PA 18-168—sHB 5163
Public Health Committee

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

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§ 85 — REPEALER

Repeals certain outdated or obsolete statutes

SUMMARY: This act makes various substantive, minor, and technical changes in Department of Public Health (DPH)-related statutes and programs.
EFFECTIVE DATE: October 1, 2018, except as otherwise noted below.

§ 1 — TECHNICAL CHANGE

Makes a technical change by correcting a statutory citation

The act makes a technical correction in a statutory citation in the tumor registry statute.

§§ 2 & 3 — NONDISCLOSURE OF PERSONNEL RECORDS

Prohibits DPH from disclosing personnel records it receives during an investigation

The act prohibits DPH, unless required by federal law, from disclosing personnel records it receives during an investigation of a person DPH licenses, certifies, or regulates. It provides that such records are not subject to disclosure under the Freedom of Information Act (FOIA). These provisions already apply to patient medical records DPH receives during an investigation or disciplinary proceeding of such a person.

§§ 4 & 82 — DENTAL HYGIENISTS

Allows dental hygienists with at least two years' experience to practice without a dentist's general supervision at senior centers, managed residential communities, or child care centers

The act permits dental hygienists with two years of experience to practice without a dentist's general supervision at senior centers, managed residential communities, or licensed child care centers. Hygienists with two years of experience can already practice without such supervision at DPH-licensed health care institutions; community health centers; group homes; schools; preschools

operated by local or regional school boards; Head Start programs; and programs offered or sponsored by the Women, Infants, and Children (WIC) program (collectively, "public health facilities").

As is already the case for such practice at other public health facilities, the act requires hygienists practicing at senior centers, managed residential communities, or licensed child care centers to refer to a dentist any patients with needs outside of the hygienist's scope of practice (CGS § 20-126*l*(f)).

Under existing law, a dental hygienist may substitute eight hours of volunteer practice at a public health facility for one hour of continuing education, up to a maximum of five hours in a two-year period (CGS § 20-126*l*(g)). This applies under the act to volunteer practice at senior centers, managed residential communities, or child care centers.

Under existing law and the act, managed residential communities are facilities consisting of private residential units that provide a managed group living environment for persons who are primarily 55 years old or older (e.g., assisted living facilities). The term does not include state-funded congregate housing facilities.

EFFECTIVE DATE: October 1, 2018, except the provision on child care centers is effective July 1, 2018.

§ 5 — SCHOOL-BASED HEALTH CENTER (SBHC) ADVISORY COMMITTEE

Adds three members to the school-based health center advisory committee

The act adds three members to the SBHC Advisory Committee, increasing its membership to 20.

The act adds to the committee the Department of Children and Families commissioner or her designee. It also adds two members, appointed by the DPH commissioner, from municipalities that operate SBHCs — one from a municipality with a population of at least 50,000 but under 100,000, and the other from a municipality with a population of at least 100,000. Under existing law, the commissioner also appoints a third member who represents an SBHC sponsored by a local health department.

By law, the committee advises the DPH commissioner on minimum service standards and other matters concerning SBHCs and expanded school health sites.

§ 6 — DEATH CERTIFICATES

Expands access to data on a death certificate except for the decedent's social security number

The act allows any adult to access all data listed on a death certificate, however it continues to restrict access to the social security number by only providing it to certain parties, as under prior law. Under the act, for deaths occurring on or after July 1, 1997, the administrative purposes section of a death certificate includes only the decedent's social security number, and only the following parties can access the full death certificate with that section:

1. the parties listed on the certificate (e.g., the funeral director, physician, and

town clerk), for purposes of processing it, and

2. the surviving spouse, next of kin, and state and federal agencies authorized by federal law.

The act requires DPH to remove or redact the social security number when providing a death certificate to any other individual, researcher, or state or federal agency.

Under prior law, the administrative purposes section also included the decedent's occupation, business or industry, race, Hispanic origin if applicable, and educational level, if known. Prior law allowed (1) only the parties listed above to access the full information in the administrative purposes section and (2) researchers to access such information, other than the social security number.

§§ 7-9 — ASTHMA PROGRAM

Consolidates certain DPH reporting requirements related to asthma screening and makes related changes

Prior law required DPH to (1) annually report on the status and results of the department's asthma monitoring system and statewide asthma plan and (2) report every three years on the asthma screening information provided to DPH by school districts (i.e., the total number of students per school and per district with asthma upon enrollment and in specified grades). The act eliminates the annual report and instead incorporates, into the triennial report, information on the asthma monitoring system's activities.

It extends the due date for the next triennial report from October 1, 2019, to October 1, 2021. It requires DPH, starting by that date and every three years after that, to post on its website the asthma monitoring system's activities, including the information the department collects from school districts.

The act also removes certain specific requirements for the asthma monitoring system, such as that (1) it include reports of asthma visits and the number of people with asthma, as voluntarily reported by health care providers, and (2) the commissioner use the system to estimate the annual incidence and distribution of asthma in the state, including based on certain demographic criteria.

The act also removes certain obsolete provisions and makes other technical changes.

§ 10 — SCHOOL SOCIAL WORKERS

Specifies that school social workers with the appropriate credentials may use that title, even if they are not licensed by DPH

The act specifies that if someone holds a professional educator certificate with a school social worker endorsement, the person may use the title "school social worker" to describe his or her activities while working at a public or private school, even if the person is not licensed as a social worker by DPH.

§ 11 — CORRECTION PLAN

Gives a health care institution more time to submit a correction plan after receiving a notice of noncompliance

Under existing law, a licensed health care institution must submit a correction plan to DPH if the department, after an inspection, issues a notice that the institution is out of compliance with applicable laws or regulations. The act requires the institution to submit the plan within 10 business days after receiving the notice of noncompliance, rather than 10 calendar days, as under prior law.

