

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 21-35—sSB 1
Public Health Committee
Appropriations Committee

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

TABLE OF CONTENTS:

§ 1 — RACISM AS A PUBLIC HEALTH CRISIS

Declares racism to be a public health crisis in the state

§§ 2-4 — COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

Establishes a 28-member Commission on Racial Equity in Public Health; outlines the commission's responsibilities, including developing a strategic plan to eliminate health disparities and inequities in various areas; establishes a goal of reducing racial disparities in certain areas by at least 70%; requires the commission to determine best practices for state agencies to evaluate structural racism within their operations and implement a plan to eliminate that racism

**§ 5 — DPH STUDY ON RECRUITMENT AND RETENTION PROGRAM
FOR HEALTH CARE WORKERS OF COLOR**

Requires DPH to study and report on developing a program to recruit and retain health care workers of color in the state

**§ 6 — DEEP ASSESSMENT OF RACIAL EQUITY WITHIN
ENVIRONMENTAL HEALTH QUALITY PROGRAMS**

Requires DEEP to assess and report on racial equity within the department's environmental health quality programs

§ 7 — HEALTH CARE PREPARATION PROGRAMS

Requires OHE to evaluate and report on the recruitment and retention of people of color in health care preparation programs and the inclusion of cultural humility education in these programs

**§ 8 — REPORTING ON RACIAL AND ETHNIC IMPACT STATEMENT
RULE CHANGES**

Requires the CWCSEO executive director to report on the status of amendments to the legislative Joint Rules on preparing racial and ethnic impact statements

**§ 9 — GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY
COMMITTEE**

OLR PUBLIC ACT SUMMARY

Establishes a committee to advise the Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of programs and strategies to reduce gun violence

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

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

§ 11 — DEMOGRAPHIC DATA COLLECTION

Sets requirements for state agencies or state entities that, directly or by contract, collect demographic data related to health care or public health; requires certain health care providers to include self-reported patient demographic data in their electronic health record systems; requires OHS to (1) create a plan to implement these provisions and (2) review demographic changes and health data and periodically reevaluate the standard race and ethnicity categories

§ 12 — MATERNAL MORTALITY REVIEW COMMITTEE

Requires DPH's Maternal Mortality Review Committee to annually report disaggregated data on its investigations to the Public Health Committee and allows the reports to include recommendations to reduce or eliminate racial inequities and other public health concerns related to its charge

§ 13 — 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

§ 14 — BREAST HEALTH AND BREAST CANCER AWARENESS WORKING GROUP

Requires the Public Health Committee chairpersons to convene a working group to advance breast health and breast cancer awareness and promote greater understanding of the importance of early breast cancer detection

§ 15 — DOULA SCOPE OF PRACTICE REVIEW

Requires DPH to (1) establish a scope of practice review committee to determine whether DPH should establish a doula certification process and (2) report to the Public Health Committee on its findings and recommendations

§ 16 — SCHOOL-BASED HEALTH CENTER WORKING GROUP

Establishes a working group to develop recommendations for the strategic expansion of school-based health center services

§ 17 — MOBILE CRISIS SERVICES

Requires DMHAS to (1) make mobile crisis services available on nights and weekends, within available appropriations, and (2) develop and report on a plan to make these services available 24 hours a day, seven days a week

§ 18 — PEER SUPPORT SERVICES TASK FORCE

OLR PUBLIC ACT SUMMARY

Establishes a task force to study peer support services and encourage health care providers to use these services when providing patient care

§ 19 — 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

§ 20 — MUNICIPAL HEALTH DEPARTMENTS

Makes various changes affecting municipal health departments, such as (1) requiring DPH approval for municipal health director appointments; (2) increasing the minimum vacancy, from 30 to 60 days, before DPH may appoint someone to fill a director vacancy; and (3) requiring municipalities, with DPH approval, to designate an acting director if the existing director is unable to act during a declared public health emergency

§ 21 — LOAN REPAYMENT PROGRAM FOR PRIMARY CARE PROVIDERS

Requires DPH, in FY 22 and within available appropriations, to implement the existing loan repayment program for community-based providers in primary care settings

