do not require construction or expansion of pumping stations, storage facilities, treatment facilities or sources of supply. Notwithstanding the provisions of this subsection, the department may approve any location of a replacement public well, if such replacement public well is (A) necessary for the water company to maintain and provide to its consumers a safe and adequate water supply, (B) located in an aquifer of adequate water quality determined by historical water quality data from the source of water supply it is replacing, and (C) in a more protected location when compared to the source of water supply it is

replacing, as determined by the department. For purposes of this subsection, "replacement public well" means a public well that (i) replaces an existing public well [in a town in southeastern Connecticut with a population between fifteen thousand and fifteen thousand three hundred, as enumerated by the 2010, federal decennial census], and (ii) does not meet the sanitary radius and minimum setback requirements as specified in the regulations of Connecticut state agencies.

Section 3.

Section 8-3i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) As used in this section “water company” means a water company, as defined in section 25-32a, and “petition” includes a petition or proposal to change the regulations, boundaries or classifications of zoning districts.

(b) When an application, petition, request or plan is filed with the zoning commission, planning and zoning commission or zoning board of appeals of any municipality concerning any project on any site that is within the aquifer protection area delineated pursuant to section 22a-354c or the watershed of a water company, the applicant or the person making the filing shall provide written notice of the application, petition, request or plan to: (1) the water company; [and the Commissioner of Public Health in a format prescribed by said commissioner, provided such water company or said commissioner has filed a map showing the boundaries of the watershed on the land records of the municipality in which the application, petition, request or plan is made and with the planning commission, zoning commission, planning and zoning commission or zoning board of appeals of such municipality or the aquifer protection area has been delineated in accordance with section 22a-354c, as the case may be] and (2) the Department of Public Health when the project exceeds five acres or is for a commercial or industrial, or both, use. Such notice shall be made to the water company by certified mail, return receipt requested, and to the department by electronic mail to the electronic mail address designated by the department on the its Internet web site for receipt of such notice, and shall be mailed and transmitted electronically not later than seven days after the date of the application. Such water company and the Commissioner of Public Health may, through a representative, appear and be heard at any hearing on any such application, petition, request or plan.

(c) Notwithstanding the provisions of subsection (b) of this section, when an agent of the zoning commission, planning and zoning commission or zoning board of appeals is authorized to approve an application, petition, request or plan concerning any site that is within the aquifer protection area delineated pursuant to section 22a-354c or the watershed of a water company without the approval of the zoning commission, planning and zoning commission or zoning board of appeals, and such agent determines that the proposed activity will not adversely affect the public water supply, the applicant

or person making the filing shall not be required to notify the water company or the Commissioner of Public Health or the Commissioner's designee.

Section 4.

Section 22a-42f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020):*

When an application is filed to conduct or cause to be conducted a regulated activity upon an inland wetland or watercourse, any portion of which is within the watershed of a water company as defined in section 25-32a, the applicant shall provide written notice of the application to: (1) the water company [and the Commissioner of Public Health in a format prescribed by said commissioner, provided such water company or said commissioner has filed a map showing the boundaries of the watershed on the land records of the municipality in which the application is made and with the inland wetlands agency of such municipality] and (2) the Department of Public Health when the project exceeds five acres or is for a commercial or industrial, or both, use. Such notice shall be made to the water company by certified mail, return receipt requested, and to the department by electronic mail to the electronic mail address designated by the department on the its Internet web site for receipt of such notice, and shall be mailed and transmitted electronically not later than seven days after the date of the application. Such water company shall provide to the department a copy of a notice it receives if the proposed activity will adversely affect its public water supply. The water company shall provide such notice to the department by electronic mail to the electronic mail address designated by the department on its Internet web site for receipt of such notice. The water company and the Commissioner of Public Health, through a representative, may appear and be heard at any hearing on the application.

Section 5. Section 19a-111 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020)*:

Upon receipt of each report of confirmed venous blood lead level equal to or greater than twenty micrograms per deciliter of blood, the local director of health shall make or cause to be made an epidemiological investigation of the source of the lead causing the increased lead level or abnormal body burden and shall order action to be taken by the appropriate person responsible for the condition that brought about such lead poisoning as may be necessary to prevent further exposure of persons to such poisoning. In the case of any residential unit where such action will not result in removal of the hazard within a reasonable time, the local director of health shall utilize such community resources as are available to effect relocation of any family occupying such unit. The local director of health may permit occupancy in said residential unit during abatement if, in such director's judgment, occupancy would not threaten the health and well-being of the occupants. The local director of health shall, not later than thirty days after the conclusion of such director's investigation, report to the Commissioner

of Public Health, using a web-based surveillance system as provided by the Commissioner, the result of such investigation and the action taken to ensure against further lead poisoning from the same source, including any measures taken to effect relocation of families. Such report shall include information relevant to the identification and location of the source of lead poisoning and such other information as the commissioner may require pursuant to regulations adopted in accordance with the provisions of chapter 54. The commissioner shall maintain comprehensive records of all reports submitted pursuant to this section and section 19a-110. Such records shall be geographically indexed in order to determine the location of areas of relatively high incidence of lead poisoning. The commissioner shall establish, in conjunction with recognized professional medical groups, guidelines consistent with the National Centers for Disease Control and Prevention for assessment of the risk of lead poisoning, screening for lead poisoning and treatment and follow-up care of individuals including children with lead poisoning, women who are pregnant and women who are planning pregnancy. Nothing in this section shall be construed to prohibit a local building official from requiring abatement of sources of lead.

Section 6.

Section 19a-37 of the general statutes, as amended by section 22 of Public Act 19-118, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020)*:

(a) 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 residential population of less than twenty-five persons per day; and (C) is owned or controlled through an easement or by the same entity that owns or controls the building or parcel that is served by the water supply well;
(3) "Public well" means a water supply well that supplies a public water system;
(4) "Semipublic well" means a water supply well that (A) does not meet the definition of a private well or public well, and (B) 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 obtaining or providing water for drinking or other domestic, industrial, commercial, agricultural, recreational or irrigation use, or other outdoor water use.

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

(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 semipublic wells. Any laboratory or firm which conducts a water quality test on a private well serving a residential property or semipublic well 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 only be required if the party for whom the laboratory or firm conducted such test informs the laboratory or firm identified on the chain of custody documentation submitted with the test samples that the test was conducted in connection with 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 semipublic well is located.

(d) Prior to the sale, exchange, purchase, transfer or rental of real property on which a [residential] private well or semipublic 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 (g) or (j) of this section.

(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.

(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] Regulations of Connecticut State Agencies 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.

(g) The local director of health may require a private [residential] well or semipublic well 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.

(h) Except as provided in subsection (i) of this section, the collection of samples for determining the water quality of private [residential] wells and semipublic wells 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.

(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.

(j) The local director of health may require private [residential] wells and semipublic wells 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 semipublic well 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.

(k) Any water transported in bulk by any means to a premises currently supplied by a private well or semipublic well where the water is to be used for purposes of drinking or domestic use shall be provided by a bulk water hauler licensed pursuant to section 20-278h. No bulk water hauler shall deliver water without first notifying the owner of the premises of such delivery. Bulk water hauling to a premises currently supplied by a private well or semipublic well shall be permitted only as a temporary measure to alleviate a water supply shortage.

Section 7.

Section 19a-524 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

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 provision of any regulation of Connecticut state agencies relating to licensure, the Fire Safety Code or the operation or maintenance of a nursing home facility or residential care home, which violation has been classified in accordance with section 19a-527, the commissioner may immediately 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 this section or sections 19-525 to 19a-528, inclusive. Each such citation shall be in writing, provide notice of the nature and scope of the alleged violation or violations, and include, but not be limited to, the citation and notice of noncompliance issued in accordance with section 19a-496. Each citation and notice of noncompliance issued under this section shall be sent by certified mail <u>or electronically</u> to the licensee at the address of the nursing home facility or residential care home in issue. A copy of such citation and notice of noncompliance shall also be sent to the licensed administrator at the address of the nursing home facility or residential care home.

Section 8.

Subsection (h) of section 19a-491c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(h) The department shall adopt regulations, in accordance with the provisions of chapter 54, to <u>temporarily suspend a long-term care facility's requirement to process individuals through the background search program as a result of an emergency or significant disruption to internet capabilities, background search system functionality, or state or long-term care facility workforce, and</u> implement the provisions of this section. The department may implement policies and procedures consistent with the provisions of this section while in the process of adopting such policies and procedures as regulation, provided notice of intention to adopt regulations is printed in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are effective.

Section 9.

Section 19a-177 of the general statutes, as amended by sections 19, 47, and 65 of Public Act 19-118, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

The commissioner shall:
(1) With the advice of the Office of Emergency Medical Services established pursuant to section 19a-178 and of an advisory committee on emergency medical services and with the benefit of meetings held pursuant to subsection (b) of section 19a-184, adopt every five years a state-wide plan for the coordinated delivery of emergency medical services;
(2) License or certify the following: (A) Ambulance operations, ambulance drivers, emergency medical services personnel and communications personnel; (B) emergency room facilities and communications facilities; and (C) transportation equipment, including land, sea and air vehicles used for transportation of patients to emergency facilities and periodically inspect life saving equipment, emergency facilities and emergency transportation vehicles to ensure state standards are maintained;
(3) Annually inventory emergency medical services resources within the state, including facilities, equipment, and personnel, for the purposes of determining the need for additional services and the effectiveness of existing services;
(4) Review and evaluate all area-wide plans developed by the emergency medical services councils pursuant to section 19a-182, in order to insure conformity with standards issued by the commissioner;
(5) Not later than thirty days after their receipt, review all grant and contract applications for federal or state funds concerning emergency medical services or related activities for conformity to policy guidelines and forward such application to the appropriate agency, when required;
(6) Establish such minimum standards and adopt such regulations in accordance with the provisions of chapter 54, as may be necessary to develop the following components of an emergency medical service system: (A) Communications, which shall include, but not be limited to, equipment, radio frequencies and operational procedures; (B) transportation services, which shall include, but not be limited to, vehicle type, design, condition and maintenance, and operational procedures; (C) training, which shall include, but not be limited to, emergency medical services personnel, communications personnel, paraprofessionals associated with emergency medical services, firefighters and state and local police; (D) emergency medical service facilities, which shall include, but not be limited to, categorization of emergency departments as to their treatment capabilities and ancillary services; and (E) mobile integrated health care programs, which shall include, but not be limited to, the standards to ensure the health, safety and welfare of the patients being served by such programs and data collection and reporting requirements to ensure and measure quality outcomes of such programs;
(7) Coordinate training of all emergency medical services personnel;
(8) (A) Develop an emergency medical services data collection system. Each emergency medical service organization licensed or certified pursuant to this chapter shall submit data to the commissioner, on a quarterly basis, from each licensed ambulance service, certified ambulance service or paramedic intercept service that provides emergency medical services. Such submitted data shall include, but not be limited to: (i) The total number of calls for emergency medical services received by such licensed ambulance service, certified ambulance service or paramedic intercept service through the 9-1-1

system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, required for each such call; (iii) the response time for each licensed ambulance service, certified ambulance service or paramedic intercept service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls, both made and received, during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The data required under this subdivision may be submitted in any electronic form selected by such licensed ambulance service, certified ambulance service or paramedic intercept service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service, certified ambulance service or paramedic intercept service in approving such electronic form. The commissioner may conduct an audit of any such licensed ambulance service, certified ambulance service or paramedic intercept service as the commissioner deems necessary in order to verify the accuracy of such reported data.

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

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

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

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

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

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

ambulance services, certified ambulance services and paramedic intercept services that do not apply for a rate increase in any year in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, or that accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall, not later than the last business day in August of such year, file with the commissioner a statement of emergency and nonemergency call volume, and, in the case of a licensed ambulance service, certified ambulance service or paramedic intercept service that is not applying for a rate increase, a written declaration by such licensed ambulance service, certified ambulance service or paramedic intercept service that no change in its currently approved maximum allowable rates will occur for the rate application year; and (iv) detailed financial and operational information filed by licensed ambulance services, certified ambulance services and paramedic intercept services to support a request for a rate increase in excess of the Medical Care Services Consumer Price Index, as published by the Bureau of Labor Statistics of the United States Department of Labor, for the prior year, shall cover the time period pertaining to the most recently completed fiscal year and the rate application year of the licensed ambulance service, certified ambulance service or paramedic intercept service.

