General Assembly

Amendment

February Session, 2022

LCO No. **6037**

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Offered by:

REP. STEINBERG, 136th Dist.
REP. GILCHREST, 18th Dist.
REP. PETIT, 22nd Dist.
SEN. ANWAR, 3rd Dist.
SEN. KUSHNER, 24th Dist.
SEN. HWANG, 28th Dist.
SEN. SOMERS, 18th Dist.

To: Subst. House Bill No. **5500** File No. 528 Cal. No. 390

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

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 19a-490 of the 2022 supplement to the general statutes, as amended by sections 29 and 30 of public act 21-2 of the June special session, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

As used in this chapter, unless the context otherwise requires:

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, nursing home facility,

home health care agency, home health aide agency, behavioral health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, outpatient clinic, clinical laboratory, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency; and a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability. "Institution" does not include any facility for the care and treatment of persons with mental illness or substance use disorder operated or maintained by any state agency, except Whiting Forensic Hospital and the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center;

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

(c) "Residential care home" or "rest home" means a community residence that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry and may qualify as a setting that allows residents to receive home and community-based services funded by state and federal programs;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or

medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

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

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

(g) "Behavioral health facility" means any facility that provides mental health services to persons eighteen years of age or older or substance use disorder services to persons of any age in an outpatient treatment or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues;

(h) **[**"Alcohol or drug treatment facility" means any facility for the care or treatment of persons suffering from alcoholism or other drug addiction**]** "Clinical laboratory" means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues for the purpose of providing information for the (1) diagnosis, prevention or treatment of any human disease or

impairment, (2) assessment of human health, or (3) assessment of the presence of drugs, poisons or other toxicological substances;

(i) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

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

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

(l) "Assisted living services agency" means an agency that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable and may have a dementia special care unit or program as defined in section 19a-562;

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

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

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

(p) "Outpatient dialysis unit" means (1) an out-of-hospital out-patient dialysis unit that is licensed by the department to provide (A) services on an out-patient basis to persons requiring dialysis on a short-term basis or for a chronic condition, or (B) training for home dialysis, or (2) an in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to (A) offer dialysis therapy on an out-patient basis, (B) provide training for home dialysis, and (C) perform renal transplantations; **[**and**]**

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

(r) "Psychiatric residential treatment facility" means a nonhospital facility with a provider agreement with the Department of Social Services to provide inpatient services to Medicaid-eligible individuals under the age of twenty-one; **[**.**]** and

(s) "Chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases.

Sec. 2. Subsection (a) of section 19a-491c of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section:

(1) "Criminal history and patient abuse background search" or "background search" means (A) a review of the registry of nurse's aides

maintained by the Department of Public Health pursuant to section 20-102bb, (B) checks of state and national criminal history records conducted in accordance with section 29-17a, and (C) a review of any other registry specified by the Department of Public Health which the department deems necessary for the administration of a background search program.

(2) "Direct access" means physical access to a patient or resident of a long-term care facility that affords an individual with the opportunity to commit abuse or neglect against or misappropriate the property of a patient or resident.

(3) "Disqualifying offense" means a conviction of (A) any crime described in 42 USC 1320a-7(a)(1), (2), (3) or (4), (B) a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i-3(g)(1)(C) or 42 USC 1396r(g)(1)(C), or (C) a conviction of any crime described in section 53a-59a, 53a-60b, 53a-60c, 53a-61a, 53a-321, 53a-322 or 53a-323.

(4) "Long-term care facility" means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a residential care home, as defined in section 19a-521, a home health care agency, hospice agency or home health aide agency, as defined in section 19a-490, as amended by this act, an assisted living services agency, as defined in section 19a-490, as amended by this act, an intermediate care facility for individuals with intellectual disabilities, as defined in 42 USC 1396d(d), except any such facility operated by a Department of Developmental Services' program subject to background checks pursuant to section 17a-227a, a chronic disease hospital, as defined in section **[**19a-550**]** 19a-490, as amended by this act, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

Sec. 3. Section 19a-535b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

[(a) As used in this section, a "facility" means a chronic disease hospital which is a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases.**]**

[(b)**]** A **[**facility**]** chronic disease hospital shall not transfer or discharge a patient from **[**the facility**]** such hospital except for medical reasons, or for the patient's welfare or the welfare of other patients, as documented in the patient's medical record; or, in the case of a self pay patient, for nonpayment or arrearage of more than fifteen days of the per diem chronic disease hospital room rates for the patient's stay, except as prohibited by the Social Security Act. In the case of an involuntary transfer or discharge, the patient and, if known, the patient's legally liable relative, guardian or conservator and the patient's personal physician, if the discharge plan is prepared by the medical director of the chronic disease hospital, shall be given at least thirty days' written notice of the proposed action to ensure orderly transfer or discharge.

Sec. 4. Subsection (a) of section 19a-537 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section and section 19a-537a:

(1) "Vacancy" means a bed that is available for an admission;

(2) "Nursing home" means any chronic and convalescent facility or any rest home with nursing supervision, as defined in section 19a-521;

(3) "Hospital" means a general short-term hospital licensed by the Department of Public Health or a hospital for mental illness, as defined in section 17a-495, or a chronic disease hospital. **[**, as defined in section 19-13-D1(a) of the Public Health Code.**]**

Sec. 5. Subsection (a) of section 19a-550 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2022*):

(a) (1) As used in this section, (A) "nursing home facility" has the same meaning as provided in section 19a-521, and (B) "residential care home" has the same meaning as provided in section 19a-521; **[**, and (C) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases;**]** and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician, physician assistant or an advanced practice registered nurse in a patient's medical record.

Sec. 6. Subsections (a) to (e), inclusive, of section 20-185r of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section:

(1) "Central service technician" means a person who decontaminates, inspects, assembles, packages and sterilizes reusable medical instruments or devices **[**in**]** for a health care facility, whether such person is employed by the health care facility or provides services pursuant to a contract with the health care facility;

(2) "Health care facility" means an outpatient surgical facility, as defined in section 19a-493b, or a hospital, as defined in section 19a-490, as amended by this act, but does not include a chronic disease hospital, as defined in section **[**19a-550**]** 19a-490, as amended by this act;

(3) "Health care provider" means a person or organization that provides health care services and is licensed in accordance with this title;

and

(4) "Central service department" means a department within a health care facility that processes, issues and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a health care facility.

(b) Unless otherwise permitted pursuant to this section, no person shall practice as a central service technician unless such person (1) (A) has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one of the following credentials: (i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Materiel Management, or its successor organization, or (ii) a certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc., or (B) was employed or otherwise contracted for services as a central service technician **[**in**]** by a health care facility before January 1, 2016, or (2) obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Materiel Management, or its successor organization, or a certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc., not later than two years after such person's date of hire or contracting for services with the health care facility.

(c) A central service technician shall complete a minimum of ten hours of continuing education annually. The continuing education shall be in areas related to the functions of a central service technician.

(d) A health care facility shall, upon the written request of a central service technician, verify, in writing, the central service technician's dates of employment or the contract period during which the central service technician provided services to the health care facility.

(e) Nothing in this section shall prohibit the following persons from performing the tasks or functions of a central service technician: (1) A

health care provider; (2) a student or intern performing the functions of a central service technician under the direct supervision of a health care provider as part of the student's or intern's training or internship; or (3) a person who does not work in a central service department in a health care facility, but who has been specially trained and determined competent, based on standards set by a health care facility's infection prevention or control committee, acting in consultation with a central service technician certified in accordance with subsection (b) of this section, to decontaminate or sterilize reusable medical equipment, instruments or devices, in a manner that meets applicable manufacturer's instructions and standards.

Sec. 7. Subsection (a) of section 12-20a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) Until the fiscal year commencing July 1, 2016, on or before January first, annually, the Secretary of the Office of Policy and Management shall determine the amount due to each municipality in the state, in accordance with this section, as a state grant in lieu of taxes with respect to real property owned by any private nonprofit institution of higher learning or any nonprofit general hospital facility or freestanding chronic disease hospital or an urgent care facility that operates for at least twelve hours a day and that had been the location of a nonprofit general hospital for at least a portion of calendar year 1996 to receive payments in lieu of taxes for such property, exclusive of any such facility operated by the federal government, except a campus of the United States Department of Veterans Affairs Connecticut Healthcare Systems, or the state of Connecticut or any subdivision thereof. As used in this section, "private nonprofit institution of higher learning" means any such institution, as defined in subsection (a) of section 10a-34, or any independent institution of higher education, as defined in subsection (a) of section 10a-173, that is engaged primarily in education beyond the high school level, and offers courses of instruction for which college or university-level credit may be given or may be received by transfer, the property of which is exempt from property tax under any of the

subdivisions of section 12-81, as amended by this act; "nonprofit general hospital facility" means any such facility that is used primarily for the purpose of general medical care and treatment, exclusive of any hospital facility used primarily for the care and treatment of special types of disease or physical or mental conditions; and "freestanding chronic disease hospital" **[**means a facility that provides for the care and treatment of chronic diseases**]** has the same meaning as "chronic disease hospital" as defined in section 19a-490, as amended by this act, excluding any such facility having an ownership affiliation with and operated in the same location as a chronic and convalescent nursing home.

Sec. 8. Section 17b-368 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

On or before July 1, 2004, the Department of Social Services shall, within the limits of available Medicaid funding, implement a pilot project in Greater Hartford with a chronic disease hospital colocated with a skilled nursing facility and with the facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic or geriatric mental conditions that require prolonged hospital or restorative care. For purposes of this section, "chronic disease hospital" **[**means a long-term hospital with facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic physical and geriatric mental health conditions that require prolonged hospital or restorative care**]** has the same meaning as provided in section 19a-490, as amended by this act.

Sec. 9. Subsection (a) of section 19a-491 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) No person acting individually or jointly with any other person shall establish, conduct, operate or maintain an institution in this state without a license as required by this chapter, except for persons issued a license by the Commissioner of Children and Families pursuant to

section 17a-145 for the operation of (1) a substance abuse treatment facility, or (2) a facility for the purpose of caring for women during pregnancies and for women and their infants following such pregnancies, provided such exception shall not apply to the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center. Application for such license shall (A) be made to the Department of Public Health upon forms provided by it, (B) be accompanied by the fee required under subsection (c), (d) or (e) of this section, (C) contain such information as the department requires, which may include affirmative evidence of ability to comply with reasonable standards and regulations prescribed under the provisions of this chapter, and (D) not be required to be notarized. The commissioner may require as a condition of licensure that an applicant sign a consent order providing reasonable assurances of compliance with the Public Health Code. The commissioner may issue more than one chronic disease hospital license to a single institution until such time as the state offers a rehabilitation hospital license.

Sec. 10. Subsection (a) of section 19a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Each institution shall, upon receipt of a notice of intention to strike by a labor organization representing the employees of such institution, in accordance with the provisions of the National Labor Relations Act, 29 USC 158, file a strike contingency plan with the commissioner not later than five days before the date indicated for the strike. Such strike contingency plan shall include the institution's staffing plan for at least the first three days of such strike. The strike contingency plan shall include, but need not be limited to, the names and titles of the individuals who will be providing services at the institution. An institution that is a residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities shall submit a strike contingency plan that contains the same information as required of

nursing homes.

Sec. 11. Subsections (a) and (b) of section 19a-515 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each nursing home administrator's license issued pursuant to the provisions of sections 19a-511 to 19a-520, inclusive, shall be renewed once every two years, in accordance with section 19a-88, except for cause, by the Department of Public Health, upon forms to be furnished by said department and upon the payment to said department, by each applicant for license renewal, of the sum of two hundred five dollars. Each such fee shall be remitted to the Department of Public Health on or before the date prescribed under section 19a-88. Such renewals shall be granted unless said department finds the applicant has acted or failed to act in such a manner or under such circumstances as would constitute grounds for suspension or revocation of such license.

(b) Each licensee shall complete a minimum of forty hours of continuing education every two years, including, but not limited to, training in (1) Alzheimer's disease and dementia symptoms and care, and (2) infection prevention and control. Such two-year period shall commence on the first date of renewal of the licensee's license after January 1, 2004. The continuing education shall be in areas related to the licensee's practice. Qualifying continuing education activities are courses offered or approved by the Connecticut Association of Healthcare Facilities, LeadingAge Connecticut, Inc., the Connecticut Assisted Living Association, the Connecticut Alliance for Subacute Care, Inc., the Connecticut Chapter of the American College of Health Care Administrators, the Association For Long Term Care Financial Managers, the Alzheimer's Association or any accredited college or university, or programs presented or approved by the National Continuing Education Review Service of the National Association of Boards of Examiners of Long Term Care Administrators, the Association for Professionals in Infection Control and Epidemiology or by federal or state departments or agencies.

Sec. 12. Subsection (a) of section 19a-492e of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) For purposes of this section "home health care agency" and "hospice agency" have the same meanings as provided in section 19a-490, as amended by this act. Notwithstanding the provisions of chapter 378, a registered nurse may delegate the administration of medications that are not administered by injection to home health aides and hospice aides who have obtained (1) certification and recertification every **[**three**]** two years thereafter for medication administration in accordance with regulations adopted pursuant to subsection (b) of this section, or (2) a current certification from the Department of Children and Families or the Department of Developmental Services in accordance with section 19a-495a, as amended by this act, unless the prescribing practitioner specifies that a medication shall only be administered by a licensed nurse. **[**Any home health aide or hospice aide who obtained certification in the administration of medications on or before June 30, 2015, shall obtain recertification on or before July 1, 2018.**]**

Sec. 13. Subsections (a) and (b) of section 19a-495a of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) (1) The Commissioner of Public Health may adopt regulations, as provided in subsection (d) of this section, to require each residential care home **[**, as defined in section 19a-490,**]** that admits residents requiring assistance with medication administration, to (A) designate unlicensed personnel to obtain certification for the administration of medication from the Department of Public Health, Department of Children and Families or Department of Developmental Services, and (B) ensure that such unlicensed personnel receive such certification and recertification every **[**three**]** two years thereafter from the Department of Public Health, Department of Children and Families or Department of Developmental Services.

