General Assembly

Amendment

January Session, 2023

LCO No. **8735**

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Offered by:
SEN. ANWAR, 3rd Dist.
SEN. SOMERS, 18th Dist.
SEN. LOPES, 6th Dist.
SEN. MARX, 20th Dist.
SEN. CABRERA, 17th Dist.

To: Senate Bill No. **9** File No. 507 Cal. No. 303

"AN ACT CONCERNING HEALTH AND WELLNESS FOR CONNECTICUT RESIDENTS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective from passage*) (a) As used in this section, (1) "assisted reproductive technology" has the same meaning as provided in 42 USC 263a-7, as amended from time to time, and (2) "assisted reproduction" has the same meaning as provided in section 46b-451 of the general statutes.

(b) No person or entity may prohibit or unreasonably limit any person from (1) accessing assisted reproductive technology or assisted reproduction, (2) continuing or completing an ongoing assisted reproductive technology treatment or procedure or an ongoing assisted

reproduction treatment or procedure pursuant to a written plan or agreement with a health care provider, or (3) retaining all rights regarding the use of reproductive genetic materials, including, but not limited to, gametes.

(c) No person or entity may prohibit or unreasonably limit a health care provider who is licensed, certified or otherwise authorized to perform assisted reproductive technology treatments or procedures or assisted reproduction treatments or procedures from (1) performing any such treatment or procedure, or (2) providing evidence-based information related to assisted reproductive technology or assisted reproduction.

Sec. 2. (*Effective July 1, 2023*) The Commissioner of Social Services shall adjust Medicaid reimbursement criteria to provide funding for same-day access to long-acting reversible contraceptives at federally qualified health centers. As used in this section, "long-acting reversible contraceptive" means any method of contraception that does not have to be used or applied more than once a menstrual cycle or once a month.

Sec. 3. (*Effective from passage*) (a) As used in this section:

(1) "Harm reduction center" means a medical facility where a person with a substance use disorder may (A) receive substance use disorder and other mental health counseling, (B) use a test strip to test a substance for traces of fentanyl or xylazine, or traces of any other substance recognized by the Commissioner of Mental Health and Addiction Services as having a high risk of causing an overdose, (C) receive educational information regarding opioid antagonists, as defined in section 17a-714a of the general statutes, and the risks of contracting diseases from sharing hypodermic needles, (D) receive referrals to substance use disorder treatment services, and (E) receive access to basic support services, including, but not limited to, laundry machines, a bathroom, a shower and a place to rest; and

(2) "Test strip" means a product that a person may use to test any substance prior to injection, inhalation or ingestion of the substance to

prevent accidental overdose by injection, inhalation or ingestion of the substance.

(b) Not later than July 1, 2027, the Department of Mental Health and Addiction Services, in consultation with the Department of Public Health, shall establish a pilot program to prevent drug overdoses through the establishment of harm reduction centers in three municipalities in the state selected by the Commissioner of Mental Health and Addiction Services, subject to the approval of the chief elected officials of each municipality selected by said commissioner. No harm reduction center established pursuant to this subsection shall be subject to regulation by the Department of Public Health until the termination of the pilot program.

(c) Each harm reduction center established pursuant to subsection (b) of this section shall (1) employ persons, including, but not limited to, licensed health care providers with experience treating persons with substance use disorders to provide substance use disorder or other mental health counseling and monitor persons utilizing the harm reduction center for the purpose of providing medical treatment to any person who experiences symptoms of an overdose, in a number determined sufficient by the Commissioner of Mental Health and Addiction Services, (2) provide persons with test strips at the request of such persons, and (3) provide referrals for substance use disorder or other mental health counseling or other mental health or medical treatment services that may be appropriate for persons utilizing the harm reduction center. A licensed health care provider's participation in the pilot program shall not be grounds for disciplinary action by the Department of Public Health pursuant to section 19a-17 of the general statutes or by any board or commission listed in subsection (b) of section 19a-14 of the general statutes.

(d) The Commissioner of Mental Health and Addiction Services may request a disbursement of funds from the Opioid Settlement Fund established pursuant to section 17a-674c of the general statutes to fund, in whole or in part, the establishment and administration of the pilot

program.

Sec. 4. Subsection (b) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, as defined in subsection (c) of section 19a-490, and nursing homes and rest homes, as defined in subsection (o) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in

accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be

used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license;

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans; **[**or**]**

(23) On or before June 30, 2026, an increase in the licensed bed capacity of a mental health facility, provided (A) the mental health facility demonstrates to the unit, in a form and manner prescribed by the unit, that it accepts reimbursement for any covered benefit provided to a covered individual under: (i) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; or (iii) HUSKY Health, as defined in section 17b-290, and (B) if the mental health facility does not accept or stops accepting reimbursement for any covered benefit provided to a covered individual under a policy, plan or program described in clause (i), (ii) or (iii) of subparagraph (A) of this subdivision, a certificate of need for such increase in the licensed bed capacity shall be required<u>; or</u>

<u>(24) The establishment of harm reduction centers through the pilot program established pursuant to section 3 of this act</u>.

Sec. 5. (NEW) (*Effective October 1, 2023*) (a) As used in this section:

(1) "Eligible entity" means (A) a municipality, (B) a local or regional board of education, (C) a similar body governing one or more nonpublic schools, (D) a district department of health, (E) a municipal health

department, (F) a law enforcement agency, or (G) an emergency medical services organization;

(2) "Emergency medical services personnel" has the same meaning as provided in section 19a-175 of the general statutes;

(3) "Opioid antagonist" means naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of a drug overdose;

(4) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(5) "Opioid use disorder" means a medical condition characterized by a problematic pattern of opioid use and misuse leading to clinically significant impairment or distress;

(6) "Pharmacist" has the same meaning as provided in section 20-609a of the general statutes; and

(7) "Wholesaler" or "distributor" has the same meaning as provided in section 21a-70 of the general statutes.

(b) There is established an Opioid Antagonist Bulk Purchase Fund which shall be a separate nonlapsing account within the General Fund. The account shall contain any (1) amounts appropriated or otherwise made available by the state for the purposes of this section, (2) moneys required by law to be deposited in the account, and (3) gifts, grants, donations or bequests made for the purposes of this section. Investment earnings credited to the assets of the account shall become part of the assets of the account. Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. The State Treasurer shall administer the account. All moneys deposited in the account shall be used by the Department of Mental Health and Addiction Services for the purposes of this section. The department may deduct and retain from the moneys in the account an amount equal to the costs incurred by the department in

administering the provisions of this section, except that said amount shall not exceed two per cent of the moneys deposited in the account in any fiscal year.

(c) Not later than January 1, 2024 the Department of Mental Health and Addiction Services, in collaboration with the Department of Public Health, shall use the Opioid Antagonist Bulk Purchase Fund for the provision of opioid antagonists to eligible entities and by emergency medical services personnel to certain members of the public. Emergency medical services personnel shall distribute an opioid antagonist kit containing a personal supply of opioid antagonists and the one-page fact sheet developed by the Connecticut Alcohol and Drug Policy Council pursuant to section 17a-667a of the general statutes regarding the risks of taking an opioid drug, symptoms of opioid use disorder and services available in the state for persons who experience symptoms of or are otherwise affected by opioid use disorder to a patient who (1) is treated by such personnel for an overdose of an opioid drug, (2) displays symptoms to such personnel of opioid use disorder, or (3) is treated at a location where such personnel observes evidence of illicit use of an opioid drug, or to such patient's family member, caregiver or friend who is present at the location. Emergency medical services personnel shall refer the patient or such patient's family member, caregiver or friend to the written instructions regarding the administration of such opioid antagonist, as deemed appropriate by such personnel.

(d) The Department of Mental Health and Addiction Services may, within available appropriations, contract with a wholesaler or distributor for the purchasing and distribution of opioid antagonists in bulk to eligible entities pursuant to subsection (c) of this section. Each eligible entity shall make such bulk-purchased opioid antagonists available at no charge to a family member, caregiver or friend of a person who has experienced an overdose of an opioid drug or displays symptoms of opioid use disorder.

(e) Emergency medical services organizations may obtain opioid antagonists for dissemination pursuant to subsection (c) of this section

from a pharmacist pursuant to section 20-633c, 20-633d or 21a-286 of the general statutes.

(f) Emergency medical services personnel shall document the number of opioid antagonist kits distributed pursuant to subsection (c) of this section, including, but not limited to, the number of doses of an opioid antagonist included in each kit.

(g) Not later than January 1, 2025, and annually thereafter, the executive director of the Office of Emergency Medical Services shall report to the Department of Mental Health and Addiction Services regarding the implementation of the provisions of subsections (c), (e) and (f) of this section, including, but not limited to, any information required under subsection (h) of this section for inclusion in the state substance use disorder plan developed pursuant to subsection (j) of section 17a-451 of the general statutes known to the executive director.

(h) The Commissioner of Mental Health and Addiction Services shall include in the state substance use disorder plan developed pursuant to subsection (j) of section 17a-451 of the general statutes the following information: (1) The amount of funds used to purchase and distribute opioid antagonists, (2) the number of eligible entities that received opioid antagonists under this section, (3) the amount of opioid antagonists purchased under this section, (4) the use of the opioid antagonists purchased by each such eligible entity, if known by the commissioner, and (5) any recommendations regarding the Opioid Antagonist Bulk Purchase Fund, including any proposed legislation to facilitate the purposes of this section.

