House of Representatives

General Assembly

File No. 539

January Session, 2021

Substitute House Bill No. 6666

House of Representatives, April 21, 2021

The Committee on Public Health reported through REP. STEINBERG of the 136th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

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 Section 73 of public act 19-117 is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):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, as amended by this act. 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.

Sec. 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 Subsection (b) of section 25-33 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):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.

Sec. 3. Section 8-3i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

(b) When an application, petition, request or plan is filed with the zoning commission, planning and zoning commission or zoning board of appeals of any municipality concerning any project on any site that is within the aquifer protection area delineated pursuant to section 22a-354c or the watershed of a water company, the applicant or the person making the filing shall: **[**provide**]** (1) Provide written notice of the

application, petition, request or plan to the water company and the [Commissioner of Public Health in a format prescribed by said commissioner, provided such water company or said commissioner has filed a map showing the boundaries of the watershed on the land records of the municipality in which the application, petition, request or plan is made and with the planning commission, zoning commission, planning and zoning commission or zoning board of appeals of such municipality or the aquifer protection area has been delineated in accordance with section 22a-354c, as the case may be] Department of Public Health; and (2) determine if the project is within the watershed of a water company by consulting the maps posted on the department's Internet web site showing the boundaries of the watershed. Such [notice shall be made] applicant shall send such notice to the water company by certified mail, return receipt requested, and to the department by electronic mail to the electronic mail address designated on its Internet web site for receipt of such notice. Such applicant shall [be mailed] mail such notice not later than seven days after the date of the application. Such water company and the Commissioner of Public Health may, through a representative, appear and be heard at any hearing on any such application, petition, request or plan.

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

Sec. 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**]** (1) Provide written notice of the application to the water company and the **[**Commissioner of Public Health in a format prescribed by said commissioner, provided such water company or said commissioner has filed a map showing the boundaries of the watershed on the land records of the municipality in which the application is made and with the inland wetlands agency of such municipality**]** Department of Public Health; and (2) determine if the project is within the watershed of a water company by consulting the maps posted on the department's Internet web site showing the boundaries of the watershed. Such **[**notice shall be made**]** applicant shall send such notice to the water company by certified mail, return receipt requested, and to the department by electronic mail to the electronic mail address designated by the department on its Internet web site for receipt of such notice. Such applicant shall **[**be mailed**]** mail 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.

Sec. 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 prescribed 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.

Sec. 6. Section 19a-37 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) "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 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.

Sec. 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, as amended by this act, 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 to the licensee electronically in a form and manner prescribed by the commissioner or by certified mail [to the licensee] at the address of the nursing home facility or residential care home in issue. A copy of such citation and notice of noncompliance shall also be sent to the licensed administrator at the address of the nursing home facility or residential care home.

Sec. 8. Subdivision (2) of subsection (c) of section 19a-491c of 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 (A) 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 (B) the commissioner determines the need to temporarily suspend the requirements of this subsection in the event of an emergency or significant disruption. The commissioner shall inform the long-term care facility when the commissioner has suspended the requirements of this subsection pursuant to subparagraph (B) of this subdivision and when such suspension is rescinded.

Sec. 9. Section 19a-177 of the general statutes 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, as amended by this act, 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, as amended by this act, 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.

Sec. 10. (NEW) (*Effective July 1, 2021*) The Commissioner of Public Health may waive any provisions of the regulations affecting an

emergency medical service organization, as defined in section 19a-175 of the general statutes, 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 or 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 the provisions of chapter 54 of the general statutes, establishing procedures for an application for a waiver pursuant to this subdivision.

Sec. 11. Section 20-207 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

As used in this chapter, unless the context otherwise requires, the following terms shall have the meanings specified:

(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 or herself 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 or her 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.

Sec. 12. 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**]** 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**]** 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 any student who is 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 human bodies under the supervision of a licensed embalmer and incidental to such student's course of study.

Sec. 13. Subsections (a) and (b) of section 20-213 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) (1) After a [student] 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] 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] 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] 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.

Sec. 14. 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] such licensed embalmer, or by a registered [student] apprentice embalmer under [his] such licensed embalmer's personal supervision.

Sec. 15. 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**]** 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 or she 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 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**]** such 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.

Sec. 16. 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, as amended by this act, 20-220 and 20-227 shall not prohibit the employment of assistants or of **[**student**]** registered apprentice embalmers and **[**student**]** registered apprentice funeral directors as provided in this chapter, provided a licensed funeral service business may employ no more than two **[**student**]** 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**]** registered apprentice funeral director at any one time, without the approval of the Board of Examiners of Embalmers and Funeral Directors.

(b) **[**Student**]** Registered apprentice embalmers and **[**student**]** registered apprentice funeral directors 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.

Sec. 17. Section 20-195dd of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

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

passed an examination prescribed by the commissioner. The provisions of subparagraphs (B)(i)(X) to (B)(i)(XII), inclusive, (B)(iii) and (B)(iv) of this subsection shall not apply to any applicant who, on or before July 1, 2017, was a matriculating student in good standing in a graduate degree program at a regionally accredited institution of higher education in one of the fields required under subparagraph (B) of this subsection.

(b) An applicant for a license as a professional counselor associate shall submit to the Commissioner of Public Health evidence satisfactory to the commissioner of having (1) earned a graduate degree in clinical mental health counseling as part of a program of higher learning accredited by the Council for Accreditation of Counseling and Related Educational Programs, or a successor organization, or (2) (A) completed at least sixty graduate semester hours in counseling or a related mental health field at a regionally accredited institution of higher education that included coursework in each of the following areas: Human growth and development; social and cultural foundations; counseling theories; counseling techniques; group counseling; career counseling; appraisals or tests and measurements to individuals and groups; research and evaluation; professional orientation to mental health counseling; addiction and substance abuse counseling; trauma and crisis counseling; and diagnosis and treatment of mental and emotional disorders, (B) completed a one-hundred-hour practicum in counseling taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state, (C) completed a six-hundred-hour clinical mental health counseling internship taught by a faculty member licensed or certified as a professional counselor or its equivalent in another state, and (D) earned from a regionally accredited institution of higher education a graduate degree in counseling or a related mental health field. The provisions of subparagraphs (A) to (C), inclusive, of subdivision (2) of this subsection shall not apply to any applicant who, on or before July 1, 2022, 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 three thousand hours of experience under professional supervision, as defined in

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.

Sec. 18. Subsection (a) of section 20-195c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Each applicant for licensure as a marital and family therapist shall present to the department satisfactory evidence that such applicant has: (1) Completed a graduate degree program specializing in marital and family therapy offered by a regionally accredited college or university or an accredited postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education 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;**]** (3) completed twelve months of relevant postgraduate experience, including (A) a minimum of one thousand hours of direct client contact offering marital and family therapy services subsequent to being awarded a master's degree or doctorate or subsequent to the training year specified in subdivision (2) of this subsection, and (B) one hundred hours of postgraduate clinical supervision provided by a licensed marital and family therapist; and (4) passed an examination prescribed by the department. The fee shall be three hundred fifteen dollars for each initial application.

Sec. 19. Subdivision (12) of subsection (a) of section 19a-14 of the 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), inclusive, (7),**]** (8), inclusive, (12) to (14), inclusive, or subdivision (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;

Sec. 20. Subsections (a) to (c), inclusive, of section 20-204a of the general statutes are 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, <u>as amended by this act,</u> 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, as amended by this act.

(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, as amended by this act.

Sec. 21. 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, 2022*):

(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, if the electronic death registry system 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) 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. Such physician, advanced practice registered nurse, physician assistant, registered nurse, nurse-midwife, chief medical officer or pathologist shall certify to the facts of death through the electronic death registry system, or, if the electronic death registry is unavailable, on a form provided by the department. 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.

Sec. 22. Section 19a-200 of the general statutes is repealed and the following is substituted 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. **[**, which**]** Such person shall possess the qualifications specified in subsection (b) of this section. Upon approval of the commissioner, such 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 such director's 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 **[**thirty**]** sixty 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 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.

Sec. 23. 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 Connecticut states 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.

Sec. 24. 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 board shall submit such written agreement to the Commissioner of Public Health upon such director's 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. At the end of each fiscal year, each director of health shall submit a report to the Department of Public Health detailing the activities of such director during the preceding fiscal year.

Sec. 25. 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;

Sec. 26. 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, as amended by this act, 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, 2021, 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.

Sec. 27. 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, as amended by this act, 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.

Sec. 28. 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, 2021. Each behavior analyst applying for license renewal shall furnish evidence satisfactory to the commissioner of having current certification with the Behavior Analyst Certification Board.

Sec. 29. Subsection (a) of 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, and any 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.

Sec. 30. 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**]** As used in this section, "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,

behavior analyst, 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.

Sec. 31. Subsection (g) of section 17b-451 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(g) The Commissioner of Social Services shall develop an educational training program to promote and encourage the accurate and prompt identification and reporting of abuse, neglect, exploitation and abandonment of elderly persons. Such training program shall be made available on the Internet web site of the Department of Social Services to **[**mandated**]** mandatory reporters and other interested persons. The

commissioner shall also make such training available in person or otherwise at various times and locations throughout the state as determined by the commissioner.

Sec. 32. Section 19a-6o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(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 shall notify the appointing authority of the identity of the commissioner's choice for appointment not later 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**]** 2022, 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.

Sec. 33. 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 post such 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.**]**

Sec. 34. Subsection (b) of section 19a-493 of the general statutes is 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, 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 company, 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.

Sec. 35. (NEW) (*Effective July 1, 2021*) A health care facility licensed pursuant to chapter 368v of the general statutes 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 any provision of the general statutes or any regulations adopted thereunder, any employee providing direct patient care in a facility licensed pursuant to chapter 368v of the general statutes shall receive tuberculosis screening and testing in compliance with the licensed health care facility's policies and procedures.

Sec. 36. Subsection (c) of section 19a-343 of the general statutes 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, or sale or delivery of alcoholic liquor to any minor under subdivision (1) of subsection (b) of section 30-86 or the sale, delivery or giving of alcoholic liquor to a minor under subdivision (2) of subsection (b) of section 30-86.

(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.

Sec. 37. 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 his or her designee, the Commissioner of Emergency Services and Public Protection, or his or her designee, the president pro tempore of the Senate, or his or her designee, the speaker of the House of Representatives, or his or her 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.

Sec. 38. 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 or any hospital. 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 of Public Health, in a form and manner prescribed by the commissioner, the name and address of each blood collection facility owned and operated by the clinical laboratory, prior to the issuance of a new license, prior to the issuance of a renewal license or whenever a blood collection facility opens or closes.

Sec. 39. 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.

Sec. 40. 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.

Sec. 41. Subsection (a) of section 20-265h of 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.

Sec. 42. Subsection (a) of section 19a-131j of the 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 to 376c, inclusive, 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.

Sec. 43. Subsection (a) of section 19a-512 of the general statutes 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 or she (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.

Sec. 44. Section 19a-490 of the 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) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

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

(k) "Home health agency" means an agency licensed as a home health care agency or a home health aide agency;

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

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

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

location where a segregated unit of services is provided by the multicare institution;

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

(p) "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; **[**.**]** and

(q) "Hospice home health care agency" means a public or private organization that provides home care and hospice services to terminally ill patients.

