OLR Bill Analysis

sSB 9 (File 507, as amended by Senate "A" and "C")*

AN ACT CONCERNING HEALTH AND WELLNESS FOR CONNECTICUT RESIDENTS.

TABLE OF CONTENTS:

§§ 9 & 10 — HEALTH CARE PROVIDERS SERVING AS ADJUNCT FACULTY

Requires public higher education institutions to consider any licensed health care provider with at least 10 years of clinical experience to be qualified for an adjunct faculty position; correspondingly requires the Office of Higher Education, within available appropriations, to establish a program providing incentive grants to these providers who become adjunct professors

§ 11 — PERSONAL CARE ATTENDANT CAREER PATHWAYS PROGRAM

Requires DSS to establish a PCA career pathways program, including both basic skills and specialized skills pathways, to improve PCAs' quality of care and incentivize their recruitment and retention in the state

§ 12 — HOSPITAL PRIVILEGES

Prohibits hospitals, for purposes of granting practice privileges, from requiring (1) board eligible physicians to become board certified until five years after becoming board eligible, or (2) board certified physicians to provide credentials of board recertification

§§ 13-15 — PHYSICIAN, APRN, OR PA NON-COMPETE CLAUSES

Places additional limitations on physician non-compete clauses when the physician does not agree to a material change to the employment contract; extends to APRN or PA non-compete clauses the limitations that apply to physician non-compete clauses under existing law and the bill

§ 16 — PHYSICAL THERAPY LICENSURE COMPACT

Enters Connecticut into the Physical Therapy Licensure Compact, which provides a process authorizing physical therapists or physical therapy assistants properly credentialed in one member state to practice across state boundaries, without requiring licensure in each state

§ 17 — BACKGROUND CHECKS FOR PT AND PT ASSISTANT LICENSURE

Requires PT and PT assistant licensure applicants to complete a fingerprint-based criminal background check

§ 18 — PODIATRIC SCOPE OF PRACTICE WORKING GROUP

Requires DPH to establish a working group to advise the department and any relevant scope of practice review committee on podiatrists' scope of practice relating to surgical procedures

§§ 19 & 20 — APRN LICENSURE BY ENDORSEMENT AND INDEPENDENT PRACTICE

Allows for licensure by endorsement for APRNs who have (1) practiced for at least three years in another state with practice requirements that are substantially similar to, or higher than, Connecticut's and (2) no disciplinary history or unresolved complaints pending; correspondingly allows these APRNs to count their out-of-state practice toward the existing requirement of three years' practice in collaboration with a physician before practicing independently

§ 21 — SPLASH PAD AND SPRAY PARK WARNING SIGNS

Requires splash pad and spray park owners or operators to post warning signs about the potential health risk of ingesting recirculated water

§ 22 — LPN EDUCATION PILOT PROGRAM

Allows the state nursing board, under certain conditions, to approve applications from higher education institutions to create a pilot program for licensed practice nurse education and training, and grants the program full approval if it meets specified requirements for two years

§ 23 — RECIPROCITY AGREEMENTS FOR CLINICAL ROTATION TRAINING

Allows OHE to enter into a reciprocity agreement with neighboring states regarding clinical training credit at higher education institutions

§ 24 — COMMISSION ON COMMUNITY GUN VIOLENCE INTERVENTION AND PREVENTION

Specifically allows the Commission on Community Gun Violence Intervention and Prevention to create a subcommission, an advisory group, or another entity for specified purposes related to providing home health care and services to people affected by gun violence

§§ 25 & 26 — MATERNAL MENTAL HEALTH TOOLKIT AND PERINATAL MOOD AND ANXIETY DISORDER TRAINING

Requires DPH, in consultation with DMHAS and certain other organizations, to develop a maternal mental health toolkit for providers and patients, including on perinatal mood and anxiety disorders; requires hospitals to include training in perinatal mood and anxiety disorders as part of their regular training for certain staff members

§ 27 — EMERGENCY DEPARTMENT CROWDING WORKING GROUP

Requires the DPH commissioner to convene a working group to advise her on how to alleviate emergency department crowding and the lack of available beds

§ 28 — PSYCHOSIS TASK FORCE

Creates a task force to study childhood and adult psychosis

§§ 29-34 — EVALUATIONS AND REPORTS RELATED TO PARENTING AND SUBSTANCE USE DISORDER

Requires DMHAS, DCF, and certain other state agencies to evaluate or report on various supports and related issues for parents, other child caregivers, or pregnant individuals with substance use disorder

§ 35 — OPIOID SETTLEMENT FUND ADVISORY COMMITTEE

Adds eight members to the Opioid Settlement Fund Advisory Committee

§ 36 — EMS DATA COLLECTION AND REPORTING

Requires EMS organizations, in their quarterly data reporting, to include the reasons for 9-1-1 calls; requires the DPH commissioner to annually submit EMS data to the Public Health Committee and expands the reporting requirements to include data on EMS personnel shortages

§ 37 — RURAL HEALTH TASK FORCE

Creates a task force to study issues concerning rural health

§ 38 — HEALTH CARE MAGNET SCHOOL STUDY

Requires the education commissioner, in consultation with the labor and DPH commissioners, to study the feasibility of establishing an interdistrict magnet school program focused on training students for health care professions

§ 39 — DELETED BY SENATE AMENDMENT "C"

§ 40 — COMMUNICATION ACCESS STUDY

Requires the aging and disability services commissioner, in consultation with the Advisory Board for Persons Who are Deaf, Hard of Hearing or Deafblind, to evaluate gaps in these individuals' access to communication with medical providers

§§ 41 & 42 — DENTAL ASSISTANTS

Provides an alternate way for dental assistants to qualify to take dental x-rays, by passing a competency assessment rather than a national exam, and requires UConn's School of Dental Medicine to develop the assessment by January 1, 2025

§ 43 — EPINEPHRINE ADMINISTRATION BY EMS PERSONNEL

Requires EMS personnel, under specified conditions, to administer epinephrine using automatic prefilled cartridge injectors, similar automatic injectable equipment, or prefilled vials and syringes

§ 44 — MEDICAL RECORDS REQUESTS

Generally sets deadlines for licensed health care institutions to send electronic copies of patient medical records to another institution upon request

§ 45 — PRACTITIONER SHORTAGE TASK FORCE

Creates a task force to study how to address the state's shortage of radiologic technologists, nuclear medicine technologists, and respiratory care practitioners

§§ 46 & 47 — BACKGROUND CHECKS FOR PHYSICIAN AND PSYCHOLOGIST LICENSURE APPLICANTS

Requires psychologist licensure applicants, and physician applicants who wish to participate in interstate compacts, to submit to a state and national fingerprint-based criminal history records check by DESPP

*Senate Amendment "A" makes numerous changes to the bill's underlying provisions, such as:

1. setting a July 1, 2027, deadline for the Department of Mental Health and Addiction Services (DMHAS) to create the harm reduction center pilot program, requiring these centers to offer fentanyl and xylazine test strips, and removing provisions on the centers offering a separate location for safe drug use;

2. requiring opioid prescribers to encourage patients to obtain an opioid antagonist, rather than requiring prescribers to provide opioid antagonist prescriptions to certain patients;

3. requiring the Office of Workforce Strategy (OWS), rather than the Department of Public Health (DPH), to convene a working group on increasing the health care workforce, and expanding the group's scope beyond nursing;

4. setting the amount of the grant for health care providers who become clinical faculty members under the bill's new grant program, and requiring the program only within available appropriations; and

5. setting additional limitations on physician non-compete agreements and extending the law's limits to non-compete agreements for advanced practice registered nurses (APRNs) and physician assistants (PAs), rather than banning these agreements for physicians and APRNs as in the underlying bill.