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

(D) Establish rates for the treatment and release of patients by a licensed or certified emergency medical services organization or a provider who does not transport such patients to an emergency department and who is operating within the scope of such organization's or provider's practice and following protocols approved by the sponsor hospital. The rates established pursuant to this subparagraph shall not apply to the treatment provided to patients through mobile integrated health care programs;

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

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

(12) Annually issue a list of minimum equipment requirements for ambulances and rescue vehicles

based upon current national standards. The commissioner shall distribute such list to all emergency medical service organizations and sponsor hospital medical directors and make such list available to other interested stakeholders. Emergency medical service organizations shall have one year from the date of issuance of such list to comply with the minimum equipment requirements; and

(13) The commissioner may waive any provisions of the regulations affecting an emergency medical service organization, as defined in section 19a-175, if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient or resident. The commissioner may impose conditions, upon granting the waiver, that assure the health, safety and welfare of patients or residents, and may revoke the waiver upon a finding that the health, safety or welfare of any patient or resident has been jeopardized. The commissioner may adopt regulations, in accordance with chapter 54, establishing procedures for an application for a waiver pursuant to this subsection.

Section 10.

Section 20-207 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(1) "Board" means the Connecticut Board of Examiners of Embalmers and Funeral Directors;
(2) "Person" means an individual or corporation, but not a partnership;
(3) "Funeral directing" means the business, practice or profession, as commonly practiced, of (A) directing or supervising funerals, or providing funeral services; (B) handling or encasing or providing services for handling and encasing dead human bodies, otherwise than by embalming, for burial or disposal; (C) providing embalming services; (D) providing transportation, interment and disinterment of dead human bodies; (E) maintaining an establishment so located, constructed and equipped as to permit the decent and sanitary handling of dead human bodies, with suitable equipment in such establishment for such handling; (F) conducting an establishment from which funerals may be held; (G) engaging in consultations concerning arrangements for the disposition of human remains, including, but not limited to, arrangements for cremation or alkaline hydrolysis; (H) casketing human remains; (I) making cemetery and cremation arrangements; and (J) preparing funeral service contracts, as defined in section 42-200;
(4) "Funeral director" means any person engaged or holding [himself] themselves out as engaged in funeral directing whether or not he or she uses in connection with his or her name or business the words "funeral director," "undertaker" or "mortician" or any other word or title intended to designate [him] such person as a funeral director or mortician or as one so engaged;
(5) "Funeral service business" means the business, practice or profession of funeral directing;
(6) "Licensed embalmer" means an embalmer holding a license as provided in this chapter;
(7) "Licensed funeral director" means a funeral director holding a license as provided in this chapter;
(8) "[Student embalmer] Registered apprentice embalmer" means a person [studying embalming and] registered with the Department of Public Health as an apprentice pursuant to the provisions of this chapter;

(9) "[Student funeral director] Registered apprentice funeral director" means a person [studying the funeral service business and] registered with the Department of Public Health as an apprentice pursuant to the provisions of this chapter;
(10) "Full-time employment" means regular and steady work during the normal working hours by any person at the establishment at which he is employed; and
(11) "Manager" means an individual who (A) is licensed as an embalmer or funeral director pursuant to this chapter and (B) has direct and personal responsibility for the daily operation and management of a funeral service business.

Section 11.

Section 20-212 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

No person, except a licensed embalmer, shall inject any fluid or substance into any dead human body, except that a [registered student embalmer] registered apprentice embalmer may, even if not in the presence of a licensed embalmer, make such injection or perform any other act under [his] such licensed embalmer's instruction; and no person, firm or corporation shall enter, engage in, carry on or manage for another the business of caring for, preserving or disposing of dead human bodies until each person, firm or corporation so engaged has obtained from the Department of Public Health and holds a license as provided in this chapter; nor shall any person be employed to remove a dead human body, except a licensed embalmer, a [registered student embalmer] registered apprentice embalmer, a licensed funeral director, or a person authorized in each instance by the Chief Medical Examiner, Deputy Medical Examiner or assistant medical examiner incidental to examining the body of a deceased person, except that once a dead human body has been prepared in accordance with the [Public Health Code] Regulations of Connecticut State Agencies and the applicable provisions of the general statutes, an embalmer or funeral director licensed in this state may authorize an unlicensed employee to transport such body. Nothing in this section shall be construed to prohibit any person licensed as an embalmer or as a funeral director under the laws of another state from bringing into or removing from this state a dead human body, provided any and all other laws of this state relative to such body have been complied with. Nothing in this chapter shall be construed to prohibit students who are enrolled in a program of education in mortuary science, approved by the board, with the consent of the Commissioner of Public Health, from embalming up to ten bodies under the supervision of an embalmer licensed pursuant to this chapter, and incidental to their course of study.

Section 12.

Section 20-213 of the general statutes is repealed and the following is substituted in lieu thereof(*Effective October 1, 2020)*:

(a)(1) After a [student embalmer] registered apprentice embalmer has (A) completed a program of education in mortuary science approved by the board with the consent of the Commissioner of Public Health, (B) successfully completed an examination prescribed by the Department of Public Health with the consent of the board, (C) completed one year of practical training and experience of a grade and character satisfactory to the commissioner in the state in full-time employment under the personal supervision and instruction of an embalmer licensed under the provisions of this chapter, and (D) embalmed fifty human bodies in not more than two years under the supervision of a licensed embalmer or embalmers, (2) the [student embalmer] registered apprentice embalmer shall (A) submit to the department an application and fee of two hundred ten dollars, (B) take a written examination on the Connecticut public health laws and the regulations of Connecticut state agencies pertaining to the activities of an embalmer, and (C) take an examination in practical embalming that shall include an actual demonstration upon a cadaver. When the [student embalmer] registered apprentice embalmer has satisfactorily passed such examinations, said department shall issue to him or her a license to practice embalming. At the expiration of such license, if the holder thereof desires a renewal, said department shall grant it pursuant to section 20-222a, except for cause.

(b) Examinations for registration as a [student embalmer] registered apprentice embalmer and for an embalmer's license shall be administered to applicants by the Department of Public Health, under the supervision of the board, semiannually and at such other times as may be determined by the department.

(c) Any person licensed as an embalmer in another state whose requirements for licensure in such capacity are substantially similar to or higher than those of this state and who is a currently practicing competent practitioner shall be eligible for licensure without examination upon application and payment of a fee of two hundred ten dollars, provided all such applicants shall be required to pass an examination, given in writing, on the Connecticut public health laws and the regulations of the Department of Public Health pertaining to the activities of an embalmer. 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.

Section 13.

Section 20-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

No licensed embalmer shall sign an affidavit attesting the preparation or embalming of any body unless such body has been prepared or embalmed by [him] the embalmer, or by a registered [student embalmer] apprentice embalmer under [his] such embalmer's personal supervision.

Section 14.

Subsection (a) of Section 20-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) When a [student funeral director] registered apprentice funeral director has completed a program of education approved by the board with the consent of the Commissioner of Public Health, has successfully completed an examination prescribed by the department with the consent of the board and furnishes the department with satisfactory proof that [he] the registered apprentice funeral director has completed one year of practical training and experience in full-time employment under the personal supervision of a licensed embalmer or funeral director, and pays to the department a fee of two hundred ten dollars, [he] such the registered apprentice funeral director shall be entitled to be examined upon the Connecticut state law and regulations pertaining to his or her professional activities. If found to be qualified by the Department of Public Health, [he] the registered apprentice funeral director shall be licensed as a funeral director. Renewal licenses shall be issued by the Department of Public Health pursuant to section 20-222a, unless withheld for cause as herein provided, upon a payment of a fee of two hundred thirty dollars.

Section 15.

Section 20-224 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) The provisions of sections 20-217, 20-220 and 20-227 shall not prohibit the employment of assistants or of [student embalmers] registered apprentice embalmers and [student funeral directors] registered apprentice funeral directors as provided in this chapter, provided a licensed funeral service business may employ no more than two [student embalmers] registered apprentice embalmers at any one time, and any person, firm, corporation or other organization engaged in the business of funeral directing may employ no more than one [student funeral director] registered apprentice funeral director at any one time, without the approval of the Board of Examiners of Embalmers and Funeral Directors.

(b) [Student embalmers] A registered apprentice embalmer and [student funeral directors] registered apprentice funeral director shall register as apprentices with the Department of Public Health, in the manner prescribed by the commissioner in regulations adopted pursuant to section 20-211, for purposes of completing practical training and experience pursuant to the provisions of this chapter.

Section 16.

Section 20-226 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

The Department of Public Health shall, on or before the tenth day of September in each year, or as soon thereafter as possible, forward to the town clerk or registrar of vital statistics of each town four printed lists duly verified[,] as follows: (1) [one containing] the names of all licensed funeral directors, [one] (2) the names of all licensed embalmers, [one] (3) the names of all [student embalmers] registered apprentice embalmers, and [one] (4) the names of all [student funeral directors] registered apprentice funeral directors[, and such]. Such lists shall be kept on file in the office to which they have been transmitted. The Department of Public Health shall issue to each person granted a license or registration subsequent to the making of such list a card stating that the holder thereof has received a license or registration, as the case may be. The holders of such cards shall have the same rights as those whose names appear in the lists on file in the office of the town clerk.

Section 17.

Section 20-195dd, as amended by section 165 of Public Act 19-117, is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(a) Except as otherwise provided in subsections (c) and (d) of this section, an applicant for a license as a professional counselor shall submit evidence satisfactory to the commissioner of having: (1) (A) Earned a graduate degree in clinical mental health counseling as part of a program of higher learning accredited by the Council for Accreditation of Counseling and Related Educational Programs, or a successor organization, or (B) (i) completed at least sixty graduate semester hours in counseling or a related mental health field at a regionally accredited institution of higher education that included coursework in each of the following areas: (I) Human growth and development; (II) social and cultural foundations; (III) counseling theories; (IV) counseling techniques; (V) group counseling; (VI) career counseling; (VII) appraisals or tests and measurements to individuals and groups; (VIII) research and evaluation; (IX) professional orientation to mental health counseling; (X) addiction and substance abuse counseling; (XI) trauma and crisis counseling; and (XII) diagnosis and treatment of mental and emotional disorders (ii) earned from a regionally accredited institution of higher education a graduate degree in counseling or a related mental health field, (iii) completed a one-hundred-hour practicum in counseling taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state, and (iv) completed a six-hundred-hour clinical mental health counseling internship taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state; (2) acquired three thousand hours of postgraduate experience under professional supervision, including a minimum of one hundred hours of direct professional supervision, in the practice of professional counseling, performed over a period of not less than two years; and (3) passed an examination prescribed by the commissioner. The provisions of subparagraphs (B)(i)(X), (XI), (XII), (B)(iii) and (B)(iv) of this subsection shall not apply to any applicant who, on or before July 1, 2017, was a matriculating student in good standing in a graduate degree program at a regionally accredited institution of higher education in one of the fields required under subparagraph (B) of this subsection.

(b) An applicant for a license as a professional counselor associate shall submit to the Commissioner of Public Health evidence satisfactory to the commissioner of having (1) earned a graduate degree in clinical mental health counseling as part of a program of higher learning accredited by the Council for Accreditation of Counseling and Related Educational Programs, or a successor organization, or (2) [(A) completed at least sixty graduate semester hours in counseling or a related mental health field at a regionally accredited institution of higher education that included coursework in each of the following areas: Human growth and development; social and cultural foundations; counseling theories; counseling techniques; group counseling; career counseling; appraisals or tests and measurements to individuals and groups; research and evaluation; professional orientation to mental health counseling; addiction and substance abuse counseling; trauma and crisis counseling; and diagnosis and treatment of mental and emotional disorders, (B) completed a one-hundred-hour practicum in counseling taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state, (C) completed a six-hundred-hour clinical mental health counseling internship taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state, and (D)] earned from a regionally accredited institution of higher education a graduate degree in counseling or a related mental health field.

(c) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant is licensed or certified as a professional counselor or professional counselor associate, or as a person entitled to perform similar services under a different designation, in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that there are no disciplinary actions or unresolved complaints pending.

(d) An applicant who is licensed or certified as a professional counselor or its equivalent in another state, territory or commonwealth of the United States may substitute three years of licensed or certified work experience in the practice of professional counseling in lieu of the requirements of subdivision (2) of subsection (a) of this section, provided the commissioner finds that such experience is equal to or greater than the requirements of this state.

Section 18.

Subsection (b) of Section 20-195c, as amended by section 170 of Public Act 19-117, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(b) Each applicant for licensure as a marital and family therapist associate shall present to the department (1) satisfactory evidence that such applicant has completed a graduate degree program specializing in marital and family therapy offered by a regionally accredited institution of higher education or an accredited postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited institution of higher education, (2) completed a supervised practicum or internship with emphasis in

marital and family therapy supervised by the program granting the requisite degree or by an accredited postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited institution of higher education in which the student received a minimum of five hundred direct clinical hours that included one hundred hours of clinical supervision, and [(2)] (3) verification from a supervising licensed marital and family therapist that the applicant is working toward completing the postgraduate experience required for licensure as a marital and family therapist under subdivision (3) of subsection (a) of this section. The fee shall be one hundred twenty-five dollars for each initial application.