§§ 12 & 13 — HEALTH CARE ASSOCIATED INFECTIONS

Expands the scope of DPH's mandatory reporting system for health care associated infections, adds to the membership of the advisory committee on such matters, and makes related changes

Mandatory Reporting System

The act expands the scope of DPH's mandatory reporting system for health care associated infections to include antimicrobial resistance. It specifies that the system must be based on nationally recognized and recommended standards.

In practice, under the existing program, DPH collects data on health care associated infections at acute care and long-term acute care hospitals, inpatient rehabilitation facilities, and outpatient dialysis facilities. The act expands the program to include other health care facilities.

Prior law required DPH to (1) annually report to the Public Health Committee on the information collected through the system, (2) make such reports available online, and (3) post online information on health care associated infections to help the public learn about them and compare infection rates at Connecticut facilities. The act eliminates the annual reporting requirement, and instead requires DPH to annually post on its website the information it collects through the mandatory reporting system. It requires such information to include:

1. the number and type of health care associated infections and antimicrobial resistance reported by each health care facility (prior law required the report to include the number and type of such infections, including certain specific types);
2. links to the National Centers for Disease Control and Prevention's health care associated infection data reports and the federal Centers for Medicare and Medicaid Services' (CMS) quality improvement program website (prior law required DPH's website to include a link to CMS's hospital compare website); and
3. information to help the public learn about health care associated infections and antimicrobial resistance and how to prevent them.

Advisory Committee

Under existing law, an advisory committee advises DPH on the health care associated infection monitoring program. To correspond with the program's expanded scope, the act renames the committee as the "advisory committee on health care associated infections and antimicrobial resistance" and makes conforming changes to the scope of the committee's charge. It also adds the

following 10 members to the committee, to be appointed by the DPH commissioner:

1. two members each representing outpatient hemodialysis centers, long-term acute care hospitals, nursing home facilities, and surgical facilities; and
2. one member each representing the Connecticut Infectious Disease Society and a clinical microbiology laboratory.

The act specifies that the committee may meet upon the commissioner's request. It also eliminates from the committee's purview recommending appropriate methods to increase public awareness about how to reduce the spread of infections.

§ 14 — QUALITY OF CARE PROGRAM

Eliminates the requirement for the DPH commissioner to annually report on the department's quality of care program

The act eliminates the requirement for the DPH commissioner to annually report on DPH's quality of care program to the governor and Public Health Committee. It also removes certain obsolete provisions on one-time reporting requirements.

§ 15 — DONATED PROPERTY

Eliminates a requirement that DPH report on certain matters related to donated property

The act eliminates the requirement that DPH annually report on certain matters related to real estate or other property donated to the department, such as the donors' names and how the property is being used.

§ 16 — NURSING HOME AND RESIDENTIAL CARE HOME INFORMATION

Eliminates a requirement for DPH to annually publish a report on nursing homes and residential care homes and instead requires the department to post certain related information online

The act eliminates a requirement for DPH to annually publish a report that lists and classifies all nursing homes and residential care homes in the state, and instead requires the department to post the information on its website.

It requires the posted information to include the number and effective date of the license and the address for each such facility. It does not require other information previously required for the published report, such as the total number of beds; number of private and semiprivate rooms; religious affiliation, and any religious services offered in the facility; and per diem cost for private patients.

§ 17 — EMERGENCY MEDICAL SERVICES (EMS) DATA

Requires the DPH commissioner to adopt specified national standards for trauma data collection and provides that an existing reporting requirement applies annually starting by December 31, 2018

Existing law requires the DPH commissioner to report to the Emergency Medical Services Advisory Board on specified EMS call data categorized by municipality, such as the total number of calls by each ambulance or paramedic intercept service, the EMS level required for each call, and response times. The act requires the commissioner to report the data annually, starting by December 31, 2018.

It also requires the commissioner, with the board's recommendation, to adopt for use in trauma data collection the most recent version of the National Trauma Data Bank's National Trauma Data Standards and Data Dictionary and nationally recognized guidelines for field triage of injured patients.

§ 18 — DENTIST LICENSURE BY ENDORSEMENT

Allows DPH to issue a dentist license without examination to a dentist licensed in another state who has worked as such for the past five years, even if the other state does not require a practical examination for licensure

Under prior law, DPH could issue a license, without examination, to a dentist licensed in another state or territory, provided the other jurisdiction's licensure requirements were similar to or higher than Connecticut's. The act instead allows DPH to issue a license without examination to a dentist licensed and practicing in another state or territory if he or she:

1. holds a license issued after examination by another state with licensing standards that, except for the practical examination, are commensurate with Connecticut's standards and
2. has worked continuously as a licensed dentist in an academic or clinical setting in another state or territory for at least five years immediately preceding the application for licensure without examination.

§ 19 — LEAD TRAINING PROVIDERS AND ASBESTOS TRAINING PROVIDERS

Specifies that lead training providers and asbestos training providers must apply to renew their certificates during the anniversary month of their initial certification

By law, lead training providers and asbestos training providers must be certified by DPH, subject to annual renewal. The act specifies that they must apply for renewal during the anniversary month of their initial certification.

§§ 20-23 — MODEL FOOD CODE

Exempts certain residential care homes from the food code's requirements and modifies the definition of a class 1 food establishment to, among other things, prohibit such an establishment from selling commercially prepackaged food that is not time or temperature controlled

PA 17-93 required DPH, by July 1, 2018, to adopt the federal Food and Drug Administration's (FDA) Food Code as the state's food code for regulating food establishments. As noted below, the act extends the deadline to January 1, 2019 (see §§ 46-48).