Sec. 6. Section 20-14o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) As used in this section:

(1) "Opioid drug" has the same meaning as provided in 42 CFR 8.2, as amended from time to time;

(2) "Adult" means a person who is at least eighteen years of age;

(3) "Prescribing practitioner" has the same meaning as provided in section 20-14c;

(4) "Minor" means a person who is under eighteen years of age;

(5) "Opioid agonist" means a medication that binds to the opiate receptors and provides relief to individuals in treatment for abuse of or dependence on an opioid drug;

(6) "Opiate receptor" means a specific site on a cell surface that interacts in a highly selective fashion with an opioid drug;

(7) "Palliative care" means specialized medical care to improve the quality of life of patients and their families facing the problems associated with a life-threatening illness; and

(8) "Opioid antagonist" has the same meaning as provided in section 17a-714a.

(b) When issuing a prescription for an opioid drug to an adult patient for the first time for outpatient use, a prescribing practitioner who is authorized to prescribe an opioid drug shall not issue a prescription for more than a seven-day supply of such drug, as recommended in the National Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain.

(c) A prescribing practitioner shall not issue a prescription for an opioid drug to a minor for more than a five-day supply of such drug.

(d) Notwithstanding the provisions of subsections (b) and (c) of this section, if, in the professional medical judgment of a prescribing practitioner, more than a seven-day supply of an opioid drug is required to treat an adult patient's acute medical condition, or more than a five-day supply of an opioid drug is required to treat a minor patient's acute medical condition, as determined by the prescribing practitioner, or is necessary for the treatment of chronic pain, pain associated with a

cancer diagnosis or for palliative care, then the prescribing practitioner may issue a prescription for the quantity needed to treat the acute medical condition, chronic pain, pain associated with a cancer diagnosis or pain experienced while the patient is in palliative care. The condition triggering the prescription of an opioid drug for more than a seven-day supply for an adult patient or more than a five-day supply for a minor patient shall be documented in the patient's medical record and the practitioner shall indicate that an alternative to the opioid drug was not appropriate to address the medical condition.

(e) The provisions of subsections (b), (c) and (d) of this section shall not apply to medications designed for the treatment of abuse of or dependence on an opioid drug, including, but not limited to, opioid agonists and opioid antagonists.

(f) When issuing a prescription for an opioid drug to an adult or minor patient, the prescribing practitioner shall (1) discuss with the patient the risks associated with the use of such opioid drug, including, but not limited to, the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reasons the prescription is necessary, and, if applicable, with the custodial parent, guardian or other person having legal custody of the minor patient if such parent, guardian or other person is present at the time of issuance of the prescription, and (2) encourage the patient and, if applicable, the custodial parent, guardian or other person having legal custody of the minor patient if such parent, guardian or other person is present at the time of issuance of the prescription, to obtain an opioid antagonist.

Sec. 7. (NEW) (*Effective July 1, 2023*) (a) The Commissioner of Education shall, in collaboration with the Chief Workforce Officer, utilize the plan required of the Office of Workforce Strategy pursuant to section 2 of special act 22-9 in (1) the promotion of the health care professions as career options to students in middle and high school, including, but not limited to, through career day presentations

regarding health care career opportunities in the state, the development of partnerships with health care career education programs in the state and the creation of counseling programs directed to high school students to inform such students about, and recruit them to, the health care professions, and (2) job shadowing and internship experiences in health care fields for high school students.

(b) Not later than September 1, 2023, the Commissioner of Education shall provide each local and regional board of education with the plan described in subsection (a) of this section, and through the Governor's Workforce Council Education Committee, support implementation of such plan.

Sec. 8. (*Effective from passage*) (a) The Office of Workforce Strategy shall convene a working group to develop recommendations for expanding the health care workforce in the state. The working group shall evaluate the following: (1) The quality of the nursing and nurse's aides education programs in the state; (2) the quality of the clinical training programs for nurses and nurse's aides in the state; (3) the potential for increasing the number of clinical training sites for nurses and nurse's aides; (4) the expansion of clinical training facilities in the state for nurses and nurse's aides; (5) barriers to recruitment and retention of health care providers, including, but not limited to, nurses and nurse's aides; (6) the impact of the state health care staffing shortage on the provision of health care services, the public's access to health care services and wait times for health care services; and (7) the impact of federal and state reimbursement for the costs of health care services on the public's access to such services.

(b) The working group shall consist of the following members:

(1) Two representatives of a labor organization representing acute care hospital workers in the state;

(2) Two representatives of a labor organization representing nurses and nurse's aides employed by the state of Connecticut or a hospital or long-term care facility in the state;

(3) Two representatives of a labor organization representing faculty and professional staff at the regional community-technical colleges;

(4) The chairperson of the Board of Regents for Higher Education, or the chairperson's designee;

(5) The president of the Connecticut State Colleges and Universities, or the president's designee;

(6) The president of The University of Connecticut, or the president's designee;

(7) One member of the administration of The University of Connecticut Health Center;

(8) Two representatives of the Connecticut Conference of Independent Colleges;

(9) The Commissioner of Public Health, or the commissioner's designee;

(10) The Commissioner of Social Services, or the commissioner's designee;

(11) The Commissioner of Administrative Services, or the commissioner's designee;

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

(13) A representative of the State Board of Examiners for Nursing;

(14) A representative of the State Employees Bargaining Agent Coalition;

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

(16) The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to higher education and employment advancement, or the chairpersons' and ranking members' designees.

(c) The cochairpersons of the working group shall be the Commissioner of Public Health, or the commissioner's designee, and the chairperson of the Board of Regents for Higher Education, or the president's designee. The cochairpersons shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) Not later than January 1, 2024, the working group shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and higher education and employment advancement on its findings and any recommendations for improving the recruitment and retention of health care providers in the state, including, but not limited to, a five-year plan and a ten-year plan for increasing the health care workforce in the state. The working group shall terminate on the date that it submits such report or January 1, 2024, whichever is later.

Sec. 9. (NEW) (*Effective July 1, 2023*) On and after January 1, 2024, notwithstanding any provision of title 10a of the general statutes, each public institution of higher education shall consider any licensed health care provider who (1) has not less than ten years of clinical health care experience in a field in which such provider is licensed, and (2) applies for a position as an adjunct faculty member at such institution of higher education in a health care related field in which such provider has such experience, to be a qualified applicant for such position and give such provider the same consideration as any other qualified applicant for such position. As used in this section, "public institution of higher education" means those constituent units identified in subdivisions (1) and (2) of section 10a-1 of the general statutes.

Sec. 10. (NEW) (*Effective July 1, 2023*) (a) On or before January 1, 2024, the Office of Higher Education shall establish and administer, within available appropriations, an adjunct professor incentive grant program. The program shall provide an incentive grant in an amount of twenty thousand dollars to each licensed health care provider who (1) accepts a position as an adjunct professor at a public institution of higher education that was offered to such provider after being considered as an applicant for such position pursuant to section 9 of this act, and (2) remains in such position for not less than one academic year. Each licensed health care provider who receives a grant under this subsection shall be eligible for an additional grant in an amount of twenty thousand dollars if the provider remains in such position for not less than two academic years. The executive director of the Office of Higher Education shall establish the application process for the grant program.

(b) Not later than January 1, 2025, and annually thereafter, the executive director of the Office of Higher Education shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the number and demographics of the adjunct professors who applied for and received incentive grants from the adjunct professor grant program established under subsection (a) of this section, the number and types of classes taught by such adjunct professors, the institutions of higher education employing such adjunct professors and any other information deemed pertinent by the executive director.

Sec. 11. (NEW) (*Effective July 1, 2023*) (a) As used in this section, "personal care attendant", "consumer" and "personal care assistance" have the same meanings as provided in section 17b-706 of the general statutes.

(b) Not later than January 1, 2024, the Department of Social Services shall establish and administer a personal care attendants career pathways program to improve the quality of care offered by personal care attendants and incentivize the recruitment and retention of

personal care attendants in the state. A personal care attendant who is not employed by a consumer, but who is eligible for employment by a consumer, may participate in the program following the completion of a program orientation developed by the Commissioner of Social Services.

(c) The career pathways program shall include, but need not be limited to, the following objectives:

(1) Increase in employment retention and recruitment of personal care attendants to maintain a stable workforce for consumers, including, but not limited to, through the creation of career pathways for such attendants that improve skill and knowledge and increase wages;

(2) Dignity in providing and receiving care through meaningful collaboration between consumers and personal care attendants;

(3) Improvement in the quality of personal care assistance and the overall quality of life of the consumer;

(4) Advancement of equity in the provision of personal care assistance;

(5) Promotion of a culturally and linguistically competent workforce of personal attendants to serve the growing racial, ethnic and linguistic diversity of an aging population of consumers; and

(6) Promotion of self-determination principles by personal care attendants.

(d) The Commissioner of Social Services shall offer the following career pathways as part of the career pathways program:

(1) The basic skills career pathways, including (A) general health and safety, and (B) adult education topics; and

(2) The specialized skills career pathways, including (A) cognitive impairments and behavioral health, (B) complex physical care needs,

and (C) transitioning to home and community-based living from out-of-home care or homelessness.

(e) The Commissioner of Social Services shall develop or identify, in consultation with a labor management committee at a hospital or health care organization, the training curriculum for each career pathway of the career pathways program.

(f) Not later than January 1, 2025, the Commissioner of Social Services shall report in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health, on the following information concerning the career pathways program:

(1) The number of personal care attendants who enrolled in the program and types of career pathways chosen by each attendant;

(2) The number of personal care attendants who successfully completed a career pathway and the types of career pathways completed by each attendant;

(3) The effectiveness of the program, as determined by surveys, focus groups and interviews of personal care attendants, and whether the successful completion of a career pathway resulted in a related license or certificate for each personal care attendant or the retention of employment as a personal care attendant;

(4) The number of personal care attendants who were employed by a consumer with specialized care needs after completing a specialized career pathway and who were retained in employment by such consumer for a period of not less than six months; and

(5) The number of personal care attendants who were employed by a consumer with specialized care needs after completing a specialized career pathway and were retained in employment by such consumer for a period of at least twelve months.