Section 19.

Section 20-266n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

As used in this section and sections 20-266o to 20-266s, inclusive, as amended by this act, and subsection (c) of section 19a-14:
(1) "Commissioner" means the Commissioner of Public Health; **[.]**
(2) "Department" means the Department of Public Health; **[.]**
(3) "Tattooing" means marking or coloring, in an indelible manner, the skin of any person by pricking in coloring matter or by producing scars; **[.]**
(4) "Tattoo technician" means a person who is licensed under the provisions of section 20-266o, as amended by this act; **[.]**
(5) "Student tattoo technician" means a person studying tattooing who is registered with the department pursuant to section 20-266o, as amended by this act; **[.]** and
(6) "Supervising tattoo technician" means a tattoo technician licensed pursuant to this chapter for not less than five years who is responsible for the personal supervision of a student tattoo technician's practical training and experience in tattooing.

Section 20.

Section 20-266o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) **[**On and after July 1, 2014, no**]** No person shall engage in the practice of tattooing unless the person is eighteen years of age or older and has obtained a license or temporary permit from the Department of Public Health pursuant to this section.

(b) **[**(1)**]** Each person seeking licensure as a tattoo technician **[**on or before January 1, 2015,**]** shall **[**make application**]** apply to the department on a form prescribed by the department **[**,**]** and pay an application fee of two hundred fifty dollars. **[**and**]** Each applicant shall present to the department satisfactory

evidence that the applicant: [(A)] (1) Is eighteen years of age or older; [(B)] (2) has successfully completed, within the three years preceding the date of application, a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, and that requires the successful completion of a proficiency examination as part of such course; [and (C)] (3) holds current certification by the American Red Cross or the American Heart Association in basic first aid; (4) presents evidence that the applicant has completed the requirements of a student tattoo technician in accordance with subsections (g) and (h) of this section and (5) signs a form prescribed by the Commissioner of Public Health attesting that such person is in compliance with infection prevention and control plan guidelines prescribed by the commissioner. The infection prevention and control plan guidelines shall include, but need not be limited to, the following: (A) Use of personal protective equipment, including, but not limited to, disposable gloves, as a barrier against infectious materials, (B) the practice of appropriate hand hygiene including the availability of a hand-washing sink in the area where the practice of tattooing occurs, (C) the decontamination and sterilization, with hospital-grade cleaner, of the area or materials used in the practice of tattooing, including, but not limited to, chairs, armrests, tables, countertops, trays, seats, furniture and reusable instruments that may come into contact with skin or mucosal surfaces, and (D) the appropriate use of disposable equipment and the disposal of sharps used during the practice of tattooing.

[(2) Each person seeking licensure as a tattoo technician after January 1, 2015, shall, in addition to satisfying the requirements of subdivision (1) of this subsection, provide documentation to the department, in the form and manner required by the commissioner, of having (A) completed not less than two thousand hours of practical training and experience under the personal supervision and instruction of a tattoo technician, or (B) practiced tattooing continuously in this state for a period of not less than five years prior to January 1, 2015.]

(c) Licenses issued under this section shall be subject to renewal once every two years. A license to practice tattooing shall be renewed in accordance with the provisions of section 19a-88 for a fee of two hundred dollars. A licensee applying for license renewal shall, as a condition of license renewal, (1) successfully complete a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, and that requires the successful completion of a proficiency examination as part of such course. Each licensee applying for license renewal shall sign a statement attesting that the licensee has successfully completed such education course within the six months preceding the expiration of the license on a form prescribed by the Commissioner of Public Health. Each licensee shall retain certificates of completion that demonstrate compliance with the requirement for a minimum of four years after the year in which the course was completed and shall submit such certificates to the department for inspection not later than forty-five days after a request by the department for such certificates; (2) hold current certification by the American Red Cross or the American Heart Association in basic first aid, and (3) sign a form prescribed

by the Commissioner of Public Health attesting that such person is in compliance with infection prevention and control plan guidelines prescribed by the commissioner.

(d) The provisions of this section shall not apply to a physician, an advanced practice registered nurse rendering service in collaboration with a physician, a registered nurse executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse, or a physician assistant rendering service under the supervision, control and responsibility of a physician.

(e) No person shall use the title "tattoo technician", "tattoo artist", "tattooist" or other similar titles unless the person holds a license issued in accordance with this section.

(f) Notwithstanding the provisions of subsection (a) of this section, a person may practice tattooing if such person has obtained a license or temporary permit pursuant to this subsection or practices tattooing temporarily in the state as an instructor or participant in an event, trade show or product demonstration in accordance with the provisions of subdivision (3) of this subsection.

(1) The department may grant licensure to any person who is licensed at the time of application as a tattoo technician, or as a person entitled to perform similar services under a different designation, in another state of the United States, the District of Columbia or a commonwealth or territory subject to the laws of the United States and who submits evidence satisfactory to the department of (A) a current license in good standing to practice tattooing from such other state, commonwealth or territory, (B) documentation of licensed practice in such state, commonwealth or territory for a period of at least two years immediately preceding application, (C) successful completion of a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, **[**and**]** (D) current certification by the American Red Cross or the American Heart Association in basic first aid, and (E) sign a form prescribed by the Commissioner of Public Health attesting that such person is in compliance with the infection prevention and control plan guidelines prescribed by the commissioner pursuant to subsection (b) of this section. Pending approval of the application for licensure, the commissioner may issue a temporary permit to such applicant upon receipt of a completed application form, accompanied by the fee for licensure, a copy of a current license from such other state, commonwealth or territory and a notarized affidavit attesting that the license is valid and belongs to the person requesting notarization. Such temporary permit shall be valid for a period not to exceed one hundred twenty calendar days and shall not be renewable.

(2) The commissioner may issue a temporary permit to an applicant previously licensed in Connecticut whose license has become void pursuant to section 19a-88. Such applicant for a temporary permit shall submit to the department a completed application form accompanied by a fee of one hundred dollars, a copy of a current license in good standing from another state and a notarized affidavit attesting that such license is valid and belongs to the person requesting notarization. A temporary permit for an

applicant previously licensed in Connecticut whose license has become void pursuant to section 19a-88 shall be valid for a period not to exceed one hundred twenty calendar days and shall not be renewable.

(3) A person who: (A) Provides instruction on tattooing techniques; or (B) participates in the demonstration of a tattooing-related product or offers tattooing as part of a professional course, seminar, workshop, trade show or other event, may practice tattooing for such purpose, provided such person described in subparagraphs (A) and (B) of this subdivision (i) is licensed or certified in the state, territory or possession of the United States or foreign country that is the primary place where such person practices tattooing if such state, territory, possession or foreign country requires licensure or certification for tattooing, (ii) has successfully completed a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, within the preceding three years, (iii) practices tattooing under the direct supervision of a tattoo technician, (iv) does not receive compensation for tattooing, other than for providing instruction or tattooing services to persons in attendance at the course, seminar, workshop, trade show or event, and (v) provides instruction, demonstrates tattooing techniques or offers tattooing only for persons enrolled in the course, seminar or workshop or attending the trade show or event at which the person provides instruction, demonstrates a product or offers tattooing. Any person or organization that holds or produces a course, seminar, workshop, trade show or other event at which a person who is not a tattoo technician licensed in the state provides tattooing instruction, participates in the demonstration of a tattooing-related product or offers tattooing to persons in attendance at the trade show or event shall ensure compliance with the provisions of this section.

(g) Notwithstanding the provisions of subsection (a) of this section, a student tattoo technician may practice tattooing under the personal supervision of a tattoo technician for a period not to exceed two years. A student tattoo technician shall (1) successfully complete a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, and that requires the successful completion of a proficiency examination as part of such course, (2) hold current certification by the American Red Cross or the American Heart Association in basic first aid, (3) obtain a notarized statement signed by a supervising tattoo technician documenting they are under the supervision of a supervising tattoo technician in accordance with subsection (h) of this section, and (4) register with the department for purposes of completing the practical training and experience required to obtain a license pursuant to this section **[**. An application for registration shall be submitted to the department**]** on a form prescribed by the commissioner. **[**and shall be accompanied by documentation that the applicant (1) has successfully completed a course on prevention of disease transmission and blood-borne pathogens that complies with the standards adopted by the federal Occupational Safety and Health Administration, as described in 29 CFR 1910.1030 et seq., as amended from time to time, and that requires the successful completion of a

proficiency examination as part of such course, and (2) holds current certification by the American Red Cross or the American Heart Association in basic first aid. Such application shall include a notarized statement signed by a tattoo technician providing that such licensee acknowledges having responsibility for personally supervising the applicant's practical training and experience in tattooing.]

(h) A supervising tattoo technician may supervise no more than two student tattoo technicians and shall maintain records, for a period of three years, of completing the minimum training requirements for each student tattoo technician. A supervising tattoo technician shall adopt a curriculum for a student tattoo technician that consist of not less than two thousand hours of practical training and experience under the personal supervision and instruction of a supervising tattoo technician, and includes the following minimum training requirements: (1) Discussion of transmission, control and symptoms of the diseases caused by blood-borne pathogens, (2) discussion of tasks involved in the practice of tattooing and the risks of exposure to blood-borne pathogens to the client and the tattoo technician during the performance of each task, (3) discussion of the types and uses of personal protective equipment, including an explanation of the limitations of the equipment, (4) discussion of the types of tasks, proper task technique and sequence of tasks before and after donning and removing personal protective equipment to avoid contamination, (5) discussion of the importance of hand hygiene and a demonstration of proper hand hygiene techniques, (6) discussion of the options, use and storage of disinfectants and antiseptics, (7) provision of information on the signage required for biohazard materials and the importance of properly labeling chemicals and supplies, (8) provision of information on the hepatitis B vaccine, including the safety and accessibility of the vaccine, (9) discussion of what constitutes a blood-borne pathogen exposure incident, including (A) examples of incidences and the actions to take in preventing or minimizing further exposure; (B) risks of infection following an exposure incident; and (C) procedures to follow after an exposure incident, including follow-up medical treatment, and (10) provision of opportunities for interactive questions and answers between the supervising tattoo technician and the student tattoo technician. The supervising tattoo technician shall provide, in writing, documentation to the student tattoo technician upon successful completion of the requirements of this subsection.

[(h)] (i) No license or temporary permit 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 in any state or jurisdiction.

[(i)] (j) The Commissioner of Public Health may, in accordance with chapter 54, adopt such regulations as are necessary to implement the provisions of sections 20-266o to 20-266s, inclusive, as amended by this act.

Section 21.

Subdivision (12) of subsection (a) of section 19a-14 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(12) With respect to any complaint filed with the department on or after October 1, 2010, alleging incompetence, negligence, fraud or deceit by a person subject to regulation or licensing by any board or commission described in subdivision (1) to [(5)] (6), inclusive, (7), (8), (12) to (14), inclusive, or (16) of subsection (b) of this section:

(A) Upon request of the person who filed the complaint, provide such person with information on the status of the complaint;

(B) Upon request of the person who filed the complaint, provide such person with an opportunity to review, at the department, records compiled as of the date of the request pursuant to any investigation of the complaint, including, but not limited to, the respondent's written response to the complaint, except that such person shall not be entitled to copy such records and the department (i) shall not disclose (I) information concerning a health care professional's referral to, participation in or completion of an assistance program in accordance with sections 19a-12a and 19a-12b, that is confidential pursuant to section 19a-12a, (II) information not related to such person's specific complaint, including, but not limited to, information concerning patients other than such person, or (III) personnel or medical records and similar files the disclosure of which would constitute an invasion of personal privacy pursuant to section 1-210, except for such records or similar files solely related to such person; (ii) shall not be required to disclose any other information that is otherwise confidential pursuant to federal law or state statute, except for information solely related to such person; and (iii) may require up to ten business days written notice prior to providing such opportunity for review;
(C) Prior to resolving the complaint with a consent order, provide the person who filed the complaint with not less than ten business days to submit a written statement as to whether such person objects to resolving the complaint with a consent order;

(D) If a hearing is held with respect to such complaint after a finding of probable cause, provide the person who filed the complaint with a copy of the notice of hearing issued pursuant to section 4-177, which shall include information concerning the opportunity to present oral or written statements pursuant to subsection (b) of section 4-177c; and

(E) Notify the person who filed the complaint of the final disposition of such complaint not later than seven business days after such final disposition;

Section 22.

Section 20-204a of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) The department shall investigate each allegation of any act or omission by a veterinarian specified in section 20-202. The investigation shall be conducted in accordance with the provisions of section 19a-14 to determine if probable cause exists to issue a statement of charges and to institute proceedings against the veterinarian. Such investigation shall be concluded not later than twelve months from the date the allegation is submitted to the department.