The act exempts certain licensed residential care homes from the food code's requirements. Specifically, it exempts those with 30 or fewer beds, as long as the home's administrator or his or her designee has passed a test as part of a food protection manager certification program approved by an accrediting agency that the Conference for Food Protection recognizes as conforming to its accreditation standards. The exemption does not apply to such a home that (1) enters into a service contract with a food establishment or (2) lends, rents, or leases any area of its facility to any person or entity for the purpose of preparing or selling food.

Under existing law, there are four classifications of food establishments in the food code. The act amends the definition of a class 1 establishment to prohibit these establishments from serving a population that is highly susceptible to foodborne illnesses. The act specifies that if such an establishment offers for sale commercially prepackaged, precooked food that is time or temperature controlled and heated, it must be served within four hours after heating.

The act makes additional minor changes to the definitions of a class 1 and 3 establishment and makes other minor and technical changes to certain provisions related to the food code.

§§ 24-29 — TECHNICAL CHANGES TO TERMINOLOGY

Replaces statutory references to "venereal disease" with references to "sexually transmitted disease"

The act makes technical changes by replacing several statutory references to "venereal disease" with "sexually transmitted disease."

§§ 30-33 — FUNERAL HOME LICENSES AND INSPECTIONS

Updates terminology related to funeral home licensure and decreases the required frequency of DPH inspections of funeral homes

Under prior law, a funeral service business could not operate unless it received a DPH-issued "inspection certificate." The act replaces the term inspection certificate with "funeral home license."

It also decreases the required frequency of DPH inspections of funeral homes, from annually to at least once every three years.

§§ 34-39 — ADVANCED PRACTICE REGISTERED NURSES (APRNS) AND ADVANCE DIRECTIVES

Adds APRNs into the laws on living wills and other advance directives

The act incorporates APRNs into the laws on living wills and other advance directives. In doing so, it extends to APRNs the authority to perform certain functions that under prior law could be performed only by a physician or, in some cases, other specified providers.

For example, prior law provided that a living will or appointment of a health care representative became operative when the document was given to the attending physician and the physician determined the person to be incapacitated.

The act provides that such a document also takes effect when given to a patient's APRN who determines the person to be incapacitated.

The act makes several corresponding and conforming changes. For example, it adds references to APRNs into the law's standard forms for advance directives (e.g., form language stating that the patient's APRN, not just physician as under prior law, may rely on the document's health care instructions and decisions made by the patient's health care representative).

It provides in the forms that an APRN, not just a physician, may make the determination that a patient is suffering from a terminal condition. It makes a corresponding change to the definition of "terminal condition" for these purposes (see § 34).

Prior law provided that, if a resident of a facility operated or licensed by the Department of Mental Health and Addiction Services or Department of Developmental Services sought to execute a document appointing a health care representative, at least one witness had to be a physician or clinical psychologist with specialized training in treating mental illness or developmental disabilities, respectively. In both situations, the act adds APRNs to the list of eligible witnesses (§ 37).

§ 40 — INSTITUTIONAL LICENSING APPLICATIONS

Prohibits DPH from requiring that a health care institution licensure application be notarized

The act prohibits DPH from requiring that a health care institution licensure application be notarized.

§ 41 — CONFORMING CHANGE

Makes a conforming change

The act makes a conforming change to reflect a statutory repeal in § 85.

§§ 42-45 — MARRIAGE AND FAMILY THERAPIST, PROFESSIONAL COUNSELOR, AND PSYCHOLOGY STUDENTS

Modifies the length of time during which marriage and family therapist, professional counselor, and psychology students may practice without a license in order to complete the supervised work experience required for licensure

By law, students who graduate with advanced degrees in marital and family therapy (MFT), professional counseling, or psychology may practice without a license in order to complete the supervised work experience required for licensure, but only if supervised by a person licensed in their respective profession.

The act permits these graduates to practice in this unlicensed capacity for up to two years after completing the supervised work experience, if they failed the respective licensing examination.

Under prior law, professional counseling and psychology students could practice in this manner until they were notified that they failed the respective

licensing examination, or one year after completing the supervised work experience, whichever occurred first. For MFT students, prior law did not specify that the licensure exemption ended on the earlier of these two dates.

The act also makes technical changes.

§§ 46-49 — MODEL FOOD CODE

Extends until January 1, 2019, the date by which DPH must adopt and administer the FDA Model Food Code as the state's food code for regulating food establishments; requires food establishments to designate an alternate person to be in charge when their certified food protection manager is absent

Implementation Date (§§ 46-48)

The act extends by six months, from July 1, 2018, to January 1, 2019, the date by which DPH must adopt and administer the FDA's Food Code, and any published supplements, as the state's food code for regulating food establishments. Currently, DPH regulates these establishments under the Public Health Code.

The act makes related conforming changes to provisions:

1. requiring food inspectors to obtain certification from DPH after meeting specified education and training requirements and
2. allowing food establishments to request from DPH a variance from Public Health Code requirements in order to use the sous vide cooking technique or acidify sushi rice, as an alternative to temperature control.

EFFECTIVE DATE: Upon passage

Certified Food Protection Managers (§ 49)

By law, Class 2, Class 3, and Class 4 food establishments must employ a "certified food protection manager." To be designated as such, the person must pass an exam that is part of a certification program evaluated and approved by an accrediting agency recognized by the Conference for Food Protection.

The act requires a food establishment's owner or manager to designate an alternate person to be in charge whenever the certified food protection manager is absent. The alternate person must ensure that:

1. all employees comply with the act's provisions,
2. foods are safely prepared in accordance with the Model Food Code's requirements,
3. emergencies are properly managed,
4. a food inspector is admitted to the establishment upon request, and
5. he or she receives and signs inspection reports.

