Agency Legislative Proposal - 2021 Session

Document Name: DPH 9.26.20 Residential Care Home Definition and Discharge Statute

(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: Facility Licensing and Investigations Section and Legal Office
Agency Analyst/Drafter of Proposal: Jill Kennedy, Joanne Yandow, Olinda Morales

Title of Proposal: An Act Concerning Revisions to the Statutes Pertaining to Discharges in a Residential Care Home
Statutory Reference: Sec. 19a-535a. Residential care home. Transfer or discharge of patients. Appeal. Hearing.
Proposal Summary: This proposal revises section 19a-535a, which governs discharges from residential care homes (RCH), to allow RCHs to comply with Home and Community Based Settings Requirements in the Center for Medicare & Medicaid Services ("CMS") regulations. .

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?

This proposal will allow residential care homes (RCHs) to qualify as home and community based settings (HCBS), as set forth in federal CMS regulations, which will allow RCH residents who are currently waiver participants to continue to participate in the waiver and receive waiver services. If the proposed changes to 19a-535a are not made, the waiver participants currently residing in RCHs will either have to move to a different residence that does qualify as a HCBS or stay at the RCH and no longer receive needed waiver services. This would also mean that the RCH would have to provide additional assistance to those individuals who are no longer receiving waiver services. Given that over 250 individuals currently reside in RCHs and receive services under Medicaid waivers, it is imperative that the state ensure that RCHs can be considered a home and community based setting under federal regulations.

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Section 19a-535a, as currently written, allows an RCH resident to request an appeal hearing from DPH when they do not agree with their transfer or discharge from a residential care home. DPH's hearing office hears these appeals and determines whether the discharge fell within the parameters outlined in the statute. That decision is final, and the resident cannot contest it. This proposal will afford the resident the ability to appeal DPH's decision before the Superior Court. Pursuant to 42 CFR 441.301, residents living in home and community based settings must have comparable protections to those provided to tenants under the state's landlord/tenant law. By providing more protections and appeal rights, the discharge statute is more likely to be viewed as comparable to landlord/tenant protections and RCHs would qualify as HCBS.

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

If this is a resubmission, please share:

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

In 2015, the Department raised House Bill 6887, AAC The Department of Public Health's Recommendations Regarding the Protection of Residents in Healthcare Institutions. This bill included minor revisions to section 19a-535a and was opposed by the industry. The bill died in Committee after the public hearing process.

Over the past two years, the Departments of Social Services and Public Health have been providing guidance to the Connecticut Association of Residential Care Homes by speaking at their association meetings regarding the importance of this statutory revision and the impact it will have on their businesses.

The language in the proposal was captured in section 12 of House Bill 5020, the Governor's Budget Implementer governing public health during the 2020 session. Because of the onset of COVID-19, the 2020 regular legislative session ended, and this proposal did not move forward.

PROPOSAL IMPACT

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

Agency Name: Department of Social Services
Agency Contact (*name, title, phone*): Alvin Wilson and David Seifel
Date Contacted:

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

Summary of Affected Agency's Comments

DSS and DPH have been meeting for over two years to discuss ways to ensure that the RCHs will be able to comply with the HCBS rules in 42 CFR §441.301. DSS fully supports this proposal and believes that is necessary to provide services for individuals residing in RCHs under Medicaid Waivers.
Will there need to be further negotiation? ☐ **YES** ☒**NO**

Agency Name: Attorney General's Office **Agency Contact (*name, title, phone*):** Nicole Lake **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 This proposal will allow a RCH to qualify as home and community based settings, which allow RCH residents who are also waiver participants to continue to receive much needed waiver services. If the RCH is not qualified as a HCBS, waiver participants will be faced with the difficult choice of moving to a residence that does qualify as a HCBS or not receiving waiver services. There should be no fiscal impact to the state as the individuals receiving waiver services will continue to receive services they are already receiving. The state is already reimbursing waiver providers for these services.
Federal RCHs will be considered HCBS and RCH residents participating in waivers can continue to participate and receiver Medicaid waiver services.
Additional notes on fiscal impact

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

DPH's Legal Office will likely see an increase in the number of appeals filed by RCH residents upon discharge. The Attorney General's Office will defend the Department's position on

appeals, as an aggrieved party will now have the right to appeal the DPH final decision to the Superior Court.

◊ 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.

This proposal will allow a Residential Care Home (RCH) to qualify as a HCBS under federal law and RCH residents will continue to receive Medicaid waiver services under the Home and Community Based Waiver programs.

Section 19a-535a of the general statutes is repealed and the following is substituted in lieu thereof (Effective October 1, 2020):

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

(1) "Facility" means a residential care home, as defined in section 19a-490; **[**.**]**

(2) "Emergency" means a situation in which a resident of a facility presents an imminent danger to his or her own health or safety, the health or safety of another resident or the health or safety of an employee or the owner of the facility;

(3) "Department" means the Department of Public Health; and

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

(b) A facility shall not transfer or discharge a resident from the facility unless (1) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility, (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, (3) the health or safety of individuals in the facility is endangered, (4) the resident has failed, after reasonable and appropriate notice, to pay for a stay or a requested service[,] at the facility or (5) the facility ceases to operate. In the case of an involuntary transfer or discharge the facility shall provide written notice to the resident and, if known, his or her legally liable relative, guardian or conservator [shall be given a thirty-day written notification which] at least thirty days prior to the proposed discharge date, except when the facility has requested an immediate transfer or discharge in accordance with subsection (e) of this section, and the notice shall include[s] the reason for the transfer or discharge, the date on which the discharge shall be effective and notice of the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection (d) of this section, and the resident's right to represent himself or herself or be represented by legal counsel. Such notice shall be in a form and manner prescribed by the

commissioner, as modified from time to time, and shall include the name, mailing address and telephone number of the State Long-Term Care Ombudsman and be sent by facsimile or electronic communication to the Office of the Long-Term Care Ombudsman on the same day as the notice is given to the resident. If the facility knows the resident has, or the facility alleges that the resident has, a mental illness or an intellectual disability, the notice shall also include the name, mailing address and telephone number of the entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system. No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge presents imminent danger of death to the resident.

(c) The facility shall be responsible for assisting the resident in finding [appropriate placement] an alternative residence. A discharge plan, prepared by the facility, in a form and manner prescribed by the commissioner, as modified from time to time, [which indicates] shall include the resident's individual needs and shall [accompany the patient] be submitted to the resident not later than seven days after the notice of discharge is issued to the resident. The facility shall submit the discharge plan to the commissioner at or before the hearing held pursuant to subsection (d) of this section.

(d) (1) [For transfers or discharges effected on or after October 1, 1989, a] A resident or his or her legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection (b) of this section, that he or she will be transferred or discharged from the facility may appeal such transfer or discharge to the Commissioner of Public Health by filing a request for a hearing with the commissioner [within ten] not later than ten days [of] after the receipt of such notice. Upon receipt of any such request, the commissioner [or his designee] shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. Such a hearing shall be held [within seven] not later than seven business days [of] after the receipt of such request. [and a determination made by the] The commissioner [or his designee] shall issue a decision not later than [within] twenty days [of the termination] after the closing of the hearing record. The hearing shall be conducted in accordance with chapter 54.

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

(3) Any involuntary transfer or discharge shall be stayed pending a determination by the commissioner

or his designee. Notwithstanding any provision of the general statutes, the determination of the commissioner or his designee after a hearing shall be final and binding upon all parties and not subject to any further appeal.**]**

(2) Any involuntary transfer or discharge that is appealed under this subsection shall be stayed pending a final determination by the commissioner.

(3) The commissioner shall send a copy of his or her decision regarding a transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party, and the State Long-Term Care Ombudsman.

(e) (1) In the case of an emergency, the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident by submitting a sworn affidavit attesting to the basis for the emergency transfer or discharge. The facility shall provide a copy of the request for an immediate transfer or discharge to the resident and the notice described in subsection (b) of this section. After receipt of such request, the commissioner may issue an order for the immediate temporary transfer or discharge of the resident from the facility. The temporary order shall remain in place until a final decision is issued by the commissioner, unless earlier rescinded. The commissioner shall issue the determination as to the need for an immediate transfer or discharge of a resident no later than seven days after receipt of the request from the facility. A hearing shall be held not later than seven business days after the determination issued pursuant to this section. The commissioner shall issue a decision not later than twenty days after the closing of the hearing record. The hearing shall be conducted in accordance with the provisions of chapter 54.

(2) The commissioner shall send a copy of his or her decision regarding an emergency transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party and the State Long-Term Care Ombudsman.

(3) If the commissioner determines, based upon the request, that an emergency does not exist, the commissioner shall proceed with a hearing in accordance with the provisions of subsection (d) of this section.

(f) A facility or resident who is aggrieved by a final decision of the commissioner may appeal to the Superior Court in accordance with the provisions of chapter 54. Pursuant to subsection (f) of section 4-183, the filing of an appeal to Superior Court shall not, of itself, stay enforcement of an agency decision. The Superior Court shall consider an appeal from a decision of the Department of Public Health pursuant to this section as a privileged case in order to dispose of the case with the least possible delay.

Agency Legislative Proposal - 2021 Session

Document Name: DPH 9.26.20 Revisions to Local Emergency Medical Services (EMS) Plans

(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: Healthcare Quality and Safety Branch, Office of Emergency Medical Services (OEMS)
Agency Analyst/Drafter of Proposal: Jill Kennedy and Raffaella Coler

Title of Proposal: An Act Concerning Revisions to Local Emergency Medical Services Plans
Statutory Reference: Section 1. Sec. 19a-181b. Local emergency medical services plan.
Proposal Summary: To impose a fine on a municipality if they are non-compliant with the statutory requirements to submit a local EMS plan.

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?

Public Act 00-151 required a municipality to establish a Local Emergency Medical Services Plan that would ensure the residents of such municipality received services during emergency situations. It is important to note that in 2000 the Department was unable enforce the provisions of this statute due to staffing issues. However, the statute was revised in 2014 through Public Act 14-217 and the Department was appropriated funding for staffing to support municipalities in their efforts to comply with this section. During that time, the Department began reaching out to municipalities to ensure their compliance with the requirement for the EMS Plan. Public Act 17-84 required a municipality to review and update their plans every five years. The revision also included timeframes for providing notification to and responses needed from municipalities. To date, there are over 65 municipalities who are not in compliance with the statute, with 13 of these facilities being between three and five years overdue. The Department has provided them

with several notifications. The Department is proposing to revise the statute to include fines for noncompliance with the requirements for local EMS Plans.

