State of Connecticut

Department of Public Health

2007 Legislative Analysis

J. Robert Galvin, M.D., M.P.H., M.B.A.
Commissioner

Norma D. Gyle, R.N., Ph.D.
Deputy Commissioner

Sources of Information

The following summaries have been compiled from the Office of Legislative Research bill analyses and tailored specifically for the Department of Public Health. Only Public Acts affecting or of interest to the Department were included in this issue.

For Further Information

For more in-depth explanations, information on other Public Acts,
or questions on legislative intent, please contact:
Karen Buckley-Bates, Nancy S. Nicolescu or Jill Kentfield

Mailing address: 410 Capitol Avenue, MS#13GRE
P.O. Box 340308
Hartford, CT 06134-0308

Telephone: (860) 509-7269
Fax: (860) 509-7100

E-mail address: Kmbates@ct.gov
Nancy.Nicolescu@ct.gov
Jill.Kentfield@ct.gov

Availability on the U:/Drive

The 2007 Legislative Analysis is available on the LAN at the following site:
u:/legalert/2007legis/summary/summary.doc

Availability on the Internet

The 2007 Public Acts and reports are available through the Connecticut General Assembly's web site:
http://www.cga.ct.gov/

Acknowledgments

Prepared by:
Department of Public Health
Office of Government Relations
Alexandra C. Shamyer - Public Health Policy Intern
May 2007

Table Of Contents

Administration

Public Act 07-1 **HB 8001**

The State Budget for the Biennium Ending June 30, 2009, and Making Appropriations Therefore

Analysis of Budget for Fiscal Year 2008	$$$	$$$	$$$	
SID number and Program Title	**2006-07 Approved Budget**	**2007-08 Adopted**	**Difference FY 07 to FY 08**	**Notes**
10010-Personal Services	31,828,691	33,380,208	1,551,517	Turnover $661,000, Holdback $225,000; 21 positions for Daycare; 3 positions Healthcare Associated Infections; 2 positions Healthcare Author.; 1 Position IT for EVRS; 1 position (Lab or RS) for Lead (11 more in 09); 2 positions WIC; 2.25 position Managed Care 4th quarter start.
10020-Other Expenses	5,502,136	5,787,452	285,316	Holdback $142,773 Reduction - $368,009 (eliminate $300,000 for eHealth; eliminates $50,000 med interp. and unspecified $18,009) and $125,000 lead; see attachment for additions
10050-Equipment	5,500	15,950	10,450	$ 9,000 for Assoc Infections; $ 2,200 for WIC;$ 3,750 for Mgt Resid. Comm; $1,000 general agency
12100-Needle and Syringe Exchange Program	488,526	490,909	2,383	Annualize FY 07 COLA
12112-Community Services Support for Persons with AIDS	198,210	199,177	967	Annualize FY 07 COLA
12126-Children's Health Initiative	1,066,466	1,598,284	531,818	$4,455 Annualize FY 07 COLA, $500,000 for Easy Breathing and $27,363 unspecified

Analysis of Budget for Fiscal Year 2008	$$$	$$$	$$$	
12227-Childhood Lead Poisoning	336,840	338,032	1,192	Annualize FY 07 COLA
12236-AIDS Services	4,664,690	7,326,662	2,661,972	$22,298 Annualize FY 07 COLA, $125,000 for prevention and $2,514,674 Ryan White pick-up (see attached).
12255-Breast and Cervical Cancer Detection and Treatment	2,343,251	2,351,494	8,243	Annualize FY 07 COLA
12259-Services for Children Affected by AIDS	263,042	264,325	1,283	Annualize FY 07 COLA
12264-Children with Special Health Care Needs	1,365,283	1,371,764	6,481	Annualize FY 07 COLA
12268-Medicaid Administration	3,462,246	3,741,609	279,363	Salary Increase
12430-Fetal and Infant Mortality Review		300,000	300,000	New (see attachment)
12431-Nursing Student Loan Forgiveness Program		125,000	125,000	New (see attachment)
16060-Community Health Services	6,679,621	9,284,758	2,605,137	$30,137 Annualize FY 07 COLA ; $75,000 Expand Comm. Hlth Access Prog to United Comm and Fam Serv ; $500,000 for transportation support and $2 million for infrastructure and technology
16085-Emergency Medical Services Training	85,485	68,171	(17,314)	Reduction for training funds
16089-Emergency Medical Services Regional Offices	675,028	677,477	2,449	Annualize FY 07 COLA
16103-Rape Crisis	424,805	426,877	2,072	Annualize FY 07 COLA
16112-X-Ray Screening and Tuberculosis Care	702,656	820,761	118,105	$1,106 Annualize FY 07 COLA ; $17,000 for latent TB testing in Greater Hfd.; $100,000 incr for costs

Analysis of Budget for Fiscal Year 2008	$$$	$$$	$$$	
16121-Genetic Diseases Programs	892,793	895,323	2,530	Annualize FY 07 COLA
16133-Loan Repayment Program	124,460	125,067	607	Annualize FY 07 COLA
16136-Immunization Services	9,044,950	9,044,950	-	
17009-Local and District Departments of Health	4,331,550	5,352,419	1,020,869	$20,864 Annualize FY 07 COLA ; $1,000,005 for changes in per cap allocations to full-time health departs and districts
17013-Venereal Disease Control	215,847	216,900	1,053	Annualize FY 07 COLA
17019-School Based Health Clinics	7,676,462	10,209,364	2,532,902	$32,902 Annualize FY 07 COLA ; $1,470,000 for expanded services and $1,030,000 for 9 locations (see attachment).
Total	**$82,378,538**	**$94,412,933**	**$12,034,395**	

Notes:				
In the OPM budget for distribution to agencies, 3 % COLA for private providers for FY 08.				
35324 Stem Cell Research	10,000,000	10,000,000		Starting in April of FY 08 $10 million per year until FY 15. This is a non-lapsing account. For FY 2008 and FY 2009, $200,000 is designated for administrative support from the resources of the Stem Cell fund account.
40001 Biomedical Research Trust Fund	4,000,000	4,000,000		May expend up to 50% of the funds.
12126 Children's Health Initiative - for Easy Breathing	500,000	500,000		Tobacco and Health Trust Fund (08 & 09)

Notes:						
12126 Children's Health Initiative - for Adult Easy Breathing Asthma Program Norwalk Hospital		150,000				Tobacco and Health Trust Fund (08 & 09)
12126 Children's Health Initiative - for Adult Easy Bthing asthma program. Bpt Hospital		150,000				Tobacco and Health Trust Fund (08 & 09)
12126 Children's Health Initiative - for state-wide asthma awareness and prevention education program.	150,000	150,000				Tobacco and Health Trust Fund (08 & 09)
12126 -Physical Fitness and Nutrition 8-18 yrs old	-	500,000				Tobacco and Health Trust Fund (no FY 09 funding)
Women's Healthy Heart Program matching grants, Competitive to Municipalities (new SID?)	-	500,000				Tobacco and Health Trust Fund (08 & 09 with different parameters)
Retain NBS fees of $800,000, a $300,000 increase for FY 08 only.						
There is $500,000 personal services funding for the birth record project. These were surplus funds and are not included in above 10010 balance.						

FY 08 AND FY 09 DPH PROGRAMS:

These notes represent certain selected programs that are new or have a significant impact with earmark of DPH funding.

Combat Healthcare Associated Infections -(B)

In PA 06-162, AAC Hospital Acquired Infections, the legislature established the Committee on Healthcare Associated Infections and charged it with advising the Department of Public Health with respect to the development, implementation, operation and monitoring of a mandatory reporting system for healthcare acquired infections in Connecticut. The Committee's recommendations were issued in April 2007.

An Education Subcommittee was charged with identifying, evaluating and recommending appropriate methods for increasing public awareness about effective measures to reduce the spread of infections.

(Legislative) Funding, in the amount of $305,000 in each of FY 08 and FY 09, is provided to enable the Department of Public Health to implement recommendations of the Committee on Healthcare Associated Infections (CHAI). Of this amount, $55,000 will support recommendations of the Education Subcommittee of the CHAI.

The remaining $250,000 shall support 3 full-time positions (1 Epidemiologist, 2 Infection Control), as well as a portion of the costs of a program supervisor and associated other expenses/equipment.

	FY 08	FY 09
Personal Services	233,000	242,000
Other Expenses	63,000	63,000
Equipment	9,000	0
Total - General Fund	305,000	305,000

Assist Healthcare Authorities -(B)

PA 07-185, AA Concerning the HealthFIrst Connecticut and Healthy Kids Initiatives, establishes a HealthFirst Connecticut Authority. Its duties include: (a) evaluating alternatives for providing health care, (b) recommending ways to contain health care costs and improve quality, and (c) making recommendations on financing health insurance for state residents.

The Act also establishes a State-wide Primary Care Access Authority, which shall be charged with developing a universal system for providing primary care services, including prescription drugs, to all Connecticut residents.

(Legislative) Funding, in the amount of $120,000 in each of FY 08 and FY 09, is provided to suppo salaries of 2 positions to allow the department to assist the HealthFIrst Connecticut Authority and t wide Primary Care Access Authority.

	FY 08	FY 09
Personal Services	120,000	120,000

Address Nursing & Allied Health Workforce Shortage -(B)

(Legislative) Funding, in the amount of $375,000 in each of FY 08 and FY 09, is provided to support initiatives to address nursing and allied health workforce shortages. Such initiatives may include, but not be limited to, a faculty scholarship program, a nursing faculty student loan program, grants to higher education institutions for faculty positions, a recruitment and retention campaign to promote awareness of nursing and allied health careers, and support for an allied health workforce policy board.

	FY 08	FY 09
Other Expenses	375,000	375,000

Inspect Managed Residential Communities -(B)

By law, the department licenses assisted living services agencies (ALSAs), which provide nursing services and assistance with activities of daily living to elderly people at assisted living facilities (i. e. , managed residential communities (MRC)). These

facilities are not licensed, but they must meet certain DPH regulatory qualifications to be defined as a "managed residential community," which is the only type of location where an ALSA is allowed to provide its services.

Sections 30-43 of PA 07-2 JSS, AA Implementing the Provisions of the Budget Concerning Human Services and Public Health, place additional requirements on the MRC. It requires DPH to review each MRC every two years and at other times if it has probable cause to believe the MRC has violated the Act's requirements.

(Legislative) Funding, in the amount of $39,500 in FY 08, is provided to support the one-quarter year salaries of 2.25 positions needed to implement biennial inspections of managed residential communities, effective 4/1/08.

$132,000 is provided in FY 09 to reflect the annualized cost of this staffing expansion.

	FY 08	FY 09
Personal Services	31,750	127,000
Other Expenses	4,000	5,000
Equipment	3,750	
Total - General Fund	39,500	

Support Women's Healthy Heart Program -(B)

(Legislative) Funding, in the amount of $500,000 in each of FY 08 and FY 09, is transferred from the Tobacco and Health Trust Fund to allow the department to support competitive grants to towns of between $5,000 and $50,000 each to support programming aimed at promoting healthy lifestyles. Section 59 of PA 07-1 JSS, the Budget Act, authorizes these transfers and establishes a local match requirement of 50%.

	FY 08	FY 09
Special Funds, Non-Appropriated	500,000	500,000
Total - Special Funds, Non-Appropriated	500,000	500,000

Prevent Childhood Obesity -(B)

(Legislative) Funding, in the amount of $500,000 in FY 08, is transferred from the Tobacco and Health Trust Fund to support physical fitness and nutrition programming for children who are overweight or at risk of becoming overweight. Section 59(a) of PA 07-1 JSS, the Budget Act, authorizes this transfer.

	FY 08
Special Funds, Non-Appropriated	500,000
Total - Special Funds, Non-Appropriated	500,000

Enhance School Based Health Services -(B)

(Legislative) Funding, in the amount of $2.5 million in each of FY 08 and FY 09, is provided to enhance school based health services. This includes

$85,000 for medical services at Norwich Free Academy,
$100,000 for mental health services at Greenville Elementary School (Norwich);
$100,000 for mental health services at Rippowam Middle School (Stamford),
$100,000 for Branford, to enhance medical and mental health services;
$125,000 for Fitch Middle School (Groton);
$130,000 for Rogers Park Middle School (Danbury);
$130,000 for Keigwin Middle School (Middletown);
$130,000 for the Interdistrict School for Arts and Communication, "ISAAC" (New London); and
$130,000 for New Britain, which may include services at Roosevelt Middle School.

It is legislative intent that the remaining $1,470,000 in each of FY 08 and FY 09 be utilized to expand medical, dental and mental health services at existing Department of Public Health funded sites providing school based health services that are located in (a) priority schools districts, or (b) areas federally designated as health professional shortage areas, medically underserved areas or areas with a medically underserved population.

	FY 08	FY 09
School Based Health Clinics	2,500,000	2,500,000
Total - General Fund	2,500,000	2,500,000

Pickup with State Funds/Ryan White Act -(B)

(Legislative) Funding, in the amount of 2,514,674 in FY 08 and $3,094,565 in FY 09, is provided to reflect the pickup with state funding of services formerly supported by federal Ryan White Act moneys. It is legislative intent that these dollars support awards in amounts as follows:

	FY 08
Hartford Transitional Grant Area	1,107,787
New Haven Transitional Grant Area	1,152,153
Mid Fairfield AIDS Project	7,528
Community Health Center, Inc.	104,083
Visiting Nurse & Health Services	94,044
Valley Mental Health Center	49,079
Total	2,514,674

	FY 09
Hartford Transitional Grant Area	1,386,135
New Haven Transitional Grant Area	1,453,696
Mid Fairfield AIDS Project	7,528
Community Health Center, Inc.	104,083

Visiting Nurse & Health Services	94,044
Valley Mental Health Center	49,079
Total	3,094,565

Continue Support for Fetal and Infant Mortality Review Programs -(B)

Community-based Fetal and Infant Mortality Review (FIMR) programs endeavor to improve the health outcomes of women and infants in identified communities through improved community resources and changes in service delivery. An interdisciplinary community team examines cases of fetal and infant deaths; identifies local social, economic, public health, educational, environmental and safety issues that relate to the deaths; and makes recommendations for needed systems improvements.

Community-based FIMR programs currently operate in Hartford, New Britain, Greater New Haven, Manchester/Vernon and Windham.

(Legislative) Funding, in the amount of $300,000 in each of FY 08 and FY 09, is provided to support grants of $60,000 each to five Fetal and Infant Mortality Review programs: East Shore District Health Department, Windham Regional Community Council, Inc., Eastern CT Health Network, Inc., Central Area Health Education Center, Inc, and the UConn Health Center's Family Planning Clinic.

	FY 08	FY 09
Fetal and Infant Mortality Review	300,000	300,000
Total - General Fund	300,000	300,000

Establish Nursing Student Loan Forgiveness Program -(B)

(Legislative) Funding, in the amount of $125,000 in each of FY 08 and FY 09, is provided to establish a loan forgiveness program for historically underrepresented students pursuing careers in nursing.

	FY 08	FY 09
Nursing Student Loan Forgiveness Program	125,000	125,000
Total - General Fund	125,000	125,000

Public Act 07-3 **HB 5706**

LEAVE FOR STATE EMPLOYEES PROVIDING DISASTER RELIEF SERVICES

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act gives a state employee who is a certified American Red Cross disaster service volunteer up to 15 working days each year, rather than 14 calendar days, to participate in Red Cross specialized disaster relief services without loss of pay or accrued leave time (vacation, sick, or earned overtime). By law, the leave must be (1) approved by the employee's supervisor and (2) requested by the Red Cross.

REQUIRED ACTION:

Human resources shall notify agency personnel.

Public Act 07-2 **HB 8002**

IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH

§ 1 — NURSING HOME PROVIDER TAX CHANGE

EFFECTIVE DATE: July 1, 2007

Beginning January 1, 2008, this bill (1) lowers the maximum nursing home provider tax from 6% to 5. 5% of the home's net revenue, consistent with a recent change in federal law (PL 109-432) and (2) requires the Department of Social Services commissioner, when setting the amount of the tax every two years, to use a percentage rate as determined by the Office of Policy and Management (OPM) secretary. (The actual tax is currently just under 5. 5%.)

PA 05-251 and PA 05-280 created the nursing home provider tax (also called a "resident user fee") as a way of providing more state matching funds to increase federal Medicaid funding for nursing homes and certain other providers. Under a federal waiver, the state exempts from the tax nursing homes owned by continuing care retirement communities.

The user fee is calculated by multiplying each home's anticipated non-Medicare net revenue, including estimated revenue from any increases in Medicaid payments, during the 12-month period ending on June 30th of the succeeding calendar year by

the provider tax rate. The product is then divided by the sum of each nursing home's anticipated non-Medicare resident days during that same 12-month period.

Currently, the tax is $ 15. 90 per resident day for homes with 230 or fewer beds and $ 12. 20 a day for those with more than 230 beds or owned by municipalities. The nursing homes must pay the tax quarterly to the Department of Revenue Services (DRS).

§ 5 — MONEY FOLLOWS THE PERSON

EFFECTIVE DATE: July 1, 2007

The bill increases the maximum number of participants in the new "Money Follows the Person" demonstration program from 100 to 700. The state has received funding for this demonstration from a new federal grant program that helps states move people who have been inappropriately institutionalized in a nursing home or other institution for six months or more back into the community (PL 109-171, § 6071). The federal grant is for five years and the expansion to 700 participants would take place gradually over that five-year period.

§ 25 — DELAY START OF DEPARTMENT ON AGING

EFFECTIVE DATE: Upon passage

This bill postpones the re-establishment date of a Department on Aging by one year, from July 1, 2007 to July 1, 2008.

Connecticut had a Department on Aging from 1969 to 1993, when it was disbanded and most of its functions and personnel merged into the newly created Department of Social Services (DSS) as the Division of Elderly Services.

PA 05-280 re-establishes a Department on Aging as of January 1, 2007, headed by a commissioner appointed by the governor. (Subsequently, PA 06-188 postponed the department's establishment to July 1, 2007.) The act transfers the functions, powers, duties, and personnel of the DSS Division of Elderly Services to the Department on Aging. (This division was merged into a larger Bureau of Aging, Community, and Social Work Services a few years ago.)

§ 28 — HOSPITAL HARDSHIP GRANTS

EFFECTIVE DATE: July 1, 2007

For FY 08, the bill authorizes the DSS commissioner, in consultation with OPM, to spend up to $ 30 million appropriated for "Hospital hardship" for grants to hospitals. The grants must be provided as necessary to (1) avoid the substantial deterioration of

a hospital's financial condition that may adversely affect patient care and (2) for continued operation of the facility when such continuation is determined necessary by the DSS commissioner, in consultation with DPH, OHCA, and the Connecticut Health and Educational Facilities Authority.

In determining grant eligibility, DSS must at least consider (1) hospital utilization by patients eligible for state assistance programs, (2) hospital licensure and certification compliance history, and (3) reasonableness of actual and projected revenues and expenses. A hospital applying must submit an application on forms prescribed by DSS and a plan describing its operating savings and nongovernmental revenue enhancements. DSS may accept or require modifications to the plan submitted. Each hospital must file quarterly reports with DSS concerning plan implementation. DSS may stop payments if the hospital fails to report according to these requirements. DSS must provide quarterly written reports to the Human Services and Appropriations committees. The reports must name those hospitals requesting a grant, the amount requested, and the action taken by DSS.

§ 30 – 43 — INCREASED OVERSIGHT OF ASSISTED LIVING

EFFECTIVE DATE: October 1, 2007

By law, the Department of Public Health (DPH) licenses assisted living services agencies (ALSAs), which provide nursing services and assistance with activities of daily living to elderly people at assisted living facilities (i. e. , managed residential communities). These facilities are not licensed, but they must meet certain DPH regulatory qualifications to be defined as a "managed residential community," which is the only type of location where an ALSA is allowed to provide its services.

This bill places additional requirements on the managed residential community (MRC). It delineates the MRCs' duties; requires it to provide each resident with a written bill of rights and residency agreement; and specifies what must be in these documents. It requires the ALSA to create a service plan for each resident. It also requires the MRC to comply with applicable state and federal laws and regulations.

It requires DPH to review each MRC every two years and at other times if it has probable cause to believe the MRC has violated the bill's requirements. It (1) specifies what these reviews must include, (2) requires DPH to establish administrative procedures for preparation, completion, and transmittal of written reports prepared as part of the reviews; (3) requires DPH notice to the MRC of alleged violations of the bill; (4) gives the MRC 15 days after receiving the notice to request an administrative hearing; and (5) allows DPH, pending the hearing's outcome, to issue a remedial order, including a civil penalty of up to $ 5,000 per violation, on the MRC and (6) authorizes the attorney general, at the DPH commissioner's request, to enforce the orders in Superior Court.

The bill exempts from its provisions low- and moderate income state-assisted elderly congregate housing facilities.

It also makes other changes in the MRCs' duties and responsibilities, and makes conforming and technical changes in other statutes.

§ 30 — Definitions

Under the bill, "activities of daily living" are activities or tasks essential for a person's healthful and safe existence, including bathing, dressing, grooming, eating, preparing meals, shopping, housekeeping, transferring from a bed to a chair, bowel and bladder care, washing clothes, communicating, self-administering medication, and ambulating.

The bill defines:

1. "assisted living services" as nursing services and help with activities of daily living provided to residents in an MRC having supportive services that encourage people primarily age 55 and older to maintain a maximum level of independence;
2. "assisted living services agency" as an entity licensed by DPH that provides, among other things, nursing services and help with activities of daily living to a population that is chronic and stable;
3. "managed residential community" as a for-profit or not-for-profit facility consisting of private residential units that provides a managed group living environment consisting of housing and services for people who are primarily age 55 and over, excluding state-funded congregate housing facilities; and
4. "private residential unit" as a private living environment designed for an MRC resident's use and occupancy that includes a full bathroom and access to facilities and equipment for food preparation and storage.

§ 31 — MRC Responsibilities

EFFECTIVE DATE: October 1, 2007

The bill requires all MRCs operating in Connecticut to:

1. provide each resident with a written residency agreement;
2. enable residents to access services provided by an ALSA and in accordance with a service plan, which the bill requires;
3. at the resident's request, arrange, in conjunction with the ALSA, for ancillary medical services, including physician, dental, and pharmacy services; restorative physical therapies; podiatry services; hospice care; and home health agency services (the ancillary medical services may not be administered by the MRC's employees unless the resident chooses to receive such services);
4. provide a formal security program for the residents' protection and safety that is designed to protect them from intruders;

5. give residents the rights and privileges granted under the state's landlord-tenant laws;
6. comply with provisions currently established in DPH regulations for MRCs (Conn. Agencies Regs. § 19-13-D105); and
7. be subject to DPH oversight and regulation.

§ 32 — DPH Required to Receive and Investigate Complaints

EFFECTIVE DATE: April 1, 2008

The bill requires DPH to receive and investigate any complaint that an MRC is engaging in, or has engaged in activities, practices, or omissions that violate the bill's provisions, the regulations DPH adopts under it, or any other regulations that apply to MRCs, including the Public Health Code. It also requires DPH to include in its biennial review of an MRC (see below) a review of the nature and type of any complaints received, as well as DPH's final determination concerning them.

§ 33 — DPH MRC Reviews, Administrative Hearings, And Penalties

EFFECTIVE DATE: April 1, 2008

The bill requires DPH to conduct biennial reviews of all MRCs. These biennial reviews must be in addition to, not in lieu of, any inspections by state or local officials to ensure a n MRC's compliance with the Public Health Code, State Building or Fire codes, or any local zoning ordinance.

In addition to the biennial review, the bill allows DPH to review an MRC at any time it has probable cause to believe that it is violating the bill's requirements, regulations adopted under it, or any other applicable regulations, including the Public Health Code. The biennial or investigatory review's purpose must be to ensure that an MRC is complying with the bill and the regulations.

Under the bill, a biennial review must include:

1. an inspection of all of the MRC's common areas, including any common kitchen or meal preparation area and
2. an inspection of private residential units, but only if the occupants provide prior written consent.

The bill allows an inspector, in the course of conducting a biennial or investigatory review to interview any MRC manager, staff member, or resident. Interviews with residents must be confidential and conducted privately.

Under the bill, DPH must establish an administrative procedure for preparing, completing, and transmitting written reports prepared as part of any biennial or investigatory review. If after a review it determines the MRC is violating the bill, DPH must provide the MRC written notice of its determination. The notice must

advise the MRC of its right to request an administrative hearing to contest the determination in accordance with the Uniform Administrative Procedure Act. The MRC must request a hearing, in writing, within 15 days after it receives DPH's notice of an alleged violation.

The bill allows DPH to issue remedial orders it considers necessary to ensure an MRC's compliance with the bill's provisions. It specifies that remedial orders available to DPH include imposing a civil penalty of up to $ 5,000 per violation. But DPH must stay the imposition of any remedial order or civil penalty pending the outcome of the administrative hearing. DPH must maintain and make available for public inspection all completed reports, the MRC's responses, and any remedial orders issued.

If an MRC fails to comply with a remedial order DPH issues, the attorney general, at the DPH commissioner's request, can apply to Hartford Superior Court to enforce the order. The bill gives all such actions precedence in the order of trial over all other civil actions except actions on probate bonds. It allows the court to issue orders necessary to obtain compliance with DPH's order.

§ 34 — Bill of Rights

EFFECTIVE DATE: October 1, 2007

The bill requires an MRC to have a written bill of rights that prescribes the rights afforded to its residents. (The ALSA must already have a bill of rights under DPH regulations.) The MRC must designate a staff person to provide and explain the bill of rights to residents when they enter into a residency agreement. The bill of rights must include each resident's right to:

1. live in a clean, safe, and habitable private residential unit;
2. be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy;
3. privacy within a private residential unit, subject to the MRC's rules reasonably designed to promote the resident's health, safety, and welfare;
4. keep and use one's own personal property in a private residential unit so as to maintain individuality and personal dignity, provided its use does not infringe on other residents' rights or threaten other residents' health, safety, and welfare;
5. private communications, including receiving and sending unopened correspondence, telephone access, and visiting with people of one's choice;
6. freedom to participate in and benefit from community services and activities so as to achieve the highest possible level of independence, autonomy, and interaction within the community;
7. directly engage or contract with licensed health care professionals and providers of one's choice to obtain necessary health care services in one's

8. manage one's own financial affairs;
9. exercise civil and religious liberties;
10. present grievances and recommend changes in policy, procedures, and services to the MRC's manager or staff, government officials, and anyone else without restraint, interference, coercion, discrimination, or reprisal from the MRC, including access to DPH or the Office of the Long-Term Care Ombudsman;
11. ask for and receive the name of the service coordinator or anyone else responsible for resident care or coordination of resident care;
12. confidential treatment of all records and communications to the extent required by state and federal law;
13. have reasonable requests responded to promptly and adequately within the MRC's capacity and with due consideration given to other residents' rights;
14. be fully advised of the MRC's relationship with an ALSA, health care facility, or educational institution to the extent that the relationship relates to resident medical care or treatment and to receive an explanation about the relationship;
15. receive a copy of the MRC's rules and regulations;
16. privacy when receiving medical treatment within the MRC's capacity;
17. refuse care and treatment and participate in the planning for the care and services the resident needs or receives, provided the refusal of care and treatment may preclude the resident from continuing to live in the MRC;
18. all rights and privileges afforded tenants under the state's landlord-tenant law.

The bill requires an MRC to post the bill of rights in a prominent place in the MRC. The posting must include contact information for DPH and the Office of the Long-Term Care Ombudsman, including names, addresses, and telephone numbers of people in those agencies who handle questions, comments, and complaints about MRCs.

§ 35 — Residency Agreement and 24-Hour Skilled Nursing Care

EFFECTIVE DATE: October 1, 2007

The bill prohibits an MRC from entering into a written residency agreement with anyone who requires 24-hour skilled nursing care unless they establish to the MRC's and ALSA's satisfaction that they have, or have arranged for, such 24-hour care and maintain it as a condition of residency if an ALSA determines that such care is necessary.

§ 36 — ALSA Individualized Service Plan

EFFECTIVE DATE: October 1, 2007

The bill requires an ALSA, after consulting with the resident and following a registered nurse's assessment, to develop and maintain an individualized service plan for any MRC resident who receives assisted living services. The plan must describe in lay terms the individual's need for such services; the service providers or intended providers; the services' scope, type, and frequency; an itemized cost of such services; and other information DPH may require. The service plan and any periodic revisions to it must be confidential and signed by the resident (or the resident's legal representative) and an ALSA representative. It must also be available for inspection by the resident and DPH.

The MRC must maintain written policies and procedures for a resident's initial evaluation and annual reassessment of his or her functional and health status and service requirements.

