
OLR Bill Analysis

SB 1

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

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§ 35 — COMMUNITY-BASED PROVIDER GRANT FUNDING

Appropriates \$500,000 to DPH in FY 22 to provide grants to community-based health care providers in primary care settings

SUMMARY

This bill includes various provisions related to physical and mental health services, racial disparities in health care, pandemic preparedness, and other related topics. For example, it:

1. declares racism as a public health crisis and creates a Truth and Reconciliation Commission to examine racial disparities in public health,
2. sets a minimum nurse staffing ratio for intensive care units,
3. requires physicians to conduct mental health examinations as part of annual physicals,
4. requires several studies, including on the state's COVID-19 response and the pandemic's impact on the state, and
5. adopts the Uniform Emergency Volunteer Health Practitioners Act.

A section-by-section summary follows.

EFFECTIVE DATE: Upon passage, unless otherwise noted below.

§ 1 — EXIT INTERVIEWS WITH WITHDRAWING STUDENTS

Requires school boards to conduct exit interviews with students who withdraw before graduation and provide them with resources on certain topics for at least a year after withdrawing

The bill requires local and regional boards of education to conduct exit interviews with students who withdraw from school without graduating or receiving a diploma. The purpose of these interviews is to collect information on: (1) whether the student has a trauma history, (2) whether the student's family has been reported to the Department of Children and Families (DCF) or any other agency for ongoing stressors in the student's life or any of the student's unaddressed needs, (3) the student's future plans, (4) whether the student was the

victim of bullying that caused a decline in academic achievement and resulted in withdrawal, and (5) whether the student is trainable in skills that will provide financial independence.

Existing law requires school districts to provide a withdrawing student's parent or similar party with information on the educational options available in the school system and community (CGS § 10-184). The bill requires boards of education, for at least one year after students withdraw, to provide them resources on mental health services, adult education opportunities, and apprenticeship programs.

Starting by July 1, 2022, each board of education must annually aggregate the information under the bill into a report and submit the report to the Department of Education (SDE) and the Department of Public Health (DPH) for evaluation.

EFFECTIVE DATE: October 1, 2021

Background — Related Bill

sSB 881 (§ 21) (File 327), favorably reported by the Higher Education and Employment Advancement Committee, raises the permissible high school dropout age from 17 to 18 beginning with the 2023-2024 school year, and requires the district to provide the withdrawing student, rather than the parent or guardian, with information on education options available in the school system and community.

§ 2 — PEER SUPPORT SPECIALISTS

Requires DPH to adopt regulations on the certification and education of peer support specialists

The bill requires DPH to adopt regulations to (1) provide for the certification and education of peer support specialists and (2) specify the peer support services that such certified specialists may provide. Under the bill, "peer support services" are nonmedical mental health care and substance abuse services provided by these specialists.

EFFECTIVE DATE: October 1, 2021

§ 3 — DMHAS MENTAL HEALTH TOOLKIT FOR EMPLOYERS

Requires DMHAS to develop and post online a mental health toolkit to help employers address their employees' mental health needs that arise due to COVID-19

The bill requires the Department of Mental Health and Addiction Services (DMHAS) to develop a mental health toolkit to help employers address employee mental health needs that arise due to COVID-19. The toolkit must (1) identify common issues and their symptoms and (2) provide information and other resources on actions that employers may take to help employees address these issues.

The bill requires DMHAS to post the toolkit on its website by October 1, 2021.

§ 4 — DPH STUDY ON STATE'S COVID-19 RESPONSE

Requires DPH to study and report on the state's COVID-19 response

The bill requires DPH to study the state's COVID-19 response. The commissioner must report the study's findings to the Public Health Committee by January 1, 2022.

The report must include the commissioner's recommendations for policy and legislative changes needed to improve the state's response to future pandemics, including how to improve administration of mass vaccinations; personal protective equipment supply; and health care facilities' patient care.

§ 5 — DPH PANDEMIC PREPAREDNESS OFFICER

Requires (1) DPH to designate an employee as pandemic preparedness officer and (2) the designated officer to annually report on the state's pandemic preparedness

The bill requires DPH to designate an employee within its Office of Public Health Preparedness and Response to serve as the pandemic preparedness officer.

Under the bill, the officer is responsible for the state's pandemic preparedness, including (1) conducting an annual inventory of the state's stockpile of medical equipment and medical supplies; (2) reviewing and ensuring the adequacy of infection prevention at health care facilities; and (3) periodically updating legislators during a pandemic-related public health emergency.

