Senate

General Assembly

File No. 315

February Session, 2024

Substitute Senate Bill No. 1

Senate, April 8, 2024

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

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

Section 1. (NEW) (*Effective October 1, 2024*) Each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, shall, during intake of a prospective client, collect and provide to any employee assigned to provide services to such client, information regarding:

(1) The client, including, if applicable, the client's (A) psychiatric history, (B) history of violence, (C) history of substance use, (D) history of domestic abuse, (E) current infections, if any, and the treatment the client has received for such infections, and (F) whether the client's diagnoses or symptoms have remained stable over time;

(2) Other persons present or anticipated to be present at the location where the employee will provide services, including, if known to the agency, each person's (A) name and relationship to the client, (B)

psychiatric history, (C) history of violence or domestic abuse, (D) criminal record, and (E) history of substance use; and

(3) The location where the employee will provide services, including, if known to the agency, the (A) crime rate for the municipality in which the employee will provide services, as determined by the most recent Crime in Connecticut annual report issued by the Department of Emergency Services and Public Protection, (B) presence of any hazardous materials at the location, including, but not limited to, used syringes, (C) presence of firearms or other weapons at the location, (D) status of the location's fire alarm system, and (E) presence of any other safety hazards at the location, including, but not limited to, electrical hazards.

Sec. 2. (NEW) (*Effective October 1, 2024*) Each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, shall (1) provide staff training consistent with the health and safety training curriculum for home care workers endorsed by the Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration, including, but not limited to, training to recognize hazards commonly encountered in home care workplaces and applying practical solutions to manage risks and improve safety; (2) conduct monthly safety assessments with each staff member; and (3) provide staff with a mechanism to perform safety checks, which may include, but need not be limited to, (A) a mobile application that allows staff to access safety information relating to a client, including information collected pursuant to section 1 of this act, and a method of communicating with local police or other staff in the event of a safety emergency, and (B) a global positioning system-enabled, wearable device that allows staff to contact local police by pressing a button or through another mechanism.

Sec. 3. (NEW) (*Effective October 1, 2024*) (a) Each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, and each staff member of any

such agency shall report each instance of verbal abuse that is perceived as a threat or danger to the staff member, physical abuse, sexual abuse or any other abuse by an agency client against a staff member in a form and manner prescribed by the Commissioner of Public Health.

(b) Not later than January 1, 2025, and annually thereafter, the commissioner shall report, 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 the number of reports received pursuant to subsection (a) of this section and the actions taken to ensure the safety of the staff member about whom the report was made.

Sec. 4. Subsection (a) of section 17b-242 of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Social Services shall determine the rates to be paid to home health care agencies and home health aide agencies by the state or any town in the state for persons aided or cared for by the state or any such town. The Commissioner of Social Services shall establish a fee schedule for home health services to be effective on and after July 1, 1994. The commissioner may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to home health care agencies and home health aide agencies in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality. The commissioner shall increase the fee schedule for home health services provided under the Connecticut home-care program for the elderly established under section 17b-342, effective July 1, 2000, by two per cent over the fee schedule for home health services for the previous year. On and after January 1, 2024, the commissioner shall increase the fee schedule for complex care nursing services provided to individuals over the age of eighteen such that the rate of reimbursement is equal to the rate for such services provided to individuals age eighteen and under. There shall be no differential in fees paid for such services based

on the age of the patient. The commissioner may increase any fee payable to a home health care agency or home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; or (3) **[**escort services; or (4)**]** extended hour services. On and after July 1, 2024, the commissioner shall increase the fee payable to a home health care agency or home health aide agency that provides escorts for safety purposes to staff conducting a home visit to cover the costs of providing such escorts. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is posted on the eRegulations System not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months. For purposes of this subsection, "complex care nursing services" means intensive, specialized nursing services provided to a patient with complex care needs who requires skilled nursing care at home.

Sec. 5. (NEW) (*Effective January 1, 2025*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state, shall provide coverage for escorts for the safety of home health care agency or home health aide agency staff, as deemed

necessary by such staff or agency.

Sec. 6. (NEW) (*Effective January 1, 2025*) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state, shall provide coverage for escorts for the safety of home health care agency or home health aide agency staff, as deemed necessary by such staff or agency.

Sec. 7. (*Effective July 1, 2024*) On or before October 1, 2024, the Commissioner of Public Health shall establish and administer a home care staff safety grant program. Such program shall provide grants to home health care and home health aide agencies for the purposes of purchasing staff safety technology, which may include, but need not be limited to, (1) a mobile application that allows staff to access safety information relating to a client, including information collected pursuant to section 1 of this act, and a method of communicating with either local police or other staff in the event of a safety emergency, and (2) a global positioning system-enabled, wearable device that allows staff to contact local police by pressing a button or through another mechanism. The commissioner shall establish eligibility requirements, priority categories, funding limitations and the application process for the grant program. Not later than January 1, 2025, and annually thereafter, the commissioner shall report, 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 the grant program.

Sec. 8. (*Effective from passage*) (a) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to study staff safety issues affecting home health care and home health aide agencies, as such terms are defined in section 19a-490 of the general statutes.

(b) The working group shall include, but need not be limited to, the following members:

(1) Three employees of a home health care or home health aide agency;

(2) Two representatives of a home health care or home health aide agency;

(3) One representative of a collective bargaining unit representing home health care or home health aide agency employees;

(4) One representative of a mobile crisis response services provider;

(5) One representative of an assertive community treatment team;

(6) One representative of a police department; and

(7) One representative of an association of hospitals in the state.

(c) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) 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 working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 9. (*Effective July 1, 2024*) The sum of one million dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2025, for the purposes of

establishing and administering the home care staff safety grant program established pursuant to section 7 of this act.

Sec. 10. (NEW) (*Effective January 1, 2025*) As used in this section and sections 11 to 18, inclusive, of this act:

(1) "Graduate physician" means a medical school graduate who:

(A) Is a resident and citizen of the United States or a resident alien in the United States; and

(B) Has successfully completed step 1 and step 2 of the United States Medical Licensing Examination, or the equivalent of step 1 and step 2 of any other medical licensing examination or combination of examinations that is approved by the National Board of Medical Examiners or National Board of Osteopathic Medical Examiners, within the two-year period immediately preceding the date of the person's application for licensure as a graduate physician, but not more than three years after graduation from a medical school or a school of osteopathic medicine;

(2) "Graduate physician collaborative practice arrangement" means an agreement between a physician licensed pursuant to chapter 370 of the general statutes and a graduate physician who meets the requirements of sections 11 to 18, inclusive, of this act;

(3) "Medical school graduate" means a person who has graduated from a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation or a medical school listed in the World Directory of Medical Schools, or its equivalent; and

(4) "Primary care services" means medical services in pediatrics, internal medicine, family medicine, obstetrics and gynecology or psychiatry.

Sec. 11. (NEW) (*Effective January 1, 2025*) (a) A graduate physician collaborative practice arrangement shall limit the graduate physician to

providing primary care services.

(b) A graduate physician shall be subject to the supervision requirements established in any controlling federal law, the supervision requirements adopted pursuant to sections 12 to 18, inclusive, of this act and any supervision requirements established by the National Board of Medical Examiners. A graduate physician shall not be subject to any additional supervision requirements.

Sec. 12. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical Examining Board, established pursuant to section 20-8a of the general statutes, shall promulgate rules to:

(1) Establish the process for licensure of graduate physicians, supervision requirements for graduate physicians and additional requirements for graduate physician collaborative practice arrangements;

(2) Set fees for licensure, including, but not limited to, a requirement that the total fees collected each year shall be greater than or equal to the total costs necessary to facilitate the graduate physician collaborative practice arrangement each year; and

(3) Address any other matters necessary to protect the public and take disciplinary action against participants in graduate physician collaborative practice arrangements.

(b) A graduate physician's license issued pursuant to sections 11 to 18, inclusive, of this act and the rules promulgated by the Connecticut Medical Examining Board concerning graduate physician collaborative practice arrangements shall be valid for two years from the date of issuance and are not subject to renewal. Said board may deny an application for licensure as a graduate physician or suspend or revoke the license of a graduate physician for violation of any provision of sections 11 to 18, inclusive, of this act, as applicable, or for a violation of the rules or standards of conduct established by said board.

(c) Any rule promulgated under the authority delegated to said board

under this section shall become effective upon promulgation, provided such rule complies with the Uniform Administrative Procedures Act, sections 4-166 to 4-189, inclusive of the general statutes.

Sec. 13. (NEW) (*Effective January 1, 2025*) A graduate physician shall clearly identify as a graduate physician and may use the identifiers "doctor" or "Dr.". A graduate physician shall not practice or attempt to practice without a graduate physician collaborative practice arrangement, except as otherwise provided in sections 11 to 18, inclusive, of this act or permitted under rules promulgated by the Connecticut Medical Examining Board pursuant to section 12 of this act.

Sec. 14. (NEW) (*Effective January 1, 2025*) A licensed physician collaborating with a graduate physician shall be responsible for supervising the activities of the graduate physician and shall accept full responsibility for the primary care services provided by the graduate physician.

Sec. 15. (NEW) (*Effective January 1, 2025*) (a) The provisions of sections 11 to 18, inclusive, of this act shall apply to all graduate physician collaborative practice arrangements. To be eligible to practice as a graduate physician, a licensed graduate physician shall enter into a graduate physician collaborative practice arrangement with a licensed physician not later than six months after the date on which the graduate physician obtains initial licensure as a graduate physician.

(b) Only a physician licensed pursuant to chapter 370 of the general statutes may enter into a graduate physician collaborative practice arrangement with a graduate physician. A graduate physician collaborative practice arrangement shall take the form of a written agreement, including mutually agreed-upon protocols or standing orders, for the delivery of primary care services. A graduate physician collaborative practice arrangement may delegate to a graduate physician the authority to administer or dispense drugs, except a controlled substance, and provide treatment, provided the delivery of the primary care services is within the scope of the graduate physician's practice and is consistent with the graduate physician's skill, training

and competence and the skill, training and competence of the collaborating physician. The collaborating physician shall be board certified in the specialty that the graduate physician is practicing, which shall only include pediatrics, internal medicine, family medicine, obstetrics and gynecology or psychiatry.

(c) A graduate physician collaborative practice arrangement shall contain the following provisions:

(1) The complete names, home and business addresses and telephone numbers of the collaborating physician and the graduate physician;

(2) A requirement that the graduate physician practice at the same location as the collaborating physician;

(3) A requirement that the graduate physician or collaborating physician prominently display, in every office where the graduate physician is authorized to prescribe, a disclosure statement informing patients that they may be seen by a graduate physician and advising patients that they have the right to see the collaborating physician;

(4) A list of each specialty and board certification of the collaborating physician and each certification of the graduate physician;

(5) The manner of collaboration between the collaborating physician and the graduate physician, including, but not limited to, a description of the manner in which the collaborating physician and the graduate physician shall:

(A) Engage in collaborative practice consistent with each professional's skill, training, education and competence; and

(B) Maintain geographic proximity to a hospital, provided the graduate physician collaborative practice arrangement may allow for geographic proximity to be waived for not more than twenty-eight days per calendar year for the provision of primary care services in health care services in a rural health clinic. As used in this subparagraph, "rural health clinic" means (i) an independent health clinic, (ii) provider-based

health clinic, if the provider is a critical access hospital, as defined in 42 USC 1395i-4, as amended from time to time, or (iii) a provider-based health clinic, if the primary location of the hospital sponsor is more than twenty-five miles from the clinic, which clinic is located in a town that has either seventy-five per cent or more of its population classified as rural in the 1990 federal decennial census of population, or in the most recent such census used by the State Office of Rural Health to determine rural towns, or a town that is not designated as a metropolitan area on the list maintained by the federal Office of Management and Budget, used by the State Office of Rural Health to determine rural towns. The collaborating physician shall maintain documentation related to the geographic proximity requirement and present the documentation to the Connecticut Medical Examining Board upon request;

(6) A requirement that the graduate physician shall not provide primary care services to a patient during the absence of the collaborating physician from the practice location for any reason;

(7) A list of all other graduate physician collaborative practice arrangements of (A) the collaborating physician with another graduate physician, and (B) the graduate physician with another collaborating physician;

(8) The duration of the graduate physician collaborative practice arrangement between the collaborating physician and the graduate physician;

(9) A provision describing the time and manner of the collaborating physician's review of the graduate physician's delivery of primary care services and requiring the graduate physician to submit to the collaborating physician every fourteen days after the initial observation year a minimum of twenty-five per cent of the charts documenting the graduate physician's delivery of primary care services for review by the collaborating physician or by any other physician designated in the graduate physician collaborative practice arrangement. For the first three months of the initial observation year, the collaborating physician shall review one hundred per cent of the charts documenting the

graduate physician's delivery of primary care services. For months four to twelve, inclusive, of the initial observation year, the collaborating physician shall review seventy-five per cent of the charts documenting the graduate physician's delivery of primary care services; and

(10) A requirement that a collaborating physician be on premises if the graduate physician performs primary care services in a hospital or emergency department.