It adds provisions on:

1. APRN independent practice requirements, a licensed practical nursing (LPN) education pilot program, reciprocity agreements for clinical rotations, dental assistants administering x-rays, and background checks for physician and psychologist licensure applicants;

2. epinephrine administration by emergency medical services (EMS) personnel, EMS data collection and reporting, and an emergency department crowding working group;

3. the Commission on Community Gun Violence Intervention and Prevention;

4. a maternal mental health toolkit and related hospital training;

5. task forces on psychosis, rural health, and shortages in certain health professions;

6. the Opioid Settlement Fund Advisory Committee's membership and various reports related to child caregivers or pregnant individuals with substance use disorder;

7. studies on a health care magnet school program, offering certain licensure examinations in Spanish, and medical provider communication gaps for certain people; and

8. deadlines for institutions to respond to medical record requests.

It removes certain provisions from the underlying bill, such as those that would have (1) created an advisory committee for the harm reduction center pilot program; (2) required the education commissioner to create a Health Care Career Advisory Council; (3) required DPH to offer nurse's aide competency tests in both English and Spanish; (4) created a medical malpractice reform task force; and (5) required the Office of Higher Education (OHE), for purposes of a health care provider loan reimbursement program, to award at least 10% of grants to providers working full-time in rural communities.

It also makes minor and conforming changes.

*Senate Amendment "C" removes a provision added by Senate Amendment "A" that would have required OWS to study the feasibility of offering competency testing for certain health care professionals in both Spanish and English.

§ 1 — ASSISTED REPRODUCTIVE TECHNOLOGY AND ASSISTED REPRODUCTION

Prohibits anyone from barring or unreasonably limiting (1) anyone from accessing ART or assisted reproduction or (2) authorized providers from performing these procedures, and makes related changes

This bill prohibits any person or entity from prohibiting or unreasonably limiting someone from:

1. accessing assisted reproductive technology (ART) or assisted reproduction;

2. continuing or completing an ongoing ART or assisted reproduction treatment or procedure under a written plan or agreement with a health care provider; or

3. retaining all rights on the use of reproductive genetic materials,

such as gametes.

The bill also prohibits anyone from prohibiting or unreasonably limiting a health care provider who is licensed, certified, or otherwise authorized to perform ART or assisted reproduction treatments or procedures from (1) doing so or (2) providing evidence-based information related to ART or assisted reproduction.

Under the bill, "assisted reproductive technology" includes all treatments or procedures in which human oocytes (i.e., cells that develop into eggs) or embryos are handled, such as (1) in vitro fertilization (IVF) and (2) gamete or zygote intrafallopian transfer (see 42 U.S.C. § 263a-7). "Assisted reproduction" is a method of causing pregnancy other than sexual intercourse and includes (1) intrauterine, intracervical, or vaginal insemination; (2) donation of gametes or embryos; (3) IVF and embryo transfer; and (4) intracytoplasmic sperm injection (see CGS § 46b-451).

EFFECTIVE DATE: Upon passage

§ 2 — MEDICAID FUNDING FOR LONG-ACTING REVERSIBLE CONTRACEPTIVES

Conforms to existing DSS policy by requiring Medicaid coverage for same-day access to long-acting reversible contraceptives at federally qualified health centers

The bill requires the Department of Social Services (DSS) commissioner to adjust Medicaid reimbursement criteria to cover same-day access to long-acting reversible contraceptives at federally qualified health centers. In doing so, the bill conforms to current DSS policy.

The bill defines this type of contraceptive as any contraception method that does not have to be used more than once per menstrual cycle or per month.

EFFECTIVE DATE: July 1, 2023

§§ 3 & 4 — DRUG USE HARM REDUCTION CENTERS

Requires DMHAS, by July 1, 2027, to create a pilot program establishing harm reduction centers where people with substance use disorder can access counseling, receive and use fentanyl or xylazine test strips, and receive various other services; exempts the centers

from DPH regulation until after the pilot program ends; exempts the centers from needing CON approval

The bill requires DMHAS, by July 1, 2027, and in consultation with DPH, to create a pilot program consisting of harm reduction centers to prevent drug overdoses. Under the bill, these centers must be established in three municipalities the DMHAS commissioner chooses, subject to their chief elected officials' approval.

For this purpose, "harm reduction centers" are medical facilities where a person with a substance use disorder may (1) receive various services, such as counseling, treatment referrals, and basic support services and (2) use test strips to test a substance for fentanyl or certain other substances (see below).

Under the bill, these centers must employ, among others, licensed providers with experience treating people with substance use disorders. The DMHAS commissioner determines the staffing level. The bill specifies that a health care provider's participation in the pilot program is not grounds for disciplinary action by DPH or professional licensing boards within the department.

The bill allows the DMHAS commissioner to request Opioid Settlement Fund disbursements to fund the program fully or partially.

Under the bill, these centers are not subject to DPH regulation until after the pilot program ends. The bill also exempts centers established through the pilot program from the requirement to obtain certificate of need (CON) approval from the Office of Health Strategy (OHS).

EFFECTIVE DATE: Upon passage

Harm Reduction Center Services and Providers

The bill requires harm reduction centers under the pilot program to offer the following services to people with a substance use disorder:

1. substance use disorder and other mental health counseling;

2. use of test strips to prevent accidental overdose (see below);

3. educational information about opioid antagonists and the risks of contracting diseases from sharing hypodermic needles;

4. referrals to substance use disorder treatment services; and

5. access to basic support services, including laundry machines, a bathroom, a shower, and a place to rest.

The bill requires the centers to offer test strips upon the person's request and allow the use of test strips at the center. The purpose of the strips is to test a substance, before injecting, inhaling, or ingesting it, for traces of fentanyl, xylazine, or any other substance that the DMHAS commissioner recognizes as having a high risk of causing an overdose. (Xylazine is a veterinary tranquilizer that is sometimes mixed with fentanyl in illegal drug sales.)

The bill requires the centers' employees to include licensed providers with experience treating people with substance use disorders. These providers must (1) provide the aforementioned counseling services and (2) monitor people using the center and provide treatment to those experiencing overdose symptoms. The centers must provide referrals for (1) substance use disorder or mental health counseling or (2) other mental health or medical treatment services that may be appropriate.