(2) Any regulations adopted pursuant to this subsection shall establish criteria to be used by such homes in determining (A) the appropriate number of unlicensed personnel who shall obtain such certification and recertification, and (B) training requirements, including ongoing training requirements for such certification and recertification.

(3) Training requirements for initial certification and recertification shall include, but shall not be limited to: Initial orientation, resident rights, identification of the types of medication that may be administered by unlicensed personnel, behavioral management, personal care, nutrition and food safety, and health and safety in general.

(b) Each residential care home **[**, as defined in section 19a-490,**]** shall ensure that an appropriate number of unlicensed personnel, as determined by the residential care home, obtain certification and recertification for the administration of medication from the Department of Public Health, Department of Children and Families or Department of Developmental Services. Certification and recertification of such personnel shall be in accordance with any regulations adopted pursuant to this section. **[**, except any personnel who obtained certification in the administration of medication on or before June 30, 2015, shall obtain recertification on or before July 1, 2018.**]** Unlicensed personnel obtaining such certification and recertification may administer medications that are not administered by injection to residents of such homes, unless a resident's physician specifies that a medication only be administered by licensed personnel.

Sec. 14. (*Effective from passage*) The Commissioner of Public Health shall conduct a scope of practice review pursuant to sections 19a-16d to 19a-16f, inclusive, of the general statutes, as amended by this act, to determine whether the Department of Public Health should regulate midwives who are not eligible for licensure as nurse-midwives, licensed pursuant to chapter 377 of the general statutes. The commissioner shall report, in accordance with the provisions of section 11-4a of the general

statutes, the findings of such review and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health on or before February 1, 2023.

Sec. 15. Section 20-90 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**Said board may adopt a seal. The Commissioner of Public Health, with advice and assistance from the board, and in consultation with the State Board of Education, shall adopt regulations, in accordance with the provisions of chapter 54, permitting and setting standards for courses for the training of practical nurses to be offered in high schools or by the Technical Education and Career System for students who have not yet acquired a high school diploma. Students who satisfactorily complete courses approved by said Board of Examiners for Nursing, with the consent of the Commissioner of Public Health, as meeting such standards shall be given credit for each such course toward the requirements for a practical nurse's license. All schools of nursing in this state, except such schools accredited by the National League for Nursing or other professional accrediting association approved by the United States Department of Education and recognized by the Commissioner of Public Health, and all schools for training licensed practical nurses and all hospitals connected to such schools**]** The Connecticut State Board of Examiners for Nursing shall have the following duties: (1) Hear and decide matters concerning suspension or revocation of licensure; (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate; (3) approve schools of nursing in the state that prepare persons for examination under the provisions of this chapter; and (4) consult, where possible, with national recognized accrediting agencies when approving schools pursuant to subdivision (3) of this subsection. The board may adopt a seal.

(b) All schools of nursing in the state that prepare persons for examination under the provisions of this chapter, shall be (1) visited periodically by a representative of the Department of Public Health who shall be a registered nurse or a person experienced in the field of nursing

education, and (2) approved by the Connecticut State Board of Examiners for Nursing pursuant to subdivisions (3) and (4) of subsection (a) of this section.

(c) The **[**board shall keep**]** Department of Public Health shall post a list of all nursing programs and all programs for training licensed practical nurses that are approved by **[**it, with the consent of the Commissioner of Public Health, as maintaining**]** the Connecticut State Board of Examiners for Nursing and maintain the standard for the education of nurses and the training of licensed practical nurses as established by the **[**commissioner. The board shall consult, where possible, with nationally recognized accrediting agencies when approving schools**]** Commissioner of Public Health on the department's Internet web site.

[(b) Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate.**]**

Sec. 16. Subsections (c) and (d) of section 19a-16d of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September **[**fifteenth**]** first of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's Internet web site.

(d) Any person or entity, acting on behalf of a health care profession

that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the department a written statement identifying the nature of the impact not later than **[**October first**]** September fifteenth of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October **[**fifteenth**]** first of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 17. Subsection (a) of section 19a-16e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On or before **[**November first**]** October fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall select from the timely scope of practice requests submitted to the department pursuant to section 19a-16d, as amended by this act, the requests on which the department will act and, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each **[**timely scope of practice**]** such request. **[**submitted to the department pursuant to section 19a-16d.**]** Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d, as amended by this act, to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-

officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

Sec. 18. Subsection (c) of section 20-132a of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) (1) Except as provided in this section, a licensee who is actively engaged in the practice of optometry shall earn a minimum of twenty hours of continuing education each registration period. The subject matter for continuing education shall reflect the professional needs of the licensee in order to meet the health care needs of the public, and shall include **[**(1)**]** (A) not less than six hours in any of the following areas: Pathology, detection of diabetes and ocular treatment; and **[**(2)**]** (B) not less than six hours in treatment as it applies to the use of ocular agents-T.

(2) Coursework shall be provided in the following manner: (A) Not less than ten hours shall be earned through direct, live instruction that the licensee physically attends; **[**either individually or as part of a group of participants or through a formal home study or distance learning program. Not**]** (B) not more than ten hours shall be earned through synchronous online education with opportunities for live interaction; (C) not more than **[**six**]** five hours shall be earned through **[**a home study or other distance learning program**]** asynchronous online education, distance learning or home study; and (D) not more than six hours shall be in practice management. For the purposes of this subdivision, "synchronous online education" means live online classes that are conducted in real time and "asynchronous online education" means a

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

(3) Qualifying continuing education activities include, but are not limited to, courses offered or approved by the Council on Optometric Practitioner Education of the Association of Regulatory Boards of Optometry, the American Optometric Association or state or local optometry associations and societies that are affiliated with the American Optometric Association, a hospital or other health care institution, a school or college of optometry or other institution of higher education accredited or recognized by the Council on Optometric Practitioner Education or the American Optometric Association, a state or local health department, or a national, state or local medical association.

Sec. 19. Subsection (b) of section 19a-14c of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, **[**an independent**]** a clinical social worker **[**certified**]** licensed pursuant to chapter 383b or a marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall

include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) the minor is voluntarily seeking such treatment; (B) the minor has discussed with the provider the possibility of involving his or her parent or guardian in the decision to pursue such treatment; (C) the minor has determined it is not in his or her best interest to involve his or her parent or guardian in such decision; and (D) the minor has been given adequate opportunity to ask the provider questions about the course of his or her treatment.

Sec. 20. Subsection (b) of section 20-12j of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license as a physician assistant shall, annually, during the month of such person's birth, **[**register**]** renew such license with the Department of Public Health, upon payment of a fee of one hundred fifty-five dollars, on **[**blanks**]** a form to be **[**furnished**]** provided by the department for such purpose, giving such person's name in full, such person's residence and business address and such other information as the department requests. No such license shall be renewed unless the department is satisfied that the practitioner (1) has met the mandatory continuing medical education requirements of the National Commission on Certification of Physician Assistants or a successor organization for the certification or recertification of physician assistants that may be approved by the department; (2) has passed any examination or continued competency assessment the passage of which may be required by said commission for maintenance of current certification by said commission; (3) has completed not less than one contact hour of training or education in prescribing controlled substances and pain management in the preceding two-year period; and (4) for registration periods beginning on **[**or before**]** and after January 1, 2022, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education screening for post-traumatic stress disorder, risk of suicide, depression and grief and suicide prevention training administered by the American **[**Association**]** Academy of Physician **[**Assistants**]**

Associates, or the American Academy of Physician Associates' successor organization, a hospital or other licensed health care institution or a regionally accredited institution of higher education.

Sec. 21. Subparagraph (B) of subdivision (8) of section 19a-177 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(B) On or before **[**December 31, 2018**]** June 1, 2023, and annually thereafter, the commissioner shall prepare a report to the Emergency Medical Services Advisory Board, established pursuant to section 19a-178a, that shall include, but not be limited to, the following data: (i) The total number of calls for emergency medical services received during the reporting year by each licensed ambulance service, certified ambulance service or paramedic intercept service; (ii) the level of emergency medical services required for each such call; (iii) the name of the emergency medical service organization that provided each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service, certified ambulance service or paramedic intercept service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179; and (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year. The commissioner shall prepare such report in a format that categorizes such data for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications.

Sec. 22. Subdivision (5) of section 14-1 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(5) "Authorized emergency vehicle" means (A) a fire department vehicle, (B) a police vehicle, or (C) an **[**ambulance**]** authorized emergency medical services vehicle, as defined in section 19a-175;

Sec. 23. Subsection (a) of section 19a-30 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section, "clinical laboratory" **[**means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances**]** has the same meaning as provided in section 19a-490, as amended by this act.

Sec. 24. Section 19a-31b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

No clinical laboratory, as defined in section **[**19a-30**]** 19a-490, as amended by this act, that offers hair follicle drug testing as part of its array of diagnostic testing services shall refuse to administer a hair follicle drug test that has been ordered by a physician or physician assistant, licensed under chapter 370, or an advanced practice registered nurse, licensed under chapter 378.

Sec. 25. Subdivisions (1) and (2) of subsection (a) of section 19a-72 of the 2022 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(1) "Clinical laboratory" **[**means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances**]** has the same meaning as provided in section 19a-490, as amended by this act;

(2) "Hospital" **[**means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals**]** has the same meaning as provided in section 19a-490, as amended by this act;

Sec. 26. Subdivision (1) of subsection (a) of section 19a-215 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(1) "Clinical laboratory" **[**means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues, for the purpose of providing information for the diagnosis, prevention or treatment of any human disease or impairment, for the assessment of human health or for the presence of drugs, poisons or other toxicological substances**]** has the same meaning as provided in section 19a-490, as amended by this act.

Sec. 27. Subsection (a) of section 19a-269b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section, "clinical laboratory" has the same meaning as provided in section **[**19a-30**]** 19a-490, as amended by this act.

Sec. 28. Subsection (d) of section 20-7a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(d) No person or entity, other than a physician licensed under chapter 370, a clinical laboratory, as defined in section **[**19a-30**]** 19a-490, as amended by this act, or a referring clinical laboratory, shall directly or indirectly charge, bill or otherwise solicit payment for the provision of anatomic pathology services, unless such services were personally rendered by or under the direct supervision of such physician, clinical

laboratory or referring laboratory in accordance with section 353 of the Public Health Service Act, (42 USC 263a). A clinical laboratory or referring laboratory may only solicit payment for anatomic pathology services from the patient, a hospital, the responsible insurer of a third party payor, or a governmental agency or such agency's public or private agent that is acting on behalf of the recipient of such services. Nothing in this subsection shall be construed to prohibit a clinical laboratory from billing a referring clinical laboratory when specimens are transferred between such laboratories for histologic or cytologic processing or consultation. No patient or other third party payor, as described in this subsection, shall be required to reimburse any provider for charges or claims submitted in violation of this section. For purposes of this subsection, (1) "referring clinical laboratory" means a clinical laboratory that refers a patient specimen for consultation or anatomic pathology services, excluding the laboratory of a physician's office or group practice that takes a patient specimen and does not perform the professional diagnostic component of the anatomic pathology services involved, and (2) "anatomic pathology services" means the gross and microscopic examination and histologic or cytologic processing of human specimens, including histopathology or surgical pathology, cytopathology, hematology, subcellular pathology or molecular pathology or blood banking service performed by a pathologist.

Sec. 29. Subsection (a) of section 20-7c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) For purposes of this section, "clinical laboratory" has the same meaning as provided in section **[**19a-30**]** 19a-490, as amended by this act. "Clinical laboratory" does not include any state laboratory established by the Department of Public Health pursuant to section 19a-26 or 19a-29.

Sec. 30. Subparagraph (A) of subdivision (6) of subsection (a) of section 38a-477aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(6) (A) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where such services were rendered by (i) such out-of-network provider at an in-network facility, during a service or procedure performed by an in-network provider or during a service or procedure previously approved or authorized by the health carrier and the insured did not knowingly elect to obtain such services from such out-of-network provider, or (ii) a clinical laboratory, as defined in section **[**19a-30**]** 19a-490, as amended by this act, that is an out-of-network provider, upon the referral of an in-network provider.

Sec. 31. Section 7-51a of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any person eighteen years of age or older may purchase certified copies of marriage and death records, and certified copies of records of births or fetal deaths which are at least one hundred years old, in the custody of any registrar of vital statistics. The department may issue uncertified copies of death certificates for deaths occurring less than one hundred years ago, and uncertified copies of birth, marriage, death and fetal death certificates for births, marriages, deaths and fetal deaths that occurred at least one hundred years ago, to researchers approved by the department pursuant to section 19a-25, and to state and federal agencies approved by the department. During all normal business hours, members of genealogical societies incorporated or authorized by the Secretary of the State to do business or conduct affairs in this state shall (1) have full access to all vital records in the custody of any registrar of vital statistics, including certificates, ledgers, record books, card files, indexes and database printouts, except for those records containing Social Security numbers protected pursuant to 42 USC 405 (c)(2)(C), and confidential files on adoptions, gender change, surrogacy agreements, and parentage, (2) be permitted to make notes from such records, (3) be permitted to purchase certified copies of such records, and (4) be permitted to incorporate statistics derived from such records in the publications of such genealogical societies. For all vital records

containing Social Security numbers that are protected from disclosure pursuant to federal law, the Social Security numbers contained on such records shall be redacted from any certified copy of such records issued to a genealogist by a registrar of vital statistics.