Sec. 16. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical Examining Board shall promulgate rules regulating the use of graduate physician collaborative practice arrangements for graduate physicians. The rules shall:

(1) Specify the geographic areas to be covered by graduate physician collaborative practice arrangements;

(2) Specify the methods of treatment that may be covered by graduate physician collaborative practice arrangements;

(3) Specify, in consultation with the deans of medical schools and primary care residency program directors in the state, the educational methods and programs to be implemented by the collaborating physician during graduate physician collaborative practice service arrangements, to facilitate the advancement of the graduate physician's medical knowledge and capabilities and the successful completion of which may lead to credit toward a future residency program that accepts the documented educational achievements of the graduate physician through such methods and programs; and

(4) Require a review of the primary care services provided under a graduate physician collaborative practice arrangement.

(b) A collaborating physician shall not enter into a graduate physician collaborative practice arrangement with more than three graduate physicians at the same time.

Sec. 17. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical

Examining Board shall promulgate rules applicable to graduate physicians that are consistent with the federal guidelines established for federally qualified health centers. The rulemaking authority granted to said board under this subsection shall not extend to any graduate physician collaborative practice arrangement governing a hospital employee providing inpatient care within a hospital.

(b) The board shall not deny, revoke, suspend or otherwise take disciplinary action against a collaborating physician for primary care services delegated to a graduate physician, provided the provisions of this section and any applicable rule promulgated by said board are satisfied.

(c) Not later than thirty days after any licensure change of a physician, the board shall require the physician to identify whether the physician is engaged in a graduate physician collaborative practice arrangement, and to report to the board the name of each graduate physician with whom the physician has entered into such an arrangement. The board may make the information regarding such arrangement available to the public. The board shall track the reported information and may routinely conduct reviews or inspections to ensure that the arrangements are being carried out in compliance with this chapter.

(d) No contract or other agreement shall require a physician to act as a collaborating physician for a graduate physician against the physician's will. A physician may refuse to act as a collaborating physician, without penalty, for a particular graduate physician. No contract or other agreement shall limit the collaborating physician's authority over any protocols or standing orders or delegate the physician's authority to a graduate physician. Nothing in this subsection shall be construed to authorize a physician, in implementing protocols, standing orders or delegation to violate any standards for safe medical practice established by a hospital's medical staff.

(e) No contract or other agreement shall require a graduate physician to serve as a graduate physician for any collaborating physician against

the graduate physician's will. A graduate physician may refuse to collaborate, without penalty, with a particular physician.

(f) Each collaborating physician and graduate physician that is party to a graduate physician collaborative practice arrangement shall wear an identification badge while acting within the scope of the arrangement. The identification badge shall prominently display the licensure status of the collaborating physician and the graduate physician.

Sec. 18. (NEW) (*Effective January 1, 2025*) (a) A collaborating physician shall complete a certification course approved by the Connecticut Medical Examining Board that shall include material on the laws pertaining to the professional relationship of a collaborating physician with a graduate physician prior to entering into a collaborative practice arrangement with a graduate physician.

(b) A graduate physician collaborative practice arrangement shall supersede any hospital licensing regulation concerning hospital medication orders under a protocol or standing order for the purpose of delivering inpatient or emergency care within a hospital if the protocol or standing order has been approved by the hospital's medical staff and pharmaceutical therapeutics committee.

Sec. 19. (NEW) (*Effective July 1, 2024*) On or before January 1, 2025, the Commissioner of Public Health, in consultation with the Commission on Community Gun Violence Intervention and Prevention, established pursuant to section 19a-112j of the general statutes, and the Connecticut chapters of a national professional association of physicians, a national professional association of advanced practice registered nurses and a national professional association of physician assistants, shall develop or procure educational material concerning gun safety practices to be provided by primary care providers to patients who are eighteen years of age or older during the patient's appointment with such patient's primary care provider. On or before February 1, 2025, the Department of Public Health shall make the educational material available to all primary care providers of persons eighteen years of age or older in the

state, at no cost to the provider, and make recommendations to such primary care providers for the effective use of such educational material. Such primary care providers shall provide such educational material to each patient who is eighteen years of age or older on an annual basis at the patient's appointment with the primary care provider.

Sec. 20. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to study nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic steatohepatitis. Such study shall include, but need not be limited to, an examination of the following:

(1) The incidences of such disease in the state compared to incidences of such disease throughout the United States;

(2) The population groups most affected by and at risk of being diagnosed with such disease and the main risk factors contributing to its prevalence in such groups;

(3) Strategies for preventing such disease in high-risk populations and how such strategies can be implemented state-wide;

(4) Methods of increasing public awareness of such disease, including, but not limited to, public awareness campaigns educating the public regarding liver health;

(5) Whether implementation of a state-wide screening program for such disease in at-risk populations is recommended;

(6) Policy changes necessary to improve care and outcomes for patients with such disease;

(7) Insurance coverage and affordability issues that affect access to treatments for such disease;

(8) The creation of patient advocacy and support networks to assist

persons living with such disease; and

(9) The manner in which social determinants of health influence the risk and outcomes of such disease and interventions needed to address such determinants.

(b) The working group shall include, but need not be limited to, the following members:

(1) A physician with expertise in hepatology and gastroenterology representing an institution of higher education in the state;

(2) Three persons in the state living with nonalcoholic fatty liver disease;

(3) A representative of a patient advocacy organization in the state;

(4) A social worker with experience working with communities in underserved areas in the state and addressing social determinants of health;

(5) An expert in health care policy in the state with experience in advising on regulatory frameworks, health care access and insurance issues;

(6) A nutritionist and dietician in the state with experience in providing guidance on preventative measures and dietary interventions related to nonalcoholic fatty liver disease;

(7) A community health worker who works directly with underserved communities in the state in addressing social determinants of health;

(8) A representative of a nonprofit organization in the state focused on liver health; and

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

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) 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 working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 21. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to study health issues experienced by nail salon workers as a result of such workers' exposure to health hazards in a nail salon. Such study shall include, but need not be limited to, (1) an identification of health hazards in a nail salon, (2) mechanisms to reduce nail salon workers' exposure to such health hazards, (3) best practices for preventing nail salon workers from acquiring health issues from exposure to health hazards in a nail salon, and (4) assessing the strengths of policies protecting nail salon workers' health that have been implemented in other states.

(b) The working group shall include, but need not be limited to, the following members:

(1) Three nail technicians, each employed by a different nail salon in the state;

(2) Three owners or managers of three different nail salons in the state;

(3) A health care professional licensed in the state with experience treating patients experiencing symptoms of an illness attributable to such patients' exposure to health hazards while working in a nail salon;

(4) A representative of a labor union in the state;

(5) An expert in occupational safety;

(6) An expert in environmental health;

(7) A director of a municipal health department in the state with more than three nail salons in the department's jurisdiction; and

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

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene the first meeting of the working group, which shall occur not later than sixty days after the effective date of this section.

(d) The members of the working group shall select two cochairpersons from among the members of the working group.

(e) 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 working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

Sec. 22. (*Effective from passage*) The Commissioner of Public Health, in

collaboration with the Commissioner of Consumer Protection, shall study incidences of prescription drug shortages in the state and whether the state has a role in alleviating such shortages. Not later than January 1, 2025, the Commissioners of Public Health and Consumer Protection shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and consumer protection regarding such study and any recommendations for legislation that would help alleviate or prevent such shortages.

Sec. 23. (NEW) (*Effective July 1, 2024*) (a) For the purposes of this section, "safety plan" means any plan established by the Department of Children and Families to address or mitigate behaviors of a parent or guardian or conditions or circumstances in a home that may render such home unsafe for a child, by (1) identifying actions that have been or will be taken to address or mitigate such behaviors, conditions or circumstances, and (2) specifying the individuals or providers responsible for taking such actions, and timeframes for review of such actions by the department.

(b) When the Commissioner of Children and Families, or the commissioner's designee, conducts a visit to, or evaluation of, a home pursuant to a safety plan, such visit or evaluation shall be conducted in person if such safety plan indicates that a parent or guardian in such home has a substance use disorder, as defined in section 20-74s of the general statutes.

Sec. 24. Section 19a-490ff of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section, (1) "board eligible" means eligible to take a qualifying examination administered by a medical specialty board after having graduated from a medical school, completed a residency program and trained under supervision in a specialty fellowship program, (2) "board certified" means having passed the qualifying examination administered by a medical specialty board to become

board certified in a particular specialty, and (3) "board recertification" means recertification in a particular specialty after a predetermined time period prescribed by a medical specialty board, including, but not limited to, through participation in any required maintenance of certification program, after having passed the qualifying examination administered by the medical specialty board to become board certified in a particular specialty.

(b) No hospital, or medical review committee of a hospital, shall require, as part of its credentialing requirements (1) for a board eligible physician to acquire privileges to practice in the hospital, that the physician provide credentials of board certification in a particular specialty until five years after the date on which the physician became board eligible in such specialty, or (2) for a board certified physician to acquire or retain privileges to practice in the hospital, that the physician provide credentials of board recertification.

Sec. 25. (NEW) (*Effective January 1, 2025*) (a) For purposes of this section:

(1) "Health care provider" has the same meaning as provided in section 38a-477aa of the general statutes;

(2) "Maintenance of certification" means any process requiring periodic recertification examinations or other professional development activities to maintain specialty certification;

(3) "Professional liability insurance" has the same meaning as provided in section 38a-393 of the general statutes; and

(4) "Specialty certification" means any certification by a medical board that specializes in one area of medicine and has requirements in addition to licensing requirements in this state.

(b) No insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy providing coverage of the type

specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes in this state on or after January 1, 2025, shall (1) deny reimbursement to such health care provider, or prevent any health care provider from participating in any provider network based solely on such health care provider's decision not to maintain a specialty certification through any maintenance of certification program, or (2) require any health care provider to maintain a specialty certification through a maintenance of certification program as a prerequisite for obtaining professional liability insurance or other indemnity against liability for professional malpractice in accordance with section 20-11b of the general statutes, provided that such health care provider does not hold such health care provider out to be a specialist under such specialty certification.

