OLR Bill Analysis

sSB 1

AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

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SUMMARY

This bill makes various changes to laws on home health care and home health aide worker safety, graduate physicians, and several other health-related matters.

EFFECTIVE DATE: Various; see below.

§ 1 — HOME HEALTH SAFETY-RELATED CLIENT INTAKE

Requires home health care and home health aide agencies to collect certain information during client intake (on the client, other people who may be at the home, and general location), and give it to the employees assigned to the client

The bill requires home health care and home health aide agencies (home health agencies; see *Background — Home Health Agencies*) to collect certain information during intake with a prospective client and give it to any employee assigned to the client. Specifically, they must collect and give information on the following:

1. the client, including, if applicable, the client's psychiatric history; history of violence, domestic abuse, or substance use; any current infections and the treatment the client has received for them; and whether the client's diagnoses or symptoms have been stable over time;

2. other people present or likely to be present at the service location, including, if known to the agency, their names and relationship to the client; psychiatric history; history of violence, domestic abuse, or substance use; and criminal record; and

3. the service location, including, if known to the agency, the municipality's crime rate, as determined by the most recent Crime in Connecticut annual report issued by the Department of Emergency Services and Public Protection (DESPP); presence of hazardous materials, including used syringes, firearms or other weapons, or other safety hazards, including electrical hazards;

and status of the location's fire alarm system.

EFFECTIVE DATE: October 1, 2024

Background — Home Health Agencies

By law, both home health care and home health aide agencies must be licensed by the Department of Public Health (DPH). They both provide services in the patient's home or a similar environment.

Home health care agencies must provide professional nursing services and at least one additional service (e.g., physical or speech therapy) directly and all others directly or through contracts.

Home health aide agencies provide supportive services such as assistance with personal hygiene, dressing, feeding, and incidental household tasks. These services must be provided under a registered nurse's supervision (directly or through contract), and if the nurse determines appropriate, must be provided by certain other professionals (e.g., a social worker) (CGS § 19a-490).

§ 2 — HOME HEALTH SAFETY TRAINING, ASSESSMENTS, AND CHECKS

Requires home health agencies to train staff on safety-related issues, do monthly safety assessments, and give staff ways to perform safety checks (such as through mobile apps)

The bill requires home health agencies to provide staff training that aligns with the health and safety training curriculum for home care workers endorsed by the National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration. This must at least include training to recognize common hazards in home care workplaces and applying practical solutions to manage risks and improve safety.

Under the bill, home health agencies must do monthly safety assessments with each staff member. They also must give staff a way to do safety checks. This may include the following, among other things:

1. a mobile application that allows staff to access safety information relating to a client (including the information collected under the bill, see § 1) and a way to communicate with local police or other

staff in an emergency or

2. a GPS-enabled wearable device that allows staff to contact local police, such as by pressing a button.

EFFECTIVE DATE: October 1, 2024

§ 3 — HOME HEALTH REPORTING OF CLIENT THREATS OR ABUSE

Requires home health agencies and their staff members to report to DPH on a client's verbal threats, abuse, or similar incidents, and DPH to annually report on this information

The bill requires home health agencies and their staff members to report to DPH on each instance of a client's (1) verbal abuse that the staff member perceives as a threat or danger, (2) physical or sexual abuse, or (3) any other client abuse of a staff member.

Starting by January 1, 2025, DPH must annually report to the Public Health Committee on the number of reported incidents and what steps were taken to ensure the affected staff member's safety.

EFFECTIVE DATE: October 1, 2024

§§ 4-6 — HOME HEALTH SAFETY ESCORT REIMBURSEMENT

Requires (1) DSS to increase state reimbursement for home health agencies that provide safety escorts for home visits and (2) certain commercial insurance policies to provide coverage for these safety escorts

The bill requires the Department of Social Services (DSS) commissioner, starting July 1, 2024, to increase state reimbursement rates for home health agencies that provide safety escorts for staff doing home visits, to cover the costs of providing these escorts. Current law permits, but does not require, her to increase reimbursement for agencies that incur extraordinary costs for escort services.

The bill also requires certain health insurance policies to cover home health staff safety escorts that the staff or agency determines necessary. This applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3)

major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage, except January 1, 2025, for the commercial insurance provisions.

Background — Related Bill

sSB 365, § 3, reported favorably by the Human Services Committee, has similar provisions on state reimbursement rates for home health escort services.