§ 37 — Residency Agreement

EFFECTIVE DATE: October 1, 2007

The bill requires an MRC to enter into a written residency agreement with each resident that clearly sets forth the resident's and the MRC's rights and responsibilities, including rights under PA 06-195, which set requirements for facilities with Alzheimer's special care units or programs. The agreement must be in plain language, at least 14-point type, and signed by the MRC's authorized agent and the resident before the resident takes possession of a private residential unit. It must include, at a minimum:

1. an itemization of assisted living services, transportation services, recreation services, and any other services, goods, lodging, and meals the MRC will provide for the resident;
2. a full and fair disclosure of all charges, fees, expenses, and costs to be borne by the resident (including a payment schedule and disclosure of all late fees or potential penalties);
3. the grievance procedure for enforcing the agreement's terms;
4. the MRC's covenant to (a) comply with all municipal, state, and federal laws and regulations regarding consumer protection and protection from financial exploitation and (b) give residents all rights and privileges afforded them under the state's landlord-tenant laws;
5. the conditions under which either party can terminate the agreement;
6. full disclosure of the MRC's and resident's rights and responsibilities in situations involving the resident's serious health deterioration, hospitalization, or death, including a provision stating that in the event of death, the resident's estate or family will only be responsible for payment

to the MRC for up to 15 days following the date of death as long as the unit has been vacated; and

7. any of the MRC's adopted rules reasonably designed to promote residents' health, safety, and welfare.

§ 38 — Applicability of Other Laws and Regulations and Commissioner's Authority to Adopt Regulations

EFFECTIVE DATE: October 1, 2007

The bill requires an MRC to meet the requirements of all applicable federal and state laws and regulation, including the Public Health Code, State Building and Fire Safety codes, and federal and state laws and regulations governing handicapped accessibility.

The bill requires the DPH commissioner to adopt regulations to carry out its provisions.

§ 39-42 — Conforming Technical Changes

§ 43 — Elderly Congregate Housing Exemption

EFFECTIVE DATE: October 1, 2007

The bill specifies that its provisions do not apply to any state-funded congregate housing facility.

These facilities are regulated by the Department of Economic and Community Development (DECD), allowed to offer assisted living services (15 of the 24 in the state do so), and have been granted DPH waivers from some of the usual assisted living and MRC requirements to enable them to offer the services. Subsidies for the assisted living services in these facilities are available for residents who qualify financially through DECD and the Department of Social Services' Connecticut Home Care Program for Elders.

MRC Core Services

By DPH regulation, MRCs must provide certain core services, including:

1. three regularly scheduled meals per day,
2. regularly scheduled housekeeping and laundry service for personal laundry and linens,
3. regularly scheduled transportation for certain needs (public bus transportation does not qualify as the only mode of transportation),
4. maintenance service for the living units, and
5. social and recreational programs.

An MRC can be a number of different settings, such as apartments, continuing care retirement communities, or other structured settings as long as the facility itself provides the basic core services to qualify as an MRC. An MRC can either provide the ALSA services itself by becoming licensed as an ALSA or contract with a separate ALSA to provide the services.

§ 47 – 60 — LEAD POISONING PREVENTION AND REMEDIATION

§ 47 — Coordinating Lead Poisoning Prevention Efforts

EFFECTIVE DATE: October 1, 2007

The bill makes the Department of Public Health (DPH) the lead agency for lead poisoning prevention in the state. The commissioner must identify the state and local agencies with responsibilities related to lead poisoning and schedule a meeting with them at least once a year to coordinate their efforts. The bill also requires DPH's lead poisoning prevention program to include the screenings it mandates.

§ 48 — Lead Screening and Risk Assessments

EFFECTIVE DATE: January 1, 2009

Screening. The bill requires primary care providers (e. g. , physicians and advanced practice registered nurses) other than hospital emergency departments, to screen annually for lead every child between nine and 35 months old. The screening must be done according to the recommendations of the Childhood Lead Poisoning Prevention Screening Advisory committee. These recommendations call for blood lead screening (capillary) tests at age 12 months and 24 months with follow-up venous blood tests if the initial screening shows an elevated blood lead level.

These providers must also screen (1) all children between 36 and 72 months old who have never been screened and (2) any child under 72 months if the provider determines screening is clinically indicated under the Lead Screening Advisory Committee's recommendations, which call for screening children who exhibit developmental delays. The committee also recommends blood lead testing of any children who have unexplained seizures, neurologic symptoms, hyperactivity, behavior disorders, growth failure, abdominal pain or other symptoms consistent with elevated lead levels or a recent history of ingesting foreign objects.

Risk Assessments. The bill requires primary care providers also to conduct annual lead risk assessments for children ages three up to six. Providers can assess younger children if they determine it is needed. Assessments must be conducted according to the Lead Screening Advisory Committee's recommendations. These recommendations call for questioning parents or guardians about the child's housing (age and location) and family history of elevated blood lead levels.

Exemptions. The bill exempts children whose parents object to blood tests on religious grounds from these screening requirements.

§ 49 — Reporting Elevated Blood Lead Levels

EFFECTIVE DATE: October 1, 2007

By law, health care institutions and clinical laboratories must notify the DPH commissioner and appropriate local health official within 48 hours of receiving or completing a report on a person with a lead level of 10 or more µg/dL of blood or other abnormal bodily lead level. The bill requires them also to report the results within 48 hours to the health care provider who ordered the test. It requires this health care provider to make reasonable efforts to notify parents or guardians of the test result for a child under age three. The provider must do this within 72 hours of learning the test results.

Another law (CGS § 19a-111b), which this bill does not alter, requires the DPH commissioner to establish an early lead diagnosis program that includes routine exams of children under age six. Under this program, exams showing blood levels of 10 or more µg/dL must be reported to the child's parents, the local health director, and DPH.

§ 50 — Local Health Department Lead Investigations

EFFECTIVE DATE: January 1, 2009

The bill requires the local health director to inform parents about the child's potential eligibility for the state's Birth to Three program, which provides services to families with children with disabilities age three and under. (The current threshold for Birth to Three eligibility is 45 µg/dL.) Health directors must already inform them about lead poisoning dangers, ways to reduce risks, and lead abatement laws.

The bill establishes a new lead source investigation and clean-up process that appears to parallel the existing process. Under the bill, whenever a local or district health director receives a report that two blood tests (venous) taken at least three months apart confirm a child's blood lead level is between 15 to 20 µg/dL, the director must conduct an on-site investigation (presumably of the child's home) to identify the source of lead causing the elevation and order whoever is responsible for the condition to remediate it. The bill lowers the threshold for investigations to 10 µg/dL if, beginning January 1, 2012, 1% or more of Connecticut children under age six have been reported with blood levels of at least 10 µg/dL.

Under current law (CGS § 19a-111), which the bill does not change, health directors must conduct, an epidemiological investigation for lead levels of 20 or more µg/dL. (An epidemiological investigation is an examination and evaluation to determine the cause of elevated blood lead levels; it is not clear how the new on-site investigation the bill requires bill differs from this). After the epidemiological investigation

identifies the lead source, the local health director must take action necessary to prevent further lead poisoning. Among other things, the director can order abatement and must try to find temporary housing for residents when the lead hazard cannot be removed from their dwelling within a reasonable time.

§§ 51 & 52 — Insurance Coverage for Lead Screening

EFFECTIVE DATE: January 1, 2009

The bill requires individual and group health insurance policies to cover the bill's lead screening and risk assessments mandates. The requirement applies to Connecticut policies delivered, issued for delivery, amended, renewed, or continued on or after January 1, 2009.

§ 53 — Data Collection

EFFECTIVE DATE: October 1, 2007

The bill requires the public health commissioner, by January 1, 2008, to review the lead poisoning data DPH collects and determine if its format is compatible with reports from institutional and private clinical labs performing lead testing. DPH must adopt regulations if it finds that data should be reported differently.

§§ 54-56, 60 — Lead Remediation, Abatement, Testing, and Management

EFFECTIVE DATE: October 1, 2007

In Dwellings Occupied by Children. Under current law, owners of dwellings with toxic lead levels occupied by children under age six must abate or manage the dangerous materials and follow DPH regulations for doing so. The bill permits them to remediate the materials, as well. It defines remediation as the use of interim controls, including paint stabilization, spot point repair, dust control, specialized cleaning, and mulching soil.

The bill requires the DPH's regulations to establish requirements and procedures for lead testing, remediation, and management of toxic materials; current law requires the regulations to address only removal, which the bill eliminates, and abatement. The bill also permits DPH to adopt regulations concerning the standards and procedures for these actions in any premises.

In Rented Houses, Mobile Homes, and Apartment Houses. The bill permits the local or district health director to order the responsible party to correct cracked, chipped, blistered, flaking, peeling, or loose lead-based paint on exposed interior surfaces in rented one- or two-family houses, mobile homes, apartment buildings and boarding houses. The bill requires DPH regulations, if they are adopted, to define testing, remediation, abatement, and management of lead paint in these circumstances.

Under existing law, anyone who fails to comply with such an order is subject to a fine of up to $ 200, imprisonment for up to 60 days, or both.

Additional Regulations. The bill permits DPH to adopt regulations regulating paint removal from buildings and structures where removal may be hazardous to nearby buildings. The regulations can set definitions, applicability and exemption criteria, notice procedures, appropriate work practices, and penalties for noncompliance.

Current law requires DPH to approve and keep a list of the encapsulation products that can be used in the state to abate toxic lead levels. The bill extends these requirements to encapsulation products used for remediation and changes the type of situations in which they are used from those involving toxic lead levels to those involving lead hazards.

Nuisance Abatement. The bill permits local health directors to order a property owner to remediate any nuisance (e. g. , plumbing, sewerage, ventilation, lead paint) they find on the owner's property. Under current law, they can only order abatement.

The bill extends nuisance law provisions to owners or occupants ordered to remediate a nuisance. By law, owners, or in some cases, occupants, who are ordered to correct a nuisance must pay the costs. If the responsible party fails to do this, the town can take corrective action and sue the person to recover damages and expenses. The town can also seek an injunction. The responsible person is subject to a $ 250 per day civil penalty for each day the nuisance persists.

The bill applies federal Occupational Health and Safety Administration (OSHA) standards for lead-related work, to the extent they apply to employers and employees, to lead abatement, removal, remediation, management, and other activities conducted under the bill's provisions.

§ 58 — Reporting

EFFECTIVE DATE: October 1, 2007

The bill requires the DPH commissioner to report annually beginning January 1, 2009 to the Public Health and Human Services committees on the status of lead poisoning prevention programs in the state. The report must include the number of children screened and those diagnosed with elevated blood lead levels in the prior calendar year and the amount of lead testing, remediation, abatement, and management done in that year.

The bill also requires the commissioner to evaluate and report on the effectiveness of the lead screening and risk assessments and recommend whether they should be continued. This report to the Public Health and Human Services committees is due by January 1, 2011.

§ 59 — Financial Aid to Local Health Departments

EFFECTIVE DATE: July 1, 2007

The bill requires DPH, within available appropriations, to establish a financial assistance program to help local health departments pay for their lead-related expenses under the bill. It may adopt implementing regulations.

§ 60 — Lead Work Standards

EFFECTIVE DATE: October 1, 2007

The bill applies federal Occupational Health and Safety Administration (OSHA) standards for lead-related work, to the extent they apply to employers and employees, to lead abatement, removal, remediation, management, and other activities conducted under the bill's provisions.

§§ 61 & 62 — FUNDING OF LOCAL HEALTH DEPARTMENTS

EFFECTIVE DATE: July 1, 2007

The bill increases funding to local and district health departments as follows: (1) from $. 94 to $ 1. 18 per capita for full-time municipal health departments, (2) from $ 1. 94 to $ 2. 43 per capita for district health departments for each town or borough in the district with a population of 5,000 or less and (3) from $ 1. 66 to $ 2. 08 per capita for each town or borough in the district with a population over 5,000.

§ 63 — ANNUAL NURSING HOME RESIDENT REVIEWS

EFFECTIVE DATE: July 1, 2007

The bill permits the Department of Mental Health and Addiction Services' (DMHAS), within available appropriations, annually to review nursing home residents with mental illness to assesses whether they need (1) nursing home level of service or (2) specialized mental health services. DMHAS does the reviews in consultation with DSS, and the bill requires nursing homes to give the agencies access to residents and their medical records for these reviews.

Under the bill, if an annual review determines a resident who has continuously lived in a nursing home for at least 30 months needs specialized care but not nursing home care, he or she can opt to stay in the home or receive Medicaid-covered services in another institutional or noninstitutional setting. The move to the alternative setting must be done according to an alternative disposition plan DSS submits to the federal government and consistent with DMHAS' requirements for specialized services. If the resident has lived in the home fewer than 30 months, the home, in consultation with DMHAS, must arrange for his or her safe discharge. If DMHAS determines the person needs an alternative residential placement, the discharge and transfer must be

done according to the DSS disposition plan. But if an alternative placement is not available, the person cannot be transferred.

By law, a nursing home must notify DMHAS when a resident who has mental illness undergoes a significant change in condition that may require specialized services. Upon notice, DMHAS and DSS must evaluate whether the resident requires a nursing home level of care or specialized mental health services.

§ 66 — CONNECTICUT HEALTH INFORMATION NETWORK PLAN

EFFECTIVE DATE: July 1, 2007

The bill authorizes DPH and the UConn Health Center, within available appropriations, to develop a Connecticut Health Information Network (CHIN) plan. The CHIN plan is to integrate state health and social services data within and across the UConn Health Center, the Office of Health Care Access (OHCA), DPH, and the Mental Retardation (DMR) and Children and Families (DCF) departments. Data from other state agencies may be integrated into the network as funding permits and as permissible by federal law. The CHIN must securely integrate this data consistent with state and federal laws.

The bill requires DPH and UConn Health Center's Center for Public Health and Health Policy to collaborate with the Department of Information Technology and DMR, DCF and OHCA in developing the CHIN plan. The plan must (1) include research in and describe existing health and human services data; (2) inventory the various health and human services data aggregation initiatives currently underway; (3) include a framework and options for implementing CHIN, including query functionality to get aggregate data on the state's key health indicators; (4) identify and comply with confidentiality, security, and privacy standards; and (5) include a detailed cost estimate for implementation and potential funding sources.

The bill eliminates provisions of PA 07-185 (Secs. 24-28, 37, 38) that established and funded the CHIN at the UConn Health Center.

§ 68 — STATEWIDE ELECTRONIC HEALTH INFORMATION TECHNOLOGY PLAN

EFFECTIVE DATE: July 1, 2007

By November 30, 2007, the bill requires DPH, in consultation with OHCA and within available appropriations, to contract for the development of a statewide health information technology plan. This must be done through a competitive bid process. The entity awarded the contract must be designated as the lead health information exchange organization for the state between December 1, 2007 and June 30, 2009.

The statewide plan must include (1) general standards and protocols for health information exchange; (2) electronic data standards to facilitate the development of a

statewide, integrated electronic health information system for use by health care providers and institutions funded by the state, including standards (a) on security, privacy, data content, structures and format, vocabulary and transmission protocols, (b) for compatibility with any national data standards in order to allow for interstate interoperability, (c) permitting the collection of health information in a standard electronic format, and (d) for compatibility with the requirements for an electronic health information system; and (3) pilot programs for health information exchange and the projected costs and sources of funding.

By December 1, 2008 and annually afterwards, DPH, in consultation with OHCA, must report to the Public Health, Human Services, Government Administration and Appropriations committees on the status of the plan.

The bill defines:

1. "electronic health information system" as computer hardware and software that includes (a) a patient electronic health record that can be accessed in real time; (b) a personal health record through which individuals and their authorized representatives can manage a person's health information; (c) computerized order entry technology that allows a health care provider to order tests, treatments, and prescriptions; (d) electronic reminders to health care providers concerning screenings, other preventive measures, and best practices; (e) error notification procedures; and (f) tools to collect, analyze, and report adverse event data and quality of care measures;
2. "interoperability" as the ability of separate systems to exchange information including (a) physically connecting to a network, (b) enabling a user who presents appropriate permission to conduct transactions over the network, and (c) enabling such a user to access, transmit, receive, and exchange information with other users; and
3. "standard electronic format" as one using open electronic standards that (a) enables using health information technology to be used for collecting clinically specific information, (b) promoting interoperability across health care settings, including government agencies at all levels, and (c) facilitating clinical decision support.

§ 70 — SCHOOL-BASED HEALTH CENTERS

EFFECTIVE DATE: July 1, 2007

The bill requires DPH, within available funding, to expand school-based health clinic services in FY 08 for (1) priority school districts as established by law (CGS § 19-266p) and (2) areas designated by the federal Health Resources and Services Administration (HRSA) as health professional shortage areas (HPSA), medically underserved areas (MUA), or areas with a medically underserved population. It repeals a provision of PA 07-185 (§ 41) that made an appropriation to DPH for the

both expansion and operating costs of school-based health clinics for priority school districts and for areas designated as HPSAs and MUAs.

HRSA develops health workforce shortage designation criteria to help determine whether a geographic area or population group is an HPSA or MUA. HPSAs may have shortages of primary medical care, dental, or mental health providers and may be urban or rural areas, population groups, or medical or other public facilities. MUAs may be a whole county or group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts where residents have a shortage of health services.

§ 71 — RYAN WHITE PROGRAM FUNDING

EFFECTIVE DATE: July 1, 2007

For FY 08, the bill authorizes the DPH commissioner, in consultation with the OPM secretary, to (1) make payments to providers to address funding reductions under Parts A and B of the federal Ryan White Program and (2) contract with health departments in the Hartford or New Haven Transitional Grant Areas to address funding reductions under the program.

The Ryan White HIV-AIDS Treatment Modernization Act , Part A, funds urban areas with the highest number of people living with AIDS while also helping mid-size cities and areas with emerging needs. Part B funds states.

§ 72 — REPEALER

EFFECTIVE DATE: July 1, 2007

The bill repeals the following provisions of PA 07-185:

1. a premium assistance program for families with incomes between 300% to 400% of FPL who have access to employer-sponsored coverage;
2. a requirement that DSS seek a federal Health Insurance Flexibility and Accountability demonstration waiver to cover pregnant women with incomes between 185% and 250% of the FPL who do not "otherwise have creditable coverage";
3. the creation of a Connecticut Health Information Network at the UConn Health Center to integrate state and social services data within and across state agencies;
4. the designation of e-Health Connecticut as the state's health information exchange organization
5. a requirement that DSS increase the rates it pays Medicaid providers, including hospitals; and
6. appropriations for (a) DSS to establish a child health quality improvement program ($ 150,000 in FY 08), (b) DPH to establish electronic health information standards ($ 250,000 in FY 08), (c) UConn Health Center to

establish a Connecticut Health Information Network ($ 1 million each in FY 08 and 09), (d) DPH for the Connecticut HealthFirst Authority ($ 500,000 in FY 09), (e) DPH for the Statewide Primary Care Access Authority ($ 500,000 in FY 09), (f) for DPH for SBHCs ($ 2. 5 million in FY 08), (g) for DPH for patient transportation to community health centers ($ 500,000 in FY 08), and (h) for DPH for community health center infrastructure improvement ($ 2 million in FY 08).

It also repeals House "B" of sHB 7163, Public Act 07-252 that requires that for FYs 08 and 09, any balance remaining in the Tobacco and Health Trust Fund, after transfers are made as required by law from the amount disbursed to the fund from the Tobacco Settlement Fund, must be allocated to DMHAS. DMHAS was to use such money for grants for tobacco education program to discourage smoking by minors.

REQUIRED ACTION:

HCSB: Section 32 requires the DPH receive and investigate complaints.

HCSB: Section 33 requires the DPH to inspect MRCs and issue findings of non-compliance or initiate other remedies.

RSB: Section 47 requires the Department to identify state and local agencies that have lead poisoning prevention responsibilities and schedule meetings with those agencies at least once a year.

RSB: Sections 47 through 60 requires Regulatory Services (EHS, LPPCP) to recruit and train new staff for the Lead Poisoning Prevention and Control Program to address added demand for child case management, environmental health, education, outreach and data management services. Education, outreach, training of local health personnel, update several existing documents and literature, revise some data collection systems, regulatory changes, increased oversight of local health department environmental and child case management activities, establish a program to administer financial assistance to local health departments (in concert with DPH fiscal office), prepare various reports to the legislature.

LAB is required to recruit and train new staff for Biochemistry and Environmental Chemistry Labs, to handle increased volume of testing, coordinate implementation with LPPCP, establish and implement Medicaid reimbursement mechanism with DSS.

RSB: Section 50 requires that the local health departments conduct inspections to identify sources of lead exposure for children with confirmed blood lead levels that are greater than or equal to 15 micrograms per deciliter but less than 20 micrograms per deciliter in two tests taken three or more months apart. The local director of health is to order remediation of any sources of lead exposure that are identified.

RSB: Section 53 requires that the Department review the format in which lead poisoning data is collected for compatibility with information that is reported by institutions and laboratories. Regulations are to be promulgated if it is determined that the data should be reported in a different manner.

RSB: Section 58 requires that beginning January 1, 2009, the Department report to the General Assembly on the status of lead poisoning prevention efforts in Connecticut.

RSB: This bill also requires that the Department evaluate lead screening and medical risk assessment in Connecticut pursuant to Section 48 and Connecticut General Statutes Section 19a-110 as amended by Section 50 of this act, and report and provide recommendations to the General Assembly on these issues by January 1, 2011.

RSB / LHAB: Section 59 requires that within appropriations, the Department of Public Health establish and administer financial assistance to local health departments for expenses incurred in complying with this act. The Commissioner may promulgate regulations to carry out this section.

PB / ORD: Section 68 requires the DPH to contract, through the RFP process, for the development of a statewide health information technology plan by November 30, 2007.

Public Act 07-181 **SB 1048**

THE INVESTIGATION OF A DISCRIMINATION COMPLAINT AGAINST OR BY AN AGENCY HEAD OR STATE COMMISSION OR BOARD MEMBER

EFFECTIVE DATE: Upon passage

SUMMARY:

This act requires investigations of discrimination complaints made against or by a state agency head, a board or commission member, or an affirmative action officer (AAO) to be shifted to another agency.

By law, each state agency, department, board, or commission must designate an AAO. Prior law required the AAO to (1) investigate all discrimination complaints made against the entity and (2) report all the findings and recommendations to the entity's commissioner or director for proper action. Under the act, complaints against or by an agency head, board or commission member, or AAO must be referred to the Commission on Human Rights and Opportunities (CHRO) for review and, if appropriate, to the Department of Administrative Services (DAS) for investigation. Also, it requires that a discrimination complaint against CHRO be handled by DAS and a complaint against DAS be handled by CHRO.

Public Act 07-195 **SB 1396**

THE STATE PURCHASE OF SERVICE CONTRACTS FOR HEALTH AND HUMAN SERVICES

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act codifies existing practice by expanding the Office of Policy and Management (OPM) secretary's authority to waive the competitive procurement requirements set out in the personal service agreement (PSA) statute for any purchase of service (POS) contract between a state agency and a human services private provider. By law, he can waive these requirements under certain circumstances for PSAs. The act also allows him to waive them for POS contracts between a state agency and a private provider organization or municipality for ongoing direct health and human services for agency clients.

The act requires the secretary, to ensure continuity of care in health and human services delivery, to develop a plan for the competitive procurement of health and human services by January 1, 2008, in consultation with the Connecticut Nonprofit Human Services Cabinet and representatives of state agencies that provide health and human services. It requires the secretary to submit the plan, by February 1, 2008, to the Human Services and Public Health committees. In developing the plan, the secretary must consider a number of factors specified in the act. The act allows the secretary to implement the plan on or after July 1, 2008.

By law, the OPM secretary is responsible for establishing uniform policies and procedures for obtaining, managing, and evaluating the quality and cost-effectiveness of human services purchased from private providers. The act adds health services to this provision and specifies that it applies to direct health and human services. It requires the secretary to report to the General Assembly on the system for purchasing such services in the state every two years, starting by January 1, 2008.

REQUIRED ACTION:

A previously existing process required the Department to submit a procurement plan to OPM to guide contract approvals. Public Act 195 will supersede that requirement and formalize a collaborative and interactive process with OPM and other State human service agencies to develop a statewide competitive procurement plan.

IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING GENERAL GOVERNMENT

§ 2 — WATER PLANNING COUNCIL ADVISORY COUNCIL

EFFECTIVE DATE: July 1, 2007

By law, the Water Planning Council must address issues involving water companies, water resources, and state drinking water policies. The bill allows the council to establish an advisory council. The advisory council must be balanced between water consumers and other interests. It can include representatives of:

1. regional and municipal water utilities;
2. investor-owned water utilities;
3. a wastewater system;
4. agricultural interests;
5. electric power generation interests;
6. business and industry interests;
7. environmental land protection interests;
8. environmental river protection interests;
9. boating interests;
10. fisheries interests;
11. recreational interests;
12. endangered species protection interests; and
13. academics with expertise in stream flow, public health, and ecology.

Currently, the council consists of the Public Utility Control Authority chairperson (i. e. , the DPUC head), the Departments of Environmental Protection and Public Health (DEP and DPH) commissioners, and the Office of Policy and Management (OPM) secretary, or their designees. It requires the members of the Water Planning Council, by July 1, 2007, (the section's effective date) and annually thereafter, to elect a chairperson from among themselves.

§ 3 — OPM RESPONSIBILITIES REGARDING THE WATER PLANNING COUNCIL

The bill requires OPM to:

1. review and prioritize the recommendations and goals the Water Planning Council developed before October 1, 2007;
2. compile information from other reports or studies on water resources planning in the state;

3. establish a mechanism to perform an in-depth analysis of existing DEP, DPH, and DPUC statutes and regulations in areas of overlapping and conflicting or inefficient procedures;
4. review and summarize other states' regulatory programs and structure relating to water resource planning, including their approaches to water allocation;
5. identify processes and funding needs for the evaluation of existing water diversion data and approaches to basin planning projects, and coordinate water data collection from, and analysis among, the DEP, DPH, DPUC, OPM, and the U. S. Geological Survey, and recommend supplemental data collection, as appropriate;
6. evaluate existing water conservation programs and recommend ways to enhance them to promote a water conservation ethic and to provide for appropriate drought response and enforcement capabilities;
7. identify funding requirements and mechanisms for ongoing efforts in water resources planning in the state; and
8. transfer sufficient funds to DEP for data collection and analysis.

The bill requires OPM, by February 1 annually, to report the findings of this study, together with proposed legislative changes, to the council and the Appropriations and Energy and Technology committees.

§ 24 — TOBACCO AND HEALTH TRUST FUND

EFFECTIVE DATE: July 1, 2007

The bill requires the 17-member board of trustees of the Tobacco and Health Trust Fund to meet at least biannually instead of bimonthly. This fund is a separate, nonlapsing fund that can accept transfers from the Tobacco Settlement Fund and apply for and accept gifts, grants, or donations from public or private sources in order to carry out its objectives. The trust fund's purpose is to create a continuing significant source of money to (1) support and encourage programs to reduce tobacco abuse through prevention, education and cessation; (2) support and encourage program development for substance abuse reduction; and (3) develop and implement programs to meet the state's unmet physical and mental health needs.

§ 27 — CONNECTICUT VALLEY HOSPITAL RESERVOIR STUDY

EFFECTIVE DATE: Upon passage

The bill requires the Department of Environmental Protection (DEP) in consultation with among others, Connecticut Valley Hospital (CVH) and the city of Middletown, to study the permanent protection of the reservoirs, watershed, aquifers, and other water supply lands located on or abutting CVH's grounds and buildings. The study must review all available maps, records, title information, and land records, including records of conservation and other easements, to determine the owner of record of the reservoirs, watershed, aquifers, and other water supply lands. In the event the review

does not result in a conclusive determination, DEP may conduct or contract for title searches and A-2 surveys to clarify ownership. DEP must submit a report on the study's findings to the Environment and Public Health committees by February 1, 2008.

Besides CVH and Middletown, DEP must consult with the departments of Mental Health and Addiction Services and Public Health, the Office of Policy and Management, and state community colleges, including Middlesex Community College.

Agency Proposals

Public Act 07-252 **HB 7163**

REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES AND REVISING THE SCOPE OF PODIATRIC MEDICINE

EFFECTIVE DATE: Various, see individual sections.

SUMMARY:

This act makes numerous substantive and technical changes to Department of Public Health (DPH) and other related statutes concerning health care professionals, health care facilities, programs and activities, as well as health care decision-making. It also addresses recording of certain instruments by town clerks.

This act expands the scope of practice of podiatric medicine to allow podiatrists to engage independently in standard and advanced ankle surgery procedures if they meet certain requirements and qualifications. Under the act, licensed podiatrists with additional qualifications beyond board qualification or certification may be permitted to perform surgical treatment of the ankle. Surgical treatment of the ankle does not include the performance of total ankle replacements or treatment of tibial pilon fractures.