Sec. 26. (NEW) (*Effective October 1, 2024*) (a) As used in this section:

(1) "Dispense" has the same meaning as provided in section 21a-240 of the general statutes;

(2) "Opioid drug" has the same meaning as provided in section 20-14o of the general statutes;

(3) "Personal opioid drug deactivation and disposal system" means a product that is designed for personal use and enables a patient to permanently deactivate and destroy an opioid drug;

(4) "Pharmacist" has the same meaning as provided in section 21a-240 of the general statutes; and

(5) "Pharmacy" has the same meaning as provided in section 21a-240 of the general statutes.

(b) (1) Except as provided in subdivision (2) of this subsection, each pharmacist who dispenses an opioid drug to a patient in this state shall provide to such patient, at the time such pharmacist dispenses such drug to such patient, a personal opioid drug deactivation and disposal system. No pharmacy or pharmacist shall charge any fee to, or impose any cost on, any patient for a personal opioid drug deactivation and

disposal system that a pharmacist provides to a patient pursuant to this subdivision.

(2) Any pharmacy or pharmacist may seek reimbursement from the Opioid Settlement Advisory Committee established pursuant to section 17a-674d of the general statutes for documented expenses incurred by such pharmacy or pharmacist in providing personal opioid drug deactivation and disposal systems to patients pursuant to subdivision (1) of this subsection. No such pharmacy or pharmacist shall be required to bear any documented expense for providing personal opioid drug deactivation and disposal systems to patients pursuant to subdivision (1) of this subsection and, if there are insufficient funds in the Opioid Settlement Fund established pursuant to section 17a-674c of the general statutes, as amended by this act, to cover such documented expenses or such funds are otherwise unavailable, no pharmacist shall be required to provide a personal opioid drug deactivation and disposal system pursuant to subdivision (1) of this subsection.

(c) The Commissioner of Consumer Protection may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 27. Subsection (f) of section 17a-674c of the 2024 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(f) Moneys in the fund shall be spent only for the following substance use disorder abatement purposes, in accordance with the controlling judgment, consent decree or settlement, as confirmed by the Attorney General's review of such judgment, consent decree or settlement and upon the approval of the committee and the Secretary of the Office of Policy and Management:

(1) State-wide, regional or community substance use disorder needs assessments to identify structural gaps and needs to inform expenditures from the fund;

(2) Infrastructure required for evidence-based substance use disorder prevention, treatment, recovery or harm reduction programs, services and supports;

(3) Programs, services, supports and resources for evidence-based substance use disorder prevention, treatment, recovery or harm reduction;

(4) Evidence-informed substance use disorder prevention, treatment, recovery or harm reduction pilot programs or demonstration studies that are not evidence-based, but are approved by the committee as an appropriate use of moneys for a limited period of time as specified by the committee, provided the committee shall assess whether the evidence supports funding such programs or studies or whether it provides a basis for funding such programs or studies with an expectation of creating an evidence base for such programs and studies;

(5) Evaluation of effectiveness and outcomes reporting for substance use disorder abatement infrastructure, programs, services, supports and resources for which moneys from the fund have been disbursed, including, but not limited to, impact on access to harm reduction services or treatment for substance use disorders or reduction in drug-related mortality;

(6) One or more publicly available data interfaces managed by the commissioner to aggregate, track and report data on (A) substance use disorders, overdoses and drug-related harms, (B) spending recommendations, plans and reports, and (C) outcomes of programs, services, supports and resources for which moneys from the fund were disbursed;

(7) Research on opioid abatement, including, but not limited to, development of evidence-based treatment, barriers to treatment, nonopioid treatment of chronic pain and harm reduction, supply-side enforcement;

(8) Documented expenses incurred in administering and staffing the

fund and the committee, and expenses, including, but not limited to, legal fees, incurred by the state or any municipality in securing settlement proceeds, deposited in the fund as permitted by the controlling judgment, consent decree or settlement;

(9) Documented expenses associated with managing, investing and disbursing moneys in the fund;

(10) Documented expenses, including legal fees, incurred by the state or any municipality in securing settlement proceeds deposited in the fund to the extent such expenses are not otherwise reimbursed pursuant to a fee agreement provided for by the controlling judgment, consent decree or settlement; **[**and**]**

(11) Provision of funds to municipal police departments for the purpose of equipping police officers with opioid antagonists, with priority given to departments that do not currently have a supply of opioid antagonists; and

(12) Documented expenses incurred by pharmacies and pharmacists in providing personal opioid drug deactivation and disposal systems to patients pursuant to section 26 of this act.

Sec. 28. Subdivision (7) of section 31-101 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

(7) "Employer" means any person acting directly or indirectly in the interest of an employer in relation to an employee, but shall not include any person engaged in farming, or any person subject to the provisions of the National Labor Relations Act, unless the National Labor Relations Board has declined to assert jurisdiction over such person, or any person subject to the provisions of the Federal Railway Labor Act, or the state or any political or civil subdivision thereof or any religious agency or corporation, or any labor organization, except when acting as an employer, or any one acting as an officer or agent of such labor organization. An employer licensed by the Department of Public Health

under section 19a-490 shall be subject to the provisions of this chapter with respect to all its employees except those licensed under **[**chapters 370 and**]** chapter 379, unless such employer is the state or any political subdivision thereof;

Sec. 29. (NEW) (*Effective January 1, 2025*) (a) As used in this section, "coronary calcium scan" means a computed tomography scan of the heart that looks for calcium deposits in the heart arteries.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall provide coverage for coronary calcium scans.

(c) The provisions of this section shall apply to a high deductible health plan, as such term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, as amended from time to time, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code of 1986, as amended from time to time, the provisions of this section shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223 of said Internal Revenue Code of 1986, as applicable.

Sec. 30. (NEW) (*Effective January 1, 2025*) (a) As used in this section, "coronary calcium scan" means a computed tomography scan of the heart that looks for calcium deposits in the heart arteries.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall

provide coverage for coronary calcium scans.

(c) The provisions of this section shall apply to a high deductible health plan, as such term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a medical savings account or an Archer MSA pursuant to Section 220 of the Internal Revenue Code of 1986, as amended from time to time, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, or a health savings account pursuant to Section 223 of said Internal Revenue Code of 1986, as amended from time to time, the provisions of this section shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under Section 220 or 223 of said Internal Revenue Code, as applicable.

Sec. 31. (NEW) (*Effective from passage*) (a) As used in this section:

(1) "Cyber security event" means any observable occurrence of action that could potentially affect the security of computer systems, networks or data; and

(2) "Health care facility" means any institution, as defined in section 19a-490 of the general statutes, that is licensed pursuant to chapter 368v of the general statutes.

(b) Not later than January 1, 2025, the Department of Public Health's Office of Public Preparedness and Response, in collaboration with the state's Chief Information Security Officer, shall include in the state's public health emergency response plan an initiative for health care facility readiness during a cyber security event. Such initiative shall include, but need not be limited to, the acquisition or establishment of the following by each health care facility for use during a cyber security event, as necessary or appropriate for each health care facility:

(1) A radio communication system to enable the various units of the health care facility to continue to function;

(2) A separate intranet system for secure communications within the health care facility;

(3) Facsimile machines, local printers or local laptops for printing and intranet communications;

(4) Medical devices that are not connected to the Internet;

(5) An intranet-based emergency management information system to document routine and emergency events or incidents;

(6) A diversion management system for hospital emergency departments to communicate to emergency medical services organizations, other first responders and patients the need to divert patients seeking emergency medical services to another emergency department or health care facility; and

(7) Methods of communicating and coordinating with the Department of Social Services and health carriers to reduce the risk of a sudden reduction in cash flow from the inability to bill for health care services.

Sec. 32. (*Effective July 1, 2024*) The sum of twenty-five thousand dollars is appropriated to the Department of Emergency Services and Public Protection, for each of the fiscal years ending June 30, 2025, June 30, 2026, June 30, 2027, and June 30, 2028, for an annual meeting focused on prevention, identification and management of a cyber security event, as defined in section 31 of this act. The annual meeting shall (1) include, but need not be limited to, representatives of the Department of Public Health, the Division of Emergency Management and Homeland Security within the Department of Emergency Services and Public Protection, the state National Guard and other local, regional and state-wide law enforcement agencies dealing with cyber security events, and (2) consider the (A) creation of cyber security event command scenarios; (B) functioning and training of individuals within hospitals working with pharmaceuticals while without technology to ensure medication administration and documentation in a safe manner; (C) functioning

and training of individuals within hospitals working with laboratory samples and testing and reporting regarding such samples and test results for patients while without technology to ensure safe and accurate documentation and communication; and (D) functioning and training of individuals within hospitals performing imaging studies and testing and reporting results for patients while working without technology to ensure safe and accurate documentation and communication.

Sec. 33. (NEW) (*Effective from passage*) (a) Not later than January 1, 2025, the Department of Public Health, in collaboration with the Office of Health Strategy, shall establish a healthy brain initiative by developing a plan to address health conditions affecting the brain, including, but not limited to, Alzheimer's disease, dementia, Parkinson's disease, stroke and epilepsy. Such plan shall include, but need not be limited to, the following objectives:

(1) Strengthening (A) policies concerning the prevention and treatment of such health conditions, and (B) partnerships with organizations and health care providers to develop such policies;

(2) Evaluating and utilizing data regarding such health conditions;

(3) Building a skilled and diverse health care workforce to engage in prevention efforts and provide treatment to persons with such health conditions, including, but not limited to, through obtaining grant funding and using data to estimate and address the gap between the health care workforce capacity and the anticipated demand for health care services from persons with such health conditions;

(4) Educating the public regarding such health conditions, methods to prevent such health conditions and treatment options for persons with such health conditions;

(5) Establishing a disease management program to promote early diagnosis of such health conditions and develop protocols for providing education, care consultation and referrals for medical and social services to persons with such health conditions and such persons' caregivers,

including, but not limited to, through collaborations among teaching hospitals in the state and partnerships with nonprofit organizations that deliver a range of support services promoting the mental and physical health of persons with such health conditions and their caregivers and family members; and

(6) Creating a program that is specific to persons with dementia, including, but not limited to (A) community-based opportunities for exercise, self-care and caregiver education, (B) peer support groups and social gatherings for such persons and their caregivers, family members and friends, (C) the provision of information on the department's Internet web site regarding dementia and support for persons with dementia and their caregivers, family members and friends, (D) the development of mobile applications that allow caregivers and family members of persons with dementia to track such persons using personal global positioning system units or mobile telephones with a global positioning system, (E) adult day care networks, and (F) transportation services.

(b) Not later than January 1, 2025, the Commissioner of Public Health shall report, 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 the plan developed pursuant to subsection (a) of this section and the department's anticipated implementation date of such plan.

Sec. 34. (NEW) (*Effective from passage*) (a) As used in this section:

(1) "Health care provider" means any person or organization that furnishes health care services to persons with Parkinson's disease or Parkinsonism and is licensed or certified to furnish such services pursuant to chapters 370 and 378 of the general statutes; and

(2) "Hospital" has the same meaning as provided in section 19a-490 of the general statutes.

(b) Not later than July 1, 2025, the Department of Public Health shall

maintain and operate a state-wide registry of data on Parkinson's disease and Parkinsonism.

(c) Each hospital and each health care provider shall make available to the registry such data concerning each patient with Parkinson's disease or Parkinsonism admitted to such hospital or treated by such health care provider for such patient's Parkinson's disease or Parkinsonism as the Commissioner of Public Health shall require by regulations adopted in accordance with chapter 54 of the general statutes. Each hospital and health care provider shall provide each such patient with notice of, and the opportunity to opt out of, such disclosure.

(d) The data contained in such registry may be used by the department and authorized researchers as specified in such regulations, provided personally identifiable information in such registry concerning any such patient with Parkinson's disease or Parkinsonism shall be held confidential pursuant to section 19a-25 of the general statutes. The data contained in the registry shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes. The commissioner may enter into a contract with a nonprofit association in this state concerned with the prevention and treatment of Parkinson's disease and Parkinsonism to provide for the implementation and administration of the registry established pursuant to this section.