§§ 7 & 9 — HOME HEALTH STAFF SAFETY GRANT PROGRAM

Requires DPH to create and administer a grant program for home health agencies to purchase staff safety technology; appropriates $1 million in FY 25 for this purpose

The bill requires the DPH commissioner, by October 1, 2024, to establish and administer a program providing grants to help home health agencies buy staff safety technology. This technology may include, among other things, a mobile application or GPS-enabled device as described above (see § 2). The bill appropriates $1 million to DPH in FY 25 from the General Fund for the grant program.

Under the bill, the commissioner must establish the program's eligibility requirements, priority categories, funding limitations, and application process. Starting by January 1, 2025, she must annually report on the program to the Public Health Committee.

EFFECTIVE DATE: July 1, 2024

§§ 8, 20, 21 & 36 — WORKING GROUPS

Requires the Public Health Committee chairpersons to convene working groups on (1) staff safety issues for home health agencies, (2) nonalcoholic fatty liver disease, (3) health issues for nail salon workers, and (4) loneliness and isolation.

The bill requires the Public Health Committee chairpersons to establish four working groups to study the following topics: (1) staff safety issues for home health agencies; (2) nonalcoholic fatty liver disease, including nonalcoholic fatty liver and nonalcoholic

steatohepatitis; (3) health issues faced by nail salon workers due to their occupational exposure to health hazards; and (4) ways to address loneliness and isolation.

For each of the working groups created by the bill, the:

1. group must select two co-chairpersons from among its members;
2. Public Health Committee's administrative staff serves in that capacity for the working group;
3. working group must report its findings and recommendations to the committee by January 1, 2025; and
4. working group terminates when it submits the report or on January 1, 2025, whichever is later.

EFFECTIVE DATE: Upon passage

Home Health Safety Working Group (§ 8)

Under the bill, this working group must study staff safety issues affecting home health agencies. The group must at least include three employees of a home health agency, two representatives of such an agency, and one representative each from the following:

1. a collective bargaining unit representing home health employees,
2. a mobile crisis response services provider,
3. an assertive community treatment team,
4. a police department, and
5. an in-state hospital association.

The Public Health Committee chairpersons must schedule the first meeting, to be held by 60 days after the bill's passage.

Nonalcoholic Fatty Liver Disease Working Group (§ 20)

This group's study must at least examine the following in relation to

nonalcoholic fatty liver disease:

1. the incidence in Connecticut compared to the entire U.S.;

2. the population groups most affected and at risk of being diagnosed with it, and the main risk factors contributing to this prevalence;

3. strategies to prevent the disease in high-risk populations and how to implement them statewide;

4. ways to increase public awareness about the disease, including public awareness campaigns about liver health;

5. whether to recommend a statewide screening program for at-risk populations;

6. policy changes needed to improve patient care and outcomes;

7. insurance coverage and affordability issues affecting treatment access;

8. creating patient advocacy and support networks; and

9. how social determinants of health influence the disease's risk and outcomes, and needed interventions to address them.

The working group must at least include the following members:

1. a physician with expertise in hepatology and gastroenterology, representing an in-state higher education institution;

2. three people in the state living with nonalcoholic fatty liver disease;

3. a representative of an in-state patient advocacy organization;

4. a social worker with experience working with communities in the state's underserved areas and addressing social determinants of health;

5. an in-state health care policy expert with experience advising on regulatory frameworks, health care access, and insurance issues;

6. an in-state nutritionist and dietician with experience providing guidance on preventative measures and dietary interventions related to the disease;

7. a community health worker who works directly with the state's underserved communities addressing social determinants of health;

8. a representative of an in-state nonprofit organization focused on liver health; and

9. the DPH commissioner or her designee.

The Public Health Committee chairpersons must convene the first meeting, to be held by 60 days after the bill's passage.

Nail Salon Worker Health Hazards Working Group (§ 21)

The bill requires this group to study health issues experienced by nail salon workers due to their exposure to health hazards at work. The study must at least include (1) identifying these hazards, (2) ways to reduce nail salon workers' exposure to them, (3) best practices for preventing these workers from acquiring health issues from exposure to these hazards, and (4) assessing the strengths of other states' policies on protecting nail salon workers' health.

The group must include at least the following members:

1. three nail technicians, each employed by a different in-state nail salon;

2. three owners or managers of different in-state nail salons;

3. a state-licensed health care professional with experience treating patients for illnesses attributable to their exposure to health hazards while working in a nail salon;

4. a representative of an in-state labor union;

5. an expert in occupational safety;

6. an expert in environmental health;

7. a director of an in-state municipal health department with at least four nail salons under the department's jurisdiction; and

8. the DPH commissioner or her designee.