(b) For marriage and civil union licenses, the Social Security numbers of the parties to the marriage or civil union shall be recorded in the "administrative purposes" section of the marriage or civil union license and the application for such license. All persons specified on the license, including the parties to the marriage or civil union, officiator and local registrar shall have access to the Social Security numbers specified on the marriage or civil union license and the application for such license for the purpose of processing the license. Only the parties to a marriage or civil union, or entities authorized by state or federal law, may receive a certified copy of a marriage or civil union license with the Social Security numbers included on the license. Any other individual, researcher or state or federal agency requesting a certified or uncertified copy of any marriage or civil union license in accordance with the provisions of this section shall be provided such copy with such Social Security numbers removed or redacted, or with the "administrative purposes" section omitted.

(c) For deaths occurring on or after July 1, 1997, the Social Security number of the deceased person shall be recorded in the "administrative purposes" section of the death certificate. Such administrative purposes section, and the Social Security number contained therein, shall be restricted and disclosed only to the following eligible parties: (1) All parties specified on the death certificate, including the informant, licensed funeral director, licensed embalmer, conservator, surviving spouse, physician or advanced practice registered nurse and town clerk, for the purpose of processing the certificate, (2) the surviving spouse, (3) the next of kin, or (4) any state and federal agencies authorized by federal law. The department shall provide any other individual, researcher or state or federal agency requesting a certified or uncertified death certificate, or the information contained within such certificate, for a death occurring on or after July 1, 1997, such certificate or

information. The decedent's Social Security number shall be removed or redacted from such certificate or information or the administrative purposes section shall be omitted from such certificate.

(d) The registrar of vital statistics of any town or city in this state that has access to an electronic vital records system, as authorized by the department, may use such system to issue certified copies of birth, death, fetal death or marriage certificates that are electronically filed in such system.

[(e) Any registrar of vital statistics who receives payment pursuant to this section may permit such payment to be made on an Internet web site designated by the registrar, in a manner prescribed by the registrar.**]**

Sec. 32. Section 7-74 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The fee for a certification of birth registration, short form, shall be fifteen dollars. The fee for a certified copy of a certificate of birth, long form, shall be twenty dollars, except that the fee for such certifications and copies when issued by the department shall be thirty dollars.

(b) (1) The fee for a certified copy of a certificate of marriage or death shall be twenty dollars. Such fees shall not be required of the department.

(2) Any fee received by the Department of Public Health for a certificate of death shall be deposited in the neglected cemetery account, established in accordance with section 19a-308b.

(c) The fee for one certified copy of a certificate of death for any deceased person who was a veteran, as defined in subsection (a) of section 27-103, shall be waived when such copy is requested by a spouse, child or parent of such deceased veteran.

(d) The fee for an uncertified copy of an original certificate of birth issued pursuant to section 7-53 shall be sixty-five dollars.

(e) Any registrar of vital statistics who receives payment pursuant to this section may permit such payment to be made on an Internet web site designated by the registrar, in a manner prescribed by the registrar, as approved by the Commissioner of Public Health, or the commissioner's designee.

Sec. 33. Subsections (c) and (d) of section 19a-36m of the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The provisions of the food code that concern the employment of a certified food protection manager and any reporting requirements relative to such certified food protection manager **[**(1)**]** shall not apply to **[**(A)**]** (1) an owner or operator of a soup kitchen that relies exclusively on services provided by volunteers, **[**(B)**]** (2) any volunteer who serves meals from a nonprofit organization, including a temporary food service establishment and a special event sponsored by a nonprofit civic organization, including, but not limited to, school sporting events, little league food booths, church suppers and fairs, or **[**(C)**]** (3) any person who serves meals to individuals at a registered congregate meal site funded under Title III of the Older Americans Act of 1965, as amended from time to time, that were prepared under the supervision of a certified food protection manager. **[**, and (2) shall not prohibit the sale or distribution of food at (A) a bed and breakfast establishment that prepares and offers food to guests, provided the operation is owner-occupied and the total building occupant load is not more than sixteen persons, including the owner and occupants, has no provisions for cooking or warming food in the guest rooms, breakfast is the only meal offered and the consumer of such operation is informed by statements contained in published advertisements, mailed brochures and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director, and (B) a noncommercial function, including, but not limited to, an educational, religious, political or charitable organization's bake sale or potluck supper, provided the seller or person distributing the food maintains the food at the temperature, pH level and water activity level conditions

that will inhibit the growth of infectious or toxigenic microorganisms. For the purposes of this subsection, "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the business of selling such food for profit.**]**

(d) The provisions of the food code shall not (1) apply to a residential care home with thirty beds or less that is licensed pursuant to chapter 368v, provided the administrator of the residential care home or the administrator's designee has satisfactorily passed a test as part of a food protection manager certification program that is evaluated and approved by an accrediting agency recognized by the Conference for Food Protection as conforming to its standard for accreditation of food protection manager certification programs, unless such residential care home enters into a service contract with a food establishment or lends, rents or leases any area of its facility to any person or entity for the purpose of preparing or selling food, at which time the provisions of the food code shall apply to such residential care home, and (2) shall not prohibit the sale or distribution of food at (A) a bed and breakfast establishment that prepares and offers food to guests, provided the operation is owner-occupied and the total building occupant load is not more than sixteen persons, including the owner and occupants, has no provisions for cooking or warming food in the guest rooms, breakfast is the only meal offered and the consumer of such operation is informed by statements contained in published advertisements, mailed brochures and placards posted in the registration area that the food is prepared in a kitchen that is not regulated and inspected by the local health director, and (B) a noncommercial function, including, but not limited to, an educational, religious, political or charitable organization's bake sale or potluck supper, provided the seller or person distributing the food maintains the food at the temperature, pH level and water activity level conditions that will inhibit the growth of infectious or toxigenic microorganisms. For the purposes of this subsection, "noncommercial function" means a function where food is sold or distributed by a person not regularly engaged in the business of selling such food for profit.

Sec. 34. Subparagraph (A) of subdivision (2) of subsection (c) of

section 16-245n of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(2) (A) There is hereby created an Environmental Infrastructure Fund which shall be within the Connecticut Green Bank. The fund may receive any amount required by law to be deposited into the fund and may receive any federal funds as may become available to the state for environmental infrastructure investments, except that the fund shall not receive: (i) Ratepayer or Regional Greenhouse Gas Initiative funds, (ii) funds that have been deposited in, or are required to be deposited in, an account of the Clean Water Fund pursuant to sections 22a-475 to **[**22a-438f**]** 22a-483f, inclusive, or (iii) funds collected from a water company, as defined in section 25-32a.

Sec. 35. Subsection (b) of section 20-191c of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(b) Qualifying continuing education activities shall be related to the practice of psychology and shall include courses, seminars, workshops, conferences and postdoctoral institutes offered or approved by: (1) The American Psychological Association; (2) a regionally accredited institution of higher education graduate program; (3) a nationally recognized provider of continuing education seminars; (4) the Department of Mental Health and Addiction Services; or (5) a behavioral science organization that is professionally or scientifically recognized. Not more than five continuing education units during each registration period shall be completed via **[**the Internet**]** asynchronous online education, distance learning or home study. Not less than five continuing education units shall be earned through synchronous online education. On and after January 1, 2016, qualifying continuing education activities shall include not less than two contact hours of training or education during the first renewal period in which continuing education is required and not less than once every six years thereafter on the topic of mental health conditions common to veterans

and family members of veterans, including (A) determining whether a patient is a veteran or family member of a veteran, (B) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (C) suicide prevention training. Qualifying continuing education activities may include a licensee's research-based presentation at a professional conference, provided not more than five continuing education units during each registration period shall be completed by such activities. A licensee who has earned a diploma from the American Board of Professional Psychology during the registration period may substitute the diploma for continuing education requirements for such registration period. For purposes of this section, "continuing education unit" means fifty to sixty minutes of participation in accredited continuing professional education. For the purposes of this subsection, "synchronous online education" means live online classes that are conducted in real time and "asynchronous online education" means a program where the instructor, learner and other participants are not engaged in the learning process at the same time, there is no real-time interaction between participants and instructors and the educational content is created and made available for later consumption.

Sec. 36. Section 19a-563h of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work, **[**are**]** a number of hours that is based on one full-time social worker per sixty residents and that shall vary proportionally based on the number of residents in the nursing home, and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 that set forth nursing home staffing level requirements to implement the provisions of this section. The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 37. Section 17b-59d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be established a State-wide Health Information Exchange to empower consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals.

(b) It shall be the goal of the State-wide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the

Department of Social Services, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange.

(c) All contracts or agreements entered into by or on behalf of the state relating to health information technology or the exchange of health information shall be consistent with the goals articulated in subsection (b) of this section and shall utilize contractors, vendors and other partners with a demonstrated commitment to such goals.

(d) (1) The executive director of the Office of Health Strategy, in consultation with the Secretary of the Office of Policy and Management and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after June 2, 2016, and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a State-wide Health Information Exchange.

(2) Such request for proposals may require an eligible organization responding to the request to: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among health care providers, patients and other authorized users

without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time health care provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) be regulated or administratively overseen by a state government agency; and (E) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the State-wide Health Information Exchange.

(e) Notwithstanding the provisions of subsection (d) of this section, if, on or before January 1, 2016, the Commissioner of Social Services, in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a State-wide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, and such plan is approved by the secretary, the commissioner may implement such plan and enter into any contracts or agreements to implement such plan.

(f) The executive director of the Office of Health Strategy shall have administrative authority over the State-wide Health Information Exchange. The executive director shall be responsible for designating, and posting on its Internet web site, the list of systems, technologies, entities and programs that shall constitute the State-wide Health Information Exchange. Systems, technologies, entities, and programs that have not been so designated shall not be considered part of said exchange.

(g) The executive director of the Office of Health Strategy shall adopt

regulations in accordance with the provisions of chapter 54 that set forth requirements necessary to implement the provisions of this section. The executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the executive director holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of intention to adopt the regulations on the Office of Health Strategy's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 38. Section 17b-59e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section:

(1) "Health care provider" means any individual, corporation, facility or institution licensed by the state to provide health care services; and

(2) "Electronic health record system" means a computer-based information system that is used to create, collect, store, manipulate, share, exchange or make available electronic health records for the purposes of the delivery of patient care.

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital licensed under chapter 368v and clinical laboratory licensed under section 19a-30, as amended by this act, shall maintain an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

(c) Not later than two years after commencement of the operation of the State-wide Health Information Exchange, (1) each health care

provider with an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange, and (2) each health care provider without an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall be capable of sending and receiving secure messages that comply with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information Technology.

(d) The executive director of the Office of Health Strategy shall adopt regulations in accordance with the provisions of chapter 54 that set forth requirements necessary to implement the provisions of this section. The executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the executive director holds a public hearing at least thirty days prior to implementing such policies and procedures and publishes notice of intention to adopt the regulations on the Office of Health Strategy's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 39. Subsection (c) of section 19a-495 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner may waive any provisions of the regulations affecting an institution **[**, as defined in section 19a-490**]** or a clinical laboratory, licensed pursuant to section 19a-30, as amended by this act, if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient or resident. The commissioner may impose conditions, upon granting the waiver, that assure the health, safety and welfare of patients or residents, and may

revoke the waiver upon a finding that the health, safety or welfare of any patient or resident has been jeopardized. The commissioner shall not grant a waiver that would result in a violation of the Fire Safety Code or State Building Code. The commissioner may adopt regulations, in accordance with chapter 54, establishing procedures for an application for a waiver pursuant to this subsection.

Sec. 40. (*Effective from passage*) (a) As used in this section:

(1) "Certified doula" means a doula that is certified by the Department of Public Health; and

(2) "Doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person before, during and after birth.

(b) The Commissioner of Public Health shall, within available resources, establish a Doula Advisory Committee within the Department of Public Health. The Doula Advisory Committee shall develop recommendations for (1) requirements for certification and certification renewal of doulas, including, but not limited to, training, experience or continuing education requirements; and (2) standards for recognizing doula training program curricula that are sufficient to satisfy the requirements for doula certification.

(c) The Commissioner of Public Health, or the commissioner's designee, shall be the chairperson of the Doula Advisory Committee.

(d) The Doula Advisory Committee shall consist of the following members:

(1) Seven appointed by the Commissioner of Public Health, or the commissioner's designee, who are actively practicing as doulas in the state;

(2) One appointed by the Commissioner of Public Health, or the commissioner's designee, who is a nurse-midwife, licensed pursuant to chapter 377 of the general statutes, who has experience working with a

doula;

(3) One appointed by the Commissioner of Public Health, or the commissioner's designee, in consultation with the Connecticut Hospital Association, who shall represent an acute care hospital;

(4) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent an association that represents hospitals and health-related organizations in the state;

(5) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall be a licensed health care provider who specializes in obstetrics and has experience working with a doula;

(6) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent a community-based doula training organization;

(7) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall represent a community-based maternal and child health organization;

(8) One appointed by the Commissioner of Public Health, or the commissioner's designee, who shall have expertise in health equity;

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

(10) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(11) The Commissioner of Early Childhood, or the commissioner's designee.

(e) Not later than January 15, 2023, the Doula Advisory Committee shall establish a Doula Training Program Review Committee. Such committee shall (1) conduct a continuous review of doula training programs; and (2) provide a list of approved doula training programs

in the state that meet the requirements established by the Doula Advisory Committee.