Sec. 45. Subsections (b) to (i), inclusive, of section 19a-491 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(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, hospice home health care agencies, or home health aide agencies, except certified home health care agencies, hospice home health care 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 hospice home health care agencies, as described in section 19a-493, as amended by this act, 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, hospice home health care 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, hospice home health care 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.

Sec. 46. Subdivision (4) of subsection (a) of section 19a-491c of the 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, hospice home health care agency or home health aide agency, as defined in section 19a-490, as amended by this act, an assisted living services agency, as defined in section 19a-490, as amended by this act, 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.

Sec. 47. Section 19a-492b of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2021*):

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

Sec. 48. Subsection (b) of section 19a-492c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) A home health care agency or hospice home health care 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; and (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.

Sec. 49. Section 19a-492d of the 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, hospice home health care 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.

Sec. 50. Section 19a-492e of the 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" **[**has**]** and "hospice home health care agency" have the same **[**meaning**]** meanings as provided in section 19a-490, as amended by this act. 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 hospice home health care 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 or hospice home health care 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 hospice home health care 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 hospice home health care aides when the registered nurse determines that it is in the best interest of the client and the home health aide or hospice home health care aide has been deemed competent to perform the task; (C) designate home health aides and hospice home health care aides to obtain certification and recertification for the administration of medication; and (D) ensure that such home health 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 and hospice home health care agencies that provide services for clients requiring assistance with medication administration in determining (A) which home health aides and hospice home health care 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 and, on or before January 1, 2022, each hospice home health care 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 care 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 hospice home health care 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 care aide to whom tasks are delegated, unless the home health aide or hospice home health care 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 care aide to whom it is delegated, (2) provided initial direction to the home health aide or hospice home health care aide, and (3) provided ongoing supervision of the home health aide or hospice home health care 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 hospice home health care 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 hospice home health care 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 hospice home health care 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.

Sec. 51. Section 19a-496a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Notwithstanding any provision of the regulations of Connecticut state agencies, all home health care agency, hospice home health care agency and 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.

Sec. 52. Section 19a-504d of the 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 hospice home health care agencies.

(b) A hospital which (1) has an ownership or investment interest in a home health care agency or hospice home health care agency, or (2)

receives compensation or remuneration for referral of patients to a home health care agency or hospice home health care 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.

Sec. 53. (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 of the general statutes, under their existing license if such licensed chronic and convalescent nursing home (1) provides services to such patients in a building that is not physically connected to its licensed facility, or (2) expands its bed capacity in a portion of a facility that is separate from the licensed facility. 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 of the general statutes.

(b) Each chronic and convalescent nursing home that intends to provide services pursuant to subsection (a) of this section shall submit an application to the Department of Public Health in a form and manner prescribed by the commissioner. Such application shall include, but need not be limited to: (1) Information regarding the facility's ability to sufficiently address the health, safety or welfare of such chronic and convalescent nursing home's residents and staff; (2) the address of such facility; (3) an attestation that all equipment located at such facility is maintained according to the manufacturers' specifications, and is capable of meeting the needs of such facility's residents; (4) information regarding such facility's maximum bed capacity; and (5) information indicating that such facility is in compliance with any provisions of the general statutes or regulations of Connecticut state agencies pertaining

to the operation of such facility.

(c) Upon receipt of an application pursuant to subsection (a) of this section, the Department of Public Health shall conduct a scheduled inspection and investigation of the applicant's facilities to ensure compliance with any provisions of the general statutes or regulations of Connecticut state agencies pertaining to the licensing of such facilities. After conducting such inspection and investigation, the department shall notify the applicant of the department's approval or denial of such application.

Sec. 54. 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 such chronic and convalescent nursing home who has been properly trained by the director of nursing or by an intravenous infusion company to (1) draw blood from a central line for laboratory purposes, provided the facility has an agreement with a laboratory to process such specimens, or (2) administer a dose of medication by intravenous injection, provided such medication is on a list of medications approved by the Commissioner of Public Health for intravenous injection by a registered nurse. Such chronic and convalescent nursing home shall notify the Commissioner of Public Health of any such services being provided under subdivisions (1) and (2) of this subsection. The Commissioner of Public Health shall notify all chronic and convalescent nursing homes of the list of medications approved for intravenous injection by a registered nurse. The administrator of each chronic and convalescent nursing home shall ensure that each registered nurse who is permitted to perform the services described in subdivisions (1) and (2) of this subsection is appropriately trained and competent to perform such services. Each administrator shall provide documentation regarding the training and competency of such registered nurses to the department upon the

department's request.

Sec. 55. (NEW) (*Effective July 1, 2021*) (a) The Commissioner of Public Health shall license assisted living services agencies, as defined in section 19a-490 of the general statutes, as amended by this act. 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 to arrange for the assisted living services to the Department of Public Health in a form and manner 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 of Public Health. Such assisted living services agencies shall ensure that they have adequate staff to meet the needs of the residents. Each assisted living services agency that offers memory care services shall submit to the Department of Public Health a list of memory care units or locations and their staffing plans for any such units and locations when completing an initial or a renewal licensure application, or upon request from the department.

(d) An assisted living services agency shall ensure that (1) all services being provided on an individual basis to clients are fully understood and agreed upon between either the client or the client's representative, and (2) the client or the client's representative are made aware of the cost of any such services.

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

Sec. 56. 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) not act as a restraint to the resident, (2) ensure that the resident's call bell, overhead bed light and privacy curtain function and are readily useable by such resident, (3) not create a hazardous situation, including, but not limited to, an entrapment possibility, or obstacle to evacuation or being close to or blocking a heat source, (4) prevent the spread of pathogens, (5) allow for infection control, (6) ensure residence privacy, and (7) provide at least six-foot clearance at the sides and foot of each bed.

Sec. 57. 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.

Sec. 58. Section 20-206jj of the 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, as amended by this act, 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, as amended by this act;

(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, as amended by this act;

(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; and

(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.**]**

Sec. 59. Subsection (f) of section 20-206mm of the 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 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.

Sec. 60. 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. Any appointment to the advisory board that is vacant for more than one year shall be filled by the Commissioner of Public Health. The commissioner shall notify the appointing authority of the identity of the commissioner's appointment not later than thirty days before making such appointment.

Sec. 61. Subsection (a) of section 19a-36h of the general statutes 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.

Sec. 62. Subsection (a) of section 19a-36j of the general statutes 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.

(1) Each person seeking certification as a food inspector shall submit an application to the department on a form prescribed by the commissioner and present to the department satisfactory evidence that such person (A) is sponsored by the director of health in the jurisdiction in which the applicant is employed to conduct food inspections, (B) possesses a bachelor's degree or three years of experience in a regulatory food protection program, (C) has successfully completed a training and verification program, (D) has successfully completed the field standardization inspection prescribed by the commissioner, and (E) is

not involved in the ownership or management of a food establishment located in the applicant's jurisdiction.

(2) Each director of health sponsoring an applicant for certification as a food inspector shall submit to the commissioner a form documenting the applicant's qualifications and successful completion of the requirements described in subdivision (1) of this subsection.

(3) Certifications issued under this section shall be subject to renewal once every three years. A food inspector applying for renewal of his or her certification shall demonstrate successful completion of twenty contact hours in food protection training, as approved by the commissioner, and reassessment by the food inspection training officer.

Sec. 63. Section 19a-36o of the general statutes 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.

Sec. 64. Subdivision (5) of section 19a-332 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(5) "Asbestos-containing material" means material composed of asbestos of any type and in an amount equal to or greater than one per

cent by weight, either alone or mixed with other fibrous or nonfibrous material;

Sec. 65. Subdivision (4) of section 20-250 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(4) "Hairdressing and cosmetology" means the art of dressing, arranging, curling, waving, weaving, cutting, singeing, bleaching and coloring the hair and treating the scalp of any person, and massaging, cleansing, stimulating, manipulating, exercising or beautifying with the use of the hands, appliances, cosmetic preparations, antiseptics, tonics, lotions, creams, powders, oils or clays and doing similar work on the face, neck and arms for compensation, removing hair from the face or neck using manual or mechanical means, excluding esthetics, as defined in section 20-265a or any of the actions listed in this subdivision performed on the nails of the hands or feet, provided nothing in this subdivision shall prohibit an unlicensed person from performing shampooing or braiding hair;

Sec. 66. Subsection (b) of section 20-265b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) On and after January 1, 2020, each person seeking an initial license as an esthetician shall apply to the department on a form prescribed by the department, accompanied by an application fee of one hundred dollars and evidence that the applicant (1) has completed a course of not less than six hundred hours of study and received a certification of completion from a school approved under section 20-265g or section 20-26 or in a school outside of the state whose requirements are equivalent to a school approved under section 20-265g, or (2) (A), if applying before January 1, 2022, has practiced esthetics continuously in this state for a period of not less than two years prior to July 1, 2020, and (B) is in compliance with the infection prevention and control plan guidelines prescribed by the department under section 19a-231 in the form of an attestation.

Sec. 67. Subsection (f) of section 10-206 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(f) On and after October 1, 2017, each local or regional board of education shall report to the local health department and the Department of Public Health, on an triennial basis, the total number of pupils per school and per school district having a diagnosis of asthma (1) at the time of public school enrollment, (2) in grade six or seven, and (3) in grade nine or ten. **[**or eleven.**]** The report shall contain the asthma information collected as required under subsections (b) and (c) of this section and shall include pupil age, gender, race, ethnicity and school. Beginning on October 1, 2021, and every three years thereafter, the Department of Public Health shall review the asthma screening information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning asthma trends and distributions among pupils enrolled in the public schools. The report shall be submitted in accordance with the provisions of section 11-4a and shall include, but not be limited to, (A) trends and findings based on pupil age, gender, race, ethnicity, school and the education reference group, as determined by the Department of Education for the town or regional school district in which such school is located, and (B) activities of the asthma screening monitoring system maintained under section 19a-62a.

Sec. 68. Subsections (b) to (f), inclusive, of section 19a-215 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(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) All personal information obtained from disease prevention and control investigations as performed in subsections (c) and (d) of this section including the health care provider's name and the identity of the

reported case of disease and suspected source persons and contacts shall not be divulged to anyone and shall be held strictly confidential pursuant to section 19a-25, by the local director of health and the director's authorized agent and by the Department of Public Health.

(f) **[**Any person who violates any reporting or confidentiality provision of this section shall be fined not more than five hundred dollars.**]** The Commissioner of Public Health may impose a civil penalty not to exceed one thousand dollars on any person who violates any reporting provision of this section for each such violation. Each failure to report a case or finding of a disease as required by this section shall constitute a separate violation.

(g) If the Commissioner of Public Health has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (f) of this section, he or she may send to such person by certified mail, return receipt requested, or personally serve upon such person, a notice which shall include: (1) A short and plain statement of the matters asserted or charged; (2) a statement of the maximum civil penalty which may be imposed for such violation; and (3) a statement of the party's right to request a hearing, which such request shall submitted in writing to the commissioner not later than ten days after the notice is mailed or served.

(h) If such person so requests, the commissioner shall cause a hearing to be held, in accordance with the provisions of chapter 54. If such person fails to request a hearing or fails to appear at the hearing or if, after the hearing, the commissioner finds that the person has committed such violation, the commissioner may, in his or her discretion, order that a civil penalty be imposed that is not greater than the penalty stated in the notice. The commissioner shall send a copy of any order issued pursuant to this subsection by certified mail, return receipt requested, to the person named in such order.

(i) No provision of this section shall be deemed to supersede section 19a-584.