The Public Health Committee chairpersons must convene the first meeting, to be held by 60 days after the bill's passage.

Loneliness and Isolation Working Group (§ 36)

Under the bill, this group must study and make recommendations on ways to address loneliness and isolation experienced by people in the state and to improve their social connection. The working group must do the following in relation to people in the state:

1. evaluate the causes of and other factors contributing to this sense of isolation and loneliness, and ways to prevent and eliminate it;

2. recommend local activities, systems, and structures to combat isolation and loneliness, including opportunities for organizing or enhancing in-person community gatherings, especially for people who have lived in isolation for a long time; and

3. explore the possibility of creating municipal-based social connection committees to address the challenges of and potential solutions for combating isolation and loneliness.

The working group must include at least the following members, all from in-state organizations or working in the state, as applicable, unless otherwise specified:

1. two high school teachers, one from an urban high school and one from a rural one;

2. a dining hall manager of a suburban soup kitchen;

3. three high school students, including one who identifies as a member of the LGBTQ+ community, one who identifies as female, and one who identifies as male;

4. two students from higher education institutions, one from a public health school and one from a social work school;

5. two residents of assisted living facilities, one at a facility for veterans and one at a suburban facility;

6. two administration members of senior centers, one in a rural area and one in an urban area;

7. a representative of an organization serving children in an urban area;

8. a representative of an organization representing municipalities;

9. a representative of an organization representing small towns;

10. a representative of an organization working on policies to improve planning and zoning laws to create an inclusive society and improve access to transit-oriented development;

11. a representative of an organization working to improve and create more walkable and accessible main streets;

12. a representative of an organization advocating for people with physical disabilities;

13. an expert (not necessarily from Connecticut) in digital health and identifying safe digital education;

14. a representative of an organization developing mobile applications intended to address loneliness and isolation;

15. two psychiatrists, one who treats adolescents and one who treats adults;

16. a librarian from a rural library;

17. a social worker who practices in an urban area; and

18. the Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) commissioners or their designees.

The Public Health Committee chairpersons must schedule the first meeting, to be held by 60 days after the bill's passage.

§§ 10-18 — GRADUATE PHYSICIANS

Creates a licensure program for medical school graduates meeting certain criteria who did not find residency placements; limits their practice to primary care services and only under a collaborative practice arrangement with a licensed physician, and only for a single two-year licensure period; requires the Medical Examining Board to issue related program rules

The bill allows medical school graduates who have passed the first two steps of the medical licensing examination, but who have not yet completed a residency, to work as a "graduate physician" for a single two-year licensure period. (By law, to become licensed as a physician, an applicant must have completed a residency, among other requirements.)

Under the bill, a graduate physician generally must work under a collaborative practice arrangement with a state-licensed physician. The arrangement must limit the graduate physician to practicing primary care services, defined as pediatrics, internal medicine, family medicine, obstetrics and gynecology, or psychiatry.

The bill requires the state Medical Examining Board to issue various rules related to graduate physicians, including to set the licensure process. It allows the board to deny a licensure application or suspend or revoke a license for a violation of the bill, the board's rules, or the board's standards of conduct.

The bill allows a physician to serve as a collaborating physician for no more than three graduate physicians at a time.

EFFECTIVE DATE: January 1, 2025

Eligibility (§ 10)

Under the bill, a graduate physician must be a U.S. resident and citizen or resident alien who has graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school in the World Directory of Medical Schools, or its equivalent.

The graduate physician must have completed steps 1 and 2 of the U.S. Medical Licensing Examination (USMLE), or an equivalent exam approved by the National Board of Medical Examiners or National Board of Osteopathic Medical Examiners, within two years immediately before applying for graduate physician licensure, but no more than three years after graduating from a medical school or a school of osteopathic medicine. (The USMLE exam has three steps.)

Supervision Requirements (§§ 11 & 14)

Under the bill, graduate physicians are subject to supervision requirements under the bill itself, any controlling federal law, and any set by the National Board of Medical Examiners. The bill specifies that graduate physicians are not subject to other supervision requirements.

The bill requires a physician collaborating with a graduate physician to be responsible for supervising the graduate physician's activities. The collaborating physician must accept full responsibility for the primary care services provided by the graduate physician.

Collaborative Practice Arrangements (§§ 13, 15 & 18)

Under the bill, to be eligible to practice as a graduate physician, the person must enter into a collaborative practice arrangement with a state-licensed physician, no later than six months after the graduate physician becomes licensed as one. The bill prohibits a graduate physician from practicing or attempting to do so without this arrangement, except as otherwise provided by the bill or as allowed under rules issued by the state Medical Examining Board.

