



Substitute Senate Bill No. 248

Public Act No. 10-122

AN ACT CONCERNING THE REPORTING OF ADVERSE EVENTS AT HOSPITALS AND OUTPATIENT SURGICAL FACILITIES AND ACCESS TO INFORMATION RELATED TO PENDING COMPLAINTS FILED WITH THE DEPARTMENT OF PUBLIC HEALTH.

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

Section 1. Section 19a-127n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) (1) For purposes of this section, an "adverse event" means any event that is identified on the National Quality Forum's List of Serious Reportable Events or on a list compiled by the Commissioner of Public Health and adopted as regulations pursuant to subsection [(d)] (c) of this section; and "corrective action plan" means a plan that (A) implements strategies that are reflective of evidenced-based best practices and that reduce the risk of similar adverse events occurring in the future, and (B) measures the effectiveness of such strategies by addressing the implementation, oversight and time lines of such strategies.

(2) The commissioner shall review the list of adverse events periodically, but not less than annually, to ascertain whether any additions, deletions or modifications to the list are necessary.

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(b) On and after October 1, 2002, a hospital or outpatient surgical facility shall report adverse events to the Department of Public Health on a form prescribed by the [Commissioner of Public Health] commissioner as follows: (1) A written report and the status of any corrective steps shall be submitted not later than seven days after the date on which the adverse event occurred; and (2) a corrective action plan shall be filed not later than thirty days after the date on which the adverse event occurred. Emergent reports, as defined in the regulations adopted pursuant to subsection (c) of this section, shall be made to the department immediately. Failure to implement a corrective action plan may result in disciplinary action by the commissioner, pursuant to section 19a-494.

(c) The [Commissioner of Public Health] commissioner shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section. Such regulations shall include, but shall not be limited to, a list of adverse events that are in addition to those contained in the National Quality Forum's List of Serious Reportable Events.

(d) On or before October first annually, the commissioner shall report, in accordance with the provisions of section 11-4a, on adverse event reporting, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. For annual reports submitted on or after July 1, 2011, the commissioner shall include hospital and outpatient surgical facility adverse event information for each facility identified (1) by the National Quality Forum's List of Serious Reportable Events category, and (2) in accordance with any list compiled by the commissioner and adopted as regulations pursuant to subsection (c) of this section. Such reports shall be prepared in a format that uses relevant contextual information. For purposes of this subsection "contextual information" includes, but is not limited to, (A) the relationship between the number of adverse events and a hospital's total number of patient days or an outpatient

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surgical facility's total number of surgical encounters expressed as a fraction in which the numerator is the aggregate number of adverse events reported by each hospital or outpatient surgical facility by category as specified in this subsection and the denominator is the total of the hospital's patient days or the outpatient surgical facility's total number of surgical encounters, and (B) information concerning the patient population served by the hospital or outpatient surgical facility, including such hospital's or outpatient surgical facility's payor or case mix. In addition, a hospital or outpatient surgical facility may provide informational comments relating to any adverse event reported to the commissioner pursuant to this section. On and after July 1, 2011, any report submitted by the commissioner pursuant to this subsection shall include any informational comments received concerning an adverse event that is included in the report.

(e) Information collected pursuant to this section shall not be disclosed pursuant to subsection (a) of section 1-210 at any time, and information collected pursuant to this section shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except as otherwise specifically provided by law. Nothing in this section shall be construed to limit access to or disclosure of investigative files, including any adverse event report contained in such files, maintained by the department as otherwise provided in section 19a-499.

(f) If the department determines that it will initiate an investigation of an adverse event that has been reported, such investigation may include review by one or more practitioners with clinical expertise of the type involved in the reported adverse event.

(g) [The Quality of Care Advisory Committee established pursuant to section 19a-127l shall establish methods for informing the public regarding access to the department's consumer and regulatory services.] No hospital or outpatient surgical facility shall discharge,

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refuse to hire, refuse to serve, retaliate in any manner or take any adverse action against any employee, applicant for employment or health care provider because such employee, applicant for employment or health care provider takes or has taken any action in furtherance of the enforcement of the provisions of this section.