(e) Each hospital shall provide access to its records to the Department of Public Health, as the department deems necessary, to perform case finding or other quality improvement audits to ensure completeness of reporting and data accuracy consistent with the purposes of this section.

(f) The Department of Public Health may enter into a contract for the receipt, storage, holding or maintenance of the data or files under its control and management for the purpose of implementing the provisions of this section.

(g) The Department of Public Health may enter into reciprocal reporting agreements with the appropriate agencies of other states to

exchange Parkinson's disease and Parkinsonism care data.

(h) The Department of Public Health shall establish a Parkinson's disease and Parkinsonism data oversight committee to (1) monitor the operations of the state-wide registry established pursuant to subsection (b) of this section, (2) provide advice regarding the oversight of such registry, (3) develop a plan to improve quality of Parkinson's disease and Parkinsonism care and address disparities in the provision of such care, and (4) develop short and long-term goals for improvement of such care.

(i) Said committee shall include, but need not be limited to, the following members, who shall be appointed by the Commissioner of Public Health not later than June 1, 2025: (1) A neurologist; (2) a movement disorder specialist; (3) a primary care provider; (4) a neuropsychiatrist who treats Parkinson's disease; (5) a patient living with Parkinson's disease; (6) a public health professional; (7) a population health researcher with experience in state-wide registries of health condition data; (8) a patient advocate; (9) a family caregiver of a person with Parkinson's disease; (10) a representative of a nonprofit organization related to Parkinson's disease; (11) a physical therapist with experience working with persons with Parkinson's disease; (12) an occupational therapist with experience working with persons with Parkinson's disease; (13) a speech therapist with experience working with persons with Parkinson's disease; (14) a social worker with experience providing services to persons with Parkinson's disease; (15) a geriatric specialist; and (16) a palliative care specialist. Each member shall serve a term of two years. The commissioner shall appoint, from among the members of the oversight committee, a chairperson who shall schedule the first meeting of the oversight committee on or before July 1, 2025. The Department of Public Health shall assist said committee in its work and provide any information or data that the committee deems necessary to fulfil its duties, unless the disclosure of such information or data is prohibited by state or federal law. Not later than January 1, 2026, and annually thereafter, the chairperson of the committee shall report, 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 the work of the committee. Not later than January 1, 2026, and at least annually thereafter, such chairperson shall report to the Commissioner of Public Health regarding the work of the committee.

(j) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 35. (NEW) (*Effective from passage*) (a) The Commissioner of Mental Health and Addiction Services, in consultation with the Commissioner of Children and Families, shall establish a program for persons diagnosed with recent-onset schizophrenia spectrum disorder, at a hospital in the state, for specialized treatment early in such persons' psychosis. Such program shall serve as a hub for the state-wide dissemination of information regarding best practices for the provision of early intervention services to persons diagnosed with a recent-onset schizophrenia spectrum disorder. Such program shall address (1) the limited knowledge of (A) region-specific needs in treating such disorder, (B) the prevalence of first-episode psychosis in persons diagnosed with such disorder, and (C) disparities across different regions in treating such disorder, (2) uncertainty regarding the availability and readiness of clinicians to implement early intervention services for persons diagnosed with such disorder and such persons' families, and (3) funding of and reimbursement for early intervention services available to persons diagnosed with such disorder.

(b) The program established pursuant to subsection (a) of this section shall perform the following functions:

(1) Develop structured curricula, online resources and videoconferencing-based case conferences to disseminate information for the development of knowledge and skills relevant to patients with first-episode psychosis and such patients' families;

(2) Assess and improve the quality of early intervention services

available to persons diagnosed with a recent-onset schizophrenic spectrum disorder across the state;

(3) Provide expert input on complex cases of a recent-onset schizophrenic spectrum disorder and launch a referral system for consultation with persons having expertise in treating such disorders;

(4) Share lessons and resources from any campaigns aimed at reducing the duration of untreated psychosis to improve local pathways to care for persons with such disorders;

(5) Serve as an incubator for new evidence-based treatment approaches and pilot such approaches for deployment across the state;

(6) Advocate for policies addressing the financing, regulation and provision of services for persons with such disorders; and

(7) Collaborate with state agencies to improve outcomes for persons diagnosed with first-episode psychosis in areas including, but not limited to, crisis services and employment services.

(c) Not later than January 1, 2025, and annually thereafter, the Commissioner of Mental Health and Addiction Services shall report, 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 the functions and outcomes of the program for specialized treatment early in psychosis and any recommendations for legislation to address the needs of persons diagnosed with recent-onset schizophrenic spectrum disorders.

Sec. 36. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to study and make recommendations concerning methods of addressing loneliness and isolation experienced by persons in the state and to improve social connection among such persons. The working group shall perform the following functions:

(1) Evaluate the causes of and other factors contributing to the sense of isolation and loneliness experienced by persons in the state;

(2) Evaluate methods of preventing and eliminating the sense of isolation and loneliness experienced by persons in the state;

(3) Recommend local activities, systems and structures to combat isolation and loneliness in the state, including, but not limited to, opportunities for organizing or enhancing in-person gatherings within communities, especially for persons who have been living in isolation for extended periods of time; and

(4) Explore the possibility of creating municipal-based social connection committees to address the challenges of and potential solutions for combatting isolation and loneliness experienced by persons in the state.

(b) The working group shall include, but need not be limited to, the following members:

(1) A high school teacher from an urban high school in the state;

(2) A high school teacher from a rural high school in the state;

(3) A dining hall manager of a soup kitchen in a suburban area of the state;

(4) Three high school students of a high school in the state, including one student who identifies as a member of the LGBTQ+ community, one student who identifies as female and one student who identifies as male;

(5) A student of a school of public health at an institution of higher education in the state;

(6) A student of a school of social work at an institution of higher education in the state;

(7) A resident of an assisted living facility for veterans in the state;

(8) A resident of an assisted living facility in a suburban town of the state;

(9) A member of the administration of a senior center in a rural area of the state;

(10) A member of the administration of a senior center in an urban area of the state;

(11) A representative of an organization serving children in an urban area of the state;

(12) A representative of an organization that represents municipalities in the state;

(13) A representative of an organization that represents small towns in the state;

(14) A representative of an organization in the state that is working on policies to improve planning and zoning laws to create an inclusive society and improve access to transit-oriented development in the state;

(15) A representative of an organization in the state that is working to improve and create more walkable and accessible main streets in towns and municipalities in the state;

(16) A representative of an organization in the state that advocates for persons with a physical disability;

(17) An expert in digital health and identifying safe digital education;

(18) A representative of an organization in the state that develops mobile applications that are intended to address loneliness and isolation;

(19) A psychiatrist who treats adolescents in the state;

(20) A psychiatrist who treats adults in the state;

(21) A librarian from a library in a rural area of the state;

(22) A social worker who practices in an urban area of the state;

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

(24) The Commissioner of Children and Families, or the commissioner's designee.

(c) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) The members of the working group shall elect two chairpersons from among the members of the working group.

(e) 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 working group.

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, 2025, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	New section
Sec. 2	*October 1, 2024*	New section
Sec. 3	*October 1, 2024*	New section
Sec. 4	*from passage*	17b-242(a)
Sec. 5	*January 1, 2025*	New section
Sec. 6	*January 1, 2025*	New section
Sec. 7	*July 1, 2024*	New section
Sec. 8	*from passage*	New section
Sec. 9	*July 1, 2024*	New section

Sec. 10	*January 1, 2025*	New section
Sec. 11	*January 1, 2025*	New section
Sec. 12	*January 1, 2025*	New section
Sec. 13	*January 1, 2025*	New section
Sec. 14	*January 1, 2025*	New section
Sec. 15	*January 1, 2025*	New section
Sec. 16	*January 1, 2025*	New section
Sec. 17	*January 1, 2025*	New section
Sec. 18	*January 1, 2025*	New section
Sec. 19	*July 1, 2024*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	New section
Sec. 22	*from passage*	New section
Sec. 23	*July 1, 2024*	New section
Sec. 24	*from passage*	19a-490ff
Sec. 25	*January 1, 2025*	New section
Sec. 26	*October 1, 2024*	New section
Sec. 27	*October 1, 2024*	17a-674c(f)
Sec. 28	*October 1, 2024*	31-101(7)
Sec. 29	*January 1, 2025*	New section
Sec. 30	*January 1, 2025*	New section
Sec. 31	*from passage*	New section
Sec. 32	*July 1, 2024*	New section
Sec. 33	*from passage*	New section
Sec. 34	*from passage*	New section
Sec. 35	*from passage*	New section
Sec. 36	*from passage*	New section

Statement of Legislative Commissioners:

In Section 4(a), " to cover the costs of providing such escorts" was added, for clarity; Section 16(a)(3) was redrafted for clarity; in Section 17, "guidelines" was changed to "federal guidelines" for clarity; in Section 18(a), "prior to entering into a collaborative practice arrangement with a graduate physician" was added for clarity; and, in Section 19, at the end of the last sentence, "at the patient's appointment with the primary care provider" was added for clarity.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 25 $	FY 26 $
Public Health, Dept.	GF - Cost	1,032,883	1,093,139
Public Health, Dept.	GF - Appropriation	1,000,000	None
State Comptroller - Fringe Benefits[1]	GF - Cost	Up to 646,000	Up to 646,000
Resources of the General Fund; Social Services, Dept.	GF - Cost	Up to 274,000	Up to $548,000
Department of Emergency Services and Public Protection	GF - Appropriation	25,000	25,000
Resources of the Opioid Settlement Fund	Opioid Settlement Fund - Potential Cost	See Below	See Below
Mental Health & Addiction Serv., Dept.	GF - Potential Cost	See Below	See Below
Social Services, Dept.	GF - Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 25 $	FY 26 $
Various Municipalities	STATE MANDATE[2] - Cost	Upwards of 77,000	Upwards of 77,000

Explanation

Section 3, which requires home health agency staff to report to the

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 41.25% of payroll in FY 25.

[2] State mandate is defined in CGS Sec. 2-32b(2) as any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

Department of Public Health (DPH) on any client whose behavior staff perceive as a threat, physical or sexual abuse, results in a cost of approximately $160,000 in FY 25 and $120,000 in FY 26 to DPH[3] as a Nurse Consultant with a salary of $120,000 will be needed for monitoring and investigations and there will be a one-time cost of approximately $40,000 in FY 25 for Information Technology (IT) consultant services to build an electronic interface to reports.[4]

Section 4 results in a cost to the Department of Social Services (DSS) by requiring increased fees to cover the costs of safety escorts provided by home health agencies. Current law allows, but does not require, DSS to provide increased fees to agencies that show extraordinary costs related to escorts. The extent of the additional cost to DSS is dependent on the cost of the service and associated utilization by providers.

Sections 5, 6, 29 and 30 result in a potential cost to the state of up to $646,000 beginning in FY 25, and annually thereafter, subject to premium increases for the state employee health insurance plan (SEHP) for the newly mandated coverage requirements.[5] The bill mandates individual and group health insurance policies to provide coverage for: (1) home health service escorts, and (2) coronary calcium scans.

