PA 22-58—sHB 5500
Public Health Committee

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES

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Starting October 1, 2022, requires property owners to test the water quality of their newly constructed private or semipublic wells; requires clinical laboratories to report water quality test results conducted on wells to DPH and local health departments; requires prospective homebuyers and renters to be given educational materials on well testing; expands the list of contaminants local health departments can test wells for when they suspect groundwater contamination

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§ 75 — MATERNAL MORTALITY REVIEW COMMITTEE EDUCATIONAL MATERIALS

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§ 76 — BIRTHING HOSPITALS PATIENT EDUCATIONAL MATERIALS

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§ 77 — DESIGNATING MATERNAL MENTAL HEALTH MONTH AND DAY

Designates the month of May as "Maternal Mental Health Month" and each May 5 as "Maternal Mental Health Day"

SUMMARY: This act makes various substantive, minor, and technical changes in Department of Public Health (DPH)-related statutes and programs.
EFFECTIVE DATE: Various; see below.

§§ 1-8 — CHRONIC DISEASE HOSPITALS

Adds a definition for "chronic disease hospital" in the statute on health care institution licensure; makes related technical and conforming changes to various public health statutes

The act adds a statutory definition for "chronic disease hospital" in the statute on health care institution licensure. Under the act, as under existing law, these hospitals are long-term hospitals that have facilities, medical staff, and all personnel necessary to diagnose, treat, and care for chronic diseases.

The act also makes related technical and conforming changes in various public health statutes.

EFFECTIVE DATE: October 1, 2022

§§ 1, 23-30 & 39 — CLINICAL LABORATORIES

Adds clinical laboratories to the statutory definition of "health care institution" to reflect current practice; allows the DPH commissioner to waive regulations for these laboratories under limited conditions

Definition

The act adds clinical laboratories to the statutory definition of "health care institution." In doing so, it extends to these laboratories statutory requirements for health care institutions about, among other things, DPH licensure, inspection, and complaint investigation requirements. (In practice, clinical laboratories are already subject to state and federal regulation.)

As under existing law, the act defines a "clinical laboratory" as a facility or other area used for microbiological, serological, chemical, hematological, immuno-hematological, biophysical, cytological, pathological, or other examinations of human bodily fluids, secretions, excretions, or excised or exfoliated tissues. The examinations must be used to provide information for (1) diagnosing, preventing, or treating a human disease or impairment; (2) assessing human health; or (3) assessing the presence of drugs, poisons, or other toxicological substances.

The act also makes related technical and conforming changes in various public health statutes.

Waivers

Additionally, the act allows the DPH commissioner to (1) waive regulations affecting clinical laboratories if she determines that doing so would not endanger a patient's health, safety, or welfare; (2) impose waiver conditions assuring patients' health, safety, and welfare; and (3) revoke the waiver if she finds that someone's health, safety, or welfare has been jeopardized.

Existing law already allows the commissioner to grant waivers for other health care institutions under these same conditions. Under existing law and the act, she cannot grant a waiver that would result in a violation of the state fire safety or building code.

EFFECTIVE DATE: October 1, 2022, except provisions on waivers are effective upon passage.

§§ 1 & 42-45 — ALCOHOL OR DRUG TREATMENT FACILITIES

Replaces the term "alcohol or drug treatment facility" with "behavioral health facility" in several statutes to reflect current practice

The act removes the statutory definition for "alcohol or drug treatment facility" and replaces this term with "behavioral health facility" in several statutes (under current practice, these facilities are licensed and regulated as behavioral health facilities).
EFFECTIVE DATE: October 1, 2022

§ 6 — CENTRAL SERVICE TECHNICIANS

Allows central service technicians to obtain certification as a registered CST from a successor organization to the International Association of Healthcare Central Service Material Management

Existing law generally requires anyone who practices as a central service technician (CST) to, among other things, be certified as either a (1) sterile processing and distribution technician by the Certification Board for Sterile Processing and Distribution, Inc. or (2) registered CST by the International Association of Healthcare Central Service Material Management (IAHCSMM).

For the latter, the act allows CSTs to also obtain certification from a successor organization to IAHCSMM (the organization is currently changing its name).

By law, CSTs decontaminate, prepare, package, sterilize, store, and distribute reusable medical instruments or devices in a hospital or outpatient surgical facility, either as an employee or under contract.
EFFECTIVE DATE: October 1, 2022

§ 9 — ALBERT J. SOLNIT CHILDREN'S CENTER

Makes a technical change to specify that Albert J. Solnit Children's Center and its psychiatric residential treatment facility units are not exempt from DPH licensure

Existing law exempts from DPH licensure Department of Children and Families (DCF)-licensed (1) substance abuse treatment facilities and (2) maternity homes that offer care to pregnant women, new mothers, and their newborns.

The act specifies that this exemption does not apply to Albert J. Solnit Children's Center and its psychiatric residential treatment facility units ("South Campus") (existing law requires that DPH license these facilities).
EFFECTIVE DATE: Upon passage

§ 10 — STRIKE CONTINGENCY PLANS

Requires health care institutions, when notified that their employees intend to strike, to include a staffing plan as part of the strike contingency plan they must file with DPH; requires ICF-IIDs, when submitting strike contingency plans, to submit the same information as nursing homes

By law, a licensed health care institution must file a strike contingency plan with the DPH commissioner if a labor organization notifies the institution of its employees' intention to strike.

The act requires each institution's contingency plan to include its staffing plan for at least the first three days of the strike. This must include the names and titles of the people who will provide services at the institution. Existing regulations already require similar information for certain types of institutions, such as nursing homes and residential care homes (Conn. Agencies Reg., § 19a-497-1).

Under existing law, these institutions must submit their strike contingency plans no later than five days before the date indicated for the strike.

The act also requires licensed, Medicaid-certified intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), when submitting strike contingency plans, to submit the same information as required of nursing homes.
EFFECTIVE DATE: July 1, 2022

§ 11 — NURSING HOME ADMINISTRATOR CONTINUING EDUCATION

Adds infection prevention and control to the mandatory topics for nursing home administrators' continuing education

The act adds infection prevention and control to the mandatory topics for nursing home administrators' continuing education. It makes a corresponding change by adding courses offered or approved by the Association for Professionals in Infection Control and Epidemiology to those that meet continuing education requirements for nursing home administrators.

By law, nursing home administrators must complete at least 40 hours of continuing education every two years, starting with their second license renewal. Existing law requires that the education include training in Alzheimer's disease and dementia symptoms and care.
EFFECTIVE DATE: Upon passage

§§ 12 & 13 — MEDICATION ADMINISTRATION BY UNLICENSED PERSONNEL

Allows a registered nurse to delegate certain medication administration to home health aides and hospice aides who obtain certification from DCF or DDS, in addition to those certified by DPH as under existing law; requires more frequent certification for home health and hospice aides

The act allows a registered nurse (RN) to delegate the administration of non-injected medications to home health aides and hospice aides who are currently certified by DCF or the Department of Developmental Services (DDS), in addition to those certified by DPH as under existing law.

The act also requires these unlicensed personnel to renew their certifications every two years instead of every three years, as under prior law.

Under existing law, unchanged by the act, RNs cannot delegate medication administration to these unlicensed personnel if a prescribing practitioner requires a medication to be administered only by a licensed nurse. Also, residential care homes that admit residents requiring medication administration assistance must employ enough unlicensed personnel certified by DPH, DCF, or DDS to perform this function.

The act also makes related technical and conforming changes to provisions requiring DPH to adopt regulations to carry out the medication administration delegation provisions.

EFFECTIVE DATE: October 1, 2022

§§ 14, 16, 17 & 55 — SCOPE OF PRACTICE REVIEW

Reduces, by two weeks, the timeframe for certain steps of DPH's scope of practice review process for health care professions; requires DPH to (1) establish a scope of practice review committee to determine whether it should regulate midwives who are ineligible for nurse-midwife licensure and (2) report its findings to the Public Health Committee

Existing law establishes a process for DPH to review requests from representatives of health care professions seeking to establish or revise a scope of practice before consideration by the legislature. Within available appropriations, DPH appoints members to scope of practice review committees (see *Background*, below).

The act moves up deadlines for certain steps in this process as shown in the table below.