Before entering into the collaborative practice arrangement, the collaborating physician must complete a board-approved certification course on the laws concerning the professional relationship between a

collaborating and graduate physician.

A collaborative practice arrangement must be in writing and include mutually agreed-upon protocols or standing orders for the delivery of primary care services. It may delegate to a graduate physician the authority to administer or dispense drugs other than controlled substances and provide treatment, as long as the delivery of services is within the graduate physician's scope practice and is consistent with the skill, training, and competence of both physicians. The collaborating physician must be board certified in the specialty that the graduate physician is practicing.

The bill provides that these practice arrangements supersede any hospital licensing regulations on hospital medication orders under a protocol or standing order for inpatient or emergency care at the hospital. This applies to protocols or standing orders approved by the hospital's medical staff and pharmaceutical therapeutics committee.

Under the bill, a graduate physician collaborative practice arrangement must contain the following:

1. the complete names, home and business addresses, and telephone numbers of both physicians;

2. a requirement that the graduate physician practice at the same location as the collaborating physician;

3. a requirement that the graduate or collaborating physician prominently display, in every office where the graduate physician may prescribe, a statement informing patients that they may be seen by a graduate physician and advising them of their right to see the collaborating physician;

4. a list of the collaborating physician's specialties and board certifications and the graduate physician's certifications;

5. the manner of collaboration, including how the physicians will engage in collaborative practice consistent with each of their skill, training, education, and competence;

6. a prohibition on the graduate physician providing primary care services to a patient during the collaborating physician's absence from the practice location for any reason;

7. a list of all other such collaborative practice arrangements either physician is a party to;

8. the arrangement's duration; and

9. a requirement that a collaborating physician be on premises if the graduate physician performs primary care services in a hospital or emergency department.

Under the bill, a collaborative practice arrangement also must address (1) proximity to a hospital and (2) services and chart review, as follows.

Proximity to Hospital; Exception. A collaborative practice arrangement must describe how the physicians will stay nearby a hospital. But the arrangement may allow for this to be waived for up to 28 days per year to provide primary care services in a rural health clinic meeting certain criteria. The collaborating physician must keep documentation related to the geographic proximity requirement and present it to the Connecticut Medical Examining Board upon request.

Services and Chart Review. A collaborative practice arrangement also must describe when and how the collaborating physician will review the graduate physician's delivery of primary care services. The bill sets a schedule for the percentage of the graduate physician's charts that the collaborating physician must review, as follows:

1. First three months of the initial observation year: 100%.

2. The rest of the initial year: 75%.

3. After that: 25%, with the charts submitted every 14 days to the collaborating physician (and at this point, the review can be done by another designated physician).

Use of Titles and ID Badges (§§ 13 & 17)

The bill requires graduate physicians to clearly identity as such. They may use the "doctor" or "Dr." identifiers.

Collaborating and graduate physicians that are parties to a collaborative practice arrangement must wear an identification badge while acting under it, prominently displaying the person's licensure status.

Medical Examining Board Rules (§§ 12 & 16-17)

Licensure and Related Matters. The bill requires the state Medical Examining Board to issue rules to do the following:

1. establish the graduate physician licensure process, supervision requirements, and additional requirements for their collaborative practice arrangements;

2. set licensure fees, including a requirement that the total fees collected each year must at least equal the total costs needed to facilitate collaborative practice arrangements; and

3. address any other matters needed to protect the public and take disciplinary action against participants in these arrangements.

These rules take effect when they are issued as long as they comply with the state's Uniform Administrative Procedure Act.

Collaborative Practice Arrangements. The bill also requires the board to issue rules regulating the use of graduate physician collaborative practice arrangements. These rules must (1) specify the geographic areas to be covered by these arrangements and the treatment methods they may include and (2) require a review of the services provided under them.

The rules also must specify the educational methods and programs that collaborating physicians must implement to facilitate the graduate physician's growth in medical knowledge and capabilities and successful completion of the arrangement, which could lead to credit

toward a future residency program. In setting rules on this, the board must consult with the medical school deans and primary care residency program directors in the state.

Consistency With Certain Federal Guidelines. The bill also requires the board to issue rules for graduate physicians that are consistent with federal guidelines for federally qualified health centers. This rulemaking authority does not extend to collaborative practice arrangements governing hospital employees providing inpatient care.