EFFECTIVE DATE: July 1, 2018

§ 50 — OFFICE OF ORAL PUBLIC HEALTH

Expands eligibility criteria to qualify as DPH's Office of Oral Public Health director

Under prior law, the director of DPH's Office of Oral Public Health had to be a licensed dentist or dental hygienist with public health experience. The act also

allows someone with the following qualifications to serve as the director:

1. a person with a Doctor of Medicine or Doctor of Osteopathy degree from an accredited higher education institution or
2. a public health professional with a graduate degree in public health.

§ 51 — LONG-TERM CARE FACILITY BACKGROUND SEARCH PROGRAM

Exempts records and information from DPH's long-term care facility background search program from disclosure under the Freedom of Information Act; exempts from the program's requirements certain intermediate care facilities for individuals with intellectual disabilities

By law, DPH administers a comprehensive criminal history and patient abuse background search program that facilitates the performance, processing, and analysis of background searches on people who have direct access to long-term care facility residents (i.e., employees and volunteers). The act exempts DPH background search program records and information from disclosure under FOIA.

Under prior law, long-term care facilities subject to the program's requirements included home health agencies, assisted living agencies, chronic disease hospitals, DPH-licensed or federally certified agencies providing hospice care, nursing homes, and intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs). The act exempts ICF-IIDs operated by a Department of Developmental Services (DDS) program already subject to background checks under existing law (see § 52).

The act also makes technical changes, including eliminating obsolete provisions requiring DPH to develop a plan to implement the program.

EFFECTIVE DATE: July 1, 2018

§ 52 — DDS FACILITY BACKGROUND SEARCH PROGRAM

Subjects DDS job applicants who will provide direct care services to fingerprint and national criminal background checks, in addition to state background checks; permits DDS to require state criminal background checks for DDS-licensed or –funded private providers; allows DDS and private providers to conditionally employ applicants while waiting for required background check results

Existing law requires DDS to conduct state criminal background checks on any job applicant who will provide direct services to people with intellectual disability. The act also subjects these job applicants to fingerprint and national criminal background checks.

Prior law allowed, but did not require, DDS to subject private subcontractors to state criminal background checks. The act instead permits DDS to subject private providers licensed or funded by the department to such background checks.

Prior law prohibited DDS and private providers from hiring an applicant until the results of a required background check were available. The act instead allows DDS and private providers to employ such applicants on a conditional basis until they receive and review the background check results.

§ 53 — NUCLEAR MEDICINE TECHNOLOGISTS

Modifies the certification examination requirements for nuclear medicine technologists to operate certain CT or MRI equipment

Existing law specifies that the radiographer licensure statutes do not prohibit a nuclear medicine technologist from fully operating a computed tomography (CT) or magnetic resonance imaging (MRI) portion of a hybrid-fusion imaging system, including diagnostic imaging, in conjunction with a (1) positron emission tomography or (2) single-photon emission CT imaging system.

To do this, the technologist must (1) hold and maintain in good standing CT or MRI certification from the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) and (2) have successfully completed the individual certification exam for CT or MRI. The act allows technologists to complete the certification exam administered by NMTCB, instead of just ARRT.

EFFECTIVE DATE: Upon passage

§ 54 — PHYSICIAN ASSISTANT (PA) ORDERS

Specifies that a PA lacks the authority to order an APRN to administer a controlled substance

The act specifies that a PA does not have the authority to order an APRN to administer a controlled substance.

EFFECTIVE DATE: Upon passage

§ 55 — ALCOHOL AND DRUG COUNSELORS

Modifies the definition of "alcohol and drug counseling" to distinguish between licensed and certified counselors; makes other minor and technical changes to licensure requirements

The act makes various changes, mostly minor and technical, to update statutory definitions and licensure requirements for alcohol and drug counselors.

Definitions

The act modifies the definition of "alcohol and drug counseling" to distinguish between the scope of practice of alcohol and drug counselors who are licensed and those who are certified. It permits licensed alcohol and drug counselors to, among other things:

1. clinically evaluate substance use and co-occurring disorders (i.e., a psychiatric or medical disorder combined with a substance use disorder) and
2. as under existing law, conduct substance use disorder screenings and risk assessments, and develop related treatment plans and referrals.

The act specifies that certified alcohol and drug counselors may apply methods to assist an individual or group to develop an understanding of alcohol and drug dependency problems, define goals, and plan action reflecting the individual's or group's interests, abilities, and needs.

Licensure

By law, to become a certified or licensed alcohol or drug counselor, an individual must, among other requirements, complete (1) 300 hours of supervised practical training in alcohol and drug counseling and (2) three years of supervised paid work experience or unpaid internship that involved direct client work (a master's degree may be substituted for one year of such experience). The act specifies that the supervisor must be a licensed alcohol and drug counselor or other licensed mental health professional whose scope of practice includes the screening, assessment, diagnosis, and treatment of substance use disorders and co-occurring disorders.

The act also makes minor and conforming changes.

§ 56 — TOBACCO AND HEALTH TRUST FUND BOARD

Requires the Tobacco and Health Trust Fund Board to report to the legislature only following a fiscal year when it receives a deposit from the Tobacco Settlement Fund, instead of annually; eliminates the requirement that the board meet at least biannually

Prior law required the Tobacco and Health Trust Fund Board to report (1) its activities and accomplishments to the Appropriations and Public Health committees by January 1 annually and (2) all disbursements and expenditures and an evaluation of fund recipients' performance and impact to the legislature by February 1 annually. The act instead requires the board to submit these reports only following a fiscal year in which the trust fund receives a deposit from the Tobacco Settlement Fund.

The act also eliminates prior law's requirement for the 17-member board to meet at least biannually.

§ 57 — ACKNOWLEDGMENTS OF PATERNITY

Allows the guardian of a person who is the subject of an acknowledgment of paternity to obtain a certified copy of the form

The act allows the legal guardian of a person whose birth is the subject of an acknowledgment of paternity to obtain a certified copy of the acknowledgment.