The bill requires the officer, starting by January 1, 2022, to annually report to the Public Health Committee on the state's preparedness to respond to a pandemic.

EFFECTIVE DATE: October 1, 2021

§§ 6 & 7 — RACISM AND RACIAL DISPARITIES IN PUBLIC HEALTH

Declares racism to be a public health crisis and establishes a Truth and Reconciliation Commission to examine racial disparities in public health.

The bill declares as state policy the recognition that racism is a public health crisis.

The bill also creates a Truth and Reconciliation Commission to examine racial disparities in public health and develop legislative proposals to address these disparities.

EFFECTIVE DATE: Upon passage, except July 1, 2021, for the provisions establishing the commission.

Commission Charge

The commission must study institutional racism in the state's public health-related laws and regulations. It also must study racial disparities in several areas, including:

1. the state's criminal justice system and these disparities' impact on the health and well-being of individuals and families, including overall health outcomes and rates of depression; suicide; substance use disorder; and chronic disease;
2. access to healthy living resources, including fresh food; produce; physical activity; public safety; clean air; and clean water;
3. access to health care; and
4. health outcomes in hospitals and long-term care facilities, including nursing homes.

Additionally, the commission must study the impact of zoning

restrictions on the creation of housing disparities and these disparities' impact on public health.

The bill requires the commission, starting by January 1, 2022, to annually report to the Public Health Committee. The reports must include a detailed summary of any of the commission's findings on racial disparities in public health and any legislative proposals to address them.

Commission Membership and Administration

Under the bill, the commission's membership includes the following officials or their designees:

1. the Commission on Women, Children, Seniors, Equity and Opportunity executive director;
2. the Public Health Committee chairpersons and ranking members;
3. the Office of Policy and Management (OPM) secretary; and
4. the Black and Puerto Rican Caucus chairperson.

The commission also includes 10 members appointed by the legislative leaders, as shown in the following table.

Table 1: Truth and Reconciliation Commission Appointed Members

<i>Appointing Authority</i>	<i>Appointee Qualifications</i>
House speaker (3)	Connecticut Health Foundation representative Health Equity Solutions representative An individual with experience in philanthropy related to health care equity and access for minority communities
Senate president pro tempore (3)	Connecticut Children's Medical Center Foundation representative Yale University representative with a professional focus on health care equity and access School-based health care center representative

House majority leader (1)	An individual with experience and expertise in infant and maternal care
Senate majority leader (1)	Civilian Corrections Academy representative with knowledge and experience on the issues faced by individuals released from correctional institutions
House minority leader (1)	Partnership for Strong Communities representative with knowledge and experience about the impact of housing issues on the health of minority communities
Senate minority leader (1)	Connecticut Bar Association representative with knowledge and experience about health care equity and access

Under the bill, initial appointments to the commission must be made by July 31, 2021, and the initial members' terms end on June 30, 2023. Members appointed on or after July 1, 2023, serve two-year terms. Members continue to serve until their successors are appointed, and vacancies during a term must be filled for the balance of the unexpired term.

The appointing authority must fill any vacancy, except the chairperson can temporarily fill a vacancy lasting more than 30 days. If the chairperson appoints someone to fill such a vacancy, that member serves until (1) the appointing authority makes an appointment or (2) the two-year term expires.

The bill requires the House speaker and Senate president pro tempore to jointly select the commission's chairperson from among its members. The chairperson must schedule the first meeting, to be held by August 31, 2021.

The bill requires the Public Health Committee's administrative staff to serve in that capacity for the commission.

§ 8 — NURSE STAFFING RATIOS IN INTENSIVE CARE UNITS

Sets a minimum nurse staffing ratio for hospital ICUs, requires hospitals to maintain certain related records and file quarterly reports, allows DPH to discipline hospitals for noncompliance, and requires DPH to adopt implementing regulations

Starting October 1, 2021, the bill requires the DPH commissioner to set a minimum daily nurse staffing ratio of two nurses per patient in

hospital intensive care units (ICUs). The minimum staffing ratio excludes time not spent on medical care for ICU patients (e.g., breaks, vacation or sick time, or training).

The bill requires hospitals to maintain daily records of (1) the number of ICU patients, (2) the number of nurses scheduled and available to provide care, and (3) whether enough nurses are scheduled and available to comply with the minimum staffing ratio.

Under the bill, hospitals must file quarterly reports with DPH on the number and percentage of days they failed to comply with the ratio and the reasons. This requirement starts in 2022, and the reports are due within fifteen days after the start of the quarters beginning in January, April, July, and October.