Sec. 69. Section 19a-490w of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2021*):

(a) Not later than October 1, 2017, and annually thereafter, any hospital that has been certified as a comprehensive stroke center, a primary stroke center, a thrombectomy-capable stroke center or an acute stroke-ready hospital by the American Heart Association, the Joint Commission or any other nationally recognized certifying organization shall submit an attestation of such certification to the Commissioner of Public Health, in a form and manner prescribed by the commissioner. Not later than October 15, 2017, and annually thereafter, the Department of Public Health shall post a list of certified stroke centers on its Internet web site.

(b) The department may remove a hospital from the list posted pursuant to subsection (a) of this section if (1) the hospital requests such removal, (2) the department is informed by the American Heart Association, the Joint Commission or other nationally recognized certifying organization that a hospital's certification has expired or been suspended or revoked, or (3) the department does not receive attestation of certification from a hospital on or before October first. The department shall report to the nationally recognized certifying organization any complaint it receives related to the certification of a hospital as a comprehensive stroke center, a primary stroke center, a thrombectomy-capable stroke center or an acute stroke-ready hospital. The department shall provide the complainant with the name and contact information of the nationally recognized certifying organization if the complainant seeks to pursue a complaint with such organization.

Sec. 70. (NEW) (*Effective October 1, 2021*) (a) The Department of Public Health shall maintain and operate a state-wide stroke registry. Said registry shall use the American Heart Association's Get With The Guidelines–Stroke program's data set platform and include information and data on stroke care in the state that align with the stroke consensus metrics developed and approved by the American Heart Association and American Stroke Association.

(b) On and after January 1, 2022, each comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital shall, on a quarterly basis, submit to the Department of Public Health data concerning stroke care that are necessary for including in the state-wide stroke registry, as determined by the Commissioner of Public Health, and that, at a minimum, align with the stroke consensus metrics developed and approved by the American Heart Association and American Stroke Association.

(c) The Department of Public Health shall be provided access to records of any comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital, 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.

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

(e) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to exchange stroke care data.

(f) (1) Failure by a comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital to comply with the reporting requirements prescribed in this section may result in the department electing to perform the registry services for such comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital. In such case, the comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital shall reimburse the department for actual expenses incurred in performing such services.

(2) Any comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital that fails to

comply with the provisions of this section shall be liable for a civil penalty not to exceed five hundred dollars for each failure to disclose a stroke care data, as determined by the commissioner.

(3) The reimbursements, expenses and civil penalties set forth in this section shall be assessed only after the Department of Public Health has provided a comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital with written notice of deficiency and such comprehensive stroke center, thrombectomy-capable stroke center, primary stroke center or acute stroke-ready hospital has been afforded not less than fourteen business days after the date of receiving such notice to provide a written response to the department. Such written response shall include any information requested by the department.

(g) The Commissioner of Public Health may request that the Attorney General initiate an action to collect any civil penalties assessed pursuant to this section and obtain such orders as necessary to enforce any provision of this section.

(h) Not later than January 1, 2022, the Department of Public Health, in consultation with the State of Connecticut Stroke Advisory Council, shall establish a stroke registry data oversight committee. Such committee shall monitor the operations of the state-wide stroke registry, provide advice regarding the oversight of such registry, develop a plan to improve quality of stroke care and address disparities in the provision of such care and develop short and long-term goals for improvement of stroke care in comprehensive stroke centers, thrombectomy-capable stroke centers, primary stroke centers and acute stroke-ready hospitals.

(i) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 71. Subsection (k) of section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from*

passage):

(k) Notwithstanding the provisions of subsection (a) of this section, any **[**volunteer, hospital-based or municipal ambulance service**]** emergency medical services organization that is licensed or certified and a primary service area responder may apply to the commissioner, on a short form application prescribed by the commissioner, to change the address of a principal or branch location or to add a branch location within its primary service area. Upon making such application, the applicant shall notify in writing all other primary service area responders in any municipality or abutting municipality in which the applicant proposes to change principal or branch locations. Unless a primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner and requests a hearing on such application not later than fifteen calendar days after receiving such notice, the application shall be deemed approved thirty calendar days after filing. If any such primary service area responder files an objection with the commissioner within the fifteen-calendar-day time period and requests a hearing, the applicant shall be required to demonstrate need to change the address of a principal or branch location within its primary service area at a public hearing as required under subsection (a) of this section.

Sec. 72. Section 7-36 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

As used in this chapter and sections 19a-40 to 19a-45, inclusive, unless the context otherwise requires:

(1) "Registrar of vital statistics" or "registrar" means the registrar of births, marriages, deaths and fetal deaths or any public official charged with the care of returns relating to vital statistics;

(2) "Registration" means the process by which vital records are completed, filed and incorporated into the official records of the department;

(3) "Institution" means any public or private facility that provides inpatient medical, surgical or diagnostic care or treatment, or nursing, custodial or domiciliary care, or to which persons are committed by law;

(4) "Vital records" means a certificate of birth, death, fetal death or marriage;

(5) "Certified copy" means a copy of a birth, death, fetal death or marriage certificate that (A) includes all information on the certificate except such information that is nondisclosable by law, (B) is issued or transmitted by any registrar of vital statistics, (C) includes an attested signature and the raised seal of an authorized person, and (D) if submitted to the department, includes all information required by the commissioner;

(6) "Uncertified copy" means a copy of a birth, death, fetal death or marriage certificate that includes all information contained in a certified copy except an original attested signature and a raised seal of an authorized person;

(7) "Authenticate" or "authenticated" means to affix to a vital record in paper format the official seal, or to affix to a vital record in electronic format the user identification, password, or other means of electronic identification, as approved by the department, of the creator of the vital record, or the creator's designee, by which affixing the creator of such paper or electronic vital record, or the creator's designee, affirms the integrity of such vital record;

(8) "Attest" means to verify a vital record in accordance with the provisions of subdivision (5) of this section;

(9) "Correction" means to change or enter new information on a certificate of birth, marriage, death or fetal death, within one year of 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 such vital event, where such changes or entries are to correct errors on such certificate due to inaccurate or incomplete information provided by the informant

at the time the certificate was prepared, or to correct transcribing, typographical or clerical errors;

(10) "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 gender change, or (C) reflect a legal name change in accordance with section 19a-42 or make a modification to a cause of death;

(11) "Acknowledgment of paternity" means to legally acknowledge paternity of a child pursuant to section 46b-172;

(12) "Adjudication of paternity" means to legally establish paternity through an order of a court of competent jurisdiction;

(13) "Parentage" includes matters relating to adoption, gestational agreements, paternity and maternity;

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

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

(16) "Gestational agreement" means a written agreement for assisted reproduction in which a woman agrees to carry a child to birth for an intended parent or intended parents, which woman contributed no genetic material to the child and which agreement (A) names each party to the agreement and indicates each party's respective obligations under the agreement, (B) is signed by each party to the agreement and the spouse of each such party, if any, and (C) is witnessed by at least two disinterested adults and acknowledged in the manner prescribed by law;

(17) "Intended parent" means a party to a gestational agreement who agrees, under the gestational agreement, to be the parent of a child born

to a woman by means of assisted reproduction, regardless of whether the party has a genetic relationship to the child;

(18) "Foundling" means (A) a child of unknown parentage, or (B) an infant voluntarily surrendered pursuant to the provisions of section 17a-58; **[**and**]**

(19) "Certified homeless youth" means a person who is at least fifteen years of age but less than eighteen years of age, is not in the physical custody of a parent or legal guardian, who is a homeless child or youth, as defined in 42 USC 11434a, as amended from time to time, and who has been certified as homeless by (A) a school district homeless liaison, (B) the director of an emergency shelter program funded by the United States Department of Housing and Urban Development, or the director's designee, **[**or**]** (C) the director of a runaway or homeless youth basic center or transitional living program funded by the United States Department of Health and Human Services, or the director's designee, **[**.**]** or (D) the director of a program of a nonprofit organization or municipality that is contracted with the homeless youth program established pursuant to section 17a-62a; and

(20) "Certified homeless young adult" means a person who is at least eighteen years of age but less than twenty-five years of age who has been certified as homeless by (A) a school district homeless liaison, (B) the director of an emergency shelter program funded by the United States Department of Housing and Urban Development, or the director's designee, (C) the director of a runaway or homeless youth basic center or transitional living program funded by the United States Department of Health and Human Services, or the director's designee, or (D) the director of a program of a nonprofit organization or municipality that is contracted with the homeless youth program established pursuant to section 17a-62a.

Sec. 73. Subsection (c) of section 7-51 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(c) (1) The registrar of the town in which the birth or fetal death occurred or of the town in which the mother resided at the time of the birth or fetal death, or the department, may issue a certified copy of the certificate of birth or fetal death of any person born in this state that is kept in paper form in the custody of the registrar. Except as provided in subdivision (2) of this subsection, such certificate shall be issued upon the written request of an eligible party listed in subsection (a) of this section. Any registrar of vital statistics in this state with access, as authorized by the department, to the electronic vital records system of the department may issue a certified copy of the electronically filed certificate of birth or fetal death of any person born in this state upon the written request of an eligible party listed in subsection (a) of this section. The registrar and the department may waive the fee for the issuance of a certified copy of the certificate of birth of a certified homeless young adult to such young adult under this subsection.

(2) In the case of a certified homeless youth, such certified homeless youth and the person who is certifying the certified homeless youth as homeless, as described in section 7-36, as amended by this act, shall appear in person when the certified homeless youth is presenting the written request described in subdivision (1) of this subsection at (A) the office of the registrar of the town in which the certified homeless youth was born, (B) the office of the registrar of the town in which the mother of the certified homeless youth resided at the time of the birth, (C) if the birth certificate of the certified homeless youth has been electronically filed, any registrar of vital statistics in the state with access, as authorized by the department, to the electronic vital records system, or (D) the state vital records office of the department. The certified homeless youth shall present to the registrar or the department information sufficient to identify himself or herself as may be required by regulations adopted by the commissioner pursuant to section 7-41. The person who is certifying the certified homeless youth as homeless shall present to the registrar or the department information sufficient to identify himself or herself as meeting the certification requirements of section 7-36, as amended by this act. The registrar and the department may waive the fee for the issuance of a certified copy of the certificate of

birth of a homeless youth to such youth under this subsection.

Sec. 74. Subsection (a) of section 1-1h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Any person who does not possess a valid motor vehicle operator's license may apply to the Department of Motor Vehicles for an identity card. The application for an identity card shall be accompanied by the birth certificate of the applicant or a certificate of identification of the applicant issued and authorized for such use by the Department of Correction and a fee of twenty-eight dollars. Such application shall include: (1) The applicant's name; (2) the applicant's address; (3) whether the address is permanent or temporary; (4) the applicant's date of birth; (5) notice to the applicant that false statements on such application are punishable under section 53a-157b; and (6) such other pertinent information as the Commissioner of Motor Vehicles deems necessary. The applicant shall sign the application in the presence of an official of the Department of Motor Vehicles. The commissioner may waive the fee for any applicant (A) who has voluntarily surrendered such applicant's motor vehicle operator's license, (B) whose license has been refused by the commissioner pursuant to subdivision (4) of subsection (e) of section 14-36, (C) who is both a veteran, as defined in subsection (a) of section 27-103, and blind, as defined in subsection (a) of section 1-1f, or (D) who is a resident of a homeless shelter or other facility for homeless persons or a certified homeless youth or certified homeless young adult. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish the procedure and qualifications for the issuance of an identity card to any such homeless applicant. For the purposes of this subsection, "certified homeless youth" and "certified homeless young adult" have the same meanings as provided in section 7-36, as amended by this act.