Existing law only allows certain parties to access the acknowledgment, including the parents named on the form, the person whose birth is acknowledged if an adult, attorneys representing the person or parent named on the form, and authorized government agencies. By law, DPH must maintain a paternity registry, which includes such voluntary acknowledgements and court-ordered adjudications of paternity (CGS § 19a-42a(a)).

EFFECTIVE DATE: July 1, 2018

§§ 58-60 — MUNICIPAL AND DISTRICT HEALTH DEPARTMENTS

Expressly permits a health district to join an existing health district; makes technical changes to statutes on municipal and district health departments

The act expands a health district's powers to include the ability to join an

existing health district. Existing law already allows municipalities to join or form a district health department.

The act also makes numerous technical changes to statutes on municipal and district health departments.

§§ 61 & 62 — PUBLIC WATER SYSTEMS

Requires small community water systems to submit to DPH a fiscal and asset management plan for all their capital assets; requires the DPH commissioner to publish a schedule of civil penalties imposed against water companies, instead of adopting them in regulations; and establishes related notification and public hearing requirements

The act makes various changes affecting public water systems and the oversight of small community water systems (i.e., those regularly serving between 25 and 1,000 year-round residents). Among other things, it requires (1) small community water systems to submit to DPH a fiscal and asset management plan for all their capital assets and (2) the DPH commissioner to at least annually publish a schedule of civil penalties imposed against water companies under the safe drinking water statutes, instead of adopting them in regulations as under prior law.

Under the act, as under existing law, "water company" means any individual, municipality, or entity that owns, maintains, operates, manages, controls, or employs any pond, lake, reservoir, well, stream, or distributing plant or system that supplies water to two or more consumers or to 25 or more people on a regular basis.

The act also makes technical and conforming changes.

Fiscal and Asset Management Plans

The act requires each small community water system to prepare a fiscal and asset management plan for all of the system's capital assets. The fiscal and asset management plan must include:

1. a list of all of the system's capital assets;
2. the assets' (a) useful life, based on their current condition, (b) maintenance and service history, and (c) manufacturer's recommendation;
3. the system's plan for reconditioning, refurbishing, or replacing the assets; and
4. information on (a) whether the system has any unaccounted for water loss (i.e., water supplied to its distribution system that never reached consumers), (b) the amount and cause of such unaccounted water loss, and (c) measures the system is taking to reduce it.

The act requires the water system to begin creating the plan by assessing its hydropneumatic pressure tanks as its initial priority.

Under the act, the "useful life" of a water system's capital asset means the manufacturer's recommended life or the estimated lifespan, taking into consideration the asset's service history and condition when the fiscal and asset management plan is prepared.

Deadline. The act requires small community water systems to complete the

fiscal and asset management plan by January 1, 2021. But they must first complete an assessment review of their hydropneumatic pressure tanks by May 2, 2019, on a form DPH prepares.

The act also requires small community water systems to update the fiscal and asset management plan annually and make it available to DPH upon request.

Exceptions. The plan requirement does not apply to a small community water system that is (1) regulated by the Public Utilities Regulatory Authority (i.e., investor-owned water companies), (2) required to submit a water supply plan to DPH (e.g., generally those serving 1,000 or more people or 250 or more customers), or (3) a state agency.

The act deems the report requirement to relate to the purity and adequacy of water supplies for the purpose of imposing a penalty for violating statutory or regulatory requirements regarding public water supply purity, adequacy, or testing described further below.

Regulations. The act authorizes the DPH commissioner to adopt regulations to implement the fiscal and asset management plan requirement.

Civil Penalties

Publishing Civil Penalty Schedule. Prior law required the DPH commissioner to adopt regulations establishing a schedule of civil penalties that may be imposed against water companies that violate state laws and regulations regarding the purity, adequacy, and testing of public water supplies.

The act instead requires the commissioner to publish the civil penalty schedule on the department's website if the penalty for a violation has not been established by statute. The commissioner must do this annually, or when he deems it necessary in response to any guidelines or rules issued by the federal Environmental Protection Agency.

Notwithstanding the Uniform Administrative Procedure Act (UAPA), the act does not require the commissioner to adopt or revise any regulations for imposing these civil penalties.

At least six months before publishing the civil penalty schedule on the DPH website, the commissioner must publish a notice in the Connecticut Law Journal of his intention to do so. The notice must include (1) the civil penalty schedule, (2) the date the commissioner intends to hold a public hearing on the matter, and (3) when the commissioner will receive public comments on the schedule. He must hold the hearing and receive public comments on the civil penalty schedule within 30 days after publishing the notice.

The act requires the commissioner to consider the public comments he receives when establishing the civil penalty schedule and publish his response to these comments on the department's website at least one month before publishing the schedule.

Notice of Violations. By law, the DPH commissioner must notify a water company before imposing a civil penalty for failing to correct a violation by a specified date. He may do this by certified mail, return receipt requested, or personal service. The act specifies that for the latter, the notification must be served to the address the water company filed with the department, or if the water

company failed to do so, the company's last known address on file.

If the civil penalty is imposed for a continuing violation, the act requires the notice to include the initial date the penalty is imposed. For an isolated violation, the notice must include the date for which it is imposed. By law, the notice must include additional information, such as a statement of the violation and the water company's right to a hearing.

Administrative Appeal. By law, a water company can contest the penalty by applying to the DPH commissioner for an administrative hearing under the UAPA within 20 days after receiving notice of the penalty. The act requires the application to include a detailed statement of all the grounds for contesting the penalty.

Existing law, unchanged by the act, requires the water company to send a copy of the application to the health director of the municipalities in which the violation occurred or that use the water that was the subject of the violation. A water company aggrieved by a DPH order may appeal to Superior Court.