Sec. 41. (*Effective from passage*) The Commissioner of Public Health shall study whether the state should adopt safe harbor legislation that permits alternative health care practitioners who are not licensed, certified or registered in the state to provide traditional health care services, to provide certain alternative health care services, including, but not limited to, aromatherapy, energetic healing, healing touch, herbology or herbalism, meditation and mind body practices, polarity therapy, reflexology and Reiki, without violating any provision of the general statutes relating to the unlicensed practice of medicine. Not later than January 1, 2023, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding such study to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 42. Subsection (c) of section 19a-498 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

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

Sec. 43. Section 19a-509g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

[An alcohol or drug treatment facility, as defined in section 19a-490,**]** A behavioral health facility shall use the criteria for admission developed by the American Society of Addiction Medicine for purposes of assessing a person for admission to such facility in consideration of

(1) the services for which the facility is licensed, and (2) the appropriate services required for treatment of such person.

Sec. 44. Subdivision (1) of subsection (b) of section 38a-493 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(1) "Hospital" means an institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of persons who have an injury, sickness or disability, or (B) medical rehabilitation services for the rehabilitation of persons who have an injury, sickness or disability. "Hospital" does not include a residential care home, nursing home, rest home or **[**alcohol or drug treatment facility**]** behavioral health facility, as defined in section 19a-490, as amended by this act;

Sec. 45. Subdivision (1) of subsection (b) of section 38a-520 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(1) "Hospital" means an institution that is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of persons who have an injury, sickness or disability, or (B) medical rehabilitation services for the rehabilitation of persons who have an injury, sickness or disability. "Hospital" does not include a residential care home, nursing home, rest home or **[**alcohol or drug treatment facility**]** behavioral health facility, as defined in section 19a-490, as amended by this act;

Sec. 46. Section 19a-535a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section: **[**, a "facility"**]**

(1) "Facility" means a residential care home, as defined in section 19a-

490, as amended by this act; **[**.**]**

(2) "Emergency" means a situation in which a resident of a facility presents an imminent danger to the resident's own health or safety, the health or safety of another resident or the health or safety of an employee or the owner of the facility;

(3) "Department" means the Department of Public Health; and

(4) "Commissioner" means the Commissioner of Public Health, or the commissioner's designee.

(b) A facility shall not transfer or discharge a resident from the facility unless (1) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility, (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility, (3) the health or safety of individuals in the facility is endangered, (4) the resident has failed, after reasonable and appropriate notice, to pay for a stay or a requested service **[**,**]** at the facility, or (5) the facility ceases to operate. In the case of an involuntary transfer or discharge, the facility shall provide written notice to the resident and, if known, **[**his**]** the resident's legally liable relative, guardian or conservator **[**shall be given a thirty-day written notification which includes**]** not less than thirty days prior to the proposed transfer or discharge date, except when the facility has requested an immediate transfer or discharge in accordance with subsection (e) of this section. Such notice shall include the reason for the transfer or discharge, **[**and notice of**]** the effective date of the transfer or discharge, the right of the resident to appeal a transfer or discharge by the facility pursuant to subsection (d) of this section and the resident's right to represent himself or herself or be represented by legal counsel. Such notice shall be in a form and manner prescribed by the commissioner, as modified from time to time, and shall include the name, mailing address and telephone number of the State Long-Term Care Ombudsman and be sent by facsimile or electronic communication to the Office of the Long-Term

Care Ombudsman on the same day as the notice is given to the resident. If the facility knows the resident has, or the facility alleges that the resident has, a mental illness or an intellectual disability, the notice shall also include the name, mailing address and telephone number of the entity designated by the Governor in accordance with section 46a-10b to serve as the Connecticut protection and advocacy system. No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge presents imminent danger of death to the resident.

(c) The facility shall be responsible for assisting the resident in finding [appropriate placement] an alternative residence. A discharge plan, prepared by the facility, [which indicates] in a form and manner prescribed by the commissioner, as modified from time to time, shall include the resident's individual needs and shall [accompany the patient] be submitted to the resident not later than seven days after the notice of transfer or discharge is issued to the resident. The facility shall submit the discharge plan to the commissioner at or before the hearing held pursuant to subsection (d) of this section.

(d) (1) [For transfers or discharges effected on or after October 1, 1989, a] A resident or [his] the resident's legally liable relative, guardian or conservator who has been notified by a facility, pursuant to subsection (b) of this section, that [he] the resident will be transferred or discharged from the facility may appeal such transfer or discharge to the Commissioner of Public Health by filing a request for a hearing with the commissioner [within] not later than ten days [of] after the receipt of such notice. Upon receipt of any such request, the commissioner [or his designee] shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. Such a hearing shall be held [within] not later than seven business days [of] after the receipt of such request. [and a determination made by the] The commissioner [or his designee within] shall issue a decision not later than twenty days [of the termination of] after the closing of the hearing record. The hearing shall be conducted in accordance with chapter 54.

[(2) In an emergency the facility may request that the commissioner

make a determination as to the need for an immediate transfer or discharge of a resident. Before making such a determination, the commissioner shall notify the resident and, if known, his legally liable relative, guardian or conservator. The commissioner shall issue such a determination no later than seven days after receipt of the request for such determination. If, as a result of such a request, the commissioner or his designee determines that a failure to effect an immediate transfer or discharge would endanger the health, safety or welfare of the resident or other residents, the commissioner or his designee shall order the immediate transfer or discharge of the resident from the facility. A hearing shall be held in accordance with the requirements of subdivision (1) of this subsection within seven business days of the issuance of any determination issued pursuant to this subdivision.

(3) Any involuntary transfer or discharge shall be stayed pending a determination by the commissioner or his designee. Notwithstanding any provision of the general statutes, the determination of the commissioner or his designee after a hearing shall be final and binding upon all parties and not subject to any further appeal.**]**

(2) Any involuntary transfer or discharge that is appealed under this subsection shall be stayed pending a final determination by the commissioner.

(3) The commissioner shall send a copy of the decision regarding a transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party, and the State Long-Term Care Ombudsman.

(e) (1) In the case of an emergency, the facility may request that the commissioner make a determination as to the need for an immediate transfer or discharge of a resident by submitting a sworn affidavit attesting to the basis for the emergency transfer or discharge. The facility shall provide a copy of the request for an immediate transfer or discharge and the notice described in subsection (b) of this section to the

resident. After receipt of such request, the commissioner may issue an order for the immediate temporary transfer or discharge of the resident from the facility. The temporary order shall remain in place until a final decision is issued by the commissioner, unless earlier rescinded. The commissioner shall issue the determination as to the need for an immediate transfer or discharge of a resident not later than seven days after receipt of the request from the facility. A hearing shall be held not later than seven business days after the date on which a determination is issued pursuant to this section. The commissioner shall issue a decision not later than twenty days after the date on which the hearing record is closed. The hearing shall be conducted in accordance with the provisions of chapter 54.

(2) The commissioner shall send a copy of the decision regarding an emergency transfer or discharge to the facility, the resident and the resident's legal guardian, conservator or other authorized representative, if known, or the resident's legally liable relative or other responsible party and the State Long-Term Care Ombudsman.

(3) If the commissioner determines, based upon the request, that an emergency does not exist, the commissioner shall proceed with a hearing in accordance with the provisions of subsection (d) of this section.

(f) A facility or resident who is aggrieved by a final decision of the commissioner may appeal to the Superior Court in accordance with the provisions of chapter 54. Pursuant to subsection (f) of section 4-183, the filing of an appeal to the Superior Court shall not, of itself, stay enforcement of an agency decision. The Superior Court shall consider an appeal from a decision of the commissioner pursuant to this section as a privileged case in order to dispose of the case with the least possible delay.

Sec. 47. (NEW) (*Effective October 1, 2022*) (a) For purposes of this section, "clinical medical assistant" means a person who (1) (A) is certified by the American Association of Medical Assistants, the

National Healthcareer Association, the National Center for Competency Testing or the American Medical Technologists, and (B) has graduated from a postsecondary medical assisting program (i) on and after January 1, 2024, that is accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools or another accrediting organization recognized by the United States Department of Education, or (ii) offered by an institution of higher education accredited by an accrediting organization recognized by the United States Department of Education and that includes a total of seven hundred twenty hours, including one hundred sixty hours of clinical practice skills, including, but not limited to, administering injections, or (2) has completed relevant medical assistant training provided by any branch of the armed forces of the United States.

(b) A clinical medical assistant may administer a vaccine under the supervision, control and responsibility of a physician licensed pursuant to chapter 370 of the general statutes, a physician assistant licensed pursuant to chapter 370 of the general statutes or an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes to any person in any setting other than a hospital setting. Prior to administering a vaccine, a clinical medical assistant shall complete not less than twenty-four hours of classroom training and not less than eight hours of training in a clinical setting regarding the administration of vaccines. Nothing in this section shall be construed to permit an employer of a physician, a physician assistant or an advanced practice registered nurse to require the physician, physician assistant or advanced practice registered nurse to oversee a clinical medical assistant in the administration of a vaccine without the consent of the physician, physician assistant or advanced practice registered nurse.

(c) On or before January first annually, the Commissioner of Public Health shall obtain from the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing and the American Medical Technologists a listing of all state residents maintained on said organizations' registries

of certified medical assistants. The commissioner shall make such listings available for public inspection.

Sec. 48. (NEW) (*Effective July 1, 2022*) (a) On and after July 1, 2023, there is established a Connecticut Rare Disease Advisory Council. The council shall advise and make recommendations to the Department of Public Health and other state agencies, as appropriate, regarding the needs of persons in the state living with a rare disease and such persons' caregivers. The council may perform the following functions:

(1) Hold public hearings and otherwise make inquiries of and solicit comments from the general public to assist with a study or survey of persons living with a rare disease and such persons' caregivers and health care providers;

(2) Consult with experts on rare diseases to develop policy recommendations for improving patient access to quality medical care in the state, affordable and comprehensive insurance coverage, medications, medically necessary diagnostics, timely treatment and other necessary services and therapies;

(3) Research and make recommendations to the department, other state agencies, as necessary, and health carriers that provide services to persons living with a rare disease regarding the adverse impact that changes to health insurance coverage, drug formularies and utilization review, as defined in section 38a-591a of the general statutes, may have on the provision of treatment or care to persons living with a rare disease;

(4) Research and identify priorities related to treatments and services provided to persons living with a rare disease and develop policy recommendations regarding (A) safeguards and legal protections against discrimination and other practices that limit access to appropriate health care, services or therapies, and (B) planning for natural disasters and other public health emergencies;

(5) Research and make recommendations regarding improving the

quality and continuity of care for persons living with a rare disease who are transitioning from pediatric to adult health care services;

(6) Research and make recommendations regarding the development of educational materials on rare diseases, including, but not limited to, online educational materials and a list of reliable resources for the department, other state agencies, as necessary, the public, persons living with a rare disease, such persons' families and caregivers, medical school students and health care providers; and

(7) Research and make recommendations for support and training resources for caregivers and health care providers of persons living with a rare disease.

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

(1) The Commissioner of Public Health, or the commissioner's designee;

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

(3) The Insurance Commissioner, or the commissioner's designee, who may be the representative of a health carrier;

(4) Two appointed by the Governor, one of whom shall be a representative of an association of hospitals in the state or an administrator of a hospital that provides health care to persons living with a rare disease, and one of whom shall be a physician licensed under chapter 370 of the general statutes who has expertise in the field of medical genetics;

(5) Two appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a representative of a patient advocacy group in the state representing all rare diseases, and one of whom shall be the family member or caregiver of a pediatric patient living with a rare disease;

(6) Two appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a representative of the biopharmaceutical industry who is involved in rare disease research and therapy development, and one of whom shall be an adult living with a rare disease;

(7) Two appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a member of the scientific community in the state who is engaged in rare disease research, and one of whom shall be the caregiver of a child or adult living with a rare disease; and

(8) Two appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall be a physician licensed to practice under chapter 370 of the general statutes who treats persons living with a rare disease, and one of whom shall be a representative, family member or caregiver of a person living with a rare disease.

(c) All initial appointments to the council shall be made not later than October 31, 2023. Any vacancy shall be filled by the appointing authority. Except for members of the council who represent state agencies, five of the members first appointed shall serve for a term of two years, five of such members shall serve for a term of three years and, thereafter, members shall serve for a term of two years. The Commissioner of Public Health shall determine which of the members first appointed shall serve for a term of two years and which of such members shall serve for a term of three years. The members of the council shall receive no compensation for their services but may be reimbursed for any necessary expenses incurred in the performance of their duties. The commissioner shall select an acting chairperson of the council from its members for the purpose of organizing the first council meeting. Such chairperson shall schedule and convene the first meeting,

which shall be held not later than November 30, 2023. The members of the council shall appoint, by majority vote, a permanent chairperson and vice-chairperson during the first meeting of the council. Nothing in this subsection shall prohibit the reappointment of the chairperson, vice-chairperson or any member of the council to their position on the council.

(d) The council shall meet in person or on a remote platform not less than six times between November 30, 2023, and October 31, 2024, as determined by the chairperson. Thereafter, the council shall meet quarterly in person or on a remote platform, as determined by the chairperson.

(e) The council shall provide opportunities at council meetings for the general public to make comments, hear updates from the council and provide input on council activities. The council shall create an Internet web site where meeting minutes, notices of upcoming meetings and feedback may be posted.

(f) The council shall be within the Department of Public Health for administrative purposes only.

(g) Not later than one year after the date of its first meeting, and annually thereafter, the council shall report to the Governor and, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding its findings and recommendations, including, but not limited to, (1) the council's activities, research findings and any recommendations for proposed legislative changes, and (2) any potential sources of funding for the council's activities, including, but not limited to, grants, donations, sponsorships or in-kind donations.