Sec. 2. Section 19a-127l of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) There is established a quality of care program within the Department of Public Health. The department shall develop for the purposes of said program (1) a standardized data set to measure the clinical performance of health care facilities, as defined in section 19a-630, and require such data to be collected and reported periodically to the department, including, but not limited to, data for the measurement of comparable patient satisfaction, and (2) methods to provide public accountability for health care delivery systems by such facilities. The department shall develop such set and methods for hospitals during the fiscal year ending June 30, 2003, and the committee established pursuant to subsection (c) of this section shall consider and may recommend to the joint standing committee of the General Assembly having cognizance of matters relating to public health the inclusion of other health care facilities in each subsequent year.

(b) In carrying out its responsibilities under subsection (a) of this section, the department shall develop the following for the quality of care program:

(1) Comparable performance measures to be reported;

(2) Selection of patient satisfaction survey measures and instruments;

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- (3) Methods and format of standardized data collection;
- (4) Format for a public quality performance measurement report;
- (5) Human resources and quality measurements;
- (6) Medical error reduction methods;
- (7) Systems for sharing and implementing universally accepted best practices;
- (8) Systems for reporting outcome data;
- (9) Systems for continuum of care;
- (10) Recommendations concerning the use of an ISO 9000 quality auditing program;
- (11) Recommendations concerning the types of statutory protection needed prior to collecting any data or information under this section and sections 19a-127m and 19a-127n, as amended by this act; and
- (12) Any other issues that the department deems appropriate.

(c) (1) There is established a Quality of Care Advisory Committee which shall advise the Department of Public Health on the issues set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section. The advisory committee shall meet at least semiannually.

(2) Said committee shall create a standing subcommittee on best practices. The subcommittee shall (A) advise the department on effective methods for sharing with providers the quality improvement information learned from the department's review of reports and corrective action plans, including quality improvement practices, patient safety issues and preventative strategies, (B) not later than January 1, 2006, review and make recommendations concerning best

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practices with respect to when breast cancer screening should be conducted using comprehensive ultrasound screening or mammogram examinations, and (C) not later than January 1, 2008, study and make recommendations to the department concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists. The department shall, at least quarterly, disseminate information regarding quality improvement practices, patient safety issues and preventative strategies to the subcommittee and hospitals.

(d) The advisory committee shall consist of (1) four members who represent and shall be appointed by the Connecticut Hospital Association, including three members who represent three separate hospitals that are not affiliated of which one such hospital is an academic medical center; (2) one member who represents and shall be appointed by the Connecticut Nursing Association; (3) two members who represent and shall be appointed by the Connecticut Medical Society, including one member who is an active medical care provider; (4) two members who represent and shall be appointed by the Connecticut Business and Industry Association, including one member who represents a large business and one member who represents a small business; (5) one member who represents and shall be appointed by the Home Health Care Association; (6) one member who represents and shall be appointed by the Connecticut Association of Health Care Facilities; (7) one member who represents and shall be appointed by the Connecticut Association of Not-For-Profit Providers for the Aging; (8) two members who represent and shall be appointed by the AFL-CIO; (9) one member who represents consumers of health care services and who shall be appointed by the Commissioner of Public Health; (10) one member who represents a school of public health and who shall be appointed by the Commissioner of Public Health; (11) the Commissioner of Public Health or said commissioner's designee; (12) the Commissioner of Social Services or said commissioner's designee;

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(13) the Secretary of the Office of Policy and Management or said secretary's designee; (14) two members who represent licensed health plans and shall be appointed by the Connecticut Association of Health Care Plans; (15) one member who represents and shall be appointed by the federally designated state peer review organization; and (16) one member who represents and shall be appointed by the Connecticut Pharmaceutical Association. The chairperson of the advisory committee shall be the Commissioner of Public Health or said commissioner's designee. The chairperson of the committee, with a vote of the majority of the members present, may appoint ex-officio nonvoting members in specialties not represented among voting members. Vacancies shall be filled by the person who makes the appointment under this subsection.

