House of Representatives

File No. 766

General Assembly

February Session, 2016 ***(Reprint of File No. 535)***

Substitute House Bill No. 5537
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 30, 2016

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

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

Section 1. Subparagraph (D) of subdivision (8) of section 19a-177 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(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 chapter **[**386d**]** 368d. 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;

Sec. 2. Section 20-266p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

On and after July 1, 2014, no person shall: (1) Buy, sell or fraudulently obtain or furnish any diploma, certificate, license, record or registration purporting to show that any person is qualified or authorized to practice tattooing, as provided in section 20-266o, or participate in buying, selling, fraudulently obtaining or furnishing any such document; (2) practice or attempt or offer to practice tattooing under cover of any diploma, certificate, license, record or registration illegally or fraudulently obtained or signed, or issued unlawfully or under fraudulent representation or mistake of fact in a material regard; (3) practice or attempt or offer to practice tattooing under a name other than such person's own name or under a false or assumed name; (4) aid or abet practice by a person not lawfully licensed to practice tattooing within this state or by a person whose license to practice has been suspended or revoked; (5) use in such person's advertising the word "tattoo", "tattooing" or any description of services involving marking or coloring, in an indelible manner, the skin of any person, without having obtained a license under the provisions of section 20-266o; **[**or**]** (6) practice tattooing on a person who is an unemancipated minor under eighteen years of age without the permission of such person's parent or guardian; or (7) engage in the practice of tattooing without having obtained a license or temporary permit under the provisions of section 20-266o. No person shall, during the time such person's license as a tattoo technician is revoked or suspended, practice or attempt or offer or advertise to practice tattooing or be employed by, work with or assist, in any way, any person licensed to practice

tattooing. Any person who violates any provision of this section shall be guilty of a class D misdemeanor.

Sec. 3. Subdivision (1) of subsection (a) of section 19a-12e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(1) "Health care professional" means any **[**person**]** individual licensed or who holds a permit pursuant to chapter 368v, 370, 372, 373, 375 to 378, inclusive, 379 to **[**381a**]** 381b, inclusive, 383 to 385, inclusive, **[**398 or 399**]** 388 or 397a to 399, inclusive;

Sec. 4. (NEW) (*Effective October 1, 2016*) A substance abuse treatment facility licensed as an institution pursuant to section 19a-490 of the general statutes, as amended by this act, and providing medication assisted treatment for opioid addiction shall be permitted to provide methadone delivery and related substance use treatment services to persons in a nursing home facility licensed pursuant to section 19a-493 of the general statutes. The Department of Public Health may allow the delivery of methadone and related substance use treatment services to a nursing home facility if the Commissioner of Public Health determines that such delivery would not endanger the health, safety or welfare of any patient. No such delivery shall be conducted unless a substance abuse treatment facility proposing the delivery of methadone and related substance use treatment services has made a request for such delivery in a form and manner prescribed by the commissioner and the commissioner has approved such request. Upon approving a request, the commissioner may impose conditions that assure the health, safety or welfare of any patient. The commissioner may revoke the approval of a request upon a finding that the health, safety or welfare of any patient has been jeopardized.

Sec. 5. Section 19a-490 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this chapter and sections 17b-261e, 38a-498b and 38a-

525b:

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, health care facility for the handicapped, nursing home facility, [rest home,] home health care agency, homemaker-home health aide agency, [mental] 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, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability;

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

(c) "Residential care home" [, "nursing home"] or "rest home" means [an establishment] 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: Homemaker-home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

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

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

(g) **[**"Mental health facility"**]** "Behavioral health facility" means any facility **[**for the care or treatment of mentally ill or emotionally disturbed persons, or any mental health outpatient treatment facility that provides treatment to persons sixteen years of age or older who are receiving services from the Department of Mental Health and Addiction Services, but does not include family care homes for the mentally ill**]** 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 homemaker-home health aide agency;

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

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

(n) "Multicare institution" means a hospital, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric disabilities, as defined in section 17a-495, or a general acute care hospital that provides outpatient behavioral health services that (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; **[**.**]** and

(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.

Sec. 6. Section 19a-541 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this section and sections 19a-542 to 19a-549, inclusive, unless the context otherwise requires:

(1) "Nursing home facility" has the same meaning as provided in section **[**19a-521**]** 19a-490, as amended by this act;

(2) "Emergency" means a situation, physical condition or one or more practices, methods or operations that presents imminent danger of death or serious physical or mental harm to residents of a nursing home facility;

(3) "Transfer trauma" means the medical and psychological reactions to physical transfer that increase the risk of death or grave illness, or both, in elderly persons;

(4) "Substantial violation" means a violation of law that presents a reasonable likelihood of serious physical or mental harm to residents of a nursing home facility or residential care home; and

(5) "Residential care home" has the same meaning as provided in section **[**19a-521**]** 19a-490, as amended by this act.

Sec. 7. Section 19a-521 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this section and sections 19a-522 to 19a-534a, inclusive, 19a-536 to 19a-539, inclusive, 19a-550 to 19a-554, inclusive, and 19a-562a, unless the context otherwise requires:

(1) "Nursing home facility" **[**means any nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or 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**]** has the same meaning as provided in section 19a-490, as amended by this act;

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

(3) "Commissioner" means the Commissioner of Public Health or the commissioner's designated representative; and

(4) "Residential care home" **[**means an establishment that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry**]** has the same meaning as provided in section 19a-490, as amended by this act.

Sec. 8. Subsection (h) of section 1 of special act 14-5, as amended by section 67 of public act 14-231, is amended to read as follows (*Effective from passage*):

(h) Any pilot program established in accordance with this section shall terminate not later than **[**October 1, 2016**]** October 2, 2017.

Sec. 9. Section 20-123b of the 2016 supplement to the general statutes is amended by adding subsection (e) as follows (*Effective October 1, 2016*):

(NEW) (e) The commissioner may deny or revoke a permit based on disciplinary action taken against a dentist pursuant to the provisions of section 20-114, as amended by this act.

Sec. 10. Subsection (b) of section 20-126c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2016*):

(b) Except as otherwise provided in this section, a licensee applying for license renewal shall earn a minimum of twenty-five contact hours of continuing education within the preceding twenty-four-month period. Such continuing education shall (1) be in an area of the licensee's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include not less than one contact hour of training or education in (A) any **[**four**]** three of the ten mandatory topics for continuing education activities prescribed by the commissioner pursuant to this subdivision, **[**and**]** (B) for registration periods beginning on and after October 1, 2016, infection control in a dental setting, and (C) prescribing controlled substances and pain management. For registration periods beginning on and after October 1, 2011, the Commissioner of Public Health, in consultation with the Dental Commission, shall on or before October 1, 2010, and biennially thereafter, issue a list that includes ten mandatory topics for continuing education activities that will be required for the following two-year registration period. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Dental Association or state, district or local dental associations and societies affiliated with the American Dental Association; national, state, district or local dental specialty organizations or the American Academy of General Dentistry; a hospital or other health care institution; dental schools and other schools of higher education accredited or recognized by the Council on Dental Accreditation or a regional accrediting organization; agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation; local, state or national medical associations; a state or local health department; or the Accreditation Council for Graduate Medical Education. Eight hours of volunteer dental practice at a public health facility, as defined in section 20-126*l*, as amended by this act, may be substituted for one contact hour of continuing education, up to a maximum of ten contact hours in one twenty-four-month period.

Sec. 11. Subsection (g) of section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(g) Each licensed dental hygienist applying for license renewal shall earn a minimum of sixteen hours of continuing education within the preceding twenty-four-month period, including, for registration periods beginning on and after October 1, 2016, at least one hour of training or education in infection control in a dental setting. The subject matter for continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public. Continuing education activities shall provide significant theoretical or practical content directly related to clinical or scientific aspects of dental hygiene. Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, that are offered or approved by dental schools and other institutions of higher education that are accredited or recognized by the Council on Dental Accreditation, a regional accrediting organization, the American Dental Association, a state, district or local dental association or society affiliated with the American Dental Association, the National Dental Association, the American Dental Hygienists Association or a state, district or local dental hygiene association or society affiliated with the American Dental Hygienists Association, the Academy of General Dentistry, the Academy of Dental Hygiene, the American Red Cross or the American Heart Association when sponsoring programs in cardiopulmonary resuscitation or cardiac life support, the United States Department of Veterans Affairs and armed forces of the United States when conducting programs at United States governmental facilities, a hospital or other health care institution, agencies or businesses whose programs are accredited or recognized by the Council on Dental Accreditation, local, state or national medical associations, or a state or local health department. Eight hours of volunteer dental practice at a public health facility, as defined in subsection (a) of this section, may be substituted for one hour of continuing education, up to a maximum of five hours in one two-year

period. Activities that do not qualify toward meeting these requirements include professional organizational business meetings, speeches delivered at luncheons or banquets, and the reading of books, articles, or professional journals. Not more than four hours of continuing education may be earned through an on-line or other distance learning program.

Sec. 12. Subsection (a) of section 20-114 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) The Dental Commission may take any of the actions set forth in section 19a-17 for any of the following causes: (1) The presentation to the department of any diploma, license or certificate illegally or fraudulently obtained, or obtained from an institution that is not reputable or from an unrecognized or irregular institution or state board, or obtained by the practice of any fraud or deception; (2) proof that a practitioner has become unfit or incompetent or has been guilty of cruelty, incompetence, negligence or indecent conduct toward patients; (3) conviction of the violation of any of the provisions of this chapter by any court of criminal jurisdiction, provided no action shall be taken under section 19a-17 because of such conviction if any appeal to a higher court has been filed until the appeal has been determined by the higher court and the conviction sustained; (4) the employment of any unlicensed person for other than mechanical purposes in the practice of dental medicine or dental surgery subject to the provisions of section 20-122a; (5) the violation of any of the provisions of this chapter or of the regulations adopted hereunder or the refusal to comply with any of said provisions or regulations; (6) the aiding or abetting in the practice of dentistry, dental medicine or dental hygiene of a person not licensed to practice dentistry, dental medicine or dental hygiene in this state; (7) designating a limited practice, except as provided in section 20-106a; (8) engaging in fraud or material deception in the course of professional activities; (9) the effects of physical or mental illness, emotional disorder or loss of motor skill, including, but not limited to, deterioration through the aging process,

upon the license holder; (10) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (11) failure to comply with the continuing education requirements set forth in section 20-126c, as amended by this act; (12) failure of a holder of a permit authorizing the use of moderate sedation, deep sedation or general anesthesia to successfully complete an on-site evaluation conducted pursuant to subsection (c) of section 20-123b, as amended by this act; (13) failure to provide information to the Department of Public Health required to complete a health care provider profile, as set forth in section 20-13j; **[**or**]** (14) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in section 20-126d; or (15) failure to adhere to the most recent version of the National Centers for Disease Control and Prevention's guidelines for infection control in dental care settings. A violation of any of the provisions of this chapter by any unlicensed employee in the practice of dentistry or dental hygiene, with the knowledge of the employer, shall be deemed a violation by the employer. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his or her physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17.

Sec. 13. Subsection (c) of section 20-195q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) Nothing in this section shall prohibit: (1) A student enrolled in a doctoral or master's degree program accredited by the Council on Social Work Education from performing such work as is incidental to his course of study, provided such person is designated by a title which clearly indicates his status as a student; (2) **[**a person holding a doctoral or master's degree from a program accredited by the Council on Social Work Education from gaining social work experience under professional supervision, provided such activities are necessary to

satisfy the work experience required by section 20-195n and such person is designated as "social work intern", "social work trainee" or other title clearly indicating the status appropriate to his level of training; (3)**]** a person licensed or certified in this state in a field other than clinical social work from practicing within the scope of such license or certification; **[**(4)**]** (3) a person enrolled in an educational program or fulfilling other state requirements leading to licensure or certification in a field other than social work from engaging in work in such other field; **[**(5)**]** (4) a person who is employed or retained as a social work designee, social worker, or social work consultant by a nursing home or rest home licensed under section 19a-490, as amended by this act, and who meets the qualifications prescribed by the department in its regulations from performing the duties required of them in accordance with state and federal laws governing those duties; **[**(6)**]** (5) for the period from October 1, 2010, to October 1, 2013, inclusive, a master social worker from engaging in independent practice; **[**(7)**]** (6) a social worker from practicing community organization, policy and planning, research or administration that does not include engaging in clinical social work or supervising a social worker engaged in clinical treatment with clients; and **[**(8)**]** (7) individuals with a baccalaureate degree in social work from a Council on Social Work Education accredited program from performing nonclinical social work functions.