◊ **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: 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)*
A municipality would have to pay a fine if they do not submit their local EMS plan on time.

State
The State may see small revenue gains from fine collections.

Federal
None.

Additional notes on fiscal impact

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

This proposal will allow OEMS staff to ensure that local EMS services are following the plans that delineate their emergency operations. These plans include information such as:
(1) the written agreements or contracts developed between the municipality, its emergency medical services providers and the public safety answering point that covers the municipality;

(2) the identification of levels of emergency medical services, including public safety answering points responsible for receiving emergency calls and notifying/assigning the appropriate provider to a call for emergency medical services, the emergency medical services provider that is notified for initial response, basic ambulance service, advanced life support level, mutual aid call arrangements; and
(3) establishment of performance standards, including, but not limited to, standards for responding to a certain percentage of initial response notifications, response times, quality assurance and service area coverage patterns, for each segment of the municipality's emergency medical services system.

◊ **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 2017 and 2018 there was significant noncompliance with the requirement to submit the EMS Plans to the Department. The Office of Emergency Medical Services will monitor the impact of a civil money penalty and plan submission. It is anticipated that the implementation of a potential fine will enhance compliance.

Insert fully drafted bill here

Section 19a-181b of the general statutes is repealed and the following is substituted in lieu thereof *(Effective July 1, 2021)*:

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

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

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

(3) The establishment of performance standards, including, but not limited to, standards for responding to a certain percentage of initial response notifications, response times, quality assurance and service area coverage patterns, for each segment of the municipality's emergency medical services system; and

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

(b) In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional emergency medical services council established pursuant to section 19a-183, its regional emergency medical services coordinator appointed pursuant to section 19a-186a, its regional emergency medical services medical advisory committees and any sponsor hospital, as defined in regulations adopted pursuant to section 19a-179, located in the area identified in the plan; and (2) shall submit the plan to its regional emergency medical services council for the council's review and comment.

(c) Each municipality shall update the plan required by subsection (a) of this section not less than once every five years. The municipality shall consult with the municipality's primary service area responder concerning any updates to the plan. The Department of Public Health shall, upon request, assist each municipality in the process of updating the plan by providing technical assistance and helping to resolve any disagreements concerning the provisions of the plan.

(d) Not less than once every five years, each municipality shall review its plan and the primary service area responder's provision of services under the plan and submit a revised plan to the Commissioner of Public Health. The commissioner shall evaluate each municipality's plan on an ongoing basis. The commissioner shall provide not less than one hundred twenty days of notice to a municipality as to when the commissioner's evaluation of the revised plan will be conducted. Upon the conclusion of such evaluation, the department shall assign a rating of “meets performance standards”, “exceeds performance standards” or “fails to comply with performance standards” for the primary service area responder and notify the municipality and primary service area responder of such rating. The commissioner may require any primary service area responder that is assigned a rating of “fails to comply with performance standards” to submit a performance improvement plan, not later than ninety days after being notified of such rating, and meet the department's requirements for compliance with performance standards. Such primary service area responder may be subject to subsequent performance reviews or removal as the municipality's primary service area responder for a failure to improve performance in accordance with section 19a-181c.

(e) Each municipality who has not complied with the requirements in subsection (d) of this section shall be fined not less than five hundred dollars for each month the plan is not submitted to the Department.

Agency Legislative Proposal - 2021 Session

Document Name: DPH 9.26.20 Amendments to Marriage Certificates

(If submitting electronically, please label with date, agency, and title of proposal – 092621_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 Concerning Amendments to Marriage Certificates
Statutory Reference: Section 1. Sec. 7-36. Definitions. Section 2. Sec. 19a-42. Amendment of vital records.
Proposal Summary: Current law does not allow the sex to be amended on a marriage certificate following gender transition. This proposal will allow such an amendment. The amendment will result in a replacement marriage certificate so that the registrant's original information will not be visible on the newly issued marriage record.

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? ***Yes***

(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? ***Yes***

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

In 2015, Connecticut law was revised through Public Act 15-132 to eliminate the need to undergo medical treatment for sex re-assignment to amend the sex designator on a birth certificate. With the elimination of this requirement, the Department has seen a large increase in requests for sex amendments. However, the law only allows for the birth certificate to be updated, with no comparable law that allows for the updating of a marriage certificate. So, if gender transition occurs after a person is already married, that person's marriage certificate cannot be amended to reflect the person's current gender. It will continue to identify the person with their former gender and name.

The Department has received several requests for amendments to marriage certificates for persons who have undergone gender transition after they were married. Under current law the Department is not authorized to make the amendments.

◊ **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: 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)* None
State The State Vital Records Office will be responsible for processing sex amendments to marriage records. The Vital Records Office is operating with minimal staff, so whether it can absorb the additional workload will be dependent on the volume of requests received.
Federal None
Additional notes on fiscal impact

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

◊ **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 number of requests to amend sex on marriage certificates will be tracked.

Many states have incorporated gender neutral terminology into their marriage certificates. New York now identifies individuals as "Spouse A" and "Spouse B", which has replaced "Bride" and "Groom".

Pursuing public acts of gender affirmation, such as legally changing one's name or gender marker on state documents, are associated with lower rates of adverse psychological health outcomes due to gender-based mistreatment among transgendered individuals (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7229467/pdf/main.pdf).

Insert fully drafted bill here

Section 1.

Subdivision (10) of section 7-36 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

"Amendment" means to (A) change or enter new information on a certificate of birth, marriage, death or fetal death, more than one year after the date of the vital event recorded in such certificate, in order to accurately reflect the facts existing at the time of the recording of the event, (B) create a replacement certificate of birth for matters pertaining to parentage, and a replacement certificate of birth or marriage for matters pertaining to gender change, or (C) reflect a legal name change in accordance with section 19a-42 or make a modification to a cause of death;

Section 2.

Section 19a-42 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) To protect the integrity and accuracy of vital records, a certificate registered under chapter 93 may be amended only in accordance with sections 19a-41 to 19a45, inclusive, chapter 93, regulations adopted by the Commissioner of Public Health pursuant to chapter 54 and uniform procedures prescribed by the commissioner. Only the commissioner may amend birth certificates to reflect changes concerning parentage, or birth or marriage certificates to reflect changes concerning gender change. Amendments related to parentage or gender change shall result in the creation of a replacement certificate that supersedes the original, and shall in no way reveal the original language changed by the amendment. Any amendment to a vital record made by the registrar of vital statistics of the town in which the vital event occurred or by the commissioner shall be in accordance with such regulations and uniform procedures.

(b) The commissioner and the registrar of vital statistics shall maintain sufficient documentation, as prescribed by the commissioner, to support amendments and shall ensure the confidentiality of such documentation as required by law. The date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made part of the record and the original certificate shall be marked "Amended", except for amendments due to parentage or gender change. When the registrar of the town in which the vital event occurred amends a certificate, such registrar shall, within ten days of making such amendment, forward an amended certificate to the commissioner and to any registrar having a copy of the certificate. When the commissioner amends a birth certificate, including changes due to parentage or gender, the commissioner shall forward an amended certificate to the registrars of vital statistics affected and their records shall be amended accordingly.

(c) An amended certificate shall supersede the original certificate that has been changed and shall be marked "Amended", except for amendments due to parentage or gender change. The original certificate in the case of parentage or gender change shall be physically or electronically sealed and kept in a confidential file by the department and the registrar of any town in which the birth was recorded, and may be unsealed for issuance only as provided in section 7-53 or upon a written order of a court of competent jurisdiction. The amended certificate shall become the official record.

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

to the acknowledgment of paternity. The commissioner shall amend the birth certificate for an adult child to change his or her name only pursuant to a court order.

(2) If another father is listed on the birth certificate, the commissioner shall not remove or replace the father's information unless presented with a certified court order that meets the requirements specified in section 7-50, or upon the proper filing of a rescission, in accordance with the provisions of section 46b-172. The commissioner shall thereafter amend such child's birth certificate to remove or change the father's name and to change the name of the child, as requested at the time of the filing of a rescission, in accordance with the provisions of section 46b-172. Birth certificates amended under this subsection shall not be marked “Amended”.

(e) When the parent or parents of a child request the amendment of the child's birth certificate to reflect a new mother's name because the name on the original certificate is fictitious, such parent or parents shall obtain an order of a court of competent jurisdiction declaring the putative mother to be the child's mother. Upon receipt of a certified copy of such order, the department shall amend the child's birth certificate to reflect the mother's true name.

(f) Upon receipt of a certified copy of an order of a court of competent jurisdiction changing the name of a person born in this state and upon request of such person or such person's parents, guardian, or legal representative, the commissioner or the registrar of vital statistics of the town in which the vital event occurred shall amend the birth certificate to show the new name by a method prescribed by the department.

(g) When an applicant submits the documentation required by the regulations to amend a vital record, the commissioner shall hold a hearing, in accordance with chapter 54, if the commissioner has reasonable cause to doubt the validity or adequacy of such documentation.

(h) When an amendment under this section involves the changing of existing language on a death certificate due to an error pertaining to the cause of death, the death certificate shall be amended in such a manner that the original language is still visible. A copy of the death certificate shall be made. The original death certificate shall be sealed and kept in a confidential file at the department and only the commissioner may order it unsealed. The copy shall be amended in such a manner that the language to be changed is no longer visible. The copy shall be a public document.

(i) The commissioner shall issue a new birth certificate to reflect a gender change upon receipt of the following documents submitted in the form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement birth certificate to reflect that the applicant's gender differs from the sex designated on the original birth certificate; (2) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state, or a psychologist licensed pursuant to

chapter 383 or holding a current license in good standing in another state, stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (3) if an applicant is also requesting a change of name listed on the original birth certificate, proof of a legal name change. The new birth certificate shall reflect the new gender identity by way of a change in the sex designation on the original birth certificate and, if applicable, the legal name change.