Additionally, the bill (1) allows the DPH commissioner to randomly audit hospitals for compliance with these provisions and take disciplinary action against a hospital for failure to comply, and (2) requires the commissioner to adopt regulations implementing these provisions.

EFFECTIVE DATE: October 1, 2021

§ 9 — BREAST HEALTH AND BREAST CANCER AWARENESS

Requires DPH, within available appropriations, to establish a program to advance breast health and breast cancer awareness, including outreach to young women of color on the importance of early detection

The bill requires the DPH commissioner, by January 1, 2022, and within available appropriations, to establish a program to advance breast health and breast cancer awareness and promote greater understanding of the importance of early breast cancer detection. The program must at least include outreach to individuals, including young women of color, on the importance of breast health and early breast cancer detection.

By law and within available appropriations, DPH administers a breast and cervical cancer early detection and treatment referral program. Among other things, the program must promote screening,

detection, and treatment of these cancers among unserved or underserved populations (CGS § 19a-266).

EFFECTIVE DATE: October 1, 2021

§ 10 — DOULA CERTIFICATION STUDY

Requires DPH to study whether to establish a doula certification program

The bill requires the DPH commissioner to conduct a study on whether the department should establish a state certification process for doulas. The commissioner must report the study's findings and any recommendations to the Public Health Committee by January 1, 2022.

The bill defines a "doula" as a trained, nonmedical professional who provides continuous physical, emotional, and informational support to a pregnant person during the antepartum and intrapartum periods (i.e., during pregnancy, labor, and delivery) and up to the first six weeks postpartum.

§ 11 — IMPLICIT BIAS TRAINING AT HOSPITALS

Requires hospitals to include implicit bias training in their regular training to staff members who care for women who are pregnant or postpartum

Starting October 1, 2021, the bill requires hospitals to include implicit bias training as part of their regular training to staff members who provide direct care to women who are pregnant or in the postpartum period.

Under the bill, "implicit bias" means an attitude or internalized stereotype that affects perceptions, actions, and decisions in an unconscious manner and often contributes to unequal treatment based on someone's race, ethnicity, gender identity, sexual orientation, age, disability, or other characteristics.

§ 12 — MATERNAL MORTALITY AND MORBIDITY TASK FORCE

Establishes a task force to study racial inequities in maternal mortality and severe maternal morbidity in the state

The bill establishes a task force to study racial inequities in maternal mortality and severe maternal morbidity in the state. Under the bill, "maternal mortality" is a woman's death during pregnancy or within

one year after the pregnancy ends.

The bill requires the task force to (1) examine and make recommendations to reduce or eliminate these inequities and (2) report its findings and recommendations to the Public Health Committee by January 1, 2022. The task force ends on that date or when it submits its report, whichever is later.

Under existing law, a (1) Maternal Mortality Review Program within DPH tracks maternal deaths and (2) Maternal Mortality Review Committee within DPH conducts multidisciplinary reviews of maternal deaths to identify associated factors and make recommendations to reduce these deaths (CGS §§ 19a-59h & -59i).

Membership and Administration

Under the bill, the task force membership includes the DPH commissioner and the Public Health Committee chairpersons, or their designees. There are also 18 appointed members, as follows:

1. three each appointed by the House speaker and Senate president pro tempore; and
2. two each appointed by the House and Senate majority and minority leaders, governor, and Black and Puerto Rican Caucus chairperson.

Any appointed member may be a legislator.

The bill requires all task force appointments to be made by 30 days after the bill's passage. The appointing authority fills any vacancy.

The bill requires the House speaker and Senate president pro tempore to jointly select the task force chairpersons from among its members. The chairpersons must schedule the first meeting, to be held within 60 days after passage. The Public Health Committee's administrative staff must serve in that capacity for the task force.

§ 13 — EMS HOME VISIT PILOT PROGRAM

Requires DPH to establish a pilot program allowing EMS personnel, in coordination with community health workers, to conduct home visits for individuals at high risk of being repeat users of EMS services

The bill requires DPH, by January 1, 2022, to establish a pilot program allowing emergency medical services (EMS) personnel, in coordination with community health workers, to conduct home visits for individuals at high risk of being repeat users of EMS services. The purpose of these visits is to help such people manage chronic illnesses and adhere to medication plans.

PA 19-118 authorized DPH, within available appropriations, to authorize EMS organizations to establish mobile integrated health programs under their existing license or certification. Generally, a “mobile integrated health program” is one in which paramedics, acting within their scope of practice and as part of an approved program, provide non-emergency services, including clinically appropriate medical evaluations; treatment; transport; or referrals to other providers.