Sec. 14. Subdivision (4) of subsection (c) of section 19a-88 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(4) Each person holding a license as a nurse-midwife shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of one hundred thirty dollars, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the person maintains current certification from the **[**American College

of Nurse-Midwives**]** Accreditation Midwifery Certification Board.

Sec. 15. Subdivision (2) of section 20-86a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(2) "Nurse-midwife" means a person who has demonstrated competence to practice nurse-midwifery through successful completion of an educational program accredited by the **[**American College of Nurse-Midwives**]** Accreditation Commission for Midwifery Education and who is certified by the **[**American College of Nurse-Midwives**]** American Midwifery Certification Board, and is licensed under the provisions of this chapter.

Sec. 16. Section 20-86b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Nurse-midwives shall practice within a health care system and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. Nurse-midwifery care shall be consistent with the standards of care established by the **[**American College of Nurse-Midwives**]** Accreditation Commission for Midwifery Education. Each nurse-midwife shall provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the midwife's scope of practice. Each nurse-midwife shall sign the birth certificate of each infant delivered by the nurse-midwife. If an infant is born alive and then dies within the twenty-four-hour period after birth, the nurse-midwife may make the actual determination and pronouncement of death provided: (1) The death is an anticipated death; (2) the nurse-midwife attests to such pronouncement on the certificate of death; and (3) the nurse-midwife or a physician licensed pursuant to chapter 370 certifies the certificate of death not later than twenty-four hours after such pronouncement. In a case of fetal death, as described in section 7-60, the nurse-midwife who delivered the fetus

may make the actual determination of fetal death and certify the date of delivery and that the fetus was born dead.

Sec. 17. Section 20-86c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

The Department of Public Health may issue a license to practice nurse-midwifery upon receipt of a fee of one hundred dollars, to an applicant who (1) is eligible for registered nurse licensure in this state, under sections 20-93 or 20-94; (2) holds and maintains current certification from the **[**American College of Nurse-Midwives**]** American Midwifery Certification Board; and (3) has completed thirty hours of education in pharmacology for nurse-midwifery. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 18. Section 20-86i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Nothing in this chapter shall be construed to prohibit graduates of nurse-midwifery programs approved by the **[**American College of Nurse-Midwives**]** Accreditation Commission for Midwifery Education from practicing midwifery for a period not to exceed (1) ninety calendar days after the date of graduation, or (2) the date upon which the graduate is notified that he or she has failed the licensure examination, whichever is shorter, provided (A) such graduate nurses are working in a hospital or organization where adequate supervision, as determined by the Commissioner of Public Health, is provided, and (B) such hospital or other organization has verified that the graduate nurse has successfully completed a midwifery program approved by the **[**American College of Nurse-Midwives**]** Accreditation Commission for Midwifery Education.

Sec. 19. Section 20-254 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Any person who holds a license at the time of application as a registered hairdresser and cosmetician, or as a person entitled to perform similar services under different designations in any other state, in the District of Columbia, or in a commonwealth or territory of the United States, and who was issued such license on the basis of successful completion of a program of education and training in hairdressing and cosmetology and an examination shall be eligible for licensing in this state and entitled to a license without examination upon payment of a fee of **[**fifty**]** one hundred dollars. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(b) If the issuance of such license in any other state, in the District of Columbia, or in a commonwealth or territory of the United States did not require an examination, an applicant who has legally practiced cosmetology for at least five years in a state outside of Connecticut shall be eligible for licensure under this section if the applicant submits to the commissioner evidence of education and experience that is satisfactory to the commissioner and upon payment of a fee of **[**fifty**]** one hundred dollars. Evidence of experience shall include, but not be limited to, (1) an original certification from the out-of-state licensing agency demonstrating at least five years of licensure, (2) correspondence from the applicant's former employers, coworkers or clients that describes the applicant's experience in the state for at least five years, and (3) a copy of tax returns that indicate cosmetology as the applicant's occupation. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint in the context of providing services as a cosmetician.

Sec. 20. Section 19a-37 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) The Commissioner of Public Health may adopt regulations in the Public Health Code for the preservation of the public health pertaining

to (1) protection and location of new water supply wells or springs for residential construction or for public or semipublic use, and (2) inspection for compliance with the provisions of municipal regulations adopted pursuant to section 22a-354p.

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

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

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

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

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

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

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

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

Sec. 21. Subdivision (1) of section 46b-20a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(1) Not a party to another marriage, or a relationship that provides substantially the same rights, benefits and responsibilities as a marriage, entered into in this state or another state or jurisdiction, unless the parties to the marriage will be the same as the parties to such other **[**marriage or**]** relationship;

Sec. 22. Section 19a-55 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

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

medium-chain acyl-CoA dehydrogenase (MCAD).

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

[(c) On or before October 1, 2015, the Commissioner of Public Health shall execute an agreement with the New York State Department of Health to conduct a screening test of newborns for adrenoleukodystrophy using dried blood spots, as well as the development of a quality assurance testing methodology for such test. The commissioner may accept private grants and donations to defray the cost of purchasing equipment that is necessary to perform the testing described in this subsection.**]**

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

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

Sec. 23. Subdivisions (1) and (2) of subsection (j) of section 19a-491

of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

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

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

Sec. 24. Section 19a-270 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

The first selectman of any town, the mayor of any city, the administrative head of any state correctional institution or the superintendent or person in charge of any almshouse, asylum, hospital, morgue or other public institution which is supported, in whole or in part, at public expense, having in his or her possession or control the dead body of any person which, if not claimed as provided in this section, would have to be buried at public expense, or at the expense of any such institution, shall, immediately upon the death of such person, notify such person's relatives thereof, if known, and, if such relatives are not known, shall notify the person or persons bringing or committing such person to such institution. **[**Such**]** An acute care hospital official shall, not later than seven days after the date on which such body came into his or her possession or control, and such other official shall, **[**within**]** not later than twenty-four hours **[**from**]** after the time such body came into his or her possession or control, give notice thereof to the Department of Public Health and shall deliver such body to The University of Connecticut, Quinnipiac University, the Yale University School of Medicine or the University of Bridgeport College of Chiropractic or its successor institution, as said department may direct and in accordance with an agreement to be made among said universities in such manner as is directed by said department and at the expense of the university receiving the body, if The University of Connecticut, Quinnipiac University, Yale University, or the University of Bridgeport College of Chiropractic or its successor institution, at any time within one year, has given notice to any of such officials that such bodies would be needed for the purposes specified in section 19a-270b; provided any such body shall not have been claimed by a relative, either by blood or marriage, or a legal representative of such deceased person prior to delivery to any of said universities. The university receiving such body shall not embalm such body for a period of at least forty-eight hours after death, and any relative, either by blood or marriage, or a legal representative of such deceased person may claim such body during said period. If any such body is not disposed of in either manner specified in this section, it may be cremated or buried. When any person has in his or her

possession or control the dead body of any person which would have to be buried at public expense or at the expense of any such institution, he or she shall, within forty-eight hours after such body has come into his or her possession or control, file, with the registrar of the town within which such death occurred, a certificate of death as provided in section 7-62b, unless such certificate has been filed by a funeral director. Before any such body is removed to any of said universities, the official or person contemplating such removal shall secure a removal, transit and burial permit which shall be delivered with the body to the official in charge of such university, who shall make return of such removal, transit and burial permit in the manner provided in section 7-66.

Sec. 25. Section 20-206q of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

A certified dietitian-nutritionist may write an order for a patient diet, including, but not limited to, a therapeutic diet for a patient in an institution, as defined in section 19a-490, as amended by this act. The certified dietitian-nutritionist shall write such order in the patient's medical record. Any order conveyed under this section shall be acted upon by the institution's nurses and physician assistants with the same authority as if the order were received directly from a physician or advanced practice registered nurse. **[**Any order conveyed in this manner shall be countersigned by a physician within seventy-two hours unless otherwise provided by state or federal law or regulations.**]** Nothing in this section shall prohibit a physician or advanced practice registered nurse from conveying a verbal order for a patient diet to a certified dietitian-nutritionist, which verbal order shall be reduced to writing and countersigned by a physician or advanced practice registered nurse not later than seventy-two hours after being conveyed, unless otherwise provided by state or federal law.

Sec. 26. (NEW) (*Effective October 1, 2016*) (a) Except for the portion of a delivered placenta that is necessary for an examination described in

subsection (d) of this section, a hospital may allow a woman who has given birth in the hospital, or a spouse of the woman if the woman is incapacitated or deceased, to take possession of and remove from the hospital the placenta if:

(1) The woman tests negative for infectious diseases; and

(2) The person taking possession of the placenta provides a written acknowledgment that (A) the person received from the hospital educational information concerning the spread of blood-borne diseases from a placenta, the danger of ingesting formalin and the proper handling of the placenta, and (B) the placenta is for personal use.

(b) A person removing a placenta from a hospital under this section may only retain the placenta for personal use and may not sell the placenta.

(c) The hospital shall retain the signed acknowledgment described in subsection (a) with the woman's medical records.

(d) This section does not (1) prohibit a pathological examination of the delivered placenta that is ordered by a physician or required by a policy of the hospital, or (2) authorize a woman or the woman's spouse to interfere with a pathological examination of the delivered placenta that is ordered by a physician or required by a policy of the hospital.

(e) A hospital that allows a person to take possession of and remove from the hospital a delivered placenta in accordance with the provisions of this section is not required to dispose of the placenta as biomedical waste.

(f) A hospital that acts in accordance with the provisions of this section shall not be liable for allowing the removal of a placenta from the hospital in a civil action, a criminal prosecution or an administrative proceeding.

Sec. 27. (NEW) (*Effective October 1, 2016*) (a) As used in this section, "psychology technician" means a person who (1) holds a bachelor's or

graduate degree in psychology or another mental health field, and (2) has undergone not less than eighty hours of training provided by a psychologist licensed pursuant to chapter 383 of the general statutes, including, but not limited to, (A) not less than four hours of education in professional ethics and best practices for the administration and scoring of objective psychological and neuropsychological tests, including, but not limited to, the American Psychological Association Ethical Principles of Psychologists and Code of Conduct and legal obligations pertaining to patient confidentiality and reporting any suspicion of abuse or neglect of a patient, (B) not less than sixteen hours of studying and mastering information from psychological and neuropsychological testing manuals, (C) not less than twenty hours of direct observation of the administration and scoring of objective psychological and neuropsychological tests by the psychologist, and (D) not less than forty hours of administering and scoring objective psychological and neuropsychological tests in the presence of the psychologist.

(b) The services provided by psychology technicians include the administration and scoring of objective psychological or neuropsychological tests with specific, predetermined and manualized administrative procedures. The responsibilities of a psychology technician include, but are not limited to, observing and describing the behavior of the patient taking the test and the patient's test responses, but shall not include evaluation, interpretation or other judgments concerning the patient or the patient's test responses.

(c) A psychology technician may provide objective psychological or neuropsychological testing services under the supervision and direction of a psychologist licensed pursuant to chapter 383 of the general statutes, provided: (1) The psychologist is satisfied as to the ability and competency of the psychology technician; (2) services provided are consistent with the health and welfare of the patient and in keeping with the practice of psychology; and (3) such services are provided under the oversight, control and direction of the psychologist.

(d) Nothing in this section shall be construed to apply to the activities and services of a person who is enrolled in a psychology technician educational program acceptable to the American Psychological Association, provided such activities and services are incidental to the course of study.

(e) A psychology technician shall not: (1) Select tests; (2) conduct intake assessments; (3) conduct clinical interviews, including, but not limited to, patient interviews and collateral interviews of relatives, friends of the patient or other professionals associated with the patient; (4) interpret patient data; (5) communicate test results or treatment recommendations to patients; or (6) administer tests in educational institutions.

Sec. 28. Subsection (b) of section 20-10b of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) during the first renewal period in which continuing medical education is required and not less than once every six years thereafter, include at least one contact hour of training or education in each of the following topics: (A) Infectious diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, (B) risk management, including, but not limited to, for registration periods beginning on or after October 1, 2015, prescribing controlled substances and pain management, (C) sexual assault, (D) domestic violence, (E) cultural competency, and (F) behavioral health, provided further that on and after January 1, 2016, such behavioral health continuing medical education may include, but not be limited to, at least 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 (i) determining whether a patient is a veteran or family member of a veteran, (ii) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (iii) suicide prevention training. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic **[**Medical**]** Association, Connecticut Hospital Association, Connecticut State Medical Society, Connecticut Osteopathic Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department. The commissioner, or the commissioner's designee, may grant a waiver for not more than ten contact hours of continuing medical education for a physician who: (i) Engages in activities related to the physician's service as a member of the Connecticut Medical Examining Board, established pursuant to section 20-8a; (ii) engages in activities related to the physician's service as a member of a medical hearing panel, pursuant to section 20-8a; or (iii) assists the department with its duties to boards and commissions as described in section 19a-14.