§§ 63-66 — MASSAGE THERAPISTS

Starting October 1, 2019, modifies the education and training requirements for massage therapist licensure; establishes minimum professional liability insurance requirements; and generally allows out-of-state massage therapists to provide voluntary services at the invitation of the emergency division of the American Massage Therapy Association Connecticut Chapter's Community Service Massage Team

The act makes various changes affecting massage therapists, including (1) modifying education and training licensure requirements; (2) establishing minimum professional liability insurance requirements; and (3) generally allowing out-of-state massage therapists to provide voluntary, supervised services at the invitation of the emergency division of the American Massage Therapy Association (AMTA) Connecticut Chapter's Community Service Massage Team.

EFFECTIVE DATE: October 1, 2019, except that the provision on voluntary services by out-of-state massage therapists takes effect October 1, 2018.

Massage Therapist Licensure

Starting October 1, 2019, the act increases, from 500 to 750, the number of classroom hours an applicant for an initial license or a license by endorsement (i.e., a person licensed by another state) must complete upon graduating from an accredited massage therapy school.

It also requires such applicants to complete at least 60 hours of unpaid, supervised clinical or internship experience.

Existing law, unchanged by the act, also requires licensure applicants to (1) pass a national examination prescribed by DPH and (2) pay a $375 application fee.

Professional Liability Insurance

The act requires licensed massage therapists who provide direct patient care to maintain professional liability insurance of at least $500,000 per person, per

occurrence, and at least $1 million aggregate.

Starting January 1, 2019, insurers who provide such policies must annually report to DPH the names and addresses of massage therapists who, in the prior year, canceled or refused to renew their professional liability insurance policies as well as their reasons for doing so. The act also requires such insurers to provide similar information to the Department of Insurance by March 1 annually.

Volunteer Services by Out-of-State Massage Therapists

The act allows massage therapists licensed in other states to provide voluntary, supervised massage therapy services if they:

1. are (a) licensed or certified in another state whose standards are equivalent or greater than Connecticut's or (b) if the state does not require such licensure or certification, AMTA members in good standing;
2. are invited by the emergency division of the AMTA Connecticut Chapter's Community Service Massage Team; and
3. do not hold themselves out to be licensed in Connecticut.

Prior law already allowed out-of-state massage therapists to provide such services to participants in the Special Olympics or other athletic competition for individuals with disabilities. The act limits such services only to the individuals with disabilities at these events.

§ 67 — DOCTORS OF PHYSICAL THERAPY

Prohibits anyone without the proper credentials from referring to himself or herself as a "Doctor of Physical Therapy" or "D.P.T."

The act prohibits anyone from using the term "Doctor of Physical Therapy" or the letters "D.P.T." unless the person is licensed as a physical therapist and has a Doctor of Physical Therapy degree from an accredited higher education institution. A violation is a class D felony (see Table on Penalties) (CGS § 20-73(c)).

EFFECTIVE DATE: July 1, 2018

§ 68 — AMNIOTIC FLUID EMBOLISM

Requires DPH, by January 1, 2019, to develop and post on its website educational materials for health care professionals on the signs and symptoms of amniotic fluid embolism and distribute them to specified health care entities by July 1, 2019

The act requires DPH to develop and post on its website materials to educate health care professionals on the signs and symptoms of amniotic fluid embolism (AFE) (see below). The department must do this by January 1, 2019, and in consultation with (1) the AFE Foundation and (2) a licensed physician specializing in obstetrics and gynecology who is recommended by the Connecticut State Medical Society.

Under the act, DPH must distribute the educational materials by July 1, 2019, to the following entities to distribute to their members and post on their websites: the Connecticut State Medical Society, American College of Nurse-Midwives'

Connecticut Affiliate, Connecticut Advanced Practice Registered Nurse Society, Connecticut Nurses Association, and Connecticut Hospital Association. DPH must also provide the materials to each Connecticut medical school for dissemination to its students.

The act also requires DPH to provide the educational materials to the Public Health Committee by July 1, 2019.

Finally, the act provides that its provisions cannot be construed to override professional medical judgment or restrict the use of other educational or instructional materials.

AFE is a pregnancy complication that is unpreventable and often fatal. It occurs when the mother or baby experiences an allergic-like reaction to amniotic fluid entering the mother's circulatory system. Among other things, the condition may cause rapid respiratory failure, cardiac arrest, and hemorrhaging at the site of the placental attachment or cesarean incision.

EFFECTIVE DATE: Upon passage

§§ 69-71 —ANKLE SURGERY BY PODIATRISTS

Changes the process and qualifications for licensed podiatrists seeking to engage in independent ankle surgery and qualifications to engage in supervised ankle surgery and makes related changes

The act:

1. modifies the process and qualifications for podiatrists seeking to independently engage in ankle surgery;
2. modifies the qualifications for podiatrists seeking to engage in supervised ankle surgery;
3. specifies that a podiatrist's privileges and scope of practice for foot surgery are not impacted by his or her privileges or scope of practice for ankle surgery; and
4. makes related minor, technical, and conforming changes, such as updating the names of national certification boards.

EFFECTIVE DATE: October 1, 2018, except a conforming change is effective July 1, 2018.

Independent Ankle Surgery

Under prior law, a licensed podiatrist could not independently engage in ankle surgery unless he or she met specified qualifications and received a separate permit from DPH. The qualifications differed for a permit to independently perform standard or advanced ankle surgery.

The act eliminates the requirement for a separate DPH permit. It correspondingly eliminates requirements that the DPH commissioner (1) appoint an advisory committee to assist him in evaluating permit applications and (2) adopt regulations identifying the number and types of procedures needed to qualify for a permit.