§ 14 — MENTAL HEALTH EXAMINATIONS DURING PHYSICALS

Requires physicians to perform mental health examinations on patients during annual physical exams

Starting October 1, 2021, the bill requires physicians to conduct mental health examinations on patients during annual physical exams.

Background — Related Bill

SB 1086 (§ 2), favorably reported by the Public Health Committee, requires physicians, physician assistants, and advanced practice registered nurses to conduct mental health examinations during annual physical exams.

§ 15 — OPM STUDY ON COVID’S IMPACT ON STATE

Requires OPM, in consultation with several other agencies, to study the impacts of the COVID-19 pandemic on the state, including disparate impacts

The bill requires the OPM secretary to study the impacts of the COVID-19 pandemic on the state, including the disparate impact on individuals based on race, ethnicity, language, and geography. The secretary must conduct the study in consultation with relevant state

agencies, including DPH, DMHAS, DCF, and SDE; the departments of Social Services, Developmental Services, Housing, Aging and Disability Services, and Labor; and the Office of Early Childhood.

The bill requires the OPM secretary to report to the Public Health Committee by February 1, 2022.

Background — Related Bill

HB 5614 (File 146), reported favorably by the Commerce Committee, establishes a commission to analyze any disparate impact of COVID-19 and the state’s response to it on different racial, ethnic, and socioeconomic groups and identify the causes of any such disparate impact.

§ 16 — ACTING MUNICIPAL HEALTH DIRECTORS

Requires municipalities to notify DPH if they appoint an acting health director and requires, rather than allows, DPH to appoint someone as a municipal health director if there is a vacancy for 30 days or more

The bill requires municipalities to notify the DPH commissioner in writing if they appoint an acting health director, including the start date of the appointment. Existing law already requires DPH approval for municipalities to designate an acting health director.

The bill also requires, rather than allows, DPH to appoint someone as a municipal health director if there is a vacancy for 30 days or more. The bill clarifies that the commissioner’s appointee must meet the standard requirements for municipal health directors (i.e., the director must (1) be a licensed physician and have a degree in public health or (2) have a graduate degree in public health).

EFFECTIVE DATE: October 1, 2021

§ 17 — DEMOGRAPHIC DATA COLLECTION BY STATE AGENCIES

Sets requirements for state agencies or state entities that, directly or by contract, collect demographic data related to health care or public health, such as that they collect the data in a manner that allows for its aggregation and disaggregation

Starting January 1, 2022, the bill establishes various requirements for state agencies, boards, or commissions (“state entities”) that,

directly or by contract, collect demographic data on state residents' ancestry or ethnic origin, ethnicity, race, or primary language in the context of health care, the provision or receipt of health care services, or for any public health purpose.

Under the bill, they must:

1. collect this data in a manner that allows for its aggregation and disaggregation;
2. expand race and ethnicity categories to include subgroup identities as specified in the Centers for Medicare and Medicaid Services' State Innovation Models Initiative and follow the hierarchical mapping to align with U.S. Office of Management and Budget standards;
3. give people the option to select one or more ethnic or racial designations, and include an "other" designation with the ability to write in identities not represented by other codes; and
4. collect primary language data using language codes set by the International Organization for Standardization.

In addition, state entities must ensure, in cases where they report data on an individual's ethnic origin, ethnicity, or race to another state entity, that it is tabulated and reported with the number and percentage of people who identify with (1) each ethnic or racial designation as their sole designation; (2) each ethnic or racial designation, whether as their sole designation or in combination with others; and (3) multiple designations.

§ 18 — HOSPITAL COMMUNITY BENEFITS PROGRAMS

Makes various changes to the law on hospital community benefits programs, such as (1) expanding their required scope; (2) modifying reporting requirements; and (3) requiring OHS to establish a minimum community benefit and community building spending threshold for hospitals based on specified criteria

The bill makes various changes to the law on hospital community benefits programs. Among other things, it:

1. conforms to existing practice by shifting oversight of this law from the Office of Healthcare Advocate (OHA) to the Office of Health Strategy (OHS);
2. requires OHS, by January 1, 2023, and every two years after that, to establish a minimum community benefit and community building spending threshold for each hospital;
3. requires, rather than allows, hospitals to develop community benefit guidelines and changes their necessary components (e.g., specifically requiring that they be intended to reduce racial, ethnic, linguistic, sexual orientation and gender identity, and cultural disparities in health);
4. requires hospitals' annual reports on community benefits to describe certain investments they made and explain how those investments addressed the needs identified in the hospital's triennial community health needs assessment (which is required by federal law for nonprofit hospitals); and
5. removes managed care organizations (MCOs) from this law.