Scope of Practice Review Step Deadlines

Scope of Practice Review Step	*Deadline Under Prior Law*	*Deadline Under the Act*
DPH must notify the Public Health Committee and post online any scope of practice request it receives	September 15	September 1
Representatives of health care professions directly impacted by a submitted scope of practice request may submit an impact statement to DPH and provide a copy to the requestor	October 1	September 15
Requestor must submit a written response to an impact statement to DPH and the entity that provided the statement	October 15	October 1
DPH commissioner must establish and appoint members to a scope of practice review committee	November 1	October 15

Prior law required the DPH commissioner to establish and appoint members to scope of practice review committees for each timely request the department receives. The act instead requires the commissioner, by October 15 each year, to select requests the department will act on from among the timely requests received and establish the review committee only for those requests.

Additionally, the act requires, rather than allows, any person or entity acting on behalf of a health care profession seeking a new or amended scope of practice to submit a written scope of practice request to DPH by August 15 of the year preceding the start of the next legislative session.

The act also makes related conforming changes.

Midwife Scope of Practice Review

Additionally, 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 regulate midwives who are ineligible for nurse-midwife licensure. The commissioner must report her findings and recommendations to the Public Health Committee by February 1, 2023.
EFFECTIVE DATE: Upon passage

Background — Scope of Practice Review Committees

By law, DPH must appoint members to scope of practice review committees to evaluate scope of practice requests from representatives of health care professions. 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).

§ 15 — STATE BOARD OF EXAMINERS FOR NURSING

Expands the duties of the State Board of Examiners for Nursing; requires DPH, instead of the board, to post a list of all approved nursing education programs for registered nurses and licensed practical nurses; eliminates a requirement that DPH adopt regulations on adult education practical nursing training programs offered in high schools

The act codifies current practice by expanding the duties of the State Board of Examiners for Nursing to explicitly include (1) approving nursing schools in the state that prepare individuals for state licensure and (2) where possible, consulting with nationally recognized accrediting agencies when doing so.

The act also requires DPH, instead of the board, to post on the department's website a list of all approved nursing education programs for registered nurses and licensed practical nurses.

Additionally, the act eliminates the requirement that DPH adopt regulations on adult education practical nursing training programs offered in high schools or through the Technical Education and Career System (i.e., technical high schools) for students without a high school diploma (in practice, these programs have all closed).
EFFECTIVE DATE: Upon passage

§ 18 — CONTINUING EDUCATION (CE) FOR OPTOMETRISTS

Explicitly allows online CE classes; increases, from six to 10, the number of CE credit hours that can be earned without attending in-person

By law, optometrists must earn at least 20 hours of CE during each annual registration period. Prior law allowed up to six CE hours to be earned through a home study or distance learning program. The act specifies that online education is an acceptable way to earn CE credit.

The act increases to 10 hours the amount of CE credit that optometrists may earn through courses that are not in-person. But it limits to (1) five hours the amount of CE credit that may be earned through asynchronous online education, distance learning, or home study programs and (2) 10 hours the amount of CE credit that may be earned though synchronous online education that includes opportunities for live instruction.

Under the act, "synchronous online education" is a live, online class conducted in real time. "Asynchronous online education" is a program in which (1) the instructor, learner, and other participants are not engaged in the learning process at the same time; (2) there is no real-time interaction between participants and instructors; and (3) the educational content is created and made available for later consumption.

EFFECTIVE DATE: Upon passage

§§ 19 & 20 — MINOR AND TECHNICAL CHANGES

Makes technical changes to statutory provisions on (1) outpatient mental health treatment provided to minors without parental consent and (2) physician assistant licensure

Prior law required physician assistants to receive at least two hours of training every six years in post-traumatic stress disorder, suicide risk, depression, grief, and suicide prevention administered by the American Association of Physician Assistants. The act instead requires it to be administered by the American Academy of Physician Associates and any successor organization to the academy.

The act also makes technical changes to statutory provisions on (1) providing outpatient mental health treatment to minors without parental consent and (2) other physician assistant licensure requirements.

EFFECTIVE DATE: Upon passage

§ 21 — EMERGENCY MEDICAL SERVICES (EMS) ADVISORY BOARD REPORT

Changes, from December 31 to June 1, the date by which the DPH commissioner must annually report to the Emergency Medical Services Advisory Board about specified information on EMS calls; delays the date the next report is due until June 1, 2023

The act changes, from December 31 to June 1, the date by which the DPH commissioner must annually report to the EMS Advisory Board. It also delays the date the next report is due until June 1, 2023.

By law, the report must include the number of EMS calls received during the year; response times; level of EMS required; names of EMS providers responding; and the number of passed, cancelled, and mutual aid calls.
EFFECTIVE DATE: Upon passage

§ 22 — AUTHORIZED EMERGENCY VEHICLES

Expands the statutory definition of "authorized emergency vehicle" to include all authorized EMS vehicles, instead of only ambulances as under prior law

The act broadens the statutory definition of "authorized emergency vehicle" as used in the laws establishing those vehicles' rights and motorists' responsibilities with respect to them (e.g., generally, these vehicle drivers may exceed posted speed limits, and motorists must pull to the right when the vehicle is using its sirens or lights).

The act expands the definition to include all authorized emergency medical services vehicles, instead of only ambulances as under prior law. In doing so, it includes invalid coaches, advanced emergency technician-staffed intercept vehicles, and paramedic-staffed intercept vehicles licensed or certified by DPH to provide emergency medical care.

Under existing law, unchanged by the act, authorized emergency vehicles also include fire and police department vehicles.
EFFECTIVE DATE: Upon passage

§§ 31 & 32 — ONLINE PAYMENTS FOR VITAL RECORDS

Specifies DPH must approve any locally allowed online payment methods

The act specifies that if a registrar of vital statistics allows online payments for vital records (e.g., a birth certificate), the DPH commissioner or her designee must approve any associated requirements. Under the act, this applies to payments for short- and long-form birth certificates, marriage certificates, death certificates, and original birth certificates.
EFFECTIVE DATE: Upon passage

§ 33 — STATE FOOD CODE

Generally exempts certain owner-occupied bed and breakfast establishments and noncommercial functions from the state's model food code requirements

Existing law requires DPH, by January 1, 2023, to adopt the federal Food and Drug Administration's Food Code as the state's food code regulating food establishments (CGS § 19a-36h). The act exempts the following establishments and functions from the food code's requirements:

1. owner-occupied bed-and-breakfast establishments (a) with no more than 16 occupants, (b) with no provisions for cooking or warming food in guest rooms, (c) where breakfast is the only meal offered, and (d) that notify

guests that food is prepared in a kitchen unregulated by the local health department and
2. noncommercial functions, including bake sales or potluck suppers at educational, religious, political, or charitable organizations.

Under prior law, these entities had to comply with the food code but were exempt from having to employ a certified food protection manger and any related reporting requirements.

Existing law, unchanged by the act, requires that sellers at noncommercial functions maintain the food under the temperature, pH level, and water acidity level conditions that inhibit the growth of infectious or toxic microorganisms (CGS § 21a-115).

EFFECTIVE DATE: Upon passage

§ 34 — TECHNICAL CHANGE

Corrects a reference to statutes on the Clean Water Fund

The act corrects a reference to statutes governing the Clean Water Fund in a provision limiting the types of funds the Green Bank's Environmental Infrastructure Fund may receive.

EFFECTIVE DATE: Upon passage

§ 35 — CONTINUING EDUCATION FOR PSYCHOLOGISTS

Establishes minimum and maximum amounts of CE earned online

Existing law allows licensed psychologists to earn up to five of their 10 annually required CE credits through online classes, distance learning, or home study. The act specifies that the five-hour cap applies to asynchronous online classes, distance learning, and home study.

The act additionally requires psychologists to earn at least five hours of CE credit through synchronous online education. (In doing so, it only allows licensees to complete up to five of their required 10 CE credits in person.)

Under the act, "synchronous online education" is a live, online class conducted in real time. "Asynchronous online education" is a program in which (1) the instructor, learner, and other participants are not engaged in the learning process at the same time; (2) there is no real-time interaction between participants and instructors; and (3) the educational content is created and made available for later consumption.

EFFECTIVE DATE: July 1, 2022

§ 36 — SOCIAL WORKER MINIMUM STAFFING REQUIREMENTS IN NURSING HOMES

Specifies that existing law's minimum social worker staffing requirement in nursing homes of one social worker per 60 residents is a number of hours that must vary proportionally, based on the

number of residents in the home; allows the DPH commissioner to implement policies and procedures while adopting minimum staffing requirements in regulation

By law, DPH must establish minimum staffing level requirements for social workers in nursing homes of one full-time social worker per 60 residents. The act specifies that this requirement is a number of hours based on this ratio that must vary proportionally, based on the number of residents in the home (e.g., a home with 90 residents would require 1.5 full-time social workers instead of two).