The act instead allows a licensed podiatrist to independently engage in ankle surgery if he or she provides documentation to DPH of having met specified qualifications (see below). It requires DPH to implement a mechanism for (1) a

podiatrist to provide the required documentation as part of the initial licensure application and (2) credentialing boards and the public to access the names of podiatrists who submitted the documentation. Any podiatrist who holds a standard ankle surgery permit on October 1, 2018, is deemed to have met the act's documentation requirements.

Qualifications. The act allows podiatrists to independently perform ankle surgery if they submit documentation that they:

1. graduated from a podiatric residency program meeting the criteria below and
2. hold current board certification or qualification in reconstructive rearfoot ankle surgery by the American Board of Foot and Ankle Surgery or its successor.

The residency program must have been accredited by the Council on Podiatric Medical Education, or its successor, at the time of graduation. The program must have been at least (1) two years in length if the person graduated before June 1, 2006, or (2) three years for graduates after that.

These qualifications are generally similar to the prior qualifications for the permit, except under prior law:

1. podiatrists who graduated before June 1, 2006, had to hold current board certification, not qualification (under the board's policies, a candidate for board certification must first become board qualified); and
2. for the advanced permit, and in some situations for the standard permit, podiatrists had to submit additional documentation of acceptable training and experience.

Surgery Under Supervision

As under prior law, the act establishes qualifications for podiatrists to engage in ankle surgery while being directly supervised by a (1) podiatrist qualified to independently perform surgery or (2) physician with hospital privileges to perform such procedures.

The act requires such podiatrists to be board certified in foot and ankle surgery. It eliminates provisions that allowed podiatrists to perform ankle surgery under supervision if they were board certified or qualified in reconstructive rearfoot ankle surgery.

§ 72 — CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM AND CONNECTICUT INSURANCE PREMIUM ASSISTANCE PROGRAM

Permits DPH to administer the Connecticut Aids Drug Assistance Program and Connecticut Insurance Premium Assistance Program; requires all program rebates and refunds to be paid to DPH; and permits DPH to implement policies and procedures to administer the programs while adopting them in regulations

Notwithstanding certain state medical assistance laws, the act permits DPH, within available resources, to administer the Connecticut Aids Drug Assistance Program and Connecticut Insurance Premium Assistance Program. It requires all rebates and refunds from the programs to be paid to DPH.

Under the act, DPH may implement policies and procedures to administer the programs while adopting them in regulations. The department may do this only if it posts the policies and procedures on the state eRegulations system before adopting them. The policies and procedures are valid until regulations are adopted.
EFFECTIVE DATE: July 1, 2018

§ 73 — NURSING HOME REPORTABLE EVENTS

Requires DPH, by January 1, 2019, to develop a system for nursing homes to electronically report "reportable events" to the department, after which nursing homes must report such events using the electronic system

The act requires DPH to develop a system for nursing homes to electronically report "reportable events" to the department. It must do this by January 1, 2019, after which nursing homes must report the events using the electronic system.

Under the act, "reportable events" are events occurring at a nursing home that the department deems to require immediate notification.
EFFECTIVE DATE: July 1, 2018

§ 74 — ART THERAPISTS

Increases the minimum education requirement for art therapists by requiring them to obtain a graduate degree, instead of a bachelor's degree, in art therapy or a related field

The act increases the minimum education requirement for art therapists by requiring them to obtain a graduate degree, instead of a bachelor's degree, in art therapy or a related field from an accredited higher education institution.

Connecticut does not license art therapists, but the law generally makes it a class D felony (see Table on Penalties) to represent oneself as an art therapist without (1) meeting the education requirement and (2) maintaining national certification by the Art Therapy Credentials Board or any successor board. The law does not apply to:

1. individuals providing art therapy within the scope of practice of their license and training, as long as they do not hold themselves out to be art therapists and
2. students enrolled in certain approved art therapy or graduate art therapy educational programs, if performing the therapy under an art therapist's direct supervision (CGS § 20-195mmm).

§§ 75-78 — RESPIRATORY CARE THERAPISTS

Expands and updates the scope of practice of respiratory therapists; makes minor changes to update licensure requirements; and increases annual continuing education requirements from six to 10 hours

The act makes various changes affecting respiratory care therapists, including (1) expanding and updating their scope of practice, (2) making minor changes to update licensure requirements, and (3) increasing annual continuing education

requirements from six to 10 hours.

Scope of Practice (§ 75)

The act expands the scope of practice of respiratory care practitioners to include:

1. percutaneous inserting, monitoring, and maintaining arterial catheters;
2. monitoring and maintaining other cardiovascular indwelling catheters, including central venous and pulmonary artery catheters;
3. inserting intravenous and intraosseous (i.e., bone marrow) catheters in appropriately identified health care settings (e.g., medical evacuation and transport vehicles and outpatient bronchoscopy, long-term care, and rehabilitation facilities) if the practitioner completed a competency-based training and education program in how to do so;
4. inserting nasogastric tubes, including those used to sense diaphragmatic movements; and
5. monitoring and maintaining extracorporeal life support, including extracorporeal membrane oxygenation (ECMO) and extracorporeal carbon dioxide removal in appropriately identified health care settings (e.g., adult, pediatric, and neonatal intensive care units), if the practitioner meets specified standards (see below).

A respiratory care therapist may only perform the functions related to extracorporeal life support if he or she:

1. is a registered respiratory therapist by the National Board for Respiratory Care and successfully completed the examination necessary to obtain such certification;
2. has neonatal, pediatric, or adult critical care clinical experience;
3. completed education and training to practice as an ECMO specialist in accordance with the Extracorporeal Life Support Organization's training and continuing education guidelines;
4. practices as an ECMO specialist under the direction and supervision of a licensed physician trained in ECMO;
5. does not participate in ECMO procedures that occur in an operating room, except in the case of a life-threatening emergency requiring the immediate resuscitation of a patient; and
6. is approved by the hospital's critical care committee if performing these functions in a hospital setting.

