PA 23-31—sHB 6733
Public Health Committee

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

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SUMMARY: This act makes various substantive, minor, and technical changes in Department of Public Health (DPH)-related statutes and programs. A section-by-section analysis follows.
EFFECTIVE DATE: Various, see below.

§§ 1 & 9 — BLOOD COLLECTION FACILITIES AND SOURCE PLASMA DONATION CENTERS

Creates new statutory definitions and DPH-administered licensure categories for source plasma donation centers and blood collection facilities; starting October 1, 2023, prohibits them from

operating unless they obtain a license; establishes related licensure requirements and modifies those for clinical laboratories

The act creates new DPH licensure categories for blood collection facilities and source plasma donation centers and, starting October 1, 2023, prohibits a person or business (e.g., corporation, partnership, limited liability company, John Dempsey Hospital, UConn Health Center) from establishing, conducting, operating, or maintaining a facility or center unless it obtains the license. (Previously, these facilities and centers were required to register with DPH and comply with regulations for clinical laboratories.)

It requires the DPH commissioner to adopt regulations implementing the new licensure categories, which must include the requirement that a registered nurse or advanced practice registered nurse (APRN) be on-site during the facility's operating hours. The act also requires the commissioner, on or before October 1, 2023, to implement policies and procedures while adopting the regulations. She must post the policies and procedures on the eRegulations System before adopting them, and they are valid until the final regulations are adopted.

The act also modifies requirements for clinical laboratory licensure by eliminating certain information included on licensure applications.

EFFECTIVE DATE: October 1, 2023

Definitions

The act adds blood collection facilities and source plasma donation centers to the statutory definition of "health care institution." In doing so, it subjects these facilities to DPH licensure, inspection, and complaint investigation requirements.

Under the act, a "blood collection facility" is a facility that performs blood component collection activities where blood is removed from a person to administer the blood, or its components, to any person. It excludes facilities that perform these activities to collect source plasma or perform testing that requires a clinical laboratory license.

A "source plasma donation center" is a facility where source plasma is collected by plasmapheresis, which is a procedure that removes blood from a donor, separates the plasma, and then returns the red blood cells to the donor at the time of donation. "Source plasma" is the liquid part of human blood collected by plasmapheresis for use as source material for further manufacturing use. It does not include single donor plasma products for intravenous use.

License Applications

The act requires blood collection facilities and plasmapheresis centers (now called "source plasma donation centers") registered with DPH on or before October 1, 2023, to apply to DPH for an initial license within 30 days after DPH implements licensure procedures.

Starting on this implementation date, the act prohibits DPH from renewing blood collection facility or plasmapheresis center registrations, instead requiring them to get the new license. The owner or responsible officer of the facility or center

must apply for the license in a form set by the commissioner. However, the act exempts from licensure requirements a (1) mobile or temporary blood collection facility, if its operator is licensed as a blood collection facility, and (2) hospital for component collection activities that take place on its campus.

The act also specifies that a licensed source plasma donation center does not need a clinical laboratory license for performing pre-donation screening tests (e.g., screenings for infectious conditions) required by federal regulations.

For clinical laboratories, the act eliminates prior law's requirement that licensure applications contain (1) an itemized rate schedule, (2) full disclosure of any written or oral contractual relationship with a practitioner using the laboratory's services, and (3) any other information DPH requires.

License Renewals and Fees

The act generally extends the $200 initial and renewal license fees for clinical laboratories to blood collection facilities and source plasma donation centers. (By law, clinical laboratories owned and operated by a government agency are exempt from these fees.)

Prior law required a clinical laboratory to apply to renew its license (1) every two years, during the 24th month; (2) before any change in owner or director; and (3) before any major expansion or change in quarters.

The act instead requires a clinical laboratory to biennially apply to renew its license during the 20th month. For a change in ownership, DPH must approve the change. If the laboratory changes its director, or intends to expand or alter its facility, it must first notify the DPH commissioner as she prescribes. The act extends these same requirements to blood collection facilities and source plasma donation centers.

Inspections and Investigation

Under the act, blood collection facilities and plasma donation centers are subject to DPH inspections, including any necessary records inspection, as existing law requires for clinical laboratories. After it receives an initial or license renewal application for a blood collection facility or source plasma donation center, DPH must conduct any inspections or investigations the commissioner deems necessary to determine an applicant's eligibility for licensure.

The act permits the DPH commissioner to require an applicant for a blood collection facility, plasma donation center, or clinical laboratory license to sign a consent order providing reasonable assurance that the applicant will comply with federal and state laws and regulations. Prior law similarly allowed DPH to require clinical laboratory licensure applicants to submit a sworn agreement to abide by the required standards. The act allows the commissioner to deny an application if she determines the applicant previously failed to comply with laws or regulations or that licensure would threaten the public's health, safety, and well-being, similar to prior law for clinical laboratories.

A license is not effective until the applicant receives notice of licensure from

DPH, including its effective date and terms.

Disciplinary Action

The act authorizes the DPH commissioner to take various disciplinary actions (e.g., probation or license suspension or revocation) against a blood collection facility or source plasma donation center after notice and a hearing. The commissioner may do this if the facility or center (1) engaged in fraudulent practices, fee-splitting inducements, or bribes or (2) violated applicable state laws and regulations. It subjects violators to a fine of between $100 and $300 for each offense.