(j) The commissioner shall issue a new marriage certificate to reflect a gender change upon receipt of the following documents submitted in the form and manner prescribed by the commissioner: (1) A written request from the applicant, signed under penalty of law, for a replacement marriage certificate to reflect that the applicant's gender differs from the sex designated on the original marriage certificate, along with an affirmation that the marriage is still legally intact; (2) a notarized statement from the spouse named on the marriage certificate to be amended, consenting to the amendment; (3) a notarized affidavit by a physician licensed pursuant to chapter 370 or holding a current license in good standing in another state, an advanced practice registered nurse licensed pursuant to chapter 378 or holding a current license in good standing in another state, or a psychologist licensed pursuant to chapter 383 or holding a current license in good standing in another state, stating that the applicant has undergone surgical, hormonal or other treatment clinically appropriate for the applicant for the purpose of gender transition; and (4) if an applicant is also requesting a change of name listed on the original marriage certificate, proof of a legal name change. The new marriage certificate shall reflect the new gender identity by way of a change in the sex designation on the original marriage certificate and, if applicable, the legal name change.

Agency Legislative Proposal - 2021 Session

Document Name: DPH 9.26.20 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 and Lisa Kessler, JD

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. Section 3. NEW
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. Lastly, the proposal creates a pilot program that will allow the Department to remotely access electronic medical records related to a birth, fetal death or death occurring in a hospital. The language ensures that all information obtained is kept confidential under Section 19a-25 of the general statutes. 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.

Subsection (c) of Conn. Gen. Stat. 19a-72 authorizes the Department to access records of any health care provider, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness and data accuracy of reportable tumor reports.

Subsection (a) of Conn. Gen. Stat. 7-48 authorizes the Department to collect medical data for each birth that occurs in Connecticut and allows the data to be used for statistical and health purposes by department and local directors of health.

Subsection (b) of Conn. Gen. Stat. 7-60 authorizes the Department to collect medical data for each fetal death that occurs in Connecticut and allows the data to be used for medical and health purposes.

Subsection (c) of Conn. Gen. Stat. 7-62b requires an attending medical practitioner to certify to the cause and manner of death, and prescribes the information listed in the medical certification portion of the death certificate.

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 workday. 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.

Office of Vital Records

The Office of Vital Records is responsible for the collection of demographic and medical data for all births, fetal deaths and deaths occurring in the state. The medical data is collected for many important purposes such as public health surveillance, medical research, and statistical analysis. Reliance on this data is widespread and includes entities at all levels of government. The importance of having accurate and timely vital records data has never been more apparent than the present, as the nation attempts to quell the ravaging effects of the COVID-19 pandemic. The Centers for Disease Control and Prevention (CDC) and state and local health programs are depending on this data for up-to-date death counts and to evaluate risk factors.

To carry out effective public health surveillance, the birth, fetal death and death data must be accurate and timely. The CDC recognizes the importance of timely data and has implemented the Vital Statistics Rapid Release program that reports surveillance data quarterly, and which increases the responsibility of the state to provide complete and accurate data as soon as possible.

The current process of verifying birth, fetal death and death data is a labor intensive and time consuming process that requires the Department to contact staff persons at the medical facilities to verify data that appears on feedback or error reports. This process often takes multiple communications and a reliance on facility staff to resolve the issues, causing significant delays in finalizing the vital records data. The process is antiquated and in critical need of modernization. Direct access to medical records will provide such modernization and create efficiencies for both the Department and hospitals by removing the barriers involved in data cleanup and maximizing the potential for providing the highest quality data to all of our public health partners.

◊ **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?

Section one of this proposal was introduced during the 2019 Regular 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.

Sections one and two were introduced during the 2020 Regular Session as House Bill 5181, but the bill, along with many others, did not pass due to the onset of the COVID-19 pandemic.

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.

It will also reduce the burdens of the quality assurance program within the Office of Vital Records.

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. It will also improve the tumor registry data and the vital records 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.

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, 2021*):

(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.

Section 2.

Subsection (c) of section 19a-72 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(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. All personal information obtained from the medical record shall not be divulged to anyone and shall be held strictly confidential pursuant to section 19a-25 by the Department of Public Health.

Section 3.

(NEW) (*Effective July 1, 2021*):

On or after July 1, 2021, the Department of Public Health shall establish a one year pilot program to initially test the impact of providing remote access to electronic medical records maintained by a hospital, for purposes of carrying out its duties pursuant to sections 7-48, 7-60 and 7-62b. A hospital shall provide the Department of Public Health with remote access to the entirety of a medical record, as the department deems necessary, to perform quality improvement audits to ensure completeness of reporting and data accuracy of birth, fetal death and death occurrences. All personal information obtained from the medical record shall not be divulged to anyone and shall be held strictly confidential pursuant to section 19a-25 by the Department of Public Health. On or after July 1, 2022, following the

implementation of such pilot program established under this section, the Commissioner of Public Health, shall evaluate such pilot program to ascertain specific improved data accuracy, timeliness and any cost efficiencies achieved. Not later than thirty days following the pilot program, the commissioner shall make a determination on full implementation of such pilot program. Based on the determination made by the commissioner, remote access shall be given on a continual basis to the Department of Public Health to perform quality improvement audits to ensure completeness of reporting and data accuracy of birth, fetal death and death occurrences.

Agency Legislative Proposal - 2020 Session

Document Name: DPH 9.26.20 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. A specimen would be collected when the infant is 24-48 hours old, unless collection is medically contraindicated, and must be shipped to the State Public Health laboratory within 24 hours of collection. If this is not feasible, then notice must be provided to the State Public Health Laboratory before the infant is 72 hours old. 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.

◊ **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:** 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 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.

◊ **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.

According to the U.S. Centers for Disease Control and Prevention, newborn screening identifies conditions that may impact a child's health outcomes and longevity. From a health equity perspective, timely newborn screening for a range of disorders – including cystic fibrosis – will provide the important foundation needed to inform future targeted initiatives to improve access to quality medical care and social services and early childhood development services and community support.

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 included on the recommended uniform screening panel pursuant to 42 USC 300b-10, as amended from time to time, 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 laboratory that performs newborn screening for cystic fibrosis shall report the number of infants screened and the 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.

Agency Legislative Proposal - 2021 Session

Document Name: DPH 9.26.20 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. Sec. 25-33. Water company: Reporting and record retention requirements. Plan required for construction or expansion of water supply system or a proposed new source of water supply. Regulations. Approval of location of replacement public well. 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. Sec. 19a-202a. Requirements re municipality designating itself as having a part-time health department. Regulations.
Section 26. Sec. 19a-244. Qualifications, term and duties of the director of health. Employees.
Section 27. Sec. 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. Sec. 19a-12d. Commissioner of Public Health to transfer certain revenue to professional assistance program account.
Section 29. Sec. 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. Sec. 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-131g. Public Health Preparedness Advisory Committee.

Section 39. Sec. 19a-30. Clinical laboratories. Regulation and licensure. Proficiency standards for tests not performed in laboratories.
Section 40. Sec. 20-365. Licensure without examination. Licensure exemptions.
Section 41. Sec. 20-195u. Continuing education requirements: Record-keeping; exemptions; waivers; reinstatement of void licenses.
Section 42. Sec. 20-265h. Requirements for management of spas or salons.
Section 43. Sec. 19a-131j. Temporary suspension of licensure, license renewal and inspection requirements upon declaration of a civil preparedness emergency or public health emergency.
Section 44. Sec. 19a-512. (Formerly Sec. 19-593). Licensure by examination. Minimum requirements.
Section 45. Sec. 19a-490. Licensing of institutions. Definitions.
Section 46. Sec. 19a-491. License and certificate required. Application. Assessment of civil penalties or a consent order. Fees. Minimum service quality standards. Regulations. Professional liability insurance. Prohibition. Maintenance of medical records.
Section 47. Sec. 19a-491c. Criminal history and patient abuse background search program. Regulations.
Section 48. Sec. 19a-492b. Home health care agencies. Discrimination against persons receiving aid. Prohibition. Penalties.
Section 49. Sec. 19a-492c. Home health care agencies. Waiver for provision of hospice services.
Section 50. Sec. 19a-492d. Vaccinations and medication administered by nurses employed by home health care agencies or homemaker-home health aide agencies.
Section 51. Sec. 19a-492e. Delegation of medication administration by registered nurse to homemaker-home health aide. Regulations.
Section 52. Sec. 19a-496a. Home health care agency services ordered by physician licensed in a state which borders Connecticut.
Section 53. Sec. 19a-504d. Hospital discharge plans; options of home health care agencies required.
Section 54. (NEW)
Section 55. Sec. 19a-522f. Chronic and convalescent nursing homes and rest homes with nursing supervision: Administration of peripherally inserted central catheter by IV therapy nurse or physician assistant.
Section 56. (NEW)
Section 57. Sec. 19a-521b. Bed clearance of nursing home facilities.
Section 58. Sec. 19a-179. Regulations
Section 59. Sec. 19a-195. Regulations re staffing of emergency medical response vehicles.
Section 60. Sec. 20-206jj. Definitions.
Section 61. Sec. 20-206mm. Qualifications for licensure and certification. Licensure and certification by endorsement. License and certificate renewal.

Section 62. Sec. 19a-178a Emergency Medical Services Advisory Board established; appointment; responsibilities.
Section 63. Sec. 19a-36h. Adoption by reference of United States Food and Drug Administration's Food Code. Regulations.
Section 64. Sec. 19a-36i. Food establishments. Permit or license. Inspections. Food protection managers. Reciprocal licensing of itinerant food vending establishment.
Section 65. Sec. 19a-36j. Food inspectors. Certification. Inspections.
Section 66. Sec. 19a-36o. Variance from requirements of Public Health Code for sous vide processing and acidification of sushi rice.
Section 67. Sec. 19a-332. Definitions: Asbestos.

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 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. It also makes a technical revision to remove the outdated term “rescue vehicles” and the word “ambulance” and align this section of the statute with the definition of an “authorized emergency medical services vehicle.”

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. Repeals the requirement for the Department to send a list of all embalmers, registered apprentice embalmers, registered apprentice funeral directors to town clerks.

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. Requires the Department to post the Chronic Disease Plan on its internet website.

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

Section 39. Requires 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.

Section 40. Inserts person first language in the statute pertaining to licensure of a sanitarian.

Section 41. Increases the number of continuing education credits clinical and master social workers can complete online.

Section 42. Allows a massage therapist to manage a salon or spa.