These sections additionally result in costs to municipalities participating in the state Partnership Plan (SPP) of up to $77,000 beginning in FY 25 and annually thereafter, subject to premium increases for the newly mandated coverage requirements.[6] Municipalities with fully insured health plans will also see costs to the extent their plans do not currently offer coverage for the provisions outlined above. Due to federal law, the coverage requirements will not

[3]There are currently 85 licensed home health care agencies, and 8 home health aide agencies in the process of initial licensing.
[4]There are approximately 1,000 hours needed for IT consultant work.
[5] Coverage requirements as outlined in the bill begin on January 1, 2025. However, SEHP and SPP premium rates run on a fiscal year basis, beginning July 1. The fiscal impact above assumes the coverage requirements will be rolled into the plan at the start of the next renewal period.
[6] The cost estimate is for the Partnership Plan rates generally. Each municipality would bear different levels of the overall cost dependent on their number of enrollees.

apply to self-insured municipalities, as they are exempt under Employee Retirement Income Security Act (ERISA).

Sections 5 - 6 result in an anticipated annual cost to the State Comptroller – Fringe Benefits account of approximately $377,000 beginning in FY 25 for the new benefit. Based on FY 23 home health visit claims, the additional coverage is estimated to increase premiums up to $0.21 per member per month (PMPM). This estimate is contingent on: (1) how frequently safety escorts will be utilized, as the health agency staff will determine if one is necessary, and (2) at what rate health insurance companies will provide coverage.[7] The cost analysis assumes claims for home health care worker escorts will be approximately 80% of the cost of a home health aide visit claim.

Sections 29 – 30 are anticipated to increase premiums for the SEHP by $0.15 PMPM. At this rate, the State Comptroller – Fringe Benefits account will incur costs of approximately $269,000 annually beginning in FY 25 for the additional coverage of coronary calcium scans. Based on FY 23 claims data across commercial and state plans, the average allowable amount payable by insurance companies is $160. The cost analysis assumes approximately a 7% utilization rate in the estimated eligible population.

The mandated coverage of safety escorts for home health staff and aides is estimated to increase premiums for fully insured municipalities at a rate of $0.20 PMPM, and $0.21 PMPM for those participating in the SPP. The fiscal impact of the mandate on fully insured municipalities is dependent on the extent premiums increase. Premiums for the SPP are anticipated to increase by approximately $45,000 in FY 25 and annually thereafter to be shared amongst the participating municipalities.

Fully insured municipalities and those in the Partnership Plan are anticipated to incur costs at a rate of $0.15 PMPM for the required coverage for coronary calcium scans. The cost to fully insured

[7] According to the Office of Health Strategy's All Payer Claims data, there were nearly 50,000 home health visit claims, including hospice care, in FY 23 across commercial and state plans.

municipalities not in the SPP is dependent on the extent the plan premiums increase resulting from the additional coverage. The SPP is estimated to incur a cost of $32,000 in FY 25 and annually thereafter to be shared amongst the participating municipalities.

Sections 5, 6, 29 and 30 also result in a potential cost to the state of up to $274,000 in FY 25 and up to $548,000 in FY 26 (and annually thereafter) to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirements for home health service escorts and coronary calcium scans are determined to increase premiums and constitute new state benefit mandates under the federal Affordable Care Act (ACA). Neither are currently covered for most enrollees.

Under the ACA, states are allowed to mandate benefits beyond the essential health benefits but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related to specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.[8] There are currently 130,141 enrollees in qualified health plans on the exchange, including 29,687 in Covered Connecticut.

To the extent the bill is determined to include one or two new state benefit mandates that require defrayal, there would be a cost to the state beginning January 1, 2025.[9] Full year costs would begin in FY 26 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the bill raises premiums for those enrollees. It is not clear how or when the ACA

[8] 45 CFR 155.170

[9]After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.

defrayal rules will be enforced for non-Covered Connecticut enrollees.

Insurance coverage for home health care worker escorts is estimated to increase premiums by up to $0.20 per member per month (PMPM). The actual increase to premiums will be calculated by insurers offering exchange plans. The premium increase will depend on: (1) how frequently such escorts are deemed necessary by the home health care agencies, and (2) the negotiated reimbursement rates insurers set with the agencies for that service. At $0.20 PMPM, the total state defrayal cost would be $157,000 for the partial year in FY 25 and $314,000 in FY 26 and annually thereafter.

Insurance coverage for coronary calcium scans, which typically cost between $100 and $200 per scan, is estimated to increase premiums by $0.15 PMPM. The actual increase to premiums will be calculated by insurers offering exchange plans and will depend on the utilization rate, which is expected to increase once it becomes a covered service. The total state defrayal cost is estimated to be $117,000 in FY 25 and $234,000 in FY 26 and annually thereafter.

DSS would incur approximately 23% of those total defrayal costs on behalf of Covered Connecticut enrollees.

Section 7 requires DPH to establish a home health agency staff safety technology program, by 10/1/24, that will provide grants to home health care and home health aide agencies. This results in a cost to DPH beginning in FY 25 that will vary dependent upon available funding.

Section 9 appropriates $1 million to DPH in FY 25 from the General Fund for the grant program established in Section 7.

Sections 10 - 18 require DPH to establish "Graduate Physician" as a new licensed practitioner category, which is anticipated to result in a state cost of $203,916 in FY 25 and $323,246 in FY 26.[10] Annual costs reflect salaries for three full-time equivalent positions of approximately $228,847 with an associated Comptroller - Fringe Benefits cost of

[10]The estimate for FY 25 reflects a partial year estimate.

$94,399.[11] One-time FY 25 other expenses of approximately $22,000 reflect equipment costs (e.g., computers, monitors, software, etc.).

Section 22, which requires DPH, in collaboration with the Department of Consumer Protection, to study incidences of prescription drug shortages and whether the state has a role in alleviating such shortages, results in an estimated, one-time cost to DPH of $50,000 in FY 25.[12]

Section 23 codifies a Department of Children and Families' best practice of conducting certain home visits in-person, which is not anticipated to result in a fiscal impact to the state or municipalities.

Sections 26-27 may result in a cost to the Opioid Settlement Fund associated with reimbursing pharmacy costs for personal opioid drug deactivation and disposal products. Pharmacies and pharmacists are not required to provide such products if funding is unavailable.

The Opioid Settlement Fund is a separate, non-lapsing fund administered by the Opioid Settlement Advisory Committee with assistance from the Department of Mental Health and Addiction Services (DMHAS). Expenditures must be approved by the Committee and used only in accordance with the controlling judgment, consent decree, or settlement.

Section 31 requires DPH's Office of Public Health Preparedness and Response to work with the state's Chief Information Security Officer to include in Connecticut's emergency operations plan an acute care hospital initiative to implement or acquire systems that will ensure operational health care facilities and services during a cyber security event, which is not anticipated to result in a fiscal impact as DPH and the Chief Information Security Officer have needed expertise.

[11]Positions are a Paralegal Specialist, a Project Manager, a half-time Health Program Associate, and a half-time Processing Technician.
[12]There are approximately 500 Registered Pharmacist consultant hours needed.

Section 31 may result in a cost to various state agencies associated with the cyber security readiness initiative. To the extent agencies supporting health care facilities (i.e. DMHAS, DCF, UConn Health Center, DSS) will be required to enhance communication and medical systems to meet the bill's requirements, the state will incur the associated costs. The initiative must be part of the state's public health emergency response plan by January 1, 2025.

Section 32 appropriates $25,000 to the Department of Emergency Services and Public Protection in FY 25 and FY 26 for an annual meeting focused on prevention, identification, and management of a cyber security event.

Sections 33 and 34 task DPH with establishing a healthy brain initiative to address health conditions affecting the brain such as Alzheimer's disease, dementia, Parkinson's disease, stroke, and epilepsy by 1/1/25, and operating a statewide data registry on Parkinson's disease and Parkinsonism by 7/1/25, results in a state cost of approximately $618,967 in FY 15 and $630,139 in FY 26. Costs included the salaries for 2.5 full-time equivalent positions[13] and fringe benefits,[14] as well as data registry IT consultation and associated hardware and software expenses.

Section 35 may result in a cost to DMHAS associated with establishing a program for people diagnosed with recent-onset schizophrenia spectrum disorder, which will serve as a hub for the state-wide dissemination of information regarding best practices. To the extent this requires DMHAS to expand their current program to an in-state hospital, the state will incur additional costs. DMHAS currently operates the Specialized Treatment in Early Psychosis (STEP) program statewide, utilizing state and federal funds.

The bill makes various other changes that have no fiscal impact to the

[13]One Nurse Consultant, one Epidemiologist II, and a half-time Data Scientist (salaries total approximately $84,224 in FY 25 and $233,727 in FY 26).
[14]Office of the State Comptroller- Fringe Benefit costs are approximately $34,743 in FY 25 and $96,412 in FY 26.

state.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, the frequency of use and cost for home health service escorts, and utilization of coronary calcium scans. The annual appropriation identified in Section 32 continues only to FY 27 and FY 28.

OLR Bill Analysis

sSB 1

AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

TABLE OF CONTENTS:

nonalcoholic fatty liver disease, (3) health issues for nail salon workers, and (4) loneliness and isolation.

§§ 10-18 — GRADUATE PHYSICIANS

Creates a licensure program for medical school graduates meeting certain criteria who did not find residency placements; limits their practice to primary care services and only under a collaborative practice arrangement with a licensed physician, and only for a single two-year licensure period; requires the Medical Examining Board to issue related program rules

§ 19 — GUN SAFETY EDUCATIONAL MATERIAL DURING PRIMARY CARE VISITS

Requires DPH, in consultation with certain entities, to develop or procure educational material on gun safety practices for primary care providers to give their adult patients; requires these providers to give this material to adult patients annually

§ 22 — PRESCRIPTION DRUG SHORTAGE STUDY

Requires the DPH and DCP commissioners to study and report on prescription drug shortages

§ 23 — DCF IN-PERSON HOME VISITS

Requires DCF, when doing a home visit or evaluation under a child's safety plan, to do so in person if the safety plan indicates that a parent or guardian in the home has a substance use disorder

§§ 24 & 25 — LIMITATIONS ON MAINTENANCE OF CERTIFICATION

Specifically prohibits hospitals from requiring a board-certified physician to participate in an MOC program in order to obtain or keep privileges; generally prohibits certain health carriers from (1) denying reimbursement or excluding a provider from a network due to the provider's non-participation in an MOC program, or (2) requiring this participation as a condition of professional liability insurance

§§ 26 & 27 — OPIOID DEACTIVATION AND DISPOSAL SYSTEMS

Requires pharmacists who dispense opioids to give the patient, for free, a personal drug deactivation and disposal system if funding is available for this, and allows pharmacies and pharmacists to seek reimbursement from the Opioid Settlement Fund for this purpose

§ 28 — PHYSICIANS AND PHYSICIAN ASSISTANTS UNDER THE STATE LABOR RELATIONS ACT

Removes an exemption from the state Labor Relations Act for physicians and PAs who work at DPH-licensed institutions

§§ 29 & 30 — INSURANCE COVERAGE OF CORONARY CALCIUM SCANS

Requires certain insurance policies to cover coronary calcium scans

§§ 31 & 32 — CYBER SECURITY EVENTS

Requires DPH, in collaboration with the state's Chief Information Security Officer, to develop an initiative for health care facility readiness during cyber security events, and appropriates $25,000 per year for four years to DESPP for a related annual meeting

§ 33 — HEALTHY BRAIN INITIATIVE

Requires DPH, in collaboration with the Office of Health Strategy, to develop a plan to address health conditions affecting the brain

§ 34 — PARKINSON'S DISEASE REGISTRY

Requires (1) DPH to maintain and operate a Parkinson's disease registry and (2) hospitals and certain health care providers to submit data to the registry as DPH requires, subject to patients opting out; establishes a data oversight committee to monitor the registry's activities

§ 35 — RECENT-ONSET SCHIZOPHRENIA SPECTRUM DISORDER

Requires DMHAS, in consultation with DCF, to create a program providing specialized treatment for people with recent-onset schizophrenia spectrum disorder

SUMMARY

This bill makes various changes to laws on home health care and home health aide worker safety, graduate physicians, and several other health-related matters.