Existing law already allows the commissioner to take disciplinary action and impose fines against a clinical laboratory in a similar manner.

Whistleblower Protection

The act prohibits blood collection facilities and source plasma donation centers from terminating an employee because the employee reported to DPH that the facility or center violated state licensure law. This prohibition already applies to clinical laboratories.

§§ 1 & 2 — ASSISTED LIVING SERVICES AGENCIES

Allows assisted living services agencies to provide nursing services and assistance with activities of daily living to people who are not chronic and stable under limited conditions

Prior law authorized assisted living services agencies (ALSAs) to provide services, including nursing services and assistance with activities of daily living, only to people who are chronic and stable. The act allows ALSAs to also serve people who are no longer chronic and stable if:

1. the person is under the care of a licensed home health care agency or hospice agency or
2. the ALSA is arranging, in conjunction with a managed residential community (MRC, see *Background — MRCs*), the delivery of ancillary medical services on the person's behalf, including physician, dental, hospice care, home health agency, pharmacy, podiatry, and restorative physical therapy services.

Under existing law, unchanged by the act, ALSAs may have a dementia special care unit or program.

EFFECTIVE DATE: Upon passage, except a conforming change is effective October 1, 2023.

Background — MRCs

Under existing law, the state does not license assisted living facilities. Instead, it licenses and regulates ALSAs that provide assisted living services. ALSAs can only provide these services at an MRC or certain federally-funded elderly housing

complexes. MRCs that wish to provide assisted living services must obtain a DPH license as an ALSA, or arrange for the services with a licensed ALSA.

§§ 3 & 4 — SOCIAL WORK LICENSURE

Requires the DPH commissioner to temporarily waive the examination requirement for master social worker license applicants until January 1, 2026; allows the required five hours of in-person continuing education to be earned through live online classes

Examination Requirement

The act requires the DPH commissioner to temporarily waive the requirement for a master social worker license applicant to pass the Association of Social Work Board's masters level examination, or other examination the DPH commissioner prescribes. She must waive the requirement until January 1, 2026, and then reinstate it. By July 1, 2025, the commissioner must also notify higher education institutions that offer social work programs about reinstating the examination requirement.

The act maintains the examination requirement for licensure by endorsement for applicants who are licensed or certified as a master social worker in good standing in another state or jurisdiction whose licensure requirements are substantially similar to Connecticut's.

By law, unchanged by the act, applicants must hold a master's degree from a program accredited by the Council on Social Work Education, or for applicants educated outside of the U.S. or its territories, a program the council deems equivalent.

Continuing Education

Existing law generally requires licensed clinical and master social workers to complete at least 15 hours of continuing education (CE) during each registration period (i.e., 12-month license renewal period). The act further specifies that:

1. at least five of the CE hours must be earned through in-person or synchronous online education (i.e., a live online class conducted in real-time) with opportunities for live interaction and
2. no more than 10 hours can be earned through asynchronous online education, distance learning, or home study.

Prior law allowed social workers to complete up to 10 hours per registration period online or through home study. Thus, the act allows social workers to earn the five hours that must be in-person via a live online class.

Under the act, "asynchronous online education" is a program where the instructor, learner, and other participants are not engaged in the learning process at the same time, there is no real-time interaction between participants and instructors, and the educational content is created and made available for later consumption.

EFFECTIVE DATE: Upon passage for the examination requirement and October 1, 2023, for the CE requirement.

§§ 5 & 6 — ESTHETICIAN AND NAIL TECHNICIAN LICENSURE

Extends the time period in which certain applicants may be grandfathered in to licensure as an esthetician or nail technician to those who apply for licensure before January 1, 2025, and grandfathers applicants who complete specified education requirements

By law, people seeking an initial DPH license as an esthetician or nail technician must generally provide evidence of completing the minimum hours of required study at an approved school, or an out-of-state school with equivalent requirements, and receiving a certification of completion from the school.

Prior law grandfathered applicants who applied before January 1, 2022, with evidence of:

1. practicing as one of these professionals continuously in the state for at least two years before a specified date, and
2. attesting to compliance with specified infection prevention and control guidelines.

The act (1) extends the grandfathering to those who apply before January 1, 2025, and (2) allows an applicant to qualify for the grandfathering if he or she completed a course of study and received a certificate of completion from an approved school in place of the practice requirement.

EFFECTIVE DATE: Upon passage

§ 7 — PARAMEDIC LICENSURE

Makes a technical change to a provision on paramedic licensure by endorsement

The act makes a technical change to a provision on paramedic licensure by removing a reference to licensure by endorsement for New England states, New York, and New Jersey. The law already allows licensure by endorsement for paramedics licensed or certified in good standing in another state or jurisdiction with requirements substantially similar to or greater than Connecticut's requirements.

EFFECTIVE DATE: Upon passage

§ 8 — EMERGENCY MEDICAL SERVICES VEHICLE INSPECTIONS

Generally codifies minimum vehicle design and equipment standards for authorized emergency medical services vehicle inspections that are currently in regulation

By law, ambulances and other authorized emergency medical services (EMS) vehicles (i.e., invalid coaches and intercept vehicles staffed by emergency technicians or paramedics) must be registered with the Department of Motor Vehicles (DMV).