Sec. 12. (NEW) (*Effective October 1, 2023*) (a) As used in this section, (1) "board eligible" means eligible to take a qualifying examination administered by a medical specialty board after having graduated from a medical school, completed a residency program and trained under supervision in a specialty fellowship program, (2) "board certified" means having passed the qualifying examination administered by a medical specialty board to become board certified in a particular specialty, and (3) "board recertification" means recertification in a particular specialty after a predetermined time period prescribed by a medical specialty board after having passed the qualifying examination administered by the medical specialty board to become board certified in a particular specialty.

(b) No hospital, or medical review committee of a hospital, shall require, as part of its credentialing requirements (1) for a board eligible physician to acquire privileges to practice in the hospital, that the physician provide credentials of board certification in a particular specialty until five years after the date on which the physician became board eligible in such specialty, or (2) for a board certified physician to acquire or retain privileges to practice in the hospital, that the physician provide credentials of board recertification.

Sec. 13. Section 20-14p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(a) For purposes of this section: (1) "Covenant not to compete" means any provision of an employment or other contract or agreement that creates or establishes a professional relationship with a physician and restricts the right of a physician to practice medicine in any geographic area of the state for any period of time after the termination or cessation of such partnership, employment or other professional relationship; (2) "physician" means an individual licensed to practice medicine under this chapter; and (3) "primary site where such physician practices" means (A) the office, facility or location where a majority of the revenue derived from such physician's services is generated, or (B) any other office, facility or location where such physician practices and mutually

agreed to by the parties and identified in the covenant not to compete.

(b) (1) A covenant not to compete is valid and enforceable only if it is: (A) Necessary to protect a legitimate business interest; (B) reasonably limited in time, geographic scope and practice restrictions as necessary to protect such business interest; and (C) otherwise consistent with the law and public policy. The party seeking to enforce a covenant not to compete shall have the burden of proof in any proceeding.

(2) A covenant not to compete that is entered into, amended, extended or renewed on or after July 1, 2016, shall not: (A) Restrict the physician's competitive activities (i) for a period of more than one year, and (ii) in a geographic region of more than fifteen miles from the primary site where such physician practices; or (B) be enforceable against a physician if (i) such employment contract or agreement was not made in anticipation of, or as part of, a partnership or ownership agreement and such contract or agreement expires and is not renewed, unless, prior to such expiration, the employer makes a bona fide offer to renew the contract on the same or similar terms and conditions, or (ii) the employment or contractual relationship is terminated by the employer, unless such employment or contractual relationship is terminated for cause.

(3) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall not be enforceable if (A) the physician who is a party to the employment or other contract or agreement does not agree to a proposed material change to the terms of the employment or other contract or agreement prior to or at the time of the extension or renewal of such contract or agreement, and (B) the contract or agreement expires and is not renewed by the employer or the employment or contractual relationship is terminated by the employer, unless such employment or contractual relationship is terminated for cause.

[(3)**]** (4) Each covenant not to compete entered into, amended or renewed on and after July 1, 2016, shall be separately and individually

signed by the physician.

(c) The remaining provisions of any contract or agreement that includes a covenant not to compete that is rendered void and unenforceable, in whole or in part, under the provisions of this section shall remain in full force and effect, including provisions that require the payment of damages resulting from any injury suffered by reason of termination of such contract or agreement.

Sec. 14. (NEW) (*Effective July 1, 2023*) (a) For purposes of this section: (1) "Covenant not to compete" means any provision of an employment or other contract or agreement that creates or establishes a professional relationship with an advanced practice registered nurse and restricts the right of an advanced practice registered nurse to practice as an advanced practice registered nurse in any geographic area of the state for any period of time after the termination or cessation of such partnership, employment or other professional relationship; and (2) "advanced practice registered nurse" means an individual licensed as an advanced practice registered nurse pursuant to chapter 378 of the general statutes.

(b) (1) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall be valid and enforceable only if it is: (A) Necessary to protect a legitimate business interest; (B) reasonably limited in time, geographic scope and practice restrictions as necessary to protect such business interest; and (C) otherwise consistent with the law and public policy. The party seeking to enforce a covenant not to compete shall have the burden of proof in any proceeding.

(2) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall not: (A) Restrict the advanced practice registered nurse's competitive activities (i) for a period of more than one year, and (ii) in a geographic region of more than fifteen miles from the primary site where such advanced practice registered nurse practices; or (B) be enforceable against an advanced

practice registered nurse if (i) such employment contract or agreement was not made in anticipation of, or as part of, a partnership or ownership agreement and such contract or agreement expires and is not renewed, unless, prior to such expiration, the employer makes a bona fide offer to renew the contract on the same or similar terms and conditions, or (ii) the employment or contractual relationship is terminated by the employer, unless such employment or contractual relationship is terminated for cause.

(3) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall not be enforceable if (A) the advanced practice registered nurse who is a party to the employment or other contract or agreement does not agree to a proposed material change to the terms of such contract or agreement prior to or at the time of the extension or renewal of such contract or agreement; and (B) the contract or agreement expires and is not renewed by the employer or the employment or contractual relationship is terminated by the employer, unless such employment or contractual relationship is terminated for cause.

(4) Each covenant not to compete entered into, amended or renewed on or after October 1, 2023, shall be separately and individually signed by the advanced practice registered nurse.

(c) The remaining provisions of any contract or agreement that includes a covenant not to compete that is rendered void and unenforceable, in whole or in part, under the provisions of this section shall remain in full force and effect, including provisions that require the payment of damages resulting from any injury suffered by reason of termination of such contract or agreement.

Sec. 15. (NEW) (*Effective July 1, 2023*) (a) For purposes of this section: (1) "Covenant not to compete" means any provision of an employment or other contract or agreement that creates or establishes a professional relationship with a physician assistant and restricts the right of a physician assistant to practice as a physician assistant in any geographic

area of the state for any period of time after the termination or cessation of such partnership, employment or other professional relationship; and (2) "physician assistant" means an individual licensed as a physician assistant pursuant to chapter 370 of the general statutes.

(b) (1) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall be valid and enforceable only if it is: (A) Necessary to protect a legitimate business interest; (B) reasonably limited in time, geographic scope and practice restrictions as necessary to protect such business interest; and (C) otherwise consistent with the law and public policy. The party seeking to enforce a covenant not to compete shall have the burden of proof in any proceeding.

(2) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall not: (A) Restrict the physician assistant's competitive activities (i) for a period of more than one year, and (ii) in a geographic region of more than fifteen miles from the primary site where such physician assistant practices; or (B) be enforceable against a physician assistant if (i) such employment contract or agreement was not made in anticipation of, or as part of, a partnership or ownership agreement and such contract or agreement expires and is not renewed, unless, prior to such expiration, the employer makes a bona fide offer to renew the contract on the same or similar terms and conditions, or (ii) the employment or contractual relationship is terminated by the employer, unless such employment or contractual relationship is terminated for cause.

(3) A covenant not to compete that is entered into, amended, extended or renewed on or after October 1, 2023, shall not be enforceable if (A) the physician assistant who is a party to the employment or other contract or agreement does not agree to a proposed material change to the terms of such contract or agreement prior to or at the time of the extension or renewal of such contract or agreement; and (B) the contract or agreement expires and is not renewed by the employer or the employment or contractual relationship is terminated by the employer,

unless such employment or contractual relationship is terminated for cause.

(4) Each covenant not to compete entered into, amended or renewed on or after October 1, 2023, shall be separately and individually signed by the physician assistant.

(c) The remaining provisions of any contract or agreement that includes a covenant not to compete that is rendered void and unenforceable, in whole or in part, under the provisions of this section shall remain in full force and effect, including provisions that require the payment of damages resulting from any injury suffered by reason of termination of such contract or agreement.

Sec. 16. (NEW) (*Effective July 1, 2023*) The Physical Therapy Licensure Compact is hereby enacted into law and entered into by the state of Connecticut with any and all jurisdictions legally joining therein in accordance with its terms. The compact is substantially as follows:

"PHYSICAL THERAPY LICENSURE COMPACT

SECTION 1. PURPOSE

The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient is located at the time of the patient encounter. The compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

The compact is designed to achieve the following objectives:

(1) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;

(2) Enhance the states' ability to protect the public's health and safety;

(3) Encourage the cooperation of member states in regulating multi-

state physical therapy practice;

(4) Support spouses of relocating military members;

(5) Enhance the exchange of licensure, investigative and disciplinary information between member states; and

(6) Allow a remote state to hold a provider of services with a compact privilege in such state accountable to such state's practice standards.