BACKGROUND

SUMMARY: This act contains various provisions related to racial disparities in public health, health care services, pandemic preparedness, and other related topics. For example, it:

1. declares racism as a public health crisis and creates a Commission on Racial Equity in Public Health to (a) make recommendations to decrease racism's effect on public health and (b) create a strategic plan to eliminate health disparities and inequities across several sectors;
2. requires the Department of Public Health (DPH) to study (a) the state's COVID-19 response and (b) developing a program to recruit and retain health care workers of color in the state;
3. establishes a committee to advise the Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention;
4. sets certain requirements related to demographic data collection in health care; and
5. establishes working groups or task forces on other matters, including breast health and breast cancer awareness, school-based health center service expansion, and peer support services.

The act also makes minor and technical changes.

A section-by-section summary follows.

EFFECTIVE DATE: Upon passage, except that the provisions on local health directors (§ 20) are effective July 1, 2021.

OLR PUBLIC ACT SUMMARY

§ 1 — RACISM AS A PUBLIC HEALTH CRISIS

Declares racism to be a public health crisis in the state

The act declares racism as a public health crisis in Connecticut. It provides that racism will continue to be such a crisis until the state meets the goal of reducing, by at least 70%, racial disparities in specified indicators in four areas (i.e., education, health care utilization and outcomes, criminal justice, and economic matters (see § 3 below)).

§§ 2-4 — COMMISSION ON RACIAL EQUITY IN PUBLIC HEALTH

Establishes a 28-member Commission on Racial Equity in Public Health; outlines the commission’s responsibilities, including developing a strategic plan to eliminate health disparities and inequities in various areas; establishes a goal of reducing racial disparities in certain areas by at least 70%; requires the commission to determine best practices for state agencies to evaluate structural racism within their operations and implement a plan to eliminate that racism

The act establishes, within the Legislative Department, a 28-member Commission on Racial Equity in Public Health to document and make recommendations to decrease racism’s effect on public health.

Commission Membership and Administration (§ 2(b)-(g))

Under the act, the commission’s membership includes the following officials or their designees:

1. the commissioners of public health, children and families, early childhood, social services, economic and community development, education, housing, energy and environmental protection, and correction;
2. the Connecticut Health Insurance Exchange chief executive officer;
3. the Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO) executive director;
4. the Office of Health Strategy (OHS) executive director; and
5. the Office of Policy and Management (OPM) secretary.

In addition, the commission includes the Public Health Committee chairpersons and 13 appointed members as shown in the following table.

Commission on Racial Equity in Public Health, Appointed Members

Appointing Authority	Appointee Qualifications
House speaker (2)	<ul style="list-style-type: none"> • Representative of a nonprofit organization that focuses on racial equity • Health Equity Solutions representative
Senate president pro tempore (2)	<ul style="list-style-type: none"> • Representative of a violence intervention program using a health-based approach to examine individuals post-incarceration and policies for integration • Connecticut Health Foundation representative

OLR PUBLIC ACT SUMMARY

House majority leader (1)	<ul style="list-style-type: none"> • Representative of the Katal Center for Equity, Health, and Justice
Senate majority leader (1)	<ul style="list-style-type: none"> • Representative of the Connecticut Children’s Office for Community Child Health
House minority leader (2)	<ul style="list-style-type: none"> • UConn-associated physician educator with experience and expertise in infant and maternal care and who has worked on diversity and inclusion policy • Partnership for Strong Communities representative
Senate minority leader (2)	<ul style="list-style-type: none"> • Medical professional with expertise in mental health • Open Communities Alliance representative
Black and Puerto Rican Caucus chairperson (2)	<ul style="list-style-type: none"> • Two members of the Black and Puerto Rican Caucus
Governor (1)	<ul style="list-style-type: none"> • Representative of the Connecticut Bar Association’s Diversity, Equity, and Inclusion Committee

Under the act, any legislative appointees may be legislators. Initial appointments to the commission must be made by August 13, 2021. Appointed members (1) serve terms that coincide with the terms of their appointing authority and (2) may serve for multiple terms.