As part of this process, DPH must at least biennially inspect the vehicles to ensure they meet minimum vehicle design and equipment standards. The act generally codifies the requirements for the minimum standards currently in regulation (Conn. Agencies Regs., § 19a-179-18). Under the act, the minimum standards must at least require:

1. ambulances to meet or exceed the design criteria of the U.S. General

Services Administration's federal specification for the star-of-life ambulance (i.e., KKK-A-1822, as amended), with an exemption for the ambulance's color scheme and decals;
2. authorized EMS vehicles to have equipment required for their specific vehicle classification specified in the 2022 Connecticut EMS Minimum Equipment Checklist; and
3. authorized EMS vehicles to comply with all state and federal safety, design, and equipment requirements.

As under prior law, the DPH commissioner may also inspect any rescue vehicle used by an EMS organization for compliance with minimum equipment standards.

In addition to the DPH inspection, existing law requires ambulances and invalid coaches to be inspected by state or municipal employees, or DMV-licensed motor vehicle repairers or dealers, who are qualified under federal regulations. They must inspect the vehicles to ensure compliance with the minimum standards described above and make a record of each inspection (CGS § 19a-181(a)).

EFFECTIVE DATE: July 1, 2023

§ 10 — STILLBORN TAX CREDIT

Makes technical and minor changes to the income tax credit for the birth of a stillborn child to conform with existing vital records laws

The act makes technical and minor changes in the statute establishing an income tax credit for the birth of a stillborn child. It replaces references to stillbirths with fetal deaths (i.e., a death occurring at 20 or more weeks of gestation) to conform with existing vital records laws.

By law, there is a $2,500 personal income tax credit for the birth of a stillborn child if the child would have been claimed as the taxpayer's dependent on his or her federal income tax return. Prior law allowed taxpayers to claim the credit for the tax year for which DPH's State Vital Records Office issued the required certificate. The act instead applies the credit for the tax year in which the fetal death occurred.

EFFECTIVE DATE: Upon passage and applicable to tax years beginning on or after January 1, 2022.

§ 11 — HEPATITIS C SCREENING

Generally requires primary care providers to offer to provide or order a hepatitis C screening or diagnostic test for patients ages 18 and older and pregnant women, instead of only patients born between 1945 and 1965

The act generally requires licensed primary care physicians, APRNs, and physician assistants (PAs) ("primary care providers") to offer to provide or order a hepatitis C screening or diagnostic test for patients ages 18 and older and pregnant women. In doing so, the act conforms to 2020 federal Centers for Disease Control and Prevention recommendations for hepatitis C screening. Prior law only required primary care providers to do this for patients born between 1945 and 1965.

Existing law, unchanged by the act, does not require a provider to offer the screening or test when he or she reasonably believes that the patient (1) is being treated for a life-threatening emergency, (2) has been previously offered or received a hepatitis C screening test, or (3) lacks the capacity to consent.

By law, a "hepatitis C screening test" is a laboratory test to detect the presence of hepatitis C virus antibodies in the blood. A "hepatitis C diagnostic test" is a laboratory test that detects the presence of the virus in the blood and confirms whether the person has a hepatitis C virus infection.

EFFECTIVE DATE: October 1, 2023

§ 12 — DPH QUALITY OF CARE PROGRAM

Allows DPH to revise its quality of care program's (1) standardized data sets for health care facilities and (2) methods to provide public accountability for facilities' health care delivery systems

By law, DPH's quality of care program for health care facilities (e.g., hospitals and outpatient surgical facilities) must have (1) a standardized data set to measure facilities' clinical performance that must be collected and periodically reported to the department and (2) methods to provide public accountability for facilities' health care delivery systems. The act allows the DPH commissioner to revise the data sets and methods as she determines is necessary.

Under the act, the commissioner must consult with a Connecticut hospital association on the scope and timing of the data reporting requirements to reduce the burden on hospitals when producing and disclosing the data. It specifies that any data collected cannot include patients' personally identifiable information.

Additionally, the act removes an obsolete provision initially applying the health care quality performance measurement and reporting system only to hospitals.

EFFECTIVE DATE: July 1, 2023

§ 13 — COMMISSION ON COMMUNITY GUN VIOLENCE

Adds three new members to the Commission on Community Gun Violence Intervention and Prevention

The act adds the following three individuals to the Commission on Community Gun Violence Intervention and Prevention, increasing its members to 26:

1. the education commissioner, or her designee;
2. one municipal police chief, appointed by the Public Health Committee House ranking member; and
3. one local health director, appointed by the Public Health Committee Senate ranking member.

By law, the commission must advise the DPH commissioner on developing evidence-based, evidence-informed, community-centric gun programs and strategies to reduce gun violence in the state. The commission is within DPH for administrative purposes only.

EFFECTIVE DATE: Upon passage

§ 14 — ENFORCEMENT OF ASBESTOS REGULATIONS

Requires the DPH commissioner to prescribe electronic reporting requirements and develop a data collection system to monitor compliance with asbestos abatement regulations

Existing law requires the DPH commissioner, in consultation with the labor commissioner, to develop regulations on asbestos abatement, including standards for proper abatement, enforcement procedures, DPH inspection procedures, and minimum standards for completing abatement projects.

The act requires the DPH commissioner to prescribe electronic reporting requirements and develop a data collection system to monitor compliance with the regulations.