SECTION 2. DEFINITIONS

As used in section 1, this section and sections 3 to 12, inclusive, of the compact, and except as otherwise provided:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 USC 1209 and 1211, as amended from time to time;

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance or a combination of both;

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a physical therapy licensing board, including, but not limited to, substance abuse issues;

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient or client is located at the time of the patient or client encounter;

(5) "Continuing competence" means a requirement, as a condition of license renewal, to provide evidence of participation in, or completion of, educational and professional activities relevant to practice or area of

work;

(6) "Data system" means a repository of information about licensees, including examination, licensure, investigative, compact privilege and adverse action;

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way;

(8) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them, by the commission;

(9) "Home state" means the member state that is the licensee's primary state of residence;

(10) "Investigative information" means information, records and documents received or generated by a physical therapy licensing board pursuant to an investigation;

(11) "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state;

(12) "Licensee" means an individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant;

(13) "Member state" means a state that has enacted the compact;

(14) "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege;

(15) "Physical therapist" means an individual who is licensed by a state to practice physical therapy;

(16) "Physical therapist assistant" means an individual who is licensed or certified by a state and who assists the physical therapist in

selected components of physical therapy;

(17) "Physical therapy", "physical therapy practice" and "the practice of physical therapy" mean the care and services provided by or under the direction and supervision of a licensed physical therapist;

(18) "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact;

(19) "Physical therapy licensing board" or "licensing board" means the agency of a state that is responsible for the licensing and regulation of physical therapists and physical therapist assistants;

(20) "Remote state" means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege;

(21) "Rule" means a regulation, principle, or directive promulgated by the commission that has the force of law; and

(22) "State" means any state, commonwealth, district or territory of the United States of America that regulates the practice of physical therapy.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

(a) To participate in the compact, a state shall:

(1) Participate fully in the commission's data system, including using the commission's unique identifier as defined in rules;

(2) Have a mechanism in place for receiving and investigating complaints about licensees;

(3) Notify the commission, in compliance with the terms of the compact and rules, of any adverse action or of the availability of investigative information regarding a licensee;

(4) Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions in accordance with subsection (b) of this section;

(5) Comply with the rules of the commission;

(6) Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the commission; and

(7) Have continuing competence requirements as a condition for license renewal.

(b) Upon adoption of the compact, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and shall submit such information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 USC 534 and 42 USC 14616, as amended from time to time.

(c) A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

(d) Member states may charge a fee for granting a compact privilege.

SECTION 4. COMPACT PRIVILEGE

(a) To exercise the compact privilege under the terms and provisions of the compact, the licensee shall:

(1) Hold a license in the home state;

(2) Have no encumbrance on any state license;

(3) Be eligible for a compact privilege in any member state in accordance with subsections (d), (g) and (h) of this section;

(4) Have not had any adverse action against any license or compact privilege within the previous two years;

(5) Notify the commission that the licensee is seeking the compact privilege within a remote state or remote states;

(6) Pay any applicable fees, including any state fee, for the compact privilege;

(7) Meet any jurisprudence requirements established by the remote state or states in which the licensee is seeking a compact privilege; and

(8) Report to the commission adverse action taken by any nonmember state not later than thirty days after the date the adverse action is taken.

(b) The compact privilege is valid until the expiration date of the home license. The licensee shall comply with the requirements of subsection (a) of this section of the compact to maintain the compact privilege in the remote state.

(c) A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

(d) A licensee providing physical therapy in a remote state is subject to such state's regulatory authority. A remote state may, in accordance with due process and such state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines and take any other necessary action to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

(e) If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

(1) The home state license is no longer encumbered; and

(2) Two years have elapsed from the date of the adverse action.

(f) Once an encumbered license in the home state is restored to good standing, the licensee shall meet the requirements of subsection (a) of this section of the compact to obtain a compact privilege in any remote state.

(g) If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until the following occur:

(1) The specific period of time for which the compact privilege was removed has ended;

(2) All fines have been paid; and

(3) Two years have elapsed from the date of the adverse action.

(h) Once the requirements of subsection (g) of this section of the compact have been met, the licensee shall meet the requirements set forth in subsection (a) of this section of the compact to obtain a compact privilege in a remote state.

SECTION 5. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one of the following as the home state:

(1) Home of record;

(2) Permanent change of station (PCS); or

(3) State of current residence if such state is different from the PCS state or home of record.

SECTION 6. ADVERSE ACTIONS

(a) A home state shall have exclusive power to impose adverse action against a license issued by the home state.

(b) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(c) Nothing in the compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states shall require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

(d) Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

(e) A remote state shall have the authority to:

(1) Take adverse actions as set forth in subsection (d) of section 4 of the compact against a licensee's compact privilege in the state;

(2) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in such other party state by any court of competent jurisdiction, according to the practice and procedure of such court applicable to subpoenas issued in proceedings pending before such court. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses or evidence are located; and

(3) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against such licensee.

(f) Joint Investigations

(1) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(2) Member states shall share any investigative, litigation or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

SECTION 7. ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

(a) The compact member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission.

(1) The commission is an instrumentality of the compact states.

(2) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent that it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in the compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting and Meetings

(1) Each member state shall have and be limited to one delegate selected by such member state's licensing board.

(2) The delegate shall be a current member of the licensing board who

is a physical therapist, a physical therapist assistant, a public member or the board administrator.

(3) Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

(4) The member state board shall fill any vacancy occurring in the commission.

(5) Each delegate shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(6) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(7) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(c) The commission shall have the following powers and duties:

(1) Establish the fiscal year of the commission;

(2) Establish bylaws;

(3) Maintain its financial records in accordance with the bylaws;

(4) Meet and take such actions as are consistent with the provisions of the compact and the bylaws;

(5) Promulgate uniform rules to facilitate and coordinate implementation and administration of the compact. The rules shall have the force and effect of law and shall be binding in all member states;

(6) Bring and prosecute legal proceedings or actions in the name of the commission, provided the standing of any state physical therapy

licensing board to sue or be sued under applicable law shall not be affected;

(7) Purchase and maintain insurance and bonds;

(8) Borrow, accept or contract for services of personnel, including, but not limited to, employees of a member state;

(9) Hire employees, elect or appoint officers, fix compensation, define duties and grant such individuals appropriate authority to carry out the purposes of the compact and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

(10) Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services and receive, utilize and dispose of such money, equipment, supplies, materials and services, provided at all times the commission shall avoid any appearance of impropriety or conflict of interest;

(11) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use any property, real, personal or mixed, provided at all times the commission shall avoid any appearance of impropriety;

(12) Sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any real, personal or mixed property;

(13) Establish a budget and make expenditures;

(14) Borrow money;

(15) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives and such other interested persons as may be designated in the compact and the bylaws;

(16) Provide and receive information from, and cooperate with, law-

enforcement agencies;

(17) Establish and elect an executive board; and

(18) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(d) The Executive Board

The executive board shall have the power to act on behalf of the commission according to the terms of the compact.

(1) The executive board shall be composed of nine members as follows:

(A) Seven voting members who are elected by the commission from the current membership of the commission;

(B) One ex-officio, nonvoting member from the recognized national physical therapy professional association; and

(C) One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(2) The ex-officio members shall be selected by their respective organizations.

(3) The commission may remove any member of the executive board as provided in bylaws.

(4) The executive board shall meet at least annually.

(5) The executive board shall have the following duties and responsibilities:

(A) Recommend to the entire commission changes to the rules or bylaws, changes to the compact legislation, fees paid by compact member states, including annual dues, and any commission compact fee

charged to licensees for the compact privilege;

(B) Ensure compact administration services are appropriately provided, contractual or otherwise;

(C) Prepare and recommend the budget;

(D) Maintain financial records on behalf of the commission;

(E) Monitor compact compliance of member states and provide compliance reports to the commission;

(F) Establish additional committees as necessary; and

(G) Perform other duties as provided in rules or bylaws.

(e) Meetings of the Commission

(1) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions of section 9 of the compact.

(2) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission shall discuss:

(A) Noncompliance of a member state with its obligations under the compact;

(B) The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

(C) Current, threatened or reasonably anticipated litigation;

(D) Negotiation of contracts for the purchase, lease or sale of goods, services or real estate;

(E) Accusing any person of a crime or formally censuring any person;

(F) Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

(G) Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(H) Disclosure of investigative records compiled for law-enforcement purposes;

(I) Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the compact; or

(J) Matters specifically exempted from disclosure by federal or member state statute.

(3) If a meeting or portion of a meeting is closed pursuant to this provision, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

(4) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(f) Financing of the Commission

(1) The commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization and ongoing activities.

(2) The commission may accept any and all appropriate revenue

sources, donations and grants of money, equipment, supplies, materials and services.

(3) The commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff, which shall be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule binding upon all member states.

(4) The commission shall not incur obligations of any kind prior to securing the funds adequate to meet such obligations, or pledge the credit of any of the member states, except by and with the authority of the member state.

(5) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the commission shall be audited annually by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the commission.

(g) Qualified Immunity, Defense and Indemnification

(1) The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional

or wilful or wanton misconduct of such person.

(2) The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided (A) nothing in this subdivision shall be construed to prohibit such person from retaining his or her own counsel, and (B) the actual or alleged act, error or omission did not result from such person's intentional or wilful or wanton misconduct.

(3) The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against such person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided the actual or alleged act, error or omission did not result from the intentional or wilful or wanton misconduct of such person.

SECTION 8. DATA SYSTEM

(a) The commission shall provide for the development, maintenance and utilization of a coordinated database and reporting system containing licensure, adverse action and investigative information on all licensed individuals in member states.

(b) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including:

(1) Identifying information;

(2) Licensure data;

(3) Adverse actions against a license or compact privilege;

(4) Nonconfidential information related to alternative program participation;

(5) Any denial of application for licensure, and the reason for such denial; and

(6) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(c) Investigative information pertaining to a licensee in any member state shall only be available to other party states.

(d) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state shall be available to any other member state.

(e) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(f) Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

SECTION 9. RULEMAKING

(a) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the member states rejects a rule,

by enactment of a statute or resolution in the same manner used to adopt the compact not later than four years after the date of adoption of the rule, such rule shall have no further force and effect in any member state.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

(d) Prior to promulgation and adoption of a final rule or rules by the commission, and at least thirty days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(1) On the Internet web site of the commission or other publicly accessible platform; and

(2) On the Internet web site of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(e) The notice of proposed rulemaking shall include:

(1) The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(g) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least twenty-five persons;

(2) A state or federal governmental subdivision or agency; or

(3) An association having at least twenty-five members.