(e) The chairperson of the advisory committee may designate one or more working groups to address specific issues and shall appoint the members of each working group. Each working group shall report its findings and recommendations to the full advisory committee.

(f) The Commissioner of Public Health shall report on the quality of care program on or before June 30, 2003, and annually thereafter, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health and to the Governor. Each report on said program shall include activities of the program during the prior year and a plan of activities for the following year.

(g) On or before April 1, 2004, the Commissioner of Public Health shall prepare a report, available to the public, that compares all licensed hospitals in the state based on the quality performance measures developed under the quality of care program.

(h) (1) The advisory committee shall examine and evaluate (A) possible approaches that would aid in the utilization of an existing

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data collection system for cardiac outcomes, and (B) the potential for state-wide use of a data collection system for cardiac outcomes, for the purpose of continuing the delivery of quality cardiac care services in the state.

(2) On or before December 1, 2007, the advisory committee shall submit, in accordance with the provisions of section 11-4a, the results of the examination authorized by this subsection, along with any recommendations, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(i) The advisory committee shall establish methods for informing the public regarding access to the department's consumer and regulatory services.

~~[(i)]~~ (j) The Department of Public Health may seek out funding for the purpose of implementing the provisions of this section. Said provisions shall be implemented upon receipt of [said] such funding.

Sec. 3. Section 19a-14 of the 2010 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2010*):

(a) The Department of Public Health shall have the following powers and duties with regard to the boards and commissions listed in subsection (b) of this section which are within the Department of Public Health. The department shall:

(1) Control the allocation, disbursement and budgeting of funds appropriated to the department for the operation of the boards and commissions;

(2) Employ and assign such personnel as the commissioner deems necessary for the performance of the functions of the boards and

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commissions;

(3) Perform all management functions including purchasing, bookkeeping, accounting, payroll, secretarial, clerical and routine housekeeping functions;

(4) Adopt, with the advice and assistance of the appropriate board or commission, and in accordance with chapter 54, any regulations which are consistent with protecting the public health and safety and which are necessary to implement the purposes of subsection (a) of section 2c-2b, this chapter, and chapters 368v, 369 to 375, inclusive, 378 to 381, inclusive, 383 to 388, inclusive, 398 and 399;

(5) Develop and perform all administrative functions necessary to process applications for licenses and certificates;

(6) Determine the eligibility of all applicants for permits, licensure, certification or registration, based upon compliance with the general statutes and administrative regulations. The department may deny the eligibility of an applicant for a permit or for licensure by examination, endorsement, reciprocity or for reinstatement of a license voided pursuant to subsection (f) of section 19a-88, or may issue a license pursuant to a consent order containing conditions that must be met by the applicant if the department determines that the applicant:

(A) Has failed to comply with the general statutes and administrative regulations governing [his] the applicant's profession;

(B) Has been found guilty or convicted as a result of an act which constitutes a felony under (i) the laws of this state, (ii) federal law or (iii) the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state;

(C) Is subject to a pending disciplinary action or unresolved complaint before the duly authorized professional disciplinary agency

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of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;

(D) Has been subject to disciplinary action similar to an action specified in subsection (a) of section 19a-17 by a duly authorized professional disciplinary agency of any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;

(E) Has committed an act which, if the applicant were licensed, would not conform to the accepted standards of practice of the profession, including, but not limited to, incompetence, negligence, fraud or deceit; illegal conduct; procuring or attempting to procure a license, certificate or registration by fraud or deceit; or engaging in, aiding or abetting unlicensed practice of a regulated profession, provided the commissioner, or [his] the commissioner's designee, gives notice and holds a hearing, in accordance with the provisions of chapter 54, prior to denying an application for a permit or a license based on this subparagraph; or