The bill also makes several related minor, technical, and conforming changes.

Community Benefits Program Scope

Under current law, a "community benefits program" is a voluntary program to promote preventive care and improve the health status of working families and at-risk populations in the communities within a hospital's or MCO's geographic service area.

The bill makes these programs mandatory for hospitals, in line with federal law for nonprofit hospitals (see BACKGROUND). It removes MCOs from this law. It also adds to the programs' objectives the (1) reduction of racial, ethnic, linguistic, sexual orientation and gender identity, and cultural disparities in health and (2) improvement in the health of all populations in the service area, not just working families and at-risk populations.

Community Benefits Reporting

Under current law, each hospital and MCO must submit a biennial report on whether it has a community benefits program. If the hospital or MCO has such a program, the report must describe its status and address various components set forth in law.

The bill instead requires hospitals to report annually on their community benefits programs. They must report to OHS's Health Systems Planning Unit or a designee selected by OHS's executive director, rather than to the Healthcare Advocate or his designee as under current law. (In practice, oversight of the community benefits law has already shifted from OHA to OHS under a memorandum of agreement.)

The bill makes related conforming changes to codify the transfer of authority over this law to OHS. This includes authorizing OHS, rather than OHA, to impose civil penalties of up to \$50 per day on hospitals that fail to report as required. As under current law, these penalties may only be imposed after notice and an opportunity for a hearing.

Report Components. The bill makes several changes to these reports' required components, including several minor and conforming changes. For example, the bill specifies that the reports must identify community health needs that were prioritized, not just considered, in the process.

The bill also adds the following to the list of required report components:

1. the demographics of the hospital's geographic service area for the prior taxable year;
2. the cost and description of each investment included in the "Financial Assistance and Certain Other Community Benefits at Cost" and "Community Building Activities" sections of the hospital's IRS Form 990 (under federal law, only nonprofit hospitals must submit this form; see BACKGROUND);

3. an explanation of how each of these investments addresses the identified needs in the hospital's triennial community health needs assessment and implementation strategy (see below); and
4. a description of available evidence showing how each of these investments improves community health outcomes.

Under the bill, a "community health needs assessment" is a hospital's written assessment, as described in federal regulations for tax-exempt hospitals, that defines the community it serves; assesses that community's health needs; and solicits and considers people that represent the community's broad interests. An "implementation strategy" is a written plan required by federal regulations that addresses community health needs identified through the assessment and that (1) describes the hospital's intended actions to address the health needs and impacts of these actions, (2) identifies resources that the hospital plans to commit to address the needs, and (3) describes the planned collaboration between the hospital and other facilities and organizations to address the needs (see BACKGROUND).

Required Posting and Analysis. Current law requires hospitals and MCOs to make copies of their community benefits program reports available to the public upon request. The bill instead requires OHS to post hospitals' reports on its website.

The bill transfers from OHA to OHS the duty to summarize and analyze the submitted reports, including for adherence to the community benefit guidelines (see below) and within available appropriations. It requires OHS, by October 1, 2022, and annually after that, to post the summary and analysis online. Under current law, OHA must make the summary and analysis available to the public biennially.

Community Benefit Guidelines

Current law allows hospitals and MCOs to develop community benefit guidelines and requires these guidelines to focus on certain principles. The bill instead requires hospitals to develop these

guidelines. It also modifies some of the principles that must inform the guidelines.

Under existing law, the guidelines must focus on seeking assistance and meaningful participation from the communities in the hospital's service area in (1) developing and implementing its community benefits program and (2) defining the targeted population and specific health needs to be addressed. The hospital must give priority to the needs outlined in DPH's most recent state health plan.

The bill extends this community participation focus to include the hospital's developing and implementing a plan for meaningful community benefit and community building investments (see below). It also requires the hospital to give priority to its triennial community health needs assessment and implementation strategy.

The bill requires each hospital to solicit commentary on its implementation strategy from the communities in its geographic service area and consider revisions based on it.

The bill makes other revisions to the required guidelines conforming to the bill's other changes, such as specifically requiring a focus on the health care needs and resources of a broad spectrum of racial and ethnic groups.

Minimum Community Benefit Spending Threshold

The bill requires the OHS executive director or her designee, by January 1, 2023, and biennially after that, to establish a minimum community benefit and community building spending threshold that hospitals must meet or exceed during the biennium. Under the bill, "community building" is activity that protects or improves a community's health or safety and may be reported on IRS Form 990.