(h) If a hearing is held on the proposed rule or amendment, the commission shall publish the place, time and date of the scheduled public hearing. If the hearing is held via electronic means, the commission shall publish the mechanism for access to the electronic hearing.

(1) All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) All hearings shall be recorded. A copy of the recording shall be made available on request.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(j) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with promulgation of the proposed rule without a public hearing.

(k) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(l) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided the usual rulemaking procedures provided in the compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, but in no event later than ninety days after the effective date of the rule. For the purposes of this subsection, an emergency rule shall be adopted immediately to:

(1) Meet an imminent threat to public health, safety or welfare;

(2) Prevent a loss of commission or member state funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the Internet web site of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the commission prior to the end of the notice period. If no challenge is made, the revision shall take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

SECTION 10. OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

(a) Oversight

(1) The executive, legislative and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated under the compact shall have standing as statutory law.

(2) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the commission.

(3) The commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission shall render a judgment or order void as to the commission, the compact or promulgated rules.

(b) Default, Technical Assistance and Termination

(1) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the promulgated rules, the commission shall:

(A) Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and or any other action to be taken by the commission; and

(B) Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default shall not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor, the majority and minority leaders of the defaulting state's legislature and each of the member states.

(4) A state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(5) The commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(6) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

(c) Dispute Resolution

(1) Upon request by a member state, the commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

(2) The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(d) Enforcement

(1) The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(2) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal

district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

(3) The remedies herein shall not be the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

SECTION 11. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL AND AMENDMENT

(a) The compact shall come into effect on the date on which the compact statute is enacted into law in the tenth member state. The provisions, which become effective at such time, shall be limited to the powers granted to the commission relating to assembly and the promulgation of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

(b) Any state that joins the compact subsequent to the commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in such state. Any rule that has been previously adopted by the commission shall have the full force and effect of law on the day the compact becomes law in such state.

(c) Any member state may withdraw from the compact by enacting a statute repealing the same.

(1) A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the

investigative and adverse action reporting requirements of the compact prior to the effective date of withdrawal.

(d) Nothing contained in the compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of the compact.

(e) The compact may be amended by the member states. No amendment to the compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 12. CONSTRUCTION AND SEVERABILITY

The compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of the compact shall be severable, and if any phrase, clause, sentence or provision of the compact is declared to be contrary to the constitution of any party state or the Constitution of the United States, or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If the compact shall be held contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters."

Sec. 17. (NEW) (*Effective July 1, 2023*) The Commissioner of Public Health shall require each person applying for licensure as a physical therapist or physical therapist assistant to submit to a state and national fingerprint-based criminal history records check pursuant to section 29-17a of the general statutes. For the purposes of this section, "physical therapist" means an individual licensed for the independent practice of physical therapy, "physical therapist assistant" means an individual licensed to assist in the practice of physical therapy in this state under the supervision of a physical therapist and "licensure" means authorization by a state physical therapy regulatory authority to engage

in the independent practice of physical therapy, the practice of which would be unlawful without such authorization.

Sec. 18. (*Effective July 1, 2023*) (a) The Commissioner of Public Health shall establish a podiatric scope of practice working group to advise the Department of Public Health and any relevant scope of practice review committee established pursuant to section 19a-16e of the general statutes regarding the scope of practice of podiatrists as it relates to surgical procedures. The working group shall consist of not less than three podiatrists licensed pursuant to chapter 375 of the general statutes and not less than three orthopedic surgeons licensed pursuant to chapter 370 of the general statutes appointed by the commissioner. Not later than January 1, 2024, the working group shall report to the commissioner and any such scope of practice review committee regarding its findings and recommendations.

(b) Not later than February 1, 2024, the Commissioner of Public Health shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on the findings and recommendations of the working group and whether the Department of Public Health and any relevant scope of practice review committee is in agreement with such findings and recommendations.

Sec. 19. Section 20-94a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, as amended by this act, upon receipt of a fee of two hundred dollars, to an applicant who: (1) Maintains a license as a registered nurse in this state, as provided by section 20-93 or 20-94; (2) holds and maintains current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced practice: The American Nurses' Association, the Nurses'

Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists, their successors or other appropriate national certifying bodies approved by the Board of Examiners for Nursing; (3) has completed thirty hours of education in pharmacology for advanced nursing practice; and (4) (A) holds a graduate degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies, or (B) (i) on or before December 31, 2004, completed an advanced nurse practitioner program that a national certifying body identified in subdivision (2) of subsection (a) of this section recognized for certification of a nurse practitioner, clinical nurse specialist, or nurse anesthetist, and (ii) at the time of application, holds a current license as an advanced practice registered nurse in another state that requires a master's degree in nursing or a related field for such licensure. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(b) During the period commencing January 1, 1990, and ending January 1, 1992, the Department of Public Health may in its discretion allow a registered nurse, who has been practicing as an advanced practice registered nurse in a nurse practitioner role and who is unable to obtain certification as a nurse practitioner by one of the national certifying bodies specified in subsection (a) of this section, to be licensed as an advanced practice registered nurse provided the individual:

(1) Holds a current Connecticut license as a registered nurse pursuant to this chapter;

(2) Presents the department with documentation of the reasons one of such national certifying bodies will not certify him as a nurse practitioner;

(3) Has been in active practice as a nurse practitioner for at least five

years in a facility licensed pursuant to section 19a-491;

(4) Provides the department with documentation of his preparation as a nurse practitioner;

(5) Provides the department with evidence of at least seventy-five contact hours, or its equivalent, of continuing education related to his nurse practitioner specialty in the preceding five calendar years;

(6) Has completed thirty hours of education in pharmacology for advanced nursing practice;

(7) Has his employer provide the department with a description of his practice setting, job description, and a plan for supervision by a licensed physician; and

(8) Notifies the department of each change of employment to a new setting where he will function as an advanced practice registered nurse and will be exercising prescriptive and dispensing privileges.

(c) Any person who obtains a license pursuant to subsection (b) of this section shall be eligible to renew such license annually provided he presents the department with evidence that he received at least fifteen contact hours, or its equivalent, eight hours of which shall be in pharmacology, of continuing education related to his nurse practitioner specialty in the preceding licensure year. If an individual licensed pursuant to subsection (b) of this subsection becomes eligible at any time for certification as a nurse practitioner by one of the national certifying bodies specified in subsection (a) of this section, the individual shall apply for certification, and upon certification so notify the department, and apply to be licensed as an advanced practice registered nurse in accordance with subsection (a) of this section.

(d) On and after October 1, 2023, a person, who is not eligible for licensure under subsection (a) of this section, may apply for licensure by endorsement as an advanced practice registered nurse. Such applicant shall (1) present evidence satisfactory to the Commissioner of Public

Health that the applicant has acquired three years of experience as an advanced practice registered nurse, or as a person entitled to perform similar services under a different designation, in another state or jurisdiction that has requirements for practicing in such capacity that are substantially similar to, or higher than, those of this state and that there are no disciplinary actions or unresolved complaints pending against such person, and (2) pay a fee of two hundred dollars to the commissioner.

[(d)**]** (e) A person who has received a license pursuant to this section shall be known as an "Advanced Practice Registered Nurse" and no other person shall assume such title or use the letters or figures which indicate that the person using the same is a licensed advanced practice registered nurse.

Sec. 20. Subsection (b) of section 20-87a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(b) (1) Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post-basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section.

(2) (A) An advanced practice registered nurse having been issued a license pursuant to section 20-94a, as amended by this act, shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state. In all settings, such advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, except such advanced practice registered nurse licensed pursuant to section 20-

94a, as amended by this act, and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed. For purposes of this subdivision, "collaboration" means a mutually agreed upon relationship between such advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of such advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between such advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that such advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that such advanced practice registered nurse may prescribe, dispense and administer.

(B) An advanced practice registered nurse having been issued a license pursuant to subsection (d) of section 20-94a, as amended by this act, who collaborated, prior to the issuance of such license, with a physician licensed to practice medicine in another state may count the time of such collaboration toward the three-year requirement set forth in subparagraph (A) of this subsection, provided such collaboration otherwise satisfies the requirements set forth in said subparagraph.

(3) An advanced practice registered nurse having (A) been issued a license pursuant to section 20-94a, as amended by this act, (B) maintained such license, or, for an advanced practice registered nurse having been issued a license pursuant to subsection (d) of said section, such license or a license to practice in another state as an advanced

practice registered nurse or as a person entitled to perform similar services under a different designation, for a period of not less than three years, and (C) engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours in accordance with the provisions of subdivision (2) of this subsection, may, thereafter, alone or in collaboration with a physician or another health care provider licensed to practice in this state: (i) Perform the acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section; and (ii) prescribe, dispense and administer medical therapeutics and corrective measures and dispense drugs in the form of professional samples as described in subdivision (2) of this subsection in all settings. Any advanced practice registered nurse electing to practice not in collaboration with a physician in accordance with the provisions of this subdivision shall maintain documentation of having engaged in the performance of advanced practice level nursing activities in collaboration with a physician for a period of not less than three years and not less than two thousand hours. Such advanced practice registered nurse shall maintain such documentation for a period of not less than three years after completing such requirements and shall submit such documentation to the Department of Public Health for inspection not later than forty-five days after a request made by the department for such documentation. Any such advanced practice registered nurse shall submit written notice to the Commissioner of Public Health of his or her intention to practice without collaboration with a physician after completing the requirements described in this subdivision and prior to beginning such practice. Not later than December first, annually, the Commissioner of Public Health shall publish on the department's Internet web site a list of such advanced practice registered nurses who are authorized to practice not in collaboration with a physician.