Section 43. Expands the types of practitioner licensure requirement waivers allowed by the Commissioner during a declared public health emergency to mirror those in Executive Order

Section 44. To remove the Department of Public Health as the entity to administer the licensure examination for nursing home administrators

Sections 45 through 53. Adds the term “home health hospice agency” throughout out the statutes and makes technical corrections. Section 45 revises the definitions of the different type of healthcare institutions to remove an several outdated definitions and adds a definition for hospice home health care agency. Section 52 of this proposal allows statute to supersede regulation to allow an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) to order home health services for a patient.

Section 54. Creates a new statute to allow a nursing home to open a facility or expand beds into a wing under their current license for patients with an infectious disease during a Governor declared emergency

Section 55. Revises the statute pertaining to IV care in a nursing home to allow a properly trained registered nurse to administer certain medications or draw blood from a patients central line

Section 56. Creates a new section of statute pertaining to licensing of assisted living services agencies.

Section 57. Revises the statutes pertaining to bed placement in a nursing home to allow a facility the flexibility to position them to enhance patient care.

Section 58. 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.

Section 59. Makes technical revisions to remove outdated terms used by the industry.

Section 60. Repeals the definition for "Continuing education platform Internet website"

Section 61. Removes the term "Continuing education platform Internet website"

Section 62. Allows the Commissioner to make legislative pending appointments on the Connecticut Emergency Medical Services Advisory Board (CEMSAB) if the appointment is vacant for at least one year.

Section 63. Extends the deadline by which DPH is required to adopt the United States Food and Drug Administration's (FDA) Food Code as the state's food code for regulating food establishments to January 1, 2022.

Section 64. Extends the deadlines by which DPH is required to submit a report to the legislature regarding reciprocal licensing of itinerant food vending establishments to January 1, 2022, and the date by which the Commissioner of DPH and each local health director shall implement such process to February 1, 2022.

Section 65. Extends the date by which food inspectors are required to obtain a certification from the Commissioner of DPH to January 1, 2022.

Section 66. Extends the date by which food establishments are allowed to request from DPH a variance from Public Health Code requirements in order to use the sous vide cooking technique or acidify sushi rice, as an alternative to temperature control to December 31, 2021.

Section 67. Revises the definition of "asbestos containing material" to clarify that material is asbestos containing material if it contains equal to or more than 1.0 per cent by weight.

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.

Amend 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.

Ensure that the Commissioner of Public Health receives electronic 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; 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 or is for commercial or industrial use.

This proposal will streamline the notification process to ensure that DPH receives electronic notification of projects that may have a potential impact to public drinking water sources.

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. 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.

Revises 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.

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.

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.

Additionally, this section allows the Commissioner to put forward an annual list of minimum equipment needed on emergency medical services vehicles used by emergency medical

services organizations licensed and certified by the Department. The revision to section 19a-177 will remove the outdated term “rescue vehicles” and the word “ambulance” and align this section of the statute with the definition of an “authorized emergency medical services vehicle.” These vehicles include ambulances, invalid coaches, advanced emergency technician staffed intercept vehicles or paramedic staff intercept vehicles.

Sections 10 through 16.

Revise 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 16 repeals section 20-226, which mandates the Department to send a list of embalmers, funeral directors, student embalmers, student funeral directors to the town clerks each year. This information is available to the public in real time on the elicensing website. Therefore, the Department no longer has to send potential outdated materials. This will also save the cost of postage.

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. 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.

Revises 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.

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.

Make 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.

Requires 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.

Allows 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. Instead the Department would post the Chronic Disease Plan on its website.

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.

Removes 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.

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 emergency.

Section 39.

Currently, the Department's regulations (Section 19a-36-D29) 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 laboratory to operate more than six blood collection facilities.

Section 40.

Inserts person first language in the statute pertaining to licensure of a sanitarian.

Section 41.

Increases the amount of continuing education licensed clinical social workers and licensed master social workers can complete online from 6 hours to 10 hours.

Section 42.

Revises the language passed in Public Act 19-117 regarding licensure of nail technicians, estheticians, and eyelash technicians to allow a licensed massage therapist to manage a salon or spa that employs these individuals, along with barber and hairdressers.

Section 43.

Revises section 19a-131j, which allows the commissioner to issue an order to temporarily suspend licensure, certification or registration requirements for several professional licensed by the Department during a public health emergency declared by the Governor. During the COVID-

19 response, the Department and healthcare industry realized that there was a healthcare workforce shortage in many other professions that were not covered by 19a-131j, and put forward an executive order to suspend the following professions: chapters 376a (occupational therapist), 376b (alcohol and drug counselor), 376c (radiographer, radiologic technologist, radiologist assistant and nuclear medicine technologist), 379 (dentist), 379a (dental hygienist), 382a (behavior analyst), 383d (genetic counselor), 383f (music therapist). 383g (art therapist), 384b (dietician-nutritionist), and 399 (speech and language pathologist). This legislation permanently adds these professions into the statute to ensure continuity during a potential future public health emergency.

Section 44.

Removes the requirement for the department to administer a licensure examination for nursing home administrators. Like many other professions licensed by the department, the department relies on a national entity to administer the examination. The Department does not currently issue a state exam but requires a nursing home administrator to take the exam offered by the National Association of Long term Care Administrator Board's (NAB) exam. The revision will bring the statute up to date with current practice.

Sections 45 through 53. Adds a definition of "hospice home health agency" and makes technical changes to include this term throughout these sections. The Department has been working with the industry on regulations pertaining to home health and hospice agencies to mirror the conditions of participation from CMS. Currently, the regulations mandate a home health hospice agency to also be licensed as a home health care agency. The Department and industry agree that this requirement is no longer needed, and the regulations should be separated out to reflect the different agency needs. The revisions throughout sections 1 through 9 of this proposal add the term "home health hospice agency" to ensure the Department has the authority to regulate these agencies.

Additionally, Section 45 removes the outdated definition of "home health agency," which was put in place in 1992. We believe this is the original definition of a home health agency. Since that date, the definitions have evolved to meet current standards. Revisions to the different statutes pertaining to home health care agencies have been modified in this proposal and this definition is no longer needed. Additionally, this section removes outdated definitions referring to substance use facilities, which are covered under the umbrella of a "behavioral health facility." Removing these definitions allows the Department to continue our compression of the five different sets of licensing statutes/regulations pertaining to behavioral health facilities into one licensure type.

Section 52 of this proposal allows the statute to supersede the regulation by allowing an APRN, and PA to order home health services along with the MD. Until COVID-19, the Centers for Medicare and Medicaid Services (CMS) only allowed a physician to order these services. The revision was made permanent by CMS and the Department is conforming with this practice. The Department has incorporated this revision into the draft regulations.

Section 54.

Allows a licensed chronic and convalescent nursing home to provide services to patients with a reportable disease, emergency illness or health condition under its existing license in a building that is not physically connected to their originally licensed facility during a public health and civil preparedness emergency declared by the Governor. Before providing these services, the licensee shall contact the Department of Public Health and agree to a consent order for the operation of the facility. During the response to COVID-19, the Department worked with a CCNH to open up two facilities that housed COVID-19 only patients. Transferring these patients to the COVID-19 only nursing home slowed the spread of the disease to healthy patients.

Section 55.

Revises the statute pertaining to IV care in a nursing home to allow a properly trained registered nurse to administer certain medications or draw blood from a patient's central line. The revisions to this section will modernize the process for IV care by allowing more residents to have specific medications administered rather than being admitted to the hospital to have these medications administered.

Section 56.

Creates a new section of statute pertaining to the licensing of assisted living services agencies. While the statutes allowed the Department to license these types of facilities under our generic authority to license an "institution," the Department felt that it would be more beneficial to outline important licensure requirements for assisted living services agencies in the statute. Currently, there is no specific references to assisted living services agencies providing services in memory care units. During the COVID-19 outbreak, there were several outbreaks in memory care units in the long term setting, on a nationwide basis. Both CDC and CMS offered guidance specific to memory care units in all long term setting types. The Department feels it would be important to include information regarding the settings where memory care is being provided on the ALSA's license, along with ensuring they have appropriate staffing levels for the safety of the patients.

Section 57.

Revises an outdates statute and overrides an outdated regulation, section 19-13-D8t(v)(7)(C) to allow a facility to position resident beds to promote more efficient resident care. The statute mandates the facility to ensure they are positioning the beds in a safe manner that does not create a hazard and are promoting infection control.

Section 58.

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 offline 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.

Section 59.

Makes a revision to section 19a-195 to replace the outdated terms "emergency medical response services" with "ambulances" and "medical response technician" with "emergency medical responder".

Sections 60 and 61.

Remove the term "Continuing education platform Internet website" from the Emergency Medical Services Personnel licensing statutes. When the Department passed this requirement in 2019, the national organization we are using for licensure stated that this would be of no cost the EMS

personnel. Their policy has since changed, and the Department doesn't feel comfortable making the EMS Personnel pay for these services. The Department has created a new tracking system for CEU's internally.

Section 62.

Allows the Commissioner to make the pending appointments on the Emergency Medical Services Advisory Board if the appointment is vacant for at least one year. The Department has difficulty obtaining the mandated legislative appointments from certain legislators resulting in vacancies on the Committee.

Section 63.

Extends the deadline by which DPH is required to adopt the FDA's Food Code as the state's food code for regulating food establishments from January 1, 2020, to January 1, 2022. This extension of time allows for the DPH time to adopt the Food Code into its regulations. Presently the regulations are drafted and are under informal review by the AGO.

Section 64.

Extends the deadlines by which DPH is required to submit a report to the legislature regarding reciprocal licensing of itinerant food vending establishments from January 1, 2019, to January 1, 2022, and the date by which the Commissioner of DPH and each local health director shall implement such process from February 1, 2019, to February 1, 2022, which will provide DPH and local health directors additional time with which to study reciprocal licensing and develop a process.

Section 65.

Extends the date by which food inspectors are required to obtain a certification from the Commissioner from January 1, 2020, to January 1, 2022. The certification requirement is linked to DPH's adoption of the food code which needs additional time to adopt in CT regulations.

Section 66.