(F) Has a condition which would interfere with the practice of [his] the applicant's profession, including, but not limited to, physical illness or loss of skill or deterioration due to the aging process, emotional disorder or mental illness, abuse or excessive use of drugs or alcohol, provided the commissioner, or [his] the commissioner's designee, gives notice and holds a hearing in accordance with the provisions of chapter 54, prior to denying an application for a permit or a license based on this subparagraph;

(7) Administer licensing examinations under the supervision of the appropriate board or commission;

(8) Develop and perform all administrative functions necessary to process complaints against persons licensed by the department;

(9) Consent to the approval or disapproval by the appropriate

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boards or commissions of schools at which educational requirements shall be met;

(10) Conduct any necessary review, inspection or investigation regarding qualifications of applicants for licenses or certificates, possible violations of statutes or regulations, and disciplinary matters. In connection with any investigation, the Commissioner of Public Health or [said] the commissioner's authorized agent may administer oaths, issue subpoenas, compel testimony and order the production of books, records and documents. If any person refuses to appear, to testify or to produce any book, record or document when so ordered, a judge of the Superior Court may make such order as may be appropriate to aid in the enforcement of this section;

(11) Conduct any necessary investigation and follow-up in connection with complaints regarding persons subject to regulation or licensing by the department;

(12) With respect to any complaint filed with the department on or after October 1, 2010, alleging incompetence, negligence, fraud or deceit by a person subject to regulation or licensing by any board or commission described in subdivision (1) to (5), inclusive, (7), (8), (12) to (14), inclusive, or (16) of subsection (b) of this section:

(A) Upon request of the person who filed the complaint, provide such person with information on the status of the complaint;

(B) Upon request of the person who filed the complaint, provide such person with an opportunity to review, at the department, records compiled as of the date of the request pursuant to any investigation of the complaint, including, but not limited to, the respondent's written response to the complaint, except that such person shall not be entitled to copy such records and the department (i) shall not disclose (I) information concerning a health care professional's referral to,

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participation in or completion of an assistance program in accordance with sections 19a-12a and 19a-12b, that is confidential pursuant to section 19a-12a, (II) information not related to such person's specific complaint, including, but not limited to, information concerning patients other than such person, or (III) personnel or medical records and similar files the disclosure of which would constitute an invasion of personal privacy pursuant to section 1-210, except for such records or similar files solely related to such person; (ii) shall not be required to disclose any other information that is otherwise confidential pursuant to federal law or state statute, except for information solely related to such person; and (iii) may require up to ten business days written notice prior to providing such opportunity for review;

(C) Prior to resolving the complaint with a consent order, provide the person who filed the complaint with not less than ten business days to submit a written statement as to whether such person objects to resolving the complaint with a consent order;

(D) If a hearing is held with respect to such complaint after a finding of probable cause, provide the person who filed the complaint with a copy of the notice of hearing issued pursuant to section 4-177, which shall include information concerning the opportunity to present oral or written statements pursuant to subsection (b) of section 4-177c; and

(E) Notify the person who filed the complaint of the final disposition of such complaint not later than seven business days after such final disposition;

[(12)] (13) Perform any other function necessary to the effective operation of a board or commission and not specifically vested by statute in the board or commission;

[(13)] (14) Contract with a third party, if the commissioner deems necessary, to administer licensing examinations and perform all

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attendant administrative functions in connection with such examination.

(b) The department shall have the powers and duties indicated in subsection (a) of this section with regard to the following professional boards and commissions:

(1) The Connecticut Medical Examining Board, established under section 20-8a;

(2) The Connecticut State Board of Examiners for Optometrists, established under subsections (a) to (c), inclusive, of section 20-128a;

(3) The Connecticut State Board of Examiners for Nursing, established under section 20-88;

(4) The Dental Commission, established under section 20-103a;

(5) The Board of Examiners of Psychologists, established under section 20-186;

(6) The Connecticut Board of Veterinary Medicine, established under section 20-196;

(7) The Connecticut Homeopathic Medical Examining Board, established under section 20-8;

(8) The Connecticut State Board of Examiners for Opticians, established under subsections (a) to (c), inclusive, of section 20-139a;

