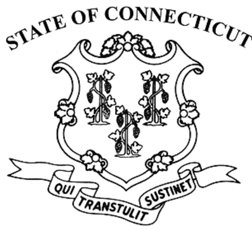

Senate

General Assembly

File No. 481

January Session, 2021

Substitute Senate Bill No. 1

Senate, April 15, 2021

The Committee on Public Health reported through SEN. DAUGHERTY ABRAMS of the 13th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

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

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

1 Section 1. (NEW) (*Effective October 1, 2021*) Each local and regional
2 board of education shall conduct an exit interview with each student
3 who withdraws from school under section 10-184 of the general statutes
4 without graduating or being granted a diploma by such board. The
5 purpose of such exit interview shall be to collect information regarding
6 (1) whether the student has a history of trauma, (2) whether the
7 student's family has been reported to the Department of Children and
8 Families or any other agency for ongoing stressors in the student's life
9 or any needs of the student that are not being addressed, (3) the future
10 plans of such student following such withdrawal, (4) whether the
11 student has been the victim of bullying that caused a decline in academic
12 achievement and resulted in such withdrawal, and (5) whether such
13 student is trainable in skills that will provide financial independence.

14 Each local and regional board of education shall provide such student,
15 for not less than one year after such student's withdrawal, resources
16 pertaining to mental health services, adult education opportunities and
17 apprenticeship programs. Not later than July 1, 2022, and annually
18 thereafter, each local and regional board of education shall aggregate
19 such information in a report and submit such report to the Departments
20 of Education and Public Health for evaluation.

21 Sec. 2. (NEW) (*Effective October 1, 2021*) (a) As used in this section:

22 (1) "Certified peer support specialist" means a peer support specialist
23 certified by the Commissioner of Public Health to provide peer support
24 services to another individual in the state;

25 (2) "Peer support services" means all nonmedical mental health care
26 services and substance abuse services provided by peer support
27 specialists; and

28 (3) "Peer support specialist" means an individual providing peer
29 support services to another individual in the state.

30 (b) The Commissioner of Public Health shall adopt regulations, in
31 accordance with chapter 54 of the general statutes, to provide for the
32 certification and education of peer support specialists and specify the
33 peer support services that a certified peer support specialist may
34 provide to another individual in the state.

35 Sec. 3. (NEW) (*Effective from passage*) The Department of Mental
36 Health and Addiction Services shall develop a mental health toolkit to
37 help employers in the state address employee mental health needs that
38 arise as a result of COVID-19. Such toolkit shall (1) identify common
39 mental health issues that employees experience as a result of COVID-19,
40 (2) identify symptoms of such mental health issues, and (3) provide
41 information and other resources regarding actions that employers may
42 take to help employees address such mental health issues. Not later than
43 October 1, 2021, the Department of Mental Health and Addiction
44 Services shall post such mental health toolkit on its Internet web site.

45 For the purposes of this section and section 4 of this act, "COVID-19"
46 means the respiratory disease designated by the World Health
47 Organization on February 11, 2020, as coronavirus 2019, and any related
48 mutation thereof recognized by said organization as a communicable
49 respiratory disease.

50 Sec. 4. (*Effective from passage*) The Department of Public Health shall
51 conduct a study on the state's COVID-19 response. Not later than
52 January 1, 2022, the Commissioner of Public Health shall report, in
53 accordance with the provisions of section 11-4a of the general statutes,
54 to the joint standing committee of the General Assembly having
55 cognizance of matters relating to public health regarding the findings of
56 such study. Such report shall include the commissioner's
57 recommendations for policy changes and amendments to the general
58 statutes necessary to improve the state's response to future pandemics,
59 including, but not limited to, recommendations regarding how to
60 improve administration of mass vaccinations, personal protective
61 equipment supply and health care facilities' care for patients.

62 Sec. 5. (NEW) (*Effective October 1, 2021*) The Department of Public
63 Health shall designate an employee within its Office of Public Health
64 Preparedness and Response to serve as the pandemic preparedness
65 officer. Such officer shall be responsible for the state's pandemic
66 preparedness, including, but not limited to (1) conducting an annual
67 inventory of the state's medical stockpile of medical equipment and
68 supplies, (2) reviewing and ensuring the adequacy of infection
69 prevention at health care facilities in the state, and (3) providing
70 periodic updates to members of the General Assembly during a
71 pandemic-related public health emergency. On or before January 1,
72 2022, and annually thereafter, the pandemic preparedness officer shall
73 report, in accordance with the provisions of section 11-4a of the general
74 statutes, to the joint standing committee of the General Assembly
75 having cognizance of matters related to public health regarding the
76 state's preparedness to respond to a pandemic.

77 Sec. 6. (NEW) (*Effective from passage*) It is hereby declared the policy

78 of the state of Connecticut to recognize that racism is a public health
79 crisis.

80 Sec. 7. (NEW) (*Effective July 1, 2021*) (a) There is established a Truth
81 and Reconciliation Commission to examine racial disparities in public
82 health. The commission shall study (1) institutional racism in the state's
83 laws and regulations impacting public health, (2) racial disparities in the
84 state's criminal justice system and the impact of such disparities on the
85 health and well-being of individuals and families, including, but not
86 limited to, overall health outcomes and rates of depression, suicide,
87 substance use disorder and chronic disease, (3) racial disparities in
88 access to healthy living resources, including, but not limited to, fresh
89 food, produce, physical activity, public safety, clean air and clean water,
90 (4) racial disparities in access to health care, (5) racial disparities in
91 health outcomes in hospitals and long-term care facilities, including, but
92 not limited to, nursing homes, and (6) the impact of zoning restrictions
93 on the creation of housing disparities and the impact of such disparities
94 on public health. The commission shall develop legislative proposals to
95 address racial disparities in public health.

96 (b) The commission shall consist of the following members:

97 (1) The executive director for the Commission on Women, Children,
98 Seniors, Equity and Opportunity, or the executive director's designee;

99 (2) The chairpersons and ranking members of the joint standing
100 committee of the General Assembly having cognizance of matters
101 relating to public health, or the chairpersons' or ranking members'
102 designees;

103 (3) The Secretary of the Office of Policy and Management, or the
104 secretary's designee;

105 (4) The chairperson of the Black and Puerto Rican Caucus of the
106 General Assembly, or the chairperson's designee;

107 (5) Three members appointed by the speaker of the House of
108 Representatives, one of whom is a representative from the Connecticut

109 Health Foundation, one of whom is a representative from Health Equity
110 Solutions and one of whom has experience in philanthropy related to
111 health care equity and access for minority communities;

112 (6) Three members appointed by the president pro tempore of the
113 Senate, one of whom is a representative from the Connecticut Children's
114 Medical Center Foundation, one of whom is a representative from Yale
115 University with a professional focus on health care equity and access
116 and one of whom is a representative from a school-based health care
117 center;

118 (7) One member appointed by the majority leader of the House of
119 Representatives, who has experience and expertise in infant and
120 maternal care;

121 (8) One member appointed by the majority leader of the Senate, who
122 is a representative from the Civilian Corrections Academy with
123 knowledge and experience regarding the issues faced by individuals
124 released from correctional institutions;

125 (9) One member appointed by the minority leader of the House of
126 Representatives, who is a representative from Partnership for Strong
127 Communities with knowledge and experience regarding the impact of
128 housing issues on the health of minority communities; and

129 (10) One member appointed by the minority leader of the Senate, who
130 is a representative from the Connecticut Bar Association with
131 knowledge and experience regarding health care equity and access.

