General Assembly **Substitute Bill No. 1**

January Session, 2021

SB00001PH 032921

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:

Section 1. (NEW) (*Effective October 1, 2021*) Each local and regional board of education shall conduct an exit interview with each student who withdraws from school under section 10-184 of the general statutes without graduating or being granted a diploma by such board. The purpose of such exit interview shall be to collect information regarding (1) whether the student has a history of trauma, (2) whether the student's family has been reported to the Department of Children and Families or any other agency for ongoing stressors in the student's life or any needs of the student that are not being addressed, (3) the future plans of such student following such withdrawal, (4) whether the student has been the victim of bullying that caused a decline in academic achievement and resulted in such withdrawal, and (5) whether such student is trainable in skills that will provide financial independence. Each local and regional board of education shall provide such student, for not less than one year after such student's withdrawal, resources pertaining to mental health services, adult education opportunities and apprenticeship programs. Not later than July 1, 2022, and annually thereafter, each local and regional board of education shall aggregate such information in a report and submit such report to the Departments

of Education and Public Health for evaluation.

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

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

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

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

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

Sec. 3. (NEW) (*Effective from passage*) (a) The Department of Mental Health and Addiction Services shall develop a mental health toolkit to help employers in the state address employee mental health needs that arise as a result of COVID-19. Such toolkit shall (1) identify common mental health issues that employees experience as a result of COVID-19, (2) identify symptoms of such mental health issues, and (3) provide information and other resources regarding actions that employers may take to help employees address such mental health issues. Not later than October 1, 2021, the Department of Mental Health and Addiction Services shall post such mental health toolkit on its Internet web site. For the purposes of this section and section 4 of this act, "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by said organization as a communicable respiratory disease.

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

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

Sec. 6. (NEW) (*Effective from passage*) It is hereby declared the policy of the state of Connecticut to recognize that racism is a public health crisis.

Sec. 7. (NEW) (*Effective July 1, 2021*) (a) There is established a Truth and Reconciliation Commission to examine racial disparities in public health. The commission shall study (1) institutional racism in the state's

laws and regulations impacting public health, (2) racial disparities in the state's criminal justice system and the impact of such disparities on the health and well-being of individuals and families, including, but not limited to, overall health outcomes and rates of depression, suicide, substance use disorder and chronic disease, (3) racial disparities in access to healthy living resources, including, but not limited to, fresh food, produce, physical activity, public safety, clean air and clean water, (4) racial disparities in access to health care, (5) racial disparities in health outcomes in hospitals and long-term care facilities, including, but not limited to, nursing homes, and (6) the impact of zoning restrictions on the creation of housing disparities and the impact of such disparities on public health. The commission shall develop legislative proposals to address racial disparities in public health.

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

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

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

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

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

(5) Three members appointed by the speaker of the House of Representatives, one of whom is a representative from the Connecticut Health Foundation, one of whom is a representative from Health Equity Solutions and one of whom has experience in philanthropy related to health care equity and access for minority communities;

(6) Three members appointed by the president pro tempore of the

Senate, one of whom is a representative from the Connecticut Children's Medical Center Foundation, one of whom is a representative from Yale University with a professional focus on health care equity and access and one of whom is a representative from a school-based health care center;

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

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

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

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

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

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

(2) Members of the commission appointed on or after July 1, 2023, shall serve for two-year terms. Members shall continue to serve until

their successors are appointed. Any vacancy occurring other than by expiration of term shall be filled for the balance of the unexpired term.

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

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

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

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

(b) On and after October 1, 2021, the Commissioner of Public Health shall require each hospital to maintain a daily minimum staffing ratio of two nurses per patient in the intensive care unit. The daily minimum staffing ratio shall not include break, vacation, sick, personal, training,

educational or other time that is not spent on medical care provided to an intensive care unit patient.

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

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

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

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

Sec. 10. (*Effective from passage*) (a) As used in this section, "doula" means a trained, nonmedical professional who provides continuous

physical, emotional and informational support to a pregnant person during the antepartum and intrapartum periods and up to the first six weeks of the postpartum period.

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

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

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

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

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

of this section, "maternal mortality" means the death of a woman during pregnancy or within one year of the end of such pregnancy.