The bill requires the threshold to be based on objective data and criteria, including:

1. the hospital's historical and current expenditures on community benefits;

2. the community needs identified in the hospital's triennial community health needs assessment;
3. the hospital's overall financial position based on audited financial statements and other objective data; and
4. the hospital's taxes paid and payments in lieu of taxes.

Under the bill, when establishing a spending threshold, OHS must (1) consult with hospital representatives and at least one expert in health care economics and (2) solicit and consider public comments.

The spending threshold must include the minimum proportion of community benefit spending to be directed to addressing health disparities and social health determinants identified in the community health needs assessment during the next biennium.

Background — Nonprofit Hospitals and Federal Requirements for Community Health Needs Assessments

To maintain tax-exempt status under federal law, a nonprofit hospital must, among other things, (1) conduct a community health needs assessment at least once every three years and (2) adopt an implementation strategy to meet the needs identified in the assessment. Federal regulations set forth various steps that hospitals must take in completing these requirements (26 C.F.R. § 1.501(r)-3).

In addition, a nonprofit hospital must include certain related information in its IRS Form 990 filing (the tax return for organizations exempt from the income tax). Along with the standard form, there is a specific attachment (Schedule H) that these hospitals must complete which addresses, among other things, the hospital's community benefits, community building activities, and financial assistance policy.

Background — Related Bill

sHB 6550 (File 231), reported favorably by the Public Health Committee, makes similar changes to hospital community benefits laws, except it excludes for-profit hospitals from the law's requirements.

§ 19 — DPH/DCF STUDY ON CHILDREN’S ACCESS TO CARE

Requires DPH, in consultation with DCF, to conduct a study to identify areas where access to quality and affordable mental and behavioral health care for children is limited

The bill requires the DPH commissioner, in consultation with the DCF commissioner, to conduct a study to identify areas in the state where children have limited access to quality and affordable mental and behavioral health care services due to geographic and transportation barriers, mental health professional shortages, lack of insurance, or other barriers.

By January 1, 2022, the DPH commissioner must report the study’s findings to the Public Health Committee.

§§ 20-32 — UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

Adopts the Uniform Emergency Volunteer Health Practitioners Act, under which (1) health care professionals may register to provide services during declared emergencies in other states, (2) health care facilities and disaster relief organizations may rely on the registration system to confirm that registrants are licensed and in good standing, and (3) participating providers are generally protected from civil liability

The bill adopts the Uniform Emergency Volunteer Health Practitioners Act. Under these provisions, licensed health practitioners from other states who are registered with a qualified registration system generally may practice in Connecticut as if they were licensed here. DPH has authority to regulate or restrict their practice, and the practitioners are generally immune from civil liability if they meet the bill’s requirements.

(Existing law allows DPH to temporarily suspend licensure requirements for certain health professions to allow licensed practitioners from other states to practice here during declared public health emergencies (CGS § 19a-131j). Last year, the governor expanded upon these provisions through executive orders (EO 7DD, § 3, Apr. 22, 2020; EO 7HHH, § 1, Jul. 14, 2020). DPH has issued multiple orders implementing the suspension authority granted by the law and the executive orders.)

Scope and Definitions (§§ 21 & 22)

The bill’s provisions apply to volunteer health practitioners

registered with a qualifying registration system and who provide health or veterinary services in Connecticut for a host entity during a public health emergency declared by the governor.

Under the bill, a “volunteer health practitioner” is someone licensed under the laws of Connecticut or another state (see below) to provide health or veterinary services. The term generally includes these practitioners providing services, whether paid or unpaid. But it does not include practitioners paid under a preexisting employment relationship with a host entity or affiliate that requires the practitioner to provide health services in this state unless the practitioner (1) is not a Connecticut resident and (2) is employed by a disaster relief organization providing services here during a declared public health emergency.

The bill defines “health services” as treatment, care, advice, guidance, or other services or supplies related to the health or death of individuals or human populations, as necessary to respond to a public health emergency. This includes (1) a range of services related to physical or mental health care (e.g., assessment, diagnosis, procedures, and counseling); (2) selling or dispensing of prescription drugs and devices; and (3) funeral and related services.

“Veterinary services” is treatment, care, advice, guidance, or other services or supplies related to the health or death of animals or animal populations, as necessary to respond to a public health emergency. This includes (1) a range of services to diagnose, treat, or prevent animal disease, including by prescription; (2) reproductive management; and (3) monitoring and treating animal populations for diseases that have or could spread to humans.