(9) The Connecticut State Board of Examiners for Barbers and Hairdressers and Cosmeticians, established under section 20-235a;

(10) The Connecticut Board of Examiners of Embalmers and Funeral Directors established under section 20-208;

(11) Repealed by P.A. 99-102, S. 51;

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(12) The State Board of Natureopathic Examiners, established under section 20-35;

(13) The State Board of Chiropractic Examiners, established under section 20-25;

(14) The Connecticut Board of Examiners in Podiatry, established under section 20-51;

(15) The Board of Examiners of Electrologists, established under section 20-268; and

(16) The Connecticut State Board of Examiners for Physical Therapists.

(c) No board shall exist for the following professions that are licensed or otherwise regulated by the Department of Public Health:

(1) Speech and language pathologist and audiologist;

(2) Hearing instrument specialist;

(3) Nursing home administrator;

(4) Sanitarian;

(5) Subsurface sewage system installer or cleaner;

(6) Marital and family therapist;

(7) Nurse-midwife;

(8) Licensed clinical social worker;

(9) Respiratory care practitioner;

(10) Asbestos contractor and asbestos consultant;

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- (11) Massage therapist;
- (12) Registered nurse's aide;
- (13) Radiographer;
- (14) Dental hygienist;
- (15) Dietitian-Nutritionist;
- (16) Asbestos abatement worker;
- (17) Asbestos abatement site supervisor;
- (18) Licensed or certified alcohol and drug counselor;
- (19) Professional counselor;
- (20) Acupuncturist;
- (21) Occupational therapist and occupational therapist assistant;
- (22) Lead abatement contractor, lead consultant contractor, lead consultant, lead abatement supervisor, lead abatement worker, inspector and planner-project designer;
- (23) Emergency medical technician, advanced emergency medical technician, emergency medical responder and emergency medical services instructor;
- (24) Paramedic;
- (25) Athletic trainer;
- (26) Perfusionist; and
- (27) On and after July 1, 2011, a radiologist assistant, subject to the provisions of section 20-74tt.

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The department shall assume all powers and duties normally vested with a board in administering regulatory jurisdiction over such professions. The uniform provisions of this chapter and chapters 368v, 369 to 381a, inclusive, 383 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c, including, but not limited to, standards for entry and renewal; grounds for professional discipline; receiving and processing complaints; and disciplinary sanctions, shall apply, except as otherwise provided by law, to the professions listed in this subsection.

(d) Except as provided in section 20-13e, as amended by this act, all records obtained by the department in connection with any investigation of a person or facility over which the department has jurisdiction under this chapter, other than a physician as defined in subdivision (5) of section 20-13a, shall not be subject to disclosure under section 1-210 for a period of one year from the date of the petition or other event initiating such investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A complaint, as defined in subdivision (6) of section 19a-13, shall be subject to the provisions of section 1-210 from the time that it is served or mailed to the respondent. Records [which] that are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this chapter. Records disclosed to a person who files a complaint pursuant to subdivision (12) of subsection (a) of this section that are otherwise confidential shall not be deemed public records merely because they have been disclosed pursuant to said subdivision (12).

Sec. 4. Section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2010*):

(a) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of [subdivision]

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subdivisions (10) and (11) of subsection (a) of section 19a-14, as amended by this act, to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (d) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, at the conclusion of such eighteen-month period. Any such investigation shall be confidential and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open, except that the department shall provide information to the person who filed the complaint pursuant to subdivision (12) of subsection (a) of section 19a-14, as amended by this act. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in [a rehabilitation] an assistance program in accordance with the provisions of sections 19a-12a and 19a-12b. The petition and all records of any physician determined to be eligible for participation in [a rehabilitation] an assistance program prior to June 11, 2007, shall remain confidential during the physician's participation and upon successful completion of the [rehabilitation] assistance program, in accordance with the terms and conditions agreed upon by the physician and the department. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause, the petition and the entire record of such investigation shall remain confidential, except as provided in subdivision (12) of subsection (a) of section 19a-14, as amended by this act, unless the physician requests that such petition and record be open.