Sec. 75. Section 20-226 of the general statutes is repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	PA 19-117, Sec. 73
Sec. 2	*October 1, 2021*	25-33(b)
Sec. 3	*October 1, 2021*	8-3i
Sec. 4	*October 1, 2021*	22a-42f
Sec. 5	*October 1, 2021*	19a-111
Sec. 6	*October 1, 2021*	19a-37
Sec. 7	*October 1, 2021*	19a-524
Sec. 8	*July 1, 2021*	19a-491c(c)(2)
Sec. 9	*October 1, 2021*	19a-177
Sec. 10	*July 1, 2021*	New section
Sec. 11	*October 1, 2021*	20-207
Sec. 12	*October 1, 2021*	20-212
Sec. 13	*October 1, 2021*	20-213(a) and (b)
Sec. 14	*October 1, 2021*	20-215
Sec. 15	*October 1, 2021*	20-217(a)
Sec. 16	*October 1, 2021*	20-224
Sec. 17	*October 1, 2021*	20-195dd
Sec. 18	*October 1, 2021*	20-195c(a)
Sec. 19	*October 1, 2021*	19a-14(a)(12)
Sec. 20	*October 1, 2021*	20-204a(a) to (c)
Sec. 21	*January 1, 2022*	7-62b(b) and (c)
Sec. 22	*July 1, 2021*	19a-200
Sec. 23	*July 1, 2021*	19a-202a
Sec. 24	*July 1, 2021*	19a-244
Sec. 25	*July 1, 2021*	19a-12a(a)(3)
Sec. 26	*July 1, 2021*	19a-12d
Sec. 27	*October 1, 2021*	19a-12e(a)
Sec. 28	*from passage*	20-185k(b)
Sec. 29	*October 1, 2021*	17a-412(a)
Sec. 30	*October 1, 2021*	17b-451(a)
Sec. 31	*October 1, 2021*	17b-451(g)
Sec. 32	*July 1, 2021*	19a-6o
Sec. 33	*from passage*	19a-6q
Sec. 34	*July 1, 2021*	19a-493(b)
Sec. 35	*July 1, 2021*	New section
Sec. 36	*October 1, 2021*	19a-343(c)
Sec. 37	*from passage*	19a-131g
Sec. 38	*July 1, 2021*	19a-30(d)

Sec. 39	*July 1, 2021*	20-365(b)
Sec. 40	*from passage*	20-195u(b)
Sec. 41	*from passage*	20-265h(a)
Sec. 42	*from passage*	19a-131j(a)
Sec. 43	*July 1, 2021*	19a-512(a)
Sec. 44	*July 1, 2021*	19a-490
Sec. 45	*July 1, 2021*	19a-491(b) to (i)
Sec. 46	*July 1, 2021*	19a-491c(a)(4)
Sec. 47	*July 1, 2021*	19a-492b
Sec. 48	*July 1, 2021*	19a-492c(b)
Sec. 49	*July 1, 2021*	19a-492d
Sec. 50	*July 1, 2021*	19a-492e
Sec. 51	*July 1, 2021*	19a-496a
Sec. 52	*July 1, 2021*	19a-504d
Sec. 53	*July 1, 2021*	New section
Sec. 54	*July 1, 2021*	19a-522f
Sec. 55	*July 1, 2021*	New section
Sec. 56	*July 1, 2021*	19a-521b
Sec. 57	*October 1, 2021*	19a-195
Sec. 58	*from passage*	20-206jj
Sec. 59	*from passage*	20-206mm(f)
Sec. 60	*from passage*	19a-178a(b)
Sec. 61	*from passage*	19a-36h(a)
Sec. 62	*from passage*	19a-36j(a)
Sec. 63	*from passage*	19a-36o
Sec. 64	*October 1, 2021*	19a-332(5)
Sec. 65	*from passage*	20-250(4)
Sec. 66	*July 1, 2021*	20-265b(b)
Sec. 67	*July 1, 2021*	10-206(f)
Sec. 68	*from passage*	19a-215(b) to (f)
Sec. 69	*October 1, 2021*	19a-490w
Sec. 70	*October 1, 2021*	New section
Sec. 71	*from passage*	19a-180(k)
Sec. 72	*July 1, 2021*	7-36
Sec. 73	*July 1, 2021*	7-51(c)
Sec. 74	*July 1, 2021*	1-1h(a)
Sec. 75	*from passage*	Repealer section

Statement of Legislative Commissioners:

Section 3(b), was redrafted for consistency with the standard drafting conventions; Section 4 was redrafted for consistency with standard drafting conventions; in Section 9, subdivision (13) was deleted and added as a new Section 10 for clarity; in Section 24 "the written agreement shall be submitted" was changed to "The board shall submit such written agreement" for clarity and consistency with standard drafting conventions; in Section 30 "The term" was bracketed and "As used in this section," was inserted immediately thereafter for consistency with the standard drafting conventions; Section 31 was added and "mandated" was bracketed and "mandatory" was inserted immediately thereafter for statutory consistency; in Section 43 "or she" was inserted after "he" for consistency with the standard drafting conventions; in Section 50(c), "on or before January 1, 2022, each" was added for clarity; in Section 54(c), "under subdivisions (1) and (2) of this subsection" was added for clarity; in Section 55(b), "Such application shall be submitted" was deleted for clarity and to eliminate redundant language; in Section 55(c), "for any such units or locations" was added for clarity; in Section 55(d), Subdiv. (1) was moved before "all" for clarity; in Section 56, "creating" was deleted for clarity; in Section 60(b), "to the advisory board" was added after "Any appointment" for clarity; and in Section 64, the brackets around "one" were removed and "1.0" was deleted for consistency with standard drafting conventions.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
Public Health, Dept.	GF - Cost	723,000	329,690
State Comptroller - Fringe Benefits[1]	GF - Cost	92,100	94,860
Public Health, Dept.	GF - Revenue Loss	7,800	7,800

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill makes various substantive, minor, and technical changes in Department of Public Health (DPH)-related statutes and programs.

Section 36 will result in a General Fund revenue loss of $7,800 as it eliminates the annual $200 licensure fee for clinical laboratories owned by hospitals. There are 39 clinical laboratories owned by hospitals in the state.

Section 68 requires DPH to maintain and operate a statewide stroke registry using the American Heart Association's "Get with the Guidelines-Stroke Program" data set platform. The registry must include information and data on stroke care in Connecticut that aligns with the stroke consensus metrics developed and approved by the American Heart Association (AHA) and American Stroke Association

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.3% of payroll in FY 22 and FY 23.

(ASA). It is estimated that the costs for DPH to utilize the AHA data set platform could cost up to $500,000 in FY 22 for the initial user fee, software and maintenance. The FY 23 cost is estimated to be up to $100,000 for the annual user fee.

In addition, DPH would need to hire three positions to fulfill the requirements of Section 68; a Nurse Consultant ($72,000), an Epidemiologist ($70,000), and an Analyst II ($81,000). The Nurse Consultant would be needed for stroke metrics and data interpretation and to work with the health care system and hospitals to support quarterly reporting. The Epidemiologist would handle data collection and analysis expertise for reporting and to support internal record keeping, auditing and database development. Lastly, the Analyst II position would be responsible for IT support for all database procurement, development and maintenance functions.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 6666

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

TABLE OF CONTENTS:

Exempts certain professional counselor and professional counselor associate licensure applicants from specified requirements

§ 18 — MARITAL AND FAMILY THERAPY LICENSURE

Removes the specific requirement that MFT licensure applicants' supervised practicum or internship include 500 clinical hours

§§ 19 & 20 — VETERINARIAN INVESTIGATIONS

Gives the complainant access to the investigation file when a complaint regarding a veterinarian is closed with no finding, and specifically extends existing procedures for complaints against other providers to complaints against veterinarians

§ 21 — ELECTRONIC DEATH REGISTRY SYSTEM

Requires funeral directors, embalmers, and heath care practitioners certifying deaths to use the electronic death registry system, if it is available

§§ 22-24 — LOCAL AND DISTRICT HEALTH DEPARTMENTS

Makes various changes affecting municipal and district health departments, including making certain requirements consistent for both types of departments

§§ 25-28 — BEHAVIOR ANALYST ELIGIBILITY FOR THE PROFESSIONAL ASSISTANCE PROGRAM AND REPORTING OF IMPAIRED HEALTH PROFESSIONALS

Adds licensed behavior analysts to the list of providers eligible for the professional assistance program for health professionals, and correspondingly increases their licensure renewal fee by $5; adds these providers to the list of health professionals who must notify DPH if they are aware that another professional may be unable to safely practice

§§ 29-31 — BEHAVIOR ANALYSTS AS MANDATED REPORTERS OF ELDER ABUSE

Makes behavior analysts mandated reporters of abuse of the elderly or long-term care facility residents

§ 32 — PALLIATIVE CARE ADVISORY COUNCIL

Requires the DPH commissioner to make an appointment to the Palliative Care Advisory Council if there is a spot that is vacant for at least one year, and decreases the council's reporting frequency from annually to biennially

§ 33 — CHRONIC DISEASE REPORTING

Eliminates the requirement for DPH to biennially report on chronic disease and the implementation of the department's chronic disease plan, and instead requires her to post the plan on the department's website

§ 34 — FACILITY OWNERSHIP CHANGES

Makes a minor change to the law on health care facility ownership changes

§ 35 — TUBERCULOSIS SCREENING

Requires health care facilities to maintain tuberculosis screening policies for their health care personnel that reflect the CDC's recommendations

§ 36 — PUBLIC NUISANCES

Specifies that violations of the state Fire Prevention Code are included within the public nuisance law

§ 37 — PUBLIC HEALTH PREPAREDNESS ADVISORY COMMITTEE

Allows members of the Public Health Preparedness advisory committee to appoint designees to serve in their place

§ 38 — CLINICAL LABORATORIES

Requires clinical laboratories to give DPH a list of the blood collection facilities they own and operate, and exempts hospital-owned clinical laboratories from licensure fees

§ 39 — TECHNICAL CHANGES

Makes technical and conforming changes

§ 40 — SOCIAL WORKER CONTINUING EDUCATION

Increases the maximum hours of continuing education that social workers may complete online or through home study

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Allows massage therapists to manage spas and salons

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§ 43 — NURSING HOME ADMINISTRATOR LICENSURE

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Requires managed residential communities (MRCs) that provide assisted living services to become licensed as assisted living services agencies (ALSAs); requires an MRC that intends to contract with an ALSA for services to apply to DPH prior to doing so; and requires an ALSA to obtain DPH approval before providing memory care to residents with early to mid-stage cognitive impairment from Alzheimer's disease or dementia

§ 51 — HOME HEALTH ORDERS

Allows physician assistants and advanced practice registered nurses to issue orders for home health care agency services

§ 53 — NURSING HOME EXPANDED BED CAPACITY DURING EMERGENCY

Allows DPH to suspend nursing home licensure requirements to allow homes to temporarily increase their bed capacity to provide services to patients during a declared public health emergency

§ 54 — IV CARE IN NURSING HOMES

Allows registered nurses employed by nursing homes to administer medications intravenously or draw blood from a central line for laboratory purposes under certain conditions