Sec. 49. Section 2-119 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a chronic kidney disease advisory committee. The advisory committee shall:

(1) Work directly with policymakers, public health organizations and educational institutions to:

(A) Increase awareness of chronic kidney disease in this state; and

(B) Develop health education programs that:

(i) Are intended to reduce the burden of kidney disease throughout this state;

(ii) Include an ongoing health and wellness campaign that is based on relevant research;

(iii) Promote preventive screenings; and

(iv) Are promoted through social media and public relations campaigns;

(2) Examine chronic kidney disease, kidney transplantation, including, but not limited to, kidney transplantation as a preferred treatment for chronic kidney disease, living and deceased kidney donation and racial disparities in the rates of individuals afflicted with chronic kidney disease;

(3) Examine methods to reduce the occurrence of chronic kidney disease by controlling the most common risk factors, diabetes and hypertension, through early detection and preventive efforts at the community level and disease management efforts in the primary care setting;

(4) Identify the barriers to the adoption of best practices and the policies available to address such barriers;

(5) Develop an equitable, sustainable, cost-effective plan to raise awareness about the importance of early detection, screening, diagnosis and treatment of chronic kidney disease and prevention; and

(6) Examine the potential for an opt-out organ or kidney donor registry.

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

[(1) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or their designees;

(2) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(3) One appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(4) One appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(5) One appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to public health;**]**

[(6)**]** (1) One appointed by the speaker of the House of Representatives, who shall represent the renal provider community;

[(7)**]** (2) One appointed by the president pro tempore of the Senate, who shall represent a medical center with a kidney-related program;

[(8)**]** (3) One appointed by the majority leader of the House of Representatives;

[(9)**]** (4) One appointed by the majority leader of the Senate;

[(10)**]** (5) One appointed by the minority leader of the House of Representatives;

[(11)**]** (6) One appointed by the minority leader of the Senate;

[(12)**]** (7) One appointed by the Governor;

[(13)**]** (8) The Commissioner of Public Health, or the commissioner's designee;

[(14)**]** (9) One appointed by the chief executive officer of the National Kidney Foundation;

[(15)**]** (10) One appointed by the chief executive officer of the American Kidney Fund; and

[(16)**]** (11) At least three additional members appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, one of whom shall represent the kidney physician community, one of whom shall represent a nonprofit organ procurement organization, one of whom shall represent the kidney patient community in this state and such other members that such chairpersons, in their discretion, agree are necessary to represent public health clinics, community health centers, minority health organizations and health insurers.

(c) Any member of the advisory committee appointed under subdivision (1), (2), (3), (4), (5), (6) **[**, (7), (8), (9), (10),**]** or (11) **[**or (16)**]** of subsection (b) of this section may be a member of the General Assembly.

(d) All initial appointments to the advisory committee shall be made not later than thirty days after **[**July 12, 2021**]** the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the advisory committee from among the members of the advisory committee. Such chairpersons shall schedule the first meeting of the advisory committee, which shall be held not later than sixty days after **[**July 12, 2021**]** the effective date of this section. Meetings of the advisory committee may, at the discretion of the chairpersons of the advisory committee, be

conducted on a virtual platform.

(f) The administrative staff of the advisory committee shall be selected by the Office of Legislative Management in consultation with the chairpersons of the advisory committee.

(g) Not later than January 1, **[**2022**]** 2024, and annually thereafter, the advisory committee shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health in accordance with the provisions of section 11-4a.

Sec. 50. Section 19a-127k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) As used in this section:

(1) "Community benefit partners" means federal, state and municipal government entities and private sector entities, including, but not limited to, faith-based organizations, businesses, educational and academic organizations, health care organizations, health departments, philanthropic organizations, organizations specializing in housing justice, planning and land use organizations, public safety organizations, transportation organizations and tribal organizations, that, in partnership with hospitals, play an essential role with respect to the policy, system, program and financing solutions necessary to achieve community benefit program goals;

[(1)**]** (2) "Community **[**benefits**]** benefit program" means any voluntary program or activity to promote preventive health care, protect health and safety, improve health equity and reduce health disparities, reduce the cost and economic burden of poor health and **[**to**]** improve the health status for **[**working families and**]** all populations **[**at risk in the communities**]** within the geographic service areas of a **[**managed care organization or a**]** hospital, **[**in accordance with guidelines established pursuant to subsection (c) of this section;

(2) "Managed care organization" has the same meaning as provided in section 38a-478;**]** regardless of whether a member of any such population is a patient of such hospital;

(3) "Community benefit program reporting" means the community health needs assessment, implementation strategy and annual report submitted by a hospital to the Office of Health Strategy pursuant to the provisions of this section;

(4) "Community health needs assessment" means a written assessment, as described in 26 CFR 1.501(r)-(3);

(5) "Health disparities" means health differences that are closely linked with social or economic disadvantages that adversely affect one or more groups of people who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation, gender identity, geographic location or other characteristics historically linked to discrimination or exclusion;

(6) "Health equity" means that every person has a fair and just opportunity to be as healthy as possible, which encompasses removing obstacles to health, such as poverty, racism and the adverse consequences of poverty and racism, including, but not limited to, a lack of equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments and health care;

[(3)**]** (7) "Hospital" **[**has the same meaning as provided in section 19a-490.**]** means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990. "Hospital" includes a for-profit entity licensed as an acute care general hospital;

(8) "Implementation strategy" means a written plan, as described in 26 CFR 1.501(r)-(3), that is adopted by an authorized body of a hospital and documents how such hospital intends to address the needs

identified in the community health needs assessment; and

(9) "Meaningful participation" means that (A) residents of a hospital's community, including, but not limited to, residents of such community that experience the greatest health disparities, have an appropriate opportunity to participate in such hospital's planning and decisions, (B) community participation influences a hospital's planning, and (C) participants receive information from a hospital summarizing how their input was or was not used by such hospital.

(b) **[**On or before January 1, 2005, and biennially thereafter, each managed care organization and**]** On and after January 1, 2023, each hospital shall submit community benefit program reporting to the **[**Healthcare Advocate, or the Healthcare Advocate's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section**]** Office of Health Strategy, or to a designee selected by the executive director of the Office of Health Strategy, in the form and manner described in subsections (c) to (e), inclusive, of this section.

[(c) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the organization's or hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation

of the program;

(3) Seeking assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas in developing and implementing the program and in defining the targeted populations and the specific health care needs it should address. In doing so, the governing body or management of the organization or hospital shall give priority to the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7; and

(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.**]**

(c) Each hospital shall submit its community health needs assessment to the Office of Health Strategy not later than thirty days after the date on which such assessment is made available to the public pursuant to 26 CFR 1.501(r)-(3)(b), provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension of time to a hospital for the filing of such assessment. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) A definition of the community served by the hospital and a description of how the community was determined;

(B) A description of the process and methods used to conduct the community health needs assessment;

(C) A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the community health needs assessment, and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the community health needs assessment;

(F) An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding community health needs assessment, to address the significant health needs identified in the hospital's prior community health needs assessment; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the community health needs assessment;

(B) The demographics of the population within the geographic service area of the hospital and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns and health care costs within such geographic service area;

(C) A description of the health status and health disparities affecting the population within the geographic service area of the hospital, including, but not limited to, the health status and health disparities affecting a representative spectrum of age, racial and ethnic groups, incomes and medically underserved populations;

(D) A description of the meaningful participation afforded to

community benefit partners and diverse community members in assessing community health needs, priorities and target populations;

(E) A description of the barriers to achieving or maintaining health and to accessing health care, including, but not limited to, social, economic and environmental barriers, lack of access to or availability of sources of health care coverage and services and a lack of access to and availability of prevention and health promotion services and support;

(F) Recommendations regarding the role that the state and other community benefit partners could play in removing the barriers described in subparagraph (E) of this subdivision and enabling effective solutions; and

(G) Any additional information, data or disclosures that the hospital voluntarily chooses to include as may be relevant to its community benefit program.

(d) Each hospital shall submit its implementation strategy to the Office of Health Strategy not later than thirty days after the date on which such implementation strategy is adopted pursuant to 26 CFR 1.501(r)-(3)(c), provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension to a hospital for the filing of such implementation strategy. Such submission shall contain the following:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)-(3)(b)(6)(i), and as included in a hospital's federal filing submitted to the Internal Revenue Service:

(A) With respect to each significant health need identified through the community health needs assessment, either (i) a description of how the hospital plans to address the health need, or (ii) identification of the health need as one which the hospital does not intend to address;

(B) For significant health needs described in subparagraph (A)(i) of this subdivision, (i) a description of the actions that the hospital intends

to take to address the health need and the anticipated impact of such actions, (ii) identification of the resources that the hospital plans to commit to address the health need, and (iii) a description of any planned collaboration between the hospital and other facilities or organizations to address the health need;

(C) For significant health needs identified in subparagraph (A)(ii) of this subdivision, an explanation of why the hospital does not intend to address such health need; and

(2) Additional documentation of the following:

(A) The names of the individuals responsible for developing the implementation strategy;

(B) A description of the meaningful participation afforded to community benefit partners and diverse community members;

(C) A description of the community health needs and health disparities that were prioritized in developing the implementation strategy with consideration given to the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7;

(D) Reference-citing evidence, if available, that shows how the implementation strategy is intended to address the corresponding health need or reduction in health disparity;

(E) A description of the planned methods for the ongoing evaluation of proposed actions and corresponding process or outcome measures intended for use in assessing progress or impact;

(F) A description of how the hospital solicited commentary on the implementation strategy from the communities within such hospital's geographic service area and revisions to such strategy based on such commentary; and

(G) Any other information that the hospital voluntarily chooses to

include as may be relevant to its implementation strategy, including, but not limited to, data, disclosures, expected or planned resource outlay, investments or commitments, including, but not limited to, staff, financial or in-kind commitments.

[(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the biennial report required by subsection (b) of this section the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the results of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (c) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.**]**

(e) On or before October 1, 2023, and annually thereafter, each hospital shall submit to the Office of Health Strategy a status report on such hospital's community benefit program, provided the executive director of the Office of Health Strategy, or the executive director's designee, may grant an extension to a hospital for the filing of such

report. Such report shall include the following:

(1) A description of major updates regarding community health needs, priorities and target populations, if any;

(2) A description of progress made regarding the hospital's actions in support of its implementation strategy;

(3) A description of any major changes to the proposed implementation strategy and associated hospital actions; and

(4) A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's implementation strategy.

(f) Notwithstanding the provisions of section 19a-755a, and to the full extent permitted by 45 CFR 164.514(e), the Office of Health Strategy shall make data in the all-payer claims database available to hospitals for use in their community benefit programs and activities solely for the purposes of (1) preparing the hospital's community health needs assessment, (2) preparing and executing the hospital's implementation strategy, and (3) fulfilling community benefit program reporting, as described in subsections (c) to (e), inclusive, of this section. Any disclosure made by said office pursuant to this subsection of information other than health information shall be made in a manner to protect the confidentiality of such information as may be required by state or federal law.

(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit program reporting requirements, as described in subsections (c) to (e), inclusive, of this section, if the all-payer claims database data is not provided to such hospital, as required by subsection (f) of this section.

[(e)**]** (h) **[**The Healthcare Advocate, or the Healthcare Advocate's designee, shall, within available appropriations,**]** On or before April 1, 2024, and annually thereafter, the executive director of the Office of

Health Strategy shall develop a summary and analysis of the community benefits program **[**reports**]** reporting submitted by **[**managed care organizations and**]** hospitals under this section **[**and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, 2005, and biennially thereafter, the Healthcare Advocate, or the Healthcare Advocate's designee, shall make such summary and analysis available to the public upon request.**]** during the previous calendar year and post such summary and analysis on its Internet web site and solicit stakeholder input through a public comment period. The Office of Health Strategy shall use such reporting and stakeholder input to:

(1) Identify additional stakeholders that may be engaged to address identified community health needs including, but not limited to, federal, state and municipal entities, nonhospital private sector health care providers and private sector entities that are not health care providers, including community-based organizations, insurers and charitable organizations;

(2) Determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) Determine whether to make recommendations to the Department of Public Health in the development of its state health plan; and

(4) Inform the state-wide health care facilities and services plan established pursuant to section 19a-634.

[(f) The Healthcare Advocate may, after notice and opportunity for a hearing, in accordance with chapter 54, impose a civil penalty on any managed care organization or hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.**]**

(i) Each for-profit entity licensed as an acute care general hospital shall submit community benefit program reporting consistent with the reporting schedules of subsections (c) to (e), inclusive, of this section, and reasonably similar to what would be included on such hospital's federal filings to the Internal Revenue Service, where applicable.

Sec. 51. (NEW) (*Effective from passage*) (a) As used in this section:

(1) "Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation;

(2) "Intellectual disability" means a significant limitation in intellectual functioning existing concurrently with deficits in adaptive behavior that originated during the developmental period before eighteen years of age;

(3) "Mental disability" means one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders";

(4) "Organ" means all or part of a human liver, pancreas, kidney, intestine or lung; and

(5) "Physical disability" means any chronic physical handicap, infirmity or impairment, whether congenital or resulting from bodily injury, organic processes or changes or from illness, including, but not limited to, blindness, epilepsy, deafness or being hard of hearing or reliance on a wheelchair or other remedial appliance or device.

(b) A person who is a candidate to receive an anatomical gift or an organ from a living donor for transplantation shall not be deemed ineligible to receive the anatomical gift or organ solely because of the person's physical, mental or intellectual disability, except to the extent that a physician has determined, following an evaluation of the person, that the person's physical, mental or intellectual disability is medically significant so as to contraindicate the acceptance of the anatomical gift or organ. If a person has the necessary support to assist the person in

complying with post-transplant medical requirements, the person's inability to comply with such requirements without assistance shall not be deemed to be medically significant. The provisions of this subsection shall apply to each part of the transplant process.