Extends the date by which food establishments are allowed to request from DPH a variance from Public Health Code requirements in order to use the sous vide cooking technique or acidify sushi rice, as an alternative to temperature control to December 31, 2021. The date by which DPH may grant a variance is tied to DPH's adoption of the food code. Once DPH adopts the food code, the

variance provisions in such code will apply to food establishments. The request for additional time is due to the need for additional time to adopt the Food Code in regulation.

Section 67.

Revises the definition of "asbestos containing material" to clarify that material is considered "asbestos containing material" if it contains asbestos in amounts equal to or more than 1.0 per cent by weight. Currently, the definition states that material is considered "asbestos containing material" if it contains more than 1 per cent of asbestos by weight, which has led to inconsistencies in the application of the definition. This proposal will assure consistency in the application of this definition.

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

If this is a resubmission, please share:

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

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

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

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

Sections 1 through 42 were introduced during the 2020 Regular Session through House Bill 5417.

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 the requirement to issue a report. Instead, we would just like to publish the chronic disease plan on DPH's website.

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 63. Section 3 of Public Act 17-93 required DPH, by July 1, 2018, to adopt the FDA's Food Code as the state's food code for regulating food establishments. Section 46 of Public Act 18-168

change the date, as did Section 23 of Public Act 19-118. We are again opening the same statute to change the date again. Section 64. Section 49 of Public Act 18-168 changed the date to December 31, 2018. We are opening the same statute to change the date again. Section 65. Section 47 of Public Act 18-168 changed the date to January 1, 2020. We are opening the same statute to change the date again.

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 – Sections 6, 64-66 **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, 39, 58-62 **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, 32, 52 **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: Department on Aging and Disability Services – Section 57 **Agency Contact (*name, title, phone*):** Mairead Painter and Andrew Norton **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.

Sections 45 through 53. Potential minimal revenue gain from home health facilities who would be dually licensed as a home health and home health hospice facility, which may be negated by facilities currently licensed as a home health facility only wishing to be a home health hospice facility.

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.

Section 39. 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.
Section 58. 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.

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, 2021*):

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 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(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, 2021*):

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 the water company and the [Commissioner of] Department Public Health in a format prescribed by said [commissioner] department[, 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]. Such notice shall be made to the water company by certified mail, return receipt requested, and [shall be mailed] to the department electronically in accordance with the instructions provided on the department's Internet web site for receipt of such notice, not later than seven days after the date of the application. The water company and the Commissioner of Public Health, through a representative, may appear and be heard at any hearing on the application.

Section 4.

Section 22a-42f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021):*

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] Department 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] department. Such notice shall be made to the water company by certified mail, return receipt requested, and to the department electronically in accordance with the instructions provided on the department's Internet web site for receipt of such notice and shall be mailed and submitted electronically not later than seven days after the date of the application. 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, 2021*):

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, 2021*):

(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, 2021*):

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 or electronically in a form and manner as prescribed by commissioner 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.

Subdivision (2) of subsection (c) of section 19a-491c of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(2) No long-term care facility shall be required to comply with the provisions of this subsection if: (1) the individual provides evidence to the long-term care facility that such individual submitted to a background search conducted pursuant to subdivision (1) of this subsection not more than three years immediately preceding the date such individual applies for employment, seeks to enter into a contract or begins volunteering with the long-term care facility and that the prior background search confirmed that the individual did not have a disqualifying offense; or (2) the commissioner has determined the need to temporarily suspend of the requirements of this subsection in the event of an emergency or significant disruption. The commissioner shall inform the long-term care facility when such an suspension is being issued and when such a suspension has been rescinded.

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, 2021*):

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] authorized emergency medical services 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, 2021*):

(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, 2021*):

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, 2021)*:

(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, 2021*):

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, 2021*):

(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, 2021*):

(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.

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 from 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. <u>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.</u>

(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. The provisions of subparagraphs (2)(A), (B), and (C) shall not apply to any applicant who, on or before July 1, 2021, earned a graduate degree at a regionally accredited institution of higher education in counseling or a related mental health field and has accumulated at least 3,000 hours of experience under professional supervision, as defined in subdivision (6) of Section 20-195aa.

(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, 2021*):

(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, 2021*):

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, 2021*):

(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, 2021*):

(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, 2021*):

(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], 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.

(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, 2021*):

(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, 2021*):

(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, 2021*):

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, 2021*):

(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, 2021*):

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, 2021*):

(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 from 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, 2021*):

(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, 2021*):

(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.

Section 19a-6q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*).

(a) The Commissioner of Public Health, in consultation with the executive director of the Office of Health Strategy, established under section 19a-754a, and local and regional health departments, shall, within available resources, develop a plan that is consistent with the Department of Public Health's Healthy Connecticut 2020 health improvement plan and the state healthcare innovation plan developed pursuant to the State Innovation Model Initiative by the Centers for Medicare and Medicaid Services Innovation Center. The commissioner shall develop and implement such plan to: (1) Reduce the incidence of tobacco use, high blood pressure, health care associated infections, asthma, unintended pregnancy and diabetes; (2) improve chronic disease care coordination in the state; and (3) reduce the incidence and effects of chronic disease and improve outcomes for conditions associated with chronic disease in the state. The Commissioner shall publish the plan on the Department of Public Health's Internet web site.

[(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, 2021*):

(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) *(Effective July 1, 2021)*:

(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, 2021*):

(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 29-291a, 29-291c, 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.

Section 19a-131g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from 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.

Section 39.

Subsection (d) of Section 19a-30 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(d) A nonrefundable fee of 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.

Section 40.

Subsection (b) of section 20-365 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) Nothing in section 19a-200, as amended by this act, subsection (a) of section 19a-206, or sections 19a-207, 19a-242, 20-358 or 20-360 to 20-365, inclusive, shall prevent any of the following persons from engaging in the performance of their duties: (1) Any person certified by the Department of Public Health as a food or sewage inspector in accordance with regulations adopted pursuant to section 19a-36, (2) any person employed by a local health department performing the duties of a lead inspector who complies with training standards established pursuant to section 20-479, (3) a director of health acting pursuant to [subsection (a) of] section 19a-200, as amended by this act, or section 19a-244, as amended by this act, (4) any employee of a water utility or federal or state agency performing his duties in accordance with applicable statutes and regulations, (5) any person employed by a local health department working under the direct supervision of a licensed sanitarian, (6) any person licensed or certified by the Department of Public Health in a specific program performing certain duties that are

included within the duties of a sanitarian, or (7) a student enrolled in an accredited academic program leading to a degree in environmental health or completing a special training course in environmental health approved by the commissioner, provided such student is clearly identified by a title which indicates his or her status as a student.

Section 41.

Subsection (b) of section 20-195u of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Continuing education required pursuant to this section shall be related to the practice of social work and shall include not less than one contact hour of training or education each registration period on the topic of cultural competency and, on and after January 1, 2016, not less than two contact hours of training or education during the first renewal period in which continuing education is required and not less than once every six years thereafter on the topic of mental health conditions common to veterans and family members of veterans, including (1) determining whether a patient is a veteran or family member of a veteran, (2) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (3) suicide prevention training. Such continuing education shall consist of courses, workshops and conferences offered or approved by the Association of Social Work Boards, the National Association of Social Workers or a school or department of social work accredited by the Council on Social Work Education. A licensee's ability to engage in on-line and home study continuing education shall be limited to not more than [six] ten hours per registration period. Within the registration period, an initial presentation by a licensee of an original paper, essay or formal lecture in social work to a recognized group of fellow professionals may account for five hours of continuing education hours of the aggregate continuing education requirements prescribed in this section.

Section 42.

Section 20-265h of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after July 1, 2021, each spa or salon that employs hairdressers and cosmeticians, estheticians, eyelash technicians, [or] nail technicians or massage therapists shall be under the management of a hairdresser and cosmetician registered under this chapter, an esthetician licensed under section 20-265b or 20-265f, an eyelash technician licensed under section 20-265c or 20-265f, [or] a nail technician licensed under section 20-265d or 20-265f or a massage therapist licensed under chapter 384a.

(b) Any such spa or salon shall be in compliance with the provisions of title 34 if applicable, and any applicable state law concerning the maintenance of payroll records, the classification of employees and the provision of workers' compensation coverage.

Section 43.

Sec. 20. Section 19a-131j of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The commissioner may issue an order to temporarily suspend, for a period not to exceed sixty consecutive days, the requirements for licensure, certification or registration, pursuant to chapters 368d, 370, 376, 376a, 376b, 376c, 378, 378a, 379, 379a, 381a, 382a, 383 to 383c, inclusive, 383d, 383f, 383g, 384b, 384d, 385, 395, 399, 400a, 400j and 474, to allow persons who are appropriately licensed, certified or registered in another state or territory of the United States or the District of Columbia, to render temporary assistance within the scope of the profession for which a person is licensed, certified or registered, in managing a public health emergency in this state, declared by the Governor pursuant to section 19a-131a. Nothing in this section shall be construed to permit a person to provide services beyond the scope allowed in the chapter specified in this section that pertains to such person's profession.

Section 44.

Subsection (a) of Section 19a-512 is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) In order to be eligible for licensure by examination pursuant to sections 19a-511 to 19a-520, inclusive, a person shall submit an application, together with a fee of two hundred dollars, and proof satisfactory to the Department of Public Health that he (1) is physically and emotionally capable of administering a nursing home; (2) has satisfactorily completed a program of instruction and training, including residency training which meets the requirements of subsection (b) of this section and which is approved by the Commissioner of Public Health; and (3) has passed an examination prescribed [and administered] by the Department of Public Health designed to test the applicant's knowledge and competence in the subject matter referred to in subsection (b) of this section. Passing scores shall be established by the department.

Section 45.

Section 19a-490 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof: (*Effective July 1, 2021*):

(a) “Institution” means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, nursing home facility, home health care agency, hospice home health care agency, home health aide agency, behavioral health facility, assisted living services agency, [substance abuse treatment facility,] outpatient surgical facility, outpatient clinic, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency; and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability. “Institution” does not include any facility for the care and treatment of persons with mental illness or substance use disorder operated or maintained by any state agency, except Whiting Forensic Hospital;

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

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

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

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

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

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

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

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

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

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

(j) “hospice home health care agency” means an agency that is engaged in coordinating the provision of home care and services to patients who are terminally ill from the time of admission to the agency throughout the course of the illness until death or discharge;

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

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

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

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

[(p)] (o) "Outpatient dialysis unit" means (1) an out-of-hospital out-patient dialysis unit that is licensed by the department to provide (A) services on an out-patient basis to persons requiring dialysis on a short-term basis or for a chronic condition, or (B) training for home dialysis, or (2) an in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to (A) offer dialysis therapy on an out-patient basis, (B) provide training for home dialysis, and (C) perform renal transplantations.