Existing law, unchanged by the act, also requires DPH to modify minimum nursing home staffing requirements to include (1) at least three hours of direct care per resident per day and (2) recreational staff at levels the commissioner deems appropriate. She must also adopt regulations to implement these requirements.

The act allows the DPH commissioner to implement policies and procedures while in the process of adopting the new staffing requirements in regulations. She must publish notice of intent to adopt the regulations in the eRegulations system within 20 days after implementing them. Under the act, the policies and procedures are valid until the final regulations are adopted.

EFFECTIVE DATE: Upon passage

§§ 37 & 38 — STATEWIDE HEALTH INFORMATION EXCHANGE

Allows the Office of Health Strategy executive director to implement policies and procedures while adopting regulations to (1) administer the Statewide Health Information Exchange and (2) require certain health care institutions and providers to connect to and participate in the exchange

The act requires the Office of Health and Strategy (OHS) executive director to adopt regulations to (1) administer the Statewide Health Information Exchange and (2) require certain health care institutions and providers to connect to and participate in the exchange. Under the act, the executive director may implement policies and procedures while in the process of adopting the regulations, so long as she (1) holds a public hearing at least 30 days before implementing them and (2) publishes notice of the intent to adopt the regulations within 20 days after implementing them. The policies and procedures are valid until final regulations take effect.

By law, OHS has administrative authority over the Statewide Health Information Exchange, which among other things must allow real-time, secure access to patient health information across all provider settings.

Under existing law, providers must begin the process of connecting to and participating in the exchange: for hospitals, within one year after the exchange began (it became operational May 3, 2021), and for health care providers with compatible electronic health records systems, two years after the exchange began.

EFFECTIVE DATE: Upon passage

§ 40 — DOULA ADVISORY COMMITTEE

Requires DPH, within available resources, to establish an 18-member Doula Advisory Committee to develop recommendations on (1) doula certification requirements and (2) standards for recognizing training programs that meet the certification requirements

The act requires the DPH commissioner, within available resources, to establish an 18-member Doula Advisory Committee within the department to develop recommendations on (1) requirements for initial and renewed doula certification, including training, experience, and continuing education requirements, and (2) standards for recognizing doula training program curricula sufficient to satisfy the certification requirements. Under the act, a doula is a trained, nonmedical professional who provides physical, emotional, and informational support, virtually or in person, to a pregnant person before, during, and after birth.

Membership

Under the act, the DPH commissioner or her designee is the advisory committee's chairperson. Additional members include (1) the commissioners of social services, mental health and addiction services, and early childhood, or their designees, and (2) 14 members appointed by the DPH commissioner, or her designee, as follows:

1. seven actively practicing doulas in the state;
2. one licensed nurse-midwife who has experience working with a doula;
3. one representative of an acute care hospital, appointed in consultation with the Connecticut Hospital Association;
4. one representative of an association representing hospitals and health-related organizations in the state;
5. one licensed health care provider who specializes in obstetrics and has experience working with a doula;
6. one representative of a community-based doula training organization;
7. one representative of a community-based maternal and child health organization; and
8. one member with expertise in health equity.

Review Committee

The act requires the advisory committee, by January 15, 2023, to establish a Doula Training Program Review Committee to (1) conduct a continuous review of doula training programs and (2) provide a list of approved doula training programs in Connecticut that meet the advisory committee's certification requirements.
EFFECTIVE DATE: Upon passage

§ 41 — SAFE HARBOR LEGISLATION

Requires the DPH commissioner to (1) study whether the state should adopt "safe harbor" legislation allowing certain unlicensed practitioners to provide alternative health care services and (2) report to the Public Health Committee by January 1, 2023

The act requires the DPH commissioner to study whether the state should adopt "safe harbor" legislation and report to the Public Health Committee by January 1, 2023.

Under the act, this legislation would allow alternative health practitioners who are not licensed, certified, or registered to provide traditional health care services in the state to do so without violating state laws on unlicensed medical practice. These services include, at a minimum, aromatherapy, energetic healing, healing touch, herbology or herbalism, meditation and mind-body practices, polarity therapy, reflexology, and Reiki.

EFFECTIVE DATE: Upon passage

§ 46 — INVOLUNTARY TRANSFERS OF RESIDENTIAL CARE HOME RESIDENTS

Modifies requirements for the involuntary discharge of residential care home residents to allow RCHs to qualify as Medicaid home- and community-based settings

The act modifies requirements for the involuntary discharge of residential care home (RCH) residents to allow RCHs to qualify as Medicaid home- and community-based settings. Primarily, it does the following:

1. requires the written discharge notice to include contact information for (a) the long-term care ombudsman for RCH residents and their legally liable residents and (b) Disability Rights Connecticut, Inc. for residents with mental illness or intellectual disability;
2. requires RCHs to provide residents with a discharge plan for alternate residency within seven days after issuing the discharge notice and, in the case of an appeal, submit it to DPH on or before the required hearing date;
3. requires the DPH commissioner to make a determination on an RCH's request for an immediate, emergency transfer within 20 days after the required hearing (prior law did not specify a deadline);
4. requires DPH to send a copy of the emergency discharge determination to the resident, the resident's legally liable representative, and the long-term care ombudsman;
5. requires DPH, if it determines an emergency discharge is not warranted, to proceed with a hearing under the regular involuntary discharge process; and
6. allows an RCH or a resident aggrieved by a DPH decision to appeal to the Superior Court, and requires the court to consider the appeal a privileged case.

The act defines "emergency" as a situation in which a resident presents an imminent danger to the health and safety of him- or herself, another resident, or an owner or employee of the facility.

Written Discharge Notice

By law, RCHs must provide a written discharge notice to residents and their legally liable representatives at least 30 days prior to the date of an involuntary transfer. The notice must include the reason for the transfer and the resident's right

to appeal the discharge.

The act also requires the notice to include the (1) resident's right to represent him- or herself or be represented by legal counsel in an appeal and (2) contact information for the long-term care ombudsman and, for residents with mental illness or intellectual disability, also include the contact information for Disability Rights Connecticut. The notice must be sent electronically or by fax to the ombudsman on the same day it is given to the resident and be in a form and manner the DPH commissioner determines.

Superior Court Appeals

The act allows an RCH or a resident who is aggrieved by the DPH commissioner's final decision to appeal to the Superior Court in accordance with the Uniform Administrative Procedure Act. Under the act, filing an appeal with the court does not in itself stay the DPH decision. The court must consider these appeals as privileged cases to dispose of them with the least possible delay.
EFFECTIVE DATE: October 1, 2022

§§ 47 & 78 — MEDICAL ASSISTANTS ADMINISTERING VACCINES

Allows clinical medical assistants meeting specified certification, education, and training requirements to administer vaccines in any setting other than a hospital if acting under the supervision, control, and responsibility of a physician, PA, or APRN

The act allows clinical medical assistants to administer vaccines under certain conditions in any setting other than a hospital. They may do so only if they (1) meet certain certification, education, and training requirements and (2) act under the supervision, control, and responsibility of a licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN). The act specifies that it does not authorize employers to require physicians, PAs, or APRNs, without their consent, to oversee clinical medical assistants administering vaccines.

The act also makes a corresponding change by adding to the list of organizations from whom DPH must obtain a list of state residents certified as medical assistants.
EFFECTIVE DATE: October 1, 2022

Required Certification, Education, and Training

To be eligible to administer vaccines under the act, a clinical medical assistant generally must be certified by the American Association of Medical Assistants, the National Healthcareer Association, the National Center for Competency Testing, or the American Medical Technologists.

The clinical medical assistant also generally must have graduated from a postsecondary medical assisting program that is either:

1. accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools, or another accrediting organization recognized by the U.S. Department of Education or

2. offered by a higher education institution accredited by an accrediting organization recognized by the U.S. Department of Education and includes 720 total hours, of which 160 hours are clinical practice skills, including administering injections.

Under the first option above, the person must also have graduated from the program on and after January 1, 2024 (PA 22-92, § 25, instead requires that the person have graduated on and after January 1, 2023; PA 22-93 removes this date limitation altogether).

The act's authorization also applies to clinical medical assistants who do not meet the above certification and education requirements but who completed relevant medical assistant training provided by any branch of the U.S. armed forces.