(4) An advanced practice registered nurse licensed under the provisions of this chapter may make the determination and pronouncement of death of a patient, provided the advanced practice

registered nurse attests to such pronouncement on the certificate of death and signs the certificate of death not later than twenty-four hours after the pronouncement.

Sec. 21. (NEW) (*Effective July 1, 2023*) Not later than January 1, 2024, the owner or operator of each splash pad and spray park where water is recirculated shall post a sign in a conspicuous location at or near the entryway to the splash pad or spray park stating that the water is recirculated and warning that there is a potential health risk to persons ingesting the water.

Sec. 22. (NEW) (*Effective from passage*) (a) Notwithstanding the provisions of chapter 378 of the general statutes, a public or independent institution of higher education that (1) is accredited as a degree-granting institution in good standing by a regional accrediting association recognized by the Secretary of the United States Department of Education and maintains such accreditation status; and (2) offers, or is seeking state approval to offer, a nursing program pursuant to section 10a-34 of the general statutes, may apply to the Connecticut State Board of Examiners for Nursing to establish a pilot program that offers licensed practical nursing education and training on or before January 30, 2024. As used in this subsection, "public institution of higher education" and "independent institution of higher education" have the same meanings as described in section 10a-173 of the general statutes.

(b) An institution of higher education that applies to the Connecticut State Board of Examiners for Nursing to establish a pilot program pursuant to subsection (a) of this section shall provide to said board the following information, in writing, not later than sixty days prior to the date on which it seeks to establish the pilot program:

(1) Identifying information regarding the pilot program, including, but not limited to, the name of the program, address where such program will be administered, responsible party for the program and contact information for the program;

(2) A description of the pilot program, including accreditation status,

any clinical partner and anticipated enrollment by academic term;

(3) An identification of resources that support the program;

(4) Graduation rates and National Council Licensure Examination licensure and certification pass rates for the past three years for any existing nursing programs offered by the institution of higher education;

(5) A plan for employing qualified faculty and administrators and clinical experiences; and

(6) Other information as requested by the Connecticut State Board of Examiners for Nursing.

(c) The Connecticut State Board of Examiners for Nursing shall review and consider an application made by an institution of higher education described in subsection (a) of this section to establish a pilot program pursuant to said subsection if the institution of higher education provides the information required pursuant to subsection (b) of this section. The Connecticut State Board of Examiners for Nursing may hold a public hearing on such application.

(d) The pilot program established pursuant to this section shall comply with the relevant provisions of chapter 378 of the general statutes and sections 20-90-45 and 20-90-59 of the regulations of Connecticut state agencies. Notwithstanding the provisions of section 10a-34 of the general statutes, if such pilot program complies with such provisions for not less than two years, and provides evidence that the program is meeting its education outcomes as demonstrated by an acceptable level of graduates' performance, as defined in subdivision (2) of subsection (b) of section 20-90-47 of the regulations of Connecticut state agencies, such pilot program shall be deemed fully approved by the Connecticut State Board of Examiners for Nursing.

Sec. 23. (NEW) (*Effective from passage*) The Office of Higher Education may enter into a reciprocity agreement with one or more neighboring

states that permits such neighboring state to allow a student attending an institution of higher education in such neighboring state to train in a clinical rotation for credit in Connecticut, provided such neighboring state allows a student attending a Connecticut institution of higher education to train in a clinical rotation for credit in such neighboring state.

Sec. 24. Subsection (f) of section 19a-112j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

(f) A majority of the membership of the commission shall constitute a quorum for the transaction of any business and any decision shall be by a majority vote of those present at a meeting, except the commission may establish such subcommissions, advisory groups or other entities as it deems necessary to further the purposes of the commission, including, but not limited to, a subcommission, advisory group or other entity to evaluate the challenges associated with the provision of home health care to victims of gun violence and methods to foster a system that unites community service providers with adults and juveniles needing supports and services in order to address trauma suffered as a result of gun violence.

Sec. 25. (*Effective from passage*) The Department of Public Health, in consultation with the Department of Mental Health and Addiction Services, and organizations representing health care facilities and licensed health care professionals, shall develop a maternal mental health toolkit to provide information and resources regarding maternal mental health to licensed health care professionals and new parents in the state. Such toolkit shall include, but need not be limited to, (1) information about perinatal mood and anxiety disorders, including, but not limited to, the symptoms of such disorders, potential impact of such disorders on families and treatment options for a person with a perinatal mood or anxiety disorder; and (2) a list of licensed health care professionals, peer support networks and nonprofit organizations in the state that treat perinatal mood and anxiety disorders or provide support

for persons with a perinatal mood or anxiety disorder and the family members of such persons. Not later than October 1, 2023, the Department of Public Health shall make such toolkit available on its Internet web site.

Sec. 26. Section 19a-490u of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) Each hospital, as defined in section 19a-490, shall include training in the symptoms of dementia as part of such hospital's regularly provided training to staff members who provide direct care to patients.

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

(c) On and after October 1, 2023, each hospital shall include training in perinatal mood and anxiety disorders as part of such hospital's regularly provided training to staff members who provide direct care to women who are pregnant or in the postpartum period.

Sec. 27. (*Effective from passage*) (a) On or before July 1, 2023, the Commissioner of Public Health shall convene a working group to advise the commissioner regarding methods to alleviate emergency department crowding and the lack of available emergency department beds in the state, including, but not limited to, the following:

(1) The establishment of a quality measure for the timeliness of the transfer of an emergency department patient, who will be admitted to the hospital, out of the hospital's emergency department;

(2) The establishment of emergency department discharge units to expedite the discharge of patients from the emergency department;

(3) (A) An evaluation of the percentage of emergency department patients who are held in the emergency department after being admitted to the hospital and while waiting for an inpatient bed to become available, and (B) the development of a plan to decrease such percentage; and

(4) The reduction in liability for hospitals and their emergency physicians when patient crowding of a hospital's emergency department has reached the point of causing significant wait times for patients seeking emergency department services.

(b) The working group convened pursuant to subsection (a) of this section may include, but need not be limited to, the following members: (1) Two emergency physicians licensed pursuant to chapter 370 of the general statutes representing the Connecticut chapter of a national college of emergency physicians; (2) two emergency physicians licensed pursuant to chapter 370 of the general statutes, one of whom shall be the director of the emergency department of a larger hospital system in the state, and one of whom shall be the director of the emergency department of an independent community hospital; (3) one primary care physician licensed pursuant to chapter 370 of the general statutes representing the Connecticut chapter of a national college of physicians; (4) two representatives of a hospital association in the state; (5) one representative of a medical society in the state; (6) one representative of the Connecticut chapter of a national organization of emergency nurses; (7) one representative of the Connecticut chapter of a national organization of pediatric physicians; (8) one representative of the Connecticut chapter of a national association of psychiatrists; (9) one representative of an association of nurses in the state; (10) two nurses licensed pursuant to chapter 378 of the general statutes, one of whom shall be the nurse director of the emergency department in a larger hospital system, and one of whom shall be the nurse director of the emergency department in an independent community hospital; (11) two

patient care navigators, one of whom shall be employed by a larger hospital system, and one of whom shall be employed by an independent community hospital; (12) one representative of hospital patients in the state; (13) one provider of emergency medical transportation services in the state; (14) one representative of a national association of retired persons; (15) the Healthcare Advocate, or the Healthcare Advocate's designee; (16) the Commissioner of Mental Health and Addiction Services, or the commissioner's designee; (17) the Commissioner of Children and Families, or the commissioner's designee; (18) one representative from the Department of Public Health's Office of Emergency Medical Services; (19) one representative from the Department of Public Health's facilities licensing and investigations section; (20) one representative of the Office of the Long-Term Care Ombudsman; (21) the Child Advocate, or the Child Advocate's designee; (22) one representative of a nonprofit nursing home in the state; (23) one representative from a for-profit nursing home in the state; (24) one representative from the insurance industry in the state; and (25) one member of an association of trial lawyers in the state. The chairpersons of the working group shall be one of the emergency physicians representing the Connecticut chapter of a national college of emergency physicians and one of the representatives of a hospital association in the state, who shall be selected by the Commissioner of Public Health. Once selected, the chairpersons of the working group may convene the first meeting of the working group whether or not any other members of the working group identified in subdivisions (1) to (25), inclusive, of this subsection have been selected by the Commissioner of Public Health. If said commissioner has not selected any member of the working group described in said subdivisions on or before August 1, 2023, the cochairpersons may jointly select such member. The first meeting of the working group shall be held not later than December 1, 2023. The working group shall meet biannually and at other times upon the call of the cochairpersons.

(c) On or before January 1, 2024, and annually thereafter until January 1, 2025, the working group shall report its findings and

recommendations to the Commissioner of Public Health and, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 28. (*Effective from passage*) (a) There is established a task force to study childhood and adult psychosis. Such study shall include, but need not be limited to, an examination of (1) the establishment of, in collaboration with the Departments of Children and Families and Mental Health and Addiction Services, clinics staffed by mental health care providers in various fields who provide comprehensive care for children and adults who are experiencing symptoms of early or first episode psychosis to prevent symptoms from becoming disabling, (2) early evaluation of children and adults with symptoms of a psychosis and management of such symptoms, including, but not limited to, initiating treatment and making any necessary referrals for additional treatment or services, (3) creating (A) care pathways that include specialty teams that treat children and adults who are experiencing early or first episode psychosis, (B) a state-wide model for coordinating specialty care for children and adults experiencing psychosis, as recommended by the National Institute of Mental Health, and (C) services for such children and adults, including, but not limited to, collaboration on psychotherapy and pharmacotherapy, family support, education, coordination with community support services and collaboration with employers and education systems, and (4) strengthening existing clinical networks that treat children and adults experiencing psychosis with a focus on collaborative research and outcomes. As used in this subsection, "psychosis" means a severe mental condition in which disruptions to a person's thoughts and perceptions make it difficult for the person to recognize what is real and what is not real and are often experienced as seeing, hearing and believing things that are not real or having strange, persistent thoughts, behaviors and emotions, including, but not limited to, hallucinations and delusions.