132 (c) The speaker of the House of Representatives and the president pro
133 tempore of the Senate shall jointly select the chairperson of the
134 commission from among the members of the commission. Such
135 chairperson shall schedule the first meeting of the commission, which
136 shall be held not later than August 31, 2021.

137 (d) (1) All initial appointments to the commission shall be made not
138 later than July 31, 2021, and the term of such initial members shall
139 terminate on June 30, 2023, regardless of when the initial appointment

140 was made.

141 (2) Members of the commission appointed on or after July 1, 2023,
142 shall serve for two-year terms. Members shall continue to serve until
143 their successors are appointed. Any vacancy occurring other than by
144 expiration of term shall be filled for the balance of the unexpired term.

145 (3) Any vacancy shall be filled by the appointing authority, provided
146 the chair of the commission shall have the authority to temporarily fill
147 any vacancy lasting more than thirty days. Any member appointed by
148 the chair of the commission to fill a vacancy lasting more than thirty
149 days shall serve as a member of the commission until an appointment is
150 made by the appointing authority as provided in subsection (b) of this
151 section or until the expiration of a two-year term if such appointment is
152 not made by the appointing authority.

153 (e) The administrative staff of the joint standing committee of the
154 General Assembly having cognizance of matters relating to public
155 health shall serve as administrative staff of the commission.

156 (f) Not later than January 1, 2022, and annually thereafter, the
157 commission shall submit a report to the joint standing committee of the
158 General Assembly having cognizance of matters relating to public
159 health, in accordance with the provisions of section 11-4a of the general
160 statutes, which shall include, but need not be limited to, a detailed
161 summary of any findings of the commission relating to racial disparities
162 in public health and any legislative proposals to address such
163 disparities.

164 Sec. 8. (NEW) (*Effective October 1, 2021*) (a) As used in this section: (1)
165 "Hospital" means an establishment licensed pursuant to chapter 368v of
166 the general statutes for lodging, care and treatment of persons suffering
167 from disease or other abnormal physical or mental conditions; and (2)
168 "nurse" means a nurse licensed in accordance with chapter 378 of the
169 general statutes.

170 (b) On and after October 1, 2021, the Commissioner of Public Health

171 shall require each hospital to maintain a daily minimum staffing ratio of
172 two nurses per patient in the intensive care unit. The daily minimum
173 staffing ratio shall not include break, vacation, sick, personal, training,
174 educational or other time that is not spent on medical care provided to
175 an intensive care unit patient.

176 (c) Each hospital shall maintain a daily record of (1) the number of
177 intensive care unit patients at such hospital, (2) the number of nurses
178 scheduled and available to provide medical care, and (3) whether a
179 sufficient number of nurses are scheduled and available to comply with
180 the requirements of this section. On and after January 1, 2022, each
181 hospital shall file quarterly reports not later than fifteen days after the
182 start of the quarters commencing in January, April, July and October of
183 each year with the Department of Public Health on the number and
184 percentage of days in the preceding quarter that such hospital has failed
185 to comply with the provisions of this section and the reasons therefore.

186 (d) The Commissioner of Public Health may randomly audit a
187 hospital for compliance with the provisions of this section and take
188 disciplinary action against the hospital as permitted under section 19a-
189 494 of the general statutes for failure to comply with the provisions of
190 this section.

191 (e) The Commissioner of Public Health, in accordance with the
192 provisions of chapter 54 of the general statutes, shall adopt regulations
193 to implement the provisions of this section.

194 Sec. 9. (*Effective October 1, 2021*) Not later than January 1, 2022, the
195 Commissioner of Public Health shall, within available appropriations,
196 establish a program to advance breast health and breast cancer
197 awareness and promote greater understanding of the importance of
198 early breast cancer detection in the state. As part of the program, the
199 commissioner shall, at a minimum, provide outreach to individuals,
200 including, but not limited to, young women of color, in the state
201 regarding the importance of breast health and early breast cancer
202 detection.

203 Sec. 10. (*Effective from passage*) (a) As used in this section, "doula"
204 means a trained, nonmedical professional who provides continuous
205 physical, emotional and informational support to a pregnant person
206 during the antepartum and intrapartum periods and up to the first six
207 weeks of the postpartum period.

208 (b) The Commissioner of Public Health shall conduct a study to
209 determine whether the Department of Public Health should establish a
210 state certification process by which a person can be certified as a doula.
211 The commissioner shall report, in accordance with the provisions of
212 section 11-4a of the general statutes, the findings of such study and any
213 recommendations to the joint standing committee of the General
214 Assembly having cognizance of matters relating to public health on or
215 before January 1, 2022.

216 Sec. 11. Section 19a-490u of the general statutes is repealed and the
217 following is substituted in lieu thereof (*Effective from passage*):

218 **[**On or after October 1, 2015, each**]** (a) Each hospital, as defined in
219 section 19a-490, shall **[**be required to**]** include training in the symptoms
220 of dementia as part of such hospital's regularly provided training to staff
221 members who provide direct care to patients.

222 (b) On and after October 1, 2021, each hospital shall include training
223 in implicit bias as part of such hospital's regularly provided training to
224 staff members who provide direct care to women who are pregnant or
225 in the postpartum period. As used in this subsection, "implicit bias"
226 means an attitude or internalized stereotype that affects a person's
227 perceptions, actions and decisions in an unconscious manner and often
228 contributes to unequal treatment of a person based on such person's
229 race, ethnicity, gender identity, sexual orientation, age, disability or
230 other characteristic.

231 Sec. 12. (*Effective from passage*) (a) There is established a task force to
232 study racial inequities in maternal mortality and severe maternal
233 morbidity in the state. The task force shall examine and make
234 recommendations to reduce or eliminate racial inequities in maternal

235 mortality and severe maternal morbidity in the state. For the purposes
236 of this section, "maternal mortality" means the death of a woman during
237 pregnancy or within one year of the end of such pregnancy.