§ 56 — BED POSITIONS IN LONG-TERM CARE FACILITIES

Requires chronic disease hospitals, nursing homes, and residential care homes to position beds in a manner that promotes resident care

§ 57 — REGULATIONS ON AMBULANCE STAFFING

Makes a technical change by updating terminology in the statute requiring DPH to adopt regulations on ambulance staffing

§§ 58 & 59 — CONTINUING EDUCATION FOR EMS PERSONNEL

Requires EMS personnel to document their required continuing education hours in a manner the DPH commissioner prescribes, instead of using a DPH-approved online database

§ 60 — EMS ADVISORY BOARD

Requires the DPH commissioner to appoint a member to the Connecticut EMS Advisory Board if the appointment is vacant for more than one year, and notify the appointing authority of the appointment at least 30 days in advance

§§ 61-63 — MODEL FOOD CODE

Extends by two years, from January 1, 2020, to January 1, 2022, the date by which DPH must implement the FDA's Model Food Code, and makes related conforming changes to these laws

§ 64 — ASBESTOS

Modifies the definition of "asbestos-containing material" to include material that contains asbestos in amounts equal to or greater than 1% by weight

§ 65 — HAIRDRESSING AND COSMETOLOGY

Expands the statutory definition of "hairdressing and cosmetology" to include removing facial or neck hair using manual or mechanical means

§ 66 — ESTHETICIAN LICENSURE

Limits the time period in which certain applicants for DPH licensure as an esthetician may be grandfathered in to those applicants who apply for licensure before January 1, 2022

§ 67 — HEALTH ASSESSMENTS FOR STUDENTS WITH ASTHMA

Requires local or regional boards of education to report to DPH and local health departments on the number of students diagnosed with asthma in grades 9 or 10, instead of grades 10 or 11, to align the reporting schedule with the schedule for conducting required student health assessments

§ 68 — DPH REPORTABLE DISEASES AND HEALTH CONDITIONS

Increases, from $500 to $1,000, the civil penalty DPH may impose against a person who fails to report a case or finding of a reportable disease; establishes an appeal process for violations; and requires health care providers and clinical laboratories to report cases and findings only electronically

§§ 69 & 70 — CERTIFIED STROKE CENTERS

Adds thrombectomy-capable stroke centers to the types of stroke-designated hospitals DPH must include on its annual list of certified stroke centers; requires DPH to maintain and operate a state-wide stroke registry and establishes related requirements for data reporting and records storage; and requires DPH to establish a registry data oversight committee

§ 71 — EMS ADDRESS CHANGES

Allows an EMS organization to change its address within its primary service area without having to complete the certificate of need process

§§ 72-74 — CERTIFIED HOMELESS YOUTH

Modifies the definition of "certified homeless youth," establishes a definition for "certified homeless young adult," and permits the fees to be waived when issuing these individuals certified copies of birth certificates or state identity cards

§ 75 — DPH LIST OF FUNERAL DIRECTORS AND EMBALMERS

Eliminates the requirement that DPH annually provide town clerks and registrars of vital statistics printed lists of all licensed funeral directors, embalmers, student funeral directors, and student embalmers

SUMMARY

This bill makes various substantive, minor, and technical changes in Department of Public Health (DPH)-related statutes and programs.

EFFECTIVE DATE: Various; see below.

§§ 1 & 2 — REPLACEMENT PUBLIC WELLS

Allows (1) DPH to approve the location of replacement public wells if certain conditions are met and (2) local or district health directors to issue permits for these wells

PA 19-117, §§ 73 & 74, allowed DPH, under certain conditions, to approve the location of a replacement public well in Ledyard that does not meet the state's sanitary radius and minimum setback requirements for these water sources. The bill extends these provisions to the entire state, under the same conditions.

As under PA 19-117, the bill allows DPH to approve the replacement well's location if the well is:

1. needed by the water company to maintain and provide safe and adequate water to customers;

2. located in an aquifer of adequate water quality, as determined by historical water quality data from the supply source it is replacing; and

3. in a more protected location than the supply source it is replacing, as determined by DPH.

Under PA 19-117, if DPH approves the well's location, the local health

director for Ledyard may issue a permit for the replacement well, but by no later than March 1, 2020. The bill instead allows all local or district health directors, upon DPH's approval, to issue these permits in their respective jurisdictions, without a deadline.

EFFECTIVE DATE: October 1, 2021

§§ 3 & 4 — NOTIFICATION OF CERTAIN PROJECTS IN WATERSHEDS OR AQUIFER PROTECTION AREAS

Broadens the circumstances under which applicants must notify water companies and DPH about certain projects in watersheds and aquifer protection areas, and requires the applicants to notify DPH by email

Current law generally requires anyone filing an application, petition, or plan with the local zoning commission or appeals board for a site within a water company's watershed or aquifer protection area to notify the water company and DPH about the application, if the company has filed a watershed map with the municipality or map of the aquifer protection area. Current law also requires applicants for regulated activities on inland wetlands or watercourses within a water company's watershed to notify the company and DPH, if the applicant has filed a map with the municipality and the inland wetlands agency.

The bill eliminates the condition requiring this notice only in cases where these maps have been filed. Instead, it generally requires applicants to (1) notify the water company and DPH and (2) determine if the project is within a water company's watershed by consulting the maps on DPH's website. It requires them to send the notice to DPH by email, to the address DPH designates on its website.

As under existing law, (1) notice to the water company must be sent by certified mail, return receipt requested; (2) the notice must be sent to the company and DPH within seven days after the application; and (3) the company and DPH have the right to be heard at any hearing on the application.

The bill retains existing's law exemption from these notice requirements for the first type of application above (those to a local zoning commission or appeals board). Specifically, an applicant is

exempt if (1) the town allows zoning agents to approve applications concerning sites within aquifer protection areas or watersheds and (2) the agent determines that the proposed activity will not adversely affect the public water supply.

EFFECTIVE DATE: October 1, 2021

§ 5 — ELECTRONIC REPORTING OF LEAD HOME INSPECTIONS

Requires local health departments and districts to use a DPH-prescribed electronic system to report lead home inspection findings and resulting actions

By law, if a local health director receives a report that a child's blood lead level exceeds a certain threshold, the director must conduct an epidemiological investigation of the lead source. After the investigation identifies the source, the director must act to prevent further lead poisoning.

Existing law requires local health directors to report to DPH on the results of the investigation and the actions they took to prevent further lead poisoning from that source. The bill specifically requires them to report using a DPH-prescribed web-based surveillance system. In practice, DPH uses the MAVEN surveillance system for this purpose.

EFFECTIVE DATE: October 1, 2021

§ 6 — PRIVATE WELLS

Clarifies that "private wells" supply water to residential populations only

The bill makes minor and technical changes to clarify that "private wells" serve residential populations. As defined under current law and the bill, for provisions related to water quality testing, permitting, and sale or transfer, among other things, private wells supply water to a population of less than 25 people per day.

EFFECTIVE DATE: October 1, 2021

§ 7 — NURSING HOME OR RESIDENTIAL CARE HOME CITATIONS

Allows DPH to electronically submit citation notices to nursing homes and residential care homes

Under current law, DPH must use certified mail to notify a nursing

home or residential care home of a citation for noncompliance with specified laws and regulations. The bill additionally allows DPH to send these notices electronically, in a form and manner the commissioner sets.

EFFECTIVE DATE: October 1, 2021

§ 8 — LONG-TERM CARE FACILITY BACKGROUND CHECKS

Exempts long-term care facilities from complying with background check requirements in in the event of an emergency or significant disruption

By law, long-term care facilities generally must require background checks for prospective employees or volunteers who will have direct access to patients or residents. The bill suspends this requirement if the DPH commissioner determines it is necessary to do so because of an emergency or significant disruption. In that case, the commissioner must inform the facility when (1) suspending the requirement and (2) lifting the suspension.

Under DPH's current policies and procedures for the long-term care facility background search program, the department may suspend the background search requirement for a facility for up to 60 days in an emergency or a significant disruption to (1) internet capabilities, (2) the functionality of the background search system, or (3) the state of the long-term care facility workforce.

EFFECTIVE DATE: July 1, 2021

§§ 9 & 10 — AUTHORITY TO WAIVE EMS ORGANIZATION REGULATIONS

Under specified conditions, allows DPH to waive regulations affecting EMS organizations

The bill allows the DPH commissioner to:

1. waive regulations affecting emergency medical services ("EMS") organizations if she determines that doing so would not endanger the health, safety, or welfare of any patient or resident;

2. impose waiver conditions assuring patients' or residents' health,

safety, and welfare;

3. revoke the waiver if she finds that health, safety, or welfare has been jeopardized; and

4. adopt regulations establishing a waiver application procedure.

Existing law grants the commissioner similar waiver authority regarding DPH-licensed health care institutions (CGS § 19a-495).

The bill also makes a technical change to another EMS statute (§ 9).

EFFECTIVE DATE: July 1, 2021, except for the technical change, which is effective October 1, 2021.

§§ 11-16 — APPRENTICE EMBALMERS AND FUNERAL DIRECTORS

Updates terminology regarding apprentice embalmers and funeral directors and allows mortuary science students to embalm up to 10 bodies under certain conditions

The bill replaces the term "student embalmer" with "registered apprentice embalmer." It similarly replaces the term "student funeral director" with "registered apprentice funeral director." Existing law already requires these individuals to register as apprentices with DPH. The bill makes related minor and technical changes.

Additionally, the bill specifies that students enrolled in approved mortuary science education programs, with the DPH commissioner's consent, may embalm up to 10 human bodies as part of that program under a licensed embalmer's supervision.

EFFECTIVE DATE: October 1, 2021

§ 17 — PROFESSIONAL COUNSELOR AND PROFESSIONAL COUNSELOR ASSOCIATE LICENSURE

Exempts certain professional counselor and professional counselor associate licensure applicants from specified requirements

Professional Counselor Applicants

The bill exempts certain applicants for professional counselor licensure from specified requirements.

This applies to applicants who, by July 1, 2017, were matriculating students in good standing in a qualifying graduate program offered by a regionally accredited institution. Specifically, the bill exempts these applicants from the requirements to have completed (1) a 100-hour counseling practicum; (2) a 600-hour clinical mental health counseling internship; and (3) graduate coursework in addiction and substance abuse counseling, trauma and crisis counseling, and diagnosing and treating mental and emotional disorders.

Professional Counselor Associate Applicants

Current law provides alternate paths for professional counselor associate licensure. On one path, an applicant qualifies by earning a graduate degree in clinical mental health counseling through a program accredited by the Council for Accreditation of Counseling and Related Educational Programs.

Alternatively, an applicant qualifies by earning a graduate degree in counseling or a related mental health field from a regionally accredited higher education institution and meeting additional requirements, including completing (1) at least 60 graduate semester hours in counseling or a related mental health field, (2) a 100-hour counseling practicum, and (3) a 600-hour clinical mental health counseling internship.

Under the bill, these additional requirements do not apply to applicants on the second path above who, by July 1, 2022, earned such a graduate degree, as long as they accumulated at least 3,000 hours of experience under professional supervision.

EFFECTIVE DATE: October 1, 2021

§ 18 — MARITAL AND FAMILY THERAPY LICENSURE

Removes the specific requirement that MFT licensure applicants' supervised practicum or internship include 500 clinical hours

Existing law for marriage and family therapist licensure requires, among other things, an applicant to have completed a supervised practicum or internship meeting certain standards.