The OPM secretary, or her designee, and the Health Equity Solutions representative (appointed by the House speaker) serve as the commission’s chairpersons. They must schedule the first meeting, to be held by August 13, 2021. If any appointments are not made by that date, the chairpersons may designate individuals with the required qualifications to serve on the commission until appointments are made as required.

Under the act, members continue to serve until their successors are appointed, and appointing authorities must fill any vacancies for the balance of the unexpired term.

A majority of the commission’s membership constitutes a quorum for transacting business and decisions are made by a majority vote of those present at a meeting, except the commission may establish committees, subcommittees, or other entities as it deems necessary for the commission’s purposes.

The act allows the commission to adopt rules of procedures. Commission members are not paid for their service, but must be reimbursed for their necessary expenses within the limits of available funds.

Executive Director (§ 2(h))

The act requires the commission, by majority vote, to hire an executive director to serve as its administrative staff. The executive director serves at the pleasure of the commission. The act allows the commission to request the Joint Committee on Legislative Management’s assistance in hiring the executive director. It allows the executive director to hire up to two executive assistants to help in carrying out the commission’s duties.

OLR PUBLIC ACT SUMMARY

Commission's General Powers and Duties (§ 2(i))

Under the act, the commission has the following powers and duties:

1. bringing together partners from different sectors to recognize the links between health and other issues and policy areas and build new partnerships to promote health and equity and increase government efficiency;
2. creating a comprehensive strategic plan to eliminate health disparities and inequities across sectors (see § 3 below);
3. studying the impact that the racism public health crisis has on vulnerable populations within diverse groups of the state, including based on race, ethnicity, sexual orientation, gender identity, and disability, and specifically including Black American descendants of slavery;
4. obtaining from any legislative or executive entity of the state, or any organization or other entity, available assistance as needed to carry out the act's purposes;
5. accepting gifts, donations, or bequests to perform the commission's duties;
6. establishing bylaws to govern commission procedures; and
7. performing other acts as may be necessary and appropriate to carry out its duties, including creating subcommittees.

Community Engagement and Related Recommendations (§ 2(j))

The act requires the commission to engage with a diverse range of community members who experience health inequities to make ongoing recommendations to relevant state agencies or other entities on specified matters. This must include people of color who identify as members of diverse groups of the state population, including based on race, ethnicity, sexual orientation, gender identity, and disability.

These recommendations must address structural racism in the state's laws and regulations impacting public health. The act defines "structural racism" as a system that structures opportunity and assigns value in a way that disproportionately and negatively impacts Black, Indigenous, Latino, or Asian people or other people of color.

The recommendations also must address 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 resources needed for healthy living, including adequate fresh food and physical activity, public safety, and decreased community pollution;
3. health outcomes; and
4. state hiring and contracting processes.

Additionally, the recommendations must address the impact of zoning

OLR PUBLIC ACT SUMMARY

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

Finally, the recommendations must include any suggestions to reduce the impact of the racism public health crisis on the vulnerable populations studied under the act.

Semiannual Reporting Requirement (§ 2(k))

The act requires the commission to report, by January 1, 2022, and every six months thereafter, to the OPM secretary and the Public Health and Appropriations committees. Each report must address:

1. the commission's activities during the prior six-month period;
2. any progress towards the goal of reducing certain racial disparities by at least 70% (see below);
3. any recommended changes to that goal based on the commission's research, any disparity study performed by a state agency or entity, or any community input;
4. the status of the commission's comprehensive strategic plan (see below); and
5. any recommended policy or legislative changes.

Comprehensive Strategic Plan and Racial Disparity Reduction Goal (§ 3)

The act requires the commission to develop and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors. The plan must consider air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, access to quality health care, social services, sustainable communities, and the impact of climate change.

The plan must address incorporating health and equity into specific policies, programs, and government decision-making processes. This must at least include disparities in (1) laws and regulations impacting public health; (2) the criminal justice system; and (3) access to quality health care and resources such as healthy food, safe housing, public safety, and environments free of excess pollution.