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

239 (1) Three appointed by the speaker of the House of Representatives;

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

241 (3) Two appointed by the majority leader of the House of
242 Representatives;

243 (4) Two appointed by the majority leader of the Senate;

244 (5) Two appointed by the minority leader of the House of
245 Representatives;

246 (6) Two appointed by the minority leader of the Senate;

247 (7) Two appointed by the Governor;

248 (8) Two appointed by the chairperson of the Black and Puerto Rican
249 Caucus of the General Assembly;

250 (9) The chairpersons of the joint standing committee of the General
251 Assembly having cognizance of matters relating to public health, or the
252 chairpersons' designees; and

253 (10) The Commissioner of Public Health, or the commissioner's
254 designee.

255 (c) Any member of the task force appointed under subdivisions (1) to
256 (9), inclusive, of subsection (b) of this section may be a member of the
257 General Assembly.

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

261 (e) The speaker of the House of Representatives and the president pro
262 tempore of the Senate shall select the chairpersons of the task force from
263 among the members of the task force. Such chairpersons shall schedule
264 the first meeting of the task force, which shall be held not later than sixty
265 days after the effective date of this section.

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

269 (g) Not later than January 1, 2022, the task force shall submit a report
270 on its findings and recommendations to the joint standing committee of
271 the General Assembly having cognizance of matters relating to public
272 health, in accordance with the provisions of section 11-4a of the general
273 statutes. The task force shall terminate on the date that it submits such
274 report or January 1, 2022, whichever is later.

275 Sec. 13. (NEW) (*Effective from passage*) Not later than January 1, 2022,
276 the Commissioner of Public Health shall establish a pilot program that
277 allows emergency medical services personnel, in coordination with
278 community health workers, to conduct home visits for individuals who
279 are at a high risk of being repeat users of emergency medical services to
280 assist such individuals with managing chronic illnesses and adhering to
281 medication plans.

282 Sec. 14. (NEW) (*Effective from passage*) On and after October 1, 2021,
283 each physician licensed pursuant to chapter 370 of the general statutes
284 shall conduct a mental health examination of a patient during the
285 patient's annual physical examination.

286 Sec. 15. (*Effective from passage*) The Secretary of the Office of Policy
287 and Management, in consultation with relevant state agencies,
288 including, but not limited to the Departments of Public Health, Mental
289 Health and Addiction Services, Children and Families, Social Services,
290 Developmental Services, Education, Housing and Aging and Disability
291 Services, the Labor Department and the Office of Early Childhood, shall
292 conduct a study on the impacts of the COVID-19 pandemic on the state

293 of Connecticut. Such study shall include, but need not be limited to, the
294 disparate impact of the COVID-19 pandemic on individuals based on
295 race, ethnicity, language and geography. Not later than February 1,
296 2022, the Secretary of the Office of Policy and Management shall submit
297 a report on the study to the joint standing committee of the General
298 Assembly having cognizance of matters relating to public health, in
299 accordance with the provisions of section 11-4a of the general statutes.
300 As used in this section, "COVID-19" means the respiratory disease
301 designated by the World Health Organization on February 11, 2020, as
302 coronavirus 2019, and any related mutation thereof recognized by said
303 organization as a communicable respiratory disease.

304 Sec. 16. Subsection (a) of section 19a-200 of the general statutes is
305 repealed and the following is substituted in lieu thereof (*Effective October*
306 *1, 2021*):

307 (a) The mayor of each city, the chief executive officer of each town
308 and the warden of each borough shall, unless the charter of such city,
309 town or borough otherwise provides, nominate some person to be
310 director of health for such city, town or borough, which nomination
311 shall be confirmed or rejected by the board of selectmen, if there be such
312 a board, otherwise by the legislative body of such city or town or by the
313 burgesses of such borough within thirty days thereafter.
314 Notwithstanding the charter provisions of any city, town or borough
315 with respect to the qualifications of the director of health, on and after
316 October 1, 2010, any person nominated to be a director of health shall
317 (1) be a licensed physician and hold a degree in public health from an
318 accredited school, college, university or institution, or (2) hold a
319 graduate degree in public health from an accredited institution of higher
320 education. The educational requirements of this section shall not apply
321 to any director of health nominated or otherwise appointed as director
322 of health prior to October 1, 2010. In cities, towns or boroughs with a
323 population of forty thousand or more for five consecutive years,
324 according to the estimated population figures authorized pursuant to
325 subsection (b) of section 8-159a, such director of health shall serve in a
326 full-time capacity, except where a town has designated such director as

327 the chief medical advisor for its public schools under section 10-205, and
328 shall not, during such director's term of office, have any financial
329 interest in or engage in any employment, transaction or professional
330 activity that is in substantial conflict with the proper discharge of the
331 duties required of directors of health by the general statutes or the
332 regulations of Connecticut state agencies or specified by the appointing
333 authority of the city, town or borough in its written agreement with such
334 director. Such director of health shall have and exercise within the limits
335 of the city, town or borough for which such director is appointed all
336 powers necessary for enforcing the general statutes, provisions of the
337 regulations of Connecticut state agencies relating to the preservation
338 and improvement of the public health and preventing the spread of
339 diseases therein. In case of the absence or inability to act of a city, town
340 or borough director of health or if a vacancy exists in the office of such
341 director, the appointing authority of such city, town or borough may,
342 with the approval of the Commissioner of Public Health, designate in
343 writing a suitable person to serve as acting director of health during the
344 period of such absence or inability or vacancy, provided the
345 commissioner may appoint such acting director if the city, town or
346 borough fails to do so. The person so designated, when sworn, shall
347 have all the powers and be subject to all the duties of such director. <u>If</u>
348 <u>the appointing authority of such city, town or borough designates a</u>
349 <u>person to serve as acting director of health, such appointing authority</u>
350 <u>shall notify the commissioner in writing of such designation, including</u>
351 <u>the start date of such acting director of health.</u> In case of vacancy in the
352 office of such director, if such vacancy exists for thirty days, said
353 commissioner **[**may**]** <u>shall</u> appoint a director of health for such city, town
354 or borough <u>who meets the qualifications specified in this subsection</u>.
355 Said commissioner, may, for cause, remove an officer the commissioner
356 or any predecessor in said office has appointed, and the common council
357 of such city, town or the burgesses of such borough may, respectively,
358 for cause, remove a director whose nomination has been confirmed by
359 them, provided such removal shall be approved by said commissioner;
360 and, within two days thereafter, notice in writing of such action shall be
361 given by the clerk of such city, town or borough, as the case may be, to

362 said commissioner, who shall, within ten days after receipt, file with the
363 clerk from whom the notice was received, approval or disapproval. Each
364 such director of health shall hold office for the term of four years from
365 the date of appointment and until a successor is nominated and
366 confirmed in accordance with this section. Each director of health shall,
367 annually, at the end of the fiscal year of the city, town or borough, file
368 with the Department of Public Health a report of the doings as such
369 director for the year preceding.