Licensure Requirements (§ 76)

The act makes minor and technical changes to update licensure requirements for respiratory care practitioners. It allows applicants to complete educational programs accredited by the Commission on the Accreditation for Respiratory Care, instead of only those programs:

1. accredited by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs, in cooperation with the Joint Review Committee for Respiratory Therapy Education, or

2. recognized by the Joint Review Committee for Respiratory Therapy Education.

Continuing Education Requirements (§§ 77 & 78)

The act increases the annual continuing education requirement for respiratory care practitioners from six to 10 hours. At least five hours must include real-time education with opportunities for live interaction, such as in-person phone conferences and real-time webinars. As under prior law, continuing education must be directly related to respiratory therapy and reflect the practitioner's professional needs in order to meet the public's health care needs.

Under the act, the requirements apply to license registration periods starting January 1, 2019.

The act also makes a related conforming change.

EFFECTIVE DATE: January 1, 2019

§ 79 — SUPERVISION OF PHYSICIAN ASSISTANTS

Removes the cap on the number of PAs that a physician may supervise

The act removes the cap on the number of PAs for whom a physician can serve as the supervising physician. Prior law limited them to supervising no more than six full-time PAs or the part-time equivalent.

EFFECTIVE DATE: July 1, 2018

§§ 80 & 81 — PUBLIC SCHOOL STUDENT ORAL HEALTH ASSESSMENTS

Requires local and regional boards of education to request that students have an oral health assessment prior to public school enrollment and in specified grades, and establishes related requirements on, among other things, parental notification and consent and assessment forms

The act requires local and regional boards of education to request that students have an oral health assessment prior to public school enrollment, in grade 6 or 7, and in grade 9 or 10. It establishes related requirements on providers authorized to perform the assessments, parental consent, assessment forms, notification, and records access.

EFFECTIVE DATE: July 1, 2018

Providers Authorized to Perform Assessments

Under the act, the assessment may be conducted by:

1. a dentist or dental hygienist, or
2. a physician, PA, or APRN, if he or she is trained in conducting such assessments as part of a DPH-approved training program.

If a dentist conducts the assessment, it must include a dental examination. If another such provider conducts the assessment, it must include a visual screening and risk assessment for oral health conditions.

Parental Consent

The act prohibits an oral health assessment as described above from being performed unless (1) the child's parent or guardian consents and (2) the assessment is made in the presence of the parent or guardian or another school employee. (PA 18-169, § 44, provides that the presence of the child's parent or guardian is not required when the assessment is conducted by a licensed outpatient clinic on school grounds.) The parent or guardian must receive prior written notice and have a reasonable opportunity to opt his or her child out of the assessment, be present at the assessment, or provide for the assessment himself or herself.

The act prohibits a school board from denying a child's public school enrollment or continued attendance for not receiving such an oral health assessment.

Notice of Free Oral Health Assessment Events

Under the act, a school board must provide prior notice to the parents or guardians of a school's students if the board hosts a free oral health assessment event at which a qualified provider performs such oral health assessments.

The parents and guardians must have the opportunity to opt their children out of the assessment event. If the parent or guardian does not do so, the child must receive an assessment free of charge.

The act prohibits the child from receiving any dental treatment as part of the assessment event without the parent's or guardian's informed consent.

Assessment Form; Review by School Health Personnel

Under the act, the results of such an oral health assessment must be recorded on forms supplied by the State Board of Education. The form must include a check box for the provider to indicate any low, moderate, or high risk factors associated with any dental or orthodontic appliance, saliva, gingival condition, visible plaque, tooth demineralization, carious lesions, restorations, pain, swelling, or trauma.

The provider performing the assessment must completely fill out and sign the form. If the provider has any recommendations, they must be in writing. For any child who receives an oral health assessment, the results must be included in the child's cumulative health record and kept on file in the school.

The act requires appropriate school health personnel to review the assessment results. When, in the health personnel's judgment, a child needs further testing or treatment, the school superintendent must give written notice to the child's parent or guardian and make reasonable efforts to ensure that further testing or treatment is provided. These efforts must including determining whether the parent or guardian obtained the necessary testing or treatment for the child and, if not, advising the parent or guardian on how to do so.

The results of the further testing or treatment must be recorded on the assessment forms and reviewed by school health personnel.

Record Access and Confidentiality

As under existing law regarding school health assessments, the act provides

the following for student oral health assessments:

1. no records of any such assessment may be open to public inspection; and
2. each provider who conducts such an assessment must provide the assessment results to the school district's designated representative and a representative of the child.

§§ 83 & 84 — DENTAL ASSISTANTS AND FLUORIDE VARNISH

Allows dental assistants to provide fluoride varnish treatments, if the dentist directly supervises the assistant in providing the treatment

The act allows dentists to delegate to dental assistants the provision of fluoride varnish treatments. The act defines such treatments as the application of a highly concentrated form of fluoride to the surface of the teeth.

As with other procedures that a dentist delegates to a dental assistant, the treatments must be performed under direct supervision and the supervising dentist must assume responsibility for the procedure.

§ 85 — REPEALER

Repeals certain outdated or obsolete statutes

The act repeals laws that required:

1. DPH and the Department of Social Services to create a program establishing a three-year media campaign to reduce adolescent pregnancy (in practice, the program was never implemented) (CGS § 19a-59e);
2. a DPH permit for public exhibitions of still or motion pictures relating to sexually transmitted diseases (CGS § 21-7); and
3. the Office of Health Care Access to adopt regulations on specified matters concerning state professional standard review organizations (CGS § 38a-558).

The act also repeals a law on public laundries that, among other things, (1) classified a public laundry as a manufacturing establishment (thus setting limits on work hours for certain employees) and (2) prohibited public laundry employers from allowing employees to work if they have certain communicable diseases (CGS § 31-43).