The act requires the commission, upon completing or updating the plan, to submit it to (1) the Public Health Committee and (2) any other legislative committee the commission determines has oversight over matters relevant to the plan.

Racial Disparity Indicators and Reduction Goal. The act requires the commission, as part of the strategic plan, to determine the percentages of racial disparity in the state in four areas. The commission must do so by January 1, 2022, and by using available scientifically based measurements. The act declares it as the state's goal to attain at least a 70% reduction in racial disparities in these areas.

Specifically, these areas are:

1. education indicators, including kindergarten readiness, third grade reading

OLR PUBLIC ACT SUMMARY

- proficiency, mastery examination scores, school-based discipline rates, high school graduation rates, and retention rates after the first year of study for in-state higher education institutions;
2. health care utilization and outcome indicators, including insurance coverage rates, pregnancy and infant health outcomes, emergency room visits, and deaths related to conditions associated with exposure to environmental pollutants including respiratory ailments, quality of life, life expectancy, lead poisoning, and access to adequate healthy nutrition and self-reported well-being surveys;
 3. criminal justice indicators, including rates of involvement with the justice system; and
 4. economic indicators, including rates of poverty, income, and housing insecurity.

Eliminating Structural Racism Within State Agencies (§ 4)

The act requires the commission to determine best practices for state agencies to (1) evaluate structural racism within their policies, practices, and operations and (2) create and implement a plan to eventually eliminate any such structural racism within the agency. The plan must include benchmarks for improvement.

The act requires the commission, by January 1, 2023, to report to the Government Administration and Elections Committee on (1) these best practices and (2) any recommended legislation to implement these practices within state agencies.

For purposes of these provisions, state agencies include the executive, legislative, and judicial branches; constituent units of the state system of higher education; and technical education and career schools.

§ 5 — DPH STUDY ON RECRUITMENT AND RETENTION PROGRAM FOR HEALTH CARE WORKERS OF COLOR

Requires DPH to study and report on developing a program to recruit and retain health care workers of color in the state

The act requires the DPH commissioner to study the development and implementation of a program to recruit and retain health care workers in the state who are people of color. She must report on the study's results to the Public Health Committee by February 1, 2022.

The report must include any legislative recommendations to improve the recruitment and retention of these individuals in the health care sector, including recommendations for implementing such a program.

§ 6 — DEEP ASSESSMENT OF RACIAL EQUITY WITHIN ENVIRONMENTAL HEALTH QUALITY PROGRAMS

Requires DEEP to assess and report on racial equity within the department's environmental health quality programs

OLR PUBLIC ACT SUMMARY

The act requires the Department of Energy and Environmental Protection (DEEP) to assess racial equity within its environmental health quality programs. By January 1, 2022, DEEP must report to the Environment Committee on the assessment's results and any legislative recommendations to improve racial equity within these programs.

§ 7 — HEALTH CARE PREPARATION PROGRAMS

Requires OHE to evaluate and report on the recruitment and retention of people of color in health care preparation programs and the inclusion of cultural humility education in these programs

The act requires the Office of Higher Education (OHE), in collaboration with the Board of Regents for Higher Education and UConn's Board of Trustees, to evaluate the (1) recruitment and retention of people of color in health care preparation programs offered by the constituent units of the state system of higher education and (2) the inclusion of cultural humility education in these programs.

The act requires OHE, by January 1, 2022, to report to the Higher Education and Employment Advancement Committee on (1) the evaluation's results and (2) any legislative recommendations to improve the recruitment and retention of people of color, and include additional cultural humility education, in these programs.

Under the act, "cultural humility" is a continuing commitment to (1) self-evaluation and critique of one's own worldview as to differences in cultural traditions and belief systems and (2) awareness and active mitigation of power imbalances between cultures.