370 Sec. 17. (NEW) (*Effective from passage*) On and after January 1, 2022,
371 any state agency, board or commission that directly, or by contract with
372 another entity, collects demographic data concerning the ancestry or
373 ethnic origin, ethnicity, race or primary language of residents of the state
374 in the context of health care or for the provision or receipt of health care
375 services or for any public health purpose shall:

376 (1) Collect such data in a manner that allows for aggregation and
377 disaggregation of data;

378 (2) Expand race and ethnicity categories to include subgroup
379 identities as specified in the Centers for Medicare and Medicaid
380 Services' State Innovation Models Initiative and follow the hierarchical
381 mapping to align with United States Office of Management and Budget
382 standards;

383 (3) Provide the option to individuals of selecting one or more ethnic
384 or racial designations and include an "other" designation with the ability
385 to write in identities not represented by other codes;

386 (4) Collect primary language data employing language codes set by
387 the International Organization for Standardization; and

388 (5) Ensure, in cases where data concerning an individual's ethnic
389 origin, ethnicity or race is reported to any other state agency, board or
390 commission, that such data is neither tabulated nor reported without all
391 of the following information: (A) The number or percentage of
392 individuals who identify with each ethnic or racial designation as their

393 sole ethnic or racial designation and not in combination with any other
394 ethnic or racial designation; (B) the number or percentage of individuals
395 who identify with each ethnic or racial designation, whether as their sole
396 ethnic or racial designation or in combination with other ethnic or racial
397 designations; and (C) the number or percentage of individuals who
398 identify with multiple ethnic or racial designations.

399 Sec. 18. Section 19a-127k of the general statutes is repealed and the
400 following is substituted in lieu thereof (*Effective from passage*):

401 (a) As used in this section:

402 (1) "Community benefits program" means any **[**voluntary**]** program
403 to promote preventive care, to reduce racial ethnic, linguistic, sexual
404 orientation and gender identity, and cultural disparities in health and to
405 improve the health status for **[**working families and**]** all populations **[**at
406 risk in the communities**]** within the geographic service areas of **[**a
407 managed care organization or**]** a hospital in accordance with guidelines
408 established pursuant to subsection (c) of this section;

409 **[**(2) "Managed care organization" has the same meaning as provided
410 in section 38a-478;**]**

411 (2) "Community building" means activity that protects or improves a
412 community's health or safety and is eligible to be reported on the
413 Internal Revenue Service form 990;

414 (3) "Community health needs assessment" means a written
415 assessment, as described in 26 CFR 1.501(r)-(3) conducted by a hospital
416 that defines the community it serves, assesses the health needs of such
417 community, and solicits and takes into account persons that represent
418 the broad interests of the community;

419 **[**(3)**]** (4) "Hospital" has the same meaning as provided in section 19a-
420 490; **[**.**]** and

421 (5) "Implementation strategy" means a written plan required by 26
422 CFR 1.501(r)-(3) that addresses community health needs identified

423 through a community health needs assessment that (A) describes the
424 actions a hospital intends to take to address the health needs and
425 impacts of such actions, (B) identifies resources that the hospital plans
426 to commit to address such needs, and (C) describes the planned
427 collaboration between the hospital and other facilities and organizations
428 to address such health needs.

429 (b) On or before January 1, [2005] 2022, and [biennially] annually
430 thereafter, [each managed care organization and] each hospital shall
431 submit to the [Healthcare Advocate, or the Healthcare Advocate's]
432 Health Systems Planning Unit of the Office of Health Strategy, or to a
433 designee selected by the executive director of the Office of Health
434 Strategy, a report on [whether the managed care organization or
435 hospital has in place a] such hospital's community benefits program. [If
436 a managed care organization or hospital elects to develop a community
437 benefits program, the] The report required by this subsection shall
438 comply with the reporting requirements of subsection (d) of this section.

439 (c) [A managed care organization or] Each hospital [may] shall
440 develop community benefit guidelines intended to promote preventive
441 care, reduce racial, ethnic, linguistic, sexual orientation and gender
442 identity, and cultural disparities in health and [to] improve the health
443 status for [working families and] all populations [at risk] within the
444 geographic service areas of such hospital, whether or not those
445 individuals are [enrollees of the managed care plan or] patients of the
446 hospital. The guidelines shall focus on the following principles:

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

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

454 (3) Seeking assistance and meaningful participation from the

455 communities within [the organization's or] such hospital's geographic
456 service areas in developing and implementing the community benefits
457 program and a plan for meaningful community benefit and community
458 building investments, and in defining the targeted populations and the
459 specific health care needs [it] such hospital should address. In doing so,
460 the governing body or management of [the organization or] such
461 hospital shall give priority to (A) the public health needs outlined in the
462 most recent version of the state health plan prepared by the Department
463 of Public Health pursuant to section 19a-7, and (B) such hospital's
464 triennial community health needs assessment and implementation
465 strategy; and

466 (4) Developing its [program] implementation strategy based upon an
467 assessment of (A) the health care needs and resources of the targeted
468 populations, particularly a broad spectrum of age, racial and ethnic
469 groups, low and middle-income [,] populations and medically
470 underserved populations, and (B) barriers to accessing health care,
471 including, but not limited to, cultural, linguistic and physical barriers to
472 accessible health care, lack of information on available sources of health
473 care coverage and services, and the benefits of preventive health care.
474 [The program shall consider the health care needs of a broad spectrum
475 of age groups and health conditions] Each hospital shall solicit
476 commentary on its implementation strategy from the communities
477 within such hospital's geographic service area and consider revisions to
478 such strategy based on such commentary.

479 (d) Each [managed care organization and each] hospital [that chooses
480 to participate in developing a community benefits program] shall
481 include in the [biennial] annual report required by subsection (b) of this
482 section [the status of the program, if any, that the organization or
483 hospital established. If the managed care organization or hospital has
484 chosen to participate in a community benefits program, the report shall
485 include] the following components: (1) The community benefits policy
486 statement of [the managed care organization or] such hospital; (2) the
487 [mechanism] process by which community input and participation is
488 solicited and incorporated in the community benefits program; (3)