§ 5 — OPIOID ANTAGONIST BULK PURCHASE FUND AND EMS PROVIDING OPIOID ANTAGONIST KITS

Creates an Opioid Antagonist Bulk Purchase Fund, which DMHAS must use to give opioid antagonists to municipalities, other eligible entities, and EMS personnel; requires EMS personnel to provide kits with opioid antagonists and an opioid-related fact sheet to certain patients, such as those showing symptoms of opioid use disorder

The bill creates an Opioid Antagonist Bulk Purchase Fund as a separate, nonlapsing General Fund account. Starting by January 1, 2024, DMHAS, in collaboration with DPH, must use the account's funds to provide opioid antagonists to eligible entities and for EMS personnel to give this medication to certain members of the public. Relatedly, it requires EMS personnel to give kits with opioid antagonists and related information (in a one-page fact sheet) to certain patients or their family members, caregivers, or friends.

As under existing law, an opioid antagonist is naloxone hydrochloride (e.g., Narcan) or any other similarly acting and equally safe drug that the Food and Drug Administration (FDA) has approved for treating a drug overdose.

EFFECTIVE DATE: October 1, 2023

Eligible Entities

Under the bill, "eligible entities" are (1) municipalities, (2) local and regional boards of education, (3) similar bodies governing nonpublic schools, (4) district and municipal health departments, (5) law enforcement agencies, and (6) EMS organizations. The DMHAS commissioner, within available appropriations, may contract with a drug wholesaler or distributer to purchase and distribute opioid antagonists in bulk to eligible entities through the program.

The bill requires eligible entities to make these bulk-purchased opioid antagonists available, for free, to family members, caregivers, or friends of people who experienced an opioid overdose or showed overdose symptoms.

Opioid Antagonist Bulk Purchase Fund

The bill requires the state treasurer to administer the Bulk Purchase Fund account. The account must contain (1) any state appropriations or other state money made available for the fund's purposes; (2) moneys required by law to be deposited into the account; (3) gifts, grants, donations, or bequests directed to it; and (4) the account's investment earnings. Any balance remaining at the end of a fiscal year must be carried forward.

DMHAS must use the funds to provide opioid antagonists as specified above, except the department may use up to 2% of the account in any fiscal year for related administrative expenses.

EMS-Provided Opioid Antagonist Kits

Under the bill, EMS personnel must distribute opioid antagonist kits with a personal supply of this medication and a one-page fact sheet to patients who (1) they are treating for an opioid overdose, (2) show

symptoms of opioid use disorder, or (3) are treated at a location where the personnel observe evidence of illicit use of opioids. The personnel must give the kits to the patients themselves or their family members, caregivers, or friends who are at the location.

The fact sheet must be the one that existing law requires the state's Alcohol and Drug Policy Council to develop, with information on the risks of taking an opioid drug, symptoms of opioid use disorder, and available in-state services for people who experience symptoms of, or are otherwise affected by, opioid use disorder.

The bill requires the EMS personnel, as they find appropriate, to refer the patient (or their family member, caregiver, or friend) to the written instructions on administering the opioid antagonist.

For these purposes, EMS personnel include emergency medical responders, emergency medical technicians (EMTs), advanced EMTs, EMS instructors, and paramedics. The bill requires them to document the number of kits they distribute through the program, including the number of doses of opioid antagonists in each kit.

The bill allows EMS organizations to obtain opioid antagonists from pharmacists to distribute through the program. The organizations may obtain them, under existing procedures, through a (1) qualified pharmacist's prescription, (2) standing order, or (3) distribution agreement with the pharmacist.

DPH's Office of Emergency Medical Services Annual Report

Starting by January 1, 2025, the bill requires the executive director of DPH's Office of Emergency Medical Services to annually report to DMHAS on the implementation of the above EMS-related provisions. This includes any information known to the executive director that must be included in the DMHAS substance use disorder plan under the bill (see below).

State Substance Use Disorder Plan

By law, the DMHAS commissioner must (1) develop and implement a comprehensive state substance use disorder plan and (2) update the

plan every three years. The bill requires her to include the following information in the plan:

1. the amount of funds used to buy and distribute opioid antagonists;

2. the number of eligible entities receiving opioid antagonists under these provisions;

3. the amount of opioid antagonists purchased and, if known by DMHAS, how the entities used them; and

4. any recommendations for the Bulk Purchase Fund, including proposed legislation to facilitate the bill's purposes.

§ 6 — ENCOURAGEMENT TO OBTAIN OPIOID ANTAGONIST

Requires prescribing practitioners, when prescribing an opioid, to encourage the patient (and parents or guardian when applicable) to obtain an opioid antagonist

The bill requires prescribing practitioners, when prescribing an opioid (whether to an adult or minor patient), to encourage the patient to obtain an opioid antagonist. If the patient is a minor, the prescriber must also encourage the patient's custodial parent, guardian, or other person with legal custody to obtain an opioid antagonist, if they are present when the prescription is being issued.

EFFECTIVE DATE: October 1, 2023

§ 7 — SDE HEALTH CARE CAREER PROMOTION

Requires the education commissioner to use an existing plan to promote health care careers and provide health care job shadowing and internship experiences; requires the commissioner to give the plan to school boards and support its implementation

Existing law required OWS, in consultation with various stakeholders, to develop a plan to work with high schools in the state to encourage students to pursue high demand health care professions (e.g., nursing and behavioral and mental health care).

The bill requires the education commissioner, in collaboration with the chief workforce officer, to use this plan in (1) promoting health care professions as career options to middle and high school students and (2)

health care job shadowing and internship experiences for high school students.

The commissioner must promote these professions through (1) career day presentations; (2) developing partnerships with in-state health care career education programs; and (3) creating counseling programs to inform high school students about, and recruit them for, health care professions.

By September 1, 2023, the education commissioner must (1) provide the OWS plan to each local and regional school board and (2) through the Governor's Workforce Council Education Committee, support the plan's implementation.

EFFECTIVE DATE: July 1, 2023

§ 8 — HEALTH CARE WORKFORCE WORKING GROUP

Requires OWS to convene a working group to develop recommendations to expand the state's health care workforce

The bill requires OWS to convene a working group to develop recommendations for expanding the health care workforce in the state. The group must evaluate:

1. the quality of in-state education and clinical training programs for nurses and nurse's aides;

2. the potential for increasing the number of these clinical training sites;

3. the expansion of these clinical training facilities;

4. any barriers to recruit and retain health care providers, including nurses and nurse's aides;

5. the impact of the state health care staffing shortage on the provision of health care services, the public's access to these services, and service wait times; and

6. the impact of federal and state reimbursement for the costs of

health care services on the public's access to them.

EFFECTIVE DATE: Upon passage

Working Group Membership and Procedures

Under the bill, the working group consists 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 or an in-state hospital or long-term care facility;
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 (BOR) and the presidents of the Connecticut State Colleges and Universities and UConn, or their designees;
5. one member of the UConn Health Center's administration;
6. two representatives of the Connecticut Conference of Independent Colleges;
7. the DPH, DSS, and Department of Administrative Services commissioners, or their designees;
8. the Office of Policy and Management secretary, or his designee;
9. a representative of the State Board of Examiners for Nursing;
10. a representative of the State Employees Bargaining Coalition; and
11. the chairpersons and ranking members of the Public Health and Higher Education and Employment Advancement committees, or their designees.

The bill requires the DPH commissioner and BOR chairperson, or their designees, to serve as the working group's chairpersons. They must schedule the first meeting, to be held within 60 days after the bill's passage.