Under the act, a podiatrist cannot engage in independent ankle surgery procedures without receiving a permit from the Department of Public Health (DPH). DPH must develop a process for issuing such permits.

The act requires the DPH commissioner to appoint a four- member advisory committee consisting of podiatrists and orthopedists to assist in evaluating permit applicants. The commissioner must also adopt regulations concerning the evaluation of an applicant's training and experience in various ankle procedures.

§§ 1, 2, & 19-21 — APPOINTMENT OF HEALTH CARE REPRESENTATIVE, POWER OF ATTORNEY FOR HEALTH CARE DECISIONS, SHOCK THERAPY

EFFECTIVE DATE: October 1, 2007

The act specifies that a short form power of attorney no longer can be used for health care decision purposes.

The act specifies that an appointment of a (1) health care agent or (2) power of attorney for health care decisions, properly executed before October 1, 2006 under the law in effect at that time has the same legal force and effect as if it had been

executed according to the law after October 1, 2006. PA 06-195 amended and updated Connecticut law on health care decision making by, among other things, (1) combining the authority of the health care agent and attorney-in-fact for health care decisions into a unified proxy known as the "health care representative" and (2) authorizing the health care representative to make any and all health care decisions for a person incapable of expressing those wishes.

For purposes of the appointment of a health care representative and health care decision making, the act specifies that "shock therapy" is as defined under the law on patients' rights for persons with psychiatric disabilities (CGS Sec. 17a-540).

§ 5 — CIVIL PENALTIES AGAINST HEALTH CARE PROFESSIONALS

EFFECTIVE DATE: October 1, 2007

The act increases, from $10,000 to $25,000, the amount of a civil penalty DPH and various health professional regulatory boards can assess a health care professional. Under the law, DPH and various health professional boards and commissions can, after a finding of good cause, take various disciplinary actions against licensed health professionals. These actions include license suspension or revocation, censure, letter of reprimand, probation, or assessment of a civil penalty.

§ 6 — LABORATORY FEES

EFFECTIVE DATE: October 1, 2007

The act allows, rather than requires, the DPH commissioner to set laboratory fees and to do so without basing them on nationally recognized standards and performance measures for analytic work effort for such services as currently required. By law, DPH can establish state laboratories to test for preventable disease, as well as perform sanitation, environmental, and occupational testing.

Laboratory services are done without charge for local health directors and local law enforcement officials. The law also allows for partial, as well as full, fee waivers for others if the commissioner determines the public health requires it. The act clarifies that the commissioner can waive the fees if he establishes a fee schedule.

§§ 7-9 — HIV AND AIDS SERVICES

EFFECTIVE DATE: October 1, 2007

The act revises funding provisions for HIV and AIDS services. It expands the type of organizations that can receive funds to provide such services and expands service recipients to include people with HIV and those at risk of contracting HIV or AIDS.

By law, DPH must establish a grant program to provide funds to private agencies that provide services to persons suffering from AIDS and their families. Under the act, qualifying individuals and organizations, including local health departments, that

serve people infected with, at risk of, and affected by HIV or AIDS are eligible for grants.

Under existing law, agencies receiving DPH funding to provide AIDS tests must give priority to persons in high risk categories and must establish a fee schedule based on ability to pay. The act eliminates the fee schedule requirement and specifies that the testing is for HIV.

The act also specifies that DPH's existing public information program must address HIV as well as AIDS.

The act broadens the eligibility criteria for grant-in-aid applicants for programs to study or treat AIDS. Under the act, such grants are available to qualifying individuals or organizations instead of just any hospital, municipality, public independent college or university, or individual. It also provides that the grants are for studying or treating HIV, AIDS, or both.

The act eliminates a requirement that DPH adopt regulations concerning administration of the grant program.

§§ 11 & 80 — CREMATORIES AND CREMATION

EFFECTIVE DATE: October 1, 2007

The act requires crematories to keep on their premises records, copies of cremation permits, cremation authorization documentation, and documentation of receipt of cremated remains for at least three years after final disposition of the cremated remains.

EFFECTIVE DATE: July 1, 2007

The act specifies that if the body of a deceased person is brought into Connecticut from another state for cremation with a permit for final disposition indicating cremation issued by the legal authority of the other state, that permit is sufficient authority for cremation and no additional permit is needed. (This amends PA 07-104.)

§§ 12 & 13 — ASSISTED LIVING SERVICES AGENCY

EFFECTIVE DATE: October 1, 2007

The act adds assisted living services agencies to the statutory list of health care institutions and makes a technical change to the definition of such agencies.

§§ 23 & 24 — ALCOHOL AND DRUG COUNSELORS

EFFECTIVE DATE: Upon passage

Existing law provides that the alcohol and drug abuse counselor licensure and certification statutes do not apply to the activities of various licensed professionals acting within the scope of their profession, doing work consistent with their training, and not holding themselves out as alcohol and drug counselors.

The act amends this exception by (1) removing chiropractors, acupuncturists, physical therapists, and occupational therapists from the exempt list; (2) adding professional counselors; and (3) specifying that nurses mean advanced practice registered nurses and registered nurses. It also specifies that the person must be working consistent with his or her license, rather than with their "training."

§ 25 — PODIATRY

EFFECTIVE DATE: October 1, 2007

The act eliminates a requirement that a podiatrist provide DPH with satisfactory evidence of a high school diploma or its equivalent in order to obtain a license.

§§ 26 & 27 — PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

EFFECTIVE DATE: October 1, 2007

The law allows DPH to license without examination physical therapists and physical therapist assistants licensed or registered in another state or nation with similar or higher requirements than Connecticut's. The act instead specifies that the other state's or nation's requirements must be deemed by DPH to be equivalent to or higher than Connecticut's.

§ 30,79 — OPTOMETRISTS

EFFECTIVE DATE: October 1, 2007

The act deletes (1) requirements that an optometrist applying for license present satisfactory evidence to DPH of graduating from an approved high school or its equivalent and (2) related provisions and examination fees concerning license applicants who have not graduated from an approved high school. It deletes a requirement that optometry schools have a minimum course of study of 1,000 attendance hours in order to be approved by the state optometry board. It also eliminates a provision that specifies that a school cannot be disapproved solely because it is located outside of the United States.

The act requires that optometric license applicants successfully complete an examination prescribed, rather than conducted, by DPH with the consent of (instead

of under the supervision of) the Board of Examiners for Optometrists. It also specifies that the examination include the treatment and management of ocular disease.

The act makes both technical and substantive changes to requirements for licensure by endorsement. (Endorsement basically means that a licensee from another state may be eligible for licensure, without examination, in this state provided that the applicant has credentials and qualifications substantially equivalent to Connecticut's licensure requirements.) The act eliminates a requirement that the other state give a similar privilege to Connecticut licensees seeking licensure in that state in order for Connecticut to license someone from that state by endorsement. It allows DPH to license by endorsement an optometrist who holds a Council on Endorsed Licensure Mobility for Optometrists certificate issued by the Association of Regulatory Boards of Optometry, or its successor.

The act eliminates (1) a requirement that DPH annually inform the optometry board of the number of applications it receives for licensure without examination and (2) a provision that specifies that an otherwise qualified person cannot be denied the right to apply for or receive an optometrist's license solely because he is not a United States citizen. It also eliminates a $50 examination fee.

The act restores "treatment of iritis" to the definition of "noninvasive procedures" for optometrists which was inadvertently dropped in PA 07-92.

§ 31 — RESPIRATORY CARE PRACTITIONERS

EFFECTIVE DATE: July 1, 2007

Existing law requires a respiratory care practitioner applying for license renewal to either (1) earn a minimum of six contact hours of continuing education within the preceding registration period or (2) maintain credentialing as a respiratory therapist from the National Board for Respiratory Care. The act eliminates the latter option. A registration period is the one-year period for which a renewed license is current and valid.

§§ 32 & 85 — FUNERALS AND FUNERAL SERVICE BUSINESSES

EFFECTIVE DATE: October 1, 2007

The act requires a person, firm, partnership, or corporation involved in the funeral service business to keep at the funeral business address of record (1) copies of all death certificates, burial permits, cremation authorizations, receipts for cremated remains, and written agreements used in making arrangements for final disposition of dead bodies, including copies of the final bill and other written evidence of agreement or obligation given to consumers, for at least three years after final disposition and (2) copies of price lists, for at least three years from the last date they were distributed to consumers.

EFFECTIVE DATE: Upon passage

PA 07-104 defines "disinfecting solution," for purposes of preparing and transporting dead bodies, as an aqueous solution or spray containing at least five percent phenol by weight. This act amends this to include "or an equivalent in germicidal action."

§ 33 — SANITARIANS

EFFECTIVE DATE: October 1, 2007

The act expands the grounds on which DPH may refuse to issue or renew, or suspend, a license or take other disciplinary action against a sanitarian as follows: (1) the sanitarian has been found guilty or convicted of an act which is a felony under Connecticut or federal law, or under the laws of another jurisdiction, which, if committed in Connecticut, would have been a felony or (2) the sanitarian has been subject to disciplinary action similar to that of Connecticut's by an authorized professional disciplinary agency in any state, the District of Columbia, a U.S. territory or possession, or a foreign country.

§ 34 — PODIATRY: STANDARD AND ADVANCED ANKLE SURGERY PROCEDURES

EFFECTIVE DATE: October 1, 2007

Types of Surgery

Under the act, "standard ankle surgery procedures" include soft tissue and osseous (bone) procedures.

"Advanced ankle surgery procedures" include ankle fracture fixation, ankle fusion, ankle arthroscopy, insertion or removal of external fixation pins into or from the tibial diaphysis (shaft of a long bone) at or below the level of the myotendinous junction (junction formed by the skeletal muscles where they adhere to tendons) of the triceps surae, and insertion and removal of retrograde tibiotalocalcaneal intramedullary rods and locking screw up to the level of the myotendinous junction of the triceps surae. It does not include the surgical treatment of complications within the tibial diaphysis related to the use of such external fixation pins.

"Triceps surae" refers to the group of lower leg muscles called the gastrocnemius and the soleus. The gastrocnemius is the two-headed, heart-shaped muscle in the back of the lower leg. The soleus is the broader, flat muscle just beneath the gastrocs. Both of these muscles attach to the heal bone via the Achilles tendon. The triceps surae makes up the superficial, posterior lower leg compartment.

Independent Ankle Surgery

Requirements for Standard Ankle Surgery. The act permits licensed podiatrists with the following qualifications to independently engage in standard ankle procedures:

1. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education, or its successor, at the time of graduation and hold and maintain current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery, or its successor;

2. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the council or its successor, at the time of graduation, who are qualified, but not certified, in reconstructive rearfoot ankle surgery by the board or its successor, and provides documentation satisfactory to DPH of their training and experience in standard or advanced midfoot, rearfoot, and ankle procedures, except that such applicants cannot perform osteotomies of the tibia and fibula until they hold and maintain current board certification as described above; or

3. those who graduated before June 1, 2006 from a residency program in podiatric medicine and surgery of at least two years that was accredited by the council at the time of graduation, hold and maintain current board certification, and provide satisfactory documentation to DPH of their training and experience in standard or advanced midfoot, rearfoot, and ankle procedures.

Requirements for Advanced Ankle Surgery. Under the act, licensed podiatrists with the following qualifications can engage independently in advanced ankle surgery procedures:

1. those who graduated on or after June 1, 2006 from a three-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education or its successor, at the time of graduation, hold and maintain current board certification in Reconstructive Rear foot/Ankle Surgery by the American Board of Podiatric Surgery or its successor, and provide satisfactory documentation to DPH of their training and experience in advanced midfoot, rearfoot, and ankle procedures; or

2. those who graduated before June 1, 2006 from a residency program in podiatric medicine and surgery of at least two years and accredited by the council at the time of graduation, hold and maintain current board certification, and provide satisfactory documentation to DPH of their training and experience in advanced midfoot, rearfoot, and ankle procedures.

Ankle Surgery Under The Direct Supervision of a Physician or Surgeon

The act specifies conditions under which a licensed podiatrist may surgically treat the ankle, including using standard and advanced podiatric ankle surgery procedures, without a permit until the podiatrist meets the requirements for a permit for independent ankle surgery. The podiatrist must perform these procedures under the direct supervision of a licensed physician or surgeon who has hospital privileges in the procedure or of a licensed podiatrist who has a permit for independent ankle surgery. The podiatrist must also:

1. have graduated from a minimum two-year residency program in podiatric medicine and surgery accredited by the Council on Podiatric Medical Education, or its successor, at the time of graduation; and

2. hold and maintain current board certification in reconstructive rearfoot ankle surgery by the American Board of Podiatric Surgery or its successor, is board qualified in such surgery by the board or its successor, or is currently board certified in foot and ankle surgery by the board or its successor.

DPH Permit Process

The act requires DPH to establish a process to issue permits to qualified licensed podiatrists to independently perform standard or advanced ankle surgery procedures as described above. No licensed podiatrist may independently engage in the surgical treatment of the ankle or the anatomical structures of the ankle, administer or prescribe drugs incidental to such treatment, or surgically treat manifestations of systemic diseases as they appear on the ankle, until the podiatrist has obtained a DPH permit.

DPH cannot issue a permit unless the applicant meets all of the requirements for independent ankle surgery as described above and pays a $100 fee.

The act specifies that "surgical treatment of the ankle" does not include the performance of total ankle replacements or the treatment of tibial pilon fractures.

Advisory Committee

The act requires the DPH commissioner to appoint a four-member advisory committee to assist and advise him in evaluating an applicant's training and experience in midfoot, rearfoot, and ankle procedures required for permit eligibility. Two committee members must be podiatrists recommended by the Connecticut Podiatric Medical Association and two must be orthopedists recommended by the Connecticut Orthopedic Society.

Regulations

The act requires DPH to adopt regulations on the permit issuance process, including evaluation of an applicant's training and experience in the procedures required for a permit. The regulations must include the number and types of procedures required

for an applicant to demonstrate training or experience in standard and advanced ankle procedures. DPH must seek the advisory committee's advice and assistance and consider nationally recognized standards for accredited residency programs in podiatric medicine and surgery in developing the regulations.

The act specifies that DPH can issue permits to qualified licensed podiatrists to independently perform standard or advanced ankle surgery procedures before the effective date of the regulations DPH must adopt.

Podiatrist Privileges

The act specifies that DPH's permit issuance to a licensed podiatrist to independently engage in ankle surgery does not obligate a hospital or outpatient surgical facility to grant privileges to that podiatrist.

§ 35 — DISCIPLINARY ACTION AGAINST PODIATRISTS

EFFECTIVE DATE: October 1, 2007

The act adds engaging in surgical treatment of the ankle without the required permit to those grounds on which the Connecticut Board of Examiners in Podiatry can take disciplinary action against a podiatrist.

§ 36 — ADMINISTRATION OF MEDICATION IN SCHOOLS BASED ON OPTOMETRISTS' WRITTEN ORDERS

EFFECTIVE DATE: July 1, 2007

The act allows school nurses and others authorized to administer medications to students to administer them pursuant to an optometrist's written order.

§ 37 — BLOOD SAMPLE TAKING BY EMERGENCY MEDICAL TECHNICIANS (EMT)

EFFECTIVE DATE: July 1, 2007

The act deletes EMTs II from the list of those who can take a blood sample following a motor vehicle accident resulting in serious injury or death.

§ 38 — CHRONIC DISEASE HOSPITALS

EFFECTIVE DATE: October 1, 2007

The act increases, from 24 to 36 hours, the time within which a physician must examine a person admitted to a chronic disease hospital for psychiatric treatment on a 15-day emergency certificate. (PA 07-49 imposed the 24 hour period.)

§ 39 — DPH DISCIPLINARY ACTION AGAINST HEALTH PROFESSIONALS

EFFECTIVE DATE: Upon passage

The act adds to DPH's disciplinary authority over licensed health practitioners the ability to not renew or reinstate a license or permit by voluntary surrender or agreement.

§ 40 — STEM CELL RESEARCH PEER REVIEW COMMITTEE

EFFECTIVE DATE: July 1, 2007

Beginning July 1, 2007, the act allows the DPH commissioner to appoint additional members to the existing Stem Cell Peer review Committee as he deems necessary to review grant applications. The total number of members cannot exceed 15. These additional members must be approved according to the requirements of existing law, but they serve two–year instead of four-year terms.

§ 41 — PHYSICIAN ASSISTANTS-USE OF TITLE, LICENSE FRAUD

EFFECTIVE DATE: July 1, 2007

The act establishes penalties for someone buying, selling, or fraudulently obtaining any diploma or license to practice as a physician assistant. This also applies to using titles or words that induce the belief that a person is practicing as a physician assistant without complying with the law on physician assistant licensure. The act establishes a fine of up to $500 or imprisonment up to five years, or both. It specifies that failure to timely renew a license is not a violation for these purposes.

§ 42 — CONTINUING EDUCATION FOR PHYSICAL THERAPISTS

EFFECTIVE DATE: July 1, 2007

The act specifies that qualifying continuing education activities for physical therapists include courses offered or approved by the American Physical Therapy Association or any of its components, a hospital, or other licensed health care institution, or a regional accredited higher education institution.

§§ 43,44 — RADIOGRAPHERS, RADIOLOGIC TECHNOLOGISTS

EFFECTIVE DATE: Upon passage

The law allows licensed radiographers to operate a medical x-ray system under the supervision and upon the written order of a physician. The act also allows operation of such a system upon the verbal order of a physician. It also allows licensed radiology technologists to administer medications, not just intravenous ones, for diagnostic procedures in various health care settings, not just hospitals.

§ 45 — GRADUATE DENTAL TRAINING

EFFECTIVE DATE: Upon passage

Existing law allows applicants for dental licensure, in lieu of a practical examination, to submit evidence of successful completion of at least one year of graduate dental training in an accredited program. The supervising dentist must provide satisfactory documentation to DPH at the end of that year.

The act allows the dental residency program director at the training facility to provide the documentation at any time rather than at the end of the year of the graduate training.

§ 46 — OFFICE OF ORAL PUBLIC HEALTH

EFFECTIVE DATE: July 1, 2007

The act establishes, within DPH, an Office of Oral Public Health under the direction of an experienced public health dentist. The office must coordinate and direct state activities concerning state and national dental public health programs; serve as DPH's chief advisor on oral health; and plan, implement and evaluate all DPH oral health programs.

§ 47 — PROFESSIONAL COUNSELORS

EFFECTIVE DATE: Upon passage

For purposes of meeting graduate educational requirements for licensure as a professional counselor, the act recognizes coursework at a regionally accredited institution in the following areas-(1) human growth and development, (2) social and cultural foundations, (3) counseling theories and techniques or helping relationships, (4) group dynamics, (5) processing and counseling, (6) career and lifestyle development, (7) appraisals or tests and measurements for individuals and groups, (8) research and evaluation, and (9) professional orientation to counseling. These replace references in prior law to the core and clinical curriculum of the Council for Accreditation of Counseling and Related Educational Programs and preparation in principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior. The act also deletes a requirement that acceptable graduate semester hours must be deemed in or related to counseling by the national Board for Certified Counselors.

§ 48 — VETERINARIANS

EFFECTIVE DATE: Upon passage

The act specifies that graduates of foreign veterinary schools must graduate from a program acceptable to the American Veterinary Medical Association as required to receive certification by the Educational Commission for Foreign Veterinary Graduates.

§ 49 — MASSAGE THERAPISTS

EFFECTIVE DATE: Upon passage

The act directs the DPH commissioner, within available appropriations, to enforce provisions of the law, including PA 07-35, concerning use of the title of "massage therapist" and related titles and advertising of massage therapy services.

§ 50 — REPLACEMENT BIRTH CERTIFICATES

EFFECTIVE DATE: Upon passage

The act requires DPH to create a replacement birth certificate according to a court order within 45 days of the order or 45 days after the child's birth, whichever is later. Prior law required DPH to do this within 45 days of the court order.

§§ 51-54 — RECORDING OF INSTRUMENTS BY TOWN CLERKS

EFFECTIVE DATE: July 1, 2007, except that the format requirements become effective October 1, 2008

Under prior law, a town clerk had to make a note on a recorded judgment lien indicating it has been released when a legally sufficient release is recorded on the land records. The act specifies that a manual notation of such release is not required if the town clerk notes the release electronically by means of a computerized notation that links the release to the recorded judgment lien.

By law, when a mortgage release or assignment is recorded a town clerk must make a notation on the first page where a mortgage or lien is recorded, stating the book and page where the release, partial release, or assignment is recorded. The act eliminates a provision that if a town's land records are not maintained in a paper form, the town clerk may make the notation on the digitized image of the first page of the mortgage or lien in a form or manner the Public Records Administrator approves. The act instead specifies that a manual notation is not required if the town clerk notes the release or assignment electronically by means of a computerized notation that links the release to the recorded mortgage or lien.

The act requires that each instrument that is to be recorded in the land records must have a return address and addressee appearing at the top of the front side of its first page. It also requires that each page of such an instrument must have a blank margin at least three-fourths of an inch wide.

But the act prohibits a town clerk from refusing to receive an instrument for recording that does not conform to these requirements. It specifies that the fact that the town clerk records a nonconforming instrument does not affect its priority or validity.

§§ 55-56 — PRESERVATION OF HISTORIC DOCUMENTS; ELECTRONIC INDEXING AND PUBLIC ACCESS

EFFECTIVE DATE: July 1, 2007

Under existing law, town clerks must collect a $3 fee in addition to those fees the law already requires them to collect for recording land documents for the purpose of generating funds for preserving and managing historic documents. The town clerks must keep $1 and remit $2 to the state treasurer for deposit in a dedicated, nonlapsing General Fund account for historic documents preservation.

The act amends the current definition of "preservation and management of historic documents" to allow towns to use their portion of these funds to provide public access to an electronic indexing system combining the grantor index and grantee index of a town's land records. The law already allows towns to use the funds to: (1) restore and conserve land records, land record indexes, maps, or other records; (2) microfilm these documents; (3) manage and track historic documents using information technology; (4) assess or upgrade facilities where records are retained; (5) recover documents after a disaster; and (6) train staff to maintain and track historic documents.

By January 1, 2009, the act requires each town to provide public access to an electronic indexing system combining the grantor and grantee indexes of a town's land records.

§ 57 — ATHLETIC TRAINERS

EFFECTIVE DATE: October 1, 2007

The act allows DPH to issue a temporary permit to practice athletic training to those applicants who have met all of the license requirements except that they have not yet taken nor received the results of the certification examination of the Board of Certification Inc., or its successor organization. The act establishes a $50 fee for this. The temporary permit allows athletic trainers to practice under the supervision of a licensed athletic trainer and is limited to settings where the supervisor is physically present and immediately available to give assistance and supervision as needed. The temporary permit is valid for 120 days and cannot be renewed. It becomes void and cannot be reissued if the permittee fails to pass the certification examination.

A permit cannot be issued to a person who has previously failed the certification examination or is the subject of an unresolved complaint or pending disciplinary action. Violating these restrictions can constitute a basis for denial of an athletic trainer license.

§ 58 — DENTISTS AND CONSCIOUS SEDATION

EFFECTIVE DATE: July 1, 2007

The act specifies that "conscious sedation" as used in the dentistry statutes does not include the administration of a single oral sedative or analgesic medication in a dose appropriate for the unsupervised treatment of insomnia, anxiety or pain that does not exceed the maximum recommended therapeutic dose established by the federal Food and Drug Administration for unmonitored home use.

§ 59 — FARMERS' MARKET PRODUCE SALES TO RESTAURANTS

EFFECTIVE DATE: Upon passage

The act permits sellers at Department of Agriculture-certified farmers' markets to sell unprocessed fruits and vegetables directly to restaurants and other food service establishments. It requires food service establishments to ask for, and the farmer or person selling the produce to provide, an invoice indicating the source of the produce and the date it was sold.

§§ 60,61 — ALZHEIMER'S SPECIAL CARE UNITS-NURSE'S AIDE TRAINING

EFFECTIVE DATE: October 1, 2007

The act requires each Alzheimer's special care unit or program to annually provide at least eight hours of Alzheimer's and dementia specific training, including pain recognition and administration of pain management techniques, to all nurse's aides who provide direct patient care to residents in the special unit or program. For staff hired on or after October 1, 2007, the training must be completed within six months of the date of employment. Existing law requires such training for all licensed and registered direct care staff providing direct patient care to residents of Alzheimer's special care units or programs. (The act amends PA 07-34, which requires Alzheimer's special care units or programs annually to provide at least one hour of Alzheimer's and dementia specific training to all unlicensed and unregistered staff .)

§ 62 — "A BETTER CHANCE HOUSING"

EFFECTIVE DATE: July 1, 2007

The act exempts houses in which students participating in "A Better Chance" programs live from DCF licensing requirements. These programs bring academically talented minority students from other states to live and attend school in Connecticut.

§§ 63-72 — MOBILE FIELD HOSPITAL

EFFECTIVE DATE: Upon passage

The act renames the facility the governor can deploy for public health emergencies from "critical access" to "mobile field" hospital. A "critical access hospital" is a facility that meets specified federal criteria (including rural location and provision of 24-hour emergency care), which Connecticut's facility does not.

The act adds providing medical services at mass gatherings and surge capacity during mass casualty events or infrastructure failures to the purposes for which the hospital can be used. The facility could already be used for isolation care and treatment during a public health or other emergency, triage and treatment during a mass casualty event, and training. The act also specifies that the facility must be modular and transportable.

The act specifies that licensed and certified ambulances can transport patients to the mobile field hospital (and be paid for doing so) when the governor or her designee has deployed it for an allowable purpose.

§§ 73-75 — PHARMACY PRACTICE

EFFECTIVE DATE: October 1, 2007

The act allows the consumer protection (DCP) and public health commissioners to (1) exchange information relating to a license or registration issued by their respective agencies or (2) exchange investigative information concerning violations of the law with each other, the Chief State's Attorney, and with law enforcement agencies.

The act increases the DCP commissioner's power to discipline controlled substance registrants, including placing a registration on probation, placing conditions on the registration, and assessing a civil penalty of up to $1,000 per violation. It adds fraudulent billing practices as a sufficient cause for taking action against a registration.

It allows certain businesses that are not licensed pharmacies to use "pharmacy," "drug," and similar words in signs and advertisements.

§ 76 — MARITAL AND FAMILY THERAPISTS

EFFECTIVE DATE: Upon passage

The act eliminates a requirement that a supervised practicum or internship for licensure as a marital and family therapist be a minimum of 12 months and completed within a 24-month period. The practicum or internship must still be completed in order to be licensed.

§ 77 — UMBILICAL CORD BLOOD BANK

EFFECTIVE DATE: Upon passage

The act requires the DPH commissioner, by October 1, 2007, to request information from umbilical cord blood banks concerning establishing a public cord blood collection operation in Connecticut for purposes of collecting, transporting, processing, and storing cord blood units from Connecticut residents for therapeutic and research purposes. The request for information must contain provisions inquiring about the ability of the cord blood bank to (1) establish and operate one or more collection sites in the state; (2) implement collection procedures designed to collect cord blood units reflecting the state's racial and ethnic diversity; (3) set up collection operations within six months after contract execution with the state, provided the bank is able to negotiate any necessary contracts related to the collection sites within that time period; (4) participate in the National Cord Blood Coordinating Center or similar national inventory center by listing cord blood units in a way assuring maximum use opportunity; (5) have a program providing units for research and agree to provide units unsuitable for therapeutic use to state researchers at no charge; and (6) maintain national accreditation by an organization recognized by the federal Health Resources and Services Administration.

The act requires the commissioner to submit a summary of the responses and any recommendations to the Governor and Public Health committee by January 1, 2008.

§ 78 — PILOT FAMILY NURSE PRACTITIONER PROGRAM

EFFECTIVE DATE: October 1, 2007

The act makes a technical change to PA 07-219 concerning a Department of Social Services report to a legislative committee.

§ 81 — HISTORIC DISTRICT SWIMMING POOL

EFFECTIVE DATE: Upon passage

The act specifies that the restoration of an existing swimming pool in Manchester's National Landmark Historic District does not have to comply with the Public Health Code or State Building Code if Manchester enters into an agreement with DPH and the Department of Public Safety, before the project starts, holding the departments harmless from any liability associated with the pool restoration, including its public use. It does not prohibit Manchester from seeking, or either department providing, technical assistance.

§ 83 — DAY CARE SERVICES IN PUBLIC SCHOOL BUILDINGS

EFFECTIVE DATE: Upon passage

The act allows day care centers and group day care homes that provide services exclusively to school-age children in a public school building to ask DPH for a variance from its regulations governing physical plant requirements. It requires, before DPH can approve a variance, the center or home to (1) document that it will satisfactorily meet the regulation's specific intent by other means and (2) enter a written agreement with DPH specifying the variance, its duration, and the terms under which it is granted. The variance is cancelled immediately if the home or center fails to comply with the agreement.