EFFECTIVE DATE: Various; see below.

§ 1 — HOME HEALTH SAFETY-RELATED CLIENT INTAKE

Requires home health care and home health aide agencies to collect certain information during client intake (on the client, other people who may be at the home, and general location), and give it to the employees assigned to the client

The bill requires home health care and home health aide agencies (home health agencies; see *Background — Home Health Agencies*) to collect certain information during intake with a prospective client and give it to any employee assigned to the client. Specifically, they must collect

and give information on the following:

1. the client, including, if applicable, the client's psychiatric history; history of violence, domestic abuse, or substance use; any current infections and the treatment the client has received for them; and whether the client's diagnoses or symptoms have been stable over time;

2. other people present or likely to be present at the service location, including, if known to the agency, their names and relationship to the client; psychiatric history; history of violence, domestic abuse, or substance use; and criminal record; and

3. the service location, including, if known to the agency, the municipality's crime rate, as determined by the most recent Crime in Connecticut annual report issued by the Department of Emergency Services and Public Protection (DESPP); presence of hazardous materials, including used syringes, firearms or other weapons, or other safety hazards, including electrical hazards; and status of the location's fire alarm system.

EFFECTIVE DATE: October 1, 2024

Background — Home Health Agencies

By law, both home health care and home health aide agencies must be licensed by the Department of Public Health (DPH). They both provide services in the patient's home or a similar environment.

Home health care agencies must provide professional nursing services and at least one additional service (e.g., physical or speech therapy) directly and all others directly or through contracts.

Home health aide agencies provide supportive services such as assistance with personal hygiene, dressing, feeding, and incidental household tasks. These services must be provided under a registered nurse's supervision (directly or through contract), and if the nurse determines appropriate, must be provided by certain other

professionals (e.g., a social worker) (CGS § 19a-490).

§ 2 — HOME HEALTH SAFETY TRAINING, ASSESSMENTS, AND CHECKS

Requires home health agencies to train staff on safety-related issues, do monthly safety assessments, and give staff ways to perform safety checks (such as through mobile apps)

The bill requires home health agencies to provide staff training that aligns with the health and safety training curriculum for home care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration. This must at least include training to recognize common hazards in home care workplaces and applying practical solutions to manage risks and improve safety.

Under the bill, home health agencies must do monthly safety assessments with each staff member. They also must give staff a way to do safety checks. This may include the following, among other things:

1. a mobile application that allows staff to access safety information relating to a client (including the information collected under the bill, see § 1) and a way to communicate with local police or other staff in an emergency or

2. a GPS-enabled wearable device that allows staff to contact local police, such as by pressing a button.

EFFECTIVE DATE: October 1, 2024

§ 3 — HOME HEALTH REPORTING OF CLIENT THREATS OR ABUSE

Requires home health agencies and their staff members to report to DPH on a client's verbal threats, abuse, or similar incidents, and DPH to annually report on this information

The bill requires home health agencies and their staff members to report to DPH on each instance of a client's (1) verbal abuse that the staff member perceives as a threat or danger, (2) physical or sexual abuse, or (3) any other client abuse of a staff member.

Starting by January 1, 2025, DPH must annually report to the Public

Health Committee on the number of reported incidents and what steps were taken to ensure the affected staff member's safety.

EFFECTIVE DATE: October 1, 2024

§§ 4-6 — HOME HEALTH SAFETY ESCORT REIMBURSEMENT

Requires (1) DSS to increase state reimbursement for home health agencies that provide safety escorts for home visits and (2) certain commercial insurance policies to provide coverage for these safety escorts

The bill requires the Department of Social Services (DSS) commissioner, starting July 1, 2024, to increase state reimbursement rates for home health agencies that provide safety escorts for staff doing home visits, to cover the costs of providing these escorts. Current law permits, but does not require, her to increase reimbursement for agencies that incur extraordinary costs for escort services.

The bill also requires certain health insurance policies to cover home health staff safety escorts that the staff or agency determines necessary. This applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage, except January 1, 2025, for the commercial insurance provisions.

Background — Related Bill

sSB 365, § 3, reported favorably by the Human Services Committee, has similar provisions on state reimbursement rates for home health escort services.

§§ 7 & 9 — HOME HEALTH STAFF SAFETY GRANT PROGRAM

Requires DPH to create and administer a grant program for home health agencies to purchase staff safety technology; appropriates $1 million in FY 25 for this purpose

The bill requires the DPH commissioner, by October 1, 2024, to

establish and administer a program providing grants to help home health agencies buy staff safety technology. This technology may include, among other things, a mobile application or GPS-enabled device as described above (see § 2). The bill appropriates $1 million to DPH in FY 25 from the General Fund for the grant program.

Under the bill, the commissioner must establish the program's eligibility requirements, priority categories, funding limitations, and application process. Starting by January 1, 2025, she must annually report on the program to the Public Health Committee.

EFFECTIVE DATE: July 1, 2024

§§ 8, 20, 21 & 36 — WORKING GROUPS

Requires the Public Health Committee chairpersons to convene working groups on (1) staff safety issues for home health agencies, (2) nonalcoholic fatty liver disease, (3) health issues for nail salon workers, and (4) loneliness and isolation.

The bill requires the Public Health Committee chairpersons to establish four working groups to study the following topics: (1) staff safety issues for home health agencies; (2) nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic steatohepatitis; (3) health issues faced by nail salon workers due to their occupational exposure to health hazards; and (4) ways to address loneliness and isolation.

For each of the working groups created by the bill, the:

1. group must select two co-chairpersons from among its members;
2. Public Health Committee's administrative staff serves in that capacity for the working group;
3. working group must report its findings and recommendations to the committee by January 1, 2025; and
4. working group terminates when it submits the report or on January 1, 2025, whichever is later.

EFFECTIVE DATE: Upon passage

Home Health Safety Working Group (§ 8)

Under the bill, this working group must study staff safety issues affecting home health agencies. The group must at least include three employees of a home health agency, two representatives of such an agency, and one representative each from the following:

1. a collective bargaining unit representing home health employees,
2. a mobile crisis response services provider,
3. an assertive community treatment team,
4. a police department, and
5. an in-state hospital association.

The Public Health Committee chairpersons must schedule the first meeting, to be held by 60 days after the bill's passage.

Nonalcoholic Fatty Liver Disease Working Group (§ 20)

This group's study must at least examine the following in relation to nonalcoholic fatty liver disease:

1. the incidence in Connecticut compared to the entire U.S.;
2. the population groups most affected and at risk of being diagnosed with it, and the main risk factors contributing to this prevalence;
3. strategies to prevent the disease in high-risk populations and how to implement them statewide;
4. ways to increase public awareness about the disease, including public awareness campaigns about liver health;
5. whether to recommend a statewide screening program for at-risk populations;
6. policy changes needed to improve patient care and outcomes;

7. insurance coverage and affordability issues affecting treatment access;

8. creating patient advocacy and support networks; and

9. how social determinants of health influence the disease's risk and outcomes, and needed interventions to address them.

The working group must at least include the following members:

1. a physician with expertise in hepatology and gastroenterology, representing an in-state higher education institution;

2. three people in the state living with nonalcoholic fatty liver disease;

3. a representative of an in-state patient advocacy organization;

4. a social worker with experience working with communities in the state's underserved areas and addressing social determinants of health;

5. an in-state health care policy expert with experience advising on regulatory frameworks, health care access, and insurance issues;

6. an in-state nutritionist and dietician with experience providing guidance on preventative measures and dietary interventions related to the disease;

7. a community health worker who works directly with the state's underserved communities addressing social determinants of health;

8. a representative of an in-state nonprofit organization focused on liver health; and

9. the DPH commissioner or her designee.

The Public Health Committee chairpersons must convene the first meeting, to be held by 60 days after the bill's passage.

Nail Salon Worker Health Hazards Working Group (§ 21)

The bill requires this group to study health issues experienced by nail salon workers due to their exposure to health hazards at work. The study must at least include (1) identifying these hazards, (2) ways to reduce nail salon workers' exposure to them, (3) best practices for preventing these workers from acquiring health issues from exposure to these hazards, and (4) assessing the strengths of other states' policies on protecting nail salon workers' health.

The group must include at least the following members:

1. three nail technicians, each employed by a different in-state nail salon;
2. three owners or managers of different in-state nail salons;
3. a state-licensed health care professional with experience treating patients for illnesses attributable to their exposure to health hazards while working in a nail salon;
4. a representative of an in-state labor union;
5. an expert in occupational safety;
6. an expert in environmental health;
7. a director of an in-state municipal health department with at least four nail salons under the department's jurisdiction; and
8. the DPH commissioner or her designee.

The Public Health Committee chairpersons must convene the first meeting, to be held by 60 days after the bill's passage.

Loneliness and Isolation Working Group (§ 36)

Under the bill, this group must study and make recommendations on ways to address loneliness and isolation experienced by people in the state and to improve their social connection. The working group must do the following in relation to people in the state:

1. evaluate the causes of and other factors contributing to this sense of isolation and loneliness, and ways to prevent and eliminate it;

2. recommend local activities, systems, and structures to combat isolation and loneliness, including opportunities for organizing or enhancing in-person community gatherings, especially for people who have lived in isolation for a long time; and

3. explore the possibility of creating municipal-based social connection committees to address the challenges of and potential solutions for combating isolation and loneliness.

The working group must include at least the following members, all from in-state organizations or working in the state, as applicable, unless otherwise specified:

1. two high school teachers, one from an urban high school and one from a rural one;

2. a dining hall manager of a suburban soup kitchen;

3. three high school students, including one who identifies as a member of the LGBTQ+ community, one who identifies as female, and one who identifies as male;

4. two students from higher education institutions, one from a public health school and one from a social work school;

5. two residents of assisted living facilities, one at a facility for veterans and one at a suburban facility;

6. two administration members of senior centers, one in a rural area and one in an urban area;

7. a representative of an organization serving children in an urban area;

8. a representative of an organization representing municipalities;

9. a representative of an organization representing small towns;

10. a representative of an organization working on policies to improve planning and zoning laws to create an inclusive society and improve access to transit-oriented development;

11. a representative of an organization working to improve and create more walkable and accessible main streets;

12. a representative of an organization advocating for people with physical disabilities;

13. an expert (not necessarily from Connecticut) in digital health and identifying safe digital education;

14. a representative of an organization developing mobile applications intended to address loneliness and isolation;

15. two psychiatrists, one who treats adolescents and one who treats adults;

16. a librarian from a rural library;

17. a social worker who practices in an urban area; and

18. the Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) commissioners or their designees.

The Public Health Committee chairpersons must schedule the first meeting, to be held by 60 days after the bill's passage.

§§ 10-18 — GRADUATE PHYSICIANS

Creates a licensure program for medical school graduates meeting certain criteria who did not find residency placements; limits their practice to primary care services and only under a collaborative practice arrangement with a licensed physician, and only for a single two-year licensure period; requires the Medical Examining Board to issue related program rules

The bill allows medical school graduates who have passed the first two steps of the medical licensing examination, but who have not yet

completed a residency, to work as a "graduate physician" for a single two-year licensure period. (By law, to become licensed as a physician, an applicant must have completed a residency, among other requirements.)

Under the bill, a graduate physician generally must work under a collaborative practice arrangement with a state-licensed physician. The arrangement must limit the graduate physician to practicing primary care services, defined as pediatrics, internal medicine, family medicine, obstetrics and gynecology, or psychiatry.

The bill requires the state Medical Examining Board to issue various rules related to graduate physicians, including to set the licensure process. It allows the board to deny a licensure application or suspend or revoke a license for a violation of the bill, the board's rules, or the board's standards of conduct.