Section 46.

Section 19a-491 of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) No person acting individually or jointly with any other person shall establish, conduct, operate or maintain an institution in this state without a license as required by this chapter, except for persons issued a license by the Commissioner of Children and Families pursuant to section 17a-145 for the operation of (1) a substance abuse treatment facility, or (2) a facility for the purpose of caring for women during pregnancies and for women and their infants following such pregnancies. Application for such license shall (A) be made to the Department of Public Health upon forms provided by it, (B) be accompanied by the fee required under subsection (c), (d) or (e) of this section, (C) contain such information as the department requires, which may include affirmative evidence of ability to comply with reasonable standards and regulations prescribed under the provisions of this chapter, and (D) not be required to be notarized. The commissioner may require as a condition of licensure that an applicant sign a consent order providing reasonable assurances of compliance with the Public Health Code. The commissioner may issue more than one chronic disease hospital license to a single institution until such time as the state offers a rehabilitation hospital license.

(b) If any person acting individually or jointly with any other person owns real property or any improvements thereon, upon or within which an institution, as defined in subsections (c) and (o) of section 19a-490, is established, conducted, operated or maintained and is not the licensee of the institution, such person shall submit a copy of the lease agreement to the department at the time of any change of ownership and with each license renewal application. The lease agreement shall, at a minimum, identify the person or entity responsible for the maintenance and repair of all buildings and structures within which such an institution is established, conducted or operated. If a violation is found as a result of an inspection or investigation, the commissioner may require the owner to sign a consent order providing assurances that repairs or improvements necessary for compliance with the provisions

of the [Public Health Code] Regulations of Connecticut State Agencies shall be completed within a specified period of time or may assess a civil penalty of not more than one thousand dollars for each day that such owner is in violation of the [Public Health Code] Regulations of Connecticut State Agencies or a consent order. A consent order may include a provision for the establishment of a temporary manager of such real property who has the authority to complete any repairs or improvements required by such order. Upon request of the Commissioner of Public Health, the Attorney General may petition the Superior Court for such equitable and injunctive relief as such court deems appropriate to ensure compliance with the provisions of a consent order. The provisions of this subsection shall not apply to any property or improvements owned by a person licensed in accordance with the provisions of subsection (a) of this section to establish, conduct, operate or maintain an institution on or within such property or improvements.

(c) Notwithstanding any regulation, the Commissioner of Public Health shall charge the following fees for the biennial licensing and inspection of the following institutions: (1) Chronic and convalescent nursing homes, per site, four hundred forty dollars; (2) chronic and convalescent nursing homes, per bed, five dollars; (3) rest homes with nursing supervision, per site, four hundred forty dollars; (4) rest homes with nursing supervision, per bed, five dollars; (5) outpatient dialysis units and outpatient surgical facilities, six hundred twenty-five dollars; (6) mental health residential facilities, per site, three hundred seventy-five dollars; (7) mental health residential facilities, per bed, five dollars; (8) hospitals, per site, nine hundred forty dollars; (9) hospitals, per bed, seven dollars and fifty cents; (10) nonstate agency educational institutions, per infirmary, one hundred fifty dollars; (11) nonstate agency educational institutions, per infirmary bed, twenty-five dollars; (12) home health care agencies, except certified home health care agencies described in subsection (d) of this section, per agency, three hundred dollars; (13) home health care agencies, home health hospice agencies or home health aide agencies, except certified home health care agencies, home health hospice agencies or home health aide agencies, described in subsection (d) of this section, per satellite patient service office, one hundred dollars; (14) assisted living services agencies, except such agencies participating in the congregate housing facility pilot program described in section 8-119n, per site, five hundred dollars; (15) short-term hospitals special hospice, per site, nine hundred forty dollars; (16) short-term hospitals special hospice, per bed, seven dollars and fifty cents; (17) hospice inpatient facility, per site, four hundred forty dollars; and (18) hospice inpatient facility, per bed, five dollars.

(d) Notwithstanding any regulation, the commissioner shall charge the following fees for the triennial licensing and inspection of the following institutions: (1) Residential care homes, per site, five hundred sixty-five dollars; (2) residential care homes, per bed, four dollars and fifty cents; (3) home health care agencies that are certified as a provider of services by the United States Department of Health and Human Services under the Medicare or Medicaid program, three hundred dollars; and (4) certified home health care agencies, or home health hospice agencies, as described in section 19a-493, per satellite patient service office, one hundred dollars.

(e) The commissioner shall charge one thousand dollars for the licensing and inspection of outpatient clinics that provide either medical or mental health service, urgent care services and well-child clinical services, except those operated by a municipal health department, health district or licensed nonprofit nursing or community health agency. Such licensing and inspection shall be performed every three years, except those outpatient clinics that have obtained accreditation from a national accrediting organization within the immediately preceding twelve-month period may be inspected by the commissioner once every four years, provided the outpatient clinic has not committed any violation that the commissioner determines would pose an immediate threat to the health, safety or welfare of the patients of the outpatient clinic. The provisions of this subsection shall not be construed to limit the commissioner's authority to inspect any applicant for licensure or renewal of licensure as an outpatient clinic, suspend or revoke any license granted to an outpatient clinic pursuant to this section or take any other legal action against an outpatient clinic that is authorized by any provision of the general statutes.

(f) Any institution that is planning a project for construction or building alteration shall provide the plan for such project to the Department of Public Health for review. Any such project shall comply with nationally established facility guidelines for health care construction, as approved by the commissioner, that are in place at the time the institution provides the plan to the department. The commissioner shall post a reference to such guidelines, including the effective date of such guidelines, on the Department of Public Health's Internet web site. No institution shall be required to include matters outside the scope and applicability of such guidelines in the institution's plan.

(g) The commissioner shall charge a fee of five hundred sixty-five dollars for the technical assistance provided for the design, review and development of an institution's construction, renovation, building alteration, sale or change in ownership when the cost of the project is one million dollars or less and shall charge a fee of one-quarter of one per cent of the total construction cost when the cost of the project is more than one million dollars. Such fee shall include all department reviews and on-site inspections. For purposes of this subsection, “institution” does not include a facility owned by the state.

(h) The commissioner may require as a condition of the licensure of a home health care [agencies] agency, home health hospice agency and home health aide [agencies] agency that each agency meet minimum service quality standards. In the event the commissioner requires such agencies to meet minimum service quality standards as a condition of their licensure, the commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define such minimum service quality standards, which shall (1) allow for training of home health aides by adult continuing education, (2) require a registered nurse to visit and assess each patient receiving home health aide services as often as necessary based on the patient's condition, but not less than once every sixty days, and (3) require the assessment prescribed by subdivision (2) of this subsection to be completed while the home health aide is providing services in the patient's home.

(i) No person acting individually or jointly with any other person shall establish, conduct, operate or maintain a home health care agency, home health hospice agency or home health aide agency without maintaining professional liability insurance or other indemnity against liability for professional malpractice. The amount of insurance which such person shall maintain as insurance or indemnity against claims for injury or death for professional malpractice shall be not less than one million dollars for one person, per occurrence, with an aggregate of not less than three million dollars.

(j) On and after June 15, 2012, until June 30, 2017, the commissioner shall not issue or renew a license under this chapter for any hospital certified to participate in the Medicare program as a long-term care hospital under Section 1886(d)(1)(B)(iv) of the Social Security Act (42 USC 1395ww) unless such hospital was so certified under said federal act on January 1, 2012.

(k) (1) A chronic disease hospital shall (A) maintain its medical records on-site in an accessible manner or be able to retrieve such records from an off-site location not later than the end of the next business day after receiving a request for such records, (B) keep a patient's medical records on-site for a minimum of ten years after the date of such patient's discharge, except the hospital may destroy the patient's original medical records prior to the expiration of the ten-year period if a copy of such medical records is preserved by a process that is consistent with current hospital standards, or (C) complete a patient's medical records not more than thirty days after the date of such patient's discharge, except in unusual circumstances that shall be specified in the hospital's rules and regulations for its medical staff. Each chronic disease hospital shall provide the Department of Public Health with a list of the process it uses for preserving a copy of medical records in accordance with subparagraph (B) of this subdivision.

(2) A children's hospital shall (A) maintain its medical records on-site in an accessible manner or be able to retrieve such records from an off-site location not later than the end of the next business day after receiving a request for such records, and (B) keep a patient's medical records on-site for a minimum of ten years after the date of such patient's discharge, except the hospital may destroy the patient's original medical records prior to the expiration of the ten-year period if a copy of such medical records is preserved by a process that is consistent with current hospital standards. Each children's hospital shall provide the Department of Public Health a list of the process it uses for preserving a copy of medical records in accordance with subparagraph (B) of this subdivision.

(3) The Department of Public Health may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this subsection.

Section 47.

Subdivision (4) of subsection (a) of Section 19a-491c of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(4) “Long-term care facility” means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a residential care home, as defined in section 19a-521, a home health care agency, home health hospice agency, or home health aide agency as defined in section 19a-490, an assisted living services agency, as defined in section 19a-490, an intermediate care facility for individuals with intellectual disabilities, as defined in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a, a chronic disease hospital, as defined in section 19a-550, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

Section 48.

Section 19a-492b of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) A home health care agency, or home health hospice agency that receives payment for rendering care to persons receiving medical assistance from the state, assistance from the Connecticut home-care program for the elderly pursuant to section 17b-342, or funds obtained through Title XVIII of the Social Security Amendments of 1965 shall be prohibited from discriminating against such persons who apply for enrollment to such home health care agency on the basis of source of payment.

(b) Any home health care agency, or home health hospice agency which violates the provisions of this section shall be subject to suspension or revocation of license.

Section 49.

Section 19a-492c of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) For purposes of this section, “rural town” means towns having either seventy-five per cent or more of their population classified as rural in the 1990 federal decennial census of population, or in the most recent such census used by the State Office of Rural Health to determine rural towns, or towns that are not designated as metropolitan areas on the list maintained by the federal Office of Management and Budget, used by the State Office of Rural Health to determine rural towns and “permanent part-time employee” means an employee who is employed and on duty a minimum of twenty hours per work week on a regular basis.