EFFECTIVE DATE: October 1, 2023

§§ 15 & 16 — ASBESTOS AND LEAD ABATEMENT PROFESSIONALS

Allows the DPH commissioner to implement policies and procedures on licensure and certification standards for asbestos and lead abatement professionals while in the process of adopting them in regulations

By law, the DPH commissioner must adopt regulations on the licensure and certification standards for asbestos and lead abatement health professionals (e.g., contractors, supervisors, consultants, inspectors, and site-workers). The act allows the commissioner to implement policies and procedures while in the process of adopting them in regulations, so long as she posts her intention to adopt regulations on the eRegulations System not later than 20 days after they are implemented. The policies and procedures are valid until the final regulations are adopted.

EFFECTIVE DATE: Upon passage

§ 17 — PUBLIC WATER SUPPLY SOURCES

Specifies that, starting July 1, 2024, DPH has jurisdiction over public water supply sources held for future or emergency use by municipalities, public institutions, or water companies

Under existing law, DPH has jurisdiction over the purity and adequacy of all public water supply sources used by municipalities, public institutions, or water companies. Starting July 1, 2024, the act extends the department's jurisdiction to include water supply sources over which these entities hold the right for future or emergency use.

EFFECTIVE DATE: Upon passage

§ 18 — AUTOMATIC RECIPROCAL DISCIPLINE FOR HEALTH PROFESSIONALS

Rescinds automatic reciprocal discipline against a pharmacist or health care professional licensed in another state or jurisdiction if the discipline in that location was based solely on terminating a pregnancy under conditions that would not violate Connecticut law or regulation

The act automatically rescinds an automatic reciprocal discipline against a pharmacist or health care professional currently or previously licensed in another state or jurisdiction when:

1. the pharmacist or health professional is subject to automatic reciprocal discipline for a disciplinary action in that state or jurisdiction and
2. that discipline was based solely on a pregnancy termination under conditions that would not violate Connecticut law or regulation.

If the above criteria are met, the act prohibits the applicable licensing entity (e.g., DPH) from entering the automatic reciprocal discipline into the health professional's or pharmacist's licensing record.

The act also specifies that it does not preclude or affect the ability of a state agency or board to seek or impose any disciplinary action authorized by state law against a Connecticut-licensed pharmacist or other health care professional.

EFFECTIVE DATE: July 1, 2023

Background — Related Acts

PA 23-52, § 4, generally prohibits a pharmacist currently or previously licensed in another state or jurisdiction from being subject to automatic reciprocal discipline in Connecticut for the other jurisdiction's disciplinary action based solely on terminating a pregnancy.

PA 23-128, §§ 1 & 2, generally prohibits DPH or the Department of Consumer Protection (and related boards and commissions) from denying a credential or disciplining a credentialed provider due to disciplinary actions in other U.S. jurisdictions solely based on the person's alleged participation in reproductive health care services.

§ 19 — LOCAL HEALTH DEPARTMENT REPORTING SYSTEM FOR SODIUM CHLORIDE DAMAGE

Extends by one year the deadline for (1) local health departments to create an electronic reporting system for property owners to report sodium chloride damage and (2) health departments to submit the reports to OPM; makes confidential certain information related to the reports

The act extends by one year, from January 1, 2023, to January 1, 2024, the deadline for local health departments (i.e., municipal and district health departments) to establish an electronic reporting system for owners of homes or wells directly damaged by sodium chloride run-off to report the damage to the local health department.

It correspondingly extends, from January 1, 2024, to January 1, 2025, the deadline for these health departments to start annually submitting the reports recorded during the prior year to the Office of Policy and Management (OPM).

Additionally, the act makes the following information confidential (i.e., not subject to disclosure or admissible as evidence in a court or agency proceeding, and used only for medical or scientific research):

1. testing results originating due to a sodium chloride run-off damage report

provided to DPH, OPM, or local health departments;
2. information obtained from DPH or local health department investigations on the results; and
3. morbidity and mortality studies DPH or local health districts conduct related to the results.

EFFECTIVE DATE: Upon passage

§ 20 — EYEBROW THREADING

Exempts eyebrow threading from esthetics licensure requirements

The act exempts individuals who perform eyebrow threading from needing a state esthetician license. It defines "eyebrow threading" as a means of shaping and removing unwanted hair on the face and around the eyebrows.

Under existing law, esthetics are skin care treatment services, including things like (1) cleansing, toning, stimulating, exfoliating, or performing a similar procedure on the human body while using cosmetic preparations, hands, devices, apparatuses, or appliances to enhance or improve the skin's appearance; (2) applying makeup; (3) beautifying lashes and brows; or (4) manually and mechanically removing unwanted hair.

Existing law already exempts from the definition of esthetics (1) using a prescriptive laser device, performing a cosmetic medical procedure, or any practice, activity, or treatment that is considered practicing medicine; (2) applying makeup at a rented kiosk in a shopping center; or (3) practicing hairdressing and cosmetology by licensed hairdressers or cosmeticians as part of their scope of practice.

EFFECTIVE DATE: Upon passage

§ 21 — FETAL DEATH CERTIFICATES

Establishes a statutory definition of "fetal death" and exempts a father or mother from filing a fetal death certificate when the birth occurs outside of an institution and a physician or midwife is not in attendance

The act establishes a statutory definition of "fetal death" for issuing fetal death certificates. It defines fetal death as (1) the death of a fetus before its complete expulsion or extraction from the uterus, regardless of the pregnancy's duration, and (2) with no evidence of life after expulsion or extraction, including heartbeat, umbilical cord pulsation, or definite voluntary muscle movement. It excludes from the definition an induced termination of pregnancy.