The act requires any clinical medical assistant, before administering vaccines, to complete at least 24 hours of classroom training and eight hours of clinical training on vaccine administration.

List of Certified Medical Assistants

Under existing law, the DPH commissioner must annually obtain from the American Association of Medical Assistants and the National Healthcareer Association a list of all state residents on each organization's registry of certified medical assistants. The act extends this requirement to also include comparable lists from the National Center for Competency Testing and the American Medical Technologists. As under existing law, DPH must make these lists available for public inspection.

§ 48 — RARE DISEASE ADVISORY COUNCIL

Establishes a 13-member Connecticut Rare Disease Advisory Council to advise and make recommendations to DPH and other state agencies on the needs of residents living with rare diseases and their caregivers

Starting July 1, 2023, the act establishes a 13-member Connecticut Rare Disease Advisory Council to advise and make recommendations to DPH and other state agencies on the needs of residents living with rare diseases and their caregivers. The council is within DPH for administrative purposes only.

Functions

Under the act, the advisory council may do the following:

1. hold public hearings and otherwise solicit public comments and information to assist with studying or surveying residents with rare diseases and their caregivers and health care providers;
2. consult with rare disease experts to develop policy recommendations for improving patient access to quality medical care in the state, affordable and comprehensive insurance coverage, medications, medically necessary diagnostics, timely treatment, and other necessary services and therapies;
3. research and make recommendations to DPH, other state agencies, and

health carriers (i.e., insurers and HMOs) that provide services to those with rare diseases on the adverse impact that changes to health insurance coverage, drug formularies, and utilization review may have on providing treatment or care to these patients;

4. research and identify priorities related to rare disease treatments and services and develop policy recommendations on (a) safeguards and legal protections against discrimination and other practices that limit access to appropriate health care, services, or therapies and (b) planning for natural disasters and other public health emergencies;
5. research and make recommendations on improving the quality and continuity of care for those living with rare diseases who are transitioning from pediatric to adult health care services;
6. research and make recommendations on developing rare disease educational materials, including online materials and a list of reliable resources for DPH, other state agencies, the public, individuals living with a rare disease and their families and caregivers, medical students, and health care providers; and
7. research and make recommendations on support and training resources for caregivers and health care providers of individuals living with a rare disease.

Membership

Under the act, the 13-member advisory council includes the insurance, public health, and social services commissioners or their designees (which, for the insurance commissioner's designee, may be a health carrier representative) and the 10 appointed members listed in the table below.

Advisory Council Appointed Members

Appointing Authority	*Appointee Qualifications*
Governor	One licensed physician with expertise in medical genetics One hospital association representative or administrator of a hospital that provides health care to patients with rare diseases
Public Health Committee Senate chairperson	One representative of a patient advocacy group in the state for all rare diseases One family member or caregiver of a pediatric patient living with a rare disease
Public Health Committee House chairperson	One representative of the biopharmaceutical industry who is involved in rare disease research One adult living with a rare disease
Public Health Committee Senate ranking member	One member of the scientific community in the state who does rare disease research One caregiver of a person living with a rare disease

Appointing Authority	*Appointee Qualifications*
Public Health Committee House ranking member	One licensed physician who treats patients living with a rare disease One representative, family member, or caregiver of a person living with a rare disease

The act requires appointing authorities to make initial appointments by October 31, 2023, and fill any vacancies.

Under the act, five of the first-appointed members serve two-year terms, five members serve three-year terms, and all members serve two-year terms thereafter. The DPH commissioner determines which of the first-appointed members serve two-year or three-year terms.

Members are not compensated for their services but may be reimbursed for necessary expenses.

Council Meetings and Leadership

Under the act, the DPH commissioner selects the acting chairperson from among the council members to organize the first meeting, which must be held by November 30, 2023. The council members must then appoint a permanent chairperson and vice-chairperson by majority vote during the council's first meeting.

The act also specifies that the chairperson, vice-chairperson, or any member may be reappointed to his or her position on the council.

The act requires the council to meet in person or remotely at least six times between November 30, 2023, and October 31, 2024, and quarterly thereafter as the chairperson determines.

During meetings, the act requires the council to provide opportunities for the public to make comments, hear council updates, and provide input on council activities. The council must also create a website where it may post meeting minutes, notices, and feedback.

Report

The act requires the council to report to the governor and Public Health Committee within one year of its first meeting and annually thereafter on its findings and recommendations, including (1) the council's activities, research findings, and recommended legislative changes and (2) any potential funding sources for its activities, including grants, donations, sponsorships, or in-kind donations.

EFFECTIVE DATE: July 1, 2022

§ 49 — CHRONIC KIDNEY DISEASE ADVISORY COMMITTEE

Removes from the advisory committee the Public Health Committee chairpersons and ranking members and four members they appoint; extends by one year, until January 1, 2024, the date by which the advisory committee must begin annually reporting to the Public Health Committee

Membership

The act removes from the state's Chronic Kidney Disease Advisory Committee the following members: the Public Health Committee chairpersons and ranking members and the four members they appoint who have cognizance in public health. In doing so, it reduces the committee's required membership from 21 to 13.

As under prior law, the remaining committee members include the public health commissioner, or her designee, and the following individuals:

1. one member each appointed by the six top legislative leaders, governor, and the chief executive officers of the National Kidney Foundation and the American Kidney Fund;
2. one representative each from the kidney physician community, a nonprofit organ procurement organization, and kidney patient community, appointed by the Public Health Committee chairpersons; and
3. any other members the Public Health Committee chairpersons appoint that they deem necessary to represent public health clinics, community health centers, minority health organizations, and health insurers.

The act extends the date by which appointing authorities must make their initial appointments to 30 days after the act's passage (i.e., June 22, 2022). The act also extends the date by which the chairpersons must schedule the committee's first meeting to 60 days after the act's passage (i.e., July 22, 2022) (prior law required these in 2021).

By law, the Chronic Kidney Disease Advisory Committee works with policymakers, public health organizations, and educational institutions to increase awareness of chronic kidney disease and develop related educational programs.

Report

The act extends by one year, until January 1, 2024, the date by which the advisory committee must begin annually reporting its findings and recommendations to the Public Health Committee.

EFFECTIVE DATE: Upon passage

§ 50 — HOSPITAL COMMUNITY BENEFIT PROGRAMS

Makes various changes to the law on hospital community benefit programs, such as requiring hospitals to submit various documents to OHS on a specified schedule and requiring OHS to make the state's all-payer claims database available to hospitals to help in this process

The act makes various changes to the law on hospital community benefit programs. Principally, it:

1. conforms to existing practice by shifting oversight of this law from the Office of the Healthcare Advocate (OHA) to OHS;

2. requires hospitals to submit their community health needs assessments, related implementation strategies, and community benefit status reports on a specified schedule, and specifies several matters that hospitals must include in this reporting;
3. requires for-profit acute care hospitals to submit community benefit program reporting consistent with the act's reporting schedules and reasonably similar to what they would report to the IRS, where applicable;
4. requires OHS to make data from the state's all-payer claims database available to hospitals to fulfill these requirements; and
5. requires OHS to annually summarize and analyze community benefit program reporting data and solicit stakeholder input through a public comment period.

The act also removes managed care organizations (MCOs) from this law and makes several minor, technical, and conforming changes.

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

EFFECTIVE DATE: January 1, 2023

Program Applicability (§ 50(a) & (i))

Prior law's community benefit provisions applied to hospitals and MCOs. The act removes MCOs from this law and instead applies the law to (1) nonprofit hospitals that must annually file IRS Form 990 (see *Background*) and (2) for-profit acute care general hospitals.

The act requires these for-profit hospitals to submit community benefit program reporting consistent with the act's requirements (see below), and reasonably similar to what the hospital would include in its federal tax filing, where applicable.

Program Scope (§ 50(a))

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

The act adds to the program purposes (1) protecting health and safety, (2) improving health equity (see below), (3) reducing health disparities, and (4) reducing the cost and economic burden of poor health. It broadens the scope of these programs to address all populations within the hospital's geographic service area, not just working families and at-risk populations as under prior law. It removes references to MCOs.

Under the act, "health equity" means that everyone has a fair and just opportunity to be as healthy as possible. This includes removing obstacles to health, such as poverty, racism, and their adverse consequences, including a lack of

equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments, and health care.

"Health disparities" are health differences that are closely linked with social or economic disadvantages that adversely affect groups who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Community Benefit Program Reporting (§ 50(b)-(e))

Under prior law, each hospital and MCO had to submit a biennial report on whether it had a community benefits program. If the entity had that program, the report had to describe its status and discuss certain parts of it. Prior law also allowed hospitals and MCOs to develop community benefit guidelines focused on specified principles.