489 identification of community health needs that were [considered]
490 prioritized in developing [and implementing] the [community benefits
491 program] implementation strategy; (4) a narrative description of the
492 community benefits, community services, and preventive health
493 education provided or proposed, which may include measurements
494 related to the number of people served and health status outcomes; (5)
495 outcome measures [taken] used to evaluate the [results] impact of the
496 community benefits program and proposed revisions to the program;
497 (6) to the extent feasible, a community benefits budget and a good faith
498 effort to measure expenditures and administrative costs associated with
499 the community benefits program, including both cash and in-kind
500 commitments; [and] (7) a summary of the extent to which [the managed
501 care organization or] such hospital has developed and met the
502 guidelines listed in subsection (c) of this section; [. Each managed care
503 organization and each hospital] (8) for the prior taxable year, the
504 demographics of the population within the geographic service area of
505 such hospital; (9) the cost and description of each investment included
506 in the "Financial Assistance and Certain Other Community Benefits at
507 Cost" and the "Community Building Activities" sections of such
508 hospital's Internal Revenue Service form 990; (10) an explanation of how
509 each investment described in subdivision (9) of this subsection
510 addresses the needs identified in the hospital's triennial community
511 health needs assessment and implementation strategy; and (11) a
512 description of available evidence that shows how each investment
513 described in subdivision (9) of this subsection improves community
514 health outcomes. The Office of Health Strategy shall [make a copy of]
515 post the annual report [available, upon request, to any member of the
516 public] required by subsection (b) of this section on its Internet web site.

517 (e) (1) Not later than January 1, 2023, and biennially thereafter, the
518 Office of Health Strategy, or a designee selected by the executive
519 director of the Office of Health Strategy, shall establish a minimum
520 community benefit and community building spending threshold that
521 hospitals shall meet or exceed during the biennium. Such threshold shall
522 be based on objective data and criteria, including, but not limited to, the
523 following: (A) Historical and current expenditures on community

524 benefits by the hospital; (B) the community needs identified in the
525 hospital's triennial community health needs assessment; (C) the overall
526 financial position of the hospital based on audited financial statements
527 and other objective data; and (D) taxes and payments in lieu of taxes
528 paid by the hospital.

529 (2) The Office of Health Strategy shall consult with hospital
530 representatives, solicit and consider comments from the public and
531 consult with one or more individuals with expertise in health care
532 economics when establishing a community benefit and community
533 building spending threshold.

534 (3) The community benefit and community building spending
535 threshold established pursuant to this subsection shall include the
536 minimum proportion of community benefit spending that shall be
537 directed to addressing health disparities and social determinants of
538 health identified in the community health needs assessment during the
539 next biennium.

540 **[**(e)**]** (f) The **[**Healthcare Advocate, or the Healthcare Advocate's**]**
541 Office of Health Strategy, or a designee selected by the executive
542 director of the Office of Health Strategy, shall, within available
543 appropriations, develop a summary and analysis of the community
544 benefits program reports submitted by **[**managed care organizations
545 and**]** hospitals under this section and shall review such reports for
546 adherence to the guidelines set forth in subsection (c) of this section. Not
547 later than October 1, **[**2005**]** 2022, and **[**biennially**]** annually thereafter,
548 the **[**Healthcare Advocate, or the Healthcare Advocate's**]** Office of
549 Health Strategy, or a designee selected by the executive director of the
550 Office of Health Strategy, shall **[**make such summary and analysis
551 available to the public upon request**]** post such summary and analysis
552 on its Internet web site.

553 **[**(f)**]** (g) The **[**Healthcare Advocate**]** executive director of the Office of
554 Health Strategy, or the executive director's designee, may, after notice
555 and opportunity for a hearing, in accordance with chapter 54, impose a
556 civil penalty on any **[**managed care organization or**]** hospital that fails to

557 submit the report required pursuant to this section by the date specified
558 in subsection (b) of this section. Such penalty shall be not more than fifty
559 dollars a day for each day after the required submittal date that such
560 report is not submitted.

561 Sec. 19. (*Effective from passage*) The Commissioner of Public Health, in
562 consultation with the Commissioner of Children and Families, shall
563 conduct a study to identify areas of the state where access to quality and
564 affordable mental and behavioral health care services for children is
565 limited due to various barriers, including, but not limited to, geographic
566 and transportation barriers, mental health professional shortages and
567 lack of insurance. Not later than January 1, 2022, the Commissioner of
568 Public Health shall submit a report, in accordance with the provisions
569 of section 11-4a of the general statutes, to the joint standing committee
570 of the General Assembly having cognizance of matters relating to public
571 health regarding the findings of such study.

572 Sec. 20. (NEW) (*Effective from passage*) Sections 21 to 32, inclusive, of
573 this act may be cited as the Uniform Emergency Volunteer Health
574 Practitioners Act.

575 Sec. 21. (NEW) (*Effective from passage*) As used in this section and
576 sections 22 to 32, inclusive, of this act:

577 (1) "Disaster relief organization" means an entity that provides
578 emergency or disaster relief services that include health or veterinary
579 services provided by volunteer health practitioners and that:

580 (A) Is designated or recognized as a provider of those services
581 pursuant to a disaster response and recovery plan adopted by an agency
582 of the federal government or the Department of Public Health; or

583 (B) Regularly plans and conducts its activities in coordination with
584 an agency of the federal government or the Department of Public
585 Health.

586 (2) "Emergency" means an event or condition that is a public health
587 emergency under section 19a-131a of the general statutes.

588 (3) "Emergency declaration" means a declaration of emergency issued
589 by a person authorized to do so under the laws of this state.

590 (4) "Emergency Management Assistance Compact" means the
591 interstate compact approved by Congress by Public Law No. 104-
592 321,110 Stat. 3877.

593 (5) "Entity" means a person other than an individual.

594 (6) "Health facility" means an entity licensed under the laws of this or
595 another state to provide health or veterinary services.

596 (7) "Health practitioner" means an individual licensed under the laws
597 of this or another state to provide health or veterinary services.

598 (8) "Health services" means the provision of treatment, care, advice
599 or guidance, or other services or supplies, related to the health or death
600 of individuals or human populations, to the extent necessary to respond
601 to an emergency, including:

602 (A) The following, concerning the physical or mental condition or
603 functional status of an individual or affecting the structure or function
604 of the body:

605 (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance or
606 palliative care; and

607 (ii) Counseling, assessment, procedures or other services;

608 (B) Sale or dispensing of a drug, a device, equipment or another item
609 to an individual in accordance with a prescription; and

610 (C) Funeral, cremation, cemetery or other mortuary services.

611 (9) "Host entity" means an entity operating in this state which uses
612 volunteer health practitioners to respond to an emergency.

613 (10) "License" means authorization by a state to engage in health or
614 veterinary services that are unlawful without the authorization.

615 "License" includes authorization under the laws of this state to an
616 individual to provide health or veterinary services based upon a
617 national certification issued by a public or private entity.

618 (11) "Person" means an individual, corporation, business trust, trust,
619 partnership, limited liability company, association, joint venture, public
620 corporation, government or governmental subdivision, agency or
621 instrumentality or any other legal or commercial entity.