By law, a fetal death certificate must be completed for each fetal death occurring after at least 20 weeks of pregnancy (i.e., stillbirth). The certificate must be signed by one of the specified health professionals and filed with the vital records registrar in the municipality where the death occurred. The act exempts a father or mother from the filing requirement when the birth occurs outside of an institution (e.g., a home birth) and a physician or midwife does not attend.

EFFECTIVE DATE: October 1, 2023

§§ 22-25 — OFFICE OF THE CHIEF MEDICAL EXAMINER

Requires the Chief Medical Examiner to be board-certified in forensic pathology by the American Board of Pathology and eliminates a requirement that the Office of the Chief Medical Examiner submit certain fingerprints and photographs to DPH and local registrars of vital records

The act expands the job requirements for the Chief Medical Examiner (CME) to include that he or she be board-certified in forensic pathology by the American Board of Pathology. Under existing law, the CME must also (1) be a Connecticut-licensed physician, (2) have at least four years of postgraduate pathology training, and (3) have any additional forensic pathology experience the Commission on Medicolegal Investigations determines.

The act also eliminates a requirement that the Office of the Chief Medical Examiner send fingerprints and a photograph of a decedent's body it investigates and cannot identify to the local vital statistics registrar and DPH. It keeps existing law's requirement that the office send the decedent's fingerprints to the State Police. This revision conforms to current practice.

Additionally, the act makes technical changes.

EFFECTIVE DATE: October 1, 2023

§ 26 — CERTIFIED FOOD INSPECTORS

Eliminates the requirement that certified food inspector applicants be employed by a local health department before certification; prohibits certified food inspectors, or their immediate family, or a business they associate with, from having a financial or ownership interest in a food establishment in their jurisdiction

The act modifies DPH certification requirements for food inspectors by doing the following:

1. eliminating the requirement that applicants be employed by a municipal or district health department before receiving their certification, which allows them to complete certification requirements before working as a food inspector, and
2. specifying that the DPH commissioner must prescribe the required training and verification program applicants must successfully complete.

Additionally, the act prohibits a certified food inspector, the inspector's immediate family, or a business the inspector associates with (e.g., as a partner or owner), from doing the following:

1. having any financial or ownership interest in a food establishment located in the jurisdiction where the food inspector works;
2. engaging in any business, employment, or management of a food establishment in that jurisdiction; or
3. owning the property where the food establishment is located.

Prior law only prohibited a certified food inspector from owning or managing a food establishment located in their jurisdiction.

The act also requires municipal and district health directors employing food inspectors to certify, on a form the DPH commissioner prescribes, that the food

inspector is not prohibited from working as a food inspector based on the above listed conditions.
EFFECTIVE DATE: January 1, 2024

§ 27 — LOCAL FOOD PROTECTION PROGRAM AUDITS

Authorizes DPH to audit local health department food protection programs; requires DPH to give local health directors a report on the audit's findings and any recommended or necessary corrective actions

The act authorizes the DPH commissioner to conduct audits of local health department (i.e., municipal and district health department) food protection programs. The audits may include, but are not limited to, (1) interviews with local health department staff and (2) joint inspections of local food establishments with local health department staff.

After completing an audit, the act requires the commissioner to give the local health director a report detailing the audit's findings and any recommended or necessary corrective actions the director must take.
EFFECTIVE DATE: Upon passage

§§ 28-42 & 52 — LEAD POISONING PREVENTION AND TREATMENT

Makes various changes related to lead poisoning prevention and treatment, such as (1) reducing the timeframe within which a health care provider must notify the parent of a child under age three with an elevated blood lead level, (2) modifying the blood lead level thresholds at which local health department programs must provide children case management services, and (3) requiring pediatricians to complete an annual lead risk assessment for all children from birth to age six and annually screen those with elevated risk

The act makes various changes affecting lead poisoning prevention and treatment, as described below.
EFFECTIVE DATE: October 1, 2023, except the provisions on (1) testing by primary care providers take effect January 1, 2024 (§ 35), and (2) DPH's annual lead poisoning report take effect upon passage (§ 36).

Reporting Blood Lead Levels (§ 29)

The act reduces the timeframe, from 72 to 24 hours, within which a health care provider must make a reasonable effort to notify the parent or guardian of a child under age three whose test results indicate a blood lead level of at least 3.5 µg/dL.

By law, licensed health care institutions and clinical laboratories must report a person with blood lead levels of at least 3.5 µg/dL to DPH, local health departments, and the health care provider who ordered the testing. The report must include specified information on the person, the provider who ordered the testing, the sample collection and analysis, and any other information the DPH commissioner requires. For the latter, the act specifies that the information must be reported as the commissioner prescribes.

It also removes the requirement under prior law that the DPH commissioner

consult with the administrative services commissioner to determine how data in individual and monthly lead testing reports, which health care institutions and clinical laboratories submit to DPH, is transmitted.

Regional Lead Poisoning Treatment Centers (§ 30)

The act requires each lead poisoning treatment center to report to the DPH commissioner on the number of people treated for lead poisoning; each person's town of residence, race, and ethnicity; and any other information the commissioner requires. The centers must report this information quarterly and as the commissioner prescribes.