Sec. 29. Subsection (a) of section 46b-24 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**No**]** Except as provided in section 46b-28a, as amended by this act, no persons may be joined in marriage in this state until both have complied with the provisions of **[**sections 46b-24,**]** this section, section 46b-25 and sections 46b-29 to 46b-33, inclusive, and have been issued a license by the registrar for the town in which the marriage is to be celebrated, which license shall bear the certification of the registrar that the persons named therein have complied with the provisions of said

sections.

Sec. 30. (NEW) (*Effective from passage*) All marriages celebrated before the effective date of this section under a tribal marriage license at the Mashantucket Pequot reservation or Mohegan reservation are recognized as a valid marriage in this state, provided the marriage is recognized under the laws of the Mashantucket Pequot Tribal Nation or the Mohegan Tribe of Indians of Connecticut and not otherwise expressly prohibited by statute in this state.

Sec. 31. Section 46b-28a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

A marriage, or a relationship that provides substantially the same rights, benefits and responsibilities as a marriage, between two persons entered into in another state or jurisdiction and recognized as valid by such other state or jurisdiction shall be recognized as a valid marriage in this state, provided such marriage or relationship is not expressly prohibited by statute in this state. For purposes of this section, "another jurisdiction" includes, but is not limited to, the Mashantucket Pequot reservation and the Mohegan reservation. The requirements set forth in section 46b-24, as amended by this act, shall not apply to a person entering into a marriage on either of said reservations.

Sec. 32. Subsection (c) of section 19a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) The Department of Mental Health and Addiction Services, with respect to any **[**mental**]** behavioral health facility or alcohol or drug treatment facility, shall be authorized, either upon the request of the Commissioner of Public Health or at such other times as they deem necessary, to enter such facility for the purpose of inspecting programs conducted at such facility. A written report of the findings of any such inspection shall be forwarded to the Commissioner of Public Health and a copy shall be maintained in such facility's licensure file.

Sec. 33. Subsections (a) and (b) of section 19a-492e of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) For purposes of this section "home health care agency" has the same meaning 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 homemaker-home health 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.

(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 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 homemaker-home health aides when the registered nurse determines that it is in the best interest of the client and the homemaker-home health aide has been deemed competent to perform the task; (C) designate homemaker-home health aides to obtain certification and recertification for the administration of medication; and (D) ensure that such homemaker-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 that provide services for clients requiring assistance with medication administration in determining (A) which homemaker-home health 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.

Sec. 34. Subsections (a) and (b) of section 19a-495a of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) (1) The Commissioner of Public Health shall adopt regulations, as provided in subsection (d) of this section, to require each residential care home, as defined in section 19a-490, as amended by this act, that admits residents requiring assistance with medication administration, to (A) designate unlicensed personnel to obtain certification for the administration of medication, and (B) to ensure that such unlicensed personnel receive such certification and recertification every three years thereafter.

(2) The regulations shall establish criteria to be used by such homes in determining (A) the appropriate number of unlicensed personnel who shall obtain such certification and recertification, and (B) training requirements, including **[**on-going**]** ongoing training requirements for such certification and recertification.

(3) Training requirements for initial certification and recertification shall include, but shall not be limited to: Initial orientation, resident rights, 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.

(b) Each residential care home, as defined in section 19a-490, as amended by this act, shall ensure that, on or before January 1, 2010, an appropriate number of unlicensed personnel, as determined by the residential care home, obtain certification and recertification for the administration of medication. Certification and recertification of such personnel shall be in accordance with regulations adopted pursuant to this section. Unlicensed personnel obtaining such certification and recertification may administer medications that are not administered by injection to residents of such homes, unless a resident's physician specifies that a medication only be administered by licensed personnel.

Sec. 35. (NEW) (*Effective October 1, 2016*) (a) As used in this section:

(1) "Music therapy" means the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed a music therapy program approved by the American Music Therapy Association, or any successor of said association; and

(2) "Music therapist" means a person who (A) has earned a bachelor's or graduate degree in music therapy or a related field from an accredited institution of higher education, and (B) is certified as a music therapist by the Certification Board for Music Therapists or any successor of said board.

(b) No person unless certified as a music therapist by the Certification Board for Music Therapists, or any successor of said board, may use the title "music therapist" or "certified music therapist" or make use of any title, words, letters, abbreviations or insignia indicating or implying that he or she is a certified music therapist. Any person who violates this section shall be guilty of a class D felony. For purposes of this section, each instance of contact or consultation with an individual that is in violation of any provision of this section shall constitute a separate offense.

(c) The provisions of this section shall not apply to a person who (1) is licensed, certified or regulated under the laws of this state in another

profession or occupation, including, but not limited to, occupational therapy, physical therapy, speech and language pathology, audiology or counseling, or is supervised by such a licensed, certified or regulated person, and uses music in the practice of his or her licensed, certified or regulated profession or occupation that is incidental to such practice, provided the person does not hold himself or herself out to the public as a music therapist, (2) is a student enrolled in a music therapy educational program or graduate music therapy educational program approved by the American Music Therapy Association, or any successor of said association, and music therapy is an integral part of the student's course of study and such student is performing such therapy under the direct supervision of a music therapist, or (3) is a professional whose training and national certification attests to such person's ability to practice his or her certified occupation or profession and whose use of music is incidental to the practice of such occupation or profession, provided such person does not hold himself or herself out to the public as a music therapist.

Sec. 36. (NEW) (*Effective October 1, 2016*) (a) As used in this section:

(1) "Art therapy" means clinical and evidence-based use of art, including art media, the creative process and the resulting artwork, to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an art therapy program approved by the American Art Therapy Association, or any successor of said association; and

(2) "Art therapist" means a person who (A) has earned a bachelor's or graduate degree in art therapy or a related field from an accredited institution of higher education, and (B) is certified as an art therapist by the Art Therapy Credentials Board or any successor of said board.

(b) No person unless certified as an art therapist may use the title "art therapist" or "certified art therapist" or make use of any title, words, letters, abbreviations or insignia indicating or implying that he or she is a certified art therapist. Any person who violates this section

shall be guilty of a class D felony. For purposes of this section, each instance of contact or consultation with an individual that is in violation of any provision of this section shall constitute a separate offense.

(c) The provisions of this section shall not apply to a person who (1) provides art therapy while acting within the scope of practice of the person's license and training, provided the person does not hold himself or herself out to the public as an art therapist, or (2) is a student enrolled in an art therapy educational program or graduate art therapy educational program approved by the American Art Therapy Association, or any successor of said association, and art therapy is an integral part of the student's course of study and such student is performing such therapy under the direct supervision of an art therapist.

Sec. 37. Section 8-3e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) No zoning regulation shall treat the following in a manner different from any single family residence: (1) Any community residence that houses six or fewer persons with intellectual disability and necessary staff persons and that is licensed under the provisions of section 17a-227, (2) any child-care residential facility that houses six or fewer children with mental or physical disabilities and necessary staff persons and that is licensed under sections 17a-145 to 17a-151, inclusive, (3) any community residence that houses six or fewer persons receiving mental health or addiction services and necessary staff persons paid for or provided by the Department of Mental Health and Addiction Services and that has been issued a license by the Department of Public Health under the provisions of section 19a-491, as amended by this act, if a license is required, or (4) any **[**hospice facility, including a hospice**]** residence **[**,**]** that provides **[**inpatient**]** licensed hospice care and services to six or fewer persons, **[**and is licensed to provide such services by the Department of Public Health,**]** provided such **[**facility**]** residence is (A) managed by an organization

that is tax exempt under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended; (B) located in a city with a population of more than one hundred thousand and within a zone that allows development on one or more acres; **[**and**]** (C) served by public sewer and water; and (D) constructed in accordance with applicable building codes for occupancy by six or fewer persons who are not capable of self-preservation.

(b) Any resident of a municipality in which such a community residence or child-care residential facility is located may, with the approval of the legislative body of such municipality, petition (1) the Commissioner of Developmental Services to revoke the license of such community residence on the grounds that such community residence is not in compliance with the provisions of any statute or regulation concerning the operation of such residences, (2) the Commissioner of Children and Families to revoke the license of such child-care residential facility on the grounds that such child-care residential facility is not in compliance with the provision of any general statute or regulation concerning the operation of such child-care residential facility, or (3) the Commissioner of Mental Health and Addiction Services to withdraw funding from such community residence on the grounds that such community residence is not in compliance with the provisions of any general statute or regulation adopted thereunder concerning the operation of a community residence.

Sec. 38. Section 20-112a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section:

(1) "Direct supervision" means a licensed dentist has authorized certain procedures to be performed on a patient by a dental assistant or an expanded function dental assistant with such dentist remaining on-site in the dental office or treatment facility while such procedures are being performed by the dental assistant or expanded function dental

assistant and that, prior to the patient's departure from the dental office, such dentist reviews and approves the treatment performed by the dental assistant or expanded function dental assistant;

(2) "Indirect supervision" means a licensed dentist is in the dental office or treatment facility, has personally diagnosed the condition, planned the treatment, authorized the procedures to be performed and remains in the dental office or treatment facility while the procedures are being performed by the dental assistant or expanded function dental assistant and evaluates the performance of the dental assistant or expanded function dental assistant;

(3) "Dental assistant" means a person who: (A) Has (i) completed on-the-job training in dental assisting under direct supervision, (ii) successfully completed a dental assistant education program accredited by the American Dental Association's Commission on Dental Accreditation, or (iii) successfully completed a dental assistant education program that is accredited or recognized by the New England Association of Schools and Colleges; and (B) meets any requirements established by the Commissioner of Public Health in regulations adopted pursuant to subsection (f) of this section; and

(4) "Expanded function dental assistant" means a dental assistant who has passed the Dental Assisting National Board's certified dental assistant or certified orthodontic assistant examination and then successfully completed: (A) An expanded function dental assistant program at an institution of higher education that is accredited by the Commission on Dental Accreditation of the American Dental Association that includes (i) educational courses relating to didactic and laboratory preclinical objectives for skills used by an expanded function dental assistant and that requires demonstration of such skills prior to advancing to clinical practice, (ii) not less than four hours of education in the area of ethics and professional standards for dental professionals, and (iii) a comprehensive clinical examination administered by the institution of higher education at the conclusion of such program; and (B) a comprehensive written examination

concerning certified preventive functions and certified restorative functions administered by the Dental Assisting National Board.

(b) Each expanded function dental assistant shall: (1) Maintain dental assistant or orthodontic assistant certification from the Dental Assisting National Board; (2) conspicuously display his or her dental assistant or orthodontic assistant certificate at his or her place of employment or place where he or she provides expanded function dental assistant services; (3) maintain professional liability insurance or other indemnity against liability for professional malpractice in an amount not less than five hundred thousand dollars for one person, per occurrence, with an aggregate liability of not less than one million five hundred thousand dollars while employed as an expanded function dental assistant; (4) provide expanded function dental assistant services only under direct or indirect supervision; and (5) meet any requirements established by the Commissioner of Public Health in regulations adopted pursuant to subsection (f) of this section.

(c) (1) A licensed dentist may delegate to dental assistants such dental procedures as the dentist may deem advisable, including: **[**the**]** (A) The taking of dental x-rays if the dental assistant can demonstrate successful completion of the dental **[**radiography portion of an examination prescribed**]** radiation health and safety examination administered by the Dental Assisting National Board; **[**, but such**]** and (B) the taking of impressions of teeth for study models. Such procedures shall be performed under **[**the dentist's**]** direct supervision **[**and control**]** and the dentist providing direct supervision shall assume responsibility for such procedures. **[**; provided such assistants may not**]**

(2) A licensed dentist may delegate to an expanded function dental assistant such dental procedures as the dentist may deem advisable, including: (A) The placing, finishing and adjustment of temporary restorations and long-term individual fillings, capping materials and cement bases; (B) oral health education for patients; (C) dental sealants; and (D) coronal polishing, provided the procedure is not represented

or billed as prophylaxis. Such procedures shall be performed under the direct or indirect supervision and the dentist providing such supervision shall assume responsibility for such procedures.