§ 8 — REPORTING ON RACIAL AND ETHNIC IMPACT STATEMENT RULE CHANGES

Requires the CWCSEO executive director to report on the status of amendments to the legislative Joint Rules on preparing racial and ethnic impact statements

By law, the CWCSEO executive director must annually submit to the Appropriations Committee a status report on the commission's efforts to promote specified quality of life results for the populations within the commission's purview. On and after January 1, 2022, the act requires these reports to also include the status of amendments to the legislative Joint Rules on the preparation of racial and ethnic impact statements.

By law, the Government Administration and Elections Committee may make recommendations for a provision in the legislature's Joint Rules on the procedure for preparing racial and ethnic impact statements, their content, and the types of bills and amendments for which they should be prepared (CGS § 2-24b).

§ 9 — GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

OLR PUBLIC ACT SUMMARY

Establishes a committee to advise the Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of programs and strategies to reduce gun violence

The act establishes a Gun Violence Intervention and Prevention Advisory Committee. The committee’s purpose is to advise the Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centered programs and strategies to reduce street-level gun violence in the state.

Committee Membership and Administration

The committee includes 15 members, as shown in the following table.

Gun Violence Intervention and Prevention Advisory Committee Membership

Appointing Authority	Appointee Qualifications (Individuals Representing the Following Entities)
House speaker (2)	<ul style="list-style-type: none"> • Connecticut Hospital Association • Compass Youth Collaborative
Senate president pro tempore (2)	<ul style="list-style-type: none"> • Connecticut Violence Intervention Program • Regional Youth Adult Social Action Partnership
House majority leader (2)	<ul style="list-style-type: none"> • Hartford Communities That Care, Inc. • CT Against Gun Violence
Senate majority leader (2)	<ul style="list-style-type: none"> • Project Longevity • Saint Francis Hospital and Medical Center
House minority leader (1)	<ul style="list-style-type: none"> • Yale New Haven Hospital
Senate minority leader (1)	<ul style="list-style-type: none"> • Hartford Hospital
Public Health Committee’s House chairperson (1)	<ul style="list-style-type: none"> • You Are Not Alone (YANA)
Public Health Committee’s Senate chairperson (1)	<ul style="list-style-type: none"> • Mothers United Against Violence
CWCSEO executive director (1)	<ul style="list-style-type: none"> • Health Alliance for Violence Intervention
DPH commissioner (2)	<ul style="list-style-type: none"> • DPH’s Injury and Violence Surveillance Unit (two individuals representing this unit)

Under the act, initial appointments must be made by July 14, 2021, and appointing authorities fill any vacancy.

The Senate president pro tempore must select the committee’s chairperson from among its members. The chairperson must schedule the first committee meeting, to be held by August 13, 2021. The committee must meet at least

OLR PUBLIC ACT SUMMARY

bimonthly.

CWCSEO's administrative staff must serve in that capacity for the committee.

Committee Charge

The act requires the committee to:

1. consult with community outreach organizations, victim service providers, community violence and gun violence victims and researchers, and public safety and law enforcement representatives on strategies to reduce these types of violence;
2. identify effective, evidence-based community violence and gun violence reduction strategies;
3. identify strategies to align state agency resources to reduce this violence;
4. identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives; and
5. develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

The act requires the committee to report on its findings and recommendations to the Public Health and Human Services committees by January 1, 2022. The committee terminates when it submits the report or on January 1, 2022, whichever is later.

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

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

The act requires DPH to study the state's COVID-19 response. The commissioner must submit a preliminary report of the study's findings to the Public Health Committee by February 1, 2022.

Under the act, the report may include recommendations for any policy and legislative changes needed to improve the state's response to future pandemics, including recommendations on laws or regulations that should automatically be waived in the event of (1) an occurrence or imminent threat of a communicable disease (except a sexually transmitted disease) or (2) a governor-declared public health emergency in response to an epidemic or pandemic.

The report may also include recommendations on how to improve administration of mass vaccinations, reporting and utilization of personal protective equipment supply during a public health emergency, cluster outbreak investigation, and health care facilities' patient care.