Reporting Requirement

The bill requires the working group to report to the Public Health and Higher Education and Employment Advancement committees by January 1, 2024. The group must report its findings and any recommendations to improve recruiting and retaining health care providers in the state, including a five-year and a 10-year plan to increase the health care workforce in the state.

The group ends when it submits its report or January 1, 2024, whichever is later.

§§ 9 & 10 — HEALTH CARE PROVIDERS SERVING AS ADJUNCT FACULTY

Requires public higher education institutions to consider any licensed health care provider with at least 10 years of clinical experience to be qualified for an adjunct faculty position; correspondingly requires the Office of Higher Education, within available appropriations, to establish a program providing incentive grants to these providers who become adjunct professors

Beginning January 1, 2024, the bill requires public higher education institutions to consider any licensed health care provider applying for an adjunct faculty position in their field to be qualified if the provider has at least 10 years of clinical experience. Under the bill, the institutions must give them the same consideration as other qualified applicants (presumably, as it relates to experience). Providers hired under this provision who remain in the position for at least one academic year are eligible for incentive grants (see below).

These provisions apply to UConn, the Connecticut State Universities, the regional community-technical colleges, and Charter Oak State College.

EFFECTIVE DATE: July 1, 2023

Grant Program

The bill requires OHE, by January 1, 2024, and within available appropriations, to establish and administer a program giving $20,000 incentive grants to licensed health care providers accepting adjunct professor positions under the provisions described above if they remain in the position for at least one academic year. These providers are eligible for another $20,000 grant if they remain in the position for at least two academic years. OHE's executive director must establish the application process.

The bill requires the executive director, starting by January 1, 2025, to annually report on the program to the Public Health Committee. The director must report on:

1. the number and demographics of the adjunct professors who applied for and received program grants,

2. which institutions employed them and the number and types of classes they taught, and

3. any other information he considers pertinent.

§ 11 — PERSONAL CARE ATTENDANT CAREER PATHWAYS PROGRAM

Requires DSS to establish a PCA career pathways program, including both basic skills and specialized skills pathways, to improve PCAs' quality of care and incentivize their recruitment and retention in the state

The bill requires DSS, by January 1, 2024, to establish and administer a career pathways program for personal care attendants (PCAs). The program's purpose is to improve PCAs' quality of care and incentivize their recruitment and retention in the state.

PCAs provide in-home and community-based personal care assistance and other non-professional services to the elderly and people with disabilities. The bill allows PCAs who are not employed by a consumer (i.e., a person receiving services under a state-funded program), but eligible for this employment, to participate in the career pathways program after completing a DSS-developed orientation.

EFFECTIVE DATE: July 1, 2023

Program Objectives

The bill requires the program to include at least the following objectives:

1. increasing PCAs' retention and recruitment to maintain a stable workforce for consumers, including by creating career pathways that improve PCAs' skill and knowledge and increase their wages;

2. dignity in how PCAs provide care, and how consumers receive it, through meaningful collaboration between them;

3. improving the quality of personal care assistance and the consumers' overall quality of life;

4. advancing equity in personal care assistance;

5. promoting a culturally and linguistically competent PCA workforce to serve the growing racial, ethnic, and linguistic diversity of an aging consumer population; and

6. promoting self-determination principles for PCAs.

Program Components

Under the bill, the DSS commissioner must offer the following pathways under the program:

1. the basic skills career pathways, including general health and safety and adult education topics; and

2. the specialized skills career pathways, including cognitive impairments and behavioral health, complex physical care needs, and transitioning to home- and community-based living from out-of-home care or homelessness.

The commissioner must develop or identify the training curriculum for each pathway. In doing so, she must consult with a hospital's or health care organization's labor management committee.

Reporting Requirement

By January 1, 2025, the bill requires the commissioner to report to the Human Services and Public Health committees on the following program information:

1. the number of enrolled PCAs and the pathways they choose;

2. the number of PCAs who completed a career pathway, by pathway type;

3. the program's effectiveness, as determined by surveys, focus groups, and interviews of PCAs, and whether completing the program led to (a) a related license or certificate or (b) continued employment for each PCA; and

4. the number of PCAs employed by consumers with specialized care needs after completing a specialized career pathway and whom the consumer kept employed for at least (a) six months and (b) 12 months.

§ 12 — HOSPITAL PRIVILEGES

Prohibits hospitals, for purposes of granting practice privileges, from requiring (1) board eligible physicians to become board certified until five years after becoming board eligible, or (2) board certified physicians to provide credentials of board recertification

The bill prohibits hospitals (and their medical review committees), for purposes of granting practice privileges, from requiring board eligible physicians to become board certified until five years after becoming board eligible. It also prohibits them, for purposes of granting practice privileges or allowing a physician to retain those privileges, from requiring board certified physicians to provide credentials of board recertification.

Under the bill, a physician is "board eligible" after graduating from medical school, completing a residency program, training under supervision in a specialty fellowship program, and then being eligible to take a medical specialty board's qualifying examination. A physician is "board certified" after passing such an exam to become board certified in a particular specialty.

EFFECTIVE DATE: October 1, 2023

§§ 13-15 — PHYSICIAN, APRN, OR PA NON-COMPETE CLAUSES

Places additional limitations on physician non-compete clauses when the physician does not agree to a material change to the employment contract; extends to APRN or PA non-compete clauses the limitations that apply to physician non-compete clauses under existing law and the bill

Existing law sets limits on physician non-compete agreements ("covenants not to compete"), including that they may extend for no more than one year and a 15-mile radius from the physician's primary practice site. The bill additionally provides that physician non-compete agreements entered into, amended, extended, or renewed on or after October 1, 2023, are unenforceable under the following conditions:

1. the physician does not agree to a proposed material change to the terms of the employment contract or agreement (or similar professional arrangement), before or when it is extended or renewed; and

2. the contract or agreement expires and is not renewed by the employer or the employer terminates the employment or contractual relationship, unless the termination is for cause.

The bill also extends the law on physician non-compete clauses, including the bill's changes, to APRN or PA non-compete agreements entered into, amended, extended, or renewed on or after October 1, 2023.

EFFECTIVE DATE: July 1, 2023

APRN or PA Non-Compete Agreements

Current law does not specifically limit APRN or PA non-compete agreements. In practice, courts generally consider certain factors when assessing whether a particular non-compete agreement is reasonable, such as its duration and geographical scope.

The bill applies the same statutory conditions and limitations for physician non-compete agreements (under existing law and the bill) to APRN or PA non-compete clauses entered into, amended, extended, or

renewed on or after October 1, 2023.

Definitions. The bill defines "covenant not to compete" for APRNs and PAs in a way that is substantially similar to the definition in existing law that applies to physicians. Under the bill, an APRN or PA "covenant not to compete" is any provision of an employment or other contract or agreement that establishes a professional relationship with an APRN or PA, respectively, and restricts their right to practice in any area of the state for any period after the end of the partnership, employment, or other professional relationship.

Conditions and Limitations. Under the bill, an APRN or PA covenant not to compete is valid and enforceable only if it is:

1. necessary to protect a legitimate business interest;

2. reasonably limited in time, geographic scope, and practice restrictions as needed to protect that interest; and

3. otherwise consistent with the law and public policy. (These factors are similar to those under the common law.)