(3) On or after January 1, 2018, (A) no licensed dentist may delegate dental procedures to a dental assistant or expanded function dental assistant unless the dental assistant or expanded function dental assistant provides records demonstrating successful completion of the Dental Assisting National Board's infection control examination, except as provided in subdivision (2) of this subsection, (B) a dental assistant may receive not more than nine months of on-the-job training by a licensed dentist for purposes of preparing the dental assistant for the Dental Assisting National Board's infection control examination, and (C) any licensed dentist who delegates dental procedures to a dental assistant shall retain and make such records available for inspection upon request of the Department of Public Health.

(4) On and after January 1, 2018, upon successful completion of the Dental Assisting National Board's infection control examination, each dental assistant or expanded function dental assistant shall complete not less than one hour of training or education in infection control in a dental setting every two years, including, but not limited to, courses, including online courses, offered or approved by a dental school or another institution of higher education that is accredited or recognized by the Commission on Dental Accreditation, a regional accrediting organization, the American Dental Association or a state, district or local dental association or society affiliated with the American Dental Association or the American Dental Assistants Association.

(d) Under no circumstances may a dental assistant or expanded function dental assistant engage in: (1) Diagnosis for dental procedures or dental treatment; (2) the cutting or removal of any hard or soft tissue or suturing; (3) the prescribing of drugs or medications that require the written or oral order of a licensed dentist or physician; (4) the administration of local, parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; (5) the

taking of any final impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; or (6) **[**the placing, finishing and adjustment of temporary or final restorations, capping materials and cement bases; or (7)**]** the practice of dental hygiene as defined in section 20-126*l*, as amended by this act.

(e) Each licensed dentist employing or otherwise engaging the services of an expanded function dental assistant shall: (1) Prior to hiring or otherwise engaging the services of the expanded function dental assistant, verify that the expanded function dental assistant meets the requirements described in subdivision (4) of subsection (a) and subdivisions (1) and (3) of subsection (b) of this section; (2) maintain documentation verifying that the expanded function dental assistant meets such requirements on the premises where the expanded function dental assistant provides services; (3) make such documentation available to the Department of Public Health upon request; and (4) provide direct or indirect supervision to not more than two expanded function dental assistants who are providing services at one time or, if the dentist's practice is limited to orthodontics, provide direct or indirect supervision to not more than four expanded function dental assistants who are providing services at one time.

(f) The Commissioner of Public Health, in consultation with the State Dental Commission, established pursuant to section 20-103a, may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of this section. Such regulations, if adopted, shall include, but need not be limited to, identification of the: (1) Specific types of procedures that may be performed by a dental assistant and an expanded function dental assistant, consistent with the provisions of this section; (2) appropriate number of didactic, preclinical and clinical hours or number of procedures to be evaluated for clinical competency for each skill employed by an expanded function dental assistant; and (3) the level of supervision, that may include direct or indirect supervision, that is required for each procedure to be performed by an expanded function dental assistant.

Sec. 39. Section 19a-244 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

On and after October 1, 2010, any 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, if any. **[**He**]** 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. **[**He shall devote his entire time to the performance of such duties as are**]** 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 **[**and as the board specifies**]** or specified by the board in its written agreement with **[**him; and shall**]** such director. Such director shall serve in a full-time capacity and act as secretary and treasurer of the board, without the right to vote. **[**He**]** 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 **[**his**]** such director's duties as treasurer, in such sum and upon such conditions as the board requires. **[**He**]** 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.

Sec. 40. Subsection (a) of section 19a-200 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2016*):

(a) The mayor of each city, the warden of each borough, and the chief executive officer of each town 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 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. 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 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. 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 shall not, **[**engage in private practice**]** 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 or specified by the appointing authority of the city, town or borough in its written agreement with such director. 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 Public Health Code relating to the preservation and improvement of the public health and preventing the spread of diseases therein. 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 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. 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. 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.

Sec. 41. Section 19a-2a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

The Commissioner of Public Health shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of the Department of Public Health and the Public Health Code. The commissioner shall have responsibility for the overall operation and administration of the Department of Public Health. The commissioner shall have the power and duty to: (1) Administer, coordinate and direct the operation of the department; (2) adopt and enforce regulations, in accordance with chapter 54, as are necessary to carry out the purposes of the department as established by statute; (3) establish rules for the internal operation and administration of the department; (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; (5) enter into a contract, including, but not limited to, a contract with another state, for facilities, services and programs to implement the purposes of the department as established by statute; (6) designate a deputy commissioner or other employee of the department to sign any license, certificate or permit issued by said department; (7) conduct a hearing, issue subpoenas, administer oaths, compel testimony and render a final decision in any case when a hearing is required or authorized under the provisions of any statute dealing with the Department of Public Health; (8) with the health authorities of this and other states, secure information and data concerning the prevention and control of epidemics and conditions

affecting or endangering the public health, and compile such information and statistics and shall disseminate among health authorities and the people of the state such information as may be of value to them; (9) annually issue a list of reportable diseases, emergency illnesses and health conditions and a list of reportable laboratory findings and amend such lists as the commissioner deems necessary and distribute such lists as well as any necessary forms to each licensed physician and clinical laboratory in this state. The commissioner shall prepare printed forms for reports and returns, with such instructions as may be necessary, for the use of directors of health, boards of health and registrars of vital statistics; and (10) specify uniform methods of keeping statistical information by public and private agencies, organizations and individuals, including a client identifier system, and collect and make available relevant statistical information, including the number of persons treated, frequency of admission and readmission, and frequency and duration of treatment. The client identifier system shall be subject to the confidentiality requirements set forth in section 17a-688 and regulations adopted thereunder. The commissioner may designate any person to perform any of the duties listed in subdivision (7) of this section. The commissioner shall have authority over directors of health and may, for cause, remove any such director; but any person claiming to be aggrieved by such removal may appeal to the Superior Court which may affirm or reverse the action of the commissioner as the public interest requires. The commissioner shall assist and advise local directors of health and district directors of health in the performance of their duties, and may require the enforcement of any law, regulation or ordinance relating to public health. In the event the commissioner reasonably suspects impropriety on the part of a local director of health or district director of health, or employee of such director, in the performance of his or her duties, the commissioner shall provide notification and any evidence of such impropriety to the appropriate governing authority of the municipal health authority, established pursuant to section 19a-200, or the district department of health, established pursuant to section 19a-244, for purposes of reviewing and

assessing a director's or an employee's compliance with such duties. Such governing authority shall provide a written report of its findings from the review and assessment to the commissioner not later than ninety days after such review and assessment. When requested by local directors of health or district directors of health, the commissioner shall consult with them and investigate and advise concerning any condition affecting public health within their jurisdiction. The commissioner shall investigate nuisances and conditions affecting, or that he or she has reason to suspect may affect, the security of life and health in any locality and, for that purpose, the commissioner, or any person authorized by the commissioner, may enter and examine any ground, vehicle, apartment, building or place, and any person designated by the commissioner shall have the authority conferred by law upon constables. Whenever the commissioner determines that any provision of the general statutes or regulation of the Public Health Code is not being enforced effectively by a local health department or health district, he or she shall forthwith take such measures, including the performance of any act required of the local health department or health district, to ensure enforcement of such statute or regulation and shall inform the local health department or health district of such measures. In September of each year the commissioner shall certify to the Secretary of the Office of Policy and Management the population of each municipality. The commissioner may solicit and accept for use any gift of money or property made by will or otherwise, and any grant of or contract for money, services or property from the federal government, the state, any political subdivision thereof, any other state or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant or contract. The commissioner may establish state-wide and regional advisory councils. For purposes of this section, "employee of such director" means an employee of, a consultant employed or retained by or an independent contractor retained by a local director of health, a district director of health, a local health department or a health district.

Sec. 42. (NEW) (*Effective October 1, 2016*) Not later than January 1, 2017, the Commissioner of Public Health shall review the general statutes governing local health departments and districts to determine whether they need revising and submit such determination, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 43. Section 19a-6f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

On or before January 1, **[**2005**]** 2017, and annually thereafter, the Commissioner of Public Health shall obtain from the American Association of Medical Assistants **[**,**]** and the National Healthcareer Association a listing of all state residents maintained on said **[**organization's**]** organizations' registry of certified medical assistants. The commissioner shall make such **[**listing**]** listings available for public inspection.

Sec. 44. (*Effective from passage*) (a) There is established a working group to consider matters relating to nail salons and the provision of services by nail technicians. Such matters may include, but need not be limited to: (1) Standards for nail salons to protect the health and safety of customers; (2) licensure or certification standards for nail technicians, including educational and training requirements for nail technicians; (3) working conditions of nail technicians; (4) fair and equitable business practices; and (5) the development of informational publications, in multiple languages as appropriate, to advise owners and managers of nail salons of applicable state laws and regulations.

(b) The working group shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives, who shall be the owner of two or more nail salons in the state;

(2) One appointed by the president pro tempore of the Senate, who shall have not less than two years of experience working as a nail

technician;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the Nail and Spa Association of Connecticut;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives, who shall be the owner of a single nail salon employing less than five persons;

(6) One appointed by the minority leader of the Senate, who shall have experience working as a nail technician; and

(7) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or the chairpersons' designees.

(c) Any member of the working group appointed under subdivision (1), (2), (3), (4), (5), (6) or (7) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the working group shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairperson of the working group from among the members of the working group. Such chairperson shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(f) Not later than January 1, 2017, the working group shall submit a report on its findings and recommendations to 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 of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2017, whichever is later.

Sec. 45. (*Effective from passage*) The Commissioner of Social Services, in consultation with the Secretary of the Office of Policy and Management, may waive recoupment of an audit finding of overpayment made under the Medicaid program to a hospital that was under prior ownership during a portion of the audit period.

Sec. 46. (*Effective from passage*) (a) There is established a task force to study the furnishing of medical records by health care providers and health care institutions. Such study shall include, but need not be limited to, an examination of (1) the time frame for a heath care provider or health care institution to respond to a request for medical records, (2) the cost for research and copies in response to a request for medical records, and (3) the requirements of 45 CFR 164.524 concerning individuals' access to their protected health information.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one who shall be a representative of a business that provides health information management services and one who shall be a member of the joint standing committee having cognizance of matters relating to public health;

(2) Two appointed by the president pro tempore of the Senate, one who shall be a representative of the Connecticut Trial Lawyers Association and one who shall be a member of the joint standing committee having cognizance of matters relating to public health;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate, who shall be a patient advocate;

(5) Two appointed by the minority leader of the House of

Representatives, one who shall be a representative of the Connecticut State Medical Society and one who shall be a member of the joint standing committee having cognizance of matters relating to public health; and

(6) Two appointed by the minority leader of the Senate, one who shall be a representative of the Connecticut Hospital Association and one who shall be a member of the joint standing committee having cognizance of matters relating to public health.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairperson of the task force from among the members of the task force. Such chairperson shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) Not later than January 1, 2017, the task force shall submit a report on its findings and recommendations to 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 of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2017, whichever is later.

Sec. 47. (NEW) (*Effective from passage*) (a) As used in this section and section 48 of this act, "Connecticut protection and advocacy system" means the nonprofit entity designated by the Governor in accordance with section 48 of this act to serve as the state's protection and advocacy system and client assistance program.

(b) The Connecticut protection and advocacy system shall provide the following:

(1) Protection and advocacy services for people with disabilities, as provided under the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 USC 15001, as amended from time to time; and

(2) A client assistance program, as provided under the Workforce Investment Act of 1998, 29 USC 732, as amended from time to time.

Sec. 48. (NEW) (*Effective from passage*) (a) Not later than October 1, 2016, the Office of Policy and Management shall issue a request for information from nonprofit entities concerning the ability of such entities to serve as the Connecticut protection and advocacy system to provide advocacy services, including, but not limited to, a client assistance program for people with disabilities, which system shall be in compliance with all federal laws setting forth protection and advocacy system requirements, including, but not limited to, 42 USC 15041 to 15045, inclusive, as amended from time to time, and all federal laws setting forth client assistance program requirements, including, but not limited to, 29 USC 732, as amended from time to time.

(b) Not later than November 1, 2016, the Office of Protection and Advocacy for Persons with Disabilities, established under section 46a-10 of the general statutes, in consultation with the Board of Protection and Advocacy for Persons with Disabilities, established under section 46a-9 of the general statutes, shall submit a plan to the Secretary of the Office of Policy and Management that (1) is consistent with state and federal law, (2) contains provisions for the effective transfer, not later than July 1, 2017, of the protection and advocacy and client assistance program functions of said office to a nonprofit entity, and (3) includes, but is not limited to, any proposed legislative changes.