(c) Nothing in this section shall be construed to require a physician to make a referral or recommendation for, or perform a medically inappropriate transplant of an anatomical gift or organ.

Sec. 52. Section 19a-563 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) As used in this section **[**,**]** and sections 19a-563a to 19a-563h, inclusive, as amended by this act: **[**, and sections 9 and 11 of public act 21-185:**]**

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

(2) "Dementia special care unit" means the unit of any assisted living facility that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

(b) Each nursing home and dementia special care unit with more than sixty residents shall employ a full-time infection prevention and control specialist. **[**who**]** Each nursing home and dementia special care unit with sixty residents or less shall employ a part-time infection prevention and

control specialist. The infection prevention and control specialist shall be responsible for the following:

(1) Ongoing training of all administrators and employees of the nursing home or dementia special care unit on infection prevention and control using multiple training methods, including, but not limited to, in-person training and the provision of written materials in English and Spanish;

(2) The inclusion of information regarding infection prevention and control in the documentation that the nursing home or dementia special care unit provides to residents regarding their rights while in the home or unit and posting of such information in areas visible to residents;

(3) Participation as a member of the infection prevention and control committee of the nursing home or dementia special care unit and reporting to such committee at its regular meetings regarding the training he or she has provided pursuant to subdivision (1) of this subsection;

(4) The provision of training on infection prevention and control methods to supplemental or replacement staff of the nursing home or dementia special care unit in the event an infectious disease outbreak or other situation reduces the staffing levels of the home or unit; and

(5) Any other duties or responsibilities deemed appropriate for the infection prevention and control specialist, as determined by the nursing home or dementia special care unit.

(c) Each nursing home and dementia special care unit shall require its infection prevention and control specialist to **[**work on a rotating schedule that ensures the specialist covers each eight-hour shift at least once per month**]** implement procedures to monitor the infection prevention and control practice of each daily shift for purposes of ensuring compliance with relevant infection prevention and control standards.

(d) An infection prevention and control specialist may provide infection prevention and control services in accordance with the provisions of this section to both a nursing home and a dementia special care unit or to two nursing homes, provided (1) the nursing home and dementia special care unit, or the two nursing homes, are (A) adjacently located to or on the same campus as one another, and (B) commonly owned or operated, and (2) the owner or operator of such nursing home and dementia special care unit, or the two nursing homes, (A) submits a written request to the Commissioner of Public Health, or the commissioner's designee, in a form and manner prescribed by the commissioner, for such infection prevention and control specialist to provide infection prevention and control services in accordance with the provisions of this section, and (B) receives notification from the Commissioner of Public Health, or the commissioner's designee, that such written request is approved.

(e) The Commissioner of Public Health may waive any requirement of this section if the commissioner determines that doing so would not endanger the life, safety or health of any resident or employee of a nursing home or dementia special care unit. If the commissioner waives any requirement, the commissioner may impose conditions that assure the health, safety and welfare of the residents and employees of each nursing home and dementia special care unit or revoke such waiver if the commissioner finds that the health, safety or welfare of any resident or employee of a nursing home or dementia special care unit has been jeopardized by such waiver.

Sec. 53. Subdivision (2) of section 19a-693 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(2) "Assisted living services" means nursing services and assistance with activities of daily living provided to residents living within (A) a managed residential community having supportive services that encourage persons primarily fifty-five years of age or older to maintain a maximum level of independence, or (B) an elderly housing complex

receiving assistance and funding through the United States Department of Housing and Urban Development's Assisted Living Conversion Program.

Sec. 54. Section 19a-564 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) The Commissioner of Public Health shall license assisted living services agencies, as defined in section 19a-490, as amended by this act. A managed residential community wishing to provide assisted living services shall become licensed as an assisted living services agency or shall arrange for assisted living services to be provided by another entity that is licensed as an assisted living services agency.

(b) A managed residential care community that intends to arrange for assisted living services shall only do so with a currently licensed assisted living services agency. Such managed residential community shall submit an application to arrange for the assisted living services to the Department of Public Health in a form and manner prescribed by the commissioner.

(c) An elderly housing complex receiving assistance and funding through the United States Department of Housing and Urban Development's Assisted Living Conversion Program that intends to arrange for assisted living services may do so with a currently licensed assisted living services agency. Such elderly housing complex shall inform the Department of Public Health of the arrangement upon request in a form and manner prescribed by the commissioner and shall not be required to register with the department as a managed residential community.

[(c)**]** (d) An assisted living services agency providing services as a dementia special care unit or program, as defined in section 19a-562, shall obtain approval for such unit or program from the Department of Public Health. Such assisted living services agencies shall ensure that they have adequate staff to meet the needs of the residents. Each assisted

living services agency that provides services as a dementia special care unit or program, as defined in section 19a-562, shall submit to the Department of Public Health a list of dementia special care units or locations and their staffing plans for any such units and locations when completing an initial or a renewal licensure application, or upon request from the department.

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

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

Sec. 55. Subsection (a) of section 19a-16d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, **[**may**]** shall submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

Sec. 56. Section 19a-408 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

After the termination of all proceedings for which the body is required by the Chief Medical Examiner, the Deputy Chief Medical Examiner, an associate medical examiner or an authorized assistant medical examiner, the body shall be delivered to a person or persons entitled by law to receive the same; but, if there are no such persons who will take charge of and dispose of the body, then to the proper

authorities of the town in which the body is lying, whose duty it shall be to dispose of it. Whenever the deceased person has not left property sufficient to defray the expenses of disposition of the body, the same shall be paid by such town. The Office of the Chief Medical Examiner may take custody and coordinate the disposition of the body, including cremation or burial, of such body. The Office of the Chief Medical Examiner shall not proceed with the disposition of such body during the twenty-one day period following the date of the pronouncement of death and during such period of time shall make a reasonable effort, including engaging the services of the law enforcement agency of the town in which the deceased person died or of such deceased person's residence to locate and contact any relatives of the deceased person. A funeral director handling the disposition of the body of such deceased person shall notify the Commissioner of Social Services in accordance with sections 17b-84 and 17b-131, as amended by this act, for reimbursement. The cremation certificate fee for any such disposition shall be waived.

Sec. 57. Subsection (d) of section 45a-318 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(d) In the absence of a written designation of an individual pursuant to subsection (a) of this section, or in the event that an individual and any alternate designated pursuant to subsection (a) of this section decline to act or cannot be located within forty-eight hours after the time of death or the discovery of the body, the following individuals, in the priority listed, shall have the right to custody and control of the disposition of a person's body upon the death of such person, subject to any directions for disposition made by such person, conservator or agent pursuant to subdivision (1) or (2) of subsection (a) of this section:

(1) The deceased person's spouse, unless such spouse abandoned the deceased person prior to the deceased person's death or has been adjudged incapable by a court of competent jurisdiction;

(2) The deceased person's surviving adult children;

(3) The deceased person's surviving parents;

(4) The deceased person's surviving siblings;

(5) Any adult person in the next degree of kinship in the order named by law to inherit the deceased person's estate, provided such adult person shall be of the third degree of kinship or higher; **[**and**]**

(6) The Office of the Chief Medical Examiner; and

[(6)**]** (7) Such adult person as the Probate Court shall determine.

Sec. 58. Section 17b-131 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) When a person in any town, or sent from such town to any licensed institution or state humane institution, dies or is found dead therein and does not leave sufficient estate and has no legally liable relative able to pay the cost of a proper funeral and burial, or upon the death of any beneficiary under the state-administered general assistance program, the Commissioner of Social Services shall give to such person a proper funeral and burial, and shall pay a sum not exceeding one thousand three hundred fifty dollars as an allowance toward the funeral expenses of such decedent. Said sum shall be paid, upon submission of a proper bill, to the funeral director, cemetery or crematory, as the case may be. Such payment for funeral and burial expenses shall be reduced by (1) the amount in any revocable or irrevocable funeral fund, (2) any prepaid funeral contract, (3) the face value of any life insurance policy owned by the decedent that names a funeral home, cemetery or crematory as a beneficiary, (4) the net value of all liquid assets in the decedent's estate, and (5) contributions in excess of three thousand four hundred dollars toward such funeral and burial expenses from all other sources including friends, relatives and all other persons, organizations, agencies, veterans' programs and other benefit programs. Notwithstanding the provisions of section 17b-90, whenever payment

for funeral, burial or cremation expenses is reduced due to liquid assets in the decedent's estate, the commissioner may disclose information concerning such liquid assets to the funeral director, cemetery or crematory providing funeral, burial or cremation services for the decedent.

(b) Notwithstanding the provisions of subsection (a) of this section and section 17b-84, the Commissioner of Social Services shall, upon submission of a proper bill, pay the maximum amount authorized under subsection (a) of this section to a funeral director, cemetery or crematory if the Chief Medical Examiner, or the Chief Medical Examiner's designee, certifies that, after an investigation, the Office of the Chief Medical Examiner was unable to locate any person with a connection to the decedent, including a relative or friend, who was willing to take possession of the decedent's remains, and that the decedent's remains were therefore transferred to such funeral director, cemetery or crematory for disposition.

[(b)**]** (c) The Commissioner of Social Services may adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

Sec. 59. Section 19a-401 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) There is established a Commission on Medicolegal Investigations, as an independent administrative commission, consisting of **[**nine**]** the Commissioner of Public Health, or the commissioner's designee, and eight members appointed by the Governor as follows: Two full professors of pathology, two full professors of law, a member of the Connecticut Medical Society, a member of the Connecticut Bar Association, and two members of the public. **[**, selected by the Governor, and the Commissioner of Public Health, or the commissioner's designee.**]** The Governor shall appoint **[**the two full professors of pathology and the two full professors of law from a panel of not less than four such professors in the field of medicine and four such

professors in the field of law recommended by a committee composed of the deans of the recognized schools and colleges of medicine and of law in the state of Connecticut;**]** the member of the Connecticut Medical Society from a panel of not less than three members of that society recommended by the council of that society; and the member of the Connecticut Bar Association from a panel of not less than three members of that association recommended by **[**the board of governors of**]** that association. **[**Initially, one professor of pathology, one professor of law, the member of the Connecticut Medical Society, and one member of the public shall serve for six years and until their successors are appointed, and one professor of pathology, one professor of law, the member of the Connecticut Bar Association and one member of the public shall serve for three years, and until their successors are appointed.**]** All appointments to full terms **[**subsequent to the initial appointments**]** shall be for six years. Vacancies shall be filled for the expiration of the term of the member being replaced. **[**in the same manner as original appointments.**]** Members shall be eligible for reappointment. **[**under the same conditions as are applicable to initial appointments.**]** The commission shall elect annually one of its members as **[**chairman**]** chairperson and one as **[**vice chairman**]** vice-chairperson. Members of the commission shall receive no compensation but shall be reimbursed for their actual expenses incurred in service on the commission. The commission shall meet at least once each year and more often as its duties require, upon the request of any two members and shall meet at least once each year with those persons and groups that are affected by commission policies and procedures. The commission shall adopt its own rules for the conduct of its meetings.

(b) The commission shall adopt regulations, in accordance with chapter 54, as necessary or appropriate to carry out effectively the administrative provisions of this chapter.

Sec. 60. Section 19a-37 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) As used in this section:

(1) "Laboratory or firm" means an environmental laboratory registered by the Department of Public Health pursuant to section 19a-29a;

(2) "Private well" means a water supply well that meets all of the following criteria: (A) Is not a public well; (B) supplies a residential population of less than twenty-five persons per day; and (C) is owned or controlled through an easement or by the same entity that owns or controls the building or parcel that is served by the water supply well;

(3) "Public well" means a water supply well that supplies a public water system;

(4) "Semipublic well" means a water supply well that (A) does not meet the definition of a private well or public well, and (B) provides water for drinking and other domestic purposes; and

(5) "Water supply well" means an artificial excavation constructed by any method for the purpose of obtaining or providing water for drinking or other domestic, industrial, commercial, agricultural, recreational or irrigation use, or other outdoor water use.

(b) (1) The Commissioner of Public Health may adopt regulations, **[**in the regulations of Connecticut state agencies**]** in accordance with the provisions of chapter 54, for the preservation of the public health pertaining to **[**(1)**]** (A) protection and location of new water supply wells or springs for residential or nonresidential construction or for public or semipublic use, and **[**(2)**]** (B) inspection for compliance with the provisions of municipal regulations adopted pursuant to section 22a-354p.

(2) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, for the testing of water quality in private wells and semipublic wells.

(3) The Commissioner of Public Health shall adopt regulations, in

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

(c) (1) **[**The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, for the testing of water quality in private wells and semipublic wells.**]** Any laboratory or firm which conducts a water quality test on a private well serving a residential property or semipublic well shall, not later than thirty days after the completion of such test, report the results of such test to **[**(1)**]** (A) the public health authority of the municipality where the property is located, and **[**(2)**]** (B) the Department of Public Health in a format specified by the department. **[**, provided such report shall only be required if the party for whom the laboratory or firm conducted such test informs the laboratory or firm identified on the chain of custody documentation submitted with the test samples that the test was conducted in connection with the sale of such property. No regulation may require such a test to be conducted as a consequence or a condition of the sale, exchange, transfer, purchase or rental of the real property on which the private well or semipublic well is located.**]** Results submitted to the Department of Public Health or the local health authority pursuant to this subsection, information obtained from any Department of Public Health or local health authority investigation regarding those results and any Department of Public Health or local health authority study of

morbidity and mortality regarding the results shall be confidential pursuant to section 19a-25.