Voluntary Nature of Agreement, Collaborating Physician Authority, Reports to Board, and Related Matters (§ 17)

The bill prohibits any contract or other agreement from requiring, against the person's will, that a (1) physician act as a collaborating physician for a graduate physician or a (2) graduate physician serve as one for any particular collaborating physician. It allows a physician to refuse to act as a collaborating physician for a particular graduate physician, and a graduate physician to refuse to collaborate with a particular physician, in both cases without penalty.

The bill also prohibits any contract or other agreement from limiting the collaborating physician's authority over any protocols or standing orders or delegating their authority to a graduate physician. But this does not authorize a collaborating physician, in doing these things, to violate a hospital's medical staff standards for safe medical practice.

Under the bill, the Medical Examining Board must require a physician, within 30 days after a licensure change, to identify whether the physician has a collaborative practice arrangement with a graduate physician, and if so, to report to the board the names of those graduate physicians. The board must track this information and may make information about these arrangements publicly available. It also may routinely do reviews or inspections to ensure that the arrangements are being carried out in compliance with the bill.

The bill prohibits the board from denying, revoking, suspending, or otherwise taking disciplinary action against a collaborating physician for the services delegated to a graduate physician, if the physician

complies with the board's applicable rules and specified requirements under the bill (such as reporting to the board on his or her collaborative arrangements).

§ 19 — GUN SAFETY EDUCATIONAL MATERIAL DURING PRIMARY CARE VISITS

Requires DPH, in consultation with certain entities, to develop or procure educational material on gun safety practices for primary care providers to give their adult patients; requires these providers to give this material to adult patients annually

The bill requires the DPH commissioner, by January 1, 2025, to develop or obtain educational material on gun safety practices, for primary care providers to give to adult patients (age 18 or older) during appointments. In doing so, the commissioner must consult with the Commission on Community Gun Violence Intervention and Prevention and the state chapters of national professional associations of physicians, advanced practice registered nurses, and physician assistants (PAs). By February 1, 2025, DPH must (1) make this material available, for free, to all in-state primary care providers for adults and (2) recommend how they can effectively use it.

The bill requires primary care providers to give this material to each of their adult patients annually at their appointments.

EFFECTIVE DATE: July 1, 2024

§ 22 — PRESCRIPTION DRUG SHORTAGE STUDY

Requires the DPH and DCP commissioners to study and report on prescription drug shortages

The bill requires the DPH commissioner, in collaboration with the Department of Consumer Protection (DCP) commissioner, to study incidences of prescription drug shortages in the state and whether the state has a role in alleviating them. By January 1, 2025, the commissioners must jointly report to the General Law and Public Health committees on the study and any legislative recommendations to help alleviate or prevent these shortages.

EFFECTIVE DATE: Upon passage

§ 23 — DCF IN-PERSON HOME VISITS

Requires DCF, when doing a home visit or evaluation under a child's safety plan, to do so in person if the safety plan indicates that a parent or guardian in the home has a substance use disorder

The bill requires the DCF commissioner or her designee to do home visits or evaluations in person, rather than by teleconference, if the department's safety plan indicates that a parent or guardian in the home has a substance use disorder.

Under the bill, a "safety plan" is a plan DCF makes to address or mitigate parent or guardian behaviors or conditions or circumstances in a home that may make the home unsafe for children. A safety plan specifies (1) actions that have been or will be taken to address or mitigate the unsafe behaviors, conditions, or circumstances; (2) who will do them; and (3) when the department will review the actions.

EFFECTIVE DATE: July 1, 2024

Background — Related Bill

SB 126 (File 8), reported favorably by the Children's Committee, has substantially similar provisions on in-person home visits.

§§ 24 & 25 — LIMITATIONS ON MAINTENANCE OF CERTIFICATION

Specifically prohibits hospitals from requiring a board-certified physician to participate in an MOC program in order to obtain or keep privileges; generally prohibits certain health carriers from (1) denying reimbursement or excluding a provider from a network due to the provider's non-participation in an MOC program, or (2) requiring this participation as a condition of professional liability insurance

Hospital Credentialing

Existing law prohibits hospitals (including their medical review committees) from requiring board-certified physicians to provide credentials of board recertification to obtain or keep their practice privileges. Under the bill, this specifically includes the hospital requiring these physicians to participate in any maintenance of certification (MOC) program required for board recertification.