The act replaces these provisions, instead requiring hospitals, starting January 1, 2023, to submit community benefit program reporting to OHS or a designee selected by the OHS executive director. This reporting includes three components: the hospital's community health needs assessment (CHNA), implementation strategy, and annual status report on its community benefit program.

The act outlines the required matters to be included with these submissions (see below). In certain respects, the required topics are similar to topics under prior law's provisions for community benefit programs and related guidelines. For example, similar to the prior guidelines, the act requires a hospital's community benefit reporting to address meaningful participation from the community, as described below.

Under the act, a hospital generally must submit these documents on the following schedule:

1. CHNA: within 30 days after the hospital makes it available to the public as required by federal regulations;
2. implementation strategy: within 30 days after the hospital adopts it as required by federal regulations; and
3. status report: annually, starting by October 1, 2023.

In each case, the OHS executive director, or her designee, may grant an extension.

Prior law allowed OHA, after notice and the opportunity for a hearing, to assess civil penalties (up to $50 a day) on hospitals or MCOs that failed to submit community benefit reports as required. The act repeals these provisions and does not transfer similar authority to OHS.

Community Health Needs Assessment (§ 50(c))

The act requires a hospital's CHNA submission to include the following information, consistent with requirements in federal regulations and as included in the hospital's federal tax filing:

1. a definition of the community the hospital serves and a description of how the hospital determined that community;
2. a description of how the hospital conducted the CHNA;
3. a description of how the hospital solicited and considered input from people representing the community's broad interests;
4. a prioritized description of the community's significant health needs identified through the CHNA, and a description of the process and criteria used in identifying and prioritizing certain needs as significant;
5. a description of the resources potentially available to address these significant health needs; and
6. an evaluation of the impact of any of the hospital's actions to address the significant health needs identified in its prior CHNA.

The act also requires hospitals, as part of the CHNA, to submit the following information:

1. the names of the people responsible for developing the CHNA;
2. the population demographics for the hospital's geographic service area and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns, and health care costs in this area;
3. a description of the health status and health disparities affecting this service area's population, including those affecting a representative range of age, racial, and ethnic groups; incomes; and medically underserved populations;
4. a description of meaningful participation for community benefit partners (see below) and diverse community members in assessing community health needs, priorities, and target populations;
5. a description of the barriers to achieving or maintaining health and accessing health care, including social, economic, and environmental barriers; lack of access to, or availability of, sources of health care coverage and services; and a lack of access to, and availability of, prevention and health promotion services and support;
6. recommendations on what role the state and other community benefit partners could play in removing these barriers and enabling effective solutions; and
7. any more information, data, or disclosures that the hospital voluntarily includes that may be relevant to its community benefit program.

Under the act, "community benefit partners" are entities that, in partnership with hospitals, play an essential role in the policy, system, program, and financing solutions needed to achieve community benefit program goals. These partners include federal, state, and municipal government entities and private sector entities, such as faith-based organizations; businesses; educational or academic organizations; health care organizations or health departments; philanthropic organizations; housing justice or planning and land use organizations; public safety or transportation organizations; and tribal organizations.

"Meaningful participation" means that (1) residents of a hospital's community, including those experiencing the greatest health disparities, have an appropriate opportunity to participate in the hospital's planning and decisions; (2) this

participation influences a hospital's planning; and (3) the hospital gives participants information summarizing how the hospital did or did not use their input.

Implementation Strategy (§ 50(d))

The act requires the hospital's implementation strategy submission, consistent with requirements in federal regulations and as included in the hospital's federal tax filing, to address each significant need identified through the CHNA.

For those needs the hospital intends to address, the submission must (1) describe how the hospital plans to do so, including the hospital's intended actions and their anticipated impact; (2) list the resources the hospital plans to commit to address the need; and (3) describe any planned collaboration with other entities in this process. For those needs the hospital does not intend to address, the submission must explain why the hospital will not do so.

Under the act, a hospital's implementation strategy submission must also include the following information:

1. the names of the people responsible for developing the strategy;
2. a description of meaningful participation for community benefit partners and diverse community members;
3. a description of the community health needs and health disparities that were prioritized in developing the strategy, considering DPH's most recent state health plan;
4. if available, reference-citing evidence showing how the strategy intends to address the corresponding need or disparity;
5. planned methods and measures for the ongoing evaluation of the proposed actions' progress or impact;
6. a description of how the hospital solicited community commentary on the strategy and revisions based on that commentary; and
7. any other relevant information that the hospital voluntarily includes, including data, disclosures, expected or planned resource allocation, investments, or commitments, including staff, financial, or in-kind commitments.

Status Report (§ 50(e))

The act requires hospital status reports on their community benefit programs to describe the following:

1. any major updates on community health needs, priorities, and target populations;
2. progress in the hospital's actions supporting its implementation strategy;
3. any major changes to the proposed implementation strategy and associated hospital actions; and
4. financial and other resources allocated or spent to support the actions associated with the implementation strategy.

All-Payer Claims Database (APCD) (§ 50(f) & (g))

The act requires OHS to make data in the state's APCD available to hospitals for specified purposes (see below) related to their community benefit programs and activities. OHS must do so (1) regardless of existing state law on using APCD data and (2) to the full extent permitted by specified regulations under the federal Health Insurance Portability and Accountability Act (HIPAA). Generally, those regulations allow covered entities, under specified conditions, to use or disclose a limited data set (i.e., protected health information that excludes various personal identifiers) for research, public health, or health care operations. The covered entity must enter into a data use agreement with the recipient (45 C.F.R. § 164.514(e)).

Under the act, OHS must make APCD data available to hospitals solely for (1) preparing their CHNAs, (2) preparing and executing their implementation strategies, and (3) meeting the act's community benefit program reporting requirements. Any OHS disclosures of non-health information must be done in a way to protect its confidentiality as may be required by state or federal law.

The act excuses hospitals from limitations in meeting their community benefit program reporting requirements if they are not provided the APCD data as required.

OHS Reporting and Solicitation of Stakeholder Input (§ 50(h))

The act (1) transfers from OHA to OHS the duty to summarize and analyze submitted community benefit program reports and (2) removes the prior condition that this had to occur only within available appropriations. It requires OHS to do so annually, starting by April 1, 2024, and post the summary and analysis online. Under prior law, OHA had to biennially make the summary and analysis available to the public upon request.

The act also requires OHS to annually solicit stakeholder input through a public comment period. OHS must use the reporting and stakeholder input to do the following:

1. identify more stakeholders to help address identified community health needs, including (a) federal, state, and municipal entities; (b) non-hospital private sector health care providers; and (c) private sector entities other than health care providers, including community-based organizations, insurers, and charities;
2. determine how these stakeholders could help address identified community health needs or supplement solutions or approaches reported in implementation strategies;
3. determine whether to make recommendations to DPH in its development of the state health plan; and
4. inform OHS's statewide health care facilities and services plan.

Background — IRS Form 990

A nonprofit hospital must include certain information related to the CHNA process in its IRS Form 990 filing (the tax return for organizations exempt from the income tax). Along with the standard form, these hospitals must complete a specific attachment (Schedule H) that addresses the hospital's community benefits,

community building activities, and financial assistance policy, among other things.

§ 51 — NON-DISCRIMINATION FOR TRANSPLANTS BASED ON DISABILITY

Generally prohibits deeming someone ineligible to receive an anatomical gift, or organ from a living donor, for transplantation solely because of the person's physical, mental, or intellectual disability

The act generally prohibits deeming someone ineligible to receive an anatomical gift, or organ from a living donor, for transplantation solely because of his or her physical, mental, or intellectual disability. The act provides an exception if a physician determines, after evaluating the person, that his or her disability medically contraindicates the transplant.

Under the act, if a person has the necessary support to help him or her comply with post-transplant medical requirements, then the person's inability to comply without assistance cannot be determined "medically significant" to make the person ineligible for a transplant.

The act specifies that (1) the above provisions apply to each part of the transplant process and (2) it does not require a physician to make a referral or recommendation for, or perform a medically inappropriate transplant of, an anatomical gift or organ.

Under the act, an "anatomical gift" is the donation of all or part of a human body to take effect after the donor's death for transplantation purposes. An "organ" is all or part of the human liver, pancreas, kidney, intestine, or lung.