(b) A home health care agency, or home health hospice agency licensed pursuant to this chapter that provides hospice services in a rural town and is unable to access licensed or Medicare-certified hospice care to consistently provide adequate services to patients in the rural town may apply to the

Commissioner of Public Health for a waiver from the regulations licensing such agency adopted pursuant to this chapter. The waiver may authorize one or more of the following: (1) The agency's supervisor of clinical services may also serve as the supervisor of clinical services assigned to the hospice program; (2) the hospice volunteer coordinator and the hospice program director may be permanent part-time employees; (3) the program director may perform other services at the agency, including, but not limited to, hospice volunteer coordinator. The commissioner shall not grant a waiver unless the commissioner determines that such waiver will not adversely impact the health, safety and welfare of hospice patients and their families. The waiver shall be in effect for two years. An agency may reapply for such a waiver.

Section 50.

Section 19a-492d of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

On and after October 1, 2007, a nurse who is employed by an agency licensed by the Department of Public Health as a home health care agency, a home health hospice agency or a home health aide agency may administer influenza and pneumococcal vaccines to persons in their homes, after an assessment for contraindications, without a physician's order in accordance with a physician-approved agency policy that includes an anaphylaxis protocol. In the event of an adverse reaction to the vaccine, such nurse may also administer epinephrine or other anaphylaxis medication without a physician's order in accordance with the physician-approved agency policy. For purposes of this section, “nurse” means an advanced practice registered nurse, registered nurse or practical nurse licensed under chapter 378.

Section 51.

Section 19a-492e of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof(*Effective July 1, 2021*):

(a) For purposes of this section “home health care agency” and “home health hospice agency” has the same meaning as provided in section 19a-490. Notwithstanding the provisions of chapter 378, a registered nurse may delegate the administration of medications that are not administered by injection to home health aides, and home health hospice aides who have obtained certification and recertification every three years thereafter for medication administration in accordance with regulations adopted pursuant to subsection (b) of this section, unless the prescribing practitioner specifies that a medication shall only be administered by a licensed nurse. Any home health aide, and home health hospice aide who obtained certification in the administration of medications on or before June 30, 2015, shall obtain recertification on or before July 1, 2018.

(b) (1) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this section. Such regulations shall require each home health care agency, or home health hospice agency that serves clients requiring assistance with medication administration to (A) adopt practices that increase and encourage client choice, dignity and independence; (B) establish policies and procedures to ensure that a registered nurse may delegate allowed tasks of nursing care, to include medication administration, to home health aides, or home health hospice aides when the registered nurse determines that it is in the best interest of the client and the home health aide has been deemed competent to perform the task; (C) designate home health aides, or home health hospice aides to obtain certification and recertification for the administration of medication; and (D) ensure that such home health aides, or home health hospice aides receive such certification and recertification.

(2) The regulations shall establish certification and recertification requirements for medication administration and the criteria to be used by home health care agencies, or home health hospice agencies that provide services for clients requiring assistance with medication administration in determining (A) which home health aides, or home health hospice aides shall obtain such certification and recertification, and (B) education and skill training requirements, including ongoing training requirements for such certification and recertification.

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

(c) Each home health care agency or home health hospice agency shall ensure that, on or before January 1, 2013, delegation of nursing care tasks in the home care setting is allowed within such agency and that policies are adopted to employ home health aides, or hospice home health aides for the purposes of allowing nurses to delegate such tasks.

(d) A registered nurse licensed pursuant to the provisions of chapter 378 who delegates the task of medication administration to a home health aide, or home health hospice aide pursuant to this section shall not be subject to disciplinary action based on the performance of the home health aide or hospice home health aide to whom tasks are delegated, unless the home health aide, or home health hospice aide is acting pursuant to specific instructions from the registered nurse or the registered nurse fails to leave instructions when the nurse should have done so, provided the registered nurse: (1) Documented in the patient's care plan that the medication administration could be properly and safely performed by the home health aide or hospice home health aide to whom it is delegated, (2) provided initial direction to the home health aide, or home health hospice aides and (3) provided ongoing supervision of the home health aide or home health hospice aide, including the periodic assessment and evaluation of the patient's health and safety related to medication administration.

(e) A registered nurse who delegates the provision of nursing care to another person pursuant to this section shall not be subject to an action for civil damages for the performance of the person to whom nursing care is delegated unless the person is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so.

(f) No person may coerce a registered nurse into compromising patient safety by requiring the nurse to delegate the administration of medication if the nurse's assessment of the patient documents a need for a nurse to administer medication and identifies why the need cannot be safely met through utilization of assistive technology or administration of medication by certified home health aides, or home health hospice aides. No registered nurse who has made a reasonable determination based on such assessment that delegation may compromise patient safety shall be subject to any employer reprisal or disciplinary action pursuant to chapter 378 for refusing to delegate or refusing to provide the required training for such delegation. The Department of Social Services, in consultation with the Department of Public Health and home health care agencies, and home health hospice agencies, shall develop protocols for documentation pursuant to the requirements of this subsection. The Department of Social Services shall notify all licensed home health care agencies, and home health hospice agencies of such protocols prior to the implementation of this section.

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

Section 52.

Section 19a-496a of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Notwithstanding the Regulations of the Connecticut State Agencies, all home health care agency, hospice home health care agency or home health aide agency services shall be performed upon the order of a physician, or physician assistant licensed pursuant to chapter 370; or an advanced practice registered nurse licensed pursuant to chapter 378.

(b) All home health care agency services which are required by law to be performed upon the order of a licensed physician may be performed upon the order of a physician, physician assistant or advanced practice registered nurse licensed in a state which borders Connecticut.

Section 53.

Section 19a-504d of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) If a hospital recommends home health care to a patient, the hospital discharge plan shall include two or more available options of home health care agencies, or home health hospice agencies.

(b) A hospital which (1) has an ownership or investment interest in a home health care agency or home health hospice agency, or (2) receives compensation or remuneration for referral of patients to a home health care agency, or home health hospice agency shall disclose such interest to any patient prior to including such agency as an option in a hospital discharge plan. Such information shall be verbally disclosed to each patient or shall be posted in a conspicuous place visible to patients. As used in this subsection, "ownership or investment interest" does not include ownership of investment securities purchased by the practitioner on terms available to the general public and which are publicly traded.

Section 54.

(NEW) (*Effective July 1, 2021*):

(a) The Commissioner of Public Health may suspend the requirements for licensure to authorize a licensed chronic and convalescent nursing home to provide services to patients with a reportable disease, emergency illness or health condition, pursuant to section 19-91, under their existing license as follows:

(1) In a building which is not physically connected to its originally licensed facility; or

(2) Expand their bed capacity in a wing of a building that is separate from the current building.

(b) Such services may only be provided in order to render temporary assistance in managing a public health emergency in this state, declared by the Governor pursuant to section 19a-131a.

(c) The chronic and convalescent nursing home that intends to provide services pursuant to subsection (a) shall submit an application to the Department of Public Health in a form and manner as prescribed by the Commissioner. Such application shall include, but not be limited to, the following:

(1) The facility's ability to sufficiently address the health, safety or welfare of the residents and staff;
(2) The address of the building;
(3) An attestation that all equipment has been maintained to the manufacturers specification, and is available to meet the needs of the residents;
(4) The maximum bed capacity; and
(5) The Department's determination that a facility is in compliance with the statutes and regulations pertaining to the operation of the facility.
(d) Upon receipt of an application from a chronic and convalescent nursing home providing services pursuant to subsection (a), the Department of Public Health shall conduct a scheduled inspection and investigation to ensure compliance with the statutes and regulations governing licensing of facilities. If the Department finds that the applicant and facility meet the requirements of the statutes and

regulations, the Department shall notify the chronic and convalescent nursing home of the approval or denial of such application.

Section 55.

Section 19a-522f of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) As used in this section:

(1) "Administer" means to initiate the venipuncture and deliver an IV fluid or IV admixture into the blood stream through a vein, and to monitor and care for the venipuncture site, terminate the procedure and record pertinent events and observations;

(2) "IV admixture" means an IV fluid to which one or more additional drug products have been added;

(3) "IV fluid" means sterile solutions of fifty milliliters or more, intended for intravenous infusion, but does not include blood and blood products;

(4) "IV therapy" means the introduction of an IV fluid or IV admixture into the blood stream through a vein for the purpose of correcting water deficit and electrolyte imbalances, providing nutrition, and delivering antibiotics and other therapeutic agents approved by a chronic and convalescent nursing home's or a rest home with nursing supervision's medical staff;

(5) "IV therapy program" means the overall plan by which a chronic and convalescent nursing home or a rest home with nursing supervision implements, monitors and safeguards the administration of IV therapy to patients; and

(6) "IV therapy nurse" means a registered nurse who is qualified by education and training and has demonstrated proficiency in the theoretical and clinical aspects of IV therapy to administer an IV fluid or IV admixture.

(b) An IV therapy nurse or a physician assistant licensed pursuant to section 20-12b, who is employed by, or operating under a contract to provide services in, a chronic and convalescent nursing home or a rest home with nursing supervision that operates an IV therapy program may administer a peripherally inserted central catheter as part of such facility's IV therapy program. The Department of Public Health shall adopt regulations in accordance with the provisions of chapter 54 to carry out the purposes of this section.

(c) A chronic and convalescent nursing home may permit a registered nurse licensed pursuant to chapter 378 and employed by a chronic and convalescent nursing home who has been properly trained by the director of nursing or by an intravenous infusion company to do the following: (1) Draw blood

from a central line for laboratory purposes, provided the facility has an agreement with a laboratory to process such specimens; and (2) administer a dose of medication ordered via an intravenous injection, provided such medications on a list approved by the Commissioner of Public Health. Such facility shall notify the Commissioner of Public Health of such services being provided. The Commissioner of Public Health shall notify all chronic and convalescent home of the list of medications approved for intravenous injection by a registered nurse. The administrator shall be responsible for documenting ensuring the registered nurse is appropriately trained and competent to perform the services outlined in subdivisions (1) and (2) of this subsection. The administrator shall make any documentation available to the Department upon request.

Section 56.