For purposes of the bill, “states” include U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, or any territory or insular possession subject to U.S. jurisdiction.

Certain other terms are defined below in context.

Regulation of Services During Emergency (§ 23)

Under the bill, during a declared public health emergency, DPH may limit, restrict, or otherwise regulate (1) the type of volunteer practitioners who may practice, (2) their practice duration, (3) the geographical areas where they may practice, or (4) any other matter needed to coordinate service delivery. The bill allows these orders to take effect immediately, without prior notice or comment, and they are not rules under the Uniform Administrative Procedure Act (UAPA).

Under the bill, a host entity (i.e., one operating here that uses volunteer practitioners to respond to an emergency) must:

1. consult and coordinate with DPH to the extent practicable for the efficient and effective use of volunteer practitioners and
2. comply with any other laws relating to the management of emergency health or veterinary services.

Volunteer Health Practitioner Registration Systems (§ 24)

As noted above, the bill applies to volunteer health practitioners registered with a qualifying registration system. The bill establishes conditions that a system must meet to qualify.

Specifically, the system must:

1. allow for registration applications before or during an emergency;
2. include information on the practitioners' licensure and good standing, for access by authorized persons; and
3. be capable of confirming the accuracy of that information before a practitioner provides services under the bill's provisions.

In addition, a system must meet one of the following conditions:

1. be an emergency volunteer practitioner advance registration system established by a state and funded through the federal Department of Health and Human Services under the Public Health Services Act;

2. be a local unit of trained and equipped emergency response, public health, and medical personnel formed under that act;
3. be operated by a (a) disaster relief organization (see below); (b) licensing board; (c) national or regional association of licensing boards or health practitioners; (d) licensed health facility that provides comprehensive inpatient and outpatient services, including a tertiary care and teaching hospital; or (e) governmental entity; or
4. be designated by DPH as a registration system under the bill.

Under the bill, a “disaster relief organization” is an entity that provides emergency or disaster relief services that include health or veterinary services provided by volunteer practitioners and that (1) is designated or recognized as a provider of such pursuant to a disaster response and recovery plan adopted by a federal agency or DPH or (2) regularly plans and conducts its activities in coordination with a federal agency or DPH.

During a declared emergency, the bill allows DPH, its authorized agents, or a host entity to confirm whether volunteer health practitioners utilized in this state are registered with a qualifying system. This confirmation is limited to obtaining their identities and determining whether the system indicates that they are licensed and in good standing. A registration system must provide this information when receiving a request from such authorized persons or similarly authorized persons in another state.

Under the bill, even if a system indicates that a registered practitioner is licensed and in good standing, a host entity is not required to use his or her services.

Recognition of Practitioners Licensed in Other States (§ 25)

During declared public health emergencies, the bill allows volunteer health practitioners from other states to practice in Connecticut, as authorized under the bill, as if they were licensed here. To do so, they must be (1) registered with a qualifying system and (2) licensed and in

good standing in the other state.

But the bill's protections do not apply to practitioners licensed in multiple states who have faced certain disciplinary actions in any of them. This includes (1) a license suspension or revocation, (2) an agency order limiting or restricting practice privileges, or (3) voluntary termination under threat of sanction.

No Effect on Credentialing or Privileging (§ 26)

The bill specifies that it does not (1) affect a health facility's credentialing or privileging standards or (2) prevent a facility from waiving or modifying those standards during a declared public health emergency.

Provision of Volunteer Services; Administrative Sanctions (§ 27)

Subject to the following conditions and limitations, the bill requires volunteer health practitioners to adhere to the scope of practice for similarly licensed practitioners established by Connecticut law.

The bill generally does not authorize volunteer practitioners to provide services outside of their scope of practice, even if a similarly licensed practitioner in this state would be allowed to do so. But it allows DPH to modify or restrict the services that volunteer practitioners may provide under the bill. Any such order may take effect immediately, without prior notice or comment, and is not a rule under the UAPA.

The bill also allows host entities to restrict the services that volunteer practitioners may provide under the bill.

Under the bill, a volunteer practitioner is not engaging in unauthorized practice unless he or she has reason to know (1) of any such limitation, modification, or restriction or (2) that a similarly licensed Connecticut practitioner would not be permitted to provide the services. A volunteer practitioner has reason to know this if he or she (1) actually knows it or (2) from all the facts and circumstances known to the practitioner at the relevant time, a reasonable person would conclude that these limitations exist.