EFFECTIVE DATE: Upon passage

§ 52 — INFECTION PREVENTION AND CONTROL SPECIALISTS

Makes various changes in requirements for infection prevention and control specialists at nursing homes and dementia special care units, such as (1) limiting the requirement that they employ a full-time specialist to only those facilities with more than 60 residents and (2) allowing these specialists to provide services at both a nursing home and dementia special care unit or at two nursing homes in some circumstances, with DPH approval

The act makes various changes in existing law's requirements for infection prevention and control specialists at nursing homes and dementia special care units (i.e., "facilities").

Prior law required all of these facilities to employ a full-time infection prevention and control specialist. The act limits this requirement to only those facilities with more than 60 residents, and instead requires smaller facilities to employ a part-time specialist.

It also removes a provision from prior law that required each facility's specialist to work on a rotating schedule that ensured he or she covered each eight-hour shift at least once monthly to ensure compliance with relevant standards. Under the act, facilities instead must require the specialists to implement procedures to monitor the infection prevention and control practices of each daily shift to ensure compliance.

The act allows infection prevention and control specialists to provide services at both a nursing home and dementia special care unit or at two nursing homes that are (1) next to each other or on the same campus and (2) commonly owned or operated. Before this may occur, the owner or operator must submit a written request to the DPH commissioner, or her designee, and receive notification that the request is approved.

The act also allows the DPH commissioner to waive the law's infection prevention and control specialist requirements if she determines that doing so would not endanger the life, safety, or health of the facilities' residents or employees. If the commissioner waives a requirement, she may (1) impose conditions assuring residents' and employees' health, safety, and welfare and (2) terminate the waiver if she finds that they have been jeopardized.

EFFECTIVE DATE: July 1, 2022

§§ 53 & 54 — ELDERLY HOUSING COMPLEXES AND ASSISTED LIVING

Allows elderly housing complexes funded and assisted through HUD's Assisted Living Conversion Program, and that intend to arrange for assisted living services, to do so with a currently licensed assisted living services agency, exempting them from having to register as a managed residential community

The act allows certain elderly housing complexes that intend to arrange for assisted living services to do so with a currently licensed assisted living services agency, exempting them from having to register as a managed residential community. This applies to elderly housing complexes funded and assisted through the federal Department of Housing and Urban Development's Assisted Living Conversion Program. Upon DPH's request, such a housing complex must inform DPH of its arrangement with a licensed agency, in a form and manner the commissioner prescribes.

EFFECTIVE DATE: July 1, 2022

§§ 56-58 — DISPOSITION OF UNCLAIMED BODIES

Allows the Office of the Chief Medical Examiner to take custody and coordinate the disposition of an unclaimed body; requires the funeral director who handles the disposition to contact the social services commissioner for reimbursement of related expenses

By law, the Office of the Chief Medical Examiner (OCME) must investigate deaths that involve certain conditions, such as those involving violence or suspicious circumstances or those that are sudden or unexpected and not caused by an easily recognizable disease. Once it completes the investigation, the office must deliver the body to the person legally entitled to receive it. For an unclaimed body, the office must return it to the authorities in the town where the death occurred. The town is responsible for final disposition of the body and must pay the associated costs if the deceased person has not left property sufficient to cover the cost.

The act allows OCME to take custody and coordinate the disposition (e.g., cremation or burial) of an unclaimed body. Before doing so, the act requires the office to wait 21 days after the death is pronounced and make a reasonable effort to

locate and contact any of the decedent's relatives. This includes using law enforcement agency services in the town where the decedent died or resided.

Under the act, a funeral director who handles the decedent's disposition must notify the Department of Social Services (DSS) commissioner to seek reimbursement for these expenses. (By law, when an individual dies in Connecticut and does not leave a sufficient estate or have a legally liable relative able to cover funeral and burial or cremation costs, DSS must provide a payment toward them.)

The act correspondingly requires DSS, when it receives a proper bill, to pay $1,350 to a funeral director, cemetery, or crematory. The department must pay this amount only if the chief medical examiner, or his designee, certifies that OCME, after its investigation, was unable to locate any of the decedent's friends or family members willing to take possession of the decedent's remains and that they were then transferred to a funeral director, cemetery, or crematory for disposition.

The act also waives the $150 cremation certificate fee required under existing law for these dispositions.

EFFECTIVE DATE: October 1, 2022

§ 59 — COMMISSION ON MEDICOLEGAL INVESTIGATIONS

Removes the requirement that the governor appoint certain members of the Commission on Medicolegal Investigations from a panel recommended by the state's medical and law school deans

By law, the Commission on Medicolegal Investigations oversees OCME and consists of the DPH commissioner and eight members appointed by the governor, including two law professors and two pathology professors. The act removes the requirement that the governor appoint the law and pathology professor members from a panel of at least four professors in each field recommended by a committee of the state's medical and law school deans. Under existing law, unchanged by the act, commission members serve six-year appointments and are eligible for reappointment.

The act also makes technical changes, such as removing references to obsolete language about initial appointments to the commission.

EFFECTIVE DATE: October 1, 2022

§ 60 — PRIVATE AND SEMIPUBLIC WELLS

Starting October 1, 2022, requires property owners to test the water quality of their newly constructed private or semipublic wells; requires clinical laboratories to report water quality test results conducted on wells to DPH and local health departments; requires prospective homebuyers and renters to be given educational materials on well testing; expands the list of contaminants local health departments can test wells for when they suspect groundwater contamination

The act makes various changes in state law affecting water quality testing for private and semipublic wells.

Laboratory Reporting of Test Results

The act requires an environmental laboratory that conducts a water quality test on a private or semipublic well to report the results within 30 days after completing the test to DPH and the local health department of the municipality where the property is located. Prior law required this only if the testing was related to a real estate transaction (e.g., property purchase or sale).

Under the act, test results submitted to DPH or local health departments, information obtained from any related investigation, and any morbidity and mortality study related to the results (1) are confidential and not subject to disclosure; (2) are not admissible as evidence in any court or agency proceeding; and (3) must be used solely for medical or scientific research or disease control and prevention purposes.

Testing Newly Constructed Wells

Starting October 1, 2022, the act requires property owners to test the water quality of newly constructed private or semipublic wells. (Current regulation already requires this.) At a minimum, the testing must screen for the following contaminants: coliform, nitrate, nitrite, sodium, chloride, iron, manganese, hardness, turbidity, pH, sulfate, apparent color, odor, lead, arsenic, and uranium. The owner must submit the test results to DPH in a form and manner the commissioner determines.

Educational Materials for Real Estate Agents

By law, homeowners must notify a purchaser or renter that educational materials about private and semipublic well testing are available on the DPH website.

The act additionally requires an electronic or hard copy of the information to be provided to prospective buyers or renters by (1) a licensed realtor, if the prospective buyer or tenant hired the realtor to facilitate the property transaction, or (2) the property owner, landlord, or closing attorney, if the prospective buyer or tenant did not hire a realtor.

Under the act, the educational materials provided to prospective buyers and tenants must include information on testing for the contaminants described above and any other related recommendations the department determines to be necessary.
EFFECTIVE DATE: October 1, 2022

§ 61 — EMS ORGANIZATIONS ADDING NEW VEHICLES

Allows commercial EMS organizations, not just other EMS organizations, who are primary service area responders to add one vehicle to their fleet every three years without necessarily completing the standard hearing process

Existing law allows certain EMS organizations to apply to DPH, on a short form application, to add one vehicle to their existing fleet every three years, without necessarily going through the standard hearing process.

Under prior law, this applied to licensed or certified volunteer, hospital-based,

or municipal ambulance services, or ambulance or paramedic intercept services operated by state agencies, that are primary service area responders (PSARs). The act instead applies this provision to any licensed or certified EMS organizations that are PSARs, thus broadening its applicability to include commercial EMS organizations.

As under existing law:

1. the applicant must notify, in writing, all other PSARs in any municipality or abutting municipality in which the applicant proposes to add a vehicle;
2. the application is deemed approved 30 days after the filing, unless one of the notified PSARs objects within 15 days after the notice; and
3. if the objecting PSAR requests a hearing, the applicant must demonstrate need for the new vehicle through the standard hearing process.

EFFECTIVE DATE: October 1, 2022

§ 62 — LEGIONELLA WORKING GROUP

Requires the DPH commissioner to (1) convene a working group on legionella prevention and mitigation in hospitals, nursing homes, and other health care facilities and (2) report to the Public Health Committee on the working group's findings and recommendations

The act requires the DPH commissioner, by July 1, 2022, to convene a working group on legionella prevention and mitigation in hospitals, nursing homes, and other health care facilities.