(b) Except as provided in subsections (c) and (d) of this section, the investigation shall be confidential and not subject to disclosure under section 1-210 and no person may disclose knowledge of the investigation to a third party unless the veterinarian requests that the investigation be open. The owner of any animal that is the subject of such an investigation shall not be deemed a third party to such an investigation for purposes of disclosure under this section.

(c) If the department makes a finding of no probable cause to take action under section 20-202 or fails to make a finding within the twelve-month period required by subsection [(b)] (a) of this section, the allegation submitted pursuant to subsection (a) of this section and the entire record of the investigation may remain confidential and no person shall disclose knowledge of such investigation to a third party unless the veterinarian requests that it be open[.], except that the department shall provide information to the person who filed the complaint pursuant to subdivision (12) of subsection (a) of section 19a-14.

(d) If the department makes a finding that there is probable cause to take action under section 20-202, the allegation submitted pursuant to subsection (a) of this section and the entire record of such investigation shall be deemed a public record, in accordance with section 1-210.

Section 23.

Subsections (b) and (c) of section 7-62b of the general statutes are repealed and the following is substituted in lieu thereof (*Effective January 1, 2021*):

(b) The funeral director or embalmer licensed by the department, or the funeral director or embalmer licensed in another state and complying with the terms of a reciprocal agreement on file with the department, in charge of the burial of the deceased person shall complete the death certificate through the electronic death registry system, or in the event that the electronic death registry is unavailable, on a form provided by the department. Said certificate shall be filed by a licensed embalmer or such embalmer's designee or a funeral director or such director's designee, in accordance with the provisions of this section, except when inquiry is required by the Chief Medical Examiner's Office, in which case the death certificate shall be filed in accordance with section 19a-409. The Social Security number of the deceased person shall be recorded on such certificate. Such licensed funeral director or licensed embalmer shall obtain the personal data from the next of kin or the best qualified person or source available and shall obtain a medical certification from the person responsible therefor, in accordance with the provisions of this section. Only a licensed embalmer may assume charge of the

burial of a deceased person who had a communicable disease, as designated in the [Public Health Code] Regulations of Connecticut State Agencies, at the time of death and such licensed embalmer shall file an affidavit, on a form provided by the department, signed and sworn to by such licensed embalmer stating that the body has been disinfected in accordance with the [Public Health Code] Regulations of Connecticut State Agencies.

(c) A practitioner shall use the electronic death registry system to certify to the facts of death, or in the event that the electronic death registry is unavailable, on a form provided by the department. The medical certification portion of the death certificate shall be completed, signed and returned to the licensed funeral director or licensed embalmer no later than twenty-four hours after death by the physician or advanced practice registered nurse in charge of the patient's care for the illness or condition which resulted in death, or upon the death of an infant delivered by a nurse-midwife, by such nurse-midwife, as provided in section 20-86b. In the absence of such physician or advanced practice registered nurse, or with the physician's or advanced practice registered nurse's approval, the medical certification may be completed and signed by an associate physician, an advanced practice registered nurse, a physician assistant as provided in subsection (d) of section 20-12d, a registered nurse as provided in section 20-101a, the chief medical officer of the institution in which death occurred, or by the pathologist who performed an autopsy upon the decedent. No physician, advanced practice registered nurse, physician assistant, registered nurse, nurse-midwife, chief medical officer or pathologist shall sign and return the medical certification unless such physician, advanced practice registered nurse, physician assistant, registered nurse, nurse-midwife, chief medical officer or pathologist has personally viewed and examined the body of the person to whom the medical certification relates and is satisfied that at the time of the examination such person was in fact dead, except in the event a medical certification is completed by a physician, advanced practice registered nurse, physician assistant, registered nurse, nurse-midwife, chief medical officer or pathologist other than the one who made the determination and pronouncement of death, an additional viewing and examination of the body shall not be required. If a physician, advanced practice registered nurse, physician assistant, registered nurse, nurse-midwife, chief medical officer or pathologist refuses or otherwise fails to complete, sign and return the medical portion of the death certificate to the licensed funeral director or licensed embalmer within twenty-four hours after death, such licensed funeral director or embalmer may notify the Commissioner of Public Health of such refusal. The commissioner may, upon receipt of notification and investigation, assess a civil penalty against such physician, advanced practice registered nurse, physician assistant, registered nurse, chief medical officer or pathologist not to exceed two hundred fifty dollars. The medical certification shall state the cause of death, defined so that such death may be classified under the international list of causes of death, the duration of disease if known and such additional information as the Department of Public Health requires. The department shall give due consideration to national uniformity in vital statistics in prescribing the form and content of such information.

Section 24. Section 19a-200 of the general statutes is repealed and the following is substitute in lieu thereof (*Effective July 1, 2020*):

(a) The mayor of each city, the chief executive officer of each town and the warden of each borough shall, unless the charter of such city, town or borough otherwise provides, nominate some person to be director of health for such city, town or borough. The mayor or chief executive official of each town shall ensure the candidate for director of health possesses the qualifications specified in subsection (b) of this section, to be a director of health. [, which] Upon approval of the commissioner, the nomination shall be confirmed or rejected by the board of selectmen, if there be such a board, otherwise by the legislative body of such city or town or by the burgesses of such borough within thirty days thereafter.

(b) Notwithstanding the charter provisions of any city, town or borough with respect to the qualifications of the director of health, on and after October 1, 2010, any person nominated to be a 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 institution of higher education. 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.

(c) In cities, towns or boroughs with a population of forty thousand or more for five consecutive years, according to the estimated population figures authorized pursuant to subsection (b) of section 8-159a, such director of health shall serve in a full-time capacity, except where a town has designated such director as the chief medical advisor for its public schools under section 10-205[, and].

(d) No director shall, [not] 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 regulations of Connecticut state agencies or specified by the appointing authority of the city, town or borough in its written agreement with such director. A written agreement with such director shall be submitted to the Commissioner of Public Health upon appointment or reappointment.

(e) Such director of health shall have and exercise within the limits of the city, town or borough for which such director is appointed all powers necessary for enforcing the general statutes, provisions of the regulations of Connecticut state agencies relating to the preservation and improvement of the public health and preventing the spread of diseases therein.

(f) In case of the absence or inability to act of a city, town or borough director of health or if a vacancy exists in the office of such director, the appointing authority of such city, town or borough may, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of health during the period of such absence or inability or vacancy, provided the commissioner may appoint such acting director if the city, town or borough fails to do so. The person

so designated, when sworn, shall have all the powers and be subject to all the duties of such director. In case of vacancy in the office of such director, if such vacancy exists for sixty [thirty] days, said commissioner may appoint a director of health for such city, town or borough. Said commissioner, may, for cause, remove an officer the commissioner or any predecessor in said office has appointed, and the common council of such city, town or the burgesses of such borough may, respectively, for cause, remove a director whose nomination has been confirmed by them, provided such removal shall be approved by said commissioner; and, within two days thereafter, notice in writing of such action shall be given by the clerk of such city, town or borough, as the case may be, to said commissioner, who shall, within ten days after receipt, file with the clerk from whom the notice was received, approval or disapproval.

(g) Each such director of health shall hold office for the term of four years from the date of appointment and until a successor is nominated and confirmed in accordance with subsection (a) of this section.

(h) Each director of health shall, annually, at the end of the fiscal year of the city, town or borough, file with the Department of Public Health a report of the doings as such director for the year preceding.

[(b)](i) On and after July 1, 1988, each city, town and borough shall provide for the services of a sanitarian licensed under chapter 395 to work under the direction of the local director of health. Where practical, the local director of health may act as the sanitarian.

[(c)](j) As used in this chapter, "authorized agent" means a sanitarian licensed under chapter 395 and any individual certified for a specific program of environmental health by the Commissioner of Public Health in accordance with the general statutes and regulations of Connecticut state agencies.

Section 25.

Section 19a-202a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) Any municipality may designate itself as having a part-time health department if: (1) The municipality has not had a full-time health department or been in a full-time health district prior to January 1, 1998; (2) the municipality has the equivalent of at least one full-time employee, as determined by the Commissioner of Public Health, who performs public health functions required by the General Statutes and the Regulations of State Agencies; and (3) the municipality annually submits a public health program plan and budget to the commissioner[; and (4) the commissioner approves the program plan and budget].

(b) The Commissioner of Public Health [shall] may adopt regulations, in accordance with the provisions of chapter 54, for the development and approval of the program plan and budget required by subdivision (3) of subsection (a) of this section.

Section 26.

Section 19a-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

On and after October 1, 2010, 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 board may specify in a written agreement with such director the term of office, which shall not exceed three 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 of Connecticut State Agencies, 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 of Connecticut State Agencies or specified by the board in its written agreement with such director. The written agreement shall be submitted to the Commissioner of Public Health upon appointment or reappointment. Such director shall serve in a full-time capacity and act as secretary and treasurer of the 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 board requires. Such director shall be the executive officer of the district department of health. Full-time employees of a city, town or borough health department at the time such city, town or borough votes to form or join 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 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 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. 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 doings as such director for the year preceding.

Section 27.

Subdivision (3) of subsection (a) of section 19a-12a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(3) "Health care professionals" includes any person licensed or who holds a permit pursuant to chapter 370, 372, 373, 375, 375a, 376, 376a, 376b, 376c, 377, 378, 379, 379a, 380, 381, 381a, 382a, 383, 383a, 383b, 383c, 384, 384a, 384b, 384c, 384d, 385, 398 or 399;

Section 28.

Section 19a-12d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

On or before the last day of January, April, July and October in each year, the Commissioner of Public Health shall certify the amount of revenue received as a result of any fee increase in the amount of five dollars (1) that took effect October 1, 2015, pursuant to sections 19a-88, 19a-515, 20-65k, 20-74bb, 20-74h, 20-74s, 20-149, 20-162o, 20-162bb, 20-191a, 20-195c, 20-195o, 20-195cc, 20-201, 20-206b, 20-206n, 20-206r, 20-206bb, 20-206*ll*, 20-222a, 20-275, 20-395d, 20-398 and 20-412, and (2) that took effect October 1, 2020, pursuant to section 20-185k as amended by this act, and transfer such amount to the professional assistance program account established in section 19a-12c.

Section 29.

Subsection (a) of section 19a-12e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) As used in this section:

(1) “Health care professional” means any individual licensed or who holds a permit pursuant to chapter 368v, 370, 372, 373, 375 to 378, inclusive, 379 to 381b, inclusive, 382a, 383 to 385, inclusive, 388 or 397a to 399, inclusive;

(2) “Assistance program” means the program established pursuant to section 19a-12a to provide education, prevention, intervention, referral assistance, rehabilitation or support services to health care professionals who have a chemical dependency, emotional or behavioral disorder or physical or mental illness; and

(3) “Hospital” has the same meaning as provided in section 19a-490.

Section 30.

Subsection (b) of section 20-185k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

(b) A license issued under this section may be renewed annually. The license shall be renewed in accordance with the provisions of section 19a-88, for a fee of one hundred [seventy-five] eighty dollars for applications for renewal of licenses that expire on or after October 1, 2020. Each behavior analyst applying for license renewal shall furnish evidence satisfactory to the commissioner of having current certification with the Behavior Analyst Certification Board.

Section 31.

Section 17a-412 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, and any registered nurse, licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, clergyman, police officer, pharmacist, physical therapist, long-term care facility administrator, nurse's aide or orderly in a long-term care facility, any person paid for caring for a patient in a long-term care facility, any staff person employed by a long-term care facility and any person who is a sexual assault counselor or a domestic violence counselor as defined in section 52-146k, or a licensed behavior analyst licensed under the provisions of chapter 382a who has reasonable cause to suspect or believe that a resident in a long-term care facility has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, shall, not later than seventy-two hours after such suspicion or belief arose, report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services pursuant to chapter 319dd. Any person required to report under the provision of this section who fails to make such report within the prescribed time period shall be fined not more than five hundred dollars, except that, if such person intentionally fails to make such report within the prescribed time period, such person shall be guilty of a class C misdemeanor for the first offense and a class A misdemeanor for any subsequent offense.

Section 32.