Existing law allows the DPH commissioner, within available appropriations, to establish two regional lead poisoning treatment centers in different areas of the state by providing grants to two participating hospitals. The act requires these two hospitals to have demonstrated expertise in lead poisoning treatment, in addition to prevention as under existing law.

The act also specifies that the (1) commissioner must determine the designated area of the state that each hospital serves and (2) centers must, at a minimum, provide consultation services to pediatricians and other primary care practitioners, instead of all physicians, on proper lead poisoning treatment.

On-Site Inspections and Remediation (§§ 29 & 31)

As under prior law, the act requires local health directors to conduct on-site inspections and order remediation for children with lead poisoning if a child has a confirmed blood lead level between (1) 10 and 15 µg/dL before January 1, 2024, and (2) 5 and 10 µg/dL from January 1, 2024, to December 31, 2024. However, the act removes prior law's requirement that these blood lead levels must be confirmed in two tests taken at least three months apart.

Under the act, an "on-site inspection" is an examination of a residential dwelling to identify lead hazards, including for deteriorating paint, lead dust, bare soil near the dwelling's perimeter, household items that may present a potential lead risk (such as toys, cookware, food products, and cosmetics), and an inquiry into the water system serving the dwelling.

Education and Publicity Program (§ 33)

By law, DPH's Lead Poisoning Prevention Program must include an education and publicity program that informs the general public and specified individuals about the danger, frequency, and sources of lead poisoning and ways to prevent it. The act requires the program to specifically direct the information to residential property owners who own housing built before 1978, instead of 1950 as under prior law.

Lead Remediation (§§ 29 & 34)

Prior law required owners of dwellings with toxic lead levels occupied by children under age six to abate, remediate, or manage the dangerous materials and follow DPH regulations for doing so. The act instead requires the owners to remediate the lead through testing, abatement, or management of the materials and correspondingly redefines these activities.

Under the act, "remediation" is the process of remedying a lead hazard condition, including investigation, abatement and, if appropriate, ongoing management measures.

"Abatement" is any set of measures designed to reduce or eliminate lead hazards, including encapsulation, replacement, removal, enclosure, or covering of paint, plaster, soil, or other material containing toxic lead levels and all preparation, clean-up, disposal, and reoccupancy clearance testing.

By law, the DPH commissioner (1) must adopt regulations on lead testing and abatement requirements and procedures and (2) may adopt regulations on paint removal from building exteriors and standards and procedures for lead remediation, including testing, abatement, and management in buildings and structures. The act allows the commissioner to implement policies and procedures while in the process of adopting them in regulations. She must post the policies and procedures on the eRegulations System before adopting them, and they are valid until the final regulations are adopted.

The act also makes related technical and conforming changes.

Primary Care Providers Testing (§ 35)

Pediatric Care Providers. Prior law required primary care providers who provide pediatric care, other than emergency departments, to conduct annual lead testing on:

1. children ages 36 to 72 months whom DPH determined to be at higher risk of lead exposure based on their enrollment in HUSKY or residence in a municipality with an elevated lead exposure risk;
2. all children ages nine to 35 months, in accordance with the Advisory Committee on Childhood Lead Poisoning Prevention recommendations;
3. all children ages 36 to 72 months who had never been tested; and
4. any child under age 72 months if the provider determined it was clinically indicated under the advisory committee's recommendations.

Prior law also required these providers to conduct an annual medical risk assessment for all children ages 36 to 72 months, and allowed them to conduct the assessment at any time for younger children when necessary, in accordance with the advisory committee's recommendations.

The act instead requires these providers to conduct lead risk assessments and testing that include the following:

1. a complete annual medical risk assessment based on guidelines the DPH commissioner prescribes for all children from birth to age six,
2. an annual lead screening test for all children with elevated risk of lead exposure based on the medical assessment findings,
3. a lead screening test for all children at ages 12 months and 24 months, and

4. follow-up testing according to a schedule the DPH commissioner sets for all children with a confirmed blood lead level of at least 3.5 µg/dL.

Similar to prior law, the act also requires these providers to give educational materials and guidance information on lead poisoning prevention to each child's parent or guardian in keeping with the DPH commissioner's childhood lead screening recommendations.

As under prior law, these requirements do not apply if the child's parents or guardians object to blood testing on religious grounds.

Prenatal Care Providers. The act requires prenatal health care providers to do the following:

1. give each pregnant patient anticipatory guidance on lead poisoning prevention during pregnancy,
2. assess each pregnant patient at the initial prenatal visit for lead exposure using a risk assessment tool the DPH commissioner recommends,
3. screen or refer for blood lead screening each pregnant patient found to be at high risk for lead exposure,
4. notify the local health director in the jurisdiction where the pregnant patient lives if the patient has a blood lead level of at least 3.5 µg/dL, and
5. give anticipatory guidance on preventing childhood lead poisoning to each patient at the patient's postpartum visit.

The act also requires a local health director, when notified by a provider of a pregnant patient's elevated blood lead level, to conduct an epidemiological investigation and take other actions required under existing law and the act for lead levels over certain thresholds (e.g., provide educational information and, in some cases, relocate the family).

Under the act, an "epidemiological investigation" is an examination and evaluation by a certified lead inspector to determine the cause of elevated blood lead levels, detect lead-based paint, and report findings. It must include an (1) on-site inspection and, if applicable, an inspection of other dwellings or areas frequented by the person that may be the source of a lead hazard, and (2) evaluation of other potential sources of lead hazards, including drinking water, soil, dust, pottery, gasoline, toys, or occupational exposure. It may include isotopic analysis of lead-containing items.