(2) On and after October 1, 2022, the owner of each newly constructed private well or semipublic well shall test the water quality of such well. Such test shall be performed by a laboratory and include, but need not be limited to, testing for coliform, nitrate, nitrite, sodium, chloride, iron, lead, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, arsenic and uranium. The owner shall submit test results to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health.

(d) Prior to the sale, exchange, purchase, transfer or rental of real property on which a private or semipublic well is located, the owner shall provide the buyer or tenant notice that educational material concerning private well testing is available on the Department of Public Health web site. If the prospective buyer or tenant has hired a real estate licensee to facilitate the property transaction, such real estate licensee, or, if the prospective buyer or tenant has not hired a real estate licensee, the owner, landlord or closing attorney shall provide to the buyer or tenant an electronic or hard copy of educational material prepared by the Department of Public Health that recommends testing for the contaminants listed in subsection (c) of this section and any other recommendation concerning well testing that the Department of Public Health deems necessary. Failure to provide such notice or educational material shall not invalidate any sale, exchange, purchase, transfer or rental of real property. If the seller or landlord provides such notice or educational material in writing, the seller or landlord and any real estate licensee shall be deemed to have fully satisfied any duty to notify the buyer or tenant. **[**that the subject real property is located in an area for which there are reasonable grounds for testing under subsection (g) or (j) of this section.**]**

[(e) The Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, to clarify the criteria under which the commissioner may issue a well permit exception and to describe the

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

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

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

(2) The local director of health may require a private well or semipublic well to be tested for pesticides, herbicides or organic

chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, "reasonable grounds" means (A) the presence of nitrate-nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (B) that the private well or semipublic well is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.

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

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

[(j) The local director of health may require private wells and semipublic wells to be tested for pesticides, herbicides or organic chemicals when there are reasonable grounds to suspect that any such contaminants might be present in the groundwater. For purposes of this subsection, "reasonable grounds" means (1) the presence of nitrate-

nitrogen in the groundwater at a concentration greater than ten milligrams per liter, or (2) that the private well or semipublic well is located on land, or in proximity to land, associated with the past or present production, storage, use or disposal of organic chemicals as identified in any public record.**]**

[(k)**]** (i) Any water transported in bulk by any means to a premises currently supplied by a private well or semipublic well where the water is to be used for purposes of drinking or domestic use shall be provided by a bulk water hauler licensed pursuant to section 20-278h. No bulk water hauler shall deliver water without first notifying the owner of the premises of such delivery. Bulk water hauling to a premises currently supplied by a private well or semipublic well shall be permitted only as a temporary measure to alleviate a water supply shortage.

Sec. 61. Subsection (i) of section 19a-180 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(i) Notwithstanding the provisions of subsection (a) of this section, any **[**volunteer, hospital-based or municipal ambulance service or any ambulance service or paramedic intercept service operated and maintained by a state agency**]** emergency medical services organization that is licensed or certified and is a primary service area responder may apply to the commissioner to add one emergency vehicle to its existing fleet every three years, on a short form application prescribed by the commissioner. No such **[**volunteer, hospital-based or municipal ambulance service or any ambulance service or paramedic intercept service**]** emergency medical services organization operated and maintained by a state agency may add more than one emergency vehicle to its existing fleet pursuant to this subsection regardless of the number of municipalities served by such volunteer, hospital-based or municipal ambulance service. Upon making such application, the applicant shall notify in writing all other primary service area responders in any municipality or abutting municipality in which the applicant proposes to add the additional emergency vehicle. Except in the case where a

primary service area responder entitled to receive notification of such application objects, in writing, to the commissioner not later than fifteen calendar days after receiving such notice, the application shall be deemed approved thirty calendar days after filing. If any such primary service area responder files an objection with the commissioner within the fifteen-calendar-day time period and requests a hearing, the applicant shall be required to demonstrate need at a public hearing as required under subsection (a) of this section.

Sec. 62. (*Effective from passage*) Not later than July 1, 2022, the Commissioner of Public Health shall convene a working group of representatives of hospitals, nursing homes and water companies for the purpose of identifying issues, evaluating data, determining appropriate action timelines and developing solutions regarding the prevention and mitigation of legionella in hospitals, nursing homes and other health care facilities. Not later than December 31, 2022, the Commissioner of Public Health shall report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on the efforts of such working group and its recommendations for legislation, regulations or other changes concerning the prevention and mitigation of legionella in hospitals, nursing homes and other health care facilities. The working group shall terminate on the date it submits such report or December 31, 2022, whichever is earlier.

Sec. 63. Section 19a-903b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

A hospital, as defined in section 19a-490b, may designate any licensed health care provider and any certified ultrasound or nuclear medicine<u>, or polysomnographic</u> technologist to perform the following oxygen-related patient care activities in a hospital: (1) Connecting or disconnecting oxygen supply; (2) transporting a portable oxygen source; (3) connecting, disconnecting or adjusting the mask, tubes and other patient oxygen delivery apparatus; and (4) adjusting the rate or flow of oxygen consistent with a medical order. Such provider or technologist

may perform such activities only to the extent permitted by hospital policies and procedures, including bylaws, rules and regulations applicable to the medical staff. A hospital shall document that each person designated to perform oxygen-related patient care activities has been properly trained, either through such person's professional education or through training provided by the hospital. In addition, a hospital shall require that such person satisfy annual competency testing. Nothing in this section shall be construed to prohibit a hospital from designating persons who are authorized to transport a patient with a portable oxygen source. The provisions of this section shall not apply to any type of ventilator, continuous positive airway pressure or bi-level positive airway pressure units or any other noninvasive positive pressure ventilation.

Sec. 64. Section 17a-52 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) There is established a **[**Youth**]** Connecticut Suicide Advisory Board, within the Department of Children and Families, which shall be a coordinating source for suicide prevention across a person's lifespan, including, but not limited to, youth suicide prevention. The board **[**shall consist of twenty members, which shall include**]** may include (1) representatives from suicide prevention foundations, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic or volunteer groups, state and local government agencies, tribal governments or organizations, health care providers or local organizations with expertise in the mental health of children or adults or mental health issues with a focus on suicide prevention, (2) one psychiatrist licensed to practice medicine in this state, (3) one psychologist licensed in this state, (4) one representative of a local or regional board of education, (5) one high school teacher, (6) one high school student, (7) one college or university faculty member, (8) one college or university student**, [**and**]** (9) one parent, and (10) a person who has experienced suicide ideation or loss, all appointed by the Commissioner of Children and Families. **[**,**]** The board shall include one representative of the Department of Public Health appointed by the

Commissioner of Public Health, one representative of the state Department of Education appointed by the Commissioner of Education and one representative of the Board of Regents for Higher Education appointed by the president of the Connecticut State Colleges and Universities. **[**The balance of the board shall be comprised of persons with expertise in the mental health of children or mental health issues with a focus on suicide prevention and shall be appointed by the Commissioner of Children and Families. Members of the board shall serve for two-year terms, without compensation. Any member who fails to attend three consecutive meetings or fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the board. The Commissioner**]** The Commissioners of Children and Families and Mental Health and Addiction Services, or the commissioners' designees, shall **[**be a nonvoting, ex-officio member of the board. The board shall elect a chairman, and a vice-chairman to act in the chairman's absence**]** serve as cochairpersons of the board and may appoint a representative of a local organization with expertise in mental health or a suicide prevention foundation to serve as a third cochairperson of the board. The board may adopt bylaws to govern it and its meetings.

(b) The board shall: (1) Increase public awareness of the existence of **[**youth**]** suicide and means of suicide prevention across a person's lifespan; (2) make recommendations to the **[**commissioner**]** Commissioners of Children and Families and Mental Health and Addiction Services for the development of state-wide training in the prevention of **[**youth**]** suicide; (3) develop a state-wide strategic **[**youth**]** suicide prevention plan; (4) recommend interagency policies and procedures for the coordination of services **[**for youths and families**]** in the area of suicide prevention, intervention and response; (5) make recommendations for the establishment and implementation of suicide prevention, intervention and response procedures in schools and communities; (6) establish a coordinated system for the utilization of data for the prevention of **[**youth**]** suicide; (7) make recommendations concerning the integration of suicide prevention and intervention

strategies into **[**other**]** youth-focused prevention and intervention programs; and (8) periodically offer, within available appropriations, **[**youth**]** suicide prevention training and education for health care and behavioral health care providers, school employees, faculty members of institutions of higher education and other persons who provide services to children, **[**young**]** adults and families.

Sec. 65. Subsection (b) of section 20-10b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) during the first renewal period in which continuing medical education is required and not less than once every six years thereafter, include at least one contact hour of training or education in each of the following topics: (A) Infectious diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, (B) risk management, including, but not limited to, prescribing controlled substances and pain management, and, for registration periods beginning on or after October 1, 2019, such risk management continuing medical education may also include screening for inflammatory breast cancer and gastrointestinal cancers, including colon, gastric, pancreatic and neuroendocrine cancers and other rare gastrointestinal tumors, (C) sexual assault, (D) domestic violence, (E) cultural competency, and (F) behavioral health, provided further that on and after January 1, 2016, such behavioral health continuing medical education may include, but not be limited to, at least two contact hours of training or education during the first renewal period in which continuing education is required and not less than once every six years thereafter, on (i) suicide prevention, or (ii) diagnosing and treating **[**(i)**]** (I) cognitive conditions, including, but not limited to,

Alzheimer's disease, dementia, delirium, related cognitive impairments and geriatric depression, or **[**(ii)**]** (II) mental health conditions, including, but not limited to, mental health conditions common to veterans and family members of veterans. Training for mental health conditions common to veterans and family members of veterans shall include best practices for **[**(I)**]** determining whether a patient is a veteran or family member of a veteran, **[**(II)**]** screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and **[**(III)**]** suicide prevention training. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Association, Connecticut Hospital Association, Connecticut State Medical Society, Connecticut Osteopathic Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department. The commissioner, or the commissioner's designee, may grant a waiver for not more than ten contact hours of continuing medical education for a physician who **[**: (I) Engages**]** engages in activities related to the physician's service as a member of the Connecticut Medical Examining Board, established pursuant to section 20-8a, **[**; (II)**]** engages in activities related to the physician's service as a member of a medical hearing panel, pursuant to section 20-8a, **[**; or (III)**]** or assists the department with its duties to boards and commissions as described in section 19a-14.

Sec. 66. Subdivision (6) of subsection (b) of section 10-222q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(6) Three appointed by the minority leader of the Senate, one of whom is a representative of the Connecticut Education Association; one of whom is a representative of the National Alliance on Mental Illness, Connecticut; and one of whom is a representative of the **[**Youth**]** Connecticut Suicide Advisory Board established pursuant to section

17a-52, as amended by this act;

Sec. 67. (NEW) (*Effective July 1, 2022*) (a) As used in this section:

(1) "Hospital" means an establishment licensed pursuant to chapter 368v of the general statutes for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions;

(2) "Outpatient surgical facility" means any entity, individual, firm, partnership, corporation, limited liability company or association, other than a hospital, licensed pursuant to chapter 368v of the general statutes to engage in providing surgical services or diagnostic procedures for human health conditions that include the use of moderate or deep sedation, moderate or deep analgesia or general anesthesia, as such levels of anesthesia are defined from time to time by the American Society of Anesthesiologists, or by such other professional or accrediting entity recognized by the Department of Public Health;

(3) "Surgical smoke" means the by-product of the use of an energy-generating device during surgery, including, but not limited to, surgical plume, smoke plume, bioaerosols, laser-generated airborne contaminants and lung-damaging dust. "Surgical smoke" does not include the by-product of the use of an energy-generating device during a gastroenterological or ophthalmic procedure, which by-product is not emitted into the operating room during surgery; and

(4) "Surgical smoke evacuation system" means a system, including, but not limited to, a smoke evacuator, laser plume evacuator or local exhaust ventilator that captures and neutralizes surgical smoke (A) at the site of origin of such surgical smoke, and (B) before the surgical smoke makes contact with the eyes or respiratory tract of any person in an operating room during surgery.

(b) Not later than January 1, 2024, each hospital and outpatient surgical facility shall develop a policy for the use of a surgical smoke evacuation system to prevent a person's exposure to surgical smoke.

Not later than January 1, 2024, each hospital and outpatient facility shall implement such policy and, upon request, provide a copy of such policy to the Department of Public Health.

Sec. 68. Section 19a-7o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2022*):

(a) For purposes of this section:

(1) "Hepatitis C screening test" means a laboratory test that detects the presence of hepatitis C virus antibodies in the blood;

(2) "Hepatitis C diagnostic test" means a laboratory test that detects the presence of hepatitis C virus in the blood and provides confirmation of whether the person whose blood is being tested has a hepatitis C virus infection;

(3) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;

(4) "HIV–related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection;

[(3)**]** (5) "Primary care provider" means a physician, advanced practice registered nurse or physician assistant who provides primary care services and is licensed by the Department of Public Health pursuant to title 20; and

[(4)**]** (6) "Primary care" means the medical fields of family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics or primary care gynecology, without regard to board certification.

(b) **[**On and after October 1, 2014, a**]** A primary care provider shall

offer to provide to, or order for, each patient who was born between 1945 to 1965, inclusive, a hepatitis C screening test or hepatitis C diagnostic test at the time the primary care provider provides services to such patient, except a primary care provider is not required to offer to provide to, or order for, such patient a hepatitis C screening test or hepatitis C diagnostic test when the primary care provider reasonably believes: (1) Such patient is being treated for a life-threatening emergency; (2) such patient has previously been offered or has received a hepatitis C screening test; or (3) such patient lacks the capacity to consent to a hepatitis C screening test.