622 (12) "Scope of practice" means the extent of the authorization to
623 provide health or veterinary services granted to a health practitioner by
624 a license issued to the practitioner in the state in which the principal part
625 of the practitioner's services are rendered, including any conditions
626 imposed by the licensing authority.

627 (13) "State" means a state of the United States, the District of
628 Columbia, Puerto Rico, the United States Virgin Islands or any territory
629 or insular possession subject to the jurisdiction of the United States.

630 (14) "Veterinary services" means the provision of treatment, care,
631 advice or guidance or other services, or supplies, related to the health or
632 death of an animal or to animal populations, to the extent necessary to
633 respond to an emergency, including:

634 (A) Diagnosis, treatment or prevention of an animal disease, injury
635 or other physical or mental condition by the prescription,
636 administration or dispensing of vaccine, medicine, surgery or therapy;

637 (B) Use of a procedure for reproductive management; and

638 (C) Monitoring and treatment of animal populations for diseases that
639 have spread or demonstrate the potential to spread to humans.

640 (15) "Volunteer health practitioner" means a health practitioner who
641 provides health or veterinary services, whether or not the practitioner
642 receives compensation for those services. "Volunteer health
643 practitioner" does not include a practitioner who receives compensation
644 pursuant to a preexisting employment relationship with a host entity or

645 affiliate which requires the practitioner to provide health services in this
646 state, unless the practitioner is not a resident of this state and is
647 employed by a disaster relief organization providing services in this
648 state while an emergency declaration is in effect.

649 Sec. 22. (NEW) (*Effective from passage*) Sections 21 to 32, inclusive, of
650 this act apply to volunteer health practitioners registered with a
651 registration system that complies with section 24 of this act and who
652 provide health or veterinary services in this state for a host entity while
653 an emergency declaration is in effect.

654 Sec. 23. (NEW) (*Effective from passage*) (a) While an emergency
655 declaration is in effect, the Department of Public Health may limit,
656 restrict or otherwise regulate:

657 (1) The duration of practice by volunteer health practitioners;

658 (2) The geographical areas in which volunteer health practitioners
659 may practice;

660 (3) The types of volunteer health practitioners who may practice; and

661 (4) Any other matters necessary to coordinate effectively the
662 provision of health or veterinary services during the emergency.

663 (b) An order issued pursuant to subsection (a) of this section may take
664 effect immediately, without prior notice or comment, and is not a rule
665 within the meaning of chapter 54 of the general statutes.

666 (c) A host entity that uses volunteer health practitioners to provide
667 health or veterinary services in this state shall:

668 (1) Consult and coordinate its activities with the Department of
669 Public Health to the extent practicable to provide for the efficient and
670 effective use of volunteer health practitioners; and

671 (2) Comply with any laws other than sections 21 to 32, inclusive, of
672 this act relating to the management of emergency health or veterinary
673 services.

674 Sec. 24. (NEW) (*Effective from passage*) (a) To qualify as a volunteer
675 health practitioner registration system, a system shall:

676 (1) Accept applications for the registration of volunteer health
677 practitioners before or during an emergency;

678 (2) Include information about the licensure and good standing of
679 health practitioners which is accessible by authorized persons;

680 (3) Be capable of confirming the accuracy of information concerning
681 whether a health practitioner is licensed and in good standing before
682 health services or veterinary services are provided under sections 21 to
683 32, inclusive, of this act; and

684 (4) Meet one of the following conditions:

685 (A) Be an emergency system for advance registration of volunteer
686 health care practitioners established by a state and funded through the
687 Department of Health and Human Services under Section 319I of the
688 Public Health Services Act, 42 USC 247d-7b, as amended from time to
689 time;

690 (B) Be a local unit consisting of trained and equipped emergency
691 response, public health and medical personnel formed pursuant to
692 Section 2801 of the Public Health Services Act, 42 USC 300hh, as
693 amended from time to time;

694 (C) Be operated by a:

695 (i) Disaster relief organization;

696 (ii) Licensing board;

697 (iii) National or regional association of licensing boards or health
698 practitioners;

699 (iv) Health facility that provides comprehensive inpatient and
700 outpatient health care services, including a tertiary care and teaching
701 hospital; or

702 (v) Governmental entity; or

703 (D) Be designated by the Department of Public Health as a
704 registration system for purposes of sections 21 to 32, inclusive, of this
705 act.

706 (b) While an emergency declaration is in effect, the Department of
707 Public Health, a person authorized to act on behalf of the Department
708 of Public Health, or a host entity, may confirm whether volunteer health
709 practitioners utilized in this state are registered with a registration
710 system that complies with subsection (a) of this section. Confirmation is
711 limited to obtaining identities of the practitioners from the system and
712 determining whether the system indicates that the practitioners are
713 licensed and in good standing.

714 (c) Upon request of a person in this state authorized under subsection
715 (b) of this section, or a similarly authorized person in another state, a
716 registration system located in this state shall notify the person of the
717 identities of volunteer health practitioners and whether the practitioners
718 are licensed and in good standing.

719 (d) A host entity is not required to use the services of a volunteer
720 health practitioner even if the practitioner is registered with a
721 registration system that indicates that the practitioner is licensed and in
722 good standing.

723 Sec. 25. (NEW) (*Effective from passage*) (a) While an emergency
724 declaration is in effect, a volunteer health practitioner, registered with a
725 registration system that complies with section 24 of this act and licensed
726 and in good standing in the state upon which the practitioner's
727 registration is based, may practice in this state to the extent authorized
728 by sections 21 to 32, inclusive, of this act as if the practitioner were
729 licensed in this state.

730 (b) A volunteer health practitioner qualified under subsection (a) of
731 this section is not entitled to the protections of sections 21 to 32,
732 inclusive, of this act if the practitioner is licensed in more than one state

733 and any license of the practitioner is suspended, revoked or subject to
734 an agency order limiting or restricting practice privileges or has been
735 voluntarily terminated under threat of sanction.

736 Sec. 26. (NEW) (*Effective from passage*) (a) As used in this section: (1)
737 "Credentialing" means obtaining, verifying and assessing the
738 qualifications of a health practitioner to provide treatment, care or
739 services in or for a health facility; and (2) "privileging" means the
740 authorizing by an appropriate authority, such as a governing body, of a
741 health practitioner to provide specific treatment, care or services at a
742 health facility subject to limits based on factors that include license,
743 education, training, experience, competence, health status and
744 specialized skill.

745 (b) Sections 21 to 32, inclusive, of this act do not affect credentialing
746 or privileging standards of a health facility and do not preclude a health
747 facility from waiving or modifying those standards while an emergency
748 declaration is in effect.

749 Sec. 27. (NEW) (*Effective from passage*) (a) Subject to subsections (b)
750 and (c) of this section, a volunteer health practitioner shall adhere to the
751 scope of practice for a similarly licensed practitioner established by the
752 licensing provisions, practice acts or other laws of this state.