(b) As part of an investigation of a petition filed pursuant to

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subsection (a) of section 20-13d, the Department of Public Health may order the physician to submit to a physical or mental examination, to be performed by a physician chosen from a list approved by the department. The department may seek the advice of established medical organizations or licensed health professionals in determining the nature and scope of any diagnostic examinations to be used as part of any such physical or mental examination. The examining physician shall make a written statement of his or her findings.

(c) If the physician fails to obey a department order to submit to examination or attend a hearing, the department may petition the superior court for the judicial district of Hartford to order such examination or attendance, and said court or any judge assigned to said court shall have jurisdiction to issue such order.

(d) Subject to the provisions of section 4-182, no license shall be restricted, suspended or revoked by the board, and no physician's right to practice shall be limited by the board, until the physician has been given notice and opportunity for hearing in accordance with the regulations established by the commissioner.

Sec. 5. (NEW) (*Effective July 1, 2010*) (a) There shall be mandatory mediation for all civil actions brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider. Each such civil action for which a valid certificate has been filed pursuant to section 52-190a of the general statutes shall be referred to mandatory mediation pursuant to subsection (b) of this section, unless the civil action is referred to another alternative dispute resolution program agreed to by the parties. Mandatory mediation under this section shall be conducted for the purpose of achieving a prompt settlement or resolution of the civil action. For the purposes of this section, "health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general

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statutes, an institution, as defined in section 19a-490 of the general statutes, or any other health care provider described in subsection (a) of section 52-184b of the general statutes.

(b) Prior to the close of pleadings in such civil action, the presiding judge of the civil session of the court of the judicial district in which the action is pending shall refer the action to mandatory mediation or any other alternative dispute resolution program agreed to by the parties. The duration of the referral shall not exceed one hundred twenty days unless the court, for good cause shown, extends the duration of the referral. The court shall stay the time periods within which all further pleadings, motions, requests, discovery and other procedures must be filed or undertaken, including, but not limited to, filings under section 52-192a of the general statutes, except with respect to any apportionment complaint under section 52-102b of the general statutes.

(c) Mediation under this section shall begin as soon as practicable, but not later than twenty business days after the date the action is referred under subsection (b) of this section. The first mediation session shall be conducted by the presiding judge or, at the discretion of the presiding judge, a different judge of the superior court or a senior judge or judge trial referee. At the first mediation session, the judge, senior judge or judge trial referee conducting the mediation session shall determine whether the action can be resolved at such mediation session, or, if the action cannot be resolved at that mediation session, whether the parties agree to participate in further mediation. If the action is not resolved at the first mediation session and the parties do not agree to further mediation, mandatory mediation under this section shall end. If the action is not resolved at the first mediation session and the parties agree to further mediation, the presiding judge of such civil session shall refer the action for mediation before an attorney who has experience as an attorney related to such civil actions

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and who has been a member of the bar of the state of Connecticut for at least five years. Upon such referral, mediation shall begin as soon as practicable, but not later than twenty business days after the referral. Fifty per cent of the cost of such mediation shall be paid by the plaintiffs, and fifty per cent of the cost of such mediation shall be apportioned among all defendants who are parties to the mediation.

(d) Each party to such action, and a representative of each insurer that may be liable to pay a claim on behalf of a defendant pursuant to such action, shall appear in person at each mediation session, unless participation by telephone or electronic means is permitted by the judge, senior judge, judge trial referee or mediator.

(e) If such mediation does not settle or conclude the civil action, and if all parties in attendance at such mediation agree, the mediator and all such parties may file a stipulation with the court setting forth any matter or conclusion that the parties and the mediator believe may be useful or relevant to narrow the issues, expedite discovery or assist the parties in preparing the civil action for trial.

(f) The judges of the Superior Court may adopt such rules as they deem necessary for the conduct of mediation pursuant to this section. Such rules shall be adopted in accordance with section 51-14 of the general statutes.

Approved June 8, 2010