(c) Notwithstanding the provisions of sections 4-212 to 4-219, inclusive, subdivision (21) of section 4e-1, and chapter 62a of the general statutes, not later than July 1, 2017, the Governor shall

designate a nonprofit entity to serve as the Connecticut protection and advocacy system.

(d) Notwithstanding the provisions of section 4e-16 and chapter 62a of the general statutes, prior to its abolishment under section 49 of this act on July 1, 2017, the Office of Protection and Advocacy for Persons with Disabilities, with the approval of the Office of Policy and Management, may contract with one or more nonstate entities to perform any functions that said office is permitted or required to perform, except those relating to investigations conducted pursuant to sections 46a-11a to 46a-11f, inclusive, of the general statutes.

(e) Nothing in chapter 10 of the general statutes shall prohibit any member of the Board of Advocacy and Protection for Persons with Disabilities or any employee of the Office of Protection and Advocacy for Persons with Disabilities from serving on the board of the Connecticut protection and advocacy system or working as an employee of such system, provided no state employee is employed by such system while employed by the state.

Sec. 49. (NEW) (*Effective July 1, 2017*) The Office of Protection and Advocacy for Persons with Disabilities and the Board of Protection and Advocacy for Persons with Disabilities are abolished. Any work in progress at said office not completed on or before July 1, 2017, other than investigations initiated pursuant to sections 46a-11a to 46a-11f, inclusive, of the general statutes, shall be completed by the Connecticut protection and advocacy system, designated under section 51 of this act, in accordance with federal regulations and in the same manner and with the same effect as if completed by said office as it existed immediately prior to July 1, 2017.

Sec. 50. Section 17b-650a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is created a Department of Rehabilitation Services. The Department of Social Services shall provide administrative support services to the Department of Rehabilitation Services until the

Department of Rehabilitation Services requests cessation of such services, or until June 30, 2013, whichever is earlier. The Department of Rehabilitation Services shall be responsible for providing the following: (1) Services to the deaf and hearing impaired; (2) services for the blind and visually impaired; and (3) rehabilitation services in accordance with the provisions of the general statutes concerning the Department of Rehabilitation Services. The Department of Rehabilitation Services shall constitute a successor authority to the Bureau of Rehabilitative Services in accordance with the provisions of sections 4-38d, 4-38e and 4-39.

(b) The department head shall be the Commissioner of Rehabilitation Services, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, and shall have the powers and duties described in said sections. The Commissioner of Rehabilitation Services shall appoint such persons as may be necessary to administer the provisions of public act 11-44 and the Commissioner of Administrative Services shall fix the compensation of such persons in accordance with the provisions of section 4-40. The Commissioner of Rehabilitation Services may create such sections within the Department of Rehabilitation Services as will facilitate such administration, including a disability determinations section for which one hundred per cent federal funds may be accepted for the operation of such section in conformity with applicable state and federal regulations. The Commissioner of Rehabilitation Services may adopt regulations, in accordance with the provisions of chapter 54, to implement the purposes of the department as established by statute.

(c) The Commissioner of Rehabilitation Services shall, annually, in accordance with section 4-60, submit to the Governor a report in electronic format on the activities of the Department of Rehabilitation Services relating to services provided by the department to individuals who (1) are blind or visually impaired, (2) are deaf or hearing impaired, or (3) receive vocational rehabilitation services. The report shall include the data the department provides to the federal

government that relates to the evaluation standards and performance indicators for the vocational rehabilitation services program. The commissioner shall submit the report in electronic format, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies.

(d) Effective July 1, 2017, the Department of Rehabilitation Services shall constitute a successor department, in accordance with the provisions of sections 4-38d and 4-39, to the Office of Protection and Advocacy for Persons with Disabilities with respect to investigations of allegations of abuse or neglect pursuant to sections 46a-11a to 46a-11f, inclusive.

Sec. 51. (*Effective from passage*) (a) There is established, within available appropriations, within the Department of Public Health, a Diabetes Advisory Council. The advisory council shall (1) analyze the current state of diabetes prevention, control and treatment in the state; and (2) advise the department on methods to achieve the goal of the Centers for Disease Control in granting funds to the state for diabetes prevention.

(b) The advisory council shall consist of the following members, who shall be appointed by the Commissioner of Public Health not later than ninety days after the effective date of this section:

(1) Two representatives of the Department of Public Health;

(2) A member of the Connecticut Alliance of Diabetes Educators;

(3) A diabetes prevention advocate;

(4) One representative each from two locations of the Young Men's Christian Association in the state that provide a diabetes prevention program;

(5) A representative of an insurance carrier that covers residents of

this state;

(6) One representative each from two federally qualified health centers;

(7) A representative of the Connecticut State Medical Society;

(8) A representative of an accountable care organization;

(9) A primary health care provider who is not employed by a hospital, federally qualified health center or accountable care organization;

(10) Two representatives of a research and bioscience manufacturer with expertise in metabolic diseases; and

(11) Any additional member the commissioner determines would be beneficial to serve as a member of the advisory council.

(b) The advisory council shall consist of the following additional members:

(1) The Commissioner of Social Services, or the commissioner's designee;

(2) The Comptroller, or the Comptroller's designee;

(3) The executive director of the Latino and Puerto Rican Affairs Commission, or the executive director's designee;

(4) The executive director of the African-American Affairs Commission, or the executive director's designee; and

(5) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or such cochairpersons' designees, one of whom may be a legislator.

(c) Members shall receive no compensation except for

reimbursement for necessary expenses incurred in performing their duties. 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.

(d) The advisory council shall (1) review the following: (A) Strategies to identify and enroll individuals at risk of diabetes in diabetes prevention programs; (B) strategies to identify and refer individuals with diabetes for enrollment in formal diabetes education classes and diabetes management programs; (C) the status of healthcare organizations reporting on clinical quality measures related to diabetes control; (D) existing state programs that address prevention, control, and treatment of diabetes; and (E) evidence that supports the need for such programs; and (2) make recommendations to enhance and financially support such programs.

(e) The advisory council may (1) study the following: (A) The effectiveness of the existing state programs identified in subsection (d) of this section; (B) the financial impact of diabetes on the state, including, but not limited to, the prevalence of the disease and the cost to the state for, among other things, administering the programs identified in subsection (d) of this section; and (C) the coordination of such programs and other efforts among state agencies to prevent, control and treat diabetes; and (2) develop an action plan that sets forth steps for reducing the impact of diabetes on the state, including, but not limited to, expected outcomes for each step toward preventing, controlling and treating diabetes.

(f) Not later than January 1, 2017, the advisory council shall submit, in accordance with the provisions of section 11-4a of the general statutes, a progress report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Not later than May 1, 2017, the advisory council shall submit, in accordance with the provisions of section 11-4a of the general statutes, a final report on its findings and

recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The advisory council shall terminate on the date that it submits such report or January 1, 2018, whichever is later.

Sec. 52. (*Effective from passage*) Notwithstanding the provisions of section 20-227 of the general statutes, the Department of Public Health shall not revoke or suspend the license of a funeral director or embalmer pursuant to subdivision (1) of section 20-227 of the general statutes prior to April 1, 2017, if the licensed funeral director or licensed embalmer completed an examination as part of a program in funeral directing and embalming at an institution of higher education that lost its accreditation within twenty-four months of the effective date of this section.

Sec. 53. Sections 19a-56a, 19a-56b, 19a-57 and 20-86d of the general statutes are repealed. (*Effective October 1, 2016*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-177(8)(D)
Sec. 2	*October 1, 2016*	20-266p
Sec. 3	*October 1, 2016*	19a-12e(a)(1)
Sec. 4	*October 1, 2016*	New section
Sec. 5	*October 1, 2016*	19a-490
Sec. 6	*October 1, 2016*	19a-541
Sec. 7	*October 1, 2016*	19a-521
Sec. 8	*from passage*	SA 14-5, Sec. 1(h)
Sec. 9	*October 1, 2016*	20-123b
Sec. 10	*October 1, 2016*	20-126c(b)
Sec. 11	*October 1, 2016*	20-126l(g)
Sec. 12	*October 1, 2016*	20-114(a)
Sec. 13	*October 1, 2016*	20-195q(c)
Sec. 14	*October 1, 2016*	19a-88(c)(4)
Sec. 15	*October 1, 2016*	20-86a(2)
Sec. 16	*October 1, 2016*	20-86b
Sec. 17	*October 1, 2016*	20-86c
Sec. 18	*October 1, 2016*	20-86i

Sec. 19	*October 1, 2016*	20-254
Sec. 20	*October 1, 2016*	19a-37
Sec. 21	*October 1, 2016*	46b-20a(1)
Sec. 22	*October 1, 2016*	19a-55
Sec. 23	*October 1, 2016*	19a-491(j)(1) and (2)
Sec. 24	*October 1, 2016*	19a-270
Sec. 25	*October 1, 2016*	20-206q
Sec. 26	*October 1, 2016*	New section
Sec. 27	*October 1, 2016*	New section
Sec. 28	*from passage*	20-10b(b)
Sec. 29	*from passage*	46b-24(a)
Sec. 30	*from passage*	New section
Sec. 31	*from passage*	46b-28a
Sec. 32	*October 1, 2016*	19a-498(c)
Sec. 33	*October 1, 2016*	19a-492e(a) and (b)
Sec. 34	*October 1, 2016*	19a-495a(a) and (b)
Sec. 35	*October 1, 2016*	New section
Sec. 36	*October 1, 2016*	New section
Sec. 37	*October 1, 2016*	8-3e
Sec. 38	*October 1, 2016*	20-112a
Sec. 39	*July 1, 2016*	19a-244
Sec. 40	*July 1, 2016*	19a-200(a)
Sec. 41	*October 1, 2016*	19a-2a
Sec. 42	*October 1, 2016*	New section
Sec. 43	*from passage*	19a-6f
Sec. 44	*from passage*	New section
Sec. 45	*from passage*	New section
Sec. 46	*from passage*	New section
Sec. 47	*from passage*	New section
Sec. 48	*from passage*	New section
Sec. 49	*July 1, 2017*	New section
Sec. 50	*from passage*	17b-650a
Sec. 51	*from passage*	New section
Sec. 52	*from passage*	New section
Sec. 53	*October 1, 2016*	Repealer section

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: See Below

Municipal Impact: None

Explanation

The sections that result in a fiscal impact are detailed below. The remaining sections make technical changes to existing public health statutes, codify current practice,[1] or create new statutory provisions that do not result in fiscal impact.

Section 2, which makes engaging in tattooing without a license or temporary permit a class D misdemeanor, results in a potential minimal General Fund revenue gain to the extent that individuals are found guilty and fined up to $250.

Sections 503 and 504 result in a potential cost to the Department of Correction and the Judicial Department associated with making violators of music therapist (Section 503) and art therapist (Section 504) statutes guilty of a class D felony. To the extent that offenders are prosecuted for new or expanded offenses under this bill, potential costs for incarceration or probation supervision in the community, or judicial revenue would result. On average, it costs the state $7,260 (including benefits) to supervise an inmate in the community as opposed to $61,320 (including benefits) to incarcerate an offender.

Section 512 may result in a cost of less than $1,000 in FY 17 to those

[1]This includes the fee increase, from $50 to $100, for a hairdresser's license without examination, due to licensure in another jurisdiction. The Department of Public Health currently charges $100, not $50, for this license. It also includes newborn screening for adrenoleukodystrophy, for which is currently underway.

agencies participating in a working group to reimburse legislators and agency staff for mileage expenses.

Section 513 may result in a revenue loss to the Department of Social Services (DSS) if DSS elects to waive the recoupment of overpayments to certain hospitals.

Section 514 may result in a cost of less than $1,000 in FY 17 to those agencies participating in a task force to reimburse legislators and agency staff for mileage expenses.

Section 516 requires the Office of Policy and Management (OPM), not later than 10/1/16, to issue a request for information from nonprofits regarding their ability to serve as Connecticut's protection and advocacy (P&A) system. It is anticipated that, pursuant to the Governor's designation of the P&A nonprofit, OPM will contract with this entity beginning 7/1/17. This will result in a contract cost to OPM in FY 18, the amount of which is unknown at this time. Nevertheless, it is anticipated that the privatization of these services will yield significant General Fund savings associated with Personal Services, fringe benefits, and the leasing of office space. Currently, there are 12 positions in the Office of Protection and Advocacy (OPA) associated with P&A services.