753 (b) Except as otherwise provided in subsection (c) of this section,
754 sections 21 to 32, inclusive, of this act do not authorize a volunteer health
755 practitioner to provide services that are outside the practitioner's scope
756 of practice, even if a similarly licensed practitioner in this state would
757 be permitted to provide the services.

758 (c) The Department of Public Health may modify or restrict the health
759 or veterinary services that volunteer health practitioners may provide
760 pursuant to sections 21 to 32, inclusive, of this act. An order under this
761 subsection may take effect immediately, without prior notice or
762 comment, and is not a rule within the meaning of chapter 54 of the
763 general statutes.

764 (d) A host entity may restrict the health or veterinary services that a
765 volunteer health practitioner may provide pursuant to sections 21 to 32,
766 inclusive, of this act.

767 (e) A volunteer health practitioner does not engage in unauthorized
768 practice unless the practitioner has reason to know of any limitation,
769 modification or restriction under this section or that a similarly licensed
770 practitioner in this state would not be permitted to provide the services.
771 A volunteer health practitioner has reason to know of a limitation,
772 modification or restriction or that a similarly licensed practitioner in this
773 state would not be permitted to provide a service if:

774 (1) The practitioner knows the limitation, modification or restriction
775 exists or that a similarly licensed practitioner in this state would not be
776 permitted to provide the service; or

777 (2) From all the facts and circumstances known to the practitioner at
778 the relevant time, a reasonable person would conclude that the
779 limitation, modification or restriction exists or that a similarly licensed
780 practitioner in this state would not be permitted to provide the service.

781 (f) In addition to the authority granted by law of this state other than
782 sections 21 to 32, inclusive, of this act to regulate the conduct of health
783 practitioners, a licensing board or other disciplinary authority in this
784 state:

785 (1) May impose administrative sanctions upon a health practitioner
786 licensed in this state for conduct outside of this state in response to an
787 out-of-state emergency;

788 (2) May impose administrative sanctions upon a practitioner not
789 licensed in this state for conduct in this state in response to an in-state
790 emergency; and

791 (3) Shall report any administrative sanctions imposed upon a
792 practitioner licensed in another state to the appropriate licensing board
793 or other disciplinary authority in any other state in which the
794 practitioner is known to be licensed.

795 (g) In determining whether to impose administrative sanctions under
796 subsection (f) of this section, a licensing board or other disciplinary
797 authority shall consider the circumstances in which the conduct took
798 place, including any exigent circumstances, and the practitioner's scope
799 of practice, education, training, experience and specialized skill.

800 Sec. 28. (NEW) (*Effective from passage*) (a) Sections 21 to 32, inclusive,
801 of this act do not limit rights, privileges or immunities provided to
802 volunteer health practitioners by laws other than sections 21 to 32,
803 inclusive, of this act. Except as otherwise provided in subsection (b) of
804 this section, sections 21 to 32, inclusive, of this act do not affect
805 requirements for the use of health practitioners pursuant to the
806 Emergency Management Assistance Compact.

807 (b) The Department of Public Health, pursuant to the Emergency
808 Management Assistance Compact, may incorporate into the emergency
809 forces of this state volunteer health practitioners who are not officers or
810 employees of this state, a political subdivision of this state or a
811 municipality or other local government within this state.

812 Sec. 29. (NEW) (*Effective from passage*) The Department of Public
813 Health may promulgate rules to implement sections 21 to 32, inclusive,
814 of this act. In doing so, the Department of Public Health shall consult
815 with and consider the recommendations of the entity established to
816 coordinate the implementation of the Emergency Management
817 Assistance Compact and shall also consult with and consider rules
818 promulgated by similarly empowered agencies in other states to
819 promote uniformity of application of sections 21 to 32, inclusive, of this
820 act and make the emergency response systems in the various states
821 reasonably compatible.

822 Sec. 30. (NEW) (*Effective from passage*) (a) Subject to subsection (c) of
823 this section, a volunteer health practitioner who provides health or
824 veterinary services pursuant to sections 21 to 32, inclusive, of this act is
825 not liable for damages for an act or omission of the practitioner in
826 providing those services.

827 (b) No person is vicariously liable for damages for an act or omission
828 of a volunteer health practitioner if the practitioner is not liable for the
829 damages under subsection (a) of this section.

830 (c) This section does not limit the liability of a volunteer health
831 practitioner for:

832 (1) Wilful misconduct or wanton, grossly negligent, reckless or
833 criminal conduct;

834 (2) An intentional tort;

835 (3) Breach of contract;

836 (4) A claim asserted by a host entity or by an entity located in this or
837 another state which employs or uses the services of the practitioner; or

838 (5) An act or omission relating to the operation of a motor vehicle,
839 vessel, aircraft or other vehicle.

840 (d) A person that, pursuant to sections 21 to 32, inclusive, of this act,
841 operates, uses or relies upon information provided by a volunteer health
842 practitioner registration system is not liable for damages for an act or
843 omission relating to that operation, use or reliance unless the act or
844 omission is an intentional tort or is wilful misconduct or wanton, grossly
845 negligent, reckless or criminal conduct.

846 Sec. 31. (NEW) (*Effective from passage*) (a) As used in this section,
847 "injury" means a physical or mental injury or disease for which an
848 employee of this state who is injured or contracts the disease in the
849 course of the employee's employment would be entitled to benefits
850 under chapter 568 of the general statutes.

851 (b) A volunteer health practitioner who dies or is injured as the result
852 of providing health or veterinary services pursuant to sections 21 to 32,
853 inclusive, of this act, is deemed to be an employee of this state for the
854 purpose of receiving benefits for the death or injury under chapter 568
855 of the general statutes if:

856 (1) The practitioner is not otherwise eligible for such benefits for the
857 injury or death under the law of this or another state; and

858 (2) The practitioner, or, in the case of death, the practitioner's personal
859 representative, elects coverage under chapter 568 of the general statutes
860 by making a claim under said chapter.

861 (c) The Labor Department shall adopt rules, enter into agreements
862 with other states or take other measures to facilitate the receipt of
863 benefits for injury or death under chapter 568 of the general statutes by
864 volunteer health practitioners who reside in other states, and may waive
865 or modify requirements for filing, processing and paying claims that
866 unreasonably burden the practitioners. To promote uniformity of
867 application of sections 21 to 32, inclusive, of this act with other states
868 that enact similar legislation, the Labor Department shall consult with
869 and consider the practices for filing, processing and paying claims by
870 agencies with similar authority in other states.

871 Sec. 32. (NEW) (*Effective from passage*) In applying and construing
872 sections 21 to 32, inclusive, of this act, consideration shall be given to the
873 need to promote uniformity of the law with respect to its subject matter
874 among states that enact it.