The day care operator must post the variance near its license and, when a child enrolls and annually thereafter, notify the child's parents or guardians of the variance. The notice must include the DPH requirements for which the variance was granted and an explanation of how the variance will achieve the requirements' intent in a way that protects the children's health and safety.

§ 84 — WOMEN, INFANTS AND CHILDREN (WIC) ADVISORY COUNCIL

EFFECTIVE DATE: October 1, 2007

The act creates an 11-member council to advise DPH on issues pertaining to increased participation in and access to WIC supplemental food services. The council consists of (1) the Public health committee chairpersons; (2) the DPH commissioner or designee; (3) the Children's Commission executive director or designee; (4) a nutrition educator, appointed by the governor; (5) two local directors of the WIC program, one appointed by the Senate president pro tempore and the other by appointed by the House speaker; (6) two WIC program recipients, one appointed by the Senate majority leader and the other by the House majority leader; and (7) two anti-hunger association representatives, one appointed by the Senate minority leader and the other by the House minority leader.

Members serve two-year terms, elect the chairperson and vice-chairperson meet twice a year, and serve without compensation. Vacancies are filled by the appointing authority.

§ 86 — SALE OF WATER COMPANY LAND

EFFECTIVE DATE: July 1, 2007

Under the act, a public auction or other procedure for public sale is not required for the sale or other disposition of real property by a water company to the state, a municipality, or land conservation organization if (1) at least 70% of the area of the real property sold or disposed of is to be used for open space or recreational purposes and (2) the consideration received is not less than the appraised value of the property.

§§ 87-88 —YOUTH CAMPS AND DAY CARE PROVIDERS

EFFECTIVE DATE: September 1, 2007 for the youth camp provision; October 1, 2007 for the day care provision.

The act amends PA 07-129 to make clear that any regularly scheduled program or organized group activity that advertises itself as a camp must be licensed as a youth camp if it operates on weekdays during the school year. That act exempted from licensure programs that operated at times other than during school vacations and weekends. And, by eliminating a prior exclusion, it requires 4-H programs to be licensed as day care centers or group day care homes.

§ 89 — TOBACCO AND HEALTH TRUST FUND

EFFECTIVE DATE: July 1, 2007

For FYs 08 and 09, the act allocates to the Department of Mental Health and Addiction Services (DMHAS), from the Tobacco and Health Trust Fund, any balance remaining in the fund after transfers required by law have been made from the amount distributed to the fund from the Tobacco Settlement Fund. DMHAS must use the funds to provide grants for tobacco education programs designed to discourage smoking by minors in grades one through eight. DMHAS must ensure that these programs are funded state-wide and must establish reporting requirements.

(PA 07-2, June Special Session, repealed this provision.)

§ 90 — REPEALERS

EFFECTIVE DATE: October 1, 2007

The act eliminates a requirement that a clinical practice performing in-vitro fertilization, gamete intra-fallopian transfer, or zygote intra-fallopian transfer procedures covered by insurance report certain information to DPH. It repeals a statute concerning grants to municipalities for a one-time mass mailing of the U.S. Surgeon General's AIDS report. Finally, it repeals a statute requiring DPH to adopt regulations concerning medical test unit operations.

REQUIRED ACTIONS:

HCSB: Sections 5, 23, 24, 25, 26, 27, 30, 31, 38, 39, 41, 42, 43, 44, 45, 47, 48, 57, 58, 76, 79 update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

PB: Sections 11 and 80 require the Department to notify town clerks and funeral directors of the legislative change. HCSB will notify crematories and funeral boards and update the website.

ORD: Section 40 requires the Office of Research and Development to assist the Commissioner in appointing potential new members to the stem cell peer review committee.

HCSB: Section 49 requires HCSB to develop a fact sheet regarding massage therapists.

PB: Section 50 requires the Department to notify town clerks and funeral directors of the legislative change for replacement birth certificates.

ORD: Section 77 requires the DPH commissioner, by October 1, 2007, to request information from umbilical cord blood banks concerning establishing a public cord blood collection operation in Connecticut for purposes of collecting, transporting, processing, and storing cord blood units from Connecticut residents for therapeutic and research purposes. The commissioner must also submit a summary of the responses and any recommendations to the Governor and Public Health committee by January 1, 2008.

RSB: Section 83, 87 and 88 requires the Department to develop forms and process for variance requests for centers and group day care homes, develop informational materials and update forms to reflect changes.

HCSB: Section 90 requires FLIS to educate staff and repeal corresponding public health code regulations.

Public Act 07-79 **SB 1190**

VITAL RECORDS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act makes a number of substantive and technical changes to statutes addressing vital records and related topics.

Under the act, the Department of Public Health (DPH) commissioner must require applicants seeking employment in, or transfer to, DPH's vital records unit to submit to state and national criminal history record checks. The checks must be done according to existing law (see BACKGROUND). The act also requires applicants to state whether they have ever been convicted of a crime or are facing pending criminal charges when they apply.

The act allows a nurse midwife who delivers a fetus born dead to sign the fetal death certificate. It also allows a nurse midwife to certify to the date of delivery and sign the fetal death certificate, provided the fetal death was anticipated, in cases in which the nurse midwife delivers a dead fetus and there is no physician present at the time of delivery. Prior law gave the nurse midwife the authority to certify to an infant death (a child born alive that dies shortly after birth), but not to a fetal death (a fetus over 20 weeks gestation that is born dead).

The act specifies that a marriage or civil union ceremony is valid in Connecticut only if conducted by and in the physical presence of someone authorized to perform such a ceremony.

Finally, the act allows a town recording a vital record event relating to a nonresident to collect up to a $2 fee from that person's town of residence. A vital record is a birth, death, marriage, or fetal death.

BACKGROUND:

Criminal History Record Checks

By law, a criminal history record check must be requested from the Department of Public Safety's (DPS) State Police Bureau of Identification and applies only to the individual identified in the request. It (1) specifies that the “requesting party” must arrange for fingerprinting or conducting other methods of positive identification that the bureau or FBI may require; (2) directs the state bureau to conduct the state criminal history record check; and (3) if a national criminal history record check is

requested, directs the bureau to submit the fingerprints or other positive identifying information to the FBI, unless the FBI permits the requesting party to submit them directly.

The law also authorizes the DPS commissioner to provide expedited service for people requesting criminal history record checks. It authorizes the commissioner to contract with any person or entity to establish and administer this service, which must include making the results of the check available to the requesting party through the Internet. It requires the commissioner to charge an additional $25 fee for each expedited check provided. It specifies that the requesting party must pay the fees for the checks in whatever manner the commissioner requires (CGS § 29-17a).

REQUIRED ACTION:

The Human Resource Department and Vital Records unit will be responsible for developing a plan necessary to implement the requirements for criminal background as called for in Section 1. Vital Records will notify Town Clerks and Registrar's of Vital Records of the changes provided for in Sections 2-5. Notification will also be made to nurse midwives outlining the ability to certify to fetal deaths.

Public Act 07-129 **SB 1192**

CHILD DAY CARE SERVICES, YOUTH CAMPS AND THE EMERGENCY DISTRIBUTION OF POTASSIUM IODIDE TABLETS IN CERTAIN FACILITIES

EFFECTIVE DATE:

October 1, 2007, except for the changes in youth camp licensing, which are effective September 1, 2007.

*****Sections 87 and 88 of HB 7163 amends HB 1192**

SUMMARY:

This act makes changes to day care and youth camp licensing laws and the law governing provision of potassium iodide at various facilities during a public health emergency. It revises (1) the types of recreational programs that are exempt from day care licensure and (2) licensure for day care operations serving six or fewer children outside of a private home. It doubles to four years the duration of a day care license and doubles the license fee, and makes anyone whose license is revoked ineligible for a new license for one year.

The act limits the programs that must be licensed as youth camps to those that (1) operate only during school vacations or on weekends and (2) serve children ages three through 15. And it excludes certain Boys and Girls Clubs' programs from licensure.

The act (1) requires nursing homes, day care providers, and youth camps to provide potassium iodide during a public health emergency to their residents, enrollees, staff, and others present, at the Department of Public Health (DPH) commissioner's direction, and (2) makes changes to related notice requirements.

CHILD DAY CARE LICENSING:

Licensing Exemption for Recreational Programs

The act changes the types of recreational programs that are exempt from day care license requirements. It adds exemptions for

1. sports-only programs,
2. rehearsals,
3. academic tutoring programs,
4. 4-H programs (PA 07-252 repeals this exemption), and
5. programs exclusively for children age 13 and above.

It ends the exemptions for (1) creative art studios for children that offer parent-child recreational programs, (2) camping, (3) community-youth programs, and (4) church-related activities (a religious institution's educational activities for members' children continue to be exempt). It modifies the exemption for library programs by requiring them to be less than two hours long; prior law contained no time limit.

Small, Facility-Based Operations

The act requires day care operations that serve between six and nine children, depending on the time of year, and regularly provide between three and 12 hours of care a day in a facility other than a private home to be licensed as group, rather than family, day care homes. The act applies to operations that serve six or fewer children, including the provider's own children who are not in school full-time or, during the school year, serve up to nine children, three of whom, including the provider's children, attend school full-time. Group day care homes must meet essentially the same licensing requirements as day care centers, which are more stringent than family day care home licensing requirements.

License Duration and Fees

Beginning October 1, 2008, the act doubles, from two to four years, the duration of center, group, and family day care home licenses. It correspondingly doubles the licensing fees, from $200 to $400 for centers, from $100 to $200 for group day care homes, and from $20 to $40 for family day care homes.

The act specifies that family day care licenses are not transferable. It also eliminates the ability of centers and group day care homes to obtain a six-month, renewable temporary license.

Revoked Licenses

The act makes any day care provider whose license is revoked for failure to comply with DPH regulations ineligible to apply for a new license for one year from the revocation date.

YOUTH CAMPS:

The act limits the programs that must be licensed as youth camps (which include resident and day camps) to those that (1) operate only during school vacations or on weekends and (2) serve children ages three through 15. Prior law covered children up to age 18. The act specifically exempts from licensing requirements (1) programs or parts of programs that serve children under age three or that operate on weekdays and outside of school vacations and (2) drop-in programs for children who are at least six years old that are administered by a nationally chartered boys' and girls' club. Boys' and Girls' Clubs' drop-in programs for three-to-five year olds that operate during school vacations or on weekends apparently must obtain a youth camp license. (PA 07-252 removes the exemption for programs operating on weekdays during the school year and makes technical changes to other provisions.)

POTASSIUM IODIDE:

Potassium iodide prevents or decreases the likelihood of developing thyroid cancer following exposure to radiation. The act requires nursing homes, day care providers (centers and group and family day care homes), and youth camps to provide potassium iodide to their residents, enrollees, staff, and others present at the DPH commissioner's direction during a public health emergency. Prior law allowed the commissioner to authorize these entities to provide potassium iodide during such an emergency.

By law, these covered entities must (1) advise people about potassium iodide's contraindications and potential side effects and that taking it is voluntary and (2) obtain prior written permission from the individual or his or her representative or a minor's parent or guardian. The act specifies that each entity must (1) provide the required notice about the medication before obtaining permission and (2) notify people of the permission requirement and obtain the permission when someone is admitted to a nursing home, enrolled in a day care program or youth camp, or hired as a new staff member. It also requires people who do not wish to receive the medication to object in writing.

REQUIRED ACTION:

The Department shall update renewal process and materials for child day care effective October 1, 2008, develop forms for variance requests for centers and group day care homes, develop informational materials and update forms to reflect changes.

Public Act 07-244 **SB 1341**

APPLICATION FOR A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY AND PROTECTING PUBLIC WATER SUPPLIES FROM CONTAMINATION

EFFECTIVE DATE:

October 1, 2007 except for the restriction on discontinuing service by a private residential well, the subsurface sewage disposal system provision, and the New Britain water company land lease and contract provisions are effective upon passage.

SUMMARY:

This act amends the certificate of public convenience and necessity applicable to certain water company construction and expansion by (1) adding "state agency" to the definition of water company, (2) creating two distinct processes for issuing certificates to residential and non-residential water systems, (3) establishing ownership responsibilities for new water supplies, and (4) establishing clearer ties to the Water Utility Coordinating Committee (WUCC) drinking water supply planning process.

The act makes changes to the permit process for replacement wells and wells on residential properties.

The act prohibits an owner of a private residential well that (1) currently supplies or previously supplied water to another household and (2) provides or previously provided continuous water service to that household for at least 50 years, from discontinuing the water service without an alternative, available water source. Each household receiving water from the private residential well must contribute equally to the well's maintenance costs.

The act allows the city of New Britain to change the use of some of its water company owned lands to allow for extraction of stone or other materials from defined acreage in Plainville, through a leasing process that is part of a contract with New Britain as a party.

Finally, the act requires notice to abutting property owners in certain cases of subsurface sewage disposal system (septic system) repair or new construction.

CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY:

Certificate Process

The law requires water companies to get a certificate of public convenience and necessity from the Department of Public Utility Control (DPUC) and the Department of Public Health (DPH) before they begin the construction or expansion of their systems. Under the law, private companies, municipal water systems, and other entities serving between 15 service connections or 25 people and 250 connections or 1,000 people on a regular basis must get a certificate when beginning construction or expanding. The act applies these provisions to state agencies by amending the definition of water company to include a state agency. Rather than supplying water to the specified number of connections or people on a regular basis, the act applies the certificate requirement to entities that supply water for at least 60 days in any one year.

Conditions for Issuing a Certificate for Residential Systems

Under the law, DPUC and DPH have to issue a certificate if they find that:

1. no feasible interconnection with an existing system is available to the applicant;
2. the applicant plans to build or expand according to DPUC-established engineering standards;
3. the applicant has the financial, technical, and managerial resources to operate the proposed water supply system reliably and efficiently enough to provide continuous service;
4. the proposed construction or expansion would not result in a duplication of service in the applicable service area; and
5. the system meets all federal and state standards for water supply systems.

The act makes these conditions applicable specifically to water systems serving 25 or more residents ("residential systems") that are not the subject of DPUC proceedings concerning failure to comply with agency orders, economic viability, or a department order for a water company to acquire another water company. But the act changes conditions 1 and 3 above as follows:

1. no interconnection is feasible with a water system owned by, or made available through an arrangement with, the provider of the exclusive service area (ESA) or with another existing water system where no ESA has been assigned; and
2. the requirement that the applicant have the financial, managerial, and technical resources to reliably operate the system is eliminated and instead ownership of the system must be assigned to the ESA provider.

The other conditions remain the same.

The act requires that an application for a certificate include, when applicable, a signed agreement between the water company and ESA provider that details the terms and conditions under which the system will be built or expanded and for which the provider will assume service and ownership responsibilities.

An ESA, under the law, is an area where public water is supplied by one system. ESAs are determined by a process involving WUCCs, which DPH convenes for public water supply management areas. Such areas are regions determined by DPH to have similar water supply problems (CGS §§ 25-33d to 25-33j).

Exemption for Municipal Systems

The act eliminates an exemption for certain municipal water systems from the interconnection feasibility and the non-duplication requirements described above. This applies to any water system (1) owned and operated or proposed to be owned and operated by a municipality, municipal district, or regional water authority; (2) owned by a municipality, municipal district, or regional authority and operated, or proposed to be so, on its behalf by an operator that has obtained all required DPH certifications; or (3) owned or operated by a nonprofit corporation on behalf of one or more municipalities for providing water service to an elderly housing project with all required DPH certifications. It also eliminates a provision of law that allowed existing municipality, municipal district, or regional water authority to voluntarily transfer ownership of a water supply system to another water company, municipal public service company, or regional water authority.

Regulations

The act requires DPUC and DPH to each adopt regulations on the certificate process for residential systems. Prior law only required DPUC, in consultation with DPH, to adopt such regulations.

Certificate Process for Non-Residential Systems

The act establishes a distinct and separate certificate process that DPH administers for water systems serving 25 or more persons, but not 25 or more residents, for at least 60 days in any one year (a “non-residential system”) that parallels the system for residential systems described above. (This applies regardless of whether the system is in DPUC proceedings). These systems serve entities such as certain schools, offices, restaurants, convenience stores, and similar entities. The conditions for obtaining the certificate are basically the same as for residential systems except that ownership of the system will be assigned to the ESA provider if agreeable to it and DPH, or may remain with the certificate applicant if agreeable to DPH. In the later case, the applicant must have the financial, managerial, and technical resources to (1) operate the proposed system in a reliable and efficient manner and (2) provide continuous and

adequate service to consumers until such time as the water system for the ESA has made an extension of the water main. At that time, the applicant must get service from the ESA provider.

The act specifies that any construction or expansion requiring a certificate must be built, maintained, and operated according to the certificate and any of its terms, limits, or conditions.

The act exempts properties held by the Department of Environmental Protection (DEP) and used for or in support of fish culture, natural resources conservation, or outdoor recreation from the certificate requirements concerning interconnection feasibility, ownership assignment to the ESA provider, and the duplication of service.

The act requires DPH to adopt regulations implementing this process for non-residential systems. The regulations may include measures to encourage water conservation and proper maintenance.

WELL PERMITS:

Replacement Wells

Existing law allows a local health director, regardless of DPH regulations, to authorize under certain conditions an existing well's use or its replacement at a single-family residence located within 200 feet of a community water supply system measured along a street, alley, or easement. This can occur:

1. for a replacement well used for domestic purposes if (a) the premises are not connected to the public water supply, (b) the water quality is tested at installation and at least every 10 years afterward or as requested by the health director, (c) the testing shows the well meets the Public Health Code's water quality standards for wells, and (d) all other regulatory requirements are met; and
2. for a new or replacement well on a premises served by a public water supply if (a) it is used solely for irrigation or some other outdoor purpose, (b) it is permanently and physically separated from the home's internal plumbing, and (c) a reduced pressure device is installed to protect against a cross-connection with the public water supply.

The act changes the 200-foot standard by specifying that this distance is measured from the property's boundary.

The act authorizes a local health director to issue an order requiring the immediate implementation of mitigation measures, up to and including permanent abandonment of the well, according to the Connecticut Well Drilling Code, if he determines that an irrigation well creates an unacceptable risk of injury to the health or safety of those using the water, the general public, or to any public water supply. The act allows the

owner of the system to terminate service to the premises if a cross connection with the public water system is found.

Permits for Wells on Residential Property

DPH regulations generally prohibit private wells on residential property within 200 feet of a public water supply. Existing law allows local health directors to issue a permit for a new or replacement well only if:

1. the well water is used only for irrigation or other outdoor purpose, is not used for human consumption, and a reduced pressure device is installed to protect against a cross-connection with the public water supply;
2. the well replaces one that was used at the premises for domestic purposes and is subject to water quality testing when it is installed and at least every 10 years afterward or as requested by the health director; or
3. DPUC has ordered the public water system to reduce the demand on it, the well is not connected to the public water supply, and use of the well does not impair the purity or adequacy of the supply or service to the system's customers.

The act gives the local health director the same authority to issue an order requiring immediate mitigation measures concerning an irrigation well as described above in the previous section. It exempts irrigation wells from the water quality testing standards and uses the same 200-foot boundary standard described earlier.

Regulations

By law, the DPH commissioner must adopt regulations clarifying criteria under which a well permit exception may be granted and describing conditions that must be imposed when a well is permitted at premises that are connected to the public water supply. The act specifies that these regulations must also address the situation when a well is permitted when the premises' boundary is within 200 feet of an approved community water system.

SUBSURFACE SEWAGE DISPOSAL SYSTEMS:

The act requires any person applying to DPH for authorization to repair or newly construct a subsurface sewage disposal system involving the waiver of the proximity requirement (the act does not describe nor further reference this requirement) as it relates to a private residential well, to notify all abutting property owners. Notice must be by certified mail, return receipt requested and must include a copy of the application. A DPH decision on the application constitutes a final decision for purposes of appeal to Superior Court.

The act specifies that approval of the application is not an affirmative defense for the system's owner concerning any liability claim for damages related to contamination caused by proximity of the system to a private residential well.

LEASE OF NEW BRITAIN WATER COMPANY LAND:

Contract Requirements

The law restricts the ability of a water company to change the use of its class I or II lands located close to water supply sources.

The act allows New Britain to change the use of its water company owned class I and II lands to allow for the lease of about 131. 4 acres (the “0 Biddle Pass” in Plainville) if the lease is part of a contract to which New Britain is a party and includes provisions to do the following:

1. The lease and subsequent use of the land increases the future safe yield of a pure and adequate drinking water supply for New Britain and the surrounding area served by the city.
2. By the lease's conclusion, the entity leasing the land prepares the (a) site for a public drinking water reservoir capable of supplying an adequate safe yield of drinking water consistent with the most recently approved water supply plan, and (b) surrounding land for reforestation including sufficient tree plantings.
3. The extraction of stone or other material from the land or any adjacent land is a sufficient distance from residential homes to prevent unreasonable disruption of residential use.
4. The lease is for no more than 40 years.
5. Any conveyance of land immediately adjacent to the 131. 4 acres must contain appropriate deed restrictions sufficient to maintain a forested buffer of at least 1,000 feet measured from the quarry zone line.

Environmental Evaluation and Other Conditions

The act requires the following before the contract can be executed by New Britain:

1. an environmental evaluation conducted by an independent third party approved by DPH to evaluate the potential impact of the purity and adequacy of the existing and future public water supply, and DPH review of the evaluation to provide the New Britain Water Department with guidance on the suitability of the best management practices identified in the evaluation for protecting the public water supply and public health;
2. a 90-day period following completion of the evaluation to give DEP and DPUC time to provide DPH with comments on the evaluation;
3. DPH approved the lease provisions relating to its jurisdiction over and duties concerning water supplies, water companies, and operators of water

treatment plants and water distribution systems; but DPH cannot approve these lease provisions unless New Britain has demonstrated, to DPH's satisfaction, through the environmental evaluation, that the contract and lease will not have a significant adverse impact on present and future purity and adequacy of the public drinking water supply and will provide for an additional water source consistent with the city's water supply plan and projected future regional supply needs;

4. DPH held a public hearing on the environmental evaluation with in 30 days of receiving it, with at least 15 days' notice by publication in the Connecticut Law Journal;
5. New Britain's mayor proposed the lease and contract to the Common Council, and within 30 days prior to submitting them to the Common Council, the mayor held a public hearing, with appropriate notice by newspaper;
6. after the public hearing, the mayor recommends approval or disapproval of the lease and contract to the Common Council ;
7. the mayor submitted the lease and contract proposal to the legislative bodies of New Britain and Plainville, the inland wetlands commissions of those municipalities, New Britain's city plan commission, and Plainville's planning and zoning commission;
8. all appropriate authorities in Plainville have approved the proposed use of the land;
9. New Britain's inland wetland commission and its city plan commission held a public hearing after receiving the mayor's proposal and voted to approve or reject it within 60 days after receiving it; and
10. New Britain's common council approved the mayor's proposal, including the lease and contract; but the council cannot consider the proposal until the inland wetland commission and the city plan commission have approved it, and cannot approve it after April 1, 2008.

Deed Restrictions

Under the act, before any activities on the parcel in question can begin, and subsequent to the lessee receiving all necessary federal, state, and municipal approvals to begin extraction or reservoir development activities on the site, the lessee must get deed restrictions for a minimum of twice the acreage that has been approved for extraction activities. These restrictions must (1) prohibit the use and development of acreage adjacent to the site for anything other than open space purposes; (2) permanently dedicate such acreage for land uses such as public parks, forests, or natural areas, including reservoirs; (3) require such acreage to be preserved predominantly in its natural scenic and open space condition that can allow for camping, hiking, forestry, fishing, and conservation activities; and (4) prohibit all other building or development except as may be required for source protection and to meet water quality standards if used as a public water supply.

If the maximum acreage amount on the site is approved for mineral extraction, such acreage restricted under the act must include a minimum of (1) 75 acres adjacent to the site and located in Southington and, if requested by Southington, it must be deeded to the town at no cost; (2) a minimum 94 acres adjacent to the site located in Plainville and, if so requested by Plainville, deeded to it at no cost; and (3) a minimum of 94 acres adjacent to the site and located in New Britain, inclusive of the reservoir, and deeded to it at no cost if so requested.

BACKGROUND:

Public Water Supply Coordination

PA 85-535 required DPH to coordinate the planning of public water supply systems. The law provides for a coordinated approach to long-range water supply planning by addressing water quality and quantity issues from an area-wide perspective. The process is designed to bring together public water system representatives and regional planning organizations to discuss long-range water supply issues and develop a plan for dealing with them.

The state is divided into seven management areas based on factors such as similarity of supply problems, such as proliferation of small water systems, groundwater contamination, and over-allocated water resources. DPH convenes a WUCC for a particular management area to address these issues. A WUCC consists of one representative from each public water system with a source of supply or service area within the public water supply management area and one representative from each regional planning agency within the management area (CGS §§ 25-33d to 25-33j; DPH Regs. § 25-33h-1 et seq.).

REQUIRED ACTION:

An Environmental Health Section Circular Letter is to be issued to all local health departments. The Circular Letter will explain the new notification requirements associated with septic system repairs that need a DPH exception to the separating distances to a private water supply well. In accordance with the bill, the applicant (property owner) must notify all abutting property owners.

The Department of Public Health and the Department of Public Utility Control will need to promulgate language for regulations in Section 1(a) through (c). DPH will also be required to promulgate regulations for Section 1(e) and Section 4(c). DPH must administer the provisions of Section 6 (b)(1), (3) and (4).

Healthcare Systems Branch

Public Act 07-49 **HB 5508**

AUTHORIZING COMMITMENT TO A CHRONIC DISEASE HOSPITAL UNDER A PHYSICIAN'S EMERGENCY CERTIFICATE

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act permits a physician to place a person for psychiatric treatment in a chronic disease hospital under a 15-day emergency certificate if the hospital has a separate psychiatric unit. Prior law permitted such a placement only in a "hospital for persons with psychiatric disabilities," that is any public or private hospital that accepts psychiatric patients.

The act permits an emergency psychiatric admission to a chronic disease hospital regardless of the law that requires the hospital's medical director to determine that the hospital and its staff can adequately care for and treat the patient. But it prohibits admission if the placing physician believes the person is actively suicidal or homicidal.

The act requires a psychiatrist to examine anyone admitted to a chronic disease hospital under a 15-day certificate within 24 hours of admission. (PA 07-252 extends the exam requirement to within 36 hours.) Patients admitted under a certificate to an acute care or psychiatric hospital must, by law, be examined within 48 hours.

Before placing someone in a chronic disease hospital under an emergency certificate a physician must find the person to (1) have psychiatric disabilities, (2) be a danger to himself or others or gravely disabled (i. e. , in danger of serious harm because the person cannot care for his or her own basic needs), and (3) be in need of immediate care and treatment in a hospital. The law applies the same requirements to people admitted under emergency certificates to psychiatric and acute care hospitals.

BACKGROUND

Chronic Disease Hospitals

A chronic disease hospital is a long-term hospital that has facilities, medical staff, and all necessary personnel to diagnose, care for, and treat chronic diseases (CGS § 19a-535b(a)). The Department of Public Health currently licenses five chronic disease

hospitals: Gaylord Hospital, Hospital for Special Care, the state Veterans' Home and Hospital, Hebrew Home and Hospital, and Mt. Sinai Rehabilitation Hospital.

REQUIRED ACTION:

Educate the institution and FLIS staff.

Public Act 07-209 **HB 5639**

THE CLOSING OF A LONG-TERM CARE FACILITY

EFFECTIVE DATE:

July 1, 2007, except for the nursing home moratorium extension, which is effective upon passage.

SUMMARY:

This act requires the Department of Social Services (DSS) commissioner to hold a public hearing at the nursing home, rest home, residential care home, or intermediate care facility for the mentally retarded within 30 days after the facility submits a letter of intent or applies for a certificate of need (CON), whichever happens first, to establish a new, additional, expanded or replacement facility, service or function; expand or reduce its services or number of beds; make certain capital expenditures; or close the facility. (The letter of intent is a preliminary step before the facility submits a CON application so that DSS can send it the correct questions and application forms for the application.) Current law allows the commissioner to hold a hearing on an application, at his discretion, in Hartford or the area served and has no deadline for holding the hearing. The act specifically prohibits any such facility from closing, terminating a service, or decreasing substantially its total bed capacity until a public hearing has been held in accordance with the bill and the commissioner has approved the facility's request.

The act allows the commissioner to impose up to a $ 5,000 civil penalty on any facility that fails to comply with these provisions. It requires the commissioner to deposit such penalty payments in an existing special fund to be used, in DSS's discretion, for the protection of the health or property of nursing home residents, including relocation costs, payment for continuing operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

The act also modifies some of the duties of a court-appointed receiver of a nursing home or residential care home and extends the timeframes for accomplishing these

duties. It also removes certain restrictions on the DSS commissioner's authority to set a higher interim rate for Medicaid payments to nursing homes sold after being in receivership.