§ 11 — DEMOGRAPHIC DATA COLLECTION

Sets requirements for state agencies or state entities that, directly or by contract, collect demographic data related to health care or public health; requires certain health care providers to include self-reported patient demographic data in their electronic health record systems; requires OHS to (1) create a plan to implement these provisions and (2) review demographic changes and health data and periodically reevaluate the standard race and ethnicity categories

OLR PUBLIC ACT SUMMARY

State Entities

Starting January 1, 2022, the act 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 act, 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 by OHS’s Community and Clinical Integration Program and follow the hierarchical mapping to align with U.S. Office of Management and Budget standards;
3. allow people 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;
4. allow people to refuse to identify with any ethnic or racial designations; and
5. collect primary language data using language codes set by the International Organization for Standardization.

In cases where state entities report data on an individual’s ethnic origin, ethnicity, or race to another state entity, they must also ensure 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; (3) multiple designations; and (4) no designation or who refuse to identify.

Health Care Providers

The act requires certain health care providers to collect and include in their electronic health record (EHR) systems self-reported patient demographic data, including race, ethnicity, primary language, insurance status, and disability status. They must do so based upon OHS’s implementation plan (see below) and using standard categories for race and ethnicity data as set forth above. These provisions apply to health care providers with an EHR system capable of connecting to and participating in the Statewide Health Information Exchange.

OHS

The act requires OHS, by August 1, 2021, to consult with consumer advocates, health equity experts, state agencies, and health care providers to create a plan to implement these provisions on demographic data collection.

The act also requires OHS to:

1. review (a) demographic changes in race and ethnicity, as determined by

OLR PUBLIC ACT SUMMARY

- the U.S. Census Bureau, and (b) health data the state collects and
- reevaluate the standard race and ethnicity categories from time to time, in consultation with health care providers, consumers, and the Public Health Committee.

§ 12 — MATERNAL MORTALITY REVIEW COMMITTEE

Requires DPH's Maternal Mortality Review Committee to annually report disaggregated data on its investigations to the Public Health Committee and allows the reports to include recommendations to reduce or eliminate racial inequities and other public health concerns related to its charge

By law, a Maternal Mortality Review Committee within DPH conducts multidisciplinary reviews of maternal deaths to identify associated factors and make recommendations to reduce these deaths.

The act requires the committee, starting by January 1, 2022, to annually report to the Public Health Committee. The reports must include confidential, disaggregated data on the information and findings obtained through its investigation process. These reports may also include recommendations to reduce or eliminate racial inequities and other public health concerns regarding maternal mortality and severe maternal morbidity in the state.

§ 13 — 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 act 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 act, “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.

§ 14 — BREAST HEALTH AND BREAST CANCER AWARENESS WORKING GROUP

Requires the Public Health Committee chairpersons to convene a working group to advance breast health and breast cancer awareness and promote greater understanding of the importance of early breast cancer detection

The act requires the Public Health Committee chairpersons to convene a working group to advance breast health and breast cancer awareness and promote greater understanding of the importance of early breast cancer detection in the state.

The group must (1) identify organizations that provide outreach, including to young women of color and high school students, on the importance of breast

OLR PUBLIC ACT SUMMARY

health and early breast cancer detection and (2) examine payment options for early detection services available to these individuals.

Under the act, by February 1, 2022, the working group must submit recommendations to the Public Health Committee on appropriations or legislative proposals to improve breast cancer awareness and early detection.

§ 15 — DOULA SCOPE OF PRACTICE REVIEW

Requires DPH to (1) establish a scope of practice review committee to determine whether DPH should establish a doula certification process and (2) report to the Public Health Committee on its findings and recommendations

The act requires the DPH commissioner to conduct a scope of practice review, under the existing process for scope of practice review committees, to determine whether DPH should establish a state certification process for doulas. By February 1, 2022, the commissioner must report the committee's findings and recommendations to the Public Health Committee.

The act defines a "doula" as a trained, nonmedical professional who provides physical, emotional, and informational support, virtually or in person, to a pregnant person before, during, and after birth.