Section 517 abolishes OPA in FY 18. Pursuant to Section 516, P&A functions will be provided by a nonprofit. Pursuant to Section 518 investigations of allegations of abuse or neglect will be performed by Department of Rehabilitative Services (DORS). It is anticipated that approximately $1.2 million and 11 positions will be transferred to DORS in FY 18.

Section 519 establishes a Diabetes Advisory Council within the Department of Public Health within available appropriations, resulting in a potential cost of less than $1,000 in FY 17 and FY 18 for members incurring necessary expenses in the performance of their duties, such as mileage reimbursement.

House "A" added additional provisions to the underlying bill. Those that result in a fiscal impact are identified above.

The Out Years

The fiscal impact identified above will continue into the future to the extent that: (1) individuals are found guilty of new offenses, (2) DSS elects to waive the recoupment of overpayments to certain hospitals, and (3) savings resulting from the privatization of P&A and the transfer of OPA investigations to DORS.

OLR Bill Analysis

sHB 5537 (as amended by House "A")*

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

SUMMARY:

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

For example, it:

1. makes changes affecting local health departments, such as establishing a process to address alleged impropriety by local health directors or their employees;

2. creates a new designation of dental assistant and requires dental professionals to take continuing education in infection control;

3. allows nursing home patients to receive methadone treatment for opioid addiction at the nursing home;

4. recognizes in statute a category of psychology technicians and allows them to provide services related to psychological testing;

5. as of July 1, 2017, eliminates the Office of Protection and Advocacy for Persons with Disabilities and requires the governor to designate a nonprofit entity to serve this function;

6. creates a diabetes advisory council in DPH, within available appropriations; and

7. creates a nail salon working group and a medical records task force.

Among other things, the bill also makes changes affecting various licensed institutions, including hospitals, nursing homes, and residential care homes; tattoo technicians; various licensed health care professionals; the medical orders for life sustaining treatment pilot program; wells for semipublic use; marriages (including those performed at tribal reservations); newborn screening; medication administration by unlicensed personnel; music or art therapists; hospice care residences; medical assistants; Medicaid overpayment audits; and funeral directors and embalmers.

A section-by-section summary appears below.

*House Amendment "A" adds provisions on (1) medication administration by unlicensed personnel, (2) music and art therapists, (3) hospice zoning regulations, (4) dental assistants and expanded function dental assistants, (5) local health departments, (6) certified medical assistants, (7) a nail salon working group, (8) Medicaid overpayment audits, (9) a medical records task force, (10) the Office of Protection and Advocacy for Persons with Disabilities, (11) a diabetes advisory council, and (12) funeral directors and embalmers.

It also makes changes to the bill's underlying provisions, such as (1) adding to the list of providers who must report on other impaired providers and (2) several minor and clarifying changes.

EFFECTIVE DATE: October 1, 2016, except as otherwise noted.

§ 1 — TECHNICAL CHANGE

This section makes a technical change, correcting an inaccurate statutory reference.

EFFECTIVE DATE: Upon passage

§ 2 — TATTOOING WITHOUT A LICENSE

Existing law generally requires an individual to have a license or temporary permit to engage in the practice of tattooing. The bill provides that engaging in tattooing without a license or temporary

permit is a class D misdemeanor (punishable by up to thirty days in prison, a fine of up to $250, or both).

§ 3 — REPORTING OF IMPAIRED HEALTH PROFESSIONALS

By law, physicians must notify DPH if they are aware that a physician or physician assistant (PA) may be unable to practice with skill and safety because he or she is impaired, and PAs must similarly notify DPH if another PA may be so impaired (CGS §§ 20-12e and 20-13d). PA 15-5, June Special Session (JSS), created a parallel reporting requirement covering most other licensed or permitted health care professionals.

The bill includes the following within the reporting requirement created by PA 15-5, JSS: physicians, PAs, nursing home administrators, perfusionists, electrologists, and audiologists.

§ 4 — METHADONE FOR OPIOID ADDICTION IN NURSING HOMES

The bill allows licensed substance abuse treatment facilities providing medication assisted treatment for opioid addiction to provide methadone and related substance abuse treatment services to patients in licensed nursing home facilities. Substance abuse treatment facilities seeking to do this must request permission from the DPH commissioner, in a form and manner he prescribes. He may grant the request if he determines that it would not endanger the health, safety, or welfare of any patient. Current law generally requires nursing home patients receiving methadone treatment for opioid addiction to receive that treatment at the substance abuse treatment facility rather than in the nursing home.

If the commissioner approves the request, he may impose conditions to ensure patients' health, safety, or welfare. He may revoke the approval if he finds that any patient's health, safety, or welfare has been jeopardized.

§§ 5-7 & 32 — INSTITUTIONAL LICENSING DEFINITIONS

The bill amends certain definitions related to the licensing of health care institutions.

Behavioral Health Facility

The bill renames a "mental health facility" as a "behavioral health facility." It defines "behavioral health facility" as any facility providing mental health services to individuals age 18 or older, or substance use disorder services to individuals of any age, in an outpatient or residential setting to ameliorate mental, emotional, behavioral, or substance use disorder issues. Current law defines "mental health facility" as any facility providing care or treatment for individuals with mental illness or emotional disturbance, or any mental health outpatient treatment facility providing treatment to individuals age 16 or older who are receiving services from the Department of Mental Health and Addiction Services, but not including family care homes for the mentally ill.

Nursing Homes, Residential Care Homes, and Rest Homes

For institutional licensing purposes, current law defines a residential care home (RCH), nursing home, or rest home as an establishment that (1) furnishes, in single or multiple facilities, food and shelter to at least two unrelated people and to the proprietor and (2) provides services beyond the basic needs of providing food, shelter, and laundry.

The bill amends this definition and applies it to RCHs and rest homes, but not nursing homes. It specifies that an RCH or rest home is a community residence that provides these services. It also provides that an RCH or rest home may qualify as a setting that allows residents to receive home- and community-based services funded by state and federal programs.

The bill removes "rest home" from the list of DPH-licensed institutions. In practice, rest homes are not licensed as their own category, but either as RCHs or as a subset of nursing home facilities (rest homes with nursing supervision).

The bill creates a separate definition for "nursing home facility" for institutional licensing purposes, defining it the same way as statutes related to nursing home oversight. Under this definition, a nursing home facility is a (1) chronic and convalescent nursing home (CCNH) or rest home with nursing supervision that provides 24-hour nursing supervision under a medical director or (2) CCNH that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic or acute diseases, convalescent stages, or injuries.

The bill also makes related technical and conforming changes.

§ 8 — MOLST PILOT PROGRAM

The bill extends the end date for DPH's medical orders for life sustaining treatment (MOLST) pilot program, from October 1, 2016 to October 2, 2017.

EFFECTIVE DATE: Upon passage

§ 9 — DENTAL ANESTHESIA

The bill allows the DPH commissioner to deny or revoke a dental permit for moderate sedation, deep sedation, or general anesthesia based on state dental commission disciplinary action against the dentist.

§§ 10-12 — INFECTION CONTROL IN DENTAL SETTINGS

Continuing Education for Dentists and Dental Hygienists

The bill requires dentists and dental hygienists to complete at least one contact hour (i.e., 50 minutes) every two years of training or education in infection control in a dental setting, as part of existing continuing education requirements. The requirement applies to registration periods beginning on and after October 1, 2016.

The bill makes a corresponding change by providing that dentists' other continuing education must include at least one contact hour in any three, rather than four, of the 10 mandatory topics prescribed by

the DPH commissioner.

By law, starting with their second license renewal, (1) dentists generally must complete 25 contact hours of continuing education every two years and (2) dental hygienists generally must complete 16 contact hours every two years.

Dental Commission Disciplinary Action

The bill allows the dental commission to take disciplinary action against a dentist for failure to adhere to the most recent version of the National Centers for Disease Control and Prevention's guidelines for infection control in dental settings.

§ 13 — SOCIAL WORK

The bill repeals an obsolete provision allowing an unlicensed person with a master's or doctoral degree to satisfy the work experience requirement for social work licensure by gaining social work experience under professional supervision.

Last year, DPH implemented a licensure program for master social workers as a separate license from clinical social workers. Master social workers must have a master's or doctoral degree and work under professional supervision while gaining the work experience needed for the clinical social worker license.

§§ 14-18 — NURSE-MIDWIFERY CERTIFYING AND ACCREDITING ORGANIZATIONS

The bill updates the names of the certification and accreditation bodies for nurse-midwives. It refers to the "Accreditation Midwifery Certification Board" and "Accreditation Commission for Midwifery Education," rather than to the "American College of Nurse-Midwives."

§ 19 — FEE FOR HAIRDRESSER LICENSE WITHOUT EXAMINATION

The bill increases, from $50 to $100, the fee for a hairdresser's license without examination (which is available to certain applicants licensed

in other jurisdictions). The existing fee for licensure by examination is $100.

§ 20 — WELLS FOR SEMIPUBLIC USE

The bill extends several existing provisions concerning private residential wells to "wells for semipublic use," which the bill does not define. This includes laws:

1. requiring the DPH commissioner to adopt regulations for testing well water quality;

2. requiring the testing company to report the results to the local health authority and DPH if a test was conducted within six months of the property's sale;

3. prohibiting regulations from requiring a test as a consequence or condition of a property sale, transfer, or rental;

4. allowing local health directors to require wells to be tested for certain contaminants if there are reasonable grounds to suspect that contaminants are present in the groundwater; and

5. specifying who may collect samples to determine water quality in the wells.

Existing law allows the DPH commissioner to adopt regulations on the protection and location of new water supply wells for public or semipublic use.

§ 21 — MARRIAGE

The bill specifies that a couple currently married to each other in any jurisdiction are not eligible to marry each other in Connecticut.

§ 22 — NEWBORN SCREENING

The bill specifies that adrenoleukodystrophy (ALD) is part of the required newborn screening tests. It repeals an obsolete provision requiring the DPH commissioner, by October 1, 2015, to execute an agreement with the New York State Department of Health to (1)

conduct a newborn screening test for ALD using dried blood spots and (2) develop a quality assurance testing method for the screening test.

It also makes a technical change.

§ 23 — HOSPITAL RECORD STORAGE

The bill allows chronic disease hospitals and children's hospitals to maintain their medical records off-site as long as they can retrieve them by the end of the next business day after a request for them. Current law requires the records to be kept on-site.

For children's hospitals, current law exempts nurses' notes from the requirement to keep records on-site. The bill removes this exemption and applies the same rule as described above.

§ 24 — DELIVERY OF UNCLAIMED DECEASED BODY

The bill gives acute care hospitals seven days to notify DPH and deliver an unclaimed dead body in its possession to a listed higher education institution for use in medical study. Current law requires hospitals to do so within 24 hours.

§ 25 — DIET ORDERS FROM A DIETITIAN-NUTRITIONIST

Existing law allows certified dietitian-nutritionists (CDNs) to directly order diets for patients, including therapeutic diets for patients in health care institutions. Under current law, a physician must countersign the order within 72 hours unless state or federal law provides otherwise. The bill eliminates this requirement.

By law, physicians may convey verbal orders to CDNs for such diets. The bill also allows advance practice registered nurses (APRNs) to do so. It requires these orders to be reduced to writing and countersigned by a physician or APRN within 72 hours unless state or federal law provides otherwise.

The bill requires nurses and PAs to act upon such CDN orders as if they were received directly by a physician or APRN, not just a physician as under current law.

§ 26 — PLACENTA REMOVAL FROM HOSPITALS

Under specified conditions, the bill permits a hospital to allow a woman who has given birth in the hospital, or her spouse if she is incapacitated or deceased, to take possession of the placenta and remove it from the hospital.

The woman who gave birth must test negative for infectious diseases. Also, the woman (or her spouse) taking possession of the placenta must:

1. do so for personal use and not for resale and

2. provide a written acknowledgment that (a) she (or her spouse) received from the hospital educational information on the spread of blood-borne diseases from a placenta, the danger of ingesting formalin, and the proper handling of a placenta, and (b) the placenta is for personal use.

The hospital must retain the signed acknowledgment with the woman's medical records.

The bill specifies that these provisions do not (1) prohibit a pathological examination of the delivered placenta ordered by a physician or required by hospital policy or (2) authorize a woman or her spouse to interfere with such an examination. The bill does not allow a woman or her spouse to take possession of the portion of a placenta needed for such an examination.