Local Health Department Lead Prevention and Control Programs (§ 37)

Existing law requires DPH, within available appropriations, to establish a financial assistance program to help local health departments pay for their lead prevention and control expenses. To be eligible for DPH funding, a local health department's lead poisoning prevention and control program must meet specific requirements for, among other things, case management and education services.

Under prior law, local health departments were required to provide case management services, including medical, behavioral, epidemiological, and environmental intervention, for children who met either of the following criteria for blood lead levels:

1. one confirmed level of at least 20 µg/dL or

2. two confirmed levels, taken at least three months apart, of at least 15 µg/dL, but less than 20 µg/dL.

The act eliminates these criteria and instead requires local health departments to provide case management services to children with a blood lead level of at least 3.5 µg/dL.

Additionally, the act lowers, from 10 to 3.5 µg/dL, the threshold for blood lead levels in children at which local health departments must give educational materials on lead poisoning prevention to the children's parents, legal guardians, and appropriate health care providers.

The act also requires these educational materials to be provided in English, Spanish, and any other language common to people in the local health department's jurisdiction.

School Health Assessments (§ 39)

The act requires all children, before enrolling in public school, to have a lead poisoning medical risk assessment and, if the assessment indicates risk, a test of their blood lead levels. The assessment must be conducted as part of the child's school health assessment required under existing law. By law, the school health assessment must be completed by a licensed physician, APRN, registered nurse, PA, or school medical advisor, in the presence of the child's parent or guardian or a school employee.

Under prior law, a child's blood lead levels were tested as part of the school health assessment only if the local or regional school board determined it was necessary, after consulting with the school medical advisor and the local health department.

Technical and Conforming Changes (§§ 28, 32, 36, 38, 40-42 & 52)

The act makes technical and conforming changes, including reorganizing certain statutes and eliminating obsolete provisions on a (1) plan to phase out DPH's program on environmentally safe housing for children and families (§ 28) and (2) DPH review of lead poisoning data it collects (§ 52).

§§ 43-47 — MUSIC THERAPIST LICENSURE

Generally requires that music therapists be licensed by DPH and establishes related licensure requirements and exemptions; creates nonrenewable temporary permits authorizing the holder to work under a licensee's supervision; sets grounds for denying licenses and taking disciplinary action against licensees

The act generally requires that music therapists be licensed by DPH. To receive a license, an applicant must (1) hold a bachelor's or graduate degree and a professional certification or (2) qualify for licensure by endorsement. The act also creates nonrenewable temporary permits authorizing the holder to work under a licensed person's supervision.

Additionally, the act specifies the grounds for DPH to deny a license or take

disciplinary action against licensees and allows license applicants with criminal convictions to ask the DPH commissioner to determine whether their conviction disqualifies them from licensure.

The act replaces provisions in prior law that generally made it a crime to represent oneself as a music therapist unless meeting certain education and certification requirements.

Under existing law, "music therapy" is the clinical and evidence-based use of music interventions to accomplish individualized goals in a therapeutic relationship by a credentialed professional who completed a music therapy program approved by the American Music Therapy Association, or its successor.

EFFECTIVE DATE: October 1, 2023

Licensure Requirements and Exemptions (§§ 43 & 44)

The act generally prohibits anyone without a music therapist license or temporary permit from using the title "music therapist," "licensed music therapist," or any title, words, letters, abbreviations, or insignia that may reasonably be confused with this credential.

These restrictions do not apply to:

1. Connecticut-licensed, -certified, or -regulated professionals (e.g., occupational or physical therapists, speech and language pathologists, audiologists, or counselors), or people they supervise, who (a) use music incidentally in their professional practice and (b) do not hold themselves out as music therapists;
2. students enrolled in music therapy or graduate music therapy educational programs approved by the American Music Therapy Association, or its successor, in which music therapy is an integral part of the program, if they perform the therapy under a music therapist's direct supervision; and
3. professionals whose training and national certification attests to their ability to practice their profession and who (a) use music incidentally in their professional practice and (b) do not hold themselves out as music therapists.

Prior law did not have a music therapist license, but it was a class D felony for someone not meeting specified credentials to refer to him or herself as a music therapist. (The act does not contain a similar criminal penalty for violating its provisions.) Prior law included the same exemptions as under the act for other licensed professionals and students.

License Applications, Qualifications, and Renewals (§ 45)

The act requires the DPH commissioner to issue a music therapist license to an applicant who submits, on a DPH form, satisfactory evidence that he or she (1) earned a bachelor's or graduate degree in music therapy or a related field from an accredited higher education institution and (2) holds current certification from the Certification Board for Music Therapists, or any successor. (These are the same requirements that a person had to meet under prior law to use the title "music therapist.")

The act also allows for licensure by endorsement. The applicant must provide satisfactory evidence that he or she is licensed or certified as a music therapist, or as someone entitled to perform similar services under a different title, in another state or jurisdiction. That jurisdiction's requirements for practicing must be substantially similar to or stricter than those in Connecticut, and there must be no pending disciplinary actions or unresolved complaints against the applicant in any state.