Subsection (a) of section 17b-451 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) A mandatory reporter, as defined in this section, who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, or is in need of protective services, shall, not later than seventy-two hours after such suspicion or belief arose, report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports. The term "mandatory reporter" means (1) any physician or surgeon licensed under the provisions of chapter 370, (2) any resident physician or intern in any hospital in this state, whether or not so licensed, (3) any registered nurse, (4) any nursing home administrator, nurse's aide or orderly in a nursing home facility or residential care home, (5) any person paid for caring for a resident in a nursing home facility or residential care home, (6) any staff person employed by a nursing home facility or residential care home, (7) any residents' advocate, other than a representative of the Office of the Long-Term Care Ombudsman, as established under section 17a-405, including the State Ombudsman, (8) any licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, <u>behavior analyst,</u> social worker, clergyman, police officer, pharmacist, psychologist or physical therapist, (9) any person paid for caring for an elderly person by any institution, organization, agency or facility, including without limitation, any employee of a community-based services provider, senior center, home care agency, homemaker and companion agency, adult day care center, village-model community and congregate housing facility, and (10) any person licensed or certified as an emergency medical services provider pursuant to chapter 368d or chapter 384d, including any such emergency medical services provider who is a member of a municipal fire department. Any mandatory reporter who fails to make such report within the prescribed time period shall be fined not more than five hundred dollars, except that, if such person intentionally fails to make such report within the prescribed time period, such person shall be guilty of a class C misdemeanor for the first offense and a class A misdemeanor for any subsequent offense. Any institution, organization, agency or facility employing individuals to care for persons sixty years of age or older shall provide mandatory training on detecting potential abuse, neglect, exploitation and abandonment of such persons and inform such employees of their obligations under this section. For purposes of this subsection, "person paid for caring for an elderly person by any institution, organization, agency or facility" includes an employee of a community-based services provider, senior center, home health care agency, homemaker and companion agency, adult day care center, village-model community and congregate housing facility.

Section 33.

Section 19a-6o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) There is established, within available appropriations, within the Department of Public Health, a Palliative Care Advisory Council. The advisory council shall: (1) Analyze the current state of palliative

care in the state; and (2) advise the department on matters relating to the improvement of palliative care and the quality of life for persons with serious or chronic illnesses.

(b) The advisory council shall consist of the following members:
(1) Two appointed by the Governor, one of whom shall be a physician certified by the American Board of Hospice and Palliative Medicine and one of whom shall be a registered nurse or advanced practice registered nurse certified by the National Board for Certification of Hospice and Palliative Nurses;
(2) Seven appointed by the Commissioner of Public Health, each of whom shall be a licensed health care provider, with each appointee having experience or expertise in the provision of one of the following: (A) Inpatient palliative care in a hospital; (B) inpatient palliative care in a nursing home facility; (C) palliative care in the patient's home or a community setting; (D) pediatric palliative care; (E) palliative care for young adults; (F) palliative care for adults or elderly persons; and (G) inpatient palliative care in a psychiatric facility;
(3) One appointed by the speaker of the House of Representatives, who shall be a licensed social worker experienced in working with persons with serious or chronic illness and their family members;
(4) One appointed by the president pro tempore of the Senate, who shall be a licensed pharmacist experienced in working with persons with serious or chronic illness;
(5) One appointed by the minority leader of the House of Representatives, who shall be a spiritual counselor experienced in working with persons with serious or chronic illness and their family members; and
(6) One appointed by the minority leader of the Senate, who shall be a representative of the American Cancer Society or a person experienced in advocating for persons with serious or chronic illness and their family members.

(c) All appointments to the advisory council shall be made not later than December 31, 2013. Advisory council members shall serve three-year terms. Any vacancy shall be filled by the appointing authority.

(d) Any appointment that is vacant for one year or more shall be made by the Commissioner of Public Health. The Commissioner of Public Health shall notify the appointing authority of the commissioner's choice of member for appointment not less than thirty days before making such appointment.

[(d)] (e) Members shall receive no compensation except for reimbursement for necessary expenses incurred in performing their duties.

[(e)] (f) The members shall elect the chairperson of the advisory council from among the members of the advisory council. A majority of the advisory council members shall constitute a quorum. Any action taken by the advisory council shall require a majority vote of those present. The first meeting of the advisory council shall be held not later than December 31, 2013. The advisory council shall meet biannually and at other times upon the call of the chairperson, upon the request of the Commissioner of Public Health or upon the request of a majority of the advisory council members.

[(f)] (g) Not later than January 1, [2015] 2021, and [annually] biennially thereafter, the advisory council shall submit a report on its findings and recommendations to the Commissioner of Public Health and the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a.

Section 34.

Subsection (b) of 19a-6q is repealed. (*Effective upon passage*).

[(b) The commissioner shall, on or before January 15, 2015, and biennially thereafter, submit a report, in consultation with the executive director of the Office of Health Strategy, in accordance with the provisions of section 11-4a to the joint standing committee of the General Assembly having cognizance of matters relating to public health concerning chronic disease and implementation of the plan described in subsection (a) of this section. The commissioner shall post each report on the Department of Public Health's Internet web site not later than thirty days after submitting such report. Each report shall include, but need not be limited to: (1) A description of the chronic diseases that are most likely to cause a person's death or disability, the approximate number of persons affected by such chronic diseases and an assessment of the financial effects of each such disease on the state and on hospitals and health care facilities; (2) a description and assessment of programs and actions that have been implemented by the department and health care providers to improve chronic disease care coordination and prevent chronic disease; (3) the sources and amounts of funding received by the department to treat persons with multiple chronic diseases and to treat or reduce the most prevalent chronic diseases in the state; (4) a description of chronic disease care coordination between the department and health care providers, to prevent and treat chronic disease; and (5) recommendations concerning actions that health care providers and persons with chronic disease may take to reduce the incidence and effects of chronic disease.]

Section 35.

Subsection (b) of section 19a-493 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(b) (1) A nursing home license may be renewed biennially after (A) an unscheduled inspection conducted by the department, (B) submission of the information required by section 19a-491a, and (C) submission of evidence satisfactory to the department that the nursing home is in compliance with the provisions of this chapter, the [Public Health Code] Regulations of Connecticut State Agencies and licensing regulations.
(2) Any change in the ownership of a facility or institution, as defined in section 19a-490, as amended by this act, owned by an individual, partnership or association or the change in ownership or beneficial

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

Section 36. (NEW)

(NEW) A healthcare facility licensed pursuant to chapter 368v shall have policies and procedures in place that reflect the National Centers for Disease Control and Prevention's recommendations for Tuberculosis screening, testing, treatment and education for health care personnel. Notwithstanding the regulations of Connecticut State Agencies, any employee providing direct patient care in a facility licensed pursuant to Chapter 368v shall be required to receive tuberculosis screening and testing in compliance with the licensed healthcare facility's policies and procedures.

Section 37.

Subsection (c) of section 19a-343 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(c) Three or more arrests, the issuance of three or more arrest warrants indicating a pattern of criminal activity and not isolated incidents or the issuance of three or more citations for a violation of a municipal ordinance as described in subdivision (14) of this subsection, for the following offenses shall constitute the basis for bringing an action to abate a public nuisance:

(1) Prostitution under section 53a-82, 53a-83, 53a-86, 53a-87, 53a-88 or 53a-89.

(2) Promoting an obscene performance or obscene material under section 53a-196 or 53a-196b, employing a minor in an obscene performance under section 53a-196a, importing child pornography under section 53a-196c, possessing child pornography in the first degree under section 53a-196d, possessing child pornography in the second degree under section 53a-196e or possessing child pornography in the third degree under section 53a-196f.

(3) Transmission of gambling information under section 53-278b or 53-278d or maintaining of a gambling premises under section 53-278e.

(4) Offenses for the sale of controlled substances, possession of controlled substances with intent to sell, or maintaining a drug factory under section 21a-277, 21a-278 or 21a-278a or use of the property by persons possessing controlled substances under section 21a-279. Nothing in this section shall prevent the state from also proceeding against property under section 21a-259 or 54-36h.

(5) Unauthorized sale of alcoholic liquor under section 30-74 or disposing of liquor without a permit under section 30-77.

(6) Maintaining a motor vehicle chop shop under section 14-149a.

(7) Inciting injury to persons or property under section 53a-179a.

(8) Murder or manslaughter under section 53a-54a, 53a-54b, 53a-55, 53a-56 or 53a-56a.

(9) Assault under section 53a-59, 53a-59a, subdivision (1) of subsection (a) of section 53a-60 or section 53a-60a or 53a-61.

(10) Sexual assault under section 53a-70 or 53a-70a.

(11) Fire safety violations under section <u>29-291a, 29-291c,</u> 29-292, subsection (b) of section 29-310, or section 29-315, 29-349 or 29-357.

(12) Firearm offenses under section 29-35, 53-202aa, 53-203, 53a-211, 53a-212, 53a-216, 53a-217 or 53a-217c.

(13) Illegal manufacture, sale, possession or dispensing of a drug under subdivision (2) of section 21a-108.

(14) Violation of a municipal ordinance resulting in the issuance of a citation for (A) excessive noise on nonresidential real property that significantly impacts the surrounding area, provided the municipality's excessive noise ordinance is based on an objective standard, (B) owning or leasing a dwelling unit that provides residence to an excessive number of unrelated persons resulting in dangerous or unsanitary conditions that significantly impact the safety of the surrounding area, or (C) impermissible operation of (i) a business that permits persons who are not licensed pursuant to section 20-206b to engage in the practice of massage therapy, or (ii) a massage parlor, as defined by the applicable municipal ordinance, that significantly impacts the safety of the surrounding area.

Section 38.

Subsection (a) of section 19a-112e of the general statutes, as amended by section 2 of public act 19-114, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) As used in this section and sections 19a-112f and 19a-112g:

(1) "Emergency contraception" means one or more prescription drugs used separately or in combination administered to or self-administered by a patient to prevent pregnancy, within a medically recommended amount of time after sexual intercourse and provided for that purpose, in accordance with professional standards of practice, and determined to be safe by the United States Food and Drug Administration.

(2) "Emergency treatment" means any medical examination or treatment provided in a licensed health care facility to a victim of sexual assault following an alleged sexual assault.

(3) "Medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable.

(4) "Victim of sexual assault" means any person who alleges or is alleged to have suffered an injury as a result of a sexual offense.

(5) "Sexual offense" means a violation of subsection (a) of section 53a-70, section 53a-70a or 53a-70b, subsection (a) of section 53a-71, section 53a-72a or 53a-72b, subdivision (2) of subsection (a) of section 53a-86, subdivision (2) of subsection (a) of section 53a-87 or section 53a-90a, 53a-196a or 53a-196b.

(6) "Independent provider" means a physician licensed under chapter 370, a physician assistant licensed under chapter 370, an advanced practice registered nurse or registered nurse licensed under chapter 378, or a nurse-midwife licensed under chapter 377, all of whom are trained and certified pursuant to the certification process implemented by the Chief Court Administrator pursuant to subsection (c) of section 19a-112f to conduct a forensic exam in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(7) "Sexual assault forensic examiner" means a physician or physician assistant licensed pursuant to chapter 370, a registered nurse or advanced practice registered nurse licensed pursuant to chapter 378 or nurse midwife licensed pursuant to chapter 377 who has successfully completed the certification process and met all continuing education and recertification requirements implemented by the Chief Court Administrator pursuant to subsection (c) of section 19a-112f.

(8) "Sexual assault nurse examiner" means a registered nurse or an advanced practice registered nurse licensed pursuant to chapter 378 who has provided care and treatment to a victim of sexual assault and collected evidence from said victim without successfully completing the training and certification process implemented by the Chief Court Administrator pursuant to subsection (c) of section 19a-112f.

(9) "Health care facility" means (A) a hospital licensed under chapter 368v that has an emergency department, including any free-standing emergency department, [or] (B) an infirmary operated by The University of Connecticut at Storrs, or (C) an infirmary operated by Yale University Health Services.

(b) The standard of care for each licensed health care facility that provides emergency treatment to a victim of sexual assault shall include promptly:

(1) Providing each victim of sexual assault with medically and factually accurate and objective information relating to emergency contraception;

(2) Informing such victim of sexual assault of the availability of emergency contraception, its use and efficacy; and

(3) Providing emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a licensed health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the United States Food and Drug Administration.

(c) In order to comply with the standard of care requirements prescribed in subsection (b) of this section, a licensed health care facility may contract with one or more independent providers to: (1) Ensure compliance at the facility with the standard of care requirements prescribed in said subsection (b), and (2) conduct at the facility a forensic exam of the sexual assault victim in accordance with the

state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(d) No licensed health care facility that provides emergency treatment to a victim of sexual assault shall determine such facility's protocol for complying with the standard of care requirements prescribed in subsection (b) of this section on any basis other than a pregnancy test approved by the United States Food and Drug Administration.

(e) No person shall use the title "sexual assault forensic examiner" or "sexual assault nurse examiner", or any variant of such titles, without successfully completing the certification requirements imposed by the Chief Court Administrator pursuant to subsection (c) of section 19a-112f.

Section 39.