Insurer Reimbursement, Provider Networks, and Liability Insurance

The bill generally prohibits certain health carriers from denying reimbursement to a health care provider, or excluding a provider from

a network, only because the provider is not maintaining a specialty certification through an MOC program. It also generally prohibits these entities from requiring a provider to maintain a specialty certification through an MOC program as a condition of getting professional liability insurance or other malpractice coverage. These provisions apply as long as the provider does not hold himself or herself out as a specialist under a specialty certification.

For purposes of these insurance provisions, "maintenance of certification" is any process requiring periodic recertification examinations or other professional development activities to maintain specialty certification. A "specialty certification" is any certification by a medical board that specializes in one area of medicine and has requirements in addition to state licensing requirements.

The bill applies to insurers and other entities that deliver, issue, renew, amend, or continue individual or group policies on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: Upon passage, except the insurer-related provisions take effect January 1, 2025.

§§ 26 & 27 — OPIOID DEACTIVATION AND DISPOSAL SYSTEMS

Requires pharmacists who dispense opioids to give the patient, for free, a personal drug deactivation and disposal system if funding is available for this, and allows pharmacies and pharmacists to seek reimbursement from the Opioid Settlement Fund for this purpose

The bill requires pharmacists, when dispensing opioids, to also give the patient a free personal opioid drug deactivation and disposal system if funding is available for this. Under the bill, these systems are products designed for personal use that allow patients to permanently deactivate and destroy opioids.

The bill allows pharmacies or pharmacists to seek reimbursement from the Opioid Settlement Advisory Committee for their documented

expenses in giving these systems to patients. It makes a corresponding change by adding these expenses to the list of allowable purposes for which the Opioid Settlement Fund may be used (see *Background — Opioid Settlement Fund and Advisory Committee*).

The bill exempts pharmacies or pharmacists from incurring any expenses for giving these drug deactivation and disposal systems, and they are not required to give them out if funding is unavailable (from the settlement fund or otherwise).

The bill allows the DCP commissioner to adopt related regulations implementing its provisions on pharmacies and pharmacists.

EFFECTIVE DATE: October 1, 2024

Background — Opioid Settlement Fund and Advisory Committee

In 2022, the legislature established an Opioid Settlement Fund as a separate non-lapsing fund administered by an Opioid Settlement Advisory Committee with assistance from DMHAS. The fund must contain moneys the state receives from opioid-related judgments, consent decrees, or settlements finalized on or after July 1, 2021. Opioid Settlement Fund moneys must be used only for specified substance use disorder abatement purposes, upon approval of the committee and the Office of Policy and Management secretary (CGS § 17a-674c).

By law, the Opioid Settlement Advisory Committee must ensure (1) that Opioid Settlement Fund moneys are allocated and spent for proper purposes and (2) robust public involvement, accountability, and transparency in allocating and accounting for the fund's moneys (CGS § 17a-674d).

§ 28 — PHYSICIANS AND PHYSICIAN ASSISTANTS UNDER THE STATE LABOR RELATIONS ACT

Removes an exemption from the state Labor Relations Act for physicians and PAs who work at DPH-licensed institutions

The bill removes a current exemption from the state Labor Relations Act for physicians or PAs who are employed by a DPH-licensed institution. Under current law, private-sector DPH-licensed institutions

are subject to this act for all of their employees except for physicians and PAs. It appears that in removing this exemption, the bill allows these providers to unionize in certain limited situations when they cannot under current law.

The state Labor Relations Act, which sets rules on unionization and related matters, generally covers private-sector employers who are not subject to the National Labor Relations Act (NLRA), unless the National Labor Relations Board has declined to assert jurisdiction. Generally, as with most other private sector employees, physicians and PAs are covered by the NLRA if they are directly employed by their employer and are not "supervisors." In practice, physicians are sometimes, but not always, considered to be supervisors for purposes of the NLRA.

Unlike the NLRA, the state Labor Relations Act includes "supervisors" within its general definition of employee.

EFFECTIVE DATE: October 1, 2024

§§ 29 & 30 — INSURANCE COVERAGE OF CORONARY CALCIUM SCANS

Requires certain insurance policies to cover coronary calcium scans

The bill requires certain health insurance policies to cover coronary calcium scans. Under the bill, these are CT scans of the heart looking for calcium deposits in arteries.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2025, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of ERISA, state insurance benefit mandates do not apply to self-insured benefit plans.

The bill also applies these requirements to high deductible health plans (HDHP) to the maximum extent permitted by federal law. If the HDHP is used to establish a health savings or similar account, the bill applies to the maximum extent permitted by federal law that does not

affect the account's tax preferred status.