The bill specifically prohibits these covenants from restricting an APRN's or PA's competitive activities for longer than one year and beyond 15 miles from the primary site where the APRN or PA practices.

The bill further provides that these covenants are unenforceable against the APRN or PA if the:

1. employer terminates the employment or contractual relationship without cause or

2. employment contract or agreement was not made in anticipation of, or as part of, a partnership or ownership agreement and the contract or agreement expires and is not renewed, unless before the expiration the employer made a bona fide offer to renew the contract on the same or similar terms.

It also provides that these agreements are unenforceable against the

provider if:

1. the APRN or PA does not agree to a proposed material change to the terms of the employment contract or agreement (or similar professional arrangement) before or when it is extended or renewed; and

2. the contract or agreement expires and is not renewed by the employer or the employer terminates the employment or contractual relationship, unless the termination is for cause.

Under the bill, each covenant must be separately and individually signed by the APRN or PA.

Other Contract Provisions and Burden of Proof. If a covenant is rendered void and unenforceable under the bill, the remaining provisions of the contract remain in full force and effect. This includes provisions requiring the payment of damages for injuries suffered due to the contract's termination.

The bill specifies that the party seeking to enforce an APRN or PA covenant not to compete bears the burden of proof at any proceeding.

§ 16 — PHYSICAL THERAPY LICENSURE COMPACT

Enters Connecticut into the Physical Therapy Licensure Compact, which provides a process authorizing physical therapists or physical therapy assistants properly credentialed in one member state to practice across state boundaries, without requiring licensure in each state

The bill enters Connecticut into the Physical Therapy Licensure Compact. The compact creates a process authorizing physical therapists (PTs) and PT assistants who are licensed or certified (as appropriate) in one member state to practice across state boundaries without requiring licensure or certification in each state. Member states must grant the "compact privilege" (i.e., the authority to practice in the state) to people holding a valid, unencumbered license who otherwise meet the compact's eligibility requirements. The compact is administered by the PT Compact Commission, which Connecticut would join under the bill.

Among various other provisions, the compact:

1. sets eligibility criteria for states to join the compact and for PTs or PT assistants to practice under it;

2. addresses several matters related to disciplinary actions for licensees practicing under the compact, such as information sharing among member states and removal of compact privileges;

3. provides that amendments to the compact only take effect if all member states adopt them into law; and

4. has a process for states to withdraw from the compact.

A broad overview of the compact appears below.

EFFECTIVE DATE: July 1, 2023

Compact Overview

The PT Compact creates a process authorizing PTs and PT assistants to work in multiple states if they are licensed (for PTs) or licensed or certified (for assistants) in one member state. A "licensee" is someone currently authorized by a state to practice as a PT or PT assistant.

Under the compact, a "state" is a U.S. state, commonwealth, district, or territory that regulates physical therapy. A "member state" is a state that has joined the compact.

A "home state" is the member state that is the licensee's primary state of residence. A "remote state" is a member state, other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

The compact allows active-duty military personnel, or their spouses, to designate as their home state their (1) home of record, (2) permanent change of station, or (3) state of current residence if different from either of those.

"Compact privilege" is a remote state's authorization to allow a licensee from another member state to practice in the remote state under

its laws and rules. The compact specifies that PT practice occurs in the member state where the patient or client is located.

State Eligibility (§ 16(3))

To participate in the compact, a state must do the following:

1. participate fully in the commission's licensee data system, including using the commission's unique identifier;

2. have a mechanism to receive and investigate complaints about licensees;

3. notify the commission, in compliance with the compact's terms and rules, about any adverse action (i.e., board disciplinary action for misconduct or unacceptable performance) or the availability of investigative information about a licensee;

4. fully implement a criminal background check requirement, within deadlines set by rule, by receiving FBI search results and using that information in making licensure decisions (see below and § 17);

5. comply with the commission's rules;

6. require passage of a recognized national examination for licensure, under the commission's rules; and

7. require continuing competence (e.g., continuing education) for license renewal.

Upon joining the compact, member states must have the authority to get biometric-based information from each PT licensure applicant and submit it to the FBI for a criminal record check.

Individual Compact Privilege (§ 16(3) & (4))

The compact requires member states to grant the compact privilege to a licensee holding a valid, unencumbered license in another member state, under the compact's terms and rules. Member states may charge a fee for granting the privilege.

To exercise the compact privilege, a licensee must meet the following requirements:

1. be licensed in the home state;
2. have no encumbrance on any state license;
3. be eligible for a compact privilege in any member state, under the compact's provisions on remote states' authority to remove that privilege (see next subheading);
4. have no adverse action against any license or compact privilege within the prior two years;
5. notify the commission that the licensee is seeking the compact privilege in one or more remote states;
6. pay any state fees or other applicable fees for the compact privilege;
7. meet any applicable remote states' jurisprudence requirements (i.e., assessment of knowledge of PT practice laws and rules for that state); and
8. report to the commission within 30 days after being subject to adverse action by any non-member state.

Under the compact, the privilege is valid until the home license expires. The licensee must comply with the above requirements to maintain the privilege in the remote state.

Respective States' Authority, Adverse Actions, and Data System (§ 16(4), (6) & (8))

The compact addresses several matters related to states' authority to investigate and discipline licensees practicing under its procedures. Broadly, the compact maintains the home state authority to regulate the home state license and grants the remote state the authority to regulate the compact privilege in that state, each according to its own regulatory structure. Additionally, a home state may take action against a licensee

based on investigative information from a remote state.

The following are examples of the regulatory structure under the compact:

1. a home state has exclusive authority to impose adverse action against a home state license, but a remote state may remove a licensee's compact privilege, investigate and issue subpoenas, impose fines, and take other necessary action;

2. if allowed by their law, remote states may recover from the licensee any investigation and disposition costs for cases leading to adverse actions;

3. if a licensee's home state license is encumbered or remote state privilege is removed, he or she cannot regain the compact privilege in any remote state until (a) the encumbrance is lifted or removal period passes; (b) two years have passed since the adverse action; (c) for remote state removals, any fines have been paid; and (d) the licensee otherwise meets the compact's eligibility requirements;

4. member states may allow licensees to participate in an alternative program (e.g., for substance abuse) rather than imposing an adverse action, but the state must require the licensee to get prior authorization from other member states before practicing there during this period; and

5. any member state may investigate actual or alleged violations in other member states where a licensee holds a license or compact privilege.

Member states must submit the same information on licensees for inclusion in a database the compact creates, and the commission must promptly notify all member states about any adverse action against licensees or licensure applicants. Investigation information about a licensee is available only to states in which a licensee holds, or is applying for, a license or compact privilege.

PT Compact Commission (§ 16(7) & (9))

The compact is administered by the PT Compact Commission, which consists of one voting member appointed by each member state's PT licensing board. The compact sets forth several powers, duties, and procedures for the commission. For example, the commission:

1. may make rules to facilitate and coordinate the compact's implementation and administration (a rule has no effect if a majority of the member states' legislatures reject it within four years of the rule's adoption),

2. may levy and collect an annual assessment from each member state and impose fees on other parties to cover the costs of its operations, and

3. must have its receipts and disbursements audited yearly and the audit report included in the commission's annual report.