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

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a child and adolescent psychiatrist with experience treating patients with psychosis and one of whom shall be a clinical researcher in the field of psychosis;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a psychiatrist with experience treating adults with psychosis and one of whom shall be a clinical researcher in the field of psychosis;

(3) One appointed by the majority leader of the House of Representatives, who shall be the parent or guardian of a child or adolescent who has been treated for psychosis;

(4) One appointed by the majority leader of the Senate, who shall be an adult who has been treated for psychosis;

(5) One appointed by the minority leader of the House of Representatives, who shall be a licensed mental health care provider who has treated children or adolescents with psychosis;

(6) One appointed by the minority leader of the Senate, who shall be a licensed mental health care provider who has treated adults with psychosis;

(7) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(8) The Commissioner of Children and Families, or the commissioner's designee.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

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

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

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

(g) Not later than January 1, 2024, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2024, whichever is later.

Sec. 29. (*Effective from passage*) (a) The Departments of Mental Health and Addiction Services, Social Services and Children and Families shall, in consultation with direct service providers and individuals with lived experience, evaluate existing programs for persons with substance use disorder who are caregivers of children and the barriers to treatment of such persons and develop a plan for the establishment and implementation of programs for the treatment of such persons and their children. Such programs shall include, but need not be limited to, the following:

(1) Same-day access, in all geographical areas, to family-centered medication-assisted treatment that includes prenatal and perinatal care and access to supports that provide a bridge to such treatment;

(2) Intensive in-home treatment supports;

(3) Gender-specific programming;

(4) Expanded access to residential programs for pregnant and parenting persons, including residential programs for parents who have

more than one child or who have children over the age of seven; and

(5) Access to recovery support specialists and peer support to provide care coordination.

(b) Not later than January 1, 2024, the Commissioners of Mental Health and Addiction Services, Social Services and Children and Families shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and children regarding such plan and recommendations for legislative changes necessary to implement the programs described in subsection (a) of this section.

Sec. 30. (*Effective from passage*) The Departments of Mental Health and Addiction Services and Social Services shall, in collaboration with the Office of Early Childhood, establish a plan to permit parents who are in treatment for substance use disorder to be eligible for child care supports and subsidies. Not later than January 1, 2024, the Commissioners of Mental Health and Addiction Services and Social Services shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services regarding such plan.

Sec. 31. (*Effective from passage*) Not later than January 1, 2024, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and housing regarding access in the state to supportive housing for pregnant and parenting persons with a substance use disorder.

Sec. 32. (*Effective from passage*) Not later than January 1, 2024, the Commissioners of Mental Health and Addiction Services, Social Services and Children and Families shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint

standing committees of the General Assembly having cognizance of matters relating to public health, human services and children regarding access for parents with a substance use disorder whose children are receiving services from the Department of Children and Families to appropriate treatment for substance use disorder in the state to prevent removal of children from their parents where possible and to support reunification when removal is necessary, including, but not limited to, consideration of in-home parenting and child care services to assist with safety planning during initial stages of treatment and recovery.

Sec. 33. (*Effective from passage*) Not later than January 1, 2024, the Commissioners of Mental Health and Addiction Services, Children and Families and Social Services shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health regarding existing substance use disorder treatment services for pregnant and parenting persons, utilization of such services and areas where additional substance use disorder treatment services for such persons are necessary.

Sec. 34. (*Effective from passage*) Not later than January 1, 2024, the Commissioner of Children and Families shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and children regarding efforts of the Department of Children and Families to mitigate child safety concerns in the home when the child is living with a caregiver with a substance use disorder.

Sec. 35. Subsection (b) of section 17a-674d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2023*):

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

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

(2) The Attorney General, or the Attorney General's designee;

(3) The Commissioners of Children and Families, Mental Health and Addiction Services and Public Health, or said commissioners' designees, who shall serve as ex-officio members;

(4) The president pro tempore of the Senate, the speaker of the House of Representatives, the majority leaders of the Senate and House of Representatives, the minority leaders of the Senate and House of Representatives, the Senate and House chairpersons of the joint standing **[**committee**]** committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and public health, or their designees, provided such persons have experience living with a substance **[**or**]** use disorder or are the family member of a person who has experience living with a substance use disorder;

(5) **[**Seventeen**]** Twenty-one individuals representing municipalities, who shall be appointed by the Governor;

(6) The executive director of the Commission on Racial Equity in Public Health, or a representative of the commission designated by the executive director; and

(7) **[**Six**]** Eight individuals appointed by the commissioner as follows: (A) A provider of community-based substance use treatment services for adults, who shall be a nonvoting member; (B) a provider of community-based substance use treatment services for adolescents, who shall be a nonvoting member; (C) an addiction medicine licensed health care professional with prescribing ability, who shall be a nonvoting member; **[**and**]** (D) three individuals with experience living with a substance use disorder or family members of an individual with experience living with a substance use disorder; and (E) two individuals with experience supporting infants and children affected by the opioid crisis.

Sec. 36. Subdivision (8) of section 19a-177 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(8) (A) Develop an emergency medical services data collection system. Each emergency medical service organization licensed or certified pursuant to this chapter shall submit data to the commissioner, on a quarterly basis, from each licensed ambulance service, certified ambulance service or paramedic intercept service that provides emergency medical services. Such submitted data shall include, but not be limited to: (i) The total number of and reasons for calls for emergency medical services received by such licensed ambulance service, certified ambulance service or paramedic intercept service through the 9-1-1 system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, required for each such call; (iii) the response time for each licensed ambulance service, certified ambulance service or paramedic intercept service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls, both made and received, during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The data required under this subdivision may be submitted in any electronic form selected by such licensed ambulance service, certified ambulance service or paramedic intercept service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service, certified ambulance service or paramedic intercept service in approving such electronic form. The commissioner may conduct an audit of any such licensed ambulance service, certified ambulance service or paramedic intercept service as the commissioner deems necessary in order to verify the accuracy of such reported data.

(B) On or before June 1, 2023, and annually thereafter, the commissioner shall prepare a report to the Emergency Medical Services Advisory Board, established pursuant to section 19a-178a, that shall include, but not be limited to, the following data: (i) The total number

of calls for emergency medical services received during the reporting year by each licensed ambulance service, certified ambulance service or paramedic intercept service; (ii) the level of emergency medical services required for each such call; (iii) the name of the emergency medical service organization that provided each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service, certified ambulance service or paramedic intercept service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179; **[**and**]** (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year; and (vi) any shortage of emergency medical services personnel in the state. The commissioner shall prepare such report in a format that categorizes such data for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications.

(C) If any licensed ambulance service, certified ambulance service or paramedic intercept service does not submit the data required under subparagraph (A) of this subdivision for a period of six consecutive months, or if the commissioner believes that such licensed ambulance service, certified ambulance service or paramedic intercept service knowingly or intentionally submitted incomplete or false data, the commissioner shall issue a written order directing such licensed ambulance service, certified ambulance service or paramedic intercept service to comply with the provisions of subparagraph (A) of this subdivision and submit all missing data or such corrected data as the commissioner may require. If such licensed ambulance service, certified ambulance service or paramedic intercept service fails to fully comply with such order not later than three months from the date such order is issued, the commissioner (i) shall conduct a hearing, in accordance with chapter 54, at which such licensed ambulance service, certified ambulance service or paramedic intercept service shall be required to show cause why the primary service area assignment of such licensed ambulance service, certified ambulance service or paramedic intercept

service should not be revoked, and (ii) may take such disciplinary action under section 19a-17 as the commissioner deems appropriate.

(D) The commissioner shall collect the data required by subparagraph (A) of this subdivision, in the manner provided in said subparagraph, from each emergency medical service organization licensed or certified pursuant to this chapter. Any such emergency medical service organization that fails to comply with the provisions of this section shall be liable for a civil penalty not to exceed one hundred dollars per day for each failure to report the required data regarding emergency medical services provided to a patient, as determined by the commissioner. The civil penalties set forth in this subparagraph shall be assessed only after the department provides a written notice of deficiency and the organization is afforded the opportunity to respond to such notice. An organization shall have not more than fifteen business days after the date of receiving such notice to provide a written response to the department. The commissioner may adopt regulations, in accordance with chapter 54, concerning the development, implementation, monitoring and collection of emergency medical service system data. All state agencies licensed or certified as emergency medical service organizations shall be exempt from the civil penalties set forth in this subparagraph.

(E) The commissioner shall, with the recommendation of the Connecticut Emergency Medical Services Advisory Board established pursuant to section 19a-178a, adopt for use in trauma data collection the most recent version of the National Trauma Data Bank's National Trauma Data Standards and Data Dictionary and nationally recognized guidelines for field triage of injured patients.

(F) On or before June 1, 2024, and annually thereafter, the commissioner shall submit the report described in subparagraph (B) of this subdivision, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health;

Sec. 37. (*Effective from passage*) (a) There is established a task force to study issues concerning rural health. Such study shall include, but need not be limited to, an examination of resources and services available to promote rural health and support health care providers in rural areas throughout the state and methods for coordinating and streamlining such resources and services.