Under the bill, a hospital that allows someone to possess and remove a placenta under these provisions:

1. is not required to dispose of the placenta as biomedical waste and

2. is immune from liability in a civil action, criminal prosecution, or administrative proceeding for allowing this.

§ 27 — PSYCHOLOGY TECHNICIANS

The bill allows psychology technicians with specified education and training to provide certain services related to psychological testing.

Under the bill, a "psychology technician" has a bachelor's or graduate degree in psychology or another mental health field and has completed at least 80 hours of training by a licensed psychologist, including at least:

1. 16 hours of studying and mastering information from psychological and neuropsychological testing manuals;

2. 20 hours of directly observing the psychologist administering and scoring objective psychological and neuropsychological tests;

3. 40 hours of administering and scoring such tests in the psychologist's presence; and

4. four hours of education in professional ethics and best practices for administering and scoring such tests, including (a) the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct and (b) legal obligations on patient confidentiality and reporting any suspicion of patient abuse or neglect.

Under the bill, a technician's services may include administering and scoring such tests with specific, predetermined, and manualized administrative procedures. A technician's responsibilities may include observing and describing the patient's behavior and test responses, but not evaluating, interpreting, or making other judgments concerning the patient or the patient's test responses.

The bill allows these technicians to provide objective psychological and neuropsychological testing services under a psychologist's supervision and direction, as long as (1) the psychologist is satisfied as to the technician's ability and competency, (2) the services are consistent with the patient's health and welfare and with the practice

of psychology, and (3) the psychologist oversees, controls, and directs the services.

The bill prohibits such a technician from:

1. selecting tests;
2. conducting intake assessments;
3. conducting clinical interviews, including interviews of the patient, the patient's relatives or friends, or other professionals associated with the patient;
4. interpreting patient data;
5. communicating test results or treatment recommendations to patients; or
6. administering tests in educational institutions.

These provisions do not apply to the activities and services of a person enrolled in a psychology technician educational program acceptable to the APA, if the activities and services are incidental to the course of study.

§ 28 — PHYSICIAN CONTINUING EDUCATION

The bill adds the Connecticut Osteopathic Medical Society to the list of qualifying continuing education providers for physicians. It also updates the name of another such qualifying organization, from "American Osteopathic Medical Association" to "American Osteopathic Association."

EFFECTIVE DATE: Upon passage

§§ 29-31 — MARRIAGES AT TRIBAL RESERVATIONS

Existing law requires recognition of marriages (or relationships that provide substantially the same rights, benefits, and responsibilities) between two people entered into in other jurisdictions and recognized

as valid in that jurisdiction, unless the relationship is expressly prohibited by Connecticut law. The bill:

1. specifies that this includes recognition of marriages entered into at the Mashantucket Pequot and Mohegan reservations;

2. exempts such marriages from requirements that generally apply to Connecticut marriages regarding marriage licenses and related matters; and

3. recognizes as valid any marriages celebrated before the bill's passage under a tribal marriage license at the Mashantucket Pequot and Mohegan reservations, as long as the marriage was recognized under the applicable tribal law and is not otherwise expressly prohibited by state law.

EFFECTIVE DATE: Upon passage

§§ 33 & 34 — MEDICATION ADMINISTRATION BY UNLICENSED PERSONNEL

Existing law permits a registered nurse to delegate the administration of medications that are not injected into patients to homemaker-home health aides who obtain certification for medication administration. It also allows residential care homes (RCH) that admit residents requiring medication administration assistance to employ a sufficient number of certified, unlicensed personnel to perform this function in accordance with DPH regulations.

The bill requires these homemaker-home health aides and RCH unlicensed personnel to obtain recertification every three years to continue to administer medication. It also makes conforming changes in requirements for DPH regulations on medication administration.

§§ 35 & 36 — MUSIC AND ART THERAPISTS

The bill generally makes it a class D felony to represent oneself as a music therapist or art therapist unless meeting certain certification and education requirements. Class D felonies are punishable by up to five

years in prison, a fine of up to $5,000, or both.

Specifically, the bill prohibits someone not certified as a music therapist (as defined below) from using (1) the title "music therapist" or "certified music therapist" or (2) any title, words, letters, abbreviations, or insignia indicating or implying that he or she is a certified music therapist. It similarly prohibits someone not certified as an art therapist (as defined below) from using the title "art therapist" or "certified art therapist" or similar terms indicating or implying such certification. Each contact or consultation with an individual in violation of these provisions is a separate offense.

For both professions, the bill provides exemptions from this prohibition, such as for other licensed individuals providing music or art therapy under specified conditions.

Definitions

The bill defines "music therapy" as the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed a music therapy program approved by the American Music Therapy Association or any successor association. It defines a "music therapist" as someone who (1) has a bachelor's or graduate degree in music therapy or a related field from an accredited higher education institution and (2) is certified as a music therapist by the Certification Board for Music Therapists or any successor board.

The bill defines "art therapy" as the clinical and evidence-based use of art, including art media, the creative process, and the resulting artwork, to accomplish individualized goals within a therapeutic relationship, by a credentialed professional who has completed an art therapy program approved by the American Art Therapy Association or any successor association. It defines an "art therapist" as someone who (1) has a bachelor's or graduate degree in art therapy or a related field from an accredited higher education institution and (2) is certified as an art therapist by the Art Therapy Credentials Board or any

successor board.

Exemptions

For music therapists, the bill's restrictions do not apply to:

1. individuals (a) licensed, certified, or regulated under state law in another profession or occupation, such as occupational or physical therapy, speech and language pathology, audiology, or counseling or (b) supervised by such a licensed, certified, or regulated individual, and who use music in their practice and incidental to it, as long as they do not hold themselves out as music therapists;

2. other professionals whose training and national certification demonstrate their ability to practice their certified occupation or profession, and whose use of music is incidental to this other practice, as long as they do not hold themselves out as music therapists; and

3. students enrolled in a music therapy or graduate music therapy educational program approved by the American Music Therapy Association or any successor association, in which music therapy is an integral part of the course of study, if performing such therapy under a music therapist's direct supervision.

For art therapists, the bill's restrictions do not apply to:

1. individuals providing art therapy while acting within the scope of practice of their license and training, as long as they do not hold themselves out as art therapists and

2. students enrolled in an art therapy or graduate art therapy educational program approved by the American Art Therapy Association or any successor association, in which art therapy is an integral part of the course of study, if performing such therapy under an art therapist's direct supervision.

§ 37 — HOSPICE FACILITIES AND ZONING

Current law requires local zoning regulations to treat as single-family homes certain DPH-licensed inpatient hospice facilities serving up to six people.

The bill instead requires local zoning regulations to treat as single-family homes certain residences that provide licensed hospice care for up to six people, presumably on an inpatient or outpatient basis. It specifies that this requirement only applies if the residence was built in compliance with the applicable building code for occupancy by six or fewer people who are not capable of self-preservation.

Under existing law, unchanged by the bill, this zoning requirement applies only to such residences that are:

1. managed by a tax-exempt nonprofit organization,
2. served by public sewer and water, and
3. located in a city with more than 100,000 residents within a zone allowing development on one or more acres.

§ 38 — DENTAL ASSISTANTS

The bill establishes a new designation of dental assistant called expanded function dental assistants ("EFDAs"). It changes some of the procedures a dentist can delegate to other dental assistants, allows a dentist to delegate more procedures if the assistant is an EFDA, and specifies the level of supervision required for both types of assistants.

The bill places a number of requirements on EFDAs and the dentists that hire them. It requires dental assistants to receive training in infection control, starting in 2018. It also allows the DPH commissioner to adopt implementing regulations.

Dental Assistant Definitions

The bill defines dental assistants and EFDAs as follows.

"Dental assistant" means a person who has met any requirements

the DPH commissioner establishes through regulations and has completed one of the following: (1) on-the-job training in dental assisting under direct supervision, as defined below, or (2) a dental assistant education program (a) accredited by the American Dental Association's (ADA) Commission on Dental Accreditation or (b) accredited or recognized by the New England Association of Schools and Colleges.

"Expanded function dental assistant" means a dental assistant who has passed the Dental Assisting National Board's (DANB) certified dental assistant or certified orthodontic assistant examination, and then successfully completed:

1. an EFDA program at a higher education institution accredited by the ADA's Commission on Dental Accreditation and

2. a DANB-administered comprehensive written examination on certified preventive and restorative functions.

An EFDA's education program must have included:

1. courses on didactic and laboratory preclinical objectives for skills used by EFDAs, with required demonstration of these skills before advancing to clinical practice;

2. at least four hours of education on the ethics and professional standards for dental professionals; and

3. a comprehensive clinical examination at the program's conclusion.

Supervision Requirement

Current law allows dentists to delegate certain dental procedures to dental assistants, and provides that any such procedures must be performed under the dentist's supervision and control.

Under the bill, if a dental assistant is not an EFDA, any such procedures must be performed under a dentist's direct supervision.

Procedures by EFDAs must be performed under a dentist's direct or indirect supervision.

"Direct supervision" means a dentist has authorized a dental assistant or EFDA to perform certain procedures with the dentist remaining on-site in the office or facility while the procedures are performed and, before the patient leaves, the dentist reviews and approves the assistant's treatment.

"Indirect supervision" means a dentist has personally diagnosed the condition, planned the treatment, authorized the procedures to be performed, remains in the dental office or facility while the assistant or EFDA performs the procedures, and evaluates the assistant's or EFDA's performance.

As under existing law for other dental assistants, the bill requires a dentist supervising an EFDA to assume responsibility for the EFDA's procedures.

Permissible and Impermissible Delegated Functions

The bill makes various changes to the list of procedures that dentists may delegate to assistants.

The bill permits dental assistants to take impressions of a patient's teeth for study models. It prohibits dental assistants from taking final impressions of the teeth or jaws for purposes of fabricating an appliance or prosthesis (current law prohibits them from taking any such impressions, not just final ones).

Current law permits dental assistants to take dental x-rays if the assistant has successfully completed the dental radiography portion of a DANB-prescribed examination. The bill changes this to a DANB-administered dental radiation health and safety exam.

Under current law, dental assistants may not place, finish, or adjust temporary or final restorations, capping materials, and cement bases. The bill allows EFDAs to perform these functions, except it refers to

"long-term individual fillings" rather than "final restorations."

The bill also allows dentists to delegate the following to EFDAs:

1. coronal polishing, as long as the procedure is not represented or billed as prophylaxis;
2. oral health education for patients; and
3. dental sealants.

EFDA Requirements

Under the bill, an EFDA must:

1. maintain dental assistant or orthodontic assistant certification from DANB;
2. conspicuously display the certificate in the place of employment or place where he or she provides EFDA services;
3. maintain professional liability insurance or other indemnity against liability for professional malpractice of at least $500,000 for one person, per occurrence, with an aggregate liability of at least $1.5 million;
4. limit his or her practice to providing services under the indirect or direct supervision of a licensed dentist; and
5. meet any requirements the DPH commissioner establishes through regulations (see below).

Dentist Requirements

Under the bill, each dentist employing an EFDA or otherwise engaging an EFDA's services must:

1. beforehand, verify that the EFDA meets the bill's education, examination, certification, and liability insurance requirements;
2. maintain, on the premises where the EFDA works,

documentation of the EFDA having met these requirements;

3. make the documentation available to DPH upon request; and

4. provide direct or indirect supervision to no more than (a) two EFDAs providing services at one time or (b) four EFDAs providing services at one time if the dentist's practice is limited to orthodontics.

Infection Control

The bill establishes requirements for dental assistants to receive training in infection control. These requirements apply to regular assistants and EFDAs.

Starting on January 1, 2018, the bill:

1. generally prohibits dentists from delegating any dental procedures to a dental assistant who has not provided the dentist a record documenting that he or she passed DANB's infection control examination (but the bill allows EFDAs to perform certain functions even if they do not receive this training);

2. allows an assistant to receive up to nine months' of on-the-job training by the dentist to prepare the assistant for the examination; and

3. requires dentists delegating procedures to an assistant to keep the records documenting passage of the examination for inspection on DPH's request.

Starting on January 1, 2018, the bill also requires dental assistants, after successfully completing DANB's infection control examination, to complete at least one hour of training or education every two years in infection control in a dental setting. This may include courses (including on-line courses) offered or approved by a dental school or another higher education institution that is accredited or recognized by

the Commission on Dental Accreditation; a regional accrediting organization; the ADA; or a state, district, or local dental association or society affiliated with the ADA or the American Dental Assistants Association.