The bill allows a physician to serve as a collaborating physician for no more than three graduate physicians at a time.

EFFECTIVE DATE: January 1, 2025

Eligibility (§ 10)

Under the bill, a graduate physician must be a U.S. resident and citizen or resident alien who has graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school in the World Directory of Medical Schools, or its equivalent.

The graduate physician must have completed steps 1 and 2 of the U.S. Medical Licensing Examination (USMLE), or an equivalent exam approved by the National Board of Medical Examiners or National Board of Osteopathic Medical Examiners, within two years immediately before applying for graduate physician licensure, but no more than three years after graduating from a medical school or a school of osteopathic medicine. (The USMLE exam has three steps.)

Supervision Requirements (§§ 11 & 14)

Under the bill, graduate physicians are subject to supervision requirements under the bill itself, any controlling federal law, and any set by the National Board of Medical Examiners. The bill specifies that graduate physicians are not subject to other supervision requirements.

The bill requires a physician collaborating with a graduate physician to be responsible for supervising the graduate physician's activities. The collaborating physician must accept full responsibility for the primary care services provided by the graduate physician.

Collaborative Practice Arrangements (§§ 13, 15 & 18)

Under the bill, to be eligible to practice as a graduate physician, the person must enter into a collaborative practice arrangement with a state-licensed physician, no later than six months after the graduate physician becomes licensed as one. The bill prohibits a graduate physician from practicing or attempting to do so without this arrangement, except as otherwise provided by the bill or as allowed under rules issued by the state Medical Examining Board.

Before entering into the collaborative practice arrangement, the collaborating physician must complete a board-approved certification course on the laws concerning the professional relationship between a collaborating and graduate physician.

A collaborative practice arrangement must be in writing and include mutually agreed-upon protocols or standing orders for the delivery of primary care services. It may delegate to a graduate physician the authority to administer or dispense drugs other than controlled substances and provide treatment, as long as the delivery of services is within the graduate physician's scope practice and is consistent with the skill, training, and competence of both physicians. The collaborating physician must be board certified in the specialty that the graduate physician is practicing.

The bill provides that these practice arrangements supersede any hospital licensing regulations on hospital medication orders under a protocol or standing order for inpatient or emergency care at the

hospital. This applies to protocols or standing orders approved by the hospital's medical staff and pharmaceutical therapeutics committee.

Under the bill, a graduate physician collaborative practice arrangement must contain the following:

1. the complete names, home and business addresses, and telephone numbers of both physicians;

2. a requirement that the graduate physician practice at the same location as the collaborating physician;

3. a requirement that the graduate or collaborating physician prominently display, in every office where the graduate physician may prescribe, a statement informing patients that they may be seen by a graduate physician and advising them of their right to see the collaborating physician;

4. a list of the collaborating physician's specialties and board certifications and the graduate physician's certifications;

5. the manner of collaboration, including how the physicians will engage in collaborative practice consistent with each of their skill, training, education, and competence;

6. a prohibition on the graduate physician providing primary care services to a patient during the collaborating physician's absence from the practice location for any reason;

7. a list of all other such collaborative practice arrangements either physician is a party to;

8. the arrangement's duration; and

9. a requirement that a collaborating physician be on premises if the graduate physician performs primary care services in a hospital or emergency department.

Under the bill, a collaborative practice arrangement also must

address (1) proximity to a hospital and (2) services and chart review, as follows.

Proximity to Hospital; Exception. A collaborative practice arrangement must describe how the physicians will stay nearby a hospital. But the arrangement may allow for this to be waived for up to 28 days per year to provide primary care services in a rural health clinic meeting certain criteria. The collaborating physician must keep documentation related to the geographic proximity requirement and present it to the Connecticut Medical Examining Board upon request.

Services and Chart Review. A collaborative practice arrangement also must describe when and how the collaborating physician will review the graduate physician's delivery of primary care services. The bill sets a schedule for the percentage of the graduate physician's charts that the collaborating physician must review, as follows:

1. First three months of the initial observation year: 100%.

2. The rest of the initial year: 75%.

3. After that: 25%, with the charts submitted every 14 days to the collaborating physician (and at this point, the review can be done by another designated physician).

Use of Titles and ID Badges (§§ 13 & 17)

The bill requires graduate physicians to clearly identity as such. They may use the "doctor" or "Dr." identifiers.

Collaborating and graduate physicians that are parties to a collaborative practice arrangement must wear an identification badge while acting under it, prominently displaying the person's licensure status.

Medical Examining Board Rules (§§ 12 & 16-17)

Licensure and Related Matters. The bill requires the state Medical Examining Board to issue rules to do the following:

1. establish the graduate physician licensure process, supervision requirements, and additional requirements for their collaborative practice arrangements;

2. set licensure fees, including a requirement that the total fees collected each year must at least equal the total costs needed to facilitate collaborative practice arrangements; and

3. address any other matters needed to protect the public and take disciplinary action against participants in these arrangements.

These rules take effect when they are issued as long as they comply with the state's Uniform Administrative Procedure Act.

Collaborative Practice Arrangements. The bill also requires the board to issue rules regulating the use of graduate physician collaborative practice arrangements. These rules must (1) specify the geographic areas to be covered by these arrangements and the treatment methods they may include and (2) require a review of the services provided under them.

The rules also must specify the educational methods and programs that collaborating physicians must implement to facilitate the graduate physician's growth in medical knowledge and capabilities and successful completion of the arrangement, which could lead to credit toward a future residency program. In setting rules on this, the board must consult with the medical school deans and primary care residency program directors in the state.

Consistency With Certain Federal Guidelines. The bill also requires the board to issue rules for graduate physicians that are consistent with federal guidelines for federally qualified health centers. This rulemaking authority does not extend to collaborative practice arrangements governing hospital employees providing inpatient care.

Voluntary Nature of Agreement, Collaborating Physician Authority, Reports to Board, and Related Matters (§ 17)

The bill prohibits any contract or other agreement from requiring,

against the person's will, that a (1) physician act as a collaborating physician for a graduate physician or a (2) graduate physician serve as one for any particular collaborating physician. It allows a physician to refuse to act as a collaborating physician for a particular graduate physician, and a graduate physician to refuse to collaborate with a particular physician, in both cases without penalty.

The bill also prohibits any contract or other agreement from limiting the collaborating physician's authority over any protocols or standing orders or delegating their authority to a graduate physician. But this does not authorize a collaborating physician, in doing these things, to violate a hospital's medical staff standards for safe medical practice.

Under the bill, the Medical Examining Board must require a physician, within 30 days after a licensure change, to identify whether the physician has a collaborative practice arrangement with a graduate physician, and if so, to report to the board the names of those graduate physicians. The board must track this information and may make information about these arrangements publicly available. It also may routinely do reviews or inspections to ensure that the arrangements are being carried out in compliance with the bill.

The bill prohibits the board from denying, revoking, suspending, or otherwise taking disciplinary action against a collaborating physician for the services delegated to a graduate physician, if the physician complies with the board's applicable rules and specified requirements under the bill (such as reporting to the board on his or her collaborative arrangements).

§ 19 — GUN SAFETY EDUCATIONAL MATERIAL DURING PRIMARY CARE VISITS

Requires DPH, in consultation with certain entities, to develop or procure educational material on gun safety practices for primary care providers to give their adult patients; requires these providers to give this material to adult patients annually

The bill requires the DPH commissioner, by January 1, 2025, to develop or obtain educational material on gun safety practices, for primary care providers to give to adult patients (age 18 or older) during

appointments. In doing so, the commissioner must consult with the Commission on Community Gun Violence Intervention and Prevention and the state chapters of national professional associations of physicians, advanced practice registered nurses, and physician assistants (PAs). By February 1, 2025, DPH must (1) make this material available, for free, to all in-state primary care providers for adults and (2) recommend how they can effectively use it.

The bill requires primary care providers to give this material to each of their adult patients annually at their appointments.

EFFECTIVE DATE: July 1, 2024

§ 22 — PRESCRIPTION DRUG SHORTAGE STUDY

Requires the DPH and DCP commissioners to study and report on prescription drug shortages

The bill requires the DPH commissioner, in collaboration with the Department of Consumer Protection (DCP) commissioner, to study incidences of prescription drug shortages in the state and whether the state has a role in alleviating them. By January 1, 2025, the commissioners must jointly report to the General Law and Public Health committees on the study and any legislative recommendations to help alleviate or prevent these shortages.

EFFECTIVE DATE: Upon passage

§ 23 — DCF IN-PERSON HOME VISITS

Requires DCF, when doing a home visit or evaluation under a child's safety plan, to do so in person if the safety plan indicates that a parent or guardian in the home has a substance use disorder

The bill requires the DCF commissioner or her designee to do home visits or evaluations in person, rather than by teleconference, if the department's safety plan indicates that a parent or guardian in the home has a substance use disorder.

Under the bill, a "safety plan" is a plan DCF makes to address or mitigate parent or guardian behaviors or conditions or circumstances in a home that may make the home unsafe for children. A safety plan

specifies (1) actions that have been or will be taken to address or mitigate the unsafe behaviors, conditions, or circumstances; (2) who will do them; and (3) when the department will review the actions.

EFFECTIVE DATE: July 1, 2024

Background — Related Bill

SB 126 (File 8), reported favorably by the Children's Committee, has substantially similar provisions on in-person home visits.

§§ 24 & 25 — LIMITATIONS ON MAINTENANCE OF CERTIFICATION

Specifically prohibits hospitals from requiring a board-certified physician to participate in an MOC program in order to obtain or keep privileges; generally prohibits certain health carriers from (1) denying reimbursement or excluding a provider from a network due to the provider's non-participation in an MOC program, or (2) requiring this participation as a condition of professional liability insurance

Hospital Credentialing

Existing law prohibits hospitals (including their medical review committees) from requiring board-certified physicians to provide credentials of board recertification to obtain or keep their practice privileges. Under the bill, this specifically includes the hospital requiring these physicians to participate in any maintenance of certification (MOC) program required for board recertification.

Insurer Reimbursement, Provider Networks, and Liability Insurance

The bill generally prohibits certain health carriers from denying reimbursement to a health care provider, or excluding a provider from a network, only because the provider is not maintaining a specialty certification through an MOC program. It also generally prohibits these entities from requiring a provider to maintain a specialty certification through an MOC program as a condition of getting professional liability insurance or other malpractice coverage. These provisions apply as long as the provider does not hold himself or herself out as a specialist under a specialty certification.

For purposes of these insurance provisions, "maintenance of certification" is any process requiring periodic recertification

examinations or other professional development activities to maintain specialty certification. A "specialty certification" is any certification by a medical board that specializes in one area of medicine and has requirements in addition to state licensing requirements.

The bill applies to insurers and other entities that deliver, issue, renew, amend, or continue individual or group policies on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage, except the insurer-related provisions take effect January 1, 2025.

§§ 26 & 27 — OPIOID DEACTIVATION AND DISPOSAL SYSTEMS

Requires pharmacists who dispense opioids to give the patient, for free, a personal drug deactivation and disposal system if funding is available for this, and allows pharmacies and pharmacists to seek reimbursement from the Opioid Settlement Fund for this purpose

The bill requires pharmacists, when dispensing opioids, to also give the patient a free personal opioid drug deactivation and disposal system if funding is available for this. Under the bill, these systems are products designed for personal use that allow patients to permanently deactivate and destroy opioids.

The bill allows pharmacies or pharmacists to seek reimbursement from the Opioid Settlement Advisory Committee for their documented expenses in giving these systems to patients. It makes a corresponding change by adding these expenses to the list of allowable purposes for which the Opioid Settlement Fund may be used (see *Background — Opioid Settlement Fund and Advisory Committee*).