Finally, the act also extends the current moratorium on new nursing homes and nursing home beds from June 30, 2007 to June 30, 2012. (The moratorium law, in effect since 1991, contains several minor exceptions.)

The act also makes several technical changes.

*House Amendment "A" adds the letter of intent language; the prohibition on closing a facility, terminating a service, or substantially reducing beds; the 30-day hearing deadline; and the $ 5,000 civil penalty. It also adds the provisions concerning the receiver's duties and the commissioner's authority to increase interim rates.

MODIFICATION OF RECEIVER'S DUTIES

Current law prescribes certain actions for a court-appointed receiver of a nursing home or residential care home. The act adds that, within 90 days after his or her appointment, the receiver must take all necessary steps to stabilize the facility's operation to ensure the residents' health, safety, and welfare. The act extends the deadline from 90 days to a reasonable time period not to exceed six months for the receiver to (1) determine whether the facility can continue to operate and provide adequate care to residents in substantial compliance with federal and state laws within its revenues from state payments, self-pay residents, Medicare, and other current sources and to report the conclusion to the court and (2) seek facility purchase proposals. The act adds to this list the receiver's responsibility, if he or she determines the existing rate the state pays is inadequate to continue the facility's operations, to determine the amount that would be needed, together with the other types of income, to continue to operate the facility in a manner that provides residents adequate care in compliance with the law and report this determination to the court.

Current law requires the receiver, if he or she determines that the facility cannot continue to operate in compliance with the above requirements, to immediately request a court order to close the facility and make arrangements for residents' orderly transfer to other facilities, unless the receiver determines that the facility's transfer to a qualified purchaser is expected within 90 days. The act removes the requirement that the receiver request an immediate court order for closure and specifies that the arrangements for transferring residents need to begin only if the court order is granted. Under current law, this timing does not apply if there is an expectation the facility will be purchased within 90 days. The act changes this exception to the six-month period beginning on the receiver's appointment date or, if it takes longer than that, within a reasonable time. It requires an immediate court order for closure only if the transfer has not been completed during this time, rather than within 180 days of the receiver's appointment as currently required, and adds that all purchase and sale proposal efforts must have been exhausted.

Public Act 07-219 **HB 5751**

ESTABLISHING A PILOT FAMILY NURSE PRACTITIONER TRAINING PROGRAM

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act requires the Department of Social Services (DSS), within available appropriations and in consultation with the Department of Public Health (DPH), to establish a pilot training program for nurse practitioners seeking to specialize in family practice. Under the program, the nurse practitioner receives one year of formal training at a community-based health center in a federally designated health professional shortage area, medically underserved area (MUA), or area with medically underserved populations (MUP).

The DSS commissioner, in consultation with the DPH commissioner, must establish program eligibility requirements. The pilot program must begin by October 1, 2008 and end by October 1, 2010.

DSS must report to the Social Services (PA 07-252, § 78 corrects this to the Human Services) and Public Health committees by January 1, 2011 on any increase in access to care at community-based health centers as a result of the pilot program.

BACKGROUND:

Nurse Practitioners

A nurse practitioner is a registered nurse who has completed advanced education (generally a minimum of a master's degree) and training in the diagnosis and management of common medical conditions, including chronic illnesses. Nurse practitioners provide a broad range of health care services.

Health Professional Shortage Area (HPSA), MUA, and MUP

The federal Health Resources and Services Administration (HRSA) develops health workforce shortage designation criteria to help determine whether a geographic area or population group is an HPSA, MUA, or MUP.

HPSAs may have shortages of primary medical care, dental, or mental health providers and may be urban or rural areas, population groups, or medical or other public facilities.

MUAs may be a whole county or group of contiguous counties, a group of county or civil divisions, or a group of urban census tracts where residents have a shortage of personal health services.

MUPs may include a group of people who face economic, cultural, or linguistic barriers to health care.

REQUIRED ACTION:

Consult with DSS on the establishment of a pilot training program for nurse practitioners seeking to specialize in family practice to receive one year of formal training in one community health center.

Public Act 07-98 **HB 6060**

DISRUPTION OF A FUNERAL

EFFECTIVE DATE: October 1, 2007, but PA 07-187 makes it effective upon passage.

SUMMARY:

This act prohibits certain activities at certain locations from 60 minutes before to 60 minutes after a funeral, which is defined as a ceremony or memorial service connected to burying or cremating an individual. It subjects to punishment anyone who:

1. (a) willfully makes or assists in making a noise or diversion that is not part of the funeral, (b) intentionally disturbs the funeral's peace or good order, and (c) is within the "boundary of the location" of the funeral or within 150 feet of the boundary's intersection with a road, pathway, or other entrance or exit from the location; or
2. (a) is within 300 feet of the boundary and (b) intentionally, willfully, and without authorization impedes the entrance or exit from the location.

The "boundary of the location" is the property line of a cemetery, mortuary, or house of worship or the reasonable property line of another location used for the funeral.

The act makes this conduct a class A misdemeanor (see Table on Penalties).

Public Act 07-82 **HB 6109**

REDUCING LICENSE RENEWAL FEES FOR RETIRED DENTISTS AND PHYSICIANS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act allows (1) retired dentists to renew their licenses at a reduced fee and (2) certain physicians volunteering their services to renew their licenses at no charge.

Under the act, a dentist who has retired may renew a license for $45. The license issued by the Department of Public Health (DPH) must indicate that the dentist is retired. DPH must adopt regulations by January 1, 2008 that include (1) a definition of "retired from the profession" as it applies to dentists, (2) procedures for a retired dentist to return to active employment, and (3) appropriate restrictions on retired dentists' scope of practice, including restricting the license to providing volunteer services without monetary compensation.

The act allows a physician who (1) practices for no fee for at least 100 hours a year at a public health facility and (2) does not otherwise practice medicine, to renew a license without charge. Current law defines a "public health facility" as a hospital, community health center, group home, school, preschool operated by a local board of education or a Head Start program, rest home, health care facility for the handicapped, nursing home, residential care home, mental health facility, home health care agency, homemaker-home health aide agency, substance-abuse treatment facility, infirmary operated by an educational institution, and an intermediate-care facility for the mentally retarded.

REQUIRED ACTION:

Establish a retired license status for dentists and physicians.

Public Act 07-53 **HB 6840**

SCREENING FOR KIDNEY DISEASE

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act exempts gynecologists from the requirement that a physician screen for kidney disease as part of a patient's routine general medical examination.

Under prior law, physicians had to order a serum creatinine test as part of each patient's annual physical examination if the patient had not had such a test within the preceding 12 months. The act instead requires that this test be done as part of each patient's routine general medical examination, if not performed within the past 12 months. It also specifies that these medical examinations do not include annual gynecological examinations.

Creatinine is a breakdown product of creatine, which is an important part of muscle. A serum creatinine test measures the amount of creatinine in the blood.

Public Act 07-119 **HB 7089**

SUPERVISING PHYSICIANS FOR PHYSICIAN ASSISTANTS

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act eliminates the requirement that licensed physicians who supervise physician assistants (PAs) register with the Department of Public Health (DPH) and pay a $37. 50 registration fee. Each PA practicing in the state or participating in a resident PA program must continue to have a clearly identified supervising physician who has the final responsibility for patient care and the PA's performance. The act eliminates a requirement that a supervising physician notify DPH in writing within 30 days of terminating a physician-PA relationship.

The act also specifies that licensed PAs who are part of the Connecticut Disaster Medical Assistance Team, the Medical Reserve Corps, or the Connecticut Urban Search and Rescue Team may provide patient services under the supervision, control, responsibility, and direction of a licensed physician.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-15 **HB 7109**

CERTIFICATION STANDARDS FOR PERSONS PROVIDING INTERPRETER SERVICES

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act broadens the law governing accreditation for individuals who are paid for providing interpreter services to deaf and hearing-impaired people. It adds interpreters who hold only a National Association of the Deaf-National Registry of Interpreters for the Deaf (NAD/RID) national interpreting certificate to those able to provide such services. And it changes the testing requirement for interpreters who use other credentials to become interpreters.

The act also makes technical changes.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-103 **HB 7155**

A PROFESSIONAL ASSISTANCE PROGRAM FOR HEALTH CARE PROFESSIONALS

EFFECTIVE DATE: Upon passage

SUMMARY:

This act allows state or local health care professional societies and organizations to establish a single assistance program to serve all health care professionals. The assistance program must have one or more medical review committees. A “medical review committee” is a committee that reviews and monitors participation by health care professionals in the assistance program.

The assistance program is an alternative, voluntary, and confidential program to rehabilitate health care professionals. It must provide a variety of educational, rehabilitative, and supportive services to health care professionals with a chemical dependency, emotional or behavioral disorder, or physical or mental illness. It must include mandatory, periodic evaluations of each participant's ability to practice with skill and safety and without posing a threat to the health and safety of any person or patient in the health care setting.

The program must annually report certain information to the Department of Public Health (DPH), licensing boards, and the Public Health Committee.

The program is available to: physicians and surgeons, physician assistants, chiropractors, naturopaths, homeopathic physicians, podiatrists, athletic trainers, physical therapists, occupational therapists, alcohol and drug counselors, radiographers and radiologic technologists, nurse-midwives, nurses, dentists, dental hygienists, optometrists, opticians, respiratory care practitioners, psychologists, marital and family therapists, clinical social workers, professional counselors, veterinarians, massage therapists, dietitian-nutritionists, acupuncturists, paramedics, hearing instrument specialists, speech pathologists and audiologists, and embalmers and funeral directors.

A medical review committee must determine a person's appropriateness for the program before admittance. The act specifies various confidentiality provisions concerning the program and participation by health care professionals.

DPH must establish an oversight committee to monitor program quality. The oversight committee must meet with the assistance program on a regular basis; the program must also undergo an annual audit.

ESTABLISHING THE PROFESSIONAL ASSISTANCE PROGRAM:

The act authorizes state or local professional societies or membership organizations of health care professionals to establish a single health care professional assistance program to provide education, prevention, intervention, referral assistance, and support services to any health care professional (and anyone who has applied to be one) with a chemical dependency, emotional or behavioral disorder, or physical or mental illness. “Chemical dependency” means abusive or excessive use of drugs, including alcohol, narcotics, or chemicals, that results in physical or psychological dependence.

The program must establish at least one medical review committee. The program and medical review committee must comply with the act.

The program must (1) be an alternative, voluntary, and confidential opportunity for rehabilitating health care professionals and licensure applicants and (2) include mandatory, periodic evaluations of each participant's ability to practice with skill and

safety, and without threat to the health and safety of any person or patient in the health care setting.

Before admitting any health care professional into the program, a medical review committee must (1) determine if the professional is an appropriate candidate for rehabilitation and participation and (2) establish terms and conditions of participation. The act specifies that a committee's actions must not be construed as practicing medicine or mental health care.

HEALTH CARE PROFESSIONAL'S DISCIPLINARY AND CRIMINAL HISTORY AND PROGRAM PARTICIPATION:

The act prohibits a medical review committee from referring to the assistance program any health care professional who has (1) pending disciplinary charges against him or her, a prior history of disciplinary action, or a consent order by a professional licensing body or (2) been charged with or convicted of a felony under Connecticut law or an offense that, if committed in Connecticut, would be a felony.

In such cases, the committee must refer the person to the Department of Public Health and provide the department with all records and files maintained by the assistance program on the individual. Upon the referral, DPH must determine if the person is eligible for the assistance program and whether participation should be confidential (see below). DPH can seek advice from professional health care societies and organizations and the assistance program to determine what intervention, referral assistance, rehabilitation program, or support services are appropriate.

The act requires a health care professional participating in the assistance program to immediately notify the program when he or she is (1) made aware of the filing of any disciplinary charges or any disciplinary action against him or her by a professional licensing or disciplinary body or (2) charged with or convicted of a felony under Connecticut law or an offense that would be a felony if committed in Connecticut. The assistance program must regularly review available sources to determine if disciplinary charges have been filed or taken against the individual, or felony charges have been filed or substantiated against a professional admitted into the program.

After notification, the program must refer the professional to DPH and provide the department with all records and files the program maintains on the person. DPH must then determine if the individual is eligible to continue participating in the program and whether participation should be treated as confidential. DPH can seek advice from professional societies and organizations on appropriate services and interventions.

If DPH determines that the health professional is an appropriate candidate for confidential participation in the assistance program, the entire record of the person's referral and investigation is confidential and cannot be disclosed, except if requested by the health care professional, for the duration of the professional's participation in,

and after successful completion of, the program. Participation must be according to the terms agreed to by DPH, the program, and the individual.

FAILURE TO PARTICIPATE IN A PROGRAM:

Under the act, if (1) the assistance program determines that a professional cannot practice with skill and safety or poses a threat to the health and safety of any person or patient and the professional does not stop practicing or fails to participate in a recommended program or (2) a health care professional referred to the program fails or refuses to participate, the assistance program must refer that professional to DPH and submit to the department all related program records and files.

DPH must then determine if the person is eligible to participate in the program and whether participation should be confidential. As discussed above, DPH can seek the advice of professional societies or organizations and the assistance program to determine the services appropriate for the individual. The same confidentiality provisions apply.

HARMING A PATIENT:

The act prohibits a medical review committee from referring to the assistance program a health care professional who is alleged to have harmed a patient. After being made aware of such an allegation, the committee and the assistance program must refer the professional to DPH along with all maintained records and files. The referral may include recommendations for appropriate services, referrals, and interventions. DPH must then determine if the person is eligible for such assistance and if so, whether they should be provided confidentially. Again, DPH can seek outside advice. If DPH determines that the person is an appropriate candidate for confidential participation in the program, the confidentiality provisions discussed above apply.

REPORTS TO DPH AND LICENSING BOARDS:

The act requires the assistance program to report on the program annually to the appropriate professional licensing board or commission, or to DPH. (Not every health care profession has a separate licensing board or commission; in some cases DPH is the licensing authority.) The report must include the number of health care professionals participating in the program, the purpose for participating, and whether participants are practicing health care with skill and safety and without posing a threat to the health and safety of any person or patient. By December 31 annually, the program must also report this information to the Public Health Committee.

CONFIDENTIALITY PROVISIONS:

Under the act, all information given or received about an intervention, rehabilitation, referral assistance, or support services provided, including a health care professional's identity, is confidential. The information cannot be disclosed to a third party or entity unless disclosure is reasonably necessary to (1) accomplish the purposes of the intervention, rehabilitation, referral assistance, or support services or (2) to complete an audit (see below). It cannot be requested or disclosed in any civil, criminal, legal, or administrative proceeding, unless the health care professional waives the privilege or disclosure is otherwise required by law.

Under the act, medical review committee proceedings are not subject to discovery and cannot be introduced as evidence in any civil action for or against a health care professional arising out of matters subject to evaluation and review by the committee. A person who attends such proceedings cannot be allowed or required to testify in any civil action about the content of the proceedings.

On the other hand, the act specifies that it should not be construed as precluding in any civil action:

1. use of any writing recorded independently of such proceedings;
2. anyone's testimony about his or her knowledge, acquired independently of the proceedings, of the facts that are the basis of the civil action;
3. arising out of allegations of patient harm caused by the professional who, at the time of providing services, had been requested to refrain from practicing or whose practice was restricted, disclosure of such request or restriction; or
4. against a professional, disclosure of the fact that the individual participated in the assistance program, dates of participation, reason for participation, and confirmation of successful completion.

The court must determine that good cause exists for the disclosure after (1) notifying the professional of the disclosure request; (2) holding a hearing concerning the disclosure, at the request of any party; and (3) imposing appropriate safeguards against unauthorized disclosure or publication of the information.

The act specifies that it should not be construed to prevent the assistance program from disclosing information about administrative proceedings related to disciplinary action taken against a professional whom the assistance program or oversight committee referred to DPH.

REQUIRED REPORTING:

Existing law requires physicians, hospitals, and medical societies to report an impaired physician or physician assistant to DPH within 30 days of knowing of the impairment (CGS §§ 20-12e & 20-13d). Impairment means that the physician is or may be unable to practice medicine with reasonable skill or safety because of:

1. physical illness or loss of motor skill;
2. emotional disorder or mental illness;
3. drug abuse;
4. illegal, incompetent, or negligent conduct in the practice of medicine;
5. possession, use, or distribution of controlled substances or legend drugs (except for therapeutic purposes); or
6. misrepresentation or concealment of a material fact in obtaining or reinstating a medical license.

Under the act, any physician, physician assistant, hospital, or state or local professional society of health care professionals that refers a physician or physician assistant for intervention to the assistance program is deemed to have satisfied the obligations of the existing law described above.

AUDITS:

By November 1, 2007 and annually thereafter, the assistance program must select an individual the program and DPH determine qualified to audit the assistance program. The audit's purpose is to examine the program's quality control and compliance with the act. By November 1, 2011, DPH, with the agreement of the professional assistance oversight committee (see below), may waive the audit requirement in writing.

An audit must be a random sampling of the greater of at least 20% of the assistance program's files or 10 files. Before auditing, the auditor must agree in writing not to

1. copy any program files or records;
2. remove any program files or records from the premises;
3. disclose personally identifying information about professionals in the program to anyone other than a person or entity employed by the program and authorized to receive disclosure; or
4. disclose in any audit report any personally identifying information about professionals participating.

The auditor must also agree to destroy all personally identifying information about health care professionals participating in assistance programs after the audit is complete.

After completing the audit, the auditor must submit a written audit report to the assistance program, the oversight committee, and the Public Health Committee.

PROFESSIONAL ASSISTANCE OVERSIGHT COMMITTEE:

Members and Responsibilities

The act requires DPH to establish a seven-member professional assistance oversight committee to oversee the program's quality assurance. The committee must include:

1. three members selected by DPH, who are health care professionals with training and experience in mental health or addiction services;
2. three members selected by the assistance program, who are not employees, board, or committee members of the assistance program and who are health care professionals with training and experience in mental health or addiction services; and
3. one member selected by the Department of Mental Health and Addiction Services, who is a health care professional.

The act requires the assistance program to provide administrative support to the committee.

Beginning January 1, 2008, the oversight committee must meet with the assistance program at least four times a year.

Under the act, the committee may request and is entitled to receive copies of files or other assistance program records it deems necessary, provided the program redacts all information about the identity of any professional. Oversight committee members cannot copy, retain, or maintain any redacted records. If the committee determines that a professional is unable to practice with skill and safety or poses a threat to the health and safety of any person or patient, and the professional has not stopped practicing or has failed to comply with the terms and conditions of participation in the assistance program, the oversight committee must notify the assistance program to refer the person to DPH. Upon notification, the assistance program must refer the professional to DPH, according to the procedures specified above.

Failure of the Assistance Program to Act According to Law; Corrective Action Plan

The act requires the oversight committee to notify the assistance program within 30 days of a determination that the assistance program (1) has not acted according to law or (2) requires remedial action based on an audit. The assistance program must develop a corrective action plan within 30 days of the notification. If the assistance program fails to comply with the corrective action plan, the oversight committee can amend it or direct the program to refer some or all of the records of persons in the program to DPH. DPH must then determine if each referred person is eligible for continued services and whether such participation should be treated as confidential.

DPH can refer health care professionals back to the program for continued intervention, rehabilitation, referral assistance, or support services after the oversight committee gives DPH written notice that the assistance program is in compliance with the corrective action plan. DPH must provide the assistance program with all records and files about the health care professionals.

Confidentiality of Committee Records

Under the act, oversight committee records are not public records and not subject to the Freedom of Information Act. They must be treated as confidential. Oversight committee proceedings are not subject to discovery or introduction into evidence in any civil action for or against a health care professional arising out of matters subject to evaluation and review by the committee. No person in attendance at committee proceedings is allowed or required to testify in any civil action about the proceedings. The act allows the same disclosures and uses of information in civil actions as described above in the "Confidentiality" section.

EXISTING PROGRAM FOR IMPAIRED PHYSICIANS:

Under existing law, physicians, hospitals, and medical societies that know a physician is unable to practice skillfully or safely due to a variety of specified reasons must report the physician to DPH, by filing a petition. The Medical Examining Board and individuals may also make such reports. The mandatory reports must be made within 30 days of knowing of the impairment. Impairment basically means that the physician is or may be unable to practice with reasonable skill or safety because of

1. physical illness or loss of motor skill;
2. emotional disorder or mental illness;
3. drug abuse;
4. illegal, incompetent or negligent conduct in the practice of medicine;
5. possession, use or distribution of controlled substances or legend drugs; or
6. misrepresentation or concealment of a material fact in obtaining or reinstating a license.

DPH must investigate each report to determine if probable cause exists to issue a statement of charges and institute proceedings against the physician. The investigation is confidential and must be concluded within 18 months. After that time, the record becomes public information.

Prior law allowed DPH to recommend that the physician participate in an appropriate rehabilitation program. DPH had to determine that the physician would pose no threat to the health and safety of any person in his practice during his participation in the program. Such a determination became part of the record of the investigation of the physician. Following completion of the rehabilitation program and during his continued participation in it according to the terms agreed upon by the physician and DPH, all records remained confidential.

Under the act, if DPH determines the physician is an appropriate candidate for rehabilitation it can instead refer him or her to the assistance program established under the act. The act specifies that the petition and all records of a physician determined eligible for participation in the existing physician rehabilitation program before the act was enacted, must remain confidential during the physician's participation in, and upon successful completion of, the program, according to the terms and conditions agreed to by the physician and DPH.

REQUIRED ACTION:

Establish the professional assistance program oversight committee and work with the professional assistance program to establish protocols.

Public Act 07-23 **HB 7156**

HOSPICE SERVICES

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act (1) requires newly licensed hospices to provide hospice services in all settings and (2) sets conditions on the use of hospice-related titles and terms.

Under the act, an organization seeking an initial hospice license from the Department of Public Health (DPH) beginning January 1, 2008 must agree to provide hospice care services for terminally ill people on a 24-hour basis in all settings, including private homes, nursing homes, residential care homes, or specialized residences providing supportive services. It must also provide DPH with satisfactory evidence that it has the necessary qualified personnel to provide the services.

The act prohibits an organization from using the title “hospice” or “hospice care program” or any titles, words, letters, or abbreviations indicating or implying hospice licensure unless it is licensed to provide hospice services by DPH and certified as a hospice by Medicare.

Public Act 07-34 **HB 7157**

STAFF TRAINING REQUIREMENTS FOR ALZHEIMER'S SPECIAL CARE UNITS AND PROGRAMS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act requires Alzheimer's special care units or programs annually to provide at least one hour of Alzheimer's and dementia-specific training to all unlicensed and unregistered staff providing care and services to residents in these programs or units. For staff hired on or after October 1, 2007, the training must be completed within six months of the date of employment. PA 07-252 changes these training requirements as they apply to nurse's aides (see BACKGROUND).

BACKGROUND:

Related Act

PA 07-252, § 61 requires each Alzheimer's special care unit or program to annually provide nurse's aides who are involved in direct patient care of residents with the same training required for licensed and registered direct care staff (see next section). For staff hired on or after October 1, 2007, the training must be completed within six months of the date of employment.

Training for Licensed and Registered Direct Care Staff

Existing law requires each Alzheimer's special care unit or program annually to provide Alzheimer's and dementia-specific training to all licensed and registered direct care staff who provide direct patient care to residents in these units or programs. At a minimum, this must include (1) at least eight hours of dementia-specific training, completed within six months after beginning employment, followed by at least three hours of such training annually and (2) at least two hours per year of training in pain recognition and administration of pain management techniques for direct care staff.

Alzheimer's Special Care Unit or Program

An “Alzheimer's special care unit or program” is any nursing home, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice, or adult foster home that locks, secures, segregates, or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia, or similar disorder. The unit or program must be one that prevents or limits a resident's access outside the designated or separated area and advertises or markets

itself as providing specialized care or services for those with Alzheimer's disease or dementia.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-92 **HB 7159**

UPDATING THE SCOPE OF PRACTICE OF OPTOMETRY

EFFECTIVE DATE:

October 1, 2007, except for the continuing education provision, which takes effect upon passage.

SUMMARY:

This act broadens the scope of practice of optometrists engaged in advanced optometric care by allowing them to remove superficial foreign bodies of the cornea. Prior law allowed them to only remove those bodies from the eye's outer layer (corneal epithelium) that had not perforated its second layer.

The act changes the conditions under which an optometrist must refer certain patients to an ophthalmologist. Finally, the act requires the Department of Public Health (DPH) to adopt regulations on continuing education for optometrists.

REFERRAL TO AN OPTOMETRIST:

The act changes the conditions under which an optometrist or an optometrist engaged in advanced optometric care must refer certain patients to an ophthalmologist.

Prior law required an optometrist to refer a patient with iritis (inflammation of the iris) or a corneal ulcer to an ophthalmologist within 72 hours after beginning initial treatment unless there was documented substantial improvement in the patient's condition within that time. Under the act, a patient showing “improvement” within that period does not have to be referred.

Prior law required an optometrist practicing advanced optometric care and involved in nonsurgical treatment of glaucoma to refer to an ophthalmologist or other physician a glaucoma patient who (1) had intraocular pressure over 35; (2) had

pediatric glaucoma, closed angle glaucoma, or secondary glaucoma; or (3) did not have documented substantial improvement in response to treatment.

The act instead requires referral only when the patient (1) has pediatric glaucoma or closed angle glaucoma or (2) does not "improve" in response to treatment.

CONTINUING EDUCATION:

The act requires DPH to adopt regulations requiring optometrists to complete a minimum of 20 hours of continuing education during each registration period (12 months) for which a license is renewed.

Existing DPH regulations require optometrists to complete at least eight hours of post graduate study each year as a prerequisite for license renewal (Conn. Agencies Reg. , § 20-128-8).

BACKGROUND:

Advanced Optometric Care

The law recognizes a category of optometric practice known as "advanced optometric care. " It allows optometrists a broader range of activities, including nonsurgical treatment of glaucoma patients. They must meet additional educational and testing requirements and be able to use certain drugs for diagnostic and therapeutic purposes in order to practice advanced optometric care. There is no separate DPH license for advanced optometric care.

As of January 1, 2005, the law requires an individual applying for initial licensure as an optometrist to meet the requirements to practice advanced optometric care. It does not apply to optometrists licensed in the state before January 1, 2005.

Related Acts

PA 07-252, § 79 makes a technical correction to the definition of "noninvasive procedure" by restoring 'treatment of iritis" to the definition which was inadvertently omitted in PA 07-92.

PA 07-252, § 30 makes both substantive and technical changes to the requirements for optometrist licensure.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-104 **HB 7160**

FUNERALS

EFFECTIVE DATE:

Upon passage for the provisions on transporting and preparing a dead body; July 1, 2007 for the other provisions.

*****Section 80 of HB 7163 amends HB 7160**

SUMMARY:

This act:

1. establishes certain requirements for transporting, handling, and cleansing dead human bodies;
2. requires that two hours of the required continuing education for licensed funeral directors and embalmers address laws on funeral services;
3. amends the procedures for bodies brought into Connecticut for cremation;
4. changes the current "burial transit removal permit" to a "removal, transit and burial permit" and makes corresponding changes to applicable statutes; and
5. amends the duties of sextons.

PREPARING AND TRANSPORTING DEAD BODIES:

The act sets out a number of specific requirements addressing how a dead body must be transported, washed, embalmed, wrapped, and disinfected and defines these and related terms. It prohibits a licensed embalmer or funeral director from removing a dead body from the place of death to another location for preparation until the body has been temporarily wrapped. "Wrap," under the act, means placing a dead body in a burial or cremation pouch that consists of at least four millimeters of plastic.

Preparation of a Dead Body to be Transported

If the body will be transported by common carrier, the act requires the embalmer or funeral director in charge of the body to have it washed or embalmed and then enclosed in a casket or outside box. Alternatively, the body can be wrapped instead of being placed in the two containers. "Washing" means bathing or treating the entire surface of the dead body with a disinfecting and deodorizing solution or treating the entire surface with embalming powder. "Disinfecting solution" refers to an aqueous solution or spray containing at least five percent phenol by weight. (PA 07-252, § 85, amends this definition to include "or an equivalent in germicidal action. ") "Embalming" means injecting the (1) circulatory system of a dead body with

embalming fluid (fluid with at least four percent formaldehyde gas by weight) in an amount of at least five percent of the body weight or (2) body cavity with enough embalming fluid to properly preserve the body and make it sanitary.

Death from a Reportable Disease

If the death resulted from a reportable disease, the embalmer or funeral director in charge of the body must meet all the requirements above and must also prepare the body for burial or cremation by having it washed, embalmed, or wrapped as soon as practicable after it arrives at the embalmers' or funeral director's place of business. If the death is not due to a reportable disease, the embalmer or funeral director must still take appropriate measures to ensure that the body is not a public health threat.