The compact addresses several other matters regarding the commission and its operations, such as setting conditions under which its officers and employees are immune from civil liability. By virtue of adopting the compact, Connecticut joins the commission.

Compact Oversight, Enforcement, Member Withdrawal, and Related Matters (§ 16(10)-(12))

Among other related provisions, the compact provides the following:

1. each member state's executive, legislative, and judicial branches must enforce the compact and take necessary steps to carry out its purposes;

2. the commission must take specified steps if a member state defaults on its obligations under the compact, and after all other means of securing compliance have been exhausted, a defaulting state is terminated from the compact upon a majority vote of the member states;

3. upon a member state's request, the commission must attempt to resolve a compact-related dispute among member states or

between member and non-member states;

4. the commission must enforce the compact and rules and may bring legal action against a member state in default upon a majority vote (the case may be brought in the U.S. District Court for the District of Columbia or the federal district where the commission's principal offices are located);

5. a member state may withdraw from the compact by repealing that state's enabling legislation, but withdrawal does not take effect until six months after the repealing statute's enactment;

6. the member states may amend the compact, but no amendment takes effect until all member states enact it into law; and

7. the compact's provisions are severable and its provisions must be liberally construed to carry out its purposes, and if the compact is held to violate a member state's constitution, it remains in effect in the remaining member states.

§ 17 — BACKGROUND CHECKS FOR PT AND PT ASSISTANT LICENSURE

Requires PT and PT assistant licensure applicants to complete a fingerprint-based criminal background check

Under the bill, the DPH commissioner must require anyone applying for PT or PT assistant licensure to submit to a state and national fingerprint-based criminal history records check by the Department of Emergency Services and Public Protection (DESPP).

EFFECTIVE DATE: July 1, 2023

§ 18 — PODIATRIC SCOPE OF PRACTICE WORKING GROUP

Requires DPH to establish a working group to advise the department and any relevant scope of practice review committee on podiatrists' scope of practice relating to surgical procedures

The bill requires the DPH commissioner to establish a working group to advise DPH and any relevant scope of practice review committee (see below) on podiatrists' scope of practice relating to surgical procedures. The commissioner appoints the working group's members, which must

include at least three podiatrists and three orthopedic surgeons.

By January 1, 2024, the working group must report its findings and recommendations to the commissioner and any such scope of practice review committee. By February 1, 2024, the commissioner must report to the Public Health Committee on (1) the group's findings and recommendations and (2) whether DPH and any relevant scope of practice review committee agrees with them.

Existing law has a process for DPH to review requests from representatives of health care professions seeking to establish or revise a scope of practice before consideration by the legislature. DPH selects the requests it will act upon and, within available appropriations, appoints members to scope of practice review committees, whose members include representatives from the profession making the request and other professions directly impacted by it (CGS § 19a-16e).

EFFECTIVE DATE: July 1, 2023

§§ 19 & 20 — APRN LICENSURE BY ENDORSEMENT AND INDEPENDENT PRACTICE

Allows for licensure by endorsement for APRNs who have (1) practiced for at least three years in another state with practice requirements that are substantially similar to, or higher than, Connecticut's and (2) no disciplinary history or unresolved complaints pending; correspondingly allows these APRNs to count their out-of-state practice toward the existing requirement of three years' practice in collaboration with a physician before practicing independently

The bill allows APRNs with certain experience who are not otherwise eligible to apply for licensure in Connecticut to apply for licensure by endorsement. To be eligible, the applicant must give DPH satisfactory evidence that he or she has (1) practiced for at least three years as an APRN (or similar services under a different designation) in another state or jurisdiction and (2) no disciplinary actions or unresolved complaints pending. The other jurisdiction must have requirements for practicing that are substantially similar to, or higher than, Connecticut's.

The bill requires these applicants to pay a $200 fee, the same as for other APRN licensure applicants under existing law.

Under current law, APRNs must practice in collaboration with a

physician for the first three years after becoming licensed in the state. They may practice without this collaboration if they have been licensed and practicing in collaboration with a physician for at least three years with at least 2,000 hours of practice. The bill allows APRNs who are licensed by endorsement under the above procedures to count their prior out-of-state practice toward this three-year requirement, if that practice was under collaboration with a physician licensed in another state and otherwise meet existing law's requirements. APRNs who meet these requirements may practice independently.

EFFECTIVE DATE: October 1, 2023

§ 21 — SPLASH PAD AND SPRAY PARK WARNING SIGNS

Requires splash pad and spray park owners or operators to post warning signs about the potential health risk of ingesting recirculated water

The bill requires owners or operators of splash pads and spray parks where water is recirculated to post a sign stating that the water is recirculated and warning of the potential health risk to people ingesting it. They must post the sign by January 1, 2024, and in a conspicuous place at or near the entrance.

EFFECTIVE DATE: July 1, 2023

§ 22 — LPN EDUCATION PILOT PROGRAM

Allows the state nursing board, under certain conditions, to approve applications from higher education institutions to create a pilot program for licensed practice nurse education and training, and grants the program full approval if it meets specified requirements for two years

The bill allows certain public or independent higher education institutions, by January 30, 2024, to apply to the State Board of Examiners for Nursing to create a pilot program offering licensed practical nursing (LPN) education and training. To be eligible, the institution must (1) maintain accreditation as a degree-granting institution in good standing by a regional accrediting association recognized by the federal Department of Education and (2) offer, or be seeking state approval to offer, a nursing program approved by the state Office of Higher Education.

Under the bill, a higher education institution that applies to the

nursing board to establish a pilot program must give the board the following information in writing, at least 60 days before the proposed program state date:

1. identifying information about the pilot program, including its name, address, contact information, and responsible party;

2. a program description, including accreditation status, any clinical partner, and anticipated enrollment by academic term;

3. identified resources to 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 the institution offers;

5. a plan for employing qualified faculty and administrators and clinical experiences; and

6. other information as the board requests.

If the institution gives this information, the nursing board must review and consider the program application. The board may hold a public hearing on it.

Under the bill, the pilot program must comply with relevant provisions of the state's Nurse Practice Act (chapter 378) and specified regulations on nursing education programs. The pilot program is deemed fully approved by the nursing board if it (1) meets these requirements for two years and (2) provides evidence that the program is meeting its education outcomes as shown by an acceptable level of graduates' performance, as defined in state regulation (e.g., an average passage rate of 80% for first-time takers of the required licensure examination).

EFFECTIVE DATE: Upon passage

§ 23 — RECIPROCITY AGREEMENTS FOR CLINICAL ROTATION TRAINING

Allows OHE to enter into a reciprocity agreement with neighboring states regarding clinical training credit at higher education institutions

The bill allows OHE to enter into a reciprocity agreement with one or more neighboring states regarding clinical training credit at higher education institutions. Under the agreement, the other state could allow students attending a higher education institution in that state to train in a clinical rotation for credit in Connecticut, as long as the state also allows a student attending a Connecticut higher education institution to train in a clinical rotation for credit in the other state.