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

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

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

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

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

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

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

(7) One each appointed by the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(8) One each appointed by the ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(9) The Commissioner of Public Health, or the commissioner's designee;

(10) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(11) The Attorney General, or the Attorney General's designee;

(12) The State Comptroller, or the State Comptroller's designee; and

(13) The executive director of the Office of Health Strategy, or the executive director's designee.

(c) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5), (6), (7) or (8) of subsection (b) of this section may be a member of the General Assembly.

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

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

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

(g) Not later than January 1, 2024, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2024, whichever is later.

Sec. 38. (*Effective from passage*) The Commissioner of Education, in consultation with the Labor Commissioner and Commissioner of Public Health, shall study the feasibility of establishing an interdistrict magnet school program that provides education and training to students interested in health care professions. The program shall provide pathways for a student to (1) graduate with a certification, license or registration that enables such student to practice in a health care field

upon graduation from the program, and (2) complete a curriculum designed to prepare such student for higher education in premedicine or nursing. Not later than February 1, 2024, the Commissioner of Education shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the results of such study.

Sec. 39. (*Effective from passage*) The Office of Workforce Strategy shall study the feasibility of offering competency testing for dental assistants, phlebotomists, electrocardiography technicians and respiratory care practitioners in both English and Spanish. Not later than February 1, 2024, the Chief Workforce Officer shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on such study.

Sec. 40. (*Effective from passage*) The Commissioner of Aging and Disability Services, in consultation with the Advisory Board for Persons Who are Deaf, Hard of Hearing or Deafblind, shall conduct a study to evaluate gaps in communication access for deaf, hard of hearing or deafblind persons to medical providers and develop recommendations for improved access, including, but not limited to, interpreting through American Sign Language for such persons and through Spanish Sign Language for such persons whose primary language is Spanish. Not later than October 1, 2023, the commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and public health on such study.

Sec. 41. Subdivision (1) of subsection (c) of section 20-112a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(c) (1) A licensed dentist may delegate to dental assistants such dental

procedures as the dentist may deem advisable, including: (A) The taking of dental x-rays if the dental assistant can demonstrate successful completion of the dental radiation health and safety examination administered by the Dental Assisting National Board or a radiation health and safety competency assessment administered by a dental education program in the state that is accredited by the American Dental Association's Commission on Dental Accreditation; (B) the taking of impressions of teeth for study models; and (C) the provision of fluoride varnish treatments. Such procedures shall be performed under the direct supervision of a licensed dentist and the dentist providing direct supervision shall assume responsibility for such procedures.

Sec. 42. (*Effective from passage*) On or before January 1, 2025, The University of Connecticut School of Dental Medicine shall develop a radiation health and safety competency assessment for dental assistants that reflects current industry practices regarding the taking of dental x-rays. Such assessment shall be a suitable competency evaluation, the successful completion of which would allow a dental assistant to take dental x-rays under the direct supervision of a licensed dentist pursuant to the provisions of subdivision (1) of subsection (c) of section 20-112a of the general statutes, as amended by this act. Not later than January 1, 2025, The University of Connecticut School of Dental Medicine shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the development of such assessment.

Sec. 43. Section 19a-197a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) As used in this section, **[**"emergency medical technician"**]** "emergency medical services personnel" means (1) any class of emergency medical technician certified **[**under regulations adopted pursuant to section 20-206oo**]** pursuant to sections 20-206*ll* and 20-206mm, including, but not limited to, any advanced emergency medical technician, **[**and**]** (2) any paramedic licensed pursuant to **[**section**]**

sections 20-206*ll* and 20-206mm, and (3) any emergency medical responder certified pursuant to sections 20-206*ll* and 20-206mm.

(b) Any emergency medical **[**technician**]** services personnel who has been trained, in accordance with national standards recognized by the Commissioner of Public Health, in the administration of epinephrine using automatic prefilled cartridge injectors**,** **[**or**]** similar automatic injectable equipment or by prefilled vial and syringe and who functions in accordance with written protocols and the standing orders of a licensed physician serving as an emergency department director **[**may**]** shall administer epinephrine using such injectors**,** **[**or**]** equipment or prefilled vial and syringe when the use of epinephrine is deemed necessary by the emergency medical services personnel for the treatment of a patient. All emergency medical **[**technicians**]** services personnel shall receive such training from an organization designated by the commissioner. All licensed or certified ambulances shall be equipped with epinephrine in such injectors**,** **[**or**]** equipment **[**which may be administered**]** or prefilled vials and syringes that the emergency medical services personnel shall administer in accordance with written protocols and standing orders of a licensed physician serving as an emergency department director.

Sec. 44. (NEW) (*Effective January 1, 2024*) (a) Each institution, as defined in section 19a-490 of the general statutes, except a facility operated by the Department of Mental Health and Addiction Services and the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center, shall, upon receipt of a medical records request directed by the patient or the patient's representative, provide an electronic copy of such patient's medical records to another such institution (1) as soon as feasible, but not later than six days after such request is received by the institution, if such request is urgent, or (2) not later than seven business days after such request is received, if such request is not urgent. Notwithstanding any other provision of the general statutes, an institution providing an electronic copy of a patient's medical records pursuant to the provisions of this section shall not be required to obtain specific written consent from such patient

before providing such electronic copy.

(b) The provisions of subsection (a) of this section shall not be construed to require an institution to provide records (1) in violation of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or 45 CFR 160.101 to 45 CFR 164.534, inclusive, as amended from time to time, (2) in response to a direct request from another health care provider, unless such provider can validate that such provider has a health provider relationship with the patient whose records are being requested, or (3) in response to a third-party request.

Sec. 45. (*Effective from passage*) (a) There is established a task force to study methods to address the shortage of radiologic technologists, nuclear medicine technologists and respiratory care practitioners in the state and develop a plan to address such shortage.

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

(1) One appointed by the speaker of the House of Representatives, who has expertise in the radiologic technologist profession and is a representative of a state-wide association of radiologic technologists;

(2) One appointed by the president pro tempore of the Senate, who has expertise in the nuclear medicine technologists profession and is a representative of a state-wide association of nuclear medicine technologists;

(3) One appointed by the majority leader of the House of Representatives, who has expertise in the respiratory care practitioners profession and is a representative of a state-wide association of respiratory care practitioners;

(4) One appointed by the majority leader of the Senate, who is a representative of an association of hospitals in the state;

(5) One appointed by the minority leader of the House of Representatives, who is a representative of a society of radiologists in

the state;

(6) One appointed by the minority leader of the Senate, who has expertise in pulmonary issues and is a representative of a medical society in the state; and

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

(c) Any member of the task force appointed under subsection (b) of this section may be a member of the General Assembly.

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

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

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

(g) Not later than January 1, 2024, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2024, whichever is later.

Sec. 46. (NEW) (*Effective July 1, 2023*) The Commissioner of Public Health shall require each person applying for licensure as a physician under section 20-13 of the general statutes, who indicates an intention

to apply for a license in one or more other states not later than one year after the date of such person's application for licensure, to submit to a state and national fingerprint-based criminal history records check by the Department of Emergency Services and Public Protection. The Commissioner of Emergency Services and Public Protection shall report the results of each such criminal history records check to the Commissioner of Public Health pursuant to the provisions of section 29-17a of the general statutes.

Sec. 47. (NEW) (*Effective July 1, 2023*) The Commissioner of Public Health shall require each person applying for licensure as a psychologist to submit to a state and national fingerprint-based criminal history records check pursuant to section 29-17a of the general statutes. For the purposes of this section, "psychologist" means an individual licensed for the independent practice of psychology and "licensure" means authorization by a state psychology regulatory authority to engage in the independent practice of psychology, the practice of which would be unlawful without such authorization."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*July 1, 2023*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	19a-638(b)
Sec. 5	*October 1, 2023*	New section
Sec. 6	*October 1, 2023*	20-14o
Sec. 7	*July 1, 2023*	New section
Sec. 8	*from passage*	New section
Sec. 9	*July 1, 2023*	New section
Sec. 10	*July 1, 2023*	New section
Sec. 11	*July 1, 2023*	New section
Sec. 12	*October 1, 2023*	New section
Sec. 13	*July 1, 2023*	20-14p
Sec. 14	*July 1, 2023*	New section
Sec. 15	*July 1, 2023*	New section
Sec. 16	*July 1, 2023*	New section

Sec. 17	*July 1, 2023*	New section
Sec. 18	*July 1, 2023*	New section
Sec. 19	*October 1, 2023*	20-94a
Sec. 20	*October 1, 2023*	20-87a(b)
Sec. 21	*July 1, 2023*	New section
Sec. 22	*from passage*	New section
Sec. 23	*from passage*	New section
Sec. 24	*July 1, 2023*	19a-112j(f)
Sec. 25	*from passage*	New section
Sec. 26	*October 1, 2023*	19a-490u
Sec. 27	*from passage*	New section
Sec. 28	*from passage*	New section
Sec. 29	*from passage*	New section
Sec. 30	*from passage*	New section
Sec. 31	*from passage*	New section
Sec. 32	*from passage*	New section
Sec. 33	*from passage*	New section
Sec. 34	*from passage*	New section
Sec. 35	*July 1, 2023*	17a-674d(b)
Sec. 36	*October 1, 2023*	19a-177(8)
Sec. 37	*from passage*	New section
Sec. 38	*from passage*	New section
Sec. 39	*from passage*	New section
Sec. 40	*from passage*	New section
Sec. 41	*October 1, 2023*	20-112a(c)(1)
Sec. 42	*from passage*	New section
Sec. 43	*October 1, 2023*	19a-197a
Sec. 44	*January 1, 2024*	New section
Sec. 45	*from passage*	New section
Sec. 46	*July 1, 2023*	New section
Sec. 47	*July 1, 2023*	New section