The bill removes the current requirement that the practicum or internship include at least 500 direct clinical hours, including 100 hours of clinical supervision. In practice, the Commission on Accreditation for Marriage and Family Therapy Education currently requires this same minimum number of hours.

EFFECTIVE DATE: October 1, 2021

§§ 19 & 20 — VETERINARIAN INVESTIGATIONS

Gives the complainant access to the investigation file when a complaint regarding a veterinarian is closed with no finding, and specifically extends existing procedures for complaints against other providers to complaints against veterinarians

The bill requires DPH to provide information to a person who filed a complaint against a veterinarian when the case is closed with no finding. This applies to cases where DPH made a finding of no probable cause or failed to make a finding within the required 12-month investigation period.

The bill also specifically extends to veterinarian investigations certain existing procedures that apply to investigations of several other DPH-licensed health professionals. For example, among these procedures:

1. the complainant must be given an opportunity to review, at DPH, certain records related to the complaint;

2. before resolving the complaint with a consent order, DPH must give the complainant at least 10 business days to submit an objection; and

3. if a hearing is held after a probable cause finding, DPH must give the complainant a copy of the hearing notice with information on the opportunity to present oral or written statements.

EFFECTIVE DATE: October 1, 2021

§ 21 — ELECTRONIC DEATH REGISTRY SYSTEM

Requires funeral directors, embalmers, and heath care practitioners certifying deaths to use the electronic death registry system, if it is available

Under current law, funeral directors or embalmers must use DPH-

provided forms when completing death certificates. The bill instead requires them to use the state's electronic death registry system unless that system is unavailable, in which case they must use the DPH forms.

Existing law authorizes certain health care practitioners to complete the medical certification portion of a death certificate. The bill requires them, when certifying the facts of a decedent's death, to use the electronic system or, if it unavailable, DPH-prescribed forms.

EFFECTIVE DATE: January 1, 2022

§§ 22-24 — LOCAL AND DISTRICT HEALTH DEPARTMENTS

Makes various changes affecting municipal and district health departments, including making certain requirements consistent for both types of departments

The bill requires DPH approval for local health director appointments by municipalities. Existing law already requires this approval for district health directors (CGS § 19a-242).

The bill increases, from 30 to 60 days, the minimum vacancy of a town's health director position before DPH may appoint someone to fill the vacancy.

In towns with a population of at least 40,000 for five consecutive years, current law prohibits municipal health directors from having a financial interest in or engaging in a job, transaction, or professional activity that substantially conflicts with the director's duties. The bill extends this prohibition to all municipal health directors, regardless of the town's size. Existing law already prohibits this for district health directors (CGS § 19a-244).

For part-time health departments, the bill removes the requirement for DPH to approve the town's public health program plan and budget. It continues to require towns with part-time health departments to submit those plans and budgets to DPH. The bill allows, rather than requires, DPH to adopt related regulations.

For both local and district health departments, the bill requires the municipality or district board, as applicable, to submit to DPH its

written agreement with the director. They must do so upon the director's appointment or reappointment.

Additionally, the bill requires district health directors, at the end of each fiscal year, to report to DPH on their activities during the prior year. This requirement already applies to municipal departments (§ 21).

The bill also makes minor and technical changes.

EFFECTIVE DATE: July 1, 2021

§§ 25-28 — BEHAVIOR ANALYST ELIGIBILITY FOR THE PROFESSIONAL ASSISTANCE PROGRAM AND REPORTING OF IMPAIRED HEALTH PROFESSIONALS

Adds licensed behavior analysts to the list of providers eligible for the professional assistance program for health professionals, and correspondingly increases their licensure renewal fee by $5; adds these providers to the list of health professionals who must notify DPH if they are aware that another professional may be unable to safely practice

The bill adds licensed behavior analysts to the list of providers eligible for the professional assistance program for health professionals (currently, the Health Assistance InterVention Education Network (HAVEN); see BACKGROUND).

The bill increases, from $175 to $180, the annual license renewal fee for behavior analysts. The increase applies to applications to renew licenses that expire on or after October 1, 2021. The DPH commissioner must (1) quarterly certify the amount of revenue received as a result of the fee increase and (2) transfer it to the professional assistance program account. (In 2015, license renewal fees were similarly increased for professions already eligible for the program.)

The bill also adds behavior analysts to the list of licensed health care professionals who must notify DPH if they are aware that another health professional may be unable to practice with skill and safety for various reasons (e.g., loss of motor skill, drug abuse, or negligence in professional practice). In some cases, this law also requires licensed health care professionals to report themselves to the department (e.g., following drug possession arrests).

Under this law, among other things:

1. the reporting professional must file a petition with DPH within 30 days after obtaining information to support the petition;

2. DPH must investigate all petitions it receives to determine if there is probable cause to issue charges and institute proceedings against the reported professional;

3. DPH may not restrict, suspend, or revoke a license until it gives the person notice and the opportunity for a hearing; and

4. a health care professional that refers an impaired professional to the assistance program for intervention satisfies the law's reporting requirement in some cases.

EFFECTIVE DATE: July 1, 2021, except for the fee increase provision, which is effective upon passage, and the provisions on reporting practitioners unable to safely practice, which are effective October 1, 2021.

§§ 29-31 — BEHAVIOR ANALYSTS AS MANDATED REPORTERS OF ELDER ABUSE

Makes behavior analysts mandated reporters of abuse of the elderly or long-term care facility residents

The bill adds licensed behavior analysts to the list of professionals who must report (1) suspected abuse, neglect, abandonment, or exploitation of the elderly or long-term care facility residents or (2) if they suspect an elderly person needs protective services. They must report to the Department of Social Services (DSS) within 72 hours.

By law, a mandated reporter who fails to report to DSS within the deadline can be fined up to $500. If the failure to report is intentional, the reporter can be charged with a Class C misdemeanor (up to three months in prison, a fine of up to $500, or both) for the first offense and a Class A misdemeanor (up to one year in prison, a fine of up to $2,000, or both) for any subsequent offense.

EFFECTIVE DATE: October 1, 2021

§ 32 — PALLIATIVE CARE ADVISORY COUNCIL

Requires the DPH commissioner to make an appointment to the Palliative Care Advisory Council if there is a spot that is vacant for at least one year, and decreases the council's reporting frequency from annually to biennially

Under existing law, the Palliative Care Advisory Council includes 13 members: two appointed by the governor, four by the legislative leaders, and seven by the DPH commissioner.

The bill requires the DPH commissioner to make an appointment to the council if a spot is vacant for at least one year. If this occurs, she must notify the appointing authority about her selection at least 30 days before making the appointment.

By law, the council must report to the Public Health Committee. The bill decreases the required reporting frequency from annually to every other year. As under current law, the next report is due January 1, 2022.

EFFECTIVE DATE: July 1, 2021

§ 33 — CHRONIC DISEASE REPORTING

Eliminates the requirement for DPH to biennially report on chronic disease and the implementation of the department's chronic disease plan, and instead requires her to post the plan on the department's website

By law, DPH must consult with the Office of Health Strategy and local health departments to develop, within available resources, a statewide chronic disease plan that is consistent with specified state and federal initiatives. DPH must implement the plan to meet certain objectives (e.g., reducing the incidence and effects of chronic diseases and improving care coordination).

The bill eliminates the requirement for DPH to report biennially to the Public Health Committee on chronic disease and the plan's implementation. Instead, it requires the commissioner to post the plan on the department's website.

EFFECTIVE DATE: Upon passage

§ 34 — FACILITY OWNERSHIP CHANGES

Makes a minor change to the law on health care facility ownership changes

By law, licensed health care institution ownership changes generally need prior DPH approval. Transfers to relatives are generally not subject to this requirement. But one current exception to this is a transfer of 10% or more of the stock of a corporation, partnership, or association which owns or operates multiple facilities. The bill specifies that this exception also applies to transfers involving limited liability companies meeting these same conditions.

EFFECTIVE DATE: July 1, 2021

§ 35 — TUBERCULOSIS SCREENING

Requires health care facilities to maintain tuberculosis screening policies for their health care personnel that reflect the CDC's recommendations

The bill requires licensed health care facilities to have policies and procedures reflecting the National Centers for Disease Control and Prevention's (CDC) recommendations for tuberculosis (TB) screening, testing, treatment, and education for health care personnel.

Under the bill, these facilities' direct patient care employees must receive TB screening and testing in compliance with these policies and procedures. This applies despite any contrary state law or regulation.

Among other things, the CDC generally recommends that health care personnel:

1. be screened for TB upon being hired and if there is a known exposure,
2. not receive annual TB testing unless there is known exposure or ongoing transmission at the facility, and
3. receive annual education in TB.

EFFECTIVE DATE: July 1, 2021

§ 36 — PUBLIC NUISANCES

Specifies that violations of the state Fire Prevention Code are included within the public nuisance law

By law, the state can bring an action to abate a public nuisance on any real property on which, within the previous year, there have been three or more (1) arrests for certain crimes, (2) arrest warrants issued for certain crimes indicating a pattern of criminal activity, or (3) municipal citations issued for certain violations. Among various other crimes, this applies to fire safety violations under specified laws. The bill specifies that this includes violations under the state's Fire Prevention Code. (In doing so, it appears that the bill reinserts statutory references that were inadvertently removed in 2017.)

EFFECTIVE DATE: October 1, 2021

§ 37 — PUBLIC HEALTH PREPAREDNESS ADVISORY COMMITTEE

Allows members of the Public Health Preparedness advisory committee to appoint designees to serve in their place

By law, the DPH commissioner must establish a Public Health Preparedness Advisory Committee to advise DPH on responses to public health emergencies.

Under current law, the committee includes the DPH and Department of Emergency Services and Public Protection commissioners; the six legislative leaders; and the chairs and ranking members of the Public Health, Public Safety and Security, and Judiciary committees. The bill allows these individuals to designate someone to serve on the committee in their place.

By law, the committee also includes (1) representatives of municipal and district health directors appointed by the DPH commissioner and any (2) other organizations or individuals the commissioner deems relevant to the effort.

EFFECTIVE DATE: Upon passage

§ 38 — CLINICAL LABORATORIES

Requires clinical laboratories to give DPH a list of the blood collection facilities they own and operate, and exempts hospital-owned clinical laboratories from licensure fees

The bill requires licensed clinical laboratories to report to DPH the name and address of each blood collection facility they own and operate. They must report this information, in a form and manner DPH prescribes, (1) before obtaining or renewing their license and (2) whenever opening or closing a blood collection facility.

Additionally, the bill exempts hospital-owned clinical laboratories from the $200 fee for licensure and license renewal. Under existing law, this exemption also applies to government-owned laboratories.

EFFECTIVE DATE: July 1, 2021

§ 39 — TECHNICAL CHANGES

Makes technical and conforming changes

The bill makes technical and conforming changes to a sanitarian statute.

EFFECTIVE DATE: July 1, 2021

§ 40 — SOCIAL WORKER CONTINUING EDUCATION

Increases the maximum hours of continuing education that social workers may complete online or through home study

The bill increases, from six to 10, the maximum hours of continuing education that social workers may complete online or through home study during each one-year registration period. By law, social workers generally must complete 15 hours of continuing education each registration period, starting with their second license renewal.