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

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

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

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

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

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

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

(7) Two appointed by the Governor;

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

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

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

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

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

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

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

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

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

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

Sec. 15. (*Effective from passage*) The Secretary of the Office of Policy and Management, in consultation with relevant state agencies, including, but not limited to the Departments of Public Health, Mental Health and Addiction Services, Children and Families, Social Services, Developmental Services, Education, Housing and Aging and Disability Services, the Labor Department and the Office of Early Childhood, shall

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

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

(a) The mayor of each city, the chief executive officer of each town and the warden of each borough shall, unless the charter of such city, town or borough otherwise provides, nominate some person to be director of health for such city, town or borough, which nomination shall be confirmed or rejected by the board of selectmen, if there be such a board, otherwise by the legislative body of such city or town or by the burgesses of such borough within thirty days thereafter. Notwithstanding the charter provisions of any city, town or borough with respect to the qualifications of the director of health, on and after October 1, 2010, any person nominated to be a director of health shall (1) be a licensed physician and hold a degree in public health from an accredited school, college, university or institution, or (2) hold a graduate degree in public health from an accredited institution of higher education. The educational requirements of this section shall not apply to any director of health nominated or otherwise appointed as director of health prior to October 1, 2010. In cities, towns or boroughs with a population of forty thousand or more for five consecutive years, according to the estimated population figures authorized pursuant to

subsection (b) of section 8-159a, such director of health shall serve in a full-time capacity, except where a town has designated such director as the chief medical advisor for its public schools under section 10-205, and shall not, during such director's term of office, have any financial interest in or engage in any employment, transaction or professional activity that is in substantial conflict with the proper discharge of the duties required of directors of health by the general statutes or the regulations of Connecticut state agencies or specified by the appointing authority of the city, town or borough in its written agreement with such director. Such director of health shall have and exercise within the limits of the city, town or borough for which such director is appointed all powers necessary for enforcing the general statutes, provisions of the regulations of Connecticut state agencies relating to the preservation and improvement of the public health and preventing the spread of diseases therein. In case of the absence or inability to act of a city, town or borough director of health or if a vacancy exists in the office of such director, the appointing authority of such city, town or borough may, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of health during the period of such absence or inability or vacancy, provided the commissioner may appoint such acting director if the city, town or borough fails to do so. The person so designated, when sworn, shall have all the powers and be subject to all the duties of such director. If the appointing authority of such city, town or borough designates a person to serve as acting director of health, such appointing authority shall notify the commissioner in writing of such designation, including the start date of such acting director of health. In case of vacancy in the office of such director, if such vacancy exists for thirty days, said commissioner **[**may**]** shall appoint a director of health for such city, town or borough who meets the qualifications specified in this subsection. Said commissioner, may, for cause, remove an officer the commissioner or any predecessor in said office has appointed, and the common council of such city, town or the burgesses of such borough may, respectively, for cause, remove a director whose nomination has been confirmed by them, provided such removal shall be approved by said commissioner;

and, within two days thereafter, notice in writing of such action shall be given by the clerk of such city, town or borough, as the case may be, to said commissioner, who shall, within ten days after receipt, file with the clerk from whom the notice was received, approval or disapproval. Each such director of health shall hold office for the term of four years from the date of appointment and until a successor is nominated and confirmed in accordance with this section. Each director of health shall, annually, at the end of the fiscal year of the city, town or borough, file with the Department of Public Health a report of the doings as such director for the year preceding.

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

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

(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 United States Office of Management and Budget standards;

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

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

(5) Ensure, in cases where data concerning an individual's ethnic origin, ethnicity or race is reported to any other state agency, board or commission, that such data is neither tabulated nor reported without all

of the following information: (A) The number or percentage of individuals who identify with each ethnic or racial designation as their sole ethnic or racial designation and not in combination with any other ethnic or racial designation; (B) the number or percentage of individuals who identify with each ethnic or racial designation, whether as their sole ethnic or racial designation or in combination with other ethnic or racial designations; and (C) the number or percentage of individuals who identify with multiple ethnic or racial designations.

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

(a) As used in this section:

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

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

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

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

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

(5) "Implementation strategy" means a written plan required by 26 CFR 1.501(r)-(3) that addresses community health needs identified through a community health needs assessment that (A) describes the actions a hospital intends to take to address the health needs and impacts of such actions, (B) identifies resources that the hospital plans to commit to address such needs, and (C) describes the planned collaboration between the hospital and other facilities and organizations to address such health needs.