EFFECTIVE DATE: Upon passage

§ 24 — COMMISSION ON COMMUNITY GUN VIOLENCE INTERVENTION AND PREVENTION

Specifically allows the Commission on Community Gun Violence Intervention and Prevention to create a subcommission, an advisory group, or another entity for specified purposes related to providing home health care and services to people affected by gun violence

PA 22-118 established a Commission on Community Gun Violence Intervention and Prevention to advise the DPH commissioner on developing evidence-based, evidenced-informed, community-centric gun programs and strategies to reduce community gun violence in the state.

The law allows the commission to establish subcommissions, advisory groups, or other entities it deems necessary to further its purposes. The bill specifically allows the commission to establish such an entity to evaluate the (1) challenges associated with providing home health care to victims of gun violence and (2) ways to foster a system uniting community service providers with adults and juveniles needing supports and services to address trauma due to gun violence.

EFFECTIVE DATE: July 1, 2023

§§ 25 & 26 — MATERNAL MENTAL HEALTH TOOLKIT AND PERINATAL MOOD AND ANXIETY DISORDER TRAINING

Requires DPH, in consultation with DMHAS and certain other organizations, to develop a maternal mental health toolkit for providers and patients, including on perinatal mood and anxiety disorders; requires hospitals to include training in perinatal mood and anxiety disorders as part of their regular training for certain staff members

The bill requires DPH to develop a toolkit to give information and resources on maternal mental health to licensed health care professionals and new parents in the state. In doing so, DPH must consult with DMHAS and organizations representing health care facilities and licensed health care professionals.

The toolkit must at least include (1) information about perinatal mood and anxiety disorders (see *Background*), including their symptoms, potential impact on families, and treatment options; and (2) a list of licensed health care professionals, peer support networks, and nonprofit organizations in the state that treat these disorders or provide related support for patients and their family members. By October 1, 2023, DPH must make the toolkit available on its website.

Starting October 1, 2023, the bill also requires hospitals to include training in perinatal mood and anxiety disorders as part of their regular training to staff members who directly care for women who are pregnant or in the postpartum period.

EFFECTIVE DATE: Upon passage, except October 1, 2023, for the hospital training provision.

Background — Perinatal Mood and Anxiety Disorders

Generally, perinatal mood and anxiety disorders refer to a range of symptoms that may occur during pregnancy and the post-partum period, such as depression and anxiety, or in rare cases, post-partum psychosis.

Background — Related Bill

SB 1160 (File 177), reported favorably by the Public Health Committee, contains identical provisions on a maternal mental health toolkit and hospital training.

§ 27 — EMERGENCY DEPARTMENT CROWDING WORKING GROUP

Requires the DPH commissioner to convene a working group to advise her on how to alleviate emergency department crowding and the lack of available beds

The bill requires the DPH commissioner, by July 1, 2023, to convene

a working group to advise her on ways to ease emergency department (ED) crowding and lack of available ED beds in the state. Specifically, the group must advise on:

1. setting a quality measure for the timeliness of transferring patients from the ED to hospital admission;

2. establishing ED discharge units to expedite the discharge process;

3. evaluating the percentage of ED patients held in the department after admission and while waiting for an inpatient bed, and making a plan to lower it; and

4. reducing liability for hospitals and their emergency physicians when ED crowding causes significant wait times for patients seeking these services.

EFFECTIVE DATE: Upon passage

Working Group Membership and Procedures

Under the bill, the working group may consist of following members, among others:

1. two emergency physicians representing the state chapter of a national college of emergency physicians;

2. two emergency physicians who are ED directors, one from a larger hospital system in the state and the other from an independent community hospital;

3. a primary care physician representing the state chapter of a national college of physicians;

4. two representatives of an in-state hospital association;

5. a representative of an in-state medical society;

6. a representative of the state chapter of a national organization of emergency nurses;

7. a representative of the state chapter of a national organization of pediatric physicians;

8. a representative of the state chapter of a national association of psychiatrists;

9. a representative of an in-state association of nurses;

10. two nurses who are ED nurse directors, one from a larger hospital system and the other from an independent community hospital;

11. two patient care navigators, one who works for a larger hospital system and the other for an independent community hospital;

12. a representative of hospital patients in the state;

13. a provider of emergency medical transportation services in the state;

14. a representative of a national association of retired people;

15. the state healthcare advocate, child advocate, DMHAS commissioner, and Department of Children and Families (DCF) commissioners, or their designees;

16. two DPH representatives, one from the Office of Emergency Medical Services and one from the department's facilities licensing and investigations section;

17. a representative of the Office of the Long-Term Care Ombudsman;

18. two representatives from in-state nursing homes, one from a for-profit and the other from a nonprofit;

19. one representative from the insurance industry in the state; and

20. one member of an association of trial lawyers in the state.

The bill requires the DPH commissioner to select the group's

chairpersons, who must be (1) one of the emergency physicians representing the state chapter of a national college of emergency physicians and (2) one of the representatives of an in-state hospital association.

Under the bill, the working group's first meeting must be held by December 1, 2023. The chairpersons may hold the first meeting even if the DPH commissioner has not yet selected all members. If the commissioner has not selected a member by August 1, 2023, the chairpersons may jointly select the member.

The group must meet twice a year and at other times upon the chairpersons' call.

Reporting Requirement

The bill requires the working group to report its findings and recommendations by January 1, 2024, and by January 1, 2025, to the DPH commissioner and Public Health Committee.

Background — Related Bill

sSB 960 (File 101), reported favorably by the Public Health Committee, has similar provisions on an ED crowding working group.

§ 28 — PSYCHOSIS TASK FORCE

Creates a task force to study childhood and adult psychosis

The bill creates a 10-member task force to study childhood and adult psychosis. The study must examine the following:

1. in collaboration with DCF and DMHAS, establishing clinics staffed by mental health care providers in various fields who provide comprehensive care for children and adults experiencing early or first episode psychosis, to prevent the symptoms from becoming disabling;

2. early evaluation of children and adults with psychosis symptoms and management of these symptoms, including starting treatment and making necessary referrals for additional treatment or services;

3. creating care pathways that include specialty teams that treat children and adults experiencing early or first episode psychosis;

4. creating a statewide model for coordinating specialty care for children and adults experiencing psychosis, as recommended by the National Institute of Mental Health;

5. creating services for these children and adults, including collaboration on psychotherapy and pharmacotherapy, family support, education, coordination with community support services, and collaboration with employers and education systems; and

6. strengthening existing clinical networks that treat people experiencing psychosis, with a focus on collaborative research and outcomes.

Under the bill, "psychosis" is a severe mental condition in which disruptions to thoughts and perceptions make it difficult for a person to recognize what is real and what is not, with these disruptions often experienced as seeing, hearing, and believing things that are not real or having strange, persistent thoughts, behaviors, and emotions, including hallucinations and delusions.

EFFECTIVE DATE: Upon passage

Membership and Administration

Under the bill, the task force includes the DMHAS and DCF commissioners, or their designees, and eight appointed members, as shown in the table below.