EFFECTIVE DATE: Upon passage

§ 41 — MANAGEMENT OF SPAS AND SALONS

Allows massage therapists to manage spas and salons

Under current law, starting on July 1, 2021, each spa or salon that employs hairdressers, cosmeticians, estheticians, or eyelash or nail technicians must be managed by someone with a DPH credential for one of those professions. The bill (1) extends this requirement to spas or salons that employ massage therapists and (2) allows licensed massage therapists to manage a spa or salon employing any of these individuals.

EFFECTIVE DATE: Upon passage

§ 42 — OUT OF STATE PRACTITIONERS ALLOWED IN EMERGENCY

Expands the types of out-of-state health care providers authorized to temporarily practice in Connecticut during a declared public health emergency

By law, DPH may temporarily suspend, for up to 60 days, licensing, certification, and registration requirements to allow various health care practitioners credentialed in another state, territory, or the District of Columbia to practice in Connecticut during a declared public health emergency (see BACKGROUND).

The bill expands the types of out-of-state practitioners allowed to practice in Connecticut under these circumstances to include: alcohol and drug counselors; art and music therapists; certified behavior analysts; certified dietician-nutritionists; dentists and dental hygienists; genetic counselors; occupational therapists; radiographers, radiologic technologists, radiologist assistants, and nuclear medicine technologists; and speech and language pathologists. (In doing so, it codifies certain provisions in the governor's 2020 executive orders 7O, 7DD, and 7HHH).

As under existing law, the bill permits these practitioners to work only within their scope of practice as permitted by Connecticut law.

EFFECTIVE DATE: Upon passage

§ 43 — NURSING HOME ADMINISTRATOR LICENSURE

Eliminates the requirement that DPH administer the required examination for nursing home administrator licensure applicants

By law, an applicant for a nursing home administrator license must meet specified education and training requirements and pass a DPH-prescribed examination. The bill eliminates the requirement that DPH also administer the examination. (In practice, these examinations are administered by national organizations.)

EFFECTIVE DATE: July 1, 2021

§§ 44-50 & 52 — HOSPICE HOME HEALTH CARE AGENCIES

Adds "hospice home health care agencies" to the statutory definition of a "health care institution," and makes related technical changes; removes "substance abuse treatment facilities" from the statutory definition of a health care institution

Definitions

The bill adds to the statutory definition of a "health care institution" a "hospice home health care agency," which it defines as a public or private organization that provides home care and hospice services to terminally ill patients.

In doing so, it extends to these agencies statutory requirements for health care institutions regarding, among other things, licensure and inspections, access to patient records, and disclosure of HIV-related information. Under current regulations, a hospice home health care agency must be licensed as a home health care agency.

The bill also makes related technical and conforming changes to long-term care statutes on, among other things, the state's long-term care facility background check program and the administration of medication by certified unlicensed personnel.

Additionally, the bill removes "substance abuse treatment facilities" from the definition of "health care institution" to conform to current practice. (DPH currently licenses these facilities as "behavioral health facilities.)

Licensure Fees

The bill extends to hospice home health care agencies and home health aide agencies the licensure and inspection fee of $100 per satellite office that existing law requires for home health care agencies. (It does not set a corresponding agency licensure and inspection fee.) As under existing law, the fee must be paid biennially to DPH, except for Medicare- and Medicaid-certified agencies, which are licensed and inspected every three years.

EFFECTIVE DATE: July 1, 2021

§§ 44 & 55 — ASSISTED LIVING SERVICES AGENCIES

Requires managed residential communities (MRCs) that provide assisted living services to become licensed as assisted living services agencies (ALSAs); requires an MRC that intends to contract with an ALSA for services to apply to DPH prior to doing so; and requires an ALSA to obtain DPH approval before providing memory care to residents with early to mid-stage cognitive impairment from Alzheimer's disease or dementia

Licensure

Under existing law, the state does not license assisted living facilities. Instead, it licenses and regulates assisted living service agencies (ALSAs) that provide assisted living services. ALSAs can only provide these services at a managed residential community (MRC). MRCs are not licensed by the state but must provide certain core services and meet regulatory requirements.

The bill requires an MRC that wishes to provide assisted living services to obtain a DPH license as an ALSA or contract for the services with a licensed ALSA. For the latter, the MRC must apply to DPH to arrange for these services in a manner the commissioner prescribes, as under current regulation (Conn Agencies Regs., § 19-D13-105).

Memory Care

The bill prohibits an ALSA from providing memory care to residents with early to mid-stage cognitive impairment from Alzheimer's disease or dementia unless they obtain DPH approval.

An ALSA that provides memory care services must (1) ensure they have adequate staff to meet residents' needs and (2) submit to DPH a list of memory care units or locations and their staffing plans when applying for an initial or renewal license or upon DPH request.

The bill also requires an ALSA to ensure that (1) all services provided individually to clients are fully understood by the client or the client's representative and (2) the client or representative are made aware of the cost of these services.

Regulations

The bill permits the DPH commissioner to adopt regulations to implement the bill's provisions.

EFFECTIVE DATE: July 1, 2021

§ 51 — HOME HEALTH ORDERS

Allows physician assistants and advanced practice registered nurses to issue orders for home health care agency services

The bill allows physician assistants (PAs) and advanced practice registered nurses (APRNs) licensed in Connecticut to issue orders for home health care agency, hospice home health care agency, and home health aide agency services. It also allows PAs and APRNs licensed in bordering states to order home health care agency services.

Under current law, only a physician may issue these orders.

EFFECTIVE DATE: July 1, 2021

§ 53 — NURSING HOME EXPANDED BED CAPACITY DURING EMERGENCY

Allows DPH to suspend nursing home licensure requirements to allow homes to temporarily increase their bed capacity to provide services to patients during a declared public health emergency

The bill allows the DPH commissioner to suspend licensure requirements for chronic and convalescent nursing homes to allow them to temporarily provide services to patients with a reportable disease, emergency illness, or health condition during a declared public health emergency.

Nursing homes may provide these services under their existing license if they (1) provide services to patients in a building that is not physically connected to their licensed facility or (2) expand their bed capacity in a portion of a facility that is separate from the licensed facility.

Under the bill, a nursing home that intends to provide services in this manner must first apply to DPH in a form and manner the commissioner prescribes. The application must include:

1. information on the facility's ability to sufficiently address residents' and staff's health, safety, or welfare;

2. the facility's address;

3. an attestation that all equipment located at the facility is maintained according to the manufacturer's specifications and can meet residents' needs;

4. information on the facility's maximum bed capacity; and

5. information indicating that the facility is in compliance with state laws and regulations regarding its operation.

The bill requires the department, upon receiving the application, to conduct a scheduled inspection and investigation of the applicant's facilities to ensure that they comply with state licensing laws and regulations. After doing so, the department must notify the applicant of its decision to approve or deny the application.

EFFECTIVE DATE: July 1, 2021

§ 54 — IV CARE IN NURSING HOMES

Allows registered nurses employed by nursing homes to administer medications intravenously or draw blood from a central line for laboratory purposes under certain conditions

The bill allows chronic and convalescent nursing homes to allow a licensed registered nurse (RN) they employ to:

1. draw blood from a central line for laboratory purposes, if the facility has an agreement with a laboratory to process the specimens, or

2. administer a medication dose by intravenous injection, if the medication is on a list approved by the DPH commissioner for intravenous injection by an RN (DPH must notify homes of the list).

Under the bill, an RN may perform these services only if he or she has been properly trained to do so by the home's nursing director or an intravenous infusion company. The home's administrator must ensure that the RN is appropriately trained and competent and provide related

documentation to DPH upon request.

The bill also requires the nursing home to notify the DPH commissioner if it employs RNs who provide these services.

EFFECTIVE DATE: July 1, 2021

§ 56 — BED POSITIONS IN LONG-TERM CARE FACILITIES

Requires chronic disease hospitals, nursing homes, and residential care homes to position beds in a manner that promotes resident care

The bill requires chronic disease hospitals, nursing homes, and residential care homes to position beds in a manner that promotes resident care. Specifically, the bed position:

1. cannot act as a restraint to the resident;
2. must ensure that the resident's call bell, overhead bed light, and privacy curtain function are readily usable by the resident;
3. cannot create a hazardous situation, including the possibility of entrapment, an obstacle to evacuation, or blocking or being close to a heat source;
4. must prevent the spread of pathogens and allow for infection control;
5. must ensure residents' privacy; and
6. must provide at least a six-foot clearance at the sides and foot of each bed, instead of a three-foot clearance required under current law.

EFFECTIVE DATE: July 1, 2021

§ 57 — REGULATIONS ON AMBULANCE STAFFING

Makes a technical change by updating terminology in the statute requiring DPH to adopt regulations on ambulance staffing

The bill makes a technical change to the statute requiring the DPH commissioner to adopt regulations that require ambulances to be staffed

with at least one certified emergency medical technician and one certified emergency medical responder. It updates terminology by replacing the terms "emergency medical response services" with "ambulance" and "medical response technician" with "emergency medical responder."

EFFECTIVE DATE: October 1, 2021

§§ 58 & 59 — CONTINUING EDUCATION FOR EMS PERSONNEL

Requires EMS personnel to document their required continuing education hours in a manner the DPH commissioner prescribes, instead of using a DPH-approved online database

The bill requires emergency medical services (EMS) personnel to enter, track, and reconcile their required continuing education hours in a form and manner the DPH commissioner prescribes, instead of using a DPH-approved online database. It also makes a related conforming change.

Under the bill, EMS personnel include emergency medical responders, emergency medical technicians (EMTs), advanced EMTs, and EMS instructors.

EFFECTIVE DATE: Upon passage

§ 60 — EMS ADVISORY BOARD

Requires the DPH commissioner to appoint a member to the Connecticut EMS Advisory Board if the appointment is vacant for more than one year, and notify the appointing authority of the appointment at least 30 days in advance

The bill requires the DPH commissioner to appoint a member to the Connecticut EMS Advisory Board, if the appointment is vacant for more than one year. The commissioner must notify the appointing authority of her appointee's identity at least 30 days before making the appointment.

By law, the EMS Advisory Board reviews and comments on all DPH regulations, medical guidelines, and EMS-related policies before they are implemented. It also assists and advises state agencies in coordinating the EMS system. The board must annually report to the

DPH commissioner and make recommendations to the governor and legislature on legislation it believes will improve EMS delivery.

EFFECTIVE DATE: Upon passage

§§ 61-63 — MODEL FOOD CODE

Extends by two years, from January 1, 2020, to January 1, 2022, the date by which DPH must implement the FDA's Model Food Code, and makes related conforming changes to these laws

The bill extends by two years, from January 1, 2020, to January 1, 2022, the date by which DPH must adopt the federal Food and Drug Administration's (FDA) Model Food Code as the state's food code for regulating food establishments.

The bill also makes related conforming changes to statutes regarding certified food inspectors and restaurant requests to use the sous vide cooking technique or the acidification of sushi rice.

EFFECTIVE DATE: Upon passage

§ 64 — ASBESTOS

Modifies the definition of "asbestos-containing material" to include material that contains asbestos in amounts equal to or greater than 1% by weight

The bill modifies the definition of "asbestos-containing material" in the statutes pertaining to asbestos abatement. It specifies that such material must contain asbestos in amounts equal to or greater than 1.0% by weight, instead of only amounts greater than 1.0% by weight, as under current law.