Section 19a-131g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective upon passage*):

The Commissioner of Public Health shall establish a Public Health Preparedness Advisory Committee for purposes of advising the Department of Public Health on matters concerning emergency responses to a public health emergency. The advisory committee shall consist of the Commissioner of Public Health, or the commissioner's designee, the Commissioner of Emergency Services and Public Protection, or the commissioner's designee, the president pro tempore of the Senate, or their designee, the speaker of the House of Representatives, or their designee, the majority and minority leaders of both houses of the General Assembly or their designees, 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, or their designees, 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 Public Health Preparedness Advisory Committee may meet to review the plan for emergency responses to a public health emergency and other matters as deemed necessary by the commissioner.

Agency Legislative Proposal - 2020 Session

Document Name: 12.3.19 DPH Safe Drinking Water Act

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Drinking Water Section
Agency Analyst/Drafter of Proposal: Lori Mathieu and Kathryn Keenan

Title of Proposal: An Act Concerning Safe Drinking Water
Statutory Reference: Section 1. (NEW) Section 2. (NEW) Section 3. Sec. 21a-150b. Analysis of source water for contaminants. Testing for unregulated contaminants. Section 4. Sec. 21a-150d. Results of analysis. Reports. Records. Section 5. Sec. 25-40a. Notification of violation of national primary drinking water standards.
Proposal Summary: Section 1. Require a water company to provide an alternative source of potable water to customers when there is a water main break, loss of system pressure, or other event that may affect the quality and quantity of water being served such consumers. Potable water must be supplied if the service interruption will last more than eight hours. Section 2. Require that, by 2026, all small Community Public Water Systems (CPWS) prepare a capacity implementation plan regarding such system's managerial, technical and financial capability to continue to own and operate such system. Section 3. Require that the bottlers in Connecticut who own the four DPH-approved sources of supply have water from each approved source of supply tested for unregulated contaminants, which includes PFAS, 1,4-dioxane, and manganese. Section 4. Require bottlers to submit the results of unregulated contaminant testing to DPH within nine days of the bottler's receipt of such results from the laboratory. The nine day timeframe is consistent with drinking water regulation requirements. Section 5. Require that environmental laboratories notify the DPH and the requestor within twenty four hours of obtaining a water quality test result showing a contaminant at a level that is in violation of the federal Environmental Protection Agency national primary drinking water standard.

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)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

Section 1. Requiring water companies to provide an alternative source of water when there is an interruption to their service will ensure that consumers have access to safe drinking water during the interruption.

Section 2. Requiring small CPWS to prepare and implement a capacity implementation plan will assist the 330 small water systems that often struggle with maintaining technical, managerial and financial capacity to meet the ever increasing requirements in the federal Safe Drinking Water Act.

Sections 3 and 4. Due to the public health concerns surrounding PFAS and other unregulated contaminants, DPH is requiring that bottlers sample all DPH-approved sources for unregulated contaminants annually, and provide the results of such testing to DPH. Presently, DPH has approved four sources in the state of Connecticut, and these are the sources that bottlers would be required to sample. If the results of such sampling exceed the levels set by the Commissioner of DPH pursuant to section 22a-471, then DPH may require the bottler to discontinue use of the source until such time as water from such source may rendered safe to drink. DPH has already required the bottlers that own the four DPH-approved sources in Connecticut to test for PFAS. The four bottlers with DPH-approved sources are: Glacier Valley (Country Pure Foods), Mountain Spring, Triple Springs and Village Springs.

Section 5. Requiring that the environmental laboratory conducting analysis of drinking water samples notify both the water system who requested the analysis and the DPH not later than twenty four hours after obtaining a test result that shows a contaminant at a level that is in violation of the federal Environmental Protection Agency national primary drinking water standards will ensure DPH is aware of all violations immediately. DPH is requiring this notice due to instances where an environmental laboratory is aware of a violation, but does not immediately share the violation information, thereby potentially subjecting the public water system consumers to unsafe drinking water. Federal guidelines for drinking water would not be met.

◊ **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 Energy and Environmental Protection
Agency Contact (*name, title, phone*): Mandi Careathers
Date Contacted:

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

Summary of Affected Agency's Comments

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

Agency Name: Department of Consumer Protection
Agency Contact (*name, title, phone*): Leslie O'Brien
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)*
Potential impact to municipally owned systems to provide potable water during an emergency and to develop small community water system capacity implementation plans.

State None
Federal None
Additional notes on fiscal impact None

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

Section 1. The water system should make available water for potable purposes during an event when there is a water main break, loss of system pressure, or other event that the DPH determines may affect the quality or quantity of water being served such consumers. This can be bottled water and/or a water filling station from a licensed water hauler/or another nearby public water system that is not compromised. Further, water systems should be aware of people who are homebound and therefore work with local health and emergency management officials to assure proper offer of alternative water to those individuals during the water system interruption. Most water systems already provide for this alternative source, DPH wishes to assure that this is recognized within statutory language.

Section 2. The small community public water system capacity plan due in 2026 provides an opportunity for the state's 330 small community public water systems to proactively identify needed system upgrades and repairs to address aging infrastructure issues noted in their Asset and Fiscal Management Plans (required to be produced by January 2021). This Plan will address the issue of small community water systems needing to recognize, fund and address upgrades prior to water system component failure and/or water quality contamination or development of a system deficiency. Many small CPWS await a public health code violation to address an issue that concerns water system maintenance, many have aging infrastructure that can turn into a system violation if left unaddressed. Many of these small CPWS are not collecting in rates the funds necessary to remain sustainable for the future and many risk partial or total system failure in the near future. This Capacity Implementation Plan once produced in 2026, will be the roadmap for the state's small CPWS to achieve and maintain public water system sustainability and resiliency. Further, once these plans are produced, DPH staff time can be spent teaching and coaching small water system owners and operators on the proactive implementation benefits of their Plan to achieve and maintain compliance with state and federal regulations.

Section 3 & 4. Owners of the four sources of bottled water that are located in Connecticut, which are presently inspected every three years by DPH Drinking Water Section staff, must be required to test for and report on unregulated contaminants to assure that their water quality addresses any issued DPH health advisory. This is important so that Drinking Water Section staff can assure

that the sources approved for use that are located in Connecticut meet the health advisory limits set by DPH.

Section 5. Receipt of drinking water sample test results will allow DPH and water systems operational staff to respond to a regulatory violation in a timely manner, and affords greater health and safety protection to the consumers of that public water system. The DPH presently operates 24/7 and is available to assist with any public drinking water quality/quantity regulatory violation. When a regulatory violation is confirmed to the DPH, Drinking Water Section staff quickly assure through direct contact with the water system owner that the water system has followed the requirements under State Law to notify the water system customers quickly and effectively, as well as assure that appropriate corrective actions are being taken to find the source of the water contamination problem and quickly address the issue. In addition, DPH assures that appropriate notice is made to local health directors, town leadership, and critical customers. Further, DPH assures that all regulatory steps are followed for all violations as well as for acute risk violations such as e.coli. Moreover, for e. coli acute risk contamination, DPH Drinking Water Section Enforcement Unit staff immediately work to issue an Administrative Order that will assure the water system addresses all requirements under state and federal law including customer notice and corrective action.

◊ EVIDENCE BASE

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Section 1. DPH Drinking Water Section currently tracks the number of water system incidents that take place, and Drinking Water Section will track the impact of this law change to address the provision of alternative water and hope to achieve 100% compliance.

Section 2. DPH Drinking Water Section Engineering staff will be tracking the Plans developed under current law for Asset and Fiscal Management Planning and will also track the Capacity Plans produced for 2026. After 2026, DPH Drinking Water Section will track small CPWS system violations to measure outcomes. The outcome that would be anticipated is that small CPWS will recognize needed system repairs and upgrades, and will work to address aging infrastructure issues thereby reducing system violations.

Sections 3 and 4. DPH Drinking Water Section staff will track the water quality of the 4 sources of bottled water over time and anticipate that if any elevated level is discovered that immediate action is taken to suspend the use of that source to address the water quality concern.

Section 5. DPH Drinking Water Section will track how many violations are not reported to us in a timely basis due to laboratory delay, the mission of this law is to assure that labs report violations in a timely manner so that appropriate corrective action and notice can take place.

Insert language here:

Section 1: (NEW) (*Effective October 1, 2020*):

A water company, as defined in section 25-32a, shall provide to its consumers, as defined in section 25-32a, an alternative source of drinking water as a temporary measure when there is a water main break, loss of system pressure, or other event that the water company determines may last more than eight hours and that the Department of Public Health determines may affect the quality or quantity of water being served such consumers. Alternative sources of water include bulk water provided by a bulk water hauler licensed pursuant to section 20-278h, bottled water, as defined in section 21a-150 or a fill station. For purposes of this section, "fill station" means a location at which customers of the affected water company may obtain drinking water from a water company that is not affected by the event.

Section 2: (NEW) (*Effective October 1, 2020*):

(a) As used in this section:

(1) "Consumer" has the same meaning as provided in section 25-32a;

(2) "Owner" means the person or entity that owns or controls the small community water system;

(3) "Small community water system" has the same meaning as provided in section 19a-37e; and

(4) "Water company" has the same meaning as provided in section 25-32a.

(b) Not later than January 1, 2026, each owner of a small community water system shall complete a small community water system capacity implementation plan on a form prescribed by the Department of Public Health demonstrating that such owner has the managerial, technical and financial capacity to continue to own and operate such system and shall implement such plan. Following the completion of the initial small community water system capacity implementation plan, each small community water system shall update such small community water system capacity implementation plan annually and make such small community water system capacity implementation plan available to the department upon request. Such plan shall include:

(1) Description of the small community water system, including the number of consumers and persons served, and sources of drinking water;

(2) Ownership and management information, including the type of ownership structure and the current names, addresses, and telephone numbers of the owners, certified operators, and emergency contact persons for the small community water system;

(3) Service area maps;

(4) Facilities maps, including the location of and specific information regarding sources, storage facilities, treatment facilities, pressure zones, booster pumps, hydrants, distribution lines, valves, and sampling points;

(5) Description of such system's cross-connection control program;

(6) Description of such system's source water protection program;

(7) A copy of such system's emergency response plan required pursuant to section 19-13-B102(w) of the Regulations of Connecticut State Agencies;

(8) Capital improvement program, including the schedule that identifies all capital improvements scheduled for a five-year planning period and capital improvements or major projects scheduled for a twenty-year planning period;

(9) Water production and consumption information;

(10) Information regarding public water systems that are nearby, including the distance from the small community water system and type of public water system, if any. Such information shall be based on the coordinated water system plan approved by the Commissioner of Public Health pursuant to section 25-33h for the water utility coordinating committee in which such small community water system is located;

(11) Financial capacity information, including:

(A) An evaluation of the small community water system's fiscal plan prepared pursuant to section 19a-37e;

(B) A summary of the income and expenses for the previous five years;

(C) A five-year balanced operation budget;

(D) Water rate structure and fees charged, including information regarding how such rates and fees are updated and whether such rates and fees are sufficient to maintain cash flow stability and to fund the capital improvement program, as well as any emergency improvements; and

(E) An evaluation that has considered the affordability of water rates.

(c) On or before July 1, 2026, and annually thereafter, the small community water system shall provide a summary of its small community water system capacity plan in the small community water system's consumer confidence report required by section 19-13-B102(i) of the Regulations of Connecticut State Agencies.

(d) This section shall not apply to a small community water system that is (1) regulated by the Public Utilities Regulatory Authority, (2) subject to the requirements set forth in section 25-32d, or (3) a state agency.

(e) The provisions of this section shall be deemed to relate to the purity and adequacy of water supplies for the purposes of the imposition of a penalty under section 25-32e.

(f) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section.

Section 3: Section 21a-150b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) Qualified employees of a bottler shall collect samples of water from each approved source used by such bottler not less than once annually to test for contaminants for which allowable levels have been established in accordance with 21 CFR 165.110 and regulations adopted pursuant to sections 21a-150 to 21a-150j, inclusive, and not less than once every three years to test for contaminants for which monitoring is required pursuant to sections 21a-150 to 21a-150j, inclusive, but for which no allowable level has been established. Qualified employees of an approved laboratory shall analyze such samples to determine whether such source complies with the provisions of sections 21a-150 to 21a-150j, inclusive, any regulation adopted pursuant to said sections and any allowable contaminant level set forth in 21 CFR 165.110. Microbiological analysis shall be conducted not less than once each calendar quarter if the source of such water is other than a public water supply and shall be in addition to any sampling and analysis conducted by any government agency or laboratory.

(b) Qualified employees of a bottler shall collect samples of water from any source used by such bottler when such bottler knows or has reason to believe that water obtained from such source contains an unregulated contaminant in an amount which may adversely affect the health or welfare of the public.

Qualified employees of an approved laboratory shall analyze such samples periodically to determine whether water obtained from any such source is safe for public consumption or use.