The bill allows Connecticut licensing boards or other disciplinary authorities to impose administrative sanctions on (1) state-licensed practitioners for their conduct outside of the state and (2) out-of-state practitioners for conduct in Connecticut, when responding to an emergency. This is in addition to authority granted to these entities by other state laws regulating health practitioners.

Under the bill, when determining whether to impose these administrative sanctions, the board or authority must consider the (1) circumstances of the conduct, including any exigent circumstances, and (2) practitioner's scope of practice, education, training, experience, and specialized skill.

For practitioners licensed in other states, the bill requires Connecticut licensing boards or disciplinary authorities to report any such sanctions to the other state's appropriate board or authority.

Relation to Other Laws (§ 28)

The bill specifies that it does not limit rights, privileges, or immunities provided to these practitioners by other laws. Except as provided below, it does not affect requirements for the use of health practitioners pursuant to the interstate Emergency Management Assistance Compact.

The bill allows DPH, pursuant to the compact, to incorporate into the state's emergency forces volunteer health practitioners who are not state or local government officers or employees.

Regulatory Authority (§ 29)

The bill allows DPH to adopt rules implementing these volunteer practitioner provisions. In doing so, DPH must consult with and consider the recommendations of the entity coordinating the implementation of the Emergency Management Assistance Compact. The department also must consult with and consider rules adopted by similar agencies in other states to promote uniformity in applying these provisions and make the various states' emergency response systems reasonably compatible.

Limitations on Civil Liability (§ 30)

Under the bill and subject to the exceptions below, volunteer health practitioners who provide services pursuant to the bill are not liable for damages for their acts or omissions in doing so. Additionally, if the practitioner is not liable, no other person may be found vicariously liable.

But the bill does not limit a volunteer practitioner's liability for:

1. willful misconduct or wanton, grossly negligent, reckless, or criminal conduct;
2. intentional torts;
3. breach of contract;
4. claims by a host entity or by an entity in this or another state which employs or uses the practitioner's services; or
5. acts or omissions relating to operating a motor vehicle, vessel, aircraft, or other vehicle.

The bill generally provides that a person who operates, uses, or relies upon information provided by a registration system is not liable for damages for acts or omissions related to doing so. But this does not apply to intentional torts; willful misconduct; or wanton, grossly negligent, reckless, or criminal conduct.

Workers' Compensation Coverage (§ 31)

Under the bill, volunteer practitioners who die or are injured as the result of providing such services are deemed to be state employees for the purpose of receiving workers' compensation benefits if (1) they are not otherwise eligible for these benefits under any state's law and (2) they (or if they died, their representatives) make a workers' compensation claim under Connecticut law. This applies to any physical or mental injuries that would entitle state employees to workers' compensation benefits.

The bill requires the state Department of Labor (DOL) to adopt

rules, enter into agreements with other states, or take other measures to facilitate these out-of-state practitioners' receipt of workers' compensation benefits.

The bill allows DOL to waive or modify requirements for filing, processing, and paying claims that unreasonably burden these practitioners. DOL must consult with other states' comparable agencies, and consider their practices on these matters, to promote uniformity in applying these provisions.

Uniformity of Application and Construction (§ 32)

The bill directs that, in applying and construing this uniform act, consideration be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

§ 33 — SCHOOL-BASED HEALTH CENTER FUNDING

Appropriates an unspecified amount to DPH in FY 22 to expand services of existing school-based health centers and establish new ones

The bill makes an unspecified General Fund appropriation to DPH in FY 22 to expand services of existing school-based health centers and establish new ones.

§ 34 — MOBILE CRISIS INTERVENTION FUNDING

Appropriates \$6 million to DMHAS in FY 22 to make mobile crisis intervention services available at all times in each mobile crisis region

The bill makes a \$6 million General Fund appropriation to DMHAS in FY 22 to make mobile crisis intervention services available 24 hours a day, seven days a week in each mobile crisis region to respond to acute mental health emergencies.

§ 35 — COMMUNITY-BASED PROVIDER GRANT FUNDING

Appropriates \$500,000 to DPH in FY 22 to provide grants to community-based health care providers in primary care settings

The bill makes a \$500,000 General Fund appropriation to DPH in FY 22 to provide three-year grants to community-based health care providers in primary care settings.

Background — Related Bill

sSB 1087, reported favorably by the Public Health Committee, requires, rather than allows, DPH to establish a program providing three-year grants to community-based primary care providers, within available appropriations, to expand access to care for the uninsured.

COMMITTEE ACTION

Public Health Committee

Joint Favorable

Yea 22 Nay 11 (03/26/2021)