Existing law establishes a process to review requests from health care professions seeking to establish or revise a scope of practice prior to consideration by the legislature. Within available appropriations, DPH appoints members to scope of practice review committees. The committees consist of (1) the DPH commissioner or her designee (who serves as the committee chairperson and in a non-voting capacity); (2) two members representing the profession making the request; and (3) two members recommended by each person or entity that submitted a written impact statement to represent the professions directly impacted by the request. DPH may also appoint additional members representing health care professions with a close relationship to the underlying scope of practice request (CGS § 19a-16e).

§ 16 — SCHOOL-BASED HEALTH CENTER WORKING GROUP

Establishes a working group to develop recommendations for the strategic expansion of school-based health center services

The act establishes a working group to develop recommendations for the strategic expansion of school-based health center (SBHC) services in the state. The working group must consider at least the following:

1. specific regions in the state where additional SBHCs may be needed;
2. options to expand or add services at existing SBHCs;
3. methods to provide additional support for SBHCs to expand telehealth services;
4. options for expanding SBHC insurance reimbursement; and
5. options to expand access to SBHCs or expand SBHC sites, which may include establishing school-based mental health clinics.

OLR PUBLIC ACT SUMMARY

Under the act, a “school-based mental health clinic” is a clinic that:

1. is located in or on the grounds of a school facility of a school district, school board, Indian tribe, or tribal organization;
2. is organized through school, community, and health provider relationships;
3. is administered by a sponsoring facility; and
4. provides on-site mental, emotional, or behavioral health services to children and adolescents according to state and local law.

The act does not define “sponsoring facility,” but under an existing law on SBHCs, sponsoring facilities include several entities, such as hospitals, community health centers, schools, and tribal organizations (CGS § 19a-6r).

Membership and Administration

Under the act, the working group includes the following members:

1. the DPH, social services, children and families, education, and insurance commissioners, or their designees;
2. the chairpersons and ranking members of the Public Health and Appropriations committees, or their designees;
3. two individuals designated by the Connecticut Association of School Based Health Centers;
4. one individual designated by the Community Health Center Association of Connecticut;
5. one individual designated by the Connecticut Association of Healthcare Plans;
6. one individual designated by Connecticut Health Center, Inc.; and
7. one children’s mental health service provider, appointed by the children and families commissioner.

Under the act, the group’s co-chairpersons are (1) the DPH commissioner or her designee and (2) a second member elected by the group’s members, chosen from among the legislative members or their designees. The chairpersons must schedule the first meeting, to be held by August 13, 2021.

Reporting Requirement

The act requires the working group, by February 1, 2022, to report its findings and any recommendations for the strategic expansion of SBHC services to the Public Health and Appropriations committees. The group terminates when it submits the report or on February 1, 2022, whichever is later.

§ 17 — MOBILE CRISIS SERVICES

Requires DMHAS to (1) make mobile crisis services available on nights and weekends, within available appropriations, and (2) develop and report on a plan to make these services available 24 hours a day, seven days a week

The act requires the Department of Mental Health and Addiction Services

OLR PUBLIC ACT SUMMARY

(DMHAS), within available appropriations, to increase access to mobile crisis services throughout the state in FYs 22 and 23. DMHAS must do so by expanding these services' hours of operation to include nights and weekends.

The act also requires DMHAS to develop a plan to increase access to these services throughout the state by making them available 24 hours a day, seven days a week. By January 1, 2022, the DMHAS commissioner must report on the plan to the Public Health and Appropriations committees. The report must include any legislative recommendations needed to implement the plan.

§ 18 — PEER SUPPORT SERVICES TASK FORCE

Establishes a task force to study peer support services and encourage health care providers to use these services when providing patient care

The act establishes a task force to study peer support services and encourage health care providers to use these services when providing patient care. Under the act, "peer support services" are nonmedical mental health care and substance use services provided by peer support specialists.

The task force study must at least examine available methods for delivering, certifying, and paying for these services.