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

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

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

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

of the program;

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

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

(d) Each **[**managed care organization and each**]** hospital **[**that chooses to participate in developing a community benefits program**]** shall include in the **[**biennial**]** annual report required by subsection (b) of this section **[**the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include**]** the following components: (1) The community benefits policy

statement of [the managed care organization or] such hospital; (2) the [mechanism] process by which community input and participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were [considered] prioritized in developing [and implementing] the [community benefits program] implementation strategy; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) outcome measures [taken] used to evaluate the [results] impact of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; [and] (7) a summary of the extent to which [the managed care organization or] such hospital has developed and met the guidelines listed in subsection (c) of this section; [. Each managed care organization and each hospital] (8) for the prior taxable year, the demographics of the population within the geographic service area of such hospital; (9) the cost and description of each investment included in the "Financial Assistance and Certain Other Community Benefits at Cost" and the "Community Building Activities" sections of such hospital's Internet Revenue Service form 990; (10) an explanation of how each investment described in subdivision (9) of this subsection addresses the needs identified in the hospital's triennial community health needs assessment and implementation strategy; and (11) a description of available evidence that shows how each investment described in subdivision (9) of this subsection improves community health outcomes. The Office of Health Strategy shall [make a copy of] post the annual report [available, upon request, to any member of the public] required by subsection (b) of this section on its Internet web site.

(e) (1) Not later than January 1, 2023, and biennially thereafter, the Office of Health Strategy, or a designee selected by the executive director of the Office of Health Strategy, shall establish a minimum

community benefit and community building spending threshold that hospitals shall meet or exceed during the biennium. Such threshold shall be based on objective data and criteria, including, but not limited to, the following: (A) Historical and current expenditures on community benefits by the hospital; (B) the community needs identified in the hospital's triennial community health needs assessment; (C) the overall financial position of the hospital based on audited financial statements and other objective data; and (D) taxes and payments in lieu of taxes paid by the hospital.

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

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

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

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

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

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

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

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

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

(B) Regularly plans and conducts its activities in coordination with

an agency of the federal government or the Department of Public Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) "License" means authorization by a state to engage in health or veterinary services that are unlawful without the authorization. "License" includes authorization under the laws of this state to an individual to provide health or veterinary services based upon a national certification issued by a public or private entity.

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

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

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

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

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

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

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

(15) "Volunteer health practitioner" means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. "Volunteer health practitioner" does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Meet one of the following conditions:

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

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

(C) Be operated by a:

(i) Disaster relief organization;

(ii) Licensing board;

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

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

(v) Governmental entity; or

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

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

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

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

good standing.

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

(b) A volunteer health practitioner qualified under subsection (a) of this section is not entitled to the protections of sections 21 to 32, inclusive, of this act if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked or subject to an agency order limiting or restricting practice privileges or has been voluntarily terminated under threat of sanction.

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

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

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

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

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

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

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

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

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

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

state:

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

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

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

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

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

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

Sec. 29. (NEW) (*Effective from passage*) The Department of Public Health may promulgate rules to implement sections 21 to 32, inclusive,

of this act. In doing so, the Department of Public Health shall consult with and consider the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact and shall also consult with and consider rules promulgated by similarly empowered agencies in other states to promote uniformity of application of sections 21 to 32, inclusive, of this act and make the emergency response systems in the various states reasonably compatible.

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

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

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

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

(2) An intentional tort;

(3) Breach of contract;

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

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

(d) A person that, pursuant to sections 21 to 32, inclusive, of this act, operates, uses or relies upon information provided by a volunteer health

practitioner registration system is not liable for damages for an act or omission relating to that operation, use or reliance unless the act or omission is an intentional tort or is wilful misconduct or wanton, grossly negligent, reckless or criminal conduct.

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

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

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

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

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

Sec. 32. (NEW) (*Effective from passage*) In applying and construing sections 21 to 32, inclusive, of this act, consideration shall be given to the

need to promote uniformity of the law with respect to its subject matter among states that enact it.

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

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

Sec. 35. (*Effective from passage*) The sum of five hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2022, for the purpose of providing three-year grants to community-based health care 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*