875 Sec. 33. (*Effective from passage*) The sum of ___ dollars is appropriated
876 to the Department of Public Health, from the General Fund, for the fiscal
877 year ending June 30, 2022, for the purpose of expanding services of
878 existing school-based health centers and establishing new school-based
879 health centers.

880 Sec. 34. (*Effective from passage*) The sum of six million dollars is
881 appropriated to the Department of Mental Health and Addiction
882 Services, from the General Fund, for the fiscal year ending June 30, 2022,
883 for the purpose of making mobile crisis intervention services available
884 twenty-four hours per day and seven days per week in each mobile
885 crisis region to respond to acute mental health emergencies.

886 Sec. 35. (*Effective from passage*) The sum of five hundred thousand

887 dollars is appropriated to the Department of Public Health, from the
888 General Fund, for the fiscal year ending June 30, 2022, for the purpose
889 of providing three-year grants to community-based health care
890 providers in primary care settings.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	New section
Sec. 2	*October 1, 2021*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*October 1, 2021*	New section
Sec. 6	*from passage*	New section
Sec. 7	*July 1, 2021*	New section
Sec. 8	*October 1, 2021*	New section
Sec. 9	*October 1, 2021*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	19a-490u
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*October 1, 2021*	19a-200(a)
Sec. 17	*from passage*	New section
Sec. 18	*from passage*	19a-127k
Sec. 19	*from passage*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	New section
Sec. 22	*from passage*	New section
Sec. 23	*from passage*	New section
Sec. 24	*from passage*	New section
Sec. 25	*from passage*	New section
Sec. 26	*from passage*	New section
Sec. 27	*from passage*	New section
Sec. 28	*from passage*	New section
Sec. 29	*from passage*	New section
Sec. 30	*from passage*	New section
Sec. 31	*from passage*	New section
Sec. 32	*from passage*	New section

Sec. 33	*from passage*	New section
Sec. 34	*from passage*	New section
Sec. 35	*from passage*	New section

Statement of Legislative Commissioners:

In section 10, the word "(NEW)" was deleted for consistency with standard drafting conventions; in Section 14, the provisions of the section were redrafted for clarity and to avoid repetition; in Section 15, "Commissioner of Public Health" was replaced with "Secretary of the Office of Policy and Management" for internal consistency; and in Section 18(c), "sexual orientation and gender identity" was added after "linguistic" for internal consistency with Section 18(a)(1).

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 22 $	FY 23 $
State Comptroller - Fringe Benefits[1]	GF - Cost	127,000	132,500
Mental Health & Addiction Serv., Dept.	GF - Cost	6 million	None
Policy & Mgmt., Off.	GF - Cost	500,000	None
Public Health, Dept.	GF - Cost	1,510,000	973,000

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Local and Regional School Districts	STATE MANDATE[2] - Potential Cost	See Below	See Below

Explanation

The bill requires the Department of Public Health (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

[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 41.3% of payroll in FY 22 and FY 23.

[2] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means 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.

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.

DPH would need to hire three positions (two full-time and one part-time) to fulfill these requirements. The Public Health Services Manager position, with a salary of $106,000 in FY 22 and $110,000 in FY 23 would be responsible for conducting an annual inventory of the state's medical stockpile of medical equipment and supplies and provide updates to the members of the general assembly during declared public health emergencies, as well as preparing a report annually for the joint standing committee of the General Assembly.

The other two positions would be filled by a full-time Nurse Consultant, with a salary of $92,000 in FY 22 and $96,000 in FY 23, and a part-time Nurse Consultant position, with a salary of $46,000 in FY 22 and $48,000 in FY 23. These two positions would be responsible for providing infection control technical assistance to support increased infection control prevention efforts in various healthcare facilities and to assist healthcare facilities to build infection control capacity and procedures in the areas of infection control staffing and training, use of PPE, and outbreak response.

Additionally, DPH needs $400,000 in FY 22 and $350,000 in FY 23 for the storage, maintenance, and management of medical equipment and supplies. This would cover storage, maintenance, and management of ventilators/aspirators, the state's mobile field hospital, and a 250-bed medical station of supplies. This equipment and supplies require temperature and humidity-controlled storage space and annual maintenance. Also, an inventory management system will be required to track the PPE inventory.

The bill also requires DPH to establish a program, within available appropriations, to advance breast health and breast cancer awareness and promote a greater understanding of the importance of breast cancer detection, but not limited to, outreach to young women of color. The CT

Early Detection and Prevention Program (CEDPP) currently provides breast cancer outreach, screening, and diagnostic service and navigation to women 40 years and over for breast health and breast cancer detection, prevention, and treatment.

To expand the program to include outreach to younger women, DPH would need to hire an additional six Community Health Workers at $50,000 per position (total cost of $300,000 annually), based at six CT Early Detection and Prevention program's health systems, to conduct prioritized outreach services to women under 40 years of age, specifically low income and women of color. DPH will also need an Outreach Coordinator at $66,000 in FY 22 and $69,000 (plus fringe benefits) in FY 23 to coordinate this program expansion.

Section 1 results in a state mandate and a cost to local and regional boards of education associated with requiring schools to conduct exit interviews on students who do not graduate. The cost to local and regional school districts is associated with additional staff time or substitute teacher coverage and will vary by the size of the district and number of students withdrawing annually. Districts with few students withdrawing will incur minimal costs.

Section 15 requires the Office of Policy and Management to study the impacts of the COVID-19 pandemic on the State of Connecticut. It is anticipated that OPM would need the assistance of a consultant to complete this study, which could cost up to $500,000.

Section 33 makes an unspecified General Fund appropriation to DPH in FY 22 to expand services of existing school-based health centers and establish new ones.

Section 34 appropriates $6 million in FY 22 to the Department of Mental Health and Addiction Services to expand mobile crisis services.

Section 35 appropriates $500,000 in FY 22 to DPH for the purpose of providing three-year grants to community health care providers in primary care settings.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, except where costs are noted as one-time.

OLR Bill Analysis

SB 1

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

TABLE OF CONTENTS:

SUMMARY

§ 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

§ 2 — PEER SUPPORT SPECIALISTS

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

§ 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

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

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

§ 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

§§ 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.

§ 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

§ 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

§ 10 — DOULA CERTIFICATION STUDY

Requires DPH to study whether to establish a doula certification program

§ 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

§ 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

§ 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

§ 14 — MENTAL HEALTH EXAMINATIONS DURING PHYSICALS

Requires physicians to perform mental health examinations on patients 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

§ 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

§ 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

§ 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

§ 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

§§ 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

§ 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

§ 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

§ 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

Appointing Authority	*Appointee Qualifications*
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, whenever 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)