(NEW) (*Effective July 1, 2021*):

(a) The Commissioner of Public Health shall license assisted living services agencies, as defined in section 19a-490. A managed residential community wishing to provide assisted living services, shall become licensed as an assisted living services agency.

(b) A managed residential care community that intends to arrange for assisted living services, shall only do so with a currently licensed assisted living services agency. Such managed residential community shall submit an application for approval to arrange for the assisted living services to the Department. Such application shall be submitted in a form and manner as prescribed by the Commissioner.

(c) No assisted living services agency shall provide memory care to residents with early to mid-stage cognitive impairment from Alzheimer's disease or other dementias unless they have obtained approval from the Department. Such assisted living services agencies shall ensure that they have adequate staff to meet the needs of the residents. All assisted living services agencies offering memory care services shall provide the Department of Public Health with a list of memory care units or locations, and their staffing plans when completing an initial or renewal licensure application, or upon request from the department.

(d) An assisted living services agency shall ensure all services being provided on an individual basis to clients are:

(1) Fully understood and agreed upon between either the client or the client's representative;

(2) The client or the client's representative are made aware of any costs of such services.

(e) The Department of Public Health may adopt regulations in accordance with the provisions of chapter 54 to carry out the purposes of this section.

Section 57.

Section 19a-521b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

[In each] Each licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, rest home with nursing supervision and residential care home, [at least a three-foot clearance shall be provided at the sides and the foot of each bed] shall position beds in a manner that promotes resident care. Such bed position shall:
1. Ensure the bed position does not act as a restraint to the resident;
2. Ensure the call bell, overhead bed light and privacy curtain are of function and use to the resident;
3. Ensure the bed position does not create a hazardous situation that includes, but is not limited to, creating an entrapment possibility, obstacle to evacuation, or is to close to, or blocking a heat source; and
4. To prevent the spread of pathogens, allow for infection control and ensure resident privacy, beds shall be spaced at least six feet apart.

Section 58.

Section 19a-179 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) The commissioner shall adopt regulations, in accordance with chapter 54, concerning (1) the methods and conditions for licensure and certification of the operations, facilities and equipment enumerated in section 19a-177, (2) complaint procedures for the public and any emergency medical service organization, and (3) exemption of members of the armed forces or the National Guard or veterans with appropriate military training, including, but not limited to, members of the armed forces or the National Guard or veterans with a designation by the National Registry of Emergency Medical Technicians and veterans or members of the United States Navy and Coast Guard, from training and testing requirements for emergency medical technician licensure and certification. Such regulations shall be in conformity with the policies and standards established by the commissioner. Such regulations shall require that, as an express condition of the purchase of any business holding a primary service area, the purchaser shall agree to abide by any performance standards to which the purchased business was obligated pursuant to its agreement with the municipality.

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

(b) The commissioner may waive any provisions of the regulations of Connecticut state agencies affecting an emergency medical services organization if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient or resident of the state. Upon granting

a waiver under this subsection, the commissioner may impose conditions that ensure the health, safety and welfare of any patient or resident of the state. The commissioner may revoke a waiver, provided the commissioner finds that the health, safety or welfare of any patient or resident of the state has been jeopardized. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish procedures for an application for a waiver under this subsection.

Section 59.

Section 19a-195 of the General Statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to require all [emergency medical response services] ambulances to be staffed by at least one certified emergency medical technician, who shall be in the patient compartment attending the patient during all periods in which a patient is being transported, and one certified [medical response technician] emergency medical responder.

Section 60.

Section 20-206jj of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

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

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

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

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

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

(7) “National organization for emergency medical certification” means a national organization approved by the Department of Public Health and identified on the department's Internet web site, or such national organization's successor organization, that tests and provides certification to emergency medical responders, emergency medical technicians, advanced medical technicians and paramedics;

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

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

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

[(11) “Continuing education platform Internet web site” means an online database, approved by the Commissioner of Public Health, for emergency medical services personnel to enter, track and reconcile the hours and topics of continuing education completed by such personnel.]

Section 61.

Subsection (f) of section 20-206mm of the Connecticut General Statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(f) A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall document the completion of his or her continuing educational requirements [through the continuing education platform Internet web site] in a form and manner as prescribed by the Commissioner. A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor who is not engaged in active professional practice in any form during a certification period shall be exempt from the continuing education requirements of this section, provided the emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor submits to the department, prior to the expiration of the certification period, an application for inactive status on a form prescribed by the department and such other documentation as may be required by the department. The application for inactive status pursuant to this subsection shall contain a statement that the emergency medical

responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor may not engage in professional practice until the continuing education requirements of this section have been met.

Section 62.

Subsection (b) of Section 19a-178a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The advisory board shall consist of members appointed in accordance with the provisions of this subsection and shall include the Commissioner of Public Health, the department's emergency medical services medical director and the president of each of the regional emergency medical services councils, or their designees. The Governor shall appoint the following members: (1) One person from the Connecticut Association of Directors of Health; (2) three persons from the Connecticut College of Emergency Physicians; (3) one person from the Connecticut Committee on Trauma of the American College of Surgeons; (4) one person from the Connecticut Medical Advisory Committee; (5) one person from the Emergency Nurses Association; (6) one person from the Connecticut Association of Emergency Medical Services Instructors; (7) one person from the Connecticut Hospital Association; (8) two persons representing commercial ambulance services; (9) one person from the Connecticut State Firefighters Association; (10) one person from the Connecticut Fire Chiefs Association; (11) one person from the Connecticut Police Chiefs Association; (12) one person from the Connecticut State Police; and (13) one person from the Connecticut Commission on Fire Prevention and Control. An additional eighteen members shall be appointed as follows: (A) Three by the president pro tempore of the Senate; (B) three by the majority leader of the Senate; (C) four by the minority leader of the Senate; (D) three by the speaker of the House of Representatives; (E) two by the majority leader of the House of Representatives; and (F) three by the minority leader of the House of Representatives. The appointees shall include a person with experience in municipal ambulance services; a person with experience in for-profit ambulance services; three persons with experience in volunteer ambulance services; a paramedic; an emergency medical technician; an advanced emergency medical technician; three consumers and four persons from state-wide organizations with interests in emergency medical services as well as any other areas of expertise that may be deemed necessary for the proper functioning of the advisory board. <u>Any appointment that is vacant for one year or more shall be filled by the Commissioner of Public Health. The commissioner shall notify the appointing authority of the commissioner's choice of member for appointment not less than thirty days before making such vacancy appointment.</u>

Section 63.

Subsection (a) of section 19a-36h is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Not later than January 1, [2020] 2022, the commissioner shall adopt and administer by reference the United States Food and Drug Administration's Food Code, as amended from time to time, and any Food Code Supplement published by said administration as the state's food code for the purpose of regulating food establishments.

Section 64.

Section 19a-36i is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No person, firm or corporation shall operate or maintain any food establishment where food or beverages are served or sold to the public in any town, city or borough without obtaining a valid permit or license to operate from the director of health of such town, city or borough, in a form and manner prescribed by the director of health. The director of health shall issue a permit [or license] to operate a food establishment upon receipt of an application if the food establishment meets the requirements of this section. All food establishments shall comply with the food code.

(b) All food establishments shall be inspected by a certified food inspector in a form and manner prescribed by the commissioner. The Commissioner of Public Health may, in consultation with the Commissioner of Consumer Protection, grant a variance for the requirements of the food code if the Commissioner of Public Health determines that such variance would not result in a health hazard or nuisance.

(c) No permit to operate a food establishment shall be issued by a director of health unless the applicant has provided the director of health with proof of registration with the department and a written application for a permit in a form and manner prescribed by the department. Temporary food establishments and certified farmers' markets, as defined in section 22-6r, shall be exempt from registering with the Department of Public Health.

(d) Each class 2 food establishment, class 3 food establishment and class 4 food establishment shall employ a certified food protection manager. No person shall serve as a certified food protection manager unless such person has satisfactorily passed a test as part of a food protection manager certification program that is evaluated and approved by an accrediting agency recognized by the Conference for Food Protection as conforming to its standards for accreditation of food protection manager certification programs. A certified food inspector shall verify that the food protection manager is certified upon inspection of the food establishment. The owner or manager of the food service establishment shall designate an alternate person or persons to be in charge at all times when the certified food protection manager cannot be present. The alternate person or persons in charge shall be responsible for ensuring the following: (1) All employees are in compliance with the requirements of this section; (2) foods are safely prepared in accordance with the requirements of the

food code; (3) emergencies are managed properly; (4) a food inspector is admitted into the food establishment upon request; and (5) he or she receives and signs inspection reports.

(e) The commissioner shall collaborate with the directors of health to develop a process that allows for the reciprocal licensing of an itinerant food vending establishment that has obtained a valid permit or license under subsection (a) of this section and seeks to operate as an itinerant food vending establishment in another town, city or borough. Not later than January 1, [2019] 2022, the commissioner shall submit a report, 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, of the process developed pursuant to this subsection. Not later than February 1, [2019] 2022, the commissioner and each director of health shall implement such process.

Section 65.

Subsection (a) of section 19a-36j is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after January 1, [2019] 2022, no person shall engage in the practice of a food inspector unless such person has obtained a certification from the commissioner in accordance with the provisions of this section. The commissioner shall develop a training and verification program for food inspector certification that shall be administered by the food inspection training officer at a local health department.

Section 66.

Section 19a-36o is repealed and the following is substituted in lieu thereof (*Effective from passage*):

Notwithstanding any provision of the general statutes, from June 30, 2017, until December 31, [2018] 2021, a food service establishment may request a variance from the Commissioner of Public Health from the requirements of the Public Health Code, established under section 19a-36, to utilize the process of sous vide and acidification of sushi rice, as defined in section 3-502.11 of the United States Food and Drug Administration's Food Code, as amended from time to time. The Commissioner of Public Health shall review the request for a variance and provide the food establishment with notification regarding the status of its request not later than thirty days after the commissioner receives such request. The commissioner may grant such variance if he or she determines that such variance would not result in a health hazard or nuisance.

Section. 67.

Subdivision (5) of section 19a-332 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2020):*

(5) "Asbestos-containing material" means material composed of asbestos of any type and in an amount equal to or greater than [one] 1.0 per cent by weight, either alone or mixed with other fibrous or nonfibrous material;