EFFECTIVE DATE: January 1, 2025

§§ 31 & 32 — CYBER SECURITY EVENTS

Requires DPH, in collaboration with the state's Chief Information Security Officer, to develop an initiative for health care facility readiness during cyber security events, and appropriates $25,000 per year for four years to DESPP for a related annual meeting

The bill requires DPH's Office of Public Health Preparedness and Response, by January 1, 2025, and in collaboration with the state's Chief Information Security Officer, to develop an initiative for DPH-licensed health care facilities' readiness during cyber security events. These events are observable occurrences that could impact the security of computer systems, networks, or data.

The initiative must be part of the state's public health emergency response plan. It must at least include, as necessary or appropriate for each health care facility, that facilities acquire or establish the following for use during cyber security events:

1. a radio communication system that enables the facility's various units to continue functioning;

2. a separate intranet system for secure communications within the facility;

3. fax machines, local printers, or local laptops for printing and intranet communications;

4. medical devices that are not connected to the internet;

5. an intranet-based emergency management information system to document routine and emergency events or incidents;

6. a diversion management system for hospital emergency departments to communicate to emergency medical services organizations, other first responders, and patients the need to divert patients seeking emergency services to another emergency department or facility; and

7. ways to communicate and coordinate with DSS and health carriers to reduce the risk of a sudden reduction in cash flow due to health care billing disruptions.

The bill also appropriates $25,000 per year for four years (FYs 25 through 28) to DESPP, for an annual meeting focused on preventing, identifying, and managing cyber security events.

The meetings must at least include representatives from DPH; DESPP's Division of Emergency Management and Homeland Security; the state National Guard; and other local, regional, and statewide law enforcement agencies dealing with cyber security events.

The meetings must consider creating cyber security event command scenarios. They also must consider the functions and training of the following people within hospitals while working without technology:

1. those working with pharmaceuticals, to ensure safe medication administration and documentation;

2. those working with laboratory samples and testing and related reporting, to ensure safe and accurate documentation and communication; and

3. those performing imaging studies and testing and related reporting, to ensure this documentation and communication.

EFFECTIVE DATE: Upon passage, except the appropriation and meeting provisions take effect July 1, 2024.

§ 33 — HEALTHY BRAIN INITIATIVE

Requires DPH, in collaboration with the Office of Health Strategy, to develop a plan to address health conditions affecting the brain

The bill requires DPH, by January 1, 2025, and in collaboration with the Office of Health Strategy, to establish a healthy brain initiative. They must do so by developing a plan to address health conditions affecting the brain, such as Alzheimer's disease, dementia, Parkinson's disease, stroke, and epilepsy.

By January 1, 2025, the DPH commissioner must report to the Public Health Committee on the plan and the department's anticipated date to implement it.

EFFECTIVE DATE: Upon passage

Plan to Address Brain-Affecting Health Conditions

Under the bill, the plan must at least include the following objectives:

1. strengthening (a) policies on preventing and treating these health conditions and (b) partnerships with organizations and health care providers to develop these policies;

2. evaluating and using data on these conditions;

3. building a skilled and diverse health care work force to engage in prevention efforts and treat people with these conditions, including by obtaining grant funding and using data to estimate and address the gap between workforce capacity and the anticipated demand for related health care services;

4. educating the public on these health conditions, ways to prevent them, and treatment options;

5. establishing a disease management program to promote early diagnosis of these conditions and develop protocols for providing education, care consultation, and referrals for medical and social services to patients and their caregivers, including through collaborations among in-state teaching hospitals and partnerships with nonprofits that deliver support services promoting the mental and physical health of these people, their caregivers, and family members; and

6. creating a program specifically for people with dementia, including (a) community-based opportunities for exercise, self-care, and caregiver education; (b) peer support groups and social gatherings for these patients and their caregivers, family members, and friends; (c) providing information on DPH's

website on dementia and support for all of these people; (d) developing mobile apps allowing caregivers and family members to track these patients using personal GPS units or cell phones with GPS; (e) adult day care networks; and (f) transportation services.

§ 34 — PARKINSON'S DISEASE REGISTRY

Requires (1) DPH to maintain and operate a Parkinson's disease registry and (2) hospitals and certain health care providers to submit data to the registry as DPH requires, subject to patients opting out; establishes a data oversight committee to monitor the registry's activities

The bill requires DPH, by July 1, 2025, to maintain and operate a statewide data registry on Parkinson's disease and Parkinsonism (which generally refers to a range of symptoms associated with Parkinson's disease and certain other conditions). Hospitals, physicians, physician assistants, and nurses must make available to the registry data, as required by DPH regulations, on patients admitted to the hospital or treated by these providers for these conditions. Hospitals and these providers must give patients a notice about these disclosures to the registry and an opportunity to opt out.