Membership and Administration

Under the act, the task force includes the DMHAS commissioner or her designee and 10 appointed members as follows:

1. two each appointed by the House speaker, Senate president pro tempore, and governor and
2. one each appointed by the House and Senate majority and minority leaders.

At least five of the appointed members must have personal experience with psychiatric or substance use disorders. This includes (1) one each of the House speaker's, Senate president's, and governor's appointees and (2) each of the minority leaders' appointees.

Under the act, legislative appointees may be legislators. Initial appointments must be made by July 14, 2021. Appointing authorities fill any vacancy.

The House speaker and Senate president pro tempore select the task force chairpersons from among its members. The chairpersons must schedule the first meeting, to be held by August 13, 2021.

The Public Health Committee's administrative staff serves in that capacity for the task force.

Reporting Requirement

The act requires the task force to report its findings and recommendations to the Public Health Committee by January 1, 2022. The task force terminates when it submits the report or on January 1, 2022, whichever is later.

OLR PUBLIC ACT SUMMARY

§ 19 — 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 act requires 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 act requires DMHAS to post the toolkit on its website by October 1, 2021.

§ 20 — MUNICIPAL HEALTH DEPARTMENTS

Makes various changes affecting municipal health departments, such as (1) requiring DPH approval for municipal health director appointments; (2) increasing the minimum vacancy, from 30 to 60 days, before DPH may appoint someone to fill a director vacancy; and (3) requiring municipalities, with DPH approval, to designate an acting director if the existing director is unable to act during a declared public health emergency

Health Directors

The act requires DPH approval for people nominated for municipal health director appointments. Existing law already requires this approval for district health directors (CGS § 19a-242).

In municipalities with a population of at least 40,000 for five consecutive years, prior law prohibited municipal health directors from having a financial interest in or engaging in a job, transaction, or professional activity that substantially conflicted with the director's duties. The act extends this prohibition to all municipal health directors, regardless of the town's size. Existing law already prohibits this for district health directors (CGS § 19a-244).

The act requires municipalities to submit to DPH their written agreement with the health director. They must do so upon the director's appointment or reappointment.

Additionally, the act increases, from 30 to 60 days, the minimum vacancy of a municipal health director position before DPH may appoint someone to fill the vacancy. The act specifies that this person, when sworn, (1) is considered to be a municipal employee and (2) has all the powers and duties of municipal health directors.

Acting Health Director During Public Health Emergency

Existing law allows municipalities, with the DPH commissioner's approval, to designate in writing a suitable acting health director if the existing director is absent or unable to act. The act requires municipalities to do so if this occurs during a declared public health emergency.

Under the act, during such an emergency, if the municipality fails to appoint

OLR PUBLIC ACT SUMMARY

someone or fails to notify DPH of the appointment within 30 days, DPH must appoint someone who meets the law's qualifications for municipal health directors (i.e., the person must (1) be a licensed physician and have a degree in public health or (2) have a graduate degree in public health).

The act specifies that someone designated as an acting health director during such an emergency, when sworn, (1) is considered to be a municipal employee and (2) has all the powers and duties of municipal health directors.

§ 21 — LOAN REPAYMENT PROGRAM FOR PRIMARY CARE PROVIDERS

Requires DPH, in FY 22 and within available appropriations, to implement the existing loan repayment program for community-based providers in primary care settings

The act requires DPH, in FY 22 and within available appropriations, to implement the state loan repayment program for community-based providers in primary care settings.

By law, this program provides three-year grants to community-based primary care providers to expand access to care for the uninsured. The grants may be used for, among other things, loan repayment to primary care clinicians (e.g., family practice physicians, pediatricians, advanced practice registered nurses, and physician assistants) and registered nurses who meet program requirements (see BACKGROUND).

BACKGROUND

Related Acts

PA 21-121, § 23, contains some similar provisions on local health directors (e.g., increasing, from 30 to 60 days, the minimum vacancy of a municipality's health director position before DPH may appoint someone to fill the vacancy).

PA 21-2, June Special Session, § 28, requires, rather than allows, DPH to establish a program providing grants to community-based primary care providers, and requires DPH to do so within available resources.