The bill exempts pharmacies or pharmacists from incurring any expenses for giving these drug deactivation and disposal systems, and they are not required to give them out if funding is unavailable (from the settlement fund or otherwise).

The bill allows the DCP commissioner to adopt related regulations implementing its provisions on pharmacies and pharmacists.

EFFECTIVE DATE: October 1, 2024

Background — Opioid Settlement Fund and Advisory Committee

In 2022, the legislature established an Opioid Settlement Fund as a separate non-lapsing fund administered by an Opioid Settlement Advisory Committee with assistance from DMHAS. The fund must contain moneys the state receives from opioid-related judgments, consent decrees, or settlements finalized on or after July 1, 2021. Opioid Settlement Fund moneys must be used only for specified substance use disorder abatement purposes, upon approval of the committee and the Office of Policy and Management secretary (CGS § 17a-674c).

By law, the Opioid Settlement Advisory Committee must ensure (1) that Opioid Settlement Fund moneys are allocated and spent for proper purposes and (2) robust public involvement, accountability, and transparency in allocating and accounting for the fund's moneys (CGS § 17a-674d).

§ 28 — PHYSICIANS AND PHYSICIAN ASSISTANTS UNDER THE STATE LABOR RELATIONS ACT

Removes an exemption from the state Labor Relations Act for physicians and PAs who work at DPH-licensed institutions

The bill removes a current exemption from the state Labor Relations Act for physicians or PAs who are employed by a DPH-licensed institution. Under current law, private-sector DPH-licensed institutions are subject to this act for all of their employees except for physicians and PAs. It appears that in removing this exemption, the bill allows these providers to unionize in certain limited situations when they cannot under current law.

The state Labor Relations Act, which sets rules on unionization and related matters, generally covers private-sector employers who are not subject to the National Labor Relations Act (NLRA), unless the National Labor Relations Board has declined to assert jurisdiction. Generally, as

with most other private sector employees, physicians and PAs are covered by the NLRA if they are directly employed by their employer and are not "supervisors." In practice, physicians are sometimes, but not always, considered to be supervisors for purposes of the NLRA.

Unlike the NLRA, the state Labor Relations Act includes "supervisors" within its general definition of employee.

EFFECTIVE DATE: October 1, 2024

§§ 29 & 30 — INSURANCE COVERAGE OF CORONARY CALCIUM SCANS

Requires certain insurance policies to cover coronary calcium scans

The bill requires certain health insurance policies to cover coronary calcium scans. Under the bill, these are CT scans of the heart looking for calcium deposits in arteries.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

The bill also applies these requirements to high deductible health plans (HDHP) to the maximum extent permitted by federal law. If the HDHP is used to establish a health savings or similar account, the bill applies to the maximum extent permitted by federal law that does not affect the account's tax preferred status.

EFFECTIVE DATE: January 1, 2025

§§ 31 & 32 — CYBER SECURITY EVENTS

Requires DPH, in collaboration with the state's Chief Information Security Officer, to develop an initiative for health care facility readiness during cyber security events, and appropriates $25,000 per year for four years to DESPP for a related annual meeting

The bill requires DPH's Office of Public Health Preparedness and

Response, by January 1, 2025, and in collaboration with the state's Chief Information Security Officer, to develop an initiative for DPH-licensed health care facilities' readiness during cyber security events. These events are observable occurrences that could impact the security of computer systems, networks, or data.

The initiative must be part of the state's public health emergency response plan. It must at least include, as necessary or appropriate for each health care facility, that facilities acquire or establish the following for use during cyber security events:

1. a radio communication system that enables the facility's various units to continue functioning;

2. a separate intranet system for secure communications within the facility;

3. fax machines, local printers, or local laptops for printing and intranet communications;

4. medical devices that are not connected to the internet;

5. an intranet-based emergency management information system to document routine and emergency events or incidents;

6. a diversion management system for hospital emergency departments to communicate to emergency medical services organizations, other first responders, and patients the need to divert patients seeking emergency services to another emergency department or facility; and

7. ways to communicate and coordinate with DSS and health carriers to reduce the risk of a sudden reduction in cash flow due to health care billing disruptions.

The bill also appropriates $25,000 per year for four years (FYs 25 through 28) to DESPP, for an annual meeting focused on preventing, identifying, and managing cyber security events.

The meetings must at least include representatives from DPH; DESPP's Division of Emergency Management and Homeland Security; the state National Guard; and other local, regional, and statewide law enforcement agencies dealing with cyber security events.

The meetings must consider creating cyber security event command scenarios. They also must consider the functions and training of the following people within hospitals while working without technology:

1. those working with pharmaceuticals, to ensure safe medication administration and documentation;

2. those working with laboratory samples and testing and related reporting, to ensure safe and accurate documentation and communication; and

3. those performing imaging studies and testing and related reporting, to ensure this documentation and communication.

EFFECTIVE DATE: Upon passage, except the appropriation and meeting provisions take effect July 1, 2024.

§ 33 — HEALTHY BRAIN INITIATIVE

Requires DPH, in collaboration with the Office of Health Strategy, to develop a plan to address health conditions affecting the brain

The bill requires DPH, by January 1, 2025, and in collaboration with the Office of Health Strategy, to establish a healthy brain initiative. They must do so by developing a plan to address health conditions affecting the brain, such as Alzheimer's disease, dementia, Parkinson's disease, stroke, and epilepsy.

By January 1, 2025, the DPH commissioner must report to the Public Health Committee on the plan and the department's anticipated date to implement it.

EFFECTIVE DATE: Upon passage

Plan to Address Brain-Affecting Health Conditions

Under the bill, the plan must at least include the following objectives:

1. strengthening (a) policies on preventing and treating these health conditions and (b) partnerships with organizations and health care providers to develop these policies;

2. evaluating and using data on these conditions;

3. building a skilled and diverse health care work force to engage in prevention efforts and treat people with these conditions, including by obtaining grant funding and using data to estimate and address the gap between workforce capacity and the anticipated demand for related health care services;

4. educating the public on these health conditions, ways to prevent them, and treatment options;

5. establishing a disease management program to promote early diagnosis of these conditions and develop protocols for providing education, care consultation, and referrals for medical and social services to patients and their caregivers, including through collaborations among in-state teaching hospitals and partnerships with nonprofits that deliver support services promoting the mental and physical health of these people, their caregivers, and family members; and

6. creating a program specifically for people with dementia, including (a) community-based opportunities for exercise, self-care, and caregiver education; (b) peer support groups and social gatherings for these patients and their caregivers, family members, and friends; (c) providing information on DPH's website on dementia and support for all of these people; (d) developing mobile apps allowing caregivers and family members to track these patients using personal GPS units or cell phones with GPS; (e) adult day care networks; and (f) transportation services.

§ 34 — PARKINSON'S DISEASE REGISTRY

Requires (1) DPH to maintain and operate a Parkinson's disease registry and (2) hospitals and certain health care providers to submit data to the registry as DPH requires, subject to patients opting out; establishes a data oversight committee to monitor the registry's activities

The bill requires DPH, by July 1, 2025, to maintain and operate a statewide data registry on Parkinson's disease and Parkinsonism (which generally refers to a range of symptoms associated with Parkinson's disease and certain other conditions). Hospitals, physicians, physician assistants, and nurses must make available to the registry data, as required by DPH regulations, on patients admitted to the hospital or treated by these providers for these conditions. Hospitals and these providers must give patients a notice about these disclosures to the registry and an opportunity to opt out.

DPH and authorized researchers can use the registry data, but they must keep confidential any personally identifiable patient information (i.e., not subject to disclosure or admissible as evidence in a court or agency proceeding, and used only for medical or scientific research). The bill exempts registry data from Freedom of Information Act disclosure.

Under the bill, hospitals must give DPH access to their records, as the department deems necessary, to perform case findings or other quality improvement audits to ensure the completeness of the registry reporting and data accuracy.

The bill allows the commissioner to contract with an in-state nonprofit Parkinson's disease and Parkinsonism association to implement and administer the registry. She may also enter into (1) a contract for receiving, storing, and maintaining the registry data and (2) reciprocal reporting agreements with other states to exchange Parkinson's disease and Parkinsonism data.

Additionally, the bill requires DPH to establish a Parkinson's disease and Parkinsonism data oversight committee. The committee must (1) monitor the registry's operation; (2) give advice on its oversight; and (3) develop a plan to improve the quality of Parkinson's disease and Parkinsonism care, address any disparities in this care, and develop

related short- and long-term goals for improving care.

The bill allows DPH to adopt regulations to implement these provisions.

EFFECTIVE DATE: Upon passage

Data Oversight Committee

Under the bill, the DPH commissioner must appoint at least 16 members to the committee, including a:

1. neurologist;
2. movement disorder specialist;
3. primary care provider;
4. neuropsychiatrist who treats Parkinson's disease;
5. patient living with the disease;
6. public health professional;
7. population health researcher with experience in statewide health condition data registries;
8. patient advocate;
9. family caregiver of someone with Parkinson's disease;
10. representative of a Parkinson's disease-related nonprofit organization;
11. physical therapist, speech therapist, and social worker and an occupational therapist, each with experience working with people with the disease;
12. geriatric specialist; and
13. palliative care specialist.

The commissioner must make her appointments by June 1, 2025, and members serve two-year terms. She must appoint a committee chairperson from among the members, and the chairperson must schedule the committee's first meeting by July 1, 2025.

The bill requires DPH to assist the committee in its work and provide any data or information the committee deems necessary to fulfill its duties, unless state or federal law prohibits the disclosure.

The committee's chairperson, starting by January 1, 2026, must annually report to the Public Health Committee and DPH commissioner on the committee's work.

§ 35 — RECENT-ONSET SCHIZOPHRENIA SPECTRUM DISORDER

Requires DMHAS, in consultation with DCF, to create a program providing specialized treatment for people with recent-onset schizophrenia spectrum disorder

The bill requires the DMHAS commissioner, in consultation with the DCF commissioner, to establish a program at an in-state hospital for people diagnosed with recent-onset schizophrenia spectrum disorder.

The DMHAS commissioner, starting by January 1, 2025, must annually report to the Public Health committee on (1) the functions and outcomes of the program for specialized treatment early in psychosis and (2) any legislative recommendations to address the needs of people diagnosed with recent-onset schizophrenic spectrum disorders.

EFFECTIVE DATE: Upon passage

Program Components

Under the bill, the program must provide specialized treatment for these people early in their psychosis. It also must serve as a hub for distributing information statewide on best practices for providing early intervention services.

The program must address the limited knowledge of this disorder with regard to its region-specific treatment needs and disparities, and the prevalence of first-episode psychosis in people diagnosed with it. It also must address the funding and reimbursement for available early

intervention services and the uncertainty regarding clinicians' availability and readiness to implement those services for patients and their families.

Under the bill, the program must do the following:

1. develop structured curricula, online resources, and videoconferencing-based case conferences to distribute information for the development of knowledge and skills relevant to patients with first-episode psychosis and their families;

2. assess and improve the quality of early intervention services available to people diagnosed with a recent-onset schizophrenic spectrum disorder across the state;

3. provide expert input on complex cases and launch a referral system for consultation with experts in treating these disorders;

4. share lessons and resources from any campaigns aimed at reducing the duration of untreated psychosis to improve local pathways to care;

5. serve as an incubator for new evidence-based treatment approaches and pilot them across the state;

6. advocate for policies on the financing, regulation, and provision of services for people with these disorders; and

7. collaborate with state agencies to improve outcomes for people diagnosed with first-episode psychosis in areas such as crisis and employment services.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 25 Nay 12 (03/20/2024)