EFFECTIVE DATE: October 1, 2021

§ 65 — HAIRDRESSING AND COSMETOLOGY

Expands the statutory definition of "hairdressing and cosmetology" to include removing facial or neck hair using manual or mechanical means

The bill expands the statutory definition of "hairdressing and cosmetology" for purposes of licensure to include removing facial or neck hair using manual or mechanical means.

Under existing law, hairdressing and cosmetology also includes (1)

dressing, arranging, curling, waving, weaving, cutting, singeing, bleaching, or coloring hair; (2) scalp treatments; and (3) massaging, stimulating, cleansing, manipulating, exercising or beautifying with the use of the hands, appliances, cosmetic preparations, antiseptics, tonics, lotions, creams, powders, oils, or clays and doing similar work on the face, neck, and arms.

EFFECTIVE DATE: Upon passage

§ 66 — ESTHETICIAN LICENSURE

Limits the time period in which certain applicants for DPH licensure as an esthetician may be grandfathered in to those applicants who apply for licensure before January 1, 2022

By law, individuals seeking an initial DPH license as an esthetician must provide evidence that he or she completed the minimum hours of required study in an approved school, or an out-of-state school with equivalent requirements, and received a certification of completion from the school.

Current law grandfathers in an applicant who (1) provides evidence that he or she practiced esthetics continuously in the state for at least two years before July 1, 2020, and (2) attests to complying with specified infection prevention and control guidelines. The bill limits the time period in which licensure applicants may be grandfathered in to those who apply before January 1, 2022.

EFFECTIVE DATE: July 1, 2021

§ 67 — HEALTH ASSESSMENTS FOR STUDENTS WITH ASTHMA

Requires local or regional boards of education to report to DPH and local health departments on the number of students diagnosed with asthma in grades 9 or 10, instead of grades 10 or 11, to align the reporting schedule with the schedule for conducting required student health assessments

By law, local or regional boards of education ("school boards") must report to DPH and local health departments triennially on the number of students in each school and school district who are diagnosed with asthma at specified timeframes.

The bill requires school boards to report on students who are

diagnosed with asthma in grades 9 or 10, instead of grades 10 or 11, as under current law. In doing so, it aligns the reporting schedule with the schedule school boards must follow for conducting student health assessments required under existing law.

Under existing law, and unchanged by the bill, school boards must also report on students diagnosed with asthma at the time they enroll in school and in grades six or seven.

EFFECTIVE DATE: July 1, 2021

§ 68 — DPH REPORTABLE DISEASES AND HEALTH CONDITIONS

Increases, from $500 to $1,000, the civil penalty DPH may impose against a person who fails to report a case or finding of a reportable disease; establishes an appeal process for violations; and requires health care providers and clinical laboratories to report cases and findings only electronically

Reporting Requirements

By law, DPH must annually issue a list of (1) reportable diseases, emergency illnesses, and health conditions and (2) reportable laboratory findings. Health care providers and clinical laboratories must report findings of the diseases, illnesses, and conditions identified on this list within 12 hours and 48 hours, respectively. The bill requires these reports to be made only electronically. Current law allows laboratories that report an average of less than 30 findings per month and providers to also report in writing or by telephone.

Civil Penalties and Appeals

The bill increases, from $500 to $1,000, the civil penalty DPH may impose on a person who fails to (1) report a case or finding of any disease on the DPH list or (2) keep certain information related to reports confidential. It specifies that each failure constitutes a separate violation.

Under the bill, if the commissioner reasonably believes that such a violation occurred, she may send the person a notice that includes:

1. a short and plain statement of the violation asserted or charged;

2. a statement of the maximum civil penalty that may be imposed

for the violation; and

3. a statement of the person's right to request a hearing, which the person must request in writing to the commissioner within 10 days after the notice is mailed or served.

The bill requires the commissioner to either send the notice by mail, return receipt requested, or personally serve it to the person.

Under the bill, the commissioner must arrange for a hearing under the Uniform Administrative Procedure Act, upon the person's request. It allows the commissioner, at her discretion, to impose a civil penalty no greater than what is stated in the notice if (1) the person fails to request or attend a hearing or (2) she finds, after the hearing, that the person committed the violation. The commissioner must send the person a copy of an order she issues by certified mail, return receipt requested.

EFFECTIVE DATE: Upon passage

§§ 69 & 70 — CERTIFIED STROKE CENTERS

Adds thrombectomy-capable stroke centers to the types of stroke-designated hospitals DPH must include on its annual list of certified stroke centers; requires DPH to maintain and operate a state-wide stroke registry and establishes related requirements for data reporting and records storage; and requires DPH to establish a registry data oversight committee

Designated Stroke Centers

By law, a hospital may apply to DPH to be designated as a comprehensive stroke center, and the department must annually send a list of these stroke-designated hospitals to the medical director of each EMS provider in the state and post the list on the DPH website.

The bill adds thrombectomy-capable stroke centers to the types of stroke-designated hospitals DPH must include on its annual list. Under existing law, DPH already includes hospitals designated as comprehensive stroke centers, primary stroke centers, or acute stroke-ready hospitals.

As under existing law, a hospital may apply to DPH for designation

as a thrombectomy-capable stroke center if it is certified as such by (1) the American Hospital Association; (2) the Joint Commission (an independent, nonprofit organization that accredits and certifies hospitals and other health care organizations and programs); or (3) another DPH-approved, nationally recognized certifying organization.

Under the bill, DPH must report to the national certifying organization any complaint it receives related to a thrombectomy-capable stroke center's certification, as it must already do for other types of stroke centers.

Statewide Registry

The bill requires DPH to maintain and operate a statewide stroke registry using the American Heart Association's "Get with the Guidelines-Stroke Program" data set platform. The registry must include information and data on stroke care in Connecticut that aligns with the stroke consensus metrics developed and approved by the American Heart Association (AHA) and American Stroke Association (ASA).

It also allows DPH to adopt regulations to implement the statewide registry.

Registry Reporting Requirements

Starting January 1, 2022, the bill requires each of the designated stroke centers listed above to submit quarterly data to DPH on stroke care that (1) the commissioner deems necessary to include in the registry and (2) at a minimum, aligns with the AHA's and ASA's developed and approved stroke consensus metrics.

Under the bill, if a stroke center fails to comply with the reporting requirements, DPH may elect to perform the registry services for the center, in which case, the center must reimburse DPH for its actual expenses doing so.

In addition, the bill subjects non-compliant stroke centers to a civil penalty of up to $500 for each failure to disclose data, as determined by

the commissioner.

The bill requires DPH, before assessing the reimbursements and civil penalties, to send written notification to the stroke center and give the center at least 14 business days to respond in writing. The center's response must include any information DPH requests.

The bill also allows the DPH commissioner to request that the attorney general initiate an action to collect any civil penalties assessed and obtain any orders necessary to enforce the bill's provisions.

Registry Data Oversight Committee

By January 1, 2022, the bill requires DPH to consult with the Connecticut Stroke Advisory Council and establish a Stroke Registry Data Oversight Committee. The committee must (1) monitor the registry's operations; (2) advise DPH on the registry's oversight; and (3) develop a plan to improve the quality of stroke care, address disparities in providing care, and develop short- and long-term goals for improving care in stroke centers.

Record Access and Storage

The bill grants DPH access to the records of any certified stroke center that it deems necessary to perform case findings or quality improvement audits to ensure the completeness of reporting and data accuracy related to the statewide registry.

It also allows DPH to contract for the receipt, storage, holding, or maintenance of data or files under its control and management. DPH may also enter into reciprocal reporting agreements with appropriate agencies in other states to exchange stroke center data.

EFFECTIVE DATE: October 1, 2021

§ 71 — EMS ADDRESS CHANGES

Allows an EMS organization to change its address within its primary service area without having to complete the certificate of need process

The bill allows an EMS organization, instead of only an ambulance service, to apply to DPH to change its address or add a branch location

within its primary service area. Current law requires an EMS organization to complete the certificate of need process in order to make such a change.

EFFECTIVE DATE: Upon passage

§§ 72-74 — CERTIFIED HOMELESS YOUTH

Modifies the definition of "certified homeless youth," establishes a definition for "certified homeless young adult," and permits the fees to be waived when issuing these individuals certified copies of birth certificates or state identity cards

Definitions

The bill expands the statutory definition of "certified homeless youth" to include youth certified as homeless by the director of a municipal or nonprofit program that contracts with the Department of Housing's homeless youth program. Existing law also includes youth certified as homeless by one of the following:

1. a school district homeless liaison;

2. the director of an emergency shelter program funded by the U. S. Department of Housing and Urban Development, or the director's designee; or

3. the director of a runaway or homeless youth basic center or transitional living program funded by the U. S. Department of Health and Human Services, or the director's designee.

By law, a certified homeless youth is a 15- to 17-year-old person, not in the physical custody of a parent or legal guardian, who is a homeless child or youth as defined in specified federal law.

The bill also establishes a definition for a "certified homeless young adult," which is an 18- to 25-year-old person who has been certified as homeless by the same individuals as for certified homeless youth listed above.

Records Access

The bill authorizes DPH and local registrars of vital records to waive

the fee for issuing a certified copy of a birth certificate to a certified homeless youth or certified homeless young adult. It similarly allows the Department of Motor Vehicles to waive the fee for issuing a state identity card to these individuals.

EFFECTIVE DATE: July 1, 2021

§ 75 — DPH LIST OF FUNERAL DIRECTORS AND EMBALMERS

Eliminates the requirement that DPH annually provide town clerks and registrars of vital statistics printed lists of all licensed funeral directors, embalmers, student funeral directors, and student embalmers

The bill repeals a provision requiring DPH to annually provide town clerks and registrars of vital statistics printed lists of all licensed funeral directors, embalmers, student funeral directors, and student embalmers. (In practice, these lists are available on the state's eLicense website.) The bill also repeals a provision requiring DPH to issue cards to those listed stating their license or registration status.

EFFECTIVE DATE: Upon passage

BACKGROUND

Health Professional Assistance Program

By law, this program is an alternative, voluntary, and confidential rehabilitation program that provides various services to health professionals with a chemical dependency, emotional or behavioral disorder, or physical or mental illness.

By law, before a health professional may enter the program, a medical review committee must (1) determine if he or she is an appropriate candidate for rehabilitation and participation and (2) establish terms and conditions for participation. The program must include mandatory, periodic evaluations of each participant's ability to practice with skill and safety and without posing a threat to the health and safety of any person or patient (CGS § 19a-12a).

Out-of-State Practitioners Allowed During Emergency

Existing law allows the following health care practitioners to

temporarily practice in Connecticut during a declared public health emergency, upon the issuance of a DPH order: emergency medical personnel, physicians and physician assistants, physical therapists, nurses and nurses' aides, respiratory care practitioners, psychologists, marital and family therapists, clinical social workers, professional counselors, paramedics, embalmers and funeral directors, sanitarians, asbestos contractors and consultants, and pharmacists.

Related Bills

sSB 1 (File 481), reported favorably by the Public Health Committee, requires, rather than allows, DPH to appoint someone as a municipal health director if there is a vacancy for 30 days or more.

SB 1070, favorably reported by the Public Health Committee, allows APRNs and PAs licensed in Connecticut or a bordering state to issue orders for home health care, hospice, and home health aide services.

sHB 6470 (File 265), favorably reported by the Human Services Committee, allows APRNs and PAs licensed in Connecticut or a bordering state to order home health care services.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 31 Nay 2 (03/31/2021)