Disposal and Cleansing of Materials

The act requires an embalmer or funeral director to dispose of any burial or cremation pouch used to wrap a dead body after each use or clean and wash it with a disinfecting solution. They are prohibited from using a disinfecting solution that does not meet the standard specified above unless it is approved in writing by the Department of Public Health (DPH).

CONTINUING EDUCATION:

The act requires that two hours of the already required six hours of continuing education for funeral directors and embalmers be dedicated to state and federal law on funeral services, including applicable Federal Trade Commission regulations. Licensees must complete their initial continuing education on these laws and regulations within 12 months after they first apply for license renewal after July 1, 2007.

Currently, each licensee must obtain a certificate of completion from the continuing education provider for all continuing education hours successfully completed and keep a copy of the certificate for a minimum of three years after license renewal. The act requires each funeral home and licensee to keep a copy of the certificate for each licensee the funeral home employs. (Presumably, the licensee only has to keep a copy for himself, not for each employee of the funeral home.)

CREMATION:

The act makes cremation procedures consistent with those for burial by specifying that a cremation certificate is not needed if the death occurred in another state and the permit for final disposition of the body is issued by the legally authorized entity from the state where the body came from. (PA 07-252, § 80 specifies that in such a case, the permit from the other state is sufficient authority to cremate the body and no additional certificate or permit is required; it also makes technical changes to this act.) When the death occurred in another state and cremation is desired, the out-of-state

permit must be submitted to the registrar of vital statistics of the Connecticut town where the funeral director has charge of the body.

Removal, Transit and Burial Permit

The act changes the current "burial transit removal permit" to a "removal, transit and burial permit" and makes applicable changes to the relevant statutes. Under existing law, an embalmer or funeral director, or one licensed in a state with a reciprocal agreement with this state, who takes custody of a dead body, must obtain a burial transit removal permit from the registrar of the town in which the death occurred. This must be done within five calendar days after death and before final disposition or removal of the body from the state.

The act makes the embalmer or funeral director assuming custody and control of the body and obtaining a removal, transit and burial permit from the town registrar where he has his business, responsible for filing the death certificate in person, electronically, or by mail.

Duties of Sextons

The act amends the duties of a sexton (a person responsible for the operation and maintenance of a cemetery) by requiring him or her to send a copy of the endorsed removal, transit and burial permit, or permit for final disposition if the death occurred in another state, to the registrar of vital statistics who filed the death certificate for the body.

BACKGROUND:

Reportable Diseases

The statutes (CGS § 19a-2a) and the Public Health Code (Conn. Agencies Reg. , § 19a-36-A2) require the DPH commissioner to annually issue a list of reportable diseases and amend it as necessary. An advisory committee of public health officials, clinicians, and laboratory personnel contributes to this process.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-157 **HB 7167**

PROFESSIONAL LICENSES OF MEMBERS OF THE UNITED STATES ARMED FORCES AND THE CONNECTICUT NATIONAL GUARD

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act extends, from six months to one year after discharge, the grace period during which the Department of Public Health (DPH) must renew certain DPH credentials that become void while the holders are on active duty in the armed forces. It establishes the same grace period for National Guard members whose credentials lapsed while they were performing military service ordered by the governor.

The act establishes a grace period during which non-DPH executive branch agencies, departments, boards (except the State Board of Education (SBE)), commissions, or officials must renew the professional credentials of all such members in the same circumstances above. The renewal is valid for one year after discharge from such duty or service or until the member successfully renews the license, whichever comes first.

The act also requires the SBE to renew expired SBE certificates, authorizations, and permits if the member applies within one year after discharge from active duty or ordered military service. The renewal must be valid for at least the amount of time the member was on active duty or ordered military service, but it cannot be valid for longer than the period for which original credential was valid.

As under existing law, the act does not apply to reservists or guard members on active duty for regularly scheduled annual training that is not part of mobilization.

DPH LICENSE RENEWAL STANDARDS:

By law, DPH must renew credentials (licenses, certificates, permits, and registrations) that lapse while their holders are serving on active duty in the armed forces. Under prior law, it had to renew any dentistry, medicine and surgery, or respiratory care license within one year after the member was discharged from active duty, and it had to renew credentials of almost all of the other health professionals within six months after the member's discharge. The act extends the grace period for renewing these latter credentials to one year after discharge. It also establishes the same one-year grace period for guard members whose credentials lapsed while they were performing military service ordered by the governor. But it does not establish this benefit for such guard members holding a license to practice dentistry or medicine and surgery.

By law, (1) DPH cannot renew the credential of anyone facing disciplinary action or an unresolved complaint; (2) members must complete any continuing education or

refresher courses that other renewal applicants must complete; and (3) members must submit to the applicable entity or official any required application or other documentation.

HEALTH-RELATED PROFESSIONS AND PROFESSIONALS AFFECTED:

The DPH professions and professionals affected by the act are as follows: emergency medical service; chiropractor; naturopathy; podiatrist; athletic trainer; physical therapist; occupational therapist; substance abuse counselor; radiographer and radiologic technologist; midwifery; nursing; dental hygienist; optometrist; optician; perfusionist; psychologist; marital and family therapist; clinical social worker; professional counselor; veterinarian; massage therapist; dietitian-nutritionist; acupuncturist; paramedic; barber; hairdresser and cosmetician; electrologist; subsurface sewage disposal system installer; sanitarian; hearing instrument specialist; speech and language pathologist and audiologist; asbestos contractor, consultant, and worker; and lead abatement consultant, contractor, and worker.

The act also includes embalmers and funeral directors and respiratory care licensees. But under CGS § 20-228, embalmers and funeral directors whose license or registration lapsed while they were on duty in the armed forces may already apply to DPH for reinstatement within one year after discharge. DPH must reinstate the credential, without an examination, if it approves the applicant's professional qualifications. And DPH must renew the respiratory care license of an armed forces member that lapsed while the member was in active duty within one year after discharge.

REQUIRED ACTION:

Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

Public Act 07-76 **HB 7222**

USE OF UNLICENSED ASSISTIVE PERSONNEL IN RESIDENTIAL CARE HOMES

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act allows unlicensed “assistive personnel” employed in residential care homes to perform limited health-related activities for residents. Under the act, they can obtain and record a resident's blood pressure and temperature with digital medical

instruments if such instruments (1) have internal decision-making electronics, microcomputers, or software that interpret physiologic signals and (2) do not require the user's discretion or judgment.

The act also allows unlicensed assistive personnel to obtain and document a resident's weight and to assist residents in using glucose monitors for obtaining and documenting blood glucose levels.

A "residential care home" is an establishment furnishing, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor. Also, it provides services that meet a need beyond the basic provisions of food, shelter, and laundry.

REQUIRED ACTION:

Provide in-service education of the FLIS staff and the provider community.

Public Act 07-35 **SB 140**

MASSAGE THERAPY

EFFECTIVE DATE: January 1, 2008

SUMMARY:

This act (1) replaces the title "Connecticut licensed massage therapist" with "massage therapist" and (2) prohibits anyone other than a licensed massage therapist or a holder of another applicable license from using the titles "massage therapist," "licensed message therapist," "massage practitioner," "massagist," "masseur," or "masseuse. "

The act also prohibits advertising any of the services that comprise massage therapy in any manner using the term "massage," unless the services are to be provided by a licensed massage therapist. It specifies that "advertising" includes (1) giving a card, sign, or device to anyone; (2) causing or allowing a sign or marking on a vehicle, building, or other structure; (3) advertising in a newspaper or magazine; and (4) placing a listing or advertisement in a directory under a heading or classification that includes the words "massage," "massage therapist," "massage therapy," or "massage therapy establishment. " It requires licensed massage therapists to include their license numbers in advertisements in newspapers, telephone directories, or other media.

It prohibits people who are not licensed massage therapists from advertising massage therapy services in either a public or private publication or communication by using "massage" or any term that implies a massage service activity.

BACKGROUND:

Massage Therapy

The law defines "massage therapy" as the systematic and scientific manipulation and treatment of the soft tissues of the body by use of pressure, friction, stroking, percussion, kneading, vibration by manual or mechanical means, range of motion, and nonspecific stretching. It may include using oil, ice, or hot and cold packs, or tub, shower, steam, dry heat, or cabinet baths. It does not include diagnosis, prescribing drugs or medicines, spinal or joint manipulations, or any service or procedure for which a license to practice medicine, chiropractic, natureopathy, physical therapy, or podiatry is required.

Related Act

PA 07-252 directs the commissioner of the Department of Public Health, within available appropriations, to enforce the provisions of the massage therapy law, including provisions concerning the use of the titles restricted by this act and the advertising of massage therapy services.

REQUIRED ACTION:

Conduct additional investigations related to falsely advertising massage therapy services.

Public Act 07-25 **SB 249**

MEDICAL MALPRACTICE DATA REGARDING MEDICAL PROFESSIONALS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act extends to insurers of any "medical professional," instead of just insurers of physicians, advanced practice registered nurses, or physician assistants, the requirement to provide to the insurance commissioner a closed claim report. A "closed claim" is one that has been settled, or otherwise disposed of, and for which the insurer has paid all claims. By law, the insurer must submit the report on a form

the commissioner prescribes within 10 days after the last day of the calendar quarter in which a claim is closed. The report includes information only about claims settled under Connecticut law.

The act defines "medical professional" as any person licensed or certified to provide health care services to individuals, including chiropractors, clinical dietitians, clinical psychologists, dentists, nurses, occupational speech and physical therapists, optometrists, pharmacists, physicians, podiatrists, and psychiatric social workers. By law, a closed claim report contains details about the insured and the insurer, the injury or loss, the claims process, and the amount paid on each claim.

Public Act 07-147 **SB 977**

RESTRAINTS AND SECLUSION IN PUBLIC SCHOOLS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act regulates the use of physical restraints and seclusion on students receiving or awaiting eligibility determinations for special education services in public schools. It (1) gives the State Board of Education (SBE) authority over their use as part of its existing mandate to regulate special education curriculum and instructional conditions and (2) requires the SBE to adopt implementing regulations.

Existing law regulates the use of these techniques on people receiving direct care and educational services from regional educational service centers; private institutions and facilities that provide special education under contract with school boards; the departments of Children and Families, Mental Health and Addiction Services, Mental Retardation, and Public Health; and entities they license or supervise. It excludes nursing homes and Department of Correction (DOC) facilities.

The act requires local and regional boards of education to tell pupils, parents, guardians, and others standing in the place of parents about:

1. the laws and regulations governing the use of physical restraints and seclusion and
2. related student and parental rights at the first planning and placement team meeting (PPT) involving the student's individual educational program (IEP).

The act also creates reporting procedures.

REPORTING REQUIREMENTS:

Local and Regional School Boards

Existing law requires institutions and facilities (other than nursing homes and DOC facilities) to report injuries caused by the use of restraints and seclusion to the state agency that supervises or has jurisdiction over them. Agencies, in turn, must review the reports when considering contract and license renewals. The act extends the reporting and review requirements to local and regional school boards and the State Department of Education, respectively. It allows the boards and institutions and facilities that provide special education to report these incidents to the SBE.

The act also requires local and regional school boards, institutions, and facilities to notify a special education student's parent or guardian of each incident in which the child was placed in physical restraints or seclusion. The boards also must keep records and compile annual reports of each instance and the nature of the underlying emergency that necessitated their use.

Public Act 07-9 **SB 1195**

ADMINISTRATION OF INFLUENZA AND PNEUMOCOCCAL POLYSACCHARIDE VACCINES BY LICENSED HOME HEALTH CARE AGENCY STAFF

EFFECTIVE DATE: Upon passage

SUMMARY:

Beginning October 1, 2007, this act allows nurses employed by licensed home health care or homemaker-home health aide agencies to administer flu and pneumococcal vaccines to patients in their homes. The vaccines may be administered without a physician's order, but must be done according to a physician-approved agency policy. The nurse must assess the patient for contraindications before administering the vaccine.

Under the act, a nurse means a registered nurse, licensed practical nurse, or an advanced practice registered nurse.

Public Act 07-24 **SB 1343**

COMPASSIONATE CARE FOR VICTIMS OF SEXUAL ASSAULT

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act establishes standard-of-care requirements for licensed health care facilities providing emergency treatment to female sexual assault victims. Each facility must promptly:

1. provide a victim with medically and factually accurate and objective information about emergency contraception;
2. inform her of emergency contraception's availability, use, and efficacy; and
3. provide her emergency contraception at the facility at her request, unless she is determined pregnant based on a U. S. Food and Drug Administration (FDA)- approved pregnancy test.

The act prohibits a facility from determining its protocol for standard-of-care compliance on any basis other than an FDA-approved pregnancy test.

The act allows a facility to contract with one or more independent providers to (1) ensure compliance at the facility with the standard-of-care requirements and (2) conduct forensic exams of victims at the facility. These exams must be conducted in accordance with the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations.

EMERGENCY CONTRACEPTION:

Under the act, “emergency contraception” means one or more prescription drugs used separately or in combination and administered to or self-administered by a patient to prevent pregnancy. It must be administered within a medically recommended time frame after intercourse, dispensed for that purpose, consistent with professional standards of practice, and determined safe by the FDA.

MEDICALLY AND FACTUALLY ACCURATE AND OBJECTIVE:

The act defines “medically and factually accurate and objective” as verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals where applicable.

INDEPENDENT PROVIDER:

Under the act, an "independent provider" means a licensed physician, physician assistant, advanced practice registered nurse, registered nurse, or nurse-midwife, all of whom are trained to conduct forensic exams in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations.

BACKGROUND:

Emergency Contraception

Plan B (levonorgestrel) tablets, approved by the FDA for emergency contraception after intercourse, is now an over-the-counter drug for women age 18 and over, but remains prescription-only for those under age 18. Another similar drug called Preven remains a prescription drug.

REQUIRED ACTION:

Provide in-service education of FLIS staff and the notification of applicable healthcare entities.

Multicultural Health and Comprehensive Cancer

Public Act 07-67 **SB 389**

HOSPITALIZATION AT AN OUT-OF-NETWORK FACILITY DURING TREATMENT IN CANCER CLINICAL TRIALS

EFFECTIVE DATE: Upon passage

SUMMARY:

By law, individual and group health insurance policies and HMO contracts must cover medically necessary hospitalization services and other routine patient care costs associated with certain cancer clinical trials. This act specifies that the required hospitalization coverage includes treatment at an out-of-network facility if (1) it is unavailable at an in-network facility and (2) the clinical trial sponsors are not paying for it. (An out-of-network facility is one that has not contracted with the insurer or HMO to provide health care services to enrollees. An in-network facility has contracted.)

Prior law subjected the required coverage to the policy's or contract's terms and limitations, including out-of-network limitations. The act instead requires the out-of-network hospital and insurer or HMO to make the out-of-network hospital treatment available at no greater cost to the patient than if treatment was available at an in-network facility. Thus, the patient is only responsible to pay any copayment, coinsurance, or deductible required under the policy or contract for in-network services.

BACKGROUND:

Coverage for Cancer Clinical Trials

By law, health insurers and HMOs must cover routine patient care costs associated with Phase III cancer clinical trials for treatment or palliation that involve therapeutic intervention and are conducted at multiple institutions. (Phase III clinical trials compare a new drug or surgical procedure to the current standard of treatment.)

The law applies to trials conducted under an independent, peer-reviewed protocol approved by (1) one of the National Institutes of Health, (2) a National Cancer Institute-affiliated cooperative group, (3) the Food and Drug Administration as part of an investigational new drug or device exemption, or (4) the U. S. Departments of Defense or Veterans' Affairs.

Payment to Out-of-Network Providers

By law, an insurer or HMO must pay out-of-network providers (including hospitals) the lesser of (1) the lowest contracted daily fee schedule or case rate it pays its Connecticut in-network providers for similar services or (2) billed charges. Out-of-network providers are prohibited from collecting more than the total of the amount paid by the insurer or HMO and the insured's deductible and copayment.

Public Act 07-107 **SB 398**

ESTABLISHING A TRAFFICKING IN PERSONS COUNCIL

EFFECTIVE DATE: Upon passage

SUMMARY:

This act creates a 26-member Trafficking in Persons Council to:

1. consult with government and non-government organizations in developing recommendations to strengthen state and local efforts to prevent trafficking, protect and assist victims, and prosecute traffickers;
2. identify criteria for providing services to adult trafficking victims and their children; and
3. hold meetings to provide updates and progress reports.

The council can request information from state and local agencies to carry out its duties.

The act requires the council to meet at least three times per year, and annually report to the General Assembly on its activities and recommended legislation, beginning January 1, 2008.

The act places the council in the Permanent Commission on the Status of Women (PCSW) for administrative purposes only.

MEMBERS:

The council consists of the following government officials or people they designate in writing to represent them:

1. the attorney general;
2. the chief state's attorney;
3. the chief public defender;

4. the commissioners of children and families, labor, mental health and addiction services, public health, public safety, and social services;
5. the child advocate;
6. the victim advocate;
7. the chairpersons of the commissions on Children, Latino and Puerto Rican Affairs, and African-American Affairs, and PCSW;
8. three Judicial Branch representatives appointed by the chief court administrator, with one representing the Office of Victim Services and one the Court Support Services Division; and
9. a municipal police chief appointed by the Connecticut Police Chiefs Association.

The council also has seven public members chosen as follows:

Appointing Authority	**Appointee Representing**
Governor	Connecticut Sexual Assault Crisis Services, Inc.
Senate president pro tempore	Organization providing civil legal services to low-income individuals
House speaker	Connecticut Coalition Against Domestic Violence
Senate majority leader	Organization that deals with behavioral health needs of women and children
House majority leader	Organization that advocates social justice and human rights issues
Senate minority leader	Connecticut Immigrant and Refugee Coalition
House minority leader	Asian-American community

The PCSW chairwoman serves as the council's chairperson. Members are not compensated but are reimbursed for necessary expenses in performing their duties.

TRAFFICKING:

The act defines “trafficking” as all acts involved in recruiting, abducting, transporting, harboring, transferring, selling, or receiving people within national or across international borders using force, coercion, fraud, or deception, to place them in situations of slavery or slavery-like conditions; forced labor or services, such as forced prostitution or sexual services; domestic servitude; bonded sweatshop labor; or other debt bondage.

REQUIRED ACTION:

The Commissioner must select a designee to be a member of the Council.

Operations

Public Act 07-134 **HB 5537**

WHEELCHAIR TRANSFER SAFETY

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act requires anyone transporting someone being transferred into or out of a motor vehicle while in a wheelchair to provide and use a device designed to secure the person in the wheelchair while transferring him or her from the ground to the vehicle or the vehicle to the ground. The device must be in the vehicle at all times.

The act requires operators of certain specific types of newly registered vehicles to provide additional protection through the use of a device that secures the wheelchair to the motor vehicle's mechanical lift, or otherwise prevents or seeks to prevent the person from falling from the vehicle.

The act authorizes the Department of Motor Vehicle (DMV) commissioner to adopt regulations, in consultation with the Departments of Transportation (DOT) and Public Health (DPH) commissioners, to implement these requirements.

It designates violations of the requirements as infractions.

VEHICLES IN WHICH WHEELCHAIR MUST BE SECURED TO LIFT:

For certain types of lift-equipped vehicles registered for the first time after September 30, 2007, the act requires that the operator provide and use an additional device that secures the wheelchair to the vehicle's mechanical lift or otherwise prevents or seeks to prevent the person in the wheelchair from falling from the vehicle. These vehicles include:

1. livery vehicles;
2. service buses;
3. invalid coaches;
4. vanpool vehicles;
5. school buses;
6. motor buses;
7. student transportation vehicles;
8. camp vehicles; and

9. vehicles used by municipal, volunteer, and commercial ambulances, rescue services, and management services.

The act requires service buses, school buses, and student transportation vehicles to meet the restraint device requirement as a condition of their required periodic DMV safety inspections. Unless a vehicle meets the requirements, the act prohibits (1) DPH from issuing a license or certificate to a volunteer, municipal, or commercial ambulance service, rescue service, or management service and (2) DOT from issuing a permit to operate livery vehicles. Any entity holding a livery permit issued before October 1, 2007 must comply with the requirements by that date.

BACKGROUND:

Definitions

A "motor vehicle in livery service" is a vehicle in the business of transporting passengers for hire, except for taxis, motor buses, school buses, and student transportation vehicles. Livery vehicles may operate only under DOT permits.

A "service bus" is a vehicle, other than a vanpool vehicle or school bus, designed and regularly used to carry 10 or more passengers in private transportation service without charge to the individual.

An "invalid coach" is a vehicle used exclusively to transport nonambulatory patients not confined to stretchers to or from medical facilities and their homes in nonemergency situations or used in emergencies as backup vehicles.

A "vanpool vehicle" primarily transports people between home and work on a prearranged nonprofit basis and is manufactured and equipped to provide seating for (1) seven to 15 people, if owned by or leased to an individual person, an employee of that person, or to an employee of a government entity in Connecticut or (2) six to 19 people, if owned by or leased to a DOT-recognized regional ridesharing organization in Connecticut.

A "motor bus" is a vehicle, other than a taxicab, operated on a highway and providing transportation by indiscriminately receiving or discharging passengers, or running on a regular route between fixed locations.

A "student transportation vehicle" is a vehicle, other than a registered school bus, used to transport students.

A "camp vehicle" is a vehicle regularly used to transport passengers under age 18 for DPH-licensed youth camp activities.

A “management service” is an employment organization that provides emergency medical technicians or paramedics to an emergency medical service organization, but does not own or lease ambulances or other emergency medical vehicles.

A “rescue service” is an organization that primarily searches for lost people or renders emergency services to people in dangerous or perilous circumstances.

Public Act 07-56 **HB 7024**

CREATING AN INTRASTATE MUTUAL AID SYSTEM

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act establishes the Intrastate Mutual Aid Compact (IMAC) and commits the state's political subdivisions (towns) to its terms. It provides a legal statewide mechanism for participating towns to request and provide mutual aid during a declared local civil preparedness emergency. IMAC is similar to the Emergency Management Assistance Compact for states, which Connecticut enacted in 2000.

Any town may withdraw from IMAC by adopting a resolution to that effect, and member towns may enter into or remain in supplementary or other interlocal mutual aid agreements.

The act describes the responsibilities of local civil preparedness organizations, compact activation procedures, permit and license reciprocity, and compact rights and liabilities, reimbursement issues.

Existing law already allows towns to establish mutual aid civil preparedness agreements and address some of the same issues this act addresses. It also requires towns, if properly ordered, to make their civil preparedness forces available to provide assistance.

COMPACT'S PURPOSE:

The compact's stated purpose is to establish a statewide municipal mutual aid system for “participating political subdivisions,” which it defines as any political subdivision whose legislative body has not adopted a resolution withdrawing from the compact. The compact creates a mechanism for towns to (1) provide mutual aid to prevent, respond to, or recover from any disaster resulting in a town declaring a local civil preparedness emergency, subject to the town's criteria for a declaration, and (2) participate in disaster-related exercises, testing, or training.

Public Act 07-173 **HB 7025**

CIVIL PREPAREDNESS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act makes several changes in the civil preparedness statutes.

It:

1. expands the governor's authority to deploy civil preparedness personnel out-of-state;
2. requires towns to (a) consider whether to address the nonmilitary evacuation of livestock and horses in their emergency plans of operation and (b) submit current plans annually for state approval;
3. requires people appointed to serve in civil preparedness organizations to take oaths annually, rather than only upon entering office;
4. requires officers administering oaths, except local civil preparedness officers, to be empowered to enlist volunteers by the Department of Emergency Management and Homeland Security (DEMHS) commissioner, instead of civil preparedness directors;
5. requires local civil preparedness officers to provide DEMHS with a roster of sworn volunteer civil preparedness personnel by August 15 each year; and
6. reduces the frequency of the Emergency Management and Homeland Security Coordinating Council meetings from monthly to quarterly.

OUT-OF-STATE DEPLOYMENT:

Prior law allowed the governor to deploy civil preparedness personnel out-of-state only if the other state's laws on the use of such personnel were substantially similar to Connecticut's. The act allows the governor to order them to operate in states that are members of the Emergency Management Assistance Compact as well.

LOCAL EMERGENCY OPERATIONS PLAN:

In order to be eligible for certain state and federal homeland security and civil preparedness funds, a town must submit an emergency operations plan, approved by the local preparedness director and local chief executive, to the DEMHS commissioner for approval. The act requires towns to submit current plans by January 1, 2008 and annually thereafter. Any town that does not change its previous year's plan may include a notice to that effect.

BACKGROUND:

Emergency Management and Homeland Coordinating Council

This council advises the Office of Emergency Management and Department of Public Safety on various emergency management and homeland security issues.

Emergency Management Assistance Compact

The state enacted this compact in 2000. It provides a mechanism for states to (1) help each other manage emergencies and disasters declared by any member state and (2) participate in emergency-related exercises, testing, or other training or activities when no emergency exists. .

Related Act

PA 07-11 requires local civil preparedness plans to include provisions for evacuating pets and service animals during emergencies.

Public Act 07-106 **HB 7270**

THE EMERGENCY 9-1-1 SURCHARGE AND MISUSE OF THE E 9-1-1 SYSTEM

EFFECTIVE DATE:

July 1, 2007, except for the provisions making misuse of E 911 a crime and the monthly fee assessments, which are effective October 1, 2007; upon passage for the council membership.

SUMMARY:

This act establishes a crime of misusing the emergency 911 (E 911) system and makes violations a class B misdemeanor (see Table of Penalties). A person is guilty of this crime if he or she (1) dials E 911 or causes it to be dialed in order to make a false alarm or complaint or (2) purposely reports false information that could result in the dispatch of emergency services.

By law, telephone companies must forward the telephone number and street address from which a 911 call is made to a safety answering point. The companies and their agents are immune from liability to the person making the call over the E 911 system for the release of this information. The act extends these provisions to companies providing voice over internet protocol (VOIP) service (e. g. , Vonage) and their

agents but allows a VOIP provider to meet the forwarding requirement by complying with relevant federal law. It also requires VOIP providers and active prepaid wireless telephone service providers providing E 911 services to comply with federal law, and also to comply with state law, if the provisions in state law are not addressed in, or inconsistent with, federal law and regulations.

By law, the Department of Public Utility Control must determine the amount of the monthly fee assessed against each telephone and commercial mobile radio services subscriber to fund the development and administration of the E 911 program. (Commercial mobile radio services include personal communications services (PCS), among others.) The act extends this requirement to cover the VOIP and prepaid wireless service providers. It requires the VOIP and prepaid wireless telephone service providers to assess their subscribers the fee.

The act increases the number of emergency management officials on the State-wide Emergency Management and Homeland Security Coordinating Council from one to two.

EMERGENCY MANAGEMENT AND HOMELAND SECURITY COUNCIL:

Under prior law, this council included one local or regional civil preparedness director appointed by the House speaker. The act adds another member and requires that, the Connecticut Emergency Management Association designate this member by July 1, 2007. It replaces the term “civil preparedness director” with “emergency management director” to conform to other statutes. Members serve three years from the time of appointment or until a successor is appointed.

The council advises the departments of Emergency Management and Homeland Security and Public Safety on emergency management and homeland security preparedness, policies, and responses, among other things.

Planning Branch

Public Act 07-133 **SB 1391**

FEE INCREASES FOR CERTAIN VITAL RECORDS

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act increases town clerks' fees (1) from $5 to $10 for each certified copy of a marriage, death, or long-form birth certificate and (2) from $1 to $2 for certifying copies of maps, surveys, and other documents filed with their offices. It also doubles the fee for a certified copy of a marriage or death certificate from the Department of Public Health's registrar of vital statistics from $5 to $10. The $5 fee for a certified copy of a birth registration, also known as the short form, remains unchanged. A birth registration contains only a person's name, sex, date and place of birth, and date of birth registration. A birth certificate also includes such information as parents' names, mother's maiden name, hospital location, and home addresses.

Lastly, the act allows blind people and people with mental retardation to get free lifetime sport fishing licenses, instead of requiring them to renew their licenses every year and provide proof of disability each time. It makes the same change to allow free lifetime hunting, sport fishing, or trapping licenses for (1) Connecticut residents who have lost, or permanently lost the use of, one or more limbs and (2) nonresidents with the those physical disabilities, if their home states have reciprocal laws.

REQUIRED ACTION:

Update both the website and application forms to reflect the fee increase for marriage, civil union and death records.