Table: Psychosis Task Force Appointed Members

Appointing Authority	*Appointee Qualifications*
House speaker (2)	A child and adolescent psychiatrist with experience treating patients with psychosis A clinical researcher in the field of psychosis
Senate president pro tempore (2)	A psychiatrist with experience treating adults with psychosis

	A clinical researcher in the field of psychosis
House majority leader (1)	A parent or guardian of a child or adolescent treated for psychosis
Senate majority leader (1)	An adult treated for psychosis
House minority leader (1)	A licensed mental health care provider who has treated children or adolescents with psychosis
Senate minority leader (1)	A licensed mental health care provider who has treated adults with psychosis

Under the bill, legislative appointees may be legislators. Initial appointments must be made within 30 days after the bill's passage. Appointing authorities fill any vacancy.

The House speaker and Senate president pro tempore select the task force chairpersons from among its members. The chairpersons must schedule the first meeting, to be held within 60 days after the bill's passage.

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

Reporting Requirement

The bill requires the task force to report its findings and recommendations to the Public Health Committee by January 1, 2024. The task force terminates when it submits the report or on January 1, 2024, whichever is later.

Background — Related Bill

sSB 919 (File 65), reported favorably by the Public Health Committee, contains identical provisions on a psychosis task force.

§§ 29-34 — EVALUATIONS AND REPORTS RELATED TO PARENTING AND SUBSTANCE USE DISORDER

Requires DMHAS, DCF, and certain other state agencies to evaluate or report on various supports and related issues for parents, other child caregivers, or pregnant individuals with substance use disorder

The bill requires various state agencies to evaluate or report on supports, programs, and related issues for parents, other child caregivers, or pregnant individuals with substance use disorder.

EFFECTIVE DATE: Upon passage

Child Caregiver Substance Use Disorder Program Plan (§ 29)

The bill requires DMHAS, DCF, and DSS to evaluate substance use disorder programs for people who are child caregivers and related treatment barriers. In doing the evaluation, the departments must consult with direct service providers and people with lived experience.

In consultation with these providers and people, the departments must also make a plan to establish and implement programs to treat these child caregivers and their children, that include the following:

1. in all geographic areas, same-day access to family-centered medication-assisted treatment, including prenatal and perinatal care, and access to supports that provide a bridge to the treatment;
2. intensive in-home treatment supports;
3. gender-specific programming;
4. expanded access to residential programs for pregnant and parenting people, including residential programs for parents who have more than one child or who have children over age seven; and
5. access to recovery support specialists and peer support to provide care coordination.

The bill requires the commissioners, by January 1, 2024, to jointly report to the Children's, Human Services, and Public Health committees on the plan and legislative recommendations needed to implement the programs.

Child Care Supports and Subsidies Plan (§ 30)

The bill requires DMHAS and DSS to collaborate with the Office of Early Childhood and create a plan to allow parents in substance use disorder treatment to qualify for child care supports and subsidies. The DMHAS and DSS commissioners must jointly report on the plan to the Human Services and Public Health committees by January 1, 2024.

Supportive Housing Access (§ 31)

The bill requires the DMHAS commissioner to report to the Housing, Human Services, and Public Health committees by January 1, 2024, on access in the state to supportive housing for pregnant and parenting people with a substance use disorder.

Substance Use Disorder Treatment for Parents Involved with DCF (§ 32)

The bill requires the DCF, DMHAS, and DSS commissioners to jointly report on access for parents involved with DCF, when applicable, to appropriate substance use disorder treatment in the state, to (1) prevent children's removal from their parents, when possible, and (2) support reunification when removal is necessary. The report must consider in-home parenting and child care services to help with safety planning during initial stages of treatment and recovery.

The commissioners must report to the Children's, Human Services, and Public Health committees by January 1, 2024.

Services For Pregnant and Parenting Individuals (§ 33)

The bill requires the DCF, DMHAS, and DSS commissioners to jointly report on existing substance use disorder treatment services for pregnant and parenting people, their use, and any areas where more services are necessary. The commissioners must report to the Public Health Committee by January 1, 2024.

Mitigating Safety Concerns for Children Whose Caregivers Have Substance Use Disorder (§ 34)

The bill requires the DCF commissioner, by January 1, 2024, to report to the Children's and Public Health committees on DCF's efforts to mitigate child safety concerns in the home when the child's caregiver has a substance use disorder.

Background — Related Bill

sHB 6913 (File 595, §§ 5-10), reported favorably by the Public Health Committee, contains similar provisions requiring plans or evaluations related to supports for parents, other child caregivers, or pregnant individuals with substance use disorder.

§ 35 — OPIOID SETTLEMENT FUND ADVISORY COMMITTEE

Adds eight members to the Opioid Settlement Fund Advisory Committee

The bill increases, from 37 to 45, the membership of the Opioid Settlement Fund Advisory Committee. It does so by (1) increasing the number of governor-appointed municipal representatives from 17 to 21; (2) adding two members with experience supporting infants and children affected by the opioid crisis, appointed by the DMHAS commissioner; and (3) adding the Public Health Committee chairpersons or their designees (the designees must have experience living with a substance use disorder or have a family member with such a disorder).

By law, the committee ensures (1) Opioid Settlement Fund moneys are allocated and spent on specified substance use disorder abatement purposes and (2) robust public involvement, accountability, and transparency in allocating and accounting for the fund's moneys.

EFFECTIVE DATE: July 1, 2023

Background — Related Bill

sHB 6913 (File 595, § 11), reported favorably by the Public Health Committee, adds to the committee two members with experience supporting infants and children affected by the opioid crisis.

§ 36 — EMS DATA COLLECTION AND REPORTING

Requires EMS organizations, in their quarterly data reporting, to include the reasons for 9-1-1 calls; requires the DPH commissioner to annually submit EMS data to the Public Health Committee and expands the reporting requirements to include data on EMS personnel shortages

Current law requires EMS organizations to report to DPH quarterly on specified EMS call data, including the number of 9-1-1 calls received. The bill requires organizations to also report the reasons for the calls. Under existing law, unchanged by the bill, EMS organizations must also report the (1) level of EMS required for each call; (2) response time; (3) number of passed, cancelled, and mutual aid calls made and received; and (4) prehospital data for unscheduled patient transport.

By law, DPH must annually report on the data it collects to the EMS

Advisory Board. The bill adds data on any EMS personnel shortages in the state to this reporting requirement. Starting by June 1, 2024, the bill requires the commissioner to annually submit the report to the Public Health Committee, as well.

EFFECTIVE DATE: October 1, 2023

Background — Related Bill

HB 1229 (File 573), reported favorably by the Public Health Committee, has similar provisions on EMS data collection and reporting.

§ 37 — RURAL HEALTH TASK FORCE

Creates a task force to study issues concerning rural health

The bill creates a task force to study issues concerning rural health. The study must examine (1) resources and services available to promote rural health and support health care providers in rural areas throughout the state and (2) ways to coordinate and streamline these resources and services.

EFFECTIVE DATE: Upon passage

Membership and Administration

Under the bill, the task force includes the DPH and DMHAS commissioners, attorney general, state comptroller, and Office of Health Strategy executive director or their designees and 10 appointed members, one each appointed by the six legislative leaders and the Public Health Committee chairpersons and ranking members.

Under the bill, legislative appointees may be legislators. Initial appointments must be made within 30 days after the bill's passage. Appointing authorities fill any vacancy.

The House speaker and Senate president pro tempore select the task force chairpersons from among its members. The chairpersons must schedule the first meeting, to be held within 60 days after the bill's passage.