(c) On or before January 1, 2021, and annually thereafter, qualified employees of a bottler shall collect samples of water from each approved source that is located in the state of Connecticut, that has been inspected and approved by the Department of Public Health pursuant to section 21a-150a(a)(2) and is used by such bottler to test for unregulated contaminants, and have such samples analyzed by an environmental laboratory registered by the Department of Public Health pursuant to 19a-29a that has the certification to conduct such analysis. For purposes of this subsection and section 21a-150d(d), as amended by this Act, "unregulated contaminant" means a contaminant for which the Commissioner of Public Health, pursuant section 22a-471, has set a level at which such contaminant creates or can reasonably be expected to create an unacceptable risk of injury to the health or safety of persons drinking such source of water.

Section 4: Section 21a-150d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) A laboratory which analyzes any water sample in accordance with any provision of sections 21a-150 to 21a-150j, inclusive, shall report the results of such analysis to the bottler of such water.
(b) Such results shall be available for inspection by the Department of Consumer Protection.

(c) A bottler shall report any result which indicates that a water sample contains contaminants in an amount exceeding any applicable standard to the Department of Consumer Protection not later than twenty-four hours after learning of such result.

(d) A bottler shall report the results of the analysis conducted pursuant to section 21a-150b(c), as amended by this Act, to the Department of Public Health and the Department of Consumer Protection not later than nine days after receipt of the results from the environmental laboratory. If such results exceed the level set by the Commissioner of Public Health pursuant to section 22a-471, for such unregulated contaminant, the Department of Public Health may require such bottler to discontinue use of its approved source until such source no longer creates an unacceptable risk of injury to the health or safety of the people who drink the bottled water that comes from such source.

(e) All records of any sampling or analysis conducted in accordance with the provisions of sections 21a-150 to 21a-150j, inclusive, shall be maintained on the premises of the bottler for not less than five years.

Section 5: Section 25-40a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(a) Not later than twenty four hours after obtaining a test result that shows a contaminant at a level that is in violation of the federal Environmental Protection Agency national primary drinking water standards, the environmental laboratory that performed the test shall notify the person or persons who requested such test and the Department of Public Health, in a form and manner prescribed by the Commissioner of Public Health, of such test result. For purposes of this subsection, "contaminant" means any physical, chemical, biological, or radiological substance or matter in water.

(b) Not later than five business days after receiving notice that a public water system is in violation of the federal Environmental Protection Agency national primary drinking water standards, the Commissioner of Public Health, or the commissioner's designee, shall give written or electronic notification of such violation to the chief elected official of the municipality where such public water system is located and of any municipality that is served by such public water system.

Agency Legislative Proposal - 2020 Session

Document Name: 11.26.19 DPH Clinical Laboratory Fees

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Health Care Quality and Safety Branch, Facility Licensing and Investigations Section
Agency Analyst/Drafter of Proposal: Donna Ortelle and Barbara Cass

Title of Proposal: An Act Implementing The Governor's Budget Recommendations Regarding Health and Human Services
Statutory Reference: Section 1. Sec. 19a-30. Clinical laboratories. Regulation and licensure. Proficiency standards for tests not performed in laboratories.
Proposal Summary: This proposal will raise the biennial licensing fee for clinical laboratories to $1250.00 and would also allow the Department to charge a $200.00 fee for each blood collection facility listed under the clinical laboratory license. Additionally, this proposal seeks to require in state statute that a licensed clinical laboratory report all blood collection facility locations they operate to the Department. This is a regulatory requirement that we would like to see codified in statute for clarity.

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)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The fee to renew a clinical laboratory license was set in statute in 1976, when the Department charged $100.00. In 2009, the fee was raised to $200.00. This proposal seeks to increase the clinical laboratory licensure fee to $1250.00, with an additional $200.00 fee for each blood collection laboratory owned and operated by the clinical laboratory.

Increasing the licensure application fee will align this licensure category with other comparable healthcare institutions, such as environmental laboratories, where the fee is $1250.00, and hospitals, where the fee is $940.00 per site plus $7.50 per bed.

Currently, the Department's regulations require a clinical laboratory to list all blood collection facilities on their licensure application. The blood collection facilities are only allowed to operate under the clinical laboratory license. Often times the Department has seen blood collection facilities open and close and not ever be reported as a part of the clinical laboratory function. The Department would like to know the locations of such facilities to enforce federal and state regulatory requirements. Note that state regulations do not allow a clinical laboratories to operate more than six blood collection facilities.

◊ **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: No other state agencies would be impacted.
Agency Contact (*name, title, phone*): N/A
Date Contacted: N/A

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

Summary of Affected Agency's Comments N/A
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. There are two municipally owned clinical labs in Stamford and Greenwich, but fees are not paid by clinical laboratories owned and operated by a municipality, the state, the United States or any agency of said municipality, state or United States.
State This proposal will provide revenue enhancement to the state. The Department currently licenses 254 clinical laboratories ($133,350), 41 hospital based laboratories ($21,000), and 384 ($38,400) approved blood collection facilities. Totals $192,750 potential revenue for FY 21.
Federal None
Additional notes on fiscal impact None

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

This proposal would allow our Facilities Licensing and Investigations staff to track the locations of blood collection facilities and would enhance the Department's ability to enforce federal and state regulatory requirements. The Department anticipates a reduction in staff time needed to process licenses and schedule site inspections because all information will be available in the licensure application.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. By clearly delineating the requirements for licensing of clinical laboratories and blood collection facilities, the Department anticipates a more efficient way of ensuring these facilities are appropriately regulated as it creates assurances that the Department is notified when a facility opens or closes. As a part of the Quality Assurance and Performance Improvement Program, the Department will monitor this process for a period of one year to determine if the efficiencies gained with assigning a $200 fee with blood collection facility registration have saved staff time.

Insert language here:

Section 1.

Subsection (d) of Section 19a-30 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(d) A nonrefundable fee of [two hundred] (1) one thousand two hundred fifty dollars per site and (2) per blood collection facility, two hundred dollars shall accompany each application for a license or for renewal thereof, except in the case of a clinical laboratory owned and operated by a municipality, the state, the United States or any agency of said municipality, state or United States. Each license shall be issued for a period of not less than twenty-four nor more than twenty-seven months from the deadline for applications established by the commissioner. Renewal applications shall be made (1) biennially within the twenty-fourth month of the current license; (2) before any change in ownership or change in director is made; and (3) prior to any major expansion or alteration in quarters. The licensed clinical laboratory shall report to the Department in a form and manner as prescribed by the Commissioner the name and address of each blood collection facility owned and operated by the clinical laboratory, prior to issuance of a new license, prior to issuance of a renewal license, or whenever a blood collection facility opens or closes.

Agency Legislative Proposal - 2020 Session

Document Name: 11.19.19 DPH Vital Records Search Fee

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

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Health Statistics and Surveillance Section, Office of Vital Records
Agency Analyst/Drafter of Proposal: Lisa Kessler and Elizabeth Frugale

Title of Proposal: An Act Implementing the Governor's Budget Recommendations Regarding Health and Human Services
Statutory Reference: Section 1. 7-74. Fees for certification of birth registration, certified copy of vital statistics certificate and uncertified copy of original certificate of birth. Waiver of fee for certificate of death for a veteran.
Proposal Summary: This proposal would allow the State Office of Vital Records and local vital records offices to charge a search fee for vital records requests. The search fee will cover the cost of a certified copy of the vital record if found, or a letter of 'No Record Found' if the record is not on file. All vital records searched or found would cost $20 per record under this proposal, with two exceptions – the Department of Public Health may charge $30 for a birth record and $65 for an original certificate of birth for an adopted person.

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, the State Office of Vital Records receives approximately 14,500 requests per year for certified copies of birth, marriage, death and fetal death certificates. Of these requests, about nine percent are unfilled because the request is incomplete or no record is on file. Local vital records offices have similar scenarios, with the number of overall requests varying depending upon the size of the town.

The State Office of Vital Records is permitted by statute to charge a fee for the issuance of a certified copy of a vital record – $30 for a birth certificate and $20 for a marriage or death certificate. Local vital records offices charge $20 for all vital records except for a Certification of Birth (wallet size), which costs $15. The fees only apply when a record is found and a certified copy of the record can be issued. When a record cannot be found, the Department and local registrars must return the fee, meaning that the vital records offices receive no compensation for the search of the record or the time spent to prepare correspondence informing the requester of the negative search result. There is much time and cost involved in searching for a record. Those records that are ultimately not found are those on which the staff expend the most time – multiple databases and index books must be searched before it is determined that the record is not on file, and communication between the different vital records offices takes place to confirm that the record is not recorded in another vital records office. Yet, the Department and local registrars receive no compensation for this considerable expenditure of time and resources.

Given the substantial time and costs involved in processing unfilled requests, the Department is proposing a fee that will apply to the ***search*** of the vital record. Since the fee applies to the search, it is applicable whether or not the record is found.

◊ **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? Unknown

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

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

(4) What was the last action taken during the past legislative session? Was not included in DPH Administration's proposals

PROPOSAL IMPACT

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

Agency Name: N/A
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)* This proposal would allow local vital records registrars to collect a twenty dollar search fee and also increases the fee for a short form birth certificate from $15 to $20 per record. The amount of revenue that could be generated is unknown.
State The search fee is expected to generate additional revenue of approximately $30,000 per year.
Federal None
Additional notes on fiscal impact None

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

This proposal would appropriately compensate vital records offices for time and effort spent on the search of the record and preparation of correspondence informing the requester of the negative search result.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. In reviewing other state policies regarding vital record search fees, it was determined that ***at least 47*** of 51 vital records jurisdictions (50 states and NYC) charge a non-refundable search fee for vital records requests. In all of the 47 jurisdictions, the search fee covers the cost of one certified copy of the record if the record is found, or a certified letter stating that no record is on file.

Insert language here:

Section 1.

Section. 7-74 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2020*):

(a) [The fee for a certification of birth registration, short form, shall be fifteen dollars. The fee for a certified copy of a certificate of birth, long form, shall be twenty dollars, except that the fee for such certifications and copies when issued by the department shall be thirty dollars.] A fee of twenty dollars

shall be charged to search for a vital record, except that the department shall charge a fee of thirty dollars to search for a birth record. Such fee shall cover the cost of the search and either one certified copy of the vital record or a certification of birth registration if the requested record is found, or a certified letter indicating that no record is on file.

(b) [(1) The fee for a certified copy of a certificate of marriage or death shall be twenty dollars. Such fees shall not be required of the department.]

[2] Any fee received by the Department of Public Health related to a search for a certificate of death shall be deposited in the neglected cemetery account, established in accordance with section 19a-308b.

(c) The search fee for one certified copy of a certificate of death for any deceased person who was a veteran, as defined in subsection (a) of section 27-103, shall be waived when such [copy] search is requested by a spouse, child or parent of such deceased veteran.

(d) The fee for [an uncertified copy] a search of an original certificate of birth issued pursuant to section 7-53 shall be sixty-five dollars.

Agency Legislative Proposal - 2020 Session

Document Name: 11.25.19 DPH Electronic Medical Records Access

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

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: Infectious Diseases Section
Agency Analyst/Drafter of Proposal: Matthew Cartter, MD, MPG

Title of Proposal: An Act Concerning The Department of Public Health's Recommendations Regarding Remote Access to Electronic Medical Records at Hospitals
Statutory Reference: Section 1. Sec. 19a-215. Commissioner's lists of reportable diseases, emergency illnesses and health conditions and reportable laboratory findings. Reporting requirements. Confidentiality. Fines. Section 2. Sec. 19a-72. Connecticut Tumor Registry. Definitions. Duties of Department of Public Health. Reporting requirements. Penalties. Regulations. Subsection (c) of 19a-215 of the general statutes authorizes the Department to contact the reporting health care provider to obtain medical information for the purposes of disease control. Section 19a-36-A1 of the Regulations of Connecticut State Agencies (RCSA) defines medical information as “recorded health information on an individual who has a reportable disease” including medical record information.
Proposal Summary: This proposal allows the Department to have remote access to electronic medical records that involve “Reportable Diseases, Emergency Illnesses and Health Conditions" and "Reportable Laboratory Findings" when information is requested for disease control and prevention. The proposal will also allow the electronic access to records pertaining to the reporting of tumors. The language ensures that all information obtained is kept confidential under Section 19a-25 of the general statutes.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Tuberculosis, Human Immunodeficiency Virus, Sexually Transmitted Diseases, Viral Hepatitis, Immunization, Health Care Associated Infections and Antibiotic Resistance, and the Epidemiology and Emerging Infections Programs

Section 164.512(b) of the HIPAA Privacy regulations permits providers to release personal health information to public health authorities for surveillance, investigation and intervention activities aimed at preventing and controlling diseases, injuries and disabilities. Medical records are reviewed to collect data related to patient demographics, disease severity, and risk factors for disease. Accurate and complete data is essential to inform prevention measures.