Public Act 07-115 **SB 1437**

THE DATE OF BIRTH OF ADOPTED PERSONS BORN OUTSIDE OF THE COUNTRY AND NOTICE PROVIDED BY THE COUNCIL ON PROBATE JUDICIAL CONDUCT

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act permits people (1) born outside the United States and (2) adopted by Connecticut residents to obtain a probate court ruling to establish their biological age and date of birth. It requires the Department of Public Health (DPH) to conform its records to the court decree.

The act also extends, from three to seven business days, the time within which the Council on Probate Judicial Conduct must notify the complaining party and judge of the completion of its investigation of a complaint alleging judicial misconduct. By law, the notice must indicate whether the council found probable cause that the judge engaged in misconduct.

AGE DETERMINATIONS:

The act permits an adoptive parent or adoptee age 18 or older to ask the probate court where the adoptee lives to determine the adoptee's birth date and biological age. The court must hold a hearing and accept medical and other relevant evidence.

It must send a certified copy of its decree to DPH when it conflicts with the agency's official birth record. The act directs the department to use the birth date set by decree in all future birth records.

Public Health Initiatives

VETOED **HB 6715**

THE PALLIATIVE USE OF MARIJUANA

GOVERNOR'S COMMENT:

Governor M. Jodi Rell has vetoed House Bill 6715, a bill approved by the General Assembly that would have allowed the medical use of marijuana.

The Governor said that while "the bill seeks to provide relief to patients suffering from severe and persistent pain, the bill also requires that patients or primary caregivers engage in illegal activity to use marijuana." The Governor noted in her veto message that the "medical profession, as well as public and private biotechnology researchers, have made great strides in both pharmacologic and non-pharmacologic modalities for pain management and they continue their search to find effective pain relieving drugs."

Public Act 07-197 **SB 66**

EXPANDING INSURANCE COVERAGE FOR SPECIALIZED FORMULAS FOR CHILDREN

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act requires health insurance policies to cover medically necessary specialized formulas administered under a physician's direction for children up to age 12, instead of age eight.

The act applies to group and individual insurance policies delivered, issued for delivery, or renewed in Connecticut after September 30, 2007 that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) accidents only; and (5) hospital or medical services, including HMO contracts. It does not apply to self-insured benefit plans, which are regulated under the federal Employee Retirement Income Security Act (ERISA).

BACKGROUND:

Specialized Formulas

"Specialized formula" is a nutritional formula that is exempt from the federal Food and Drug Administration's general nutritional labeling requirements and is intended for use solely under medical supervision in the dietary management of specific diseases.

Related Act

PA 07-75 requires insurers and HMOs to include a specified "medically necessary" definition in health insurance policies.

Public Act 07-58 **SB 260**

HEALTH ASSESSMENTS FOR ADOLESCENTS

EFFECTIVE DATE: July 1, 2008

SUMMARY:

This act requires public school students to have health assessments in either grade nine or 10, instead of grade 10 or 11. Under existing law, unchanged by the act, students must also have health assessments in either grade six or seven.

The law requires such assessments to include (1) a physical examination and a chronic disease assessment, including asthma; (2) an updating of required immunizations; (3) vision, hearing, postural, and dental screenings; and (4) other information, including a health history, that the physician feels is necessary and appropriate. In certain situations, the assessment must also include other tests such as for tuberculosis and sickle cell anemia or Cooley's anemia.

Public Act 07-180 **SB 703**

FIRE SAFE CIGARETTES AND APPEALS OF DECISIONS BY LOCAL TREE WARDENS

EFFECTIVE DATE: July 1, 2008

SUMMARY:

Beginning July 1, 2008, this act, with minor exceptions, requires cigarettes sold or offered for sale to consumers in Connecticut by cigarette manufacturers to be fire-safe. Fire-safe cigarettes have the same characteristics as conventional cigarettes but are designed to be self-extinguishing (i. e. , they stop burning when left unattended).

The act:

1. requires cigarette manufacturers to (a) certify to the State Fire Marshal's Office that any cigarette they sell in Connecticut is tested in accordance with the act and meets a minimum fire-safe performance standard and (b) pay a $250 fee for each brand family listed in the certification;
2. allows the revenue services commissioner to revoke or suspend the license of manufacturers who sell cigarettes that are not fire-safe, certified, or marked in accordance with the act;
3. allows the attorney general to bring a civil action to recover up to $10,000 for certain manufacturer violations;
4. requires the State Fire Marshal's Office to administer the fire-safe cigarette program and dedicates certification fees and civil fines to the office to fund its processing, testing, and administrative activities; and
5. allows the state fire marshal to adopt implementing regulations consistent with the New York fire safety standards.

Public Act 07-185 **SB 1484**

THE HEALTHFIRST CONNECTICUT AND HEALTHY KIDS INITIATIVES

*****Section 72 of House Bill 8002 – Public Act 07-02 REPEALS Sections 10, 12, 24 to 28, inclusive, and 34 to 43, inclusive of Senate Bill 1484 – Public Act 07-185**

***** See Sections 19-21 of HB 8003 - below**

SUMMARY:

This act establishes a board to govern a network that integrates state and social services data within and across various departments. It requires the Public Health Department (DPH) to develop standards to facilitate the development of a statewide, integrated "electronic health information system" for use by health care providers and institutions that are funded by the state. And it designates a nonprofit entity to act as the state's lead health information exchange organization for five years.

It requires (1) DSS to inventory public disease management programs, (2) DPH to develop an electronic license renewal system for certain professions, and (3) the healthcare advocate to create a consumer health information website. It appropriates funds for various school- and community-based health center operations. And the bill makes technical changes.

*Senate Amendment "A" eliminates provisions in the original bill (File 472) (1) increasing the income limit for the Medicaid medically needy coverage group, (2) restoring continuous eligibility for HUSKY children and guaranteed eligibility for HUSKY A adults, (3) eliminating cost sharing in HUSKY A, and (4) requiring DSS to establish a fee schedule for dental services provided to HUSKY A and other Medicaid recipients and HUSKY B recipients and to reimburse all Medicaid providers using higher, Medicare payment rates. But it requires DSS to increase Medicaid provider rates within available appropriations. It also reduces the original bill's expansion of HUSKY A pregnant women coverage and scales back the outreach provisions.

The amendment adds the two health care authorities, electronic health information system standards, children's preventive care and quality improvement plans, and Health Reinsurance Association plan provisions. It reduces the extension of dependent care coverage to age 26, rather than 30.

§ 11 — ON-LINE DPH LICENSE RENEWAL

The act requires DPH to establish, by July 1, 2008, a secure on-line license renewal system for physicians, surgeons, dentists, and nurses. Nurses include advanced practice registered nurses, registered nurses, and licensed practical nurses. DPH must allow those using the on-line system to pay their fees by credit card or electronic funds transfer from a bank or credit union account. The act allows DPH to charge a service fee of up to $ 5 for payments made in this manner.

§§ 14 & 35 — CHILDREN'S HEALTH QUALITY IMPROVEMENT PROGRAM

EFFECTIVE DATE: July 1, 2007

The act requires the DSS commissioner to establish a child health quality improvement program to promote the implementation of evidence-based strategies by HUSKY providers to improve the delivery of and access to children's health services. He must do this in collaboration with the DPH and DCF commissioners.

The evidence-based strategies must focus on physical, dental, and mental health services. They must include: (1) methods for early identification of children with special health care needs; (2) integration of care coordination and care planning into children's health services; (3) implementation of standardized data collection to measure performance improvement; and (4) implementation of family-centered services in patient care, including the development of parent-provider partnerships. The act defines “evidence-based strategies” as policies, procedures, and tools that are informed by research and supported by empirical evidence, including research developed by organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, and the Institute of Medicine.

The DSS commissioner must seek the participation of various public and private entities including medical, dental, and mental health providers; academic professionals with experience in health services research and performance measurement and improvement; and any other entity the commissioner deems appropriate to promote such strategies. The commissioner shall ensure that the strategies reflect new developments and best practices in the field of children's health services.

The commissioner must annually report to the Human Services, Public Health, and Appropriations committees and the Medicaid Managed Care Council beginning July 1, 2008. The report must address the implementation of any strategies developed and the extent to which they improved delivery of and access to care for HUSKY children.

The act appropriates $ 150,000 in FY 08 to DSS for this program.

§ 22 — CONSUMER HEALTHCARE WEBSITE

EFFECTIVE DATE: October 1, 2007

The act requires the Healthcare Advocate's Office, within available appropriations, to create and maintain a website for consumer health care information. At a minimum, the website must contain (1) information about wellness programs, such as disease prevention and health promotion, available in various regions; (2) hospital quality and experience data; and (3) a link to the Insurance Department's managed care consumer report card.

REPEALED (HB 8002)-§§ 24, 25, 36 — ELECTRONIC HEALTH RECORDS STANDARDS

The act designates eHealth Connecticut, a nonprofit corporation, as the state's lead health information exchange organization from July 1, 2007 to July 1, 2012. It requires the DPH commissioner to contract with eHealth to develop a statewide health information technology plan that includes standards, protocols, and pilot programs for health information exchange.

The act requires DPH to develop electronic data standards to facilitate the development of a statewide, integrated "electronic health information system" for use by health care providers and institutions that are funded by the state. DPH must do this by July 1, 2008 and in consultation with DSS, DOIT, and any other entity the DPH commissioner deems appropriate. DPH may contract for the standards' development through a request for proposal process.

The standards must (1) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) be compatible with any national data standards in order to allow for interstate "interoperability"; (3) permit the collection of health information in a "standard electronic format," and (4) be compatible with the requirements for an electronic health information system (see below).

REPEALED (HB 8002)- §§ 26-28, 37, 38 — CONNECTICUT HEALTH INFORMATION NETWORK (CHIN)

CHIN Creation and Framework

The act establishes the Connecticut Health Information Network at the UConn Health Center. The network is to integrate state and social services data within and across the UConn Health Center, Office of Health Care Access (OCHA), DPH, and the Mental Retardation (DMR) and Children and Families (DCF) departments. Data from other departments could be integrated into the network as federal law and funding permits. The CHIN must securely integrate this data, consistent with state and federal privacy laws.

§ 29 — DISEASE MANAGEMENT

EFFECTIVE DATE: Upon passage

By January 1, 2008, the act requires DSS to inventory public disease management initiatives in the HUSKY, SAGA medical assistance, and other Medicaid programs implemented as of the date the bill passes and report to the Human Services and Public Health committees. The report must include a summary, total spent, and number of people served.

§ 30 & 39 — HEALTHFIRST CONNECTICUT AUTHORITY

EFFECTIVE DATE: Upon passage, except for the appropriation, which is effective July 1, 2008.

The act creates a 12-member HealthFirst Connecticut Authority to:

1. evaluate alternatives for providing quality, affordable, and sustainable health care for all state residents including a single-payer system and employer-sponsored insurance.
2. recommend ways to contain health care costs and improve health care quality, including health information technology; disease management and other incentives to improve care for people with chronic diseases; monitoring and reporting on cost, quality, and utilization; and ways to encourage or require providing health care coverage to certain groups through participation in an insurance pool; and
3. make recommendations on financing insurance for state residents, including ways to maximize federal funding for subsidies; contributions from employers, employees, and individuals; and ways to pay the state's share of costs.

The panel must report its recommendations, including recommended strategies for increasing access, by December 1, 2008. The report goes to the Public Health, Human Services, and Insurance committees.

Legislative leaders and the governor appoint nine members some of whom must represent specific interests as Table 1 shows. The DPH and DSS commissioners and the comptroller, or their designees, are ex-officio, nonvoting. All members must be familiar with the Institute of Medicine's health care reform principles (see BACKGROUND) and be committed to making recommendations consistent with them.

Table 1: Health Care Panel Appointments

Appointing Authority *Appointments*	*Appointee*
Governor (2)	• Health quality or patient safety advocate • Person with information technology experience
Senate president pro tempore (2)	• Representative of businesses with fewer than 50 employees • Person with community-based health experience
House speaker (2)	• Health care provider • Representative of businesses with 50 or more employees
Senate majority leader (1)	Labor representative
House majority leader (1)	Consumer representative
Senate minority leader (1)	Hospital representative
House minority leader (1)	Insurance company representative

All appointments must be made within 30 days after the bill is enacted, and if a vacancy occurs, the appointing authority must fill it within 30 days. The speaker and president pro tempore each choose one chairperson, and the two must schedule the first panel's meeting no more than 60 day's after the bill's enactment. If an appointing authority fails to make an initial or vacancy appointment within the 30 day-period, the authority chairpeople must do so.

The authority can apply for grants or financial assistance from state and federal agencies, individuals, groups, and corporations. The bill appropriates $ 500,000 to DPH in FY 09 for the authority.

§§ 31 — STATEWIDE PRIMARY CARE ACCESS AUTHORITY

EFFECTIVE DATE: Upon passage, except the appropriation, which is effective July 1, 2008.

Developing a Universal Primary Care System

The act establishes an 11-member authority to develop, a universal system for providing primary care services, including prescription drugs, to all Connecticut residents. It must develop the system by December 31, 2008 and a plan for implementing it by July 1, 2010. The system must be designed to maximize federal participation in Medicaid and Medicare.

In developing the system, the authority must define primary care and inventory the state's existing primary care infrastructure including

1. the number of primary care providers practicing in the state (i. e. , physicians, dentists, nurses, people providing services to people with mental illness and mental retardation, and others providing primary medical, nursing, counseling, or other health cares, substance abuse, or mental health services, including those providing services through an HMO or medical services plan);
2. the total amount spent on public and private primary care services during the last fiscal year; and
3. the number of public and private buildings and offices used primarily for primary care services, including hospitals, mental health facilities, dental offices, community- and school-based health centers, and academic health centers.

The committee must also:

1. estimate the cost of fully implementing a universal primary care system,
2. identify additional personnel or infrastructure needed to implement a system,
3. determine the state's and third parties' role in administering a system,
4. identify funding sources for a system, and
5. determine private insurers' role in a universal system.

Implementation Plan

The authority's implementation plan must (1) include a timetable, (2) establish benchmarks to assess progress toward implementation, and (3) establish ways to assess the system's effectiveness once it begins operating.

Authority Composition, Powers, and Reporting Requirements

The authority is composed of (1) the chairpersons of the HealthFirst Connecticut Authority (see above), who also serve as this authority's chairpersons; (2) the DPH and DSS commissioners; (3) the comptroller; and (4) members appointed by the Connecticut Primary Care Association, State Medical Society, Chapter of the American Academy of Pediatrics, Nurses Association, and Association of School-

Based Health Centers, and the Weitzman Center for Innovation in Community Health and Primary Care (which is affiliated with Community Health Center, Inc. All members must be familiar with the Institute of Medicine's health care reform principles (see BACKGROUND) and be committed to making recommendations consistent with them.

All initial appointments must be made by July 15, 2007, and the chairpersons must convene the first meeting by August 1, 2007. Any member who fails to attend three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned. Appointing authorities fill vacant positions. Members serve without pay but are reimbursed for their expenses.

The authority can hire consultants or assistants under contracts or other means to render professional, legal, financial, technical, or other assistance or advice.

The authority must report annually to the Public Health, Insurance, and Human Services committees on its progress in developing the universal primary care system and on the system's implementation. The first report is due by February 1, 2008; subsequent reports are due by January 1.

§ 32-33 — SCHOOL-BASED HEALTH CENTER GRANTS

EFFECTIVE DATE: July 1, 2007, except for the provisions concerning the SBHC committee, which is effective upon passage

It makes permanent the ad hoc committee established in 2006 to advise DPH on SBHCs. It requires the committee to meet at least quarterly and annually report recommendations to the Public Health and Education committees for statutory and regulatory changes to improve health care access through SBHCs.

The act requires any SBHC constructed on or after October 1, 2007 that is located in, or attached to, a school building, to have an entrance separate from the school.

REPEALED (HB 8002)-§ 42 & 43—COMMUNITY-BASED HEALTH CENTER GRANTS

The act appropriates to DPH in FY 08 (1) $ 2 million for infrastructure grants to community-based health centers, including health information technology and (2) $ 500,000 for grants to these centers to transport patients to medical appointments. In making the latter grants, DPH must give priority to Federally Qualified Health Centers in areas with limited public transportation options.

UPDATED LANGUAGE IN SECTIONS 19-21 OF HB 8003

Early Childhood Education Cabinet (§§ 19-21 HB 8003)

The bill requires SDE to provide administrative services to the statutory Early Childhood Education Cabinet and the Governor's Early Childhood Research and Policy Council established by executive order.

It requires the Cabinet to begin, by July 1, 2008, the statewide longitudinal evaluation of the school readiness program that is required to conduct. It requires the study to examine the educational progress of children from pre-kindergarten to grade three.

It extends from January 1, 2000 to January 1, 2008, the date by which the commissioner must adopt assessment measures of school readiness programs for their use in conducting annual evaluations.

The bill requires the Cabinet to develop and implement an accountability plan for early child education services annually beginning by December 1, 2008. The plan must identify and define appropriate population indicators and program and system measures of the readiness of children to enter kindergarten. As part of the accountability plan, the Cabinet, in consultation with SDE and the Office of Policy and Management (OPM), must consider the development of data sharing agreements between state agencies and analyze whether the data can be combined in a manner required to assess the progress of children toward school readiness.

Annually, beginning by December 31, 2008, the Cabinet must report on the measures implemented to the Appropriations, Education, Human Services, and Higher Education committees.

State-funded early childhood education providers must use the program measures developed under the accountability plan to evaluate the effectiveness of their services. Each provider must report the evaluation results to the Early Childhood Education Cabinet annually beginning by June 30, 2009.

REQUIRED ACTION:

Section 11 calls for online license renewal for physicians, dentists and nurses to be implemented by July 1, 2008.

Section 30: The Department is on the HealthFirst Connecticut Authority.

Section 31: The Commissioner is on the Statewide Primary Care Access Authority.

Regulatory Service Branch

Public Act 07-47 **HB 5108**

REPORTING REQUIREMENTS RELATED TO THE CHILD POVERTY AND PREVENTION COUNCIL

EFFECTIVE DATE: October1, 2007

SUMMARY:

This act extends reporting responsibilities related to the state's 10-year plan to reduce child poverty by 50% by June 2014. By law, each agency represented on the legislatively-established Child Poverty and Prevention Council whose budget includes poverty prevention programs must report to the council by November 1, 2007 on at least two programs, and describe the performance-based measurements it uses to gauge their effectiveness. The act extends this annual reporting requirement through November 1, 2014. It makes a conforming change to the law requiring the council to file progress reports with the governor's office and legislative committees each January.

It also extends, from FY 08 through FY 21, the requirement that the governor's biennial budget document include a (1) prevention report and recommended agency appropriations for prevention services and (2) report on the state's progress in meeting the goal that, by 2020, at least 10% of total recommended appropriations for each budgeted agency be allocated for prevention services.

AFFECTED STATE AGENCIES:

The budgeted agencies represented on the council are the:

1. Chief Court Administrator, Child Advocate, and Policy and Management offices;
2. Children and Families, Correction, Education, Economic and Community Development, Higher Education and Employment Advancement, Labor, Mental Health and Addiction Services, Mental Retardation, Public Health, Social Services, and Transportation departments; and
3. Children's Trust Fund.

BACKGROUND:

Child Poverty and Prevention Council

The 21-member council is composed of legislative and executive branch appointees. Among other things, it monitors state prevention programs and the extent to which the state's actions conform to the legislative goal of reducing poverty by 50% by June 2014. It must also consult with experts and service providers and make budget priority recommendations.

Prevention Services and Programs

Prevention services are policies and programs that promote healthy, safe, and productive lives. Their purposes include reducing crime, violence, substance abuse, illness, academic failure, and other socially destructive behavior.

REQUIRED ACTION:

The Public Health Initiatives Branch and the Regulatory Services Branch will have annual reporting requirements. Reports will be due November 1, 2007 through November 1, 2015.

Public Act 07-168 **HB 5234**

BANNING PESTICIDE USE ON SCHOOL GROUNDS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act:

1. expands a ban on applying lawn care pesticides at preschools and elementary schools to schools with students through grade eight, but allows a school superintendent and other appropriate authorities to authorize emergency applications of lawn care pesticides in health emergencies at such schools;
2. extends, for one year, an exemption to the ban for pesticides applied according to certain integrated pest management plans (IPMs); and
3. makes the Department of Environmental Protection (DEP) responsible for administering and enforcing school pesticide applications.

Under prior law, the DEP commissioner could designate DEP officers or employees to enforce pesticide laws by, among other things, observing pesticide applications, inspecting equipment, obtaining pesticide samples, and verifying applicator certifications. The act (1) permits the commissioner to authorize any such enforcement actions only within available appropriations, and (2) authorizes her to designate officers and employees to enforce school pesticide applications.

Also under prior law, the commissioner (1) had to annually review a sampling of state department, agency, or institution pest control management plans required by regulation and (2) could review an application of pesticides at the departments, agencies, or institutions to determine whether they used IPM at their facilities if the commissioner has provided a model IPM plan pertaining to those facilities. The act applies these provisions to schools and requires that the commissioner's annual review of department, agency, institution, and school pest control management plans be conducted within available appropriations.

APPLICATION OF LAWN CARE PESTICIDES:

Integrated Pest Management Plans

Prior law barred anyone from applying a lawn care pesticide on the playing fields and playgrounds of public and private preschools and elementary schools, except that pesticides could be applied until July 1, 2008 on their grounds according to an IPM. The act expands the ban to public and private schools with students through grade eight and extends the IPM exemption for one year, to July 1, 2009. The IPM plan may be developed by a local or regional school board for public schools it controls and must be consistent with DEP's model pest control management plan.

Emergency Applications

Despite the ban, prior law allowed emergency applications of lawn care pesticides on public and private preschool and elementary school grounds to eliminate a threat to human health, as determined by the local health director, public health or environmental protection commissioner, and, in the case of a public elementary school, a school superintendent. The act allows these officials to determine health threats at schools with students through grade eight.

DEP ADMINISTRATION AND ENFORCEMENT:

The act gives DEP the authority, under the Connecticut Pesticide Control Act (CGS § 22a-46 et seq.), to administer and enforce the laws concerning school pesticide applications, within available appropriations. These laws include registration, notice, and record-keeping provisions, in addition to the provisions concerning the applications themselves. The act makes it unlawful to violate the school pesticide statutes and applies Pesticide Control Act penalties to violators, as follows.

1. Any registrant; commercial applicator; uncertified person who performs, advertises, or solicits to perform commercial application; wholesaler; dealer; retailer; or other distributor who knowingly violates the law may be fined up to $5,000, imprisoned up to one year, or both.
2. A private applicator or other person, not included in the above categories, who knowingly violates the law, may be fined up to $1,000, imprisoned up to 30 days, or both.

Under the Pesticide Control Act, the action, omission, or failure to act of any officer, agent, or other person acting or working for any person is deemed to be the action, omission, or failure of the employer as well as the employee. The act extends this provision to school pesticide applications.

It also applies to school pesticide applications existing law authorizing the attorney general, on the complaint of the DEP commissioner, to seek a civil penalty in Hartford Superior Court against violators of the Pesticide Control Act of up to $2,500 per day for each day a violation continues.

DEP Review of Pesticide Applications

By law, state agencies, departments, and institutions must use IPM at facilities they control if the DEP commissioner has provided a model IPM plan pertaining to those facilities. The law allows each agency, department, or institution that enters into a contract for pest control and pesticide application to revise and maintain its bidding procedures to require contractors to supply IPM services.

The act allows schools to revise and maintain their bidding procedures to require contractors to supply IPM services. It requires that DEP's annual review of department, agency, institution, and school pest control management plans be within available appropriations, and authorizes it to review any school pesticide application to determine if it used IPM as the law requires.

BACKGROUND:

Integrated Pest Management

IPM means the use of all available pest control techniques, including judicious use of pesticides, when warranted, to maintain a pest population at or below an acceptable level, while decreasing the use of pesticides (CGS § 10-231a).

Public Act 07-51 **HB 5728**

BONDS OF MUNICIPAL WATER POLLUTION CONTROL AUTHORITIES

EFFECTIVE DATE: Upon passage.

SUMMARY:

This act makes it easier for towns to finance relatively small sewer and water system projects with bonds that combine the elements of general obligation (GO) and revenue bonds (i. e., hybrid bonds). It does this by establishing a separate procedure for issuing these bonds without a referendum. That procedure supersedes any contrary statutory, special act, or charter provision.

Towns can use the procedure to issue no more than $3 million in hybrid bonds, which must be backed by the revenue the system generates, including charges imposed specifically on its users to repay the bonds. As with other bonds, the procedure requires a town to repay the hybrid bonds according to a set schedule. But it also allows the town to vary that schedule over the repayment period as long as the agency repays the town the full amount. The act specifies the town's rights and remedies for securing the payments.

OPERATING AGENCY:

The act's procedure for approving hybrid bonds for small sewer and water system projects varies depending on the entity that maintains and operates the system. If a town elects its legislative body (as distinct from the unelected town meeting), then that body can designate itself as the sewer system's operating agency or designate an existing board or commission as such. Alternatively, it can, by ordinance create a quasi-public water pollution control authority (WPCA) to operate the system (CGS § 7-246). With respect to a water system, the legislative body can designate an existing department to operate and maintain the system or create a department or a water company for that purpose (CGS § 7-148ee).

ELIGIBLE PROJECTS:

The act specifies the range of sewer and water system projects towns may finance with hybrid bonds issued under the act's procedure. The bond proceeds can be used to acquire, purchase, construct, reconstruct, improve, or extend a sewer or water system or system facility. These activities include related road, water, and drainage improvements. The law already allowed towns to issue bonds for acquiring and constructing sewer systems. It also allows them to issue bonds to acquire, construct, extend, enlarge, or maintain water systems.

Public Act 07-222 **HB 5927**

THE CONNECTICUT SITING COUNCIL AND CELLULAR TOWERS

EFFECTIVE DATE:

July 1, 2007 for the per diem increase, upon passage for the remaining provisions, with the telecommunications assessment calculation changes applicable to assessment period beginning on or after July 1, 2006.

SUMMARY:

This act requires each telecommunications services provider, by January 1, 2008, to submit to the Siting Council, at its request, all information on (1) locations in a municipality that do not have coverage or have inconsistent coverage and (2) the provider's existing and projected demand for coverage in a municipality. The act requires the Siting Council, by January 1, 2008 (the same date as when it receives the provider information), to develop a telecommunications coverage assessment for a municipality upon the municipality's request. The assessment must (1) identify locations in the municipality that do not have coverage or have inconsistent coverage and (2) analyze existing and projected demands for coverage in the municipality. Information from providers can be used only to prepare the assessment.

The act requires the council to request a municipality that is the proposed site of a telecommunications tower to submit its location preferences or criteria to the council within 30 days after a tower application is filed with the council and the municipality is notified. The council must consider the location criteria and preferences that the municipality submits or those that were in its zoning regulations as of the date of the application when evaluating it.

The act allows the Siting Council to order the restoration of vegetation in overhead transmission line rights-of-way (ROW).

The act (1) modifies how the Siting Council's assessment of telecommunications companies is calculated, (2) increases the maximum assessment on electric retailers from $1 million to $1. 5 million, and (3) imposes penalties on late assessments. It increases the per diem that council members receive for attending council hearings and other council business from $150 to $200 and eliminates the $12,000 annual cap on the per diem.

Public Act 07-100 **HB 6396**

THE USE OF CLEANING PRODUCTS IN STATE AND MUNICIPAL BUILDINGS AND SCHOOLS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act bans the use of cleaning products that do not meet certain guidelines or environmental standards instate-owned buildings beginning October 1, 2007. The guidelines or standards must be set by a national or international environmental certification program, which the Department of Administrative Services (DAS) must approve in consultation with the Department of Environmental Protection (DEP) commissioner. To be eligible for use, the cleaning products must minimize the potential harmful impact on human health and the environment to the maximum extent possible.

The act specifies that for its purposes "cleaning product" does not include any disinfectant, disinfecting cleaner, sanitizer, or any other antimicrobial product regulated by federal law.

Public Act 07-231 **HB 6768**

THE APPROVAL OF SMALL ALTERNATIVE ON-SITE SEWAGE TREATMENT SYSTEMS

EFFECTIVE DATE: July 1, 2007

***** Updated language in Section 154 of HB 8001**

SUMMARY:

This act requires the Department of Public Health (DPH) commissioner, by December 31, 2008, to establish and define discharge categories for alternative on-site sewage treatment systems that have a daily capacity of 5,000 gallons or less. It gives the commissioner jurisdiction over such systems once he has done so and requires him to establish minimum requirements for the systems. (PA 07-1, June

Special Session, requires the commissioner to accomplish these tasks within available appropriations.) The Department of Environmental Protection (DEP), which under prior law had jurisdiction over all alternative on-site sewage treatment systems, retains jurisdiction over any system not under DPH's jurisdiction.