Under the act, the working group consists of representatives of hospitals, nursing homes, and water companies who must identify issues, evaluate data, determine appropriate action timelines, and develop solutions for preventing and mitigating legionella in the above-described facilities.

The act requires the DPH commissioner to report to the Public Health Committee by December 31, 2022, on the working group's efforts and recommendations for legislative, regulatory, or other changes on preventing and mitigating legionella in these facilities. The working group terminates on either the date it submits the report or December 31, 2022, whichever occurs first.

EFFECTIVE DATE: Upon passage

§ 63 — POLYSOMNOGRAPHIC TECHNOLOGISTS

Authorizes polysomnographic (i.e., sleep) technologists to perform certain oxygen-related patient care activities in hospitals just as existing law allows for designated licensed health care providers and certified ultrasound or nuclear medicine technologists

The act allows polysomnographic technologists ("sleep technologists") to perform the following oxygen-related patient care activities in hospitals: (1) connecting or disconnecting oxygen supply; (2) transporting a portable oxygen source; (3) connecting, disconnecting, or adjusting the mask, tubes, and other patient oxygen delivery apparatus; and (4) adjusting the oxygen rate or flow consistent with a medical order. Existing law already allows designated licensed health care providers and certified ultrasound or nuclear medicine technologists to

do this.

As under existing law, this authorization does not apply to any type of ventilator, continuous positive airway pressure or bi-level positive airway pressure unit, or other noninvasive positive pressure ventilation.

Under prior law, the state did not regulate polysomnographic technologists. Because oxygen is considered a prescription drug and can only be administered by licensed health professionals within their scope of practice, polysomnographic technologists were prohibited from administering oxygen.

EFFECTIVE DATE: October 1, 2022

§§ 64-66 — SUICIDE ADVISORY BOARD

Renames and expands the scope of DCF's Youth Suicide Advisory Board, revises its membership and procedures, and specifically allows physicians' continuing medical education in behavioral health to include suicide prevention training

The act codifies existing practice by expanding the scope of DCF's Youth Suicide Advisory Board to address suicide prevention across a person's lifespan. It correspondingly renames the board as the Connecticut Suicide Advisory Board, reflecting existing practice.

It makes conforming changes to the board's responsibilities to reflect its broader scope, such as requiring the board to develop a statewide strategic suicide prevention plan, not just one focused on youth. The act specifically adds behavioral health care providers and higher education faculty members to the list of people to whom the board must periodically offer training, within available appropriations. It requires the board's recommendations to address suicide intervention and response, not just prevention, procedures for schools, communities, and interagency service coordination.

The act also makes several changes to the board's membership and procedures. Instead of requiring 20 members as under prior law, it adds to the types of organizations that can be represented on the board and makes certain prior appointments optional. Among other things, it (1) adds an additional co-chair to the board and allows for the co-chairs to appoint a third co-chair and (2) allows the board to adopt bylaws.

Lastly, the act specifically allows physicians' continuing medical education in behavioral health to include training on suicide prevention (§ 65). By law, physicians generally must complete at least one contact hour of behavioral health continuing education during their first renewal period in which continuing education is required and then every six years, and a total of 50 contact hours of continuing education every two years, starting with their second license renewal.

EFFECTIVE DATE: July 1, 2022

Board Membership

Under prior law, the board consisted of the following members:

1. eight appointed by the DCF commissioner, including a state-licensed psychiatrist and psychologist, local or regional school board representative,

high school teacher and student, college or university faculty member and student, and parent;
2. additional DCF commissioner appointees with expertise in children's mental health or mental health issues with a focus on suicide prevention;
3. one representative each from DPH, the State Department of Education, (SDE), and the Board of Regents for Higher Education (BOR), appointed by the applicable department commissioner or Connecticut State Colleges and Universities (CSCU) president; and
4. the DCF commissioner, who served in a non-voting, ex-officio capacity.

The act makes several changes to the board's membership, as reflected in the table below.

Connecticut Suicide Advisory Board Membership Under the Act

Permissible Appointments (Appointed by the DCF Commissioner)	***Required Members***
Representatives from suicide prevention foundations, youth-serving organizations, law enforcement agencies, religious or fraternal organizations, civic or volunteer groups, state and local government agencies, tribal governments or organizations, health care providers, or local organizations with expertise in the mental health of children or adults or mental health issues with a focus on suicide prevention A state-licensed psychiatrist, state-licensed psychologist, local or regional school board representative, high school teacher, high school student, college or university faculty member, college or university student, parent, or person who has experienced suicide ideation or loss	One representative each from DPH, SDE, and BOR, appointed by the applicable commissioner or CSCU president DCF commissioner or designee (who now serves as a voting member) Department of Mental Health and Addiction Services (DMHAS) commissioner or designee

Board Chairpersons

Under prior law, the board elected a chairperson, as well as a vice-chairperson to act in the chairperson's absence.

The act instead reflects current practice by requiring the DCF and DMHAS commissioners, or their designees, to serve as co-chairpersons. It also allows them to appoint a third co-chairperson, who must represent a (1) local organization with mental health expertise or (2) suicide prevention foundation.

Changes to Board Procedures

The act allows the board to adopt bylaws to govern itself and its meetings. It

also eliminates provisions in prior law that provided that board members (1) served two-year terms without compensation and (2) were deemed to have resigned from the board if they missed three meetings in a row or half of all meetings in a calendar year.

§ 67 — SURGICAL SMOKE EVACUATION POLICIES

Requires each licensed hospital and outpatient surgical facility to develop and implement a policy for using a surgical smoke evacuation system to prevent exposure to surgical smoke

The act requires each licensed hospital and outpatient surgical facility, by January 1, 2024, to develop a policy for using a surgical smoke evacuation system to prevent a person's exposure to surgical smoke. Also by this date, these facilities must implement the policy and, upon request, provide a copy to DPH.

Under the act, "surgical smoke" is the by-product of using an energy-generating device during surgery, such as surgical or smoke plume, bioaerosols, laser-generated airborne contaminants, or lung-damaging dust. But the term excludes by-products produced during gastroenterological or ophthalmic procedures that are not emitted into the operating room during surgery.

A "surgical smoke evacuation system" is a system, such as a smoke or laser plume evacuator or local exhaust ventilator, that captures and neutralizes surgical smoke (1) at the smoke's site of origin and (2) before the smoke contacts the eyes or respiratory tract of anyone in an operating room during surgery.

EFFECTIVE DATE: July 1, 2022

§§ 68 & 69 — HIV TESTING

Generally requires primary care providers and hospital emergency departments to offer HIV testing to patients age 13 or older; requires hospitals to adopt related protocols

Starting January 1, 2023, the act generally requires primary care physicians, APRNs, and PAs ("primary care providers") to offer HIV testing to patients age 13 or older. Specifically, the provider or a designee must offer to provide, order, or arrange to order the test unless one of the act's exceptions applies.

Starting January 1, 2024, the act generally requires hospital employees or staff members treating a patient age 13 or older in the emergency department to offer the patient an HIV test. By this same date, it requires hospitals to develop protocols, with specified components, for implementing this requirement.

For both primary care providers and hospitals, the act provides various exceptions to the requirement to offer HIV testing, such as when the patient is treated for a life-threatening emergency. Also, the act requires primary care providers or their designees, and hospital employees or staff members, to comply with all requirements under existing law on HIV testing and related information (see *Background*).

Under the act, "primary care" is family medicine, general pediatrics, primary care, internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification.

EFFECTIVE DATE: October 1, 2022

Exceptions to Required Offer of HIV Test

For primary care providers or their designees, the act's requirement does not apply if the provider reasonably believes that the patient (1) is being treated for a life-threatening emergency, (2) has previously been offered or received an HIV test, or (3) lacks the capacity to consent.

For hospital employees or staff members, the act's requirement does not apply if they document that the patient (1) is being treated for a life-threatening emergency, (2) received an HIV test in the prior year, (3) lacks the capacity to provide general consent to the test, or (4) declines the test.

Hospital Protocols

The act's required hospital protocols must comply with existing law's provisions on general consent requirements for HIV testing, counseling and referral as needed, and related exceptions.

Additionally, the protocols must at least include:

1. offering and providing this testing to patients and notifying them of the results;
2. tracking and documenting the number of tests performed and declined and the test results;
3. reporting positive test results to DPH, as required under existing law; and
4. referring patients who test positive to an appropriate health care provider for treatment.