The initial application fee is $315, and licenses must be renewed annually for $190. To renew, licensees must show satisfactory evidence of:

1. a current certification from the Certification Board for Music Therapists, or any successor, and
2. completion of any continuing education the board requires for the certification.

Temporary Permits (§ 46)

The act allows DPH to issue nonrenewable temporary permits to licensure applicants with a bachelor's degree or higher in music therapy or a related field. The permit allows the holder to practice under the general supervision of a licensee and is valid for up to 365 calendar days after the person receives his or her degree. The permit fee is $50.

The act prohibits DPH from issuing a temporary permit to someone who is the subject of a pending professional disciplinary action or an unresolved complaint in any state. It allows the commissioner to revoke a temporary permit for good cause, as she determines.

Enforcement and Disciplinary Action (§ 47)

The act allows the DPH commissioner to deny a license application or take disciplinary action against a music therapist for the following:

1. failing to conform to the profession's accepted standards;
2. a felony conviction, if the action taken is based on (a) the nature of the conviction and its relationship to the license holder's ability to safely or competently practice music therapy, (b) information on the licensee's degree of rehabilitation, and (c) the time elapsed since the conviction or release;
3. fraud or deceit in obtaining or seeking reinstatement of a license or in the practice of music therapy;
4. negligence, incompetence, or wrongful conduct in professional activities;
5. an inability to conform to professional standards because of a physical, mental, or emotional illness;
6. alcohol or substance abuse; or
7. willfully falsifying entries in a hospital, patient, or other record pertaining to music therapy.

By law, disciplinary actions available to DPH include, among other things, (1) revoking or suspending a license, (2) censuring the violator, (3) issuing a letter of

reprimand, (4) placing the violator on probationary status, or (5) imposing a civil penalty (CGS § 19a-17).

Under the act, the commissioner may order a licensee to undergo a reasonable physical or mental examination if his or her capacity to practice safely is under investigation. The act allows the commissioner to petition Hartford Superior Court to enforce such an examination order or any DPH disciplinary action. The commissioner must give the person notice and an opportunity to be heard before taking disciplinary action.

License Disqualification Based on Criminal Convictions (§ 45)

The act allows a person with a criminal conviction to ask the DPH commissioner, at any time, to determine whether the conviction disqualifies the person from obtaining a music therapist license based on (1) the nature of the conviction and its relationship to the ability to practice music therapy safely or competently, (2) information on the degree of the person's rehabilitation, and (3) the time elapsed since the conviction or release.

The act requires the requestor to include the details of the criminal conviction and any payment the commissioner requires. It authorizes the commissioner to charge up to $15 per request and waive any fee.

Under the act, the DPH commissioner must notify the requestor, within 30 days after receiving the request, whether he or she is disqualified from music therapist licensure. It specifies that the commissioner is not bound by this determination if, after further investigation, she determines that the requestor's criminal conviction differs from the information included in the request.

§ 48 — MASSAGE THERAPIST CONTINUING EDUCATION

Increases, from six to 18, the number of continuing education units a licensed massage therapist may complete via the Internet or distance learning

By law, licensed massage therapists generally must complete at least 24 hours of continuing education (CE) every four years. The act increases, from six to 18, the number of CE units (i.e., one unit is 50-60 minutes of participation) that may be completed via the internet or distance learning.

As under prior law, CE must be in areas related to the massage therapist's practice, and no more than 12 units may be obtained from providers not approved by the National Certification Board for Therapeutic Massage and Bodywork.
EFFECTIVE DATE: July 1, 2023

§ 49 — FUNERAL DIRECTORS

Requires the DPH commissioner to give access to the state's electronic death registry system to state-licensed funeral directors who operate or are affiliated with out-of-state funeral homes or funeral businesses that have reciprocal agreements filed with DPH

The act requires the DPH commissioner to give access to the state's electronic

death registry system to state-licensed funeral directors who operate or are affiliated with out-of-state funeral homes or funeral businesses that have reciprocal agreements filed with DPH.
EFFECTIVE DATE: January 1, 2024

§§ 50 & 51 — LICENSED PROFESSIONAL COUNSELORS AND MARITAL AND FAMILY THERAPISTS

Allows new graduates of professional counseling and marital and family therapy programs to practice without a license for up to 120 days after they complete their program, if they do so under clinical supervision by specified licensed health professionals

The act allows new graduates of professional counseling and marital and family therapy (MFT) education and training programs to practice without a license for up to 120 days after the date they completed their program under specified conditions.

Under the act, MFT graduates may do so if they practice under the clinical supervision of a licensed MFT and successfully completed a (1) graduate degree program specializing in marital and family therapy offered by a regionally accredited college or university or (2) postgraduate clinical training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education and offered by a regionally accredited college or university.

Professional counseling graduates may do so if they practice under the clinical supervision of specified licensed health professionals (i.e., a clinical social worker, MFT, professional counselor, psychiatrist, psychiatric APRN with a specified certification, or psychologist) and successfully completed (1) a graduate degree in clinical mental health counseling as part of a higher education program accredited by the Council for Accreditation of Counseling and Related Educational Programs or (2) at least 60 graduate semester hours in counseling or a related mental health field at a regionally accredited higher education institution and with coursework in specified subjects (e.g., counseling techniques), a practicum and clinical internship meeting specified requirements, and a graduate degree in counseling or a related field from a regionally accredited college or university.
EFFECTIVE DATE: July 1, 2023