ALTERNATIVE ON-SITE SEWAGE TREATMENT SYSTEMS:

Under the act, an alternative on-site sewage treatment system (1) serves at least one building on a single piece of property, (2) is an alternative to a subsurface sewage disposal system (septic system), and (3) discharges domestic sewage to state groundwaters.

The act gives the DPH commissioner jurisdiction to issue or deny permits and approvals for alternative on-site sewage treatment systems and domestic sewage they discharge to state groundwater, once he has established and defined discharge categories for these systems. The commissioner must establish minimum requirements for the systems according to the Public Health Code, including (1) requirements related to activities that may occur on the property; (2) changes that may occur to the property or to buildings on it that may affect a system's installation or operation; and (3) procedures for the commissioner, a local health director, or a licensed sanitarian to issue permits or approvals.

The permit or approval must:

1. be consistent with the federal Water Pollution Control and Safe Drinking Water acts and state water quality standards;
2. not be construed as or deemed an approval for another purpose, including planning and zoning or municipal inland-wetlands and watercourses requirements; and
3. be instead of a DEP individual or general water discharge permit.

Permits or approvals that the DPH commissioner, local health director, or licensed sanitarians deny may be appealed in the same manner as appeals of local health department orders.

In establishing and defining the categories of discharge and in establishing minimum requirements for alternative on-site sewage treatment systems, the commissioner must consider (1) the individual and cumulative impact the systems or discharges may have on public health, the environment, and land use patterns and (2) recommendations for responsible growth made by the Office of Policy and Management secretary through the Office of Responsible Growth established by Executive Order 15.

The DEP commissioner retains jurisdiction over, and environmental laws apply to, any alternative on-site sewage treatment system not under the DPH commissioner's jurisdiction. The act does not affect any DEP permit issued before July 1, 2007, and applicable environmental laws continue to apply to such permits until they expire.

BACKGROUND:

Water Pollution Control and Safe Drinking Water Acts

The Water Pollution Control Act (33 USC § 1251 *et seq*.), also known as the Clean Water Act, seeks to restore and maintain the chemical, physical, and biological integrity of the nation's waters. The Safe Drinking Water Act (42 USC § 300f *et seq*.) is the main federal law ensuring drinking water quality.

RELATED BILLS:

Section 154 of HB 8001

House "B" makes provisions of HB 6768, as amended, subject to being within available appropriations. The bill requires the Department of Public Health to initiate a regulatory process for alternative on-site sewage treatment systems. DPH costs of $200,300 in FY 08, $376,150 in FY 09 and $402,230 in FY 10 and subsequent years are associated with the bill.

No funding has been included within HB 8001 for purposes of the regulatory program. The requirement that it be implemented within available appropriations will likely result in one of four outcomes: (1) DPH will proceed with the program, and will require a deficiency appropriation; (2) DPH will delay the implementation of the program pending the approval of additional appropriations to meet this mandate in future fiscal years; (3) DPH will shift resources from other department priorities, thereby impacting existing departmental programs; or (4) DPH will not implement the regulatory program.

The amendment makes other minor and technical revisions which results in no fiscal impact.

REQUIRED ACTION:

The act requires the Department, with available appropriations, to adopt regulations that establish and define categories for alternative treatment (AT) systems by December 31, 2008.

Public Act 07-102 **HB 7040**

RESUBDIVISIONS AND CLARIFYING CONSIDERATIONS OF INLAND WETLANDS DECISIONS BY PLANNING AND ZONING COMMISSIONS

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act requires a planning commission to accept an application it has received to subdivide or resubdivide land regulated as an inland wetland or watercourse by a local wetland agency, and process it on the commission's schedule set in existing law. By law, the commission must consider the wetland agency's report in making its decision. The act requires the commission, if it imposes terms and conditions that are not consistent with the wetland agency's final decision, to state its reasons for being so on the record.

The act imposes the same requirements on zoning commissions when they act on site plan applications that are also subject to a wetlands agency jurisdiction.

Public Act 07-85 **HB 7121**

THE AQUIFER PROTECTION AREA PROGRAM

EFFECTIVE DATE: October 1, 2007

SUMMARY:

This act specifies when public and private water companies must submit maps of new well fields to the Department of Environmental Protection (DEP), amends aquifer protection agencies' hearing and decision schedules, authorizes municipalities to fine people who violate municipal aquifer regulations, and makes minor changes.

§§ 2, 3, 4 & 8 — MAPPING REQUIREMENTS

An aquifer is a geologic formation which provides water to wells and springs. Water flows to wells from “contribution” areas, and to contribution areas from “recharge” areas. The law requires public and private water companies to map contribution and recharge areas to two different standards: level B (initial mapping) and level A (more precise mapping). The act requires a water company to map contribution and recharge

areas for new, unmapped well fields serving 1,000 or more people to (1) level B standards no later than one year, and (2) level A standards no later than three years, after receiving a water diversion permit.

Under prior law, a water company serving more than 10,000 people (large water company) and those serving between 1,000 and 10,000 people (small water company) had to map the contribution and recharge areas they identified as future water supply sources to level B standards two years after the public health commissioner approved their coordinated water system plans. The act instead requires them to map to level B standards within two years after the DEP commissioner requests such mapping. It eliminates requirements that large and small water companies map to level A standards, four years and five years, respectively, after approval of their water system plans. As under existing law, the DEP commissioner must approve the aquifer maps.

Public Act 07-139 **HB 7178**

WATER COMPANY INFRASTRUCTURE PROJECTS

EFFECTIVE DATE: Upon passage

SUMMARY:

This act authorizes the Department of Public Utility Control (DPUC) to allow a water company to use a rate adjustment mechanism (e. g. , a surcharge) in the period between rate cases in order to recover the depreciation, property taxes, and related return for certain company capital projects that have been completed. The act specifies how DPUC must establish such mechanisms and how they would work.

*House Amendment "A" (1) limits the type of projects eligible for the rate adjustment mechanism by excluding certain main extensions and stream gauging stations, (2) adds the deadline for DPUC to issue its decision in the initial generic proceeding, (3) modifies DPUC's deadline to act on individual applications, and (4) makes various minor changes.

DPUC ESTABLISHMENT OF THE MECHANISM

Under the act, a water company may only use the adjustment to the extent allowed by DPUC based on the company's infrastructure assessment report, as approved by DPUC, and semi-annual filings by the company that reflect plant additions consistent with the report.

The act requires DPUC, by 90 days after the bill's passage, to begin a generic proceeding to determine what must be included in the assessment report. The act

requires the report to identify the company's water system infrastructure needs and its criteria for determining which are priority projects. The proceeding must also specify the contents of an annual reconciliation report, described below. DPUC can hold a hearing to solicit input on the contents of these reports and on the criteria for determining project priority. It must issue its decision within 180 days after the deadline for interested parties to submit their recommendations.

ELIGIBLE PROJECTS

To be eligible for the adjustment mechanism, a capital project (1) must not have been previously included in the water company's rate base in its most recent rate case and (2) must be intended to improve or protect the quality and reliability of service. Eligible projects can include:

1. the renewal or replacement of existing infrastructure, such as, mains and valves, that have reached the end of their useful life, are worn out, are deteriorated, are or will be contributing to unacceptable levels of unaccounted-for water, or are harmful to water quality or reliability of service if not replaced;
2. main cleaning and relining projects;
3. relocation of facilities as a result of government actions, when the capital costs are not otherwise eligible for reimbursement; and
4. purchasing leak detection equipment or installing production meters or pressure reducing valves.

Public Act 07-240 **HB 7311**

GEOTHERMAL HEAT SYSTEMS

EFFECTIVE DATE:

Upon passage for the study, October 1, 2007 and applicable to assessment years starting on or after that date for the tax exemption.

SUMMARY:

This act allows a municipality to adopt an ordinance exempting from the property tax electric generating facilities used on a farm that use class I renewable energy sources, such as solar and wind power and certain hydropower facilities. The law already permitted municipalities to exempt such facilities installed for private residential use.

The act requires the Clean Energy Fund advisory committee to study (1) the cost-effectiveness and efficiency of geothermal and other advanced heat pump systems;

(2) appropriate geothermal applications for industrial, commercial, and municipal purposes; and (3) financial and other barriers to greater applications and ways to promote more applications. The committee must consult with the Department of Public Utility Control and the Energy Conservation Management Board (ECMB) in conducting the study. ECMB must report its findings and recommendations to the Energy and Technology Committee by February 1, 2008.

Public Act 07-233 **HB 7369**

IMPLEMENTING THE RECOMMENDATIONS OF THE BROWNFIELDS TASK FORCE

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act makes many changes to the state's policies and programs for cleaning up and redeveloping contaminated property (i. e. , brownfields). It establishes a new program to finance the remediation and redevelopment of these sites. It allows the Connecticut Development Authority (CDA) to guarantee loans banks make for this purpose and allows CDA to issue bonds on towns' behalf for remediating sites for residential and mixed uses. The act allows tax assessors to reduce the value of contaminated business property if the owner agrees to remediate it.

The act gives property owners more options for voluntarily cleaning up contaminated properties. It expands the role of licensed environmental professionals (LEPs) in overseeing the remediation process and establishes procedures for documenting, verifying, and auditing their work. The act also broadens the conditions for entering into covenants not sue with owners of land undergoing remediation. It sets conditions for developing contaminated property in floodplains in state-designated development areas.

The act authorizes a pilot program for identifying brownfields in areas the State Plan of Conservation and Development designates for development. It reestablishes the Brownfields Task Force and requires it to submit additional recommendations to the legislature for remediating brownfields by February 1, 2008.

The act expands Office of Brownfield Remediation and Development's (OBRD) duties and makes it a unit of DECD. It also increases the number of towns OBRD must select for the Brownfields Pilot Program from four to five.

*House Amendment "A" adds all the provisions except the reestablishment of the Brownfields Task Force, which is in the underlying bill.

Brownfields Task Force

This act reestablishes the Brownfields Task Force indefinitely and requires it to report additional recommendations to the legislature on how to clean up contaminated properties. The report is due February 1, 2008. The initial report was due January 1, 2007.

The act increases the task force's membership to 11 by appointing the DECD commissioner and the OPM secretary or their designees to the task force. The current members are legislative appointees; a representative of the Department of Environmental Protection, appointed by its commissioner; and two gubernatorial appointees. All members must have expertise in environmental law, engineering, finance, development, consulting, insurance, or other relevant areas.

OBRD

§ 1 (b) — Expanded Duties

The act expands OBRD's duties and refines and expands some existing ones. OBRD's new duties include:

1. providing a single point of contact for financial and technical assistance for state and quasi-public agencies;
2. developing a common application to be used by all state and quasi-public entities providing financial assistance for assessing, remediating, and developing brownfields; and
3. direct its outreach program to towns and individuals, in addition to existing and potential property owners.

The act redefines OBRD's duties regarding providing information about existing programs and services. Under current law, it must create a place where towns and economic development agencies can help developers comply with state and federal clean up requirements and qualify for state funds. Under the act, OBRD must create an office to provide technical assistance and information about the state's technical assistance, funding, regulatory, and permitting programs.

The act eliminates OBRD duty to analyze state browfield programs and to create new funding sources for them.

§ 1 (a) — Coordination

The act makes OBRD an organizational unit of DECD and requires DPH to assign a liaison to work with the office. Current law places OBRD within DECD for administrative purposes only.

The law requires DEP and CDA to assign liaisons to the office. The act requires the Department of Public Health (DPH) to assign a liaison as well. It also requires DECD, DEP, and DECD commissioners and the CDA executive director to enter into a memorandum of understanding regarding their agencies respective responsibilities vis-à-vis the OBRD.

Lastly, the act allows rather that requires OBRD to recruit volunteers with brownfield remediation experience to help it achieve its goals.

§§ 1(c) & 2 — Pilot Program

PA 06-184 required OBRD to establish a pilot program to clean up contaminated properties that hinder a town's economic development. It required OBRD to run the program in four towns, one of which must have between 25,000 and 50,000 people, one between 50,000 and 100,000 people, and two must have more than 100,000. The act increases the number of participating towns to five and changes some of the criteria for selecting the pilot towns. It drops the requirement to select a town that has between 25,000 and 50,000 and instead requires OBRD to select a town with less than 50,000 people. It also requires OBRD to select a town without regard to population.

The act specifies that the sites in these towns must be assessed and remediated according to prevailing standards and practices.

The act shifts responsibility for the program from OBRD to the DECD commissioner and expands the funding criteria. Under current law, OBRD must base its decision on (1) the remediated site's potential for economic development and (2) the extent to which the redeveloped site will contribute to the town's tax base. Under the act, the commissioner must consider these criteria plus the feasibility of the project and its environmental and public health benefits.

BACKGROUND:

Legislative History

The House referred the act (File 340) to the Appropriations Committee, which reported a substitute, deleting provisions establishing new brownfield remediation programs, expanding the Office of Brownfield Remediation and Development's (OBRD) pilot program for remediating and redeveloping contaminated sites in targeted cities, and increasing OBRD's duties and its capacity to fulfill them.

REQUIRED ACTION:

Designate one or more staff members to act as a liaison with the Office of Brownfield Remediation and Development. The Bureau has two staff members already acting in this capacity. The DPH must also enter into a memorandum of understanding with DEP, DECD and CDA concerning each entity's responsibilities for brownfields.

Public Act 07-22 **SB 695**

LICENSURE OF CHILD DAY CARE CENTERS

EFFECTIVE DATE: Upon passage

SUMMARY:

The Department of Public Health requires a separate license for each building in which a child day care center operator provides services. This act specifies that a center operating in two or more buildings needs only one license if (1) the same licensee provides services in each building and (2) all buildings are contiguous to a common playground that is governed by the one license.

Public Act 07-124 **SB 1051**

THE INSPECTION AND EVALUATION OF AIR QUALITY IN STATE BUILDINGS

EFFECTIVE DATE: July 1, 2007

SUMMARY:

This act requires state departments to follow certain guidelines for indoor air quality before they can accept all or part of a building to be occupied by state employees or others under a lease, lease renewal, or purchase. Each department must (1) provide for an inspection of the premises and (2) develop a protocol for the periodic assessment and remediation of indoor air quality issues. The protocol must include (1) the best practices for commercial office space and (2) all applicable provisions of the Environmental Protection Agency's (EPA) Indoor Air Quality "Tools for

Schools" Program. It is not clear how commercial space and school guidelines can be combined into a single protocol.

The act also requires that each lease agreement any state department signs on or after July 1, 2007 contain a provision requiring the lessor to make all necessary efforts to maintain the structure and its mechanical systems to keep the indoor air quality at the same level as when the premises were accepted. The lessor must also agree to carry out the air quality protocol the department is required to establish under the act.

It is not clear how the act's requirements will function in concert with existing statutory requirements that give, with some exceptions, the Department of Public Works (DPW) commissioner the responsibility to negotiate property leases and purchases for state agencies (see BACKGROUND).

BACKGROUND:

Tools for Schools

The EPA created the Indoor Air Quality Tools for Schools Program to help schools identify and address indoor air quality issues. Schools and districts throughout Connecticut have implemented the program through the efforts of the Connecticut School Indoor Environment Resource Team. In Connecticut, more than 100 schools use the program in some form.

Public Works Commissioner

Except for certain agencies (mentioned below), the DPW commissioner is solely authorized to represent the state in its dealings with third parties to acquire, construct, or lease office or equipment space for state agencies. At the commissioner's request, the attorney general can assist in contract negotiations. The State Properties Review Board reviews all real estate acquisitions, leases, and subleases that DPW proposes (CGS § 4b-3).

The attorney general is responsible for determining the legal sufficiency, both as to substance and form, of all contracts and leases. He must enforce all terms including the obligations of landlords to meet lease terms (CGS § 4b-26).

The Joint Committee on Legislative Management, boards of trustees for higher education, the commissioners of labor and mental retardation, and the Connecticut Marketing Authority all have statutory authority to negotiate real estate contracts.

Acts Affecting Multiple Branches

Public Act 07-33 **HB 6997**

THE SUNSET LAW

EFFECTIVE DATE: Upon passage

SUMMARY:

This act delays for two years the review of all agencies and programs subject to termination under the sunset law. The act also requires the Legislative Program Review and Investigations Committee to study the sunset law, addressing its needs and merits, alternatives, and other methods to measure performance. The committee must report its findings and recommendations by January 15, 2008.

SUNSET REVIEW:

Under the sunset law, 78 licensing, regulatory, and other state agencies and programs terminate on set dates unless the General Assembly reestablishes them after the Legislative Program Review and Investigations Committee conducts a performance audit of each. The committee must review the public need for each entity according to established criteria and report to the legislature its recommendations for the entity's abolition, reestablishment, modification, or consolidation. The act delays the termination dates as follows:

Current Termination Date	*New Termination Date*
July 1, 2008	July 1, 2010
July 1, 2009	July 1, 2011
July 1, 2010	July 1, 2012
July 1, 2011	July 1, 2013
July 1, 2012	July 1, 2014

REQUIRED ACTION:

Respond to information requested by the Legislative Program Review and Investigations Committee.

Public Act 07-239 **HB 7090**

RESPONSIBLE GROWTH

EFFECTIVE DATE:

Upon passage for the task force provisions; July 1, 2007 for the provisions dealing with consistency with the State Plan of Conservation and Development; October 1, 2007 for the provisions dealing with regionally significant projects, local plans of conservation and development, and zoning commissions; and July 1, 2008 for the requirement of consistency with responsible growth development criteria and sanctions for failing to amend local plans of conservation and development.

SUMMARY:

This act establishes a 13-member Responsible Growth Task Force and specifies its membership. It requires the task force to (1) identify responsible growth criteria and standards to guide the state's future investment decisions and (2) study transfer of development rights laws, policies, and programs. The task force must report its recommendations to the governor by October 1, 2007.

TASK FORCE MEMBERS

Under the act, the task force consists of seven agency heads or their designees and six legislatively appointed members. The agencies are OPM, the Connecticut Housing Finance Authority, and the departments of Agriculture, Economic and Community Development, Environmental Protection, Public Health, and Transportation. The top six legislative leaders each appoint one task force member. The OPM secretary or his designee serves as the chairperson.

REQUIRED ACTION:

The Commissioner is a member of a 13-member task force. The Regulatory Services Branch is currently participating in responsible growth review teams (project and policy) that will be making recommendations that will be taken up by the task force.

Required Actions

Administration Branch

Bill #	PA #	Title	Required Action
HB 5706	07-3	LEAVE FOR STATE EMPLOYEES PROVIDING DISASTER RELIEF SERVICES	Human resources shall notify agency personnel.
HB 8002	07-2	IMPLEMENTING THE PROVISIONS OF THE BUDGET CONCERNING HUMAN SERVICES AND PUBLIC HEALTH	*HCSB:* Section 32 requires the DPH receive and investigate complaints. *HCSB:* Section 33 requires the DPH to inspect MRCs and issue findings of non-compliance or initiate other remedies. *RSB:* Section 47 requires the Department to identify state and local agencies that have lead poisoning prevention responsibilities and schedule meetings with those agencies at least once a year. *RSB:* Sections 47 through 60 requires Regulatory Services (EHS, LPPCP) to recruit and train new staff for the Lead Poisoning Prevention and Control Program to address added demand for child case management, environmental health, education, outreach and data management services. Education, outreach, training of local health personnel, update several existing documents and literature, revise some data collection systems, regulatory changes, increased oversight of local health department environmental and child case management activities, establish a program to administer financial assistance to local health departments (in concert with DPH fiscal office), prepare various reports to the legislature. *LAB:* required to recruit and train new staff for Biochemistry and Environmental Chemistry Labs, to handle increased volume of testing, coordinate implementation with LPPCP, establish and implement Medicaid reimbursement mechanism with DSS. *RSB:* Section 50 requires that the local health departments conduct inspections to identify sources of lead exposure for children with confirmed blood lead levels that are greater than or equal to 15 micrograms per deciliter but less than 20 micrograms per deciliter in two tests taken three or more months apart. The local director of health is to order remediation of any sources of lead exposure that are identified. *RSB:* Section 53 requires that the Department review the format in which lead poisoning data is collected for compatibility with information that is reported by institutions and laboratories. Regulations are to be promulgated if it is determined that the data should be reported in a different manner.

			RSB: Section 58 requires that beginning January 1, 2009, the Department report to the General Assembly on the status of lead poisoning prevention efforts in Connecticut. *RSB:* This bill also requires that the Department evaluate lead screening and medical risk assessment in Connecticut pursuant to Section 48 and Connecticut General Statutes Section 19a-110 as amended by Section 50 of this act, and report and provide recommendations to the General Assembly on these issues by January 1, 2011. *RSB / LHAB:* Section 59 requires that within appropriations, the Department of Public Health establish and administer financial assistance to local health departments for expenses incurred in complying with this act. The Commissioner may promulgate regulations to carry out this section. *PB:* Section 66 requires the DPH to develop the Connecticut Health Information Network plan. *PB / ORD:* Section 68 requires the DPH to contract, through the RFP process, for the development of a statewide health information technology plan by November 30, 2007.
SB 1396	07-195	THE STATE PURCHASE OF SERVICE CONTRACTS FOR HEALTH AND HUMAN SERVICES	A previously existing process required the Department to submit a procurement plan to OPM to guide contract approvals. Public Act 195 will supersede that requirement and formalize a collaborative and interactive process with OPM and other State human service agencies to develop a statewide competitive procurement plan.

Agency Proposals

Bill #	PA #	Title	Required Action
HB 7163	07-252	REVISIONS TO DEPARTMENT OF PUBLIC HEALTH STATUTES AND REVISING THE SCOPE OF PODIATRIC MEDICINE	*HCSB:* Sections 5, 23, 24, 25, 26, 27, 30, 31, 38, 39, 41, 42, 43, 44, 45, 47, 48, 57, 58, 76, 79 update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website. *PB:* Sections 11 and 80 require the Department to notify town clerks and funeral directors of the legislative change. HCSB will notify crematories and funeral boards and update the website. *ORD:* Section 40 requires the Office of Research and Development to assist the Commissioner in appointing potential new members to the stem cell peer review committee.

			HCSB: Section 49 requires HCSB to develop a fact sheet regarding massage therapists. *PB:* Section 50 requires the Department to notify town clerks and funeral directors of the legislative change for replacement birth certificates. *ORD:* Section 77 requires the DPH commissioner, by October 1, 2007, to request information from umbilical cord blood banks concerning establishing a public cord blood collection operation in Connecticut for purposes of collecting, transporting, processing, and storing cord blood units from Connecticut residents for therapeutic and research purposes. The commissioner must also submit a summary of the responses and any recommendations to the Governor and Public Health committee by January 1, 2008. *RSB*: Section 83, 87 and 88 requires the Department to develop forms and process for variance requests for centers and group day care homes, develop informational materials and update forms to reflect changes. *HCSB:* Section 90 requires FLIS to educate staff and repeal corresponding public health code regulations.
SB 1190	07-79	VITAL RECORDS	The Human Resource Department and Vital Records unit will be responsible for developing a plan necessary to implement the requirements for criminal background as called for in Section 1. Vital Records will notify Town Clerks and Registrar's of Vital Records of the changes provided for in Sections 2-5. Notification will also be made to nurse midwives outlining the ability to certify to fetal deaths.
SB 1192	07-129	CHILD DAY CARE SERVICES, YOUTH CAMPS AND THE EMERGENCY DISTRIBUTION OF POTASSIUM IODIDE TABLETS IN CERTAIN FACILITIES	The Department shall update renewal process and materials for child day care effective October 1, 2008, develop forms for variance requests for centers and group day care homes, develop informational materials and update forms to reflect changes.
SB 1341	07-244	APPLICATION FOR A CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY AND PROTECTING PUBLIC WATER SUPPLIES FROM CONTAMINATION	An Environmental Health Section Circular Letter is to be issued to all local health departments. The Circular Letter will explain the new notification requirements associated with septic system repairs that need a DPH exception to the separating distances to a private water supply well. In accordance with the bill, the applicant (property owner) must notify all abutting property owners. The Department of Public Health and the Department of Public Utility Control will need to promulgate language for regulations in Section 1(a) through (c). DPH will also be required to promulgate regulations for Section 1(e) and Section 4(c). DPH must administer the provisions of Section 6 (b)(1), (3) and (4).

Healthcare Systems Branch

Bill #	PA #	Title	Required Action
HB 5508	07-49	AUTHORIZING COMMITMENT TO A CHRONIC DISEASE HOSPITAL UNDER A PHYSICIAN'S EMERGENCY CERTIFICATE	Educate the institution and FLIS staff.
HB 5751	07-219	ESTABLISHING A PILOT FAMILY NURSE PRACTITIONER TRAINING PROGRAM	Consult with DSS on the establishment of a pilot training program for nurse practitioners seeking to specialize in family practice to receive one year of formal training in one community health center.
HB 6109	07-82	REDUCING LICENSE RENEWAL FEES FOR RETIRED DENTISTS AND PHYSICIANS	Establish a retired license status for dentists and physicians.
HB 7089	07-119	SUPERVISING PHYSICIANS FOR PHYSICIAN ASSISTANTS	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.
HB 7109	07-15	CERTIFICATION STANDARDS FOR PERSONS PROVIDING INTERPRETER SERVICES	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.
HB 7155	07-103	A PROFESSIONAL ASSISTANCE PROGRAM FOR HEALTH CARE PROFESSIONALS	Establish the professional assistance program oversight committee and work with the professional assistance program to establish protocols.
HB 7157	07-34	STAFF TRAINING REQUIREMENTS FOR ALZHEIMER'S SPECIAL CARE UNITS AND PROGRAMS	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.
HB 7159	07-92	UPDATING THE SCOPE OF PRACTICE OF OPTOMETRY	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.
HB 7160	07-104	FUNERALS	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.
HB 7167	07-157	PROFESSIONAL LICENSES OF MEMBERS OF THE UNITED STATES ARMED FORCES AND THE CONNECTICUT NATIONAL GUARD	Update application materials and statutes that are provided to the practitioners, hospitals and health care facilities via mail and/or website.

HB 7222	07-76	USE OF UNLICENSED ASSISTIVE PERSONNEL IN RESIDENTIAL CARE HOMES	Provide in-service education of the FLIS staff and the provider community.
SB 140	07-35	MASSAGE THERAPY	Conduct additional investigations related to falsely advertising massage therapy services.
SB 1343	07-24	COMPASSIONATE CARE FOR VICTIMS OF SEXUAL ASSAULT	Provide in-service education of FLIS staff and the notification of applicable healthcare entities.

Multicultural Health and Comprehensive Cancer

Bill #	PA #	Title	Required Action
SB 398	07-107	ESTABLISHING A TRAFFICKING IN PERSONS COUNCIL	The Commissioner must select a designee to be a member of the Council.

Planning Branch

Bill #	PA #	Title	Required Action
SB 1391	07-133	FEE INCREASES FOR CERTAIN VITAL RECORDS	Update both the website and application forms to reflect the fee increase for marriage, civil union and death records.

Public Health Initiatives Branch

Bill #	PA #	Title	Required Action
SB 1484	07-185	THE HEALTHFIRST CONNECTICUT AND HEALTHY KIDS INITIATIVES	*HCSB:* Section 11 calls for online license renewal for physicians, dentists and nurses to be implemented by July 1, 2008. *CMR:* Sections 30 and 39: The Department is a member of the HealthFirst Connecticut Authority. *CMR:* Section 31: The Commissioner is a member of the Statewide Primary Care Access Authority.

Regulatory Services Branch

Bill #	PA #	Title	Required Action
HB 5108	07-47	REPORTING REQUIREMENTS RELATED TO THE CHILD POVERTY AND PREVENTION COUNCIL	The Public Health Initiatives Branch and the Regulatory Services Branch will have annual reporting requirements. Reports will be due November 1, 2007 through November 1, 2015.
HB 6768	07-231	THE APPROVAL OF SMALL ALTERNATIVE ON-SITE	The act requires the Department, with available appropriations, to adopt regulations that establish and define categories for alternative treatment (AT) systems by December 31, 2008.

		SEWAGE TREATMENT SYSTEMS	
HB 7369	07-233	IMPLEMENTING THE RECOMMENDATIONS OF THE BROWNFIELDS TASK FORCE	Designate one or more staff members to act as a liaison with the Office of Brownfield Remediation and Development. The Bureau has two staff members already acting in this capacity. The DPH must also enter into a memorandum of understanding with DEP, DECD and CDA concerning each entity's responsibilities for brownfields.

Acts Affecting Multiple Branches

Bill #	PA #	Title	Required Action
HB 6997	07-33	THE SUNSET LAW	Respond to information requested by the Legislative Program Review and Investigations Committee.
HB 7090	07-239	RESPONSIBLE GROWTH	The Commissioner is a member of a 13-member task force. The Regulatory Services Branch is currently participating in responsible growth review teams (project and policy) that will be making recommendations that will be taken up by the task force.