DPH and authorized researchers can use the registry data, but they must keep confidential any personally identifiable patient information (i.e., not subject to disclosure or admissible as evidence in a court or agency proceeding, and used only for medical or scientific research). The bill exempts registry data from Freedom of Information Act disclosure.

Under the bill, hospitals must give DPH access to their records, as the department deems necessary, to perform case findings or other quality improvement audits to ensure the completeness of the registry reporting and data accuracy.

The bill allows the commissioner to contract with an in-state nonprofit Parkinson's disease and Parkinsonism association to implement and administer the registry. She may also enter into (1) a contract for receiving, storing, and maintaining the registry data and (2) reciprocal reporting agreements with other states to exchange

Parkinson's disease and Parkinsonism data.

Additionally, the bill requires DPH to establish a Parkinson's disease and Parkinsonism data oversight committee. The committee must (1) monitor the registry's operation; (2) give advice on its oversight; and (3) develop a plan to improve the quality of Parkinson's disease and Parkinsonism care, address any disparities in this care, and develop related short- and long-term goals for improving care.

The bill allows DPH to adopt regulations to implement these provisions.

EFFECTIVE DATE: Upon passage

Data Oversight Committee

Under the bill, the DPH commissioner must appoint at least 16 members to the committee, including a:

1. neurologist;
2. movement disorder specialist;
3. primary care provider;
4. neuropsychiatrist who treats Parkinson's disease;
5. patient living with the disease;
6. public health professional;
7. population health researcher with experience in statewide health condition data registries;
8. patient advocate;
9. family caregiver of someone with Parkinson's disease;
10. representative of a Parkinson's disease-related nonprofit organization;
11. physical therapist, speech therapist, and social worker and an

occupational therapist, each with experience working with people with the disease;

12. geriatric specialist; and

13. palliative care specialist.

The commissioner must make her appointments by June 1, 2025, and members serve two-year terms. She must appoint a committee chairperson from among the members, and the chairperson must schedule the committee's first meeting by July 1, 2025.

The bill requires DPH to assist the committee in its work and provide any data or information the committee deems necessary to fulfill its duties, unless state or federal law prohibits the disclosure.

The committee's chairperson, starting by January 1, 2026, must annually report to the Public Health Committee and DPH commissioner on the committee's work.

§ 35 — RECENT-ONSET SCHIZOPHRENIA SPECTRUM DISORDER

Requires DMHAS, in consultation with DCF, to create a program providing specialized treatment for people with recent-onset schizophrenia spectrum disorder

The bill requires the DMHAS commissioner, in consultation with the DCF commissioner, to establish a program at an in-state hospital for people diagnosed with recent-onset schizophrenia spectrum disorder.

The DMHAS commissioner, starting by January 1, 2025, must annually report to the Public Health committee on (1) the functions and outcomes of the program for specialized treatment early in psychosis and (2) any legislative recommendations to address the needs of people diagnosed with recent-onset schizophrenic spectrum disorders.

EFFECTIVE DATE: Upon passage

Program Components

Under the bill, the program must provide specialized treatment for these people early in their psychosis. It also must serve as a hub for distributing information statewide on best practices for providing early

intervention services.

The program must address the limited knowledge of this disorder with regard to its region-specific treatment needs and disparities, and the prevalence of first-episode psychosis in people diagnosed with it. It also must address the funding and reimbursement for available early intervention services and the uncertainty regarding clinicians' availability and readiness to implement those services for patients and their families.

Under the bill, the program must do the following:

1. develop structured curricula, online resources, and videoconferencing-based case conferences to distribute information for the development of knowledge and skills relevant to patients with first-episode psychosis and their families;

2. assess and improve the quality of early intervention services available to people diagnosed with a recent-onset schizophrenic spectrum disorder across the state;

3. provide expert input on complex cases and launch a referral system for consultation with experts in treating these disorders;

4. share lessons and resources from any campaigns aimed at reducing the duration of untreated psychosis to improve local pathways to care;

5. serve as an incubator for new evidence-based treatment approaches and pilot them across the state;

6. advocate for policies on the financing, regulation, and provision of services for people with these disorders; and

7. collaborate with state agencies to improve outcomes for people diagnosed with first-episode psychosis in areas such as crisis and employment services.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 25 Nay 12 (03/20/2024)