The act allows a hospital, in developing and implementing the protocols, to collaborate with a municipal or district health department, regional mental health board, emergency medical services council, or community organization.

Background — HIV Testing and Information

By law, a person who gives general consent for medical procedures and tests is generally not required to also sign or be given a specific informed consent form on HIV testing. General consent includes instruction to the patient that (1) the patient may be tested for HIV as part of the medical procedures or tests and (2) this testing is voluntary. Among other things, the law provides that a parent's or guardian's consent is not required for a minor to get tested.

By law, the person ordering an HIV test, when communicating its result, must generally give the test subject or his or her authorized representative counseling information or referrals as needed, addressing certain matters.

The law establishes exceptions to these consent and counseling provisions in 10 situations, such as significant occupational exposure (CGS § 19a-582).

The law establishes various other requirements related to HIV testing and information. For example, subject to certain exceptions, the law prohibits anyone who obtains confidential HIV-related information from disclosing it or being

compelled to disclose it (CGS § 19a-583).

§ 70 — PLASMAPHERESIS, CLINICAL LABORATORIES, AND BLOOD DONATION CENTERS

Requires the DPH commissioner to review statutes and regulations on, or otherwise impacting, the practice of plasmapheresis, clinical laboratories, and blood donation centers in the state and report her findings and recommendations to the legislature

The act requires the DPH commissioner to review statutes and regulations on, or otherwise impacting, the practice of plasmapheresis, clinical laboratories, and blood donation centers in the state.

In conducting the review, the act requires the commissioner to (1) consult clinical laboratories, businesses, and nonprofit organizations with expertise in blood collection, plasmapheresis, and clinical laboratory operations and facilities and (2) review federal regulations on the practice of plasmapheresis and blood collection.

The act requires the commissioner, by January 1, 2023, to report to the legislature on the review and her recommendations on how the state can better align with related federal regulations while maintaining a high level of blood donor safety.

EFFECTIVE DATE: Upon passage

§§ 71 & 72 — MANDATED ELDER ABUSE REPORTER TRAINING

Modifies provisions in PA 22-57, extending until June 30, 2023, the date by which mandated elder abuse reporters must generally complete the DSS elder abuse training program or another DSS-approved program

The act modifies provisions in PA 22-57, extending by six months until June 30, 2023, the date by which mandated elder abuse reporters must generally complete the DSS elder abuse training program or another DSS-approved program. Under the act, the training must be completed by this date or within 90 days after becoming a mandated elder abuse reporter.

The requirement does not apply to any reporter who has already received the training from an entity that must provide the training to its employees. By law, any institution, organization, agency, or facility that employs people to care for seniors age 60 and older must (1) provide mandatory training on detecting potential elder abuse and (2) inform employees of their obligation to report such incidences.

By law, the DSS commissioner must develop a training program on identifying and reporting elder abuse, neglect, exploitation, and abandonment and make the program available on the department's website and in-person or otherwise throughout the state.

Background — Mandated Elder Abuse Reporters

Existing law requires doctors, nurses, long-term care (LTC) facility administrators and staff, other health care personnel, and certain other professionals

to report suspected abuse, neglect, abandonment, or exploitation of the elderly and LTC facility residents to DSS within 72 hours of suspecting the abuse or face penalties. They must also report to the department if they suspect an elderly person needs protective services (CGS §§ 17a-412 & 17b-451).
EFFECTIVE DATE: Upon passage

§ 73 — TECHNICAL STANDARDS FOR MEDICAL DIAGNOSTIC EQUIPMENT

Requires health care facilities to consider certain federal technical standards for accessibility of medical diagnostic equipment when purchasing this equipment

Starting January 1, 2023, the act requires health care facilities to consider certain federal technical accessibility standards when purchasing medical diagnostic equipment. Specifically, facilities must consider the technical standards developed by the federal Architectural and Transportation Barriers Compliance Board (ATBCB) in accordance with the federal Patient Protection and Affordable Care Act.

Starting by December 1, 2022, the DPH commissioner must annually notify each health care facility and licensed physician, physician assistant, and advanced practice registered nurse about information on providing health care to individuals with accessibility needs, including the ATBCB technical standards. DPH must also post the information on its website.

Under the act, a "health care facility" is a hospital, outpatient clinic, and LTC or hospice facility. "Medical diagnostic equipment" includes an examination table or chair; weight scale; mammography equipment; and x-ray, imaging, and other radiological diagnostic equipment.
EFFECTIVE DATE: Upon passage

Background — Architectural and Transportation Barriers Compliance Board

The board is an independent federal agency that provides information, technical assistance, and training on accessibility design for people with disabilities. Among other things, it provides design criteria for transit vehicles, telecommunications equipment, and electronic information technology.

§ 74 — ASSISTED LIVING SERVICES AGENCIES TASK FORCE

Establishes a task force to study the regulation and staffing levels of assisted living services agencies that provide services as dementia special care units or programs; requires it to report its findings and recommendations to the Public Health Committee

The act establishes a nine-member task force to study assisted living services agencies that provide services as dementia special care units or programs. The study must examine (1) DPH regulation of these agencies and whether additional department oversight is required; (2) whether minimum staffing levels should be required; and (3) agencies' maintenance of records on meals served to, bathing of,

medication administration to, and overall health of residents.

Membership

Under the act, the task force consists of the following nine members: (1) two each appointed by the Senate president pro tempore and House speaker; (2) one each appointed by the Senate and House majority and minority leaders; and (3) the DPH commissioner or her designee.

Under the act, appointing authorities must make their initial appointments within 30 days after the act's passage (i.e., by June 22, 2022) and fill any vacancies. Appointed members may be legislators.

The act requires the Senate president pro tempore and House speaker to select the task force chairpersons from among its members. The chairpersons must schedule and hold the first meeting within 60 days after the act's passage (i.e., by July 22, 2022).

Under the act, the Public Health Committee's administrative staff must serve as the task force's administrative staff.

Report

The act requires the task force, by January 1, 2023, to report its findings and recommendations to the Public Health Committee. The task force terminates when it submits the report or on January 1, 2023, whichever is later.

EFFECTIVE DATE: Upon passage

§ 75 — MATERNAL MORTALITY REVIEW COMMITTEE EDUCATIONAL MATERIALS

Requires DPH's Maternal Mortality Review Committee to develop educational materials on intimate partner violence and pregnant and postpartum persons with mental health disorders, which DPH must distribute to specified hospitals and health care providers

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, by January 1, 2023, to develop educational materials on the following topics:

1. the health and safety of pregnant and postpartum persons with mental health disorders, including perinatal mood and anxiety disorders, for DPH to distribute to each birthing hospital in the state;
2. evidence-based screening tools for screening patients for intimate partner violence, peripartum mood disorders, and substance use disorder for DPH to distribute to obstetricians and other health care providers who practice obstetrics; and
3. indicators of intimate partner violence for DPH to distribute to (a) hospitals for emergency department health care providers and social workers to use and (b) obstetricians and other health care providers who practice obstetrics.

EFFECTIVE DATE: Upon passage

§ 76 — BIRTHING HOSPITALS PATIENT EDUCATIONAL MATERIALS

Requires birthing hospitals to provide (1) caesarean section patients with written information on the importance of mobility following the procedure and (2) postpartum patients certain educational materials and establish a patient portal for them to virtually access any educational materials and information provided to the patients during their stay or discharge

The act requires birthing hospitals, starting October 1, 2022, to give each patient who has undergone a caesarean section written information on the importance of mobility and the associated risks of immobility following the procedure.

By January 1, 2023, the act requires birthing hospitals to establish a patient portal where a postpartum patient can virtually access, through the internet or an application, any educational materials and information that the hospital gave the patient during the hospital stay and discharge.

Also starting by this date, the act requires birthing hospitals to give each postpartum patient the Maternal Mortality Review Committee's educational materials on the health and safety of pregnant and postpartum persons with mental health disorders as described above (see § 75).

EFFECTIVE DATE: July 1, 2022

§ 77 — DESIGNATING MATERNAL MENTAL HEALTH MONTH AND DAY

Designates the month of May as "Maternal Mental Health Month" and each May 5 as "Maternal Mental Health Day"

The act designates the month of May as "Maternal Mental Health Month" and each May 5 as "Maternal Mental Health Day" and allows suitable exercises to be held at the capitol and other locations the governor designates.

EFFECTIVE DATE: Upon passage