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

Hospitals have been slowly transitioning to web-based electronic medical records systems. Many use “Epic Systems Software” also known as “Epic.” The Yale Healthcare system was the first network that allowed some DPH Infectious Disease staff remote access to electronic medical records. However, recently, three other hospital networks (Hartford Healthcare, Western Connecticut Health, and Trinity Health) have also granted remote medical record access to some DPH Infectious Disease staff. The 11 remaining Connecticut hospitals require us to go on-site.

We provide a list of patients for whom we need to do record reviews to a contact in medical records. Our contact adds these patients to a queue associated with our user identifications. When agency staff log into Epic from DPH we are restricted to those patients’ records. This has benefited DPH in several ways.

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

The Epic system allows us to navigate through a patient’s record in much the same way a clinician would. There are separate tabs for various parts of the records (e.g., demographics, lab results, surgical reports, medications administered, dictated reports, etc.) that allow us to easily compile the data we need. When electronic access is not granted, hospitals must compile PDFs from their electronic medical records’ systems for us to view. Depending upon the length of the patient’s hospitalization, these PDFs could be hundreds of pages long. Often PDFs have no logical

subsections - making it necessary to look at each and every page in order to find what we need. This lack of chart organization has greatly increased the time it takes to do reviews. Needed data is often not present in the PDFs and likely impacts identification of risk factors for disease.

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

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

Tumor Registry Program

The Department is grateful that some Infectious Disease staff now have remote access to medical records at many of our hospitals, however, the access has not been uniformly applied to staff within different DPH Infectious Disease programs, and the same level of access has not been made available to the staff of the Tumor Registry Program.

The Tumor Registry Program currently has full remote access to a free-standing oncology center; the Harold Leever Regional Cancer Center in Waterbury. Program staff also have remote connectivity on a time-limited basis to the Laboratory Information Management Systems at Danbury/New Milford, Norwalk, and Day Kimball Hospitals. These connections are for case finding audits. Access is terminated once the audit has been completed.

All hospitals and health care professionals are required to provide the Department with medical information regarding any person who has been diagnosed with a reportable tumor. Accurate and complete data is essential to inform data collection and investigations.

The full efficiencies of remote electronic access can only be realized if all Infectious Diseases Programs and the Tumor Registry are granted equal access.

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

If this is a resubmission, please share:

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

This proposal was introduced during the 2019 legislative session as House Bill 7301. The draft below is from File Copy 971, which includes the revisions made through House Amendment A. That amendment was negotiated with the Connecticut Hospital Association and is consensus language. This bill did not pass the Senate Chamber in the last days of the 2019 regular session.

PROPOSAL IMPACT

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

Agency Name: University of Connecticut Health Center/John Dempsey Hospital **Agency Contact (*name, title, phone*):** Joann Lombardo and Kelly Sinko **Date Contacted:** 11/20/19 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 This will result in a savings for the State of Connecticut because DPH epidemiologists will no longer have to physically travel to licensed health care facilities to review medical records onsite.
Federal This will result in a savings of federal cooperative agreement funds, because the federally-funded DPH epidemiologists who do this work will no longer have to physically travel to licensed health care facilities to review medical records onsite. This will also make DPH more competitive in applying for these federal funds.
Additional notes on fiscal impact None

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

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

Insert language here:

Section 1. Section 19a-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(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 in which such case resides and to the Department of Public Health, no later than twelve hours after such provider's recognition of the disease. Such reports shall be in writing, by telephone or in an electronic format approved by the commissioner. **[**Such reports of disease shall be confidential and not open to public inspection except as provided for in section 19a-25.**]**

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

to the director of health of the town, city or borough in which the affected person resides or, in the absence of such information, the town where the specimen originated.

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

(e) A hospital, as defined in section 19a-490 and licensed pursuant to chapter 368v, shall provide the Department of Public Health with access, including remote access if technically feasible, in a manner approved by the Commissioner of Public Health, to the entirety of each electronic medical record that concerns a reportable disease, emergency illness or health condition listed by the commissioner pursuant to subdivision (9) of section 19a-2a that occurs at such hospital.

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

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

Sec. 2. Subsection (c) of section 19a-72 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020*):

(c) [The] (1) A health care provider shall provide the Department of Public Health, [shall be provided such] at the request of the department, with access to the clinical records of any [health care provider] patient, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(2) A hospital shall provide the Department of Public Health with access, including remote access if technically feasible, to the entirety of a patient's medical record, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.


STATE OF CONNECTICUT
QUI TRANSTULIT SUSTINET

Agency Legislative Proposal - 2020 Session

Document Name: DPH 12.12.19 DPH Newborn Screening

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Department of Public Health
Liaison: Brie Wolf / Av Harris **Phone:** (860) 509-7246 / (860) 509-7106 **E-mail:** brie.wolf@ct.gov / av.harris@ct.gov
Lead agency division requesting this proposal: State Public Health Laboratory, Newborn Screening Program
Agency Analyst/Drafter of Proposal: Marie Burlette and Adrienne Manning

Title of Proposal: An Act Concerning Revisions to the Department of Public Health's Newborn Screening Statute
Statutory Reference: Section 1. Sec. 19a-55. Newborn infant health screening. Tests required. Fees. Report to Department of Public Health. Exemptions. Regulations.
Proposal Summary: The statute pertaining to the collection and shipping of newborn screening blood spot specimens does not align with the Newborn Screening Program's current practice, nor national guidelines on timeliness quality assurance indicators. The Department would like to update the statute to reflect: 1) Health Resources and Services Administration (HRSA) Advisory Committee on Heritable Disorders in Newborns and Children recommendations for timeliness in newborn screening, 2) Clinical Laboratory Institute newborn screening specimen collection and handling guidance and 3) Newborn Screening Program Genetic Advisory Committee recommendations. The State Public Health Laboratory conducts blood spot screenings for over 60 disorders; with the exception of Cystic Fibrosis (CF) screening, which is conducted at the UConn Health Center and Yale Laboratories. The Newborn Screening Program currently reports de-identified data on the number of infants screened, types of disorders screened and confirmed cases for the Title V Maternal Health Block Grant and to the Association of Public Health Laboratories National Data Repository. This is done for all disorders screened, except Cystic Fibrosis. There is no current requirement for laboratories that screen for Cystic Fibrosis to report the number of newborns screened and screening results to DPH. This proposal will require laboratories conducting blood spot screening for Cystic Fibrosis to report data to DPH for epidemiologic 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)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

The Connecticut newborn screening panel has expanded from twenty-three disorders in early 2005 to over sixty disorders in 2019 (with the planned addition of three new disorders in upcoming months) as a result of advances in screening technology, as well as the ability to identify and treat a variety of genetic conditions. Similar expansion has occurred across the country and has resulted in the development of new best practice guidelines by the authorities noted above. Similar practices related to specimen collection and handling have been instituted in many other states; resulting in a demonstrated improvement in the timeliness of newborn screening.

The Connecticut Newborn Screening Program updated its specimen collection and handling guidance several years ago in response to public concern surrounding delays in newborn screening, but due to outdated statutory language, the program has no ability to enforce compliance. Failure to enact this language could delay the identification of a time-critical disorder in a newborn; potentially resulting in permanent damage to, or death of, a newborn.

Connecticut is the only state in the country that is unable to provide epidemiologic data for Cystic Fibrosis. Adopting reporting requirements would close this reporting gap.

The Department has seen a trend nationally to retain newborn screening data longer to support long term follow-up. Extended retention of newborn screening testing results will prevent college-age athletes from undergoing unnecessary screening. The National Collegiate Athletic Association now requires that all student-athletes be tested for Sickle Cell trait, or show proof of a previous test prior to participation in intercollegiate athletics. Parents routinely call the Newborn Screening Program to obtain their college-aged children's sickle cell screening results, reporting that the primary care provider does not have a copy of the results. The Newborn Screening Program staff explain to parents that results are destroyed after five years, and advise them to ask their primary care provider about how to obtain a blood test for sickle cell.

Extended retention of newborn screening testing results will also allow individuals to access their newborn screening results for family planning purposes during their early adult reproductive years. Further, it coincides with the newborn data retention process recently implemented through an agreement with Connecticut Children's Medical Center for the collection of specific milestone data and long term follow-up of abnormal newborn testing results through age 21.

Many newborn screening programs, including Connecticut's, are beginning to transition from short-term follow-up to long-term follow-up, since some of the disorders for which we screen do not present in the newborn timeframe, but rather later in childhood or adolescence.

◊ **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?

N/A

PROPOSAL IMPACT

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

Agency Name: University of Connecticut Health Center, Clinical Laboratory and Pathology Services
Agency Contact (*name, title, phone*): Kelly Sinko
Date Contacted: 11/20/19

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

Summary of Affected Agency's Comments
Clarified language in subsection (b) to make clear that the institution performing the testing for cystic fibrosis is to annually report to the Department of Public Health the number of infants screened and the aggregate results of such testing.

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
University of Connecticut Health Center and Yale Laboratories will be expected to put reporting practices and systems in place. The fiscal impact is unknown, but is not anticipated to be significant.

Federal
None

Additional notes on fiscal impact

None

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

The Newborn Screening Program will develop reporting practices and systems to collect Cystic Fibrosis data within existing resources. The Program will provide the state's birthing hospitals with feedback on timeliness indicators using existing HRSA grant funding. The Program will respond requests for Sickle Cell screening results using the established procedure. Screening results will be stored electronically.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. The MAVEN newborn screening follow-up database and the Association of Public Health Laboratories national newborn screening data repository will be used to measure outcome data. The Newborn Screening Program has an existing Memorandum of Agreement in place that authorizes the reporting of de-identified newborn screening data into the national data repository, which allows the program to measure its performance in meeting national quality indicators, and compare performance to other programs nationally. The outcomes will be a more complete data set and an improvement in the timeliness of collection, shipping and reporting of newborn screening results.

Insert language here:

Section 1.

(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] amino acid disorders, including phenylketonuria, organic acid disorders, fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD), 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] other metabolic and genetic disorders as [shall be] prescribed by the [Department] Commissioner of Public Health, and subject to the approval of the Secretary of the Office of Policy and Management. [The tests shall be

administered as soon after birth as is medically appropriate.] Testing for such diseases shall be performed using a blood spot specimen, which shall be collected not before twenty-four hours of age and not later than forty-eight hours of age, unless the institution determines that a situation exists to warrant an early collection of the specimen or specimen collection is medically contraindicated. Such situations that warrant early collection of the specimen shall include, but may not be limited to, the imminent transfusion of blood products; dialysis; early discharge of the infant; transfer of the newborn to another institution; or imminent death. If the newborn expires before a blood spot specimen can be obtained, the specimen shall be collected as soon as practicable after death. The institution licensed pursuant to section 19a-490 caring for newborn infants, or nurse midwife or midwife licensed pursuant to chapter 377, shall notify the Department of Public Health when a specimen is not collected by forty-eight hours of age due to medical fragility; refusal by parents when newborn screening is in conflict with their religious tenets and practice; when a newborn is receiving comfort measures only; or other reason. Such notification shall be documented in the Department of Public Health's Newborn Screening database pursuant to section 19a-53 by the institution caring for newborn infants, nurse midwife or midwife, or sent in writing to the Department of Public Health not later than seventy-two hours of age. The institution caring for newborn infants or nurse midwife or midwife shall ship the blood spot specimen to the State Public Health Laboratory not later than twenty-four hours from the time of collection. The Department of Public Health may request an additional blood spot specimen for the following reasons: the first specimen is collected at less than twenty four hours of age; the first specimen was collected following a transfusion of blood products; the specimen is unsatisfactory for testing; or the Department determines there is an out of range result. 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, fatty acid oxidation disorders, including, but not limited to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD) and medium-chain acyl-CoA dehydrogenase (MCAD), and, subject to the approval of the Secretary of the Office of Policy and Management, any other disorder included on the recommended uniform screening panel pursuant to 42 USC 300b-10, as amended from time to time].

(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, or nurse midwife or midwife licensed pursuant to chapter 377, shall cause to have administered to (1) every such infant in its care a screening test for (A) cystic fibrosis, and (B) critical congenital heart disease, [and (C) on and after January 1, 2020, spinal muscular atrophy,] 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. 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 enter the results of such test into the newborn screening system pursuant to section 19a-53. The administrative officer or other person in charge of each institution who performs the testing for cystic fibrosis shall report the number of infants screened and the aggregate results of such testing on an annual basis to the Department of Public Health, in a form and manner as prescribed by the Commissioner of Public Health. The provisions of this section shall apply irrespective of the patient's insurance status or source of payment, including self-pay status. Such screening tests shall be administered as soon after birth as is medically appropriate.