(c) On and after January 1, 2023, a primary care provider, or such provider's designee, shall offer to provide to, order for, or arrange for the order for, each patient who is thirteen years of age or older, an HIV-related test, except a primary care provider, or such provider's designee, is not required to offer to provide to, or order for, such patient an HIV-related test when the primary care provider reasonably believes: (1) Such patient is being treated for a life-threatening emergency; (2) such patient has previously been offered or has received an HIV-related test; or (3) such patient lacks the capacity to consent to an HIV-related test. The primary care provider, or such provider's designee, shall comply with all requirements concerning HIV-related testing and HIV-related information prescribed in chapter 368x.

Sec. 69. (NEW) (*Effective October 1, 2022*) (a) On and after January 1, 2024, an employee or a staff member of a hospital licensed under chapter 386v of the general statutes who is treating a patient thirteen years of age or older in the emergency department shall offer the patient an HIV-related test unless the employee or staff member documents that any of the following conditions have been met: (1) The patient is being treated for a life-threatening emergency; (2) the patient received an HIV-related test in the preceding year; (3) the patient lacks the capacity to provide general consent to the HIV-related test as required under subsection (a) of section 19a-582 of the general statutes; or (4) the patient declines the HIV-related test. Any hospital employee or staff member offering an HIV-related test under this subsection shall comply with all

requirements concerning HIV-testing and HIV-related information prescribed in chapter 368x of the general statutes.

(b) Prior to January 1, 2024, each hospital shall develop protocols, in accordance with the provisions of section 19a-582 of the general statutes, for implementing the HIV-related testing required under subsection (a) of this section, including, but not limited to, the following: (1) Offering and providing such testing to a patient and notifying the patient of the results of such testing; (2) tracking and documenting the number of HIV-related tests that were performed, the number of HIV-related tests that were declined, and the results of the HIV-related tests; (3) reporting of positive HIV-related test results to the Department of Public Health pursuant to section 19a-215 of the general statutes, as amended by this act; and (4) referring patients who test positive for the human immunodeficiency virus to an appropriate health care provider for treatment of such virus. A hospital may collaborate with a municipal health department, district department of health, regional mental health board, emergency medical services council or community organization in developing and implementing such protocols.

Sec. 70. (*Effective from passage*) The Commissioner of Public Health shall conduct a review of statutes and regulations pertaining to, or otherwise impacting, the practice of plasmapheresis, clinical laboratories, and blood donation centers in the state. For purposes of such review, the commissioner shall (1) consult clinical laboratories, businesses and nonprofit organizations with expertise in the practice of clinical laboratory operations and facilities, plasmapheresis and blood collection, and (2) review the federal regulations governing the practice of plasmapheresis and blood collections. Not later than January 1, 2023, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, regarding such review and make recommendations regarding how the state may better align with federal requirements for clinical laboratories, plasmapheresis and blood collection while maintaining a high level of donor safety.

Sec. 71. Subsection (g) of section 17b-451 of the 2022 supplement to

the general statutes, as amended by section 12 of substitute house bill 5313 of the current session, as amended by House Amendment Schedule "A", is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(g) The Commissioner of Social Services shall develop an educational training program to promote and encourage the accurate and prompt identification and reporting of abuse, neglect, exploitation and abandonment of elderly persons. Such training program shall be made available on the Internet web site of the Department of Social Services to mandatory reporters and other interested persons. The commissioner shall also make such training available in person or otherwise at various times and locations throughout the state as determined by the commissioner. Except for a mandatory reporter who has received training from an institution, organization, agency or facility required to provide such training pursuant to subsection (a) of this section, a mandatory reporter shall complete the educational training program developed by the commissioner, or an alternate program approved by the commissioner, not later than **[**December 31, 2022**]** June 30, 2023, or not later than ninety days after becoming a mandatory reporter.

Sec. 72. Subsection (i) of section 17a-412 of the 2022 supplement to the general statutes, as amended by section 13 of substitute house bill 5313 of the current session, as amended by House Amendment Schedule "A", is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(i) Any person required to report suspected abuse, neglect, exploitation or abandonment pursuant to subsection (a) of this section shall complete the educational training program provided by the Commissioner of Social Services pursuant to subsection (g) of section 17b-451, as amended by **[**this act**]** substitute house bill 5313 of the current session, as amended by House Amendment Schedule "A", or an alternate program approved by the commissioner, not later than **[**December 31, 2022**]** June 30, 2023, or not later than ninety days after beginning employment as a person required to report suspected abuse,

neglect, exploitation or abandonment pursuant to subsection (a) of this section.

Sec. 73. (NEW) (*Effective from passage*) (a) As used in this section: (1) "Health care facility" means a hospital or an outpatient clinic, as such terms are defined in section 19a-490 of the general statutes, a long-term care facility, as defined in section 17a-405 of the general statutes, and a hospice facility, licensed pursuant to section 19a-122b of the general statutes; and (2) "medical diagnostic equipment" means (A) an examination table, (B) an examination chair, (C) a weight scale, (D) mammography equipment, and (E) x-ray, imaging and other radiological diagnostic equipment.

(b) On and after January 1, 2023, each health care facility shall take into consideration the technical standards for accessibility developed by the federal Architectural and Transportation Barriers Compliance Board in accordance with Section 4203 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, when purchasing medical diagnostic equipment.

(c) Not later than December 1, 2022, and annually thereafter, the Commissioner of Public Health shall notify each health care facility, physician licensed pursuant to chapter 370 of the general statutes, physician assistant licensed pursuant to chapter 370 of the general statutes and advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes, of information pertaining to the provision of health care to individuals with accessibility needs, including, but not limited to, the technical standards for accessibility developed by the federal Architectural and Transportation Barriers Compliance Board in accordance with Section 4203 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, for medical diagnostic equipment. The Department of Public Health shall post such information on its Internet web site.

Sec. 74. (*Effective from passage*) (a) There is established a task force to study assisted living services agencies that provide services as a

dementia special care unit or program, as defined in section 19a-562 of the general statutes. Such study shall include, but need not be limited to, an examination of (1) the regulation of such agencies by the Department of Public Health and whether additional oversight by the department is required, (2) whether minimum staffing levels for such agencies should be required, and (3) the maintenance of records by such agencies of meals served to, bathing of, administration of medication to and the overall health of each resident.

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

(1) Two appointed by the speaker of the House of Representatives;

(2) Two appointed by the president pro tempore of the Senate;

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

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

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate; and

(7) The Commissioner of Public Health, or the commissioner's designee.

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

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

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule

the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(g) Not later than January 1, 2023, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2023, whichever is later.

Sec. 75. Section 19a-59i of the 2022 supplement to the general statutes is amended by adding subsection (g) as follows (*Effective from passage*):

(NEW) (g) Not later than January 1, 2023, the maternal mortality review committee shall develop educational materials regarding:

(1) The health and safety of pregnant and postpartum persons with mental health disorders, including, but not limited to, perinatal mood and anxiety disorders, for distribution by the Department of Public Health to each birthing hospital in the state. As used in this subdivision, "birthing hospital" means a health care facility, as defined in section 19a-630, operated and maintained in whole or in part for the purpose of caring for patients during the delivery of a child and for a postpartum person and such person's newborn following birth;

(2) Evidence-based screening tools for screening patients for intimate partner violence, peripartum mood disorders and substance use disorder for distribution by the Department of Public Health to obstetricians and other health care providers who practice obstetrics; and

(3) Indicators of intimate partner violence for distribution by the Department of Public Health to (A) hospitals for use by health care

providers in the emergency department and hospital social workers, and (B) obstetricians and other health care providers who practice obstetrics.

Sec. 76. (NEW) (*Effective July 1, 2022*) (a) As used in this section, "birthing hospital" means a health care facility, as defined in section 19a-630 of the general statutes, operated and maintained in whole or in part for the purpose of caring for a person during the delivery of a child and for a postpartum person and such person's newborn following birth.

(b) On and after October 1, 2022, each birthing hospital shall provide to each patient who has undergone a caesarean section written information regarding the importance of mobility following a caesarean section and the risks associated with immobility following a caesarean section.

(c) Not later than January 1, 2023, each birthing hospital shall establish a patient portal through which a postpartum patient can virtually access, through an Internet web site or application, any educational materials and other information that the birthing hospital provided to the patient during the patient's stay at the birthing hospital and at the time of the patient's discharge from the birthing hospital.

(d) On and after January 1, 2023, each birthing hospital shall provide to each postpartum patient the educational materials regarding the health and safety of pregnant and postpartum persons with mental health disorders, including, but not limited to, perinatal mood and anxiety disorders, developed by the maternal mortality review committee pursuant to subsection (g) of section 19a-59i of the general statutes, as amended by this act.

Sec. 77. Subsection (a) of section 10-29a of the 2022 supplement to the general statutes is amended by adding subdivisions (104) and (105) as follows (*Effective from passage*):

(NEW) (104) Maternal Mental Health Month. The Governor shall proclaim the month of May of each year to be Maternal Mental Health

Month, to raise awareness of issues surrounding maternal mental health. Suitable exercises may be held in the State Capitol and elsewhere as the Governor designates for the observance of the month.

(NEW) (105) Maternal Mental Health Day. The Governor shall proclaim May fifth of each year to be Maternal Mental Health Day, to raise awareness of issues surrounding maternal mental health. Suitable exercises may be held in the State Capitol and elsewhere as the Governor designates for the observance of the day.

Sec. 78. Section 19a-6f of the general statutes is repealed. (*Effective October 1, 2022*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2022*	19a-490
Sec. 2	*October 1, 2022*	19a-491c(a)
Sec. 3	*October 1, 2022*	19a-535b
Sec. 4	*October 1, 2022*	19a-537(a)
Sec. 5	*October 1, 2022*	19a-550(a)
Sec. 6	*October 1, 2022*	20-185r(a) to (e)
Sec. 7	*October 1, 2022*	12-20a(a)
Sec. 8	*October 1, 2022*	17b-368
Sec. 9	*from passage*	19a-491(a)
Sec. 10	*July 1, 2022*	19a-497(a)
Sec. 11	*from passage*	19a-515(a) and (b)
Sec. 12	*October 1, 2022*	19a-492e(a)
Sec. 13	*October 1, 2022*	19a-495a(a) and (b)
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	20-90
Sec. 16	*from passage*	19a-16d(c) and (d)
Sec. 17	*from passage*	19a-16e(a)
Sec. 18	*from passage*	20-132a(c)
Sec. 19	*from passage*	19a-14c(b)
Sec. 20	*from passage*	20-12j(b)
Sec. 21	*from passage*	19a-177(8)(B)
Sec. 22	*from passage*	14-1(5)
Sec. 23	*October 1, 2022*	19a-30(a)
Sec. 24	*October 1, 2022*	19a-31b

Sec. 25	*October 1, 2022*	19a-72(a)(1) and (2)
Sec. 26	*October 1, 2022*	19a-215(a)(1)
Sec. 27	*October 1, 2022*	19a-269b(a)
Sec. 28	*October 1, 2022*	20-7a(d)
Sec. 29	*October 1, 2022*	20-7c(a)
Sec. 30	*October 1, 2022*	38a-477aa(a)(6)(A)
Sec. 31	*from passage*	7-51a
Sec. 32	*from passage*	7-74
Sec. 33	*from passage*	19a-36m(c) and (d)
Sec. 34	*from passage*	16-245n(c)(2)(A)
Sec. 35	*July 1, 2022*	20-191c(b)
Sec. 36	*from passage*	19a-563h
Sec. 37	*from passage*	17b-59d
Sec. 38	*from passage*	17b-59e
Sec. 39	*from passage*	19a-495(c)
Sec. 40	*from passage*	New section
Sec. 41	*from passage*	New section
Sec. 42	*October 1, 2022*	19a-498(c)
Sec. 43	*October 1, 2022*	19a-509g
Sec. 44	*October 1, 2022*	38a-493(b)(1)
Sec. 45	*October 1, 2022*	38a-520(b)(1)
Sec. 46	*October 1, 2022*	19a-535a
Sec. 47	*October 1, 2022*	New section
Sec. 48	*July 1, 2022*	New section
Sec. 49	*from passage*	2-119
Sec. 50	*January 1, 2023*	19a-127k
Sec. 51	*from passage*	New section
Sec. 52	*July 1, 2022*	19a-563
Sec. 53	*July 1, 2022*	19a-693(2)
Sec. 54	*July 1, 2022*	19a-564
Sec. 55	*from passage*	19a-16d(a)
Sec. 56	*October 1, 2022*	19a-408
Sec. 57	*October 1, 2022*	45a-318(d)
Sec. 58	*October 1, 2022*	17b-131
Sec. 59	*October 1, 2022*	19a-401
Sec. 60	*October 1, 2022*	19a-37
Sec. 61	*October 1, 2022*	19a-180(i)
Sec. 62	*from passage*	New section
Sec. 63	*October 1, 2022*	19a-903b
Sec. 64	*July 1, 2022*	17a-52

Sec. 65	*July 1, 2022*	20-10b(b)
Sec. 66	*July 1, 2022*	10-222q(b)(6)
Sec. 67	*July 1, 2022*	New section
Sec. 68	*October 1, 2022*	19a-7o
Sec. 69	*October 1, 2022*	New section
Sec. 70	*from passage*	New section
Sec. 71	*from passage*	17b-451(g)
Sec. 72	*from passage*	17a-412(i)
Sec. 73	*from passage*	New section
Sec. 74	*from passage*	New section
Sec. 75	*from passage*	19a-59i
Sec. 76	*July 1, 2022*	New section
Sec. 77	*from passage*	10-29a(a)
Sec. 78	*October 1, 2022*	Repealer section