Regulations

The bill authorizes the DPH commissioner, in consultation with the State Dental Commission, to adopt implementing regulations. If the commissioner adopts regulations, they must identify the:

1. types of procedures that a dental assistant and EFDA can perform, consistent with the bill;

2. appropriate number of didactic, preclinical, and clinical hours or number of procedures to be evaluated for clinical competency for each skill an EFDA can employ; and

3. level of supervision required for each procedure an EFDA can perform.

§§ 39-42 — LOCAL HEALTH DEPARTMENTS

Serving in a Full-Time Capacity

The bill requires district health directors to serve in a full-time capacity, instead of devoting their "entire time" to performing the duties of the position, as is required under current law. Existing law requires this of certain municipal health directors (see BACKGROUND).

Additionally, it prohibits (1) district health directors and (2) municipal health directors in towns with a population of at least 40,000 for five consecutive years from having a financial interest or engaging in a job, transaction, or professional activity that substantially conflicts with the director's duties.

By law, a municipal or district health director generally must (1) be a licensed physician and hold a public health degree from an accredited school, college, university, or institution or (2) hold a

graduate public health degree from an accredited school, college, or institution.

EFFECTIVE DATE: July 1, 2016

Impropriety on Behalf of Local Health Department Directors or Employees

The bill requires the DPH commissioner to take certain action if he reasonably suspects impropriety on the part of a municipal or district health director or the director's employee related to the performance of their duties. Specifically, the commissioner must notify the municipal or district health department's governing authority and provide any evidence of such impropriety for the purposes of reviewing and assessing the director's or employee's compliance with their duties.

The governing authority must report its findings to the commissioner within 90 days after completing the review and assessment.

Under the bill, a director's employee includes (1) an employee of, (2) a consultant employed or retained by, or (3) an independent contractor retained by, a municipal or district health department or a director.

Review of Local Health Department Statutes

The bill requires the DPH commissioner to review the statutes related to local health departments to determine if they need revising. He must submit his determination to the Public Health Committee by January 1, 2017.

§ 43 — LIST OF CERTIFIED MEDICAL ASSISTANTS

By law, the DPH commissioner must annually obtain from the American Association of Medical Assistants a list of all state residents on the organization's registry of certified medical assistants. DPH must make the list available to the public. The bill extends this requirement to also include a comparable list from the National Healthcareer Association.

EFFECTIVE DATE: Upon passage

§ 44 — NAIL SALON WORKING GROUP

The bill establishes an eight-member working group to consider matters relating to nail salons and nail technicians' services. These matters may include, among other things:

1. standards for nail salons to protect customers' health and safety;
2. licensure or certification standards for nail technicians, including educational and training requirements;
3. nail technicians' working conditions;
4. fair and equitable business practices; and
5. developing informational publications, in multiple languages as appropriate, to advise nail salon owners and managers of applicable state laws and regulations.

The working group must report its findings and recommendations to the Public Health Committee by January 1, 2017. The group terminates on the date it submits the report or January 1, 2017, whichever is later.

Membership and Procedure

Under the bill, the working group's membership includes the Public Health committee chairs or their designees and one member appointed by each of the six legislative leaders, as follows.

Table 1: Legislative Leaders' Appointments to Nail Salon Working Group

Appointing Authority	*Member Qualifications*
House speaker	Owner of two or more nail salons in Connecticut
Senate president pro tempore	Individual with at least two years' work experience as a nail technician
House	Representative of the Nail and Spa Association of Connecticut

majority leader	
Senate majority leader	Qualifications unspecified
House minority leader	Owner of one nail salon employing fewer than five people
Senate minority leader	Individual with experience working as a nail technician

Appointments must be made no later than 30 days after the bill's passage. Any member of the working group may be a legislator. The appropriate appointing authority fills any vacancy.

The House speaker and Senate president pro tempore must select a chairperson from among the group members. The chairperson must schedule the first working group meeting, which must be held within 60 days after the bill's passage.

EFFECTIVE DATE: Upon passage

§ 45 — MEDICAID OVERPAYMENT AUDITS

The bill allows the Department of Social Services (DSS), in consultation with the Office of Policy and Management (OPM) secretary, to waive recoupment of an audit finding of a Medicaid overpayment made to a hospital that was under prior ownership during part of the audit period.

EFFECTIVE DATE: Upon passage

§ 46 — MEDICAL RECORDS TASK FORCE

The bill establishes a 10-member task force to study the furnishing of medical records by health care providers and institutions. The study must examine the (1) time frame for health care providers or institutions to respond to a request for medical records, (2) cost for research and copies in response to such requests, and (3) requirements of HIPAA regulations concerning individuals' access to their own protected health information.

By January 1, 2017, the task force must report its findings and recommendations to the Public Health Committee. The task force terminates on the date that it submits its report or January 1, 2017, whichever is later.

The task force must include the appointees designated in Table 1. Any of the appointees may be a legislator.

Table 1: Appointed Task Force Members

Appointing Authority	*Number of Appointees*	*Qualifications*
House speaker	2	• One must be a representative of a business that provides health information management services • One must be a member of the Public Health Committee
Senate president pro tempore	2	• one must be a representative of the Connecticut Trial Lawyers Association • one must be a member of the Public Health Committee
House majority leader	1	None specified
Senate majority leader	1	• A patient advocate
House minority leader	2	• One must be a representative of the Connecticut State Medical Society • One must be a member of the Public Health Committee
Senate minority leader	2	• One must be a representative of the Connecticut Hospital Association • One must be a member of the Public Health Committee

The House speaker and the Senate president pro tempore select the chairperson from among the task force members. All appointments must be made and the chairperson must schedule and hold the first meeting within 30 and 60 days, respectively, after the bill's passage. Appointing authorities must fill any vacancies.

EFFECTIVE DATE: Upon passage

§§ 47-50 — OFFICE OF PROTECTION AND ADVOCACY FOR PERSONS WITH DISABILITIES AND THE BOARD OF ADVOCACY AND PROTECTION FOR PERSONS WITH DISABILITIES

Effective July 1, 2017, the bill eliminates the Office of Protection and Advocacy for Persons with Disabilities (OPA) and the Board of Advocacy and Protection for Persons with Disabilities ("the board"). OPA currently (1) provides protection, advocacy, and client assistance functions to people with disabilities and (2) investigates alleged abuse of individuals with intellectual disabilities or receiving services from the Department of Developmental Services' Division of Autism Spectrum Disorder Services. The board currently advises the OPA executive director on matters relating to advocacy policy, client service priorities, and issues affecting persons with disabilities.

The bill also establishes the Connecticut protection and advocacy system ("the system"), which is a nonprofit entity designated by the governor to serve as the state's protection and advocacy system and client assistance program. Under the bill, the system must provide (1) protection and advocacy services for people with disabilities, as provided by federal law and (2) a client assistance program for people with disabilities as provided by federal law. (Certain federal funding is contingent on the state having such a program in place.) Former OPA employees and board members may serve on the system's board or work as a system employee, provided they are not employed by the system while employed by the state.

The bill requires (1) OPM, by October 1, 2016, to issue a request for information from nonprofit entities regarding their ability to serve as the system and (2) the governor to designate an entity to serve as the system by July 1, 2017. For the governor's designation, the bill waives certain state contracting requirements, including those related to privatization contracts and personal service contracts.

It transfers OPA's (1) investigatory responsibilities to the Department of Rehabilitation Services effective July 1, 2017 and (2)

protection and advocacy and client assistance functions to the system, though it allows OPA, prior to its elimination and with OPM approval, to contract out any of its non-investigatory services to one or more non-state entities. For this purpose, the bill waives requirements related to state contracting and privatization of state services.

The bill requires OPA, by November 1, 2016 and in consultation with the board, to submit a plan to the OPM secretary that (1) is consistent with state and federal law, (2) provides for the effective transfer, by July 1, 2017, of OPA's protection, advocacy and client assistance program functions to a nonprofit entity, and (3) includes any proposed legislative changes. Any work in progress, other than investigations, on July 1, 2017, must be completed by the system in accordance with federal regulations and in the same manner and with the same effect as if OPA completed it prior to its elimination.

EFFECTIVE DATE: Upon passage, except for the provision that eliminates OPA and the board, which is effective July 1, 2017.

§ 51 — DIABETES ADVISORY COUNCIL

The bill establishes, within available appropriations, a Diabetes Advisory Council within DPH. The council must (1) analyze the current state of diabetes prevention, control, and treatment in Connecticut and (2) advise DPH on methods to achieve the federal Centers for Disease Control and Prevention's goal in granting funds to the state for diabetes prevention. It consists of state officials and appointees.

Duties

The bill requires the council to make recommendations to enhance and support diabetes prevention, control and treatment programs. To do this, the council must review the following:

1. strategies to identify and enroll individuals at risk of diabetes in prevention programs;

2. strategies to identify and refer individuals with diabetes for

enrollment in formal education classes and management programs;

3. the status of health care organizations reporting on clinical quality measures related to diabetes control;

4. existing state programs that address prevention, control, and treatment; and

5. evidence that supports the need for such programs.

Additionally, the bill permits the council to study the (1) effectiveness of existing state diabetes programs; (2) financial impact of diabetes on the state, including disease prevalence and the cost for administering related programs; and (3) coordination of state agency programs and other efforts to prevent, control, and treat diabetes.

The council may also develop an action plan with steps to reduce diabetes impact on the state, including expected outcomes for each step toward prevention, control, and treatment.

Lastly, the bill requires the council, by January 1, 2017, to submit a progress report on its findings and recommendations to the Public Health Committee. It must then report final findings and recommendations to the committee by May 1, 2017. The council terminates on the date it submits the final report or January 1, 2018, whichever is later.

Membership

The state officials on the council are the social services commissioner, comptroller, executive directors of the Latino and Puerto Rican Affairs and African-American Affairs Commissions, and Public Health Committee co-chairs, or their designees. Under the bill, one of the Public Health Committee co-chairs' designees may be a legislator.

The bill requires the DPH commissioner to appoint the following

council members within 90 days after the bill's passage:

1. two DPH representatives;
2. one member of the Connecticut Alliance of Diabetes Educators;
3. one diabetes prevention advocate;
4. one representative each from two locations of the Young Men's Christian Association in the state that provide a diabetes prevention program;
5. one representative of an insurance carrier that covers Connecticut residents;
6. one representative each from two federally qualified health centers;
7. one representative of the Connecticut State Medical Society;
8. one representative of an accountable care organization;
9. one primary health care provider who is not employed by a hospital, federally qualified health center, or accountable care organization;
10. two representatives of a research and bioscience manufacturer with expertise in metabolic diseases; and
11. any additional member the commissioner determines would be beneficial to serve on the council.

The members must elect a chairperson from among its membership. A majority of council members constitutes a quorum and any action the council takes requires a majority vote of those present.

Council members are not compensated, but are reimbursed for necessary expenses incurred in performing their duties.

EFFECTIVE DATE: Upon passage

§ 52 — FUNERAL DIRECTORS AND EMBALMERS

Under existing law, DPH may take disciplinary action against a funeral director or embalmer for various reasons, including fraud or deceit in obtaining or attempting to obtain a license, registration, or inspection certificate.

Notwithstanding these provisions, the bill prohibits DPH from revoking or suspending the license of a funeral director or embalmer for the reason noted above before April 1, 2017 if the individual completed an examination as part of a program in funeral directing and embalming at a higher education institution that lost its accreditation within 24 months of the bill's passage.

EFFECTIVE DATE: Upon passage

§ 53 — REPEALER

The bill repeals laws:

1. establishing within DPH a birth defects surveillance program, within available funds, and specifying the confidentiality of information collected by the program (CGS §§ 19a-56a and -56b);

2. allowing DPH to provide loans for the purchase of in-home hemodialysis machines (CGS § 19a-57); and

3. requiring DPH to appoint an advisory panel on the regulation of nurse-midwives (CGS § 20-86d).

BACKGROUND

Local Health Departments

Connecticut has 73 local health departments, of which 53 are full-time departments and 20 are part-time. The full-time departments include 33 individual municipal health departments and 20 health district departments (multi-town departments serving from two to 20

towns).

Municipal Health Directors

By law, a municipal health director in a town with a population of at least 40,000 for five consecutive years must serve in a full-time capacity. But the director may serve part-time if the town also designates him or her as the chief medical advisor for its public schools.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 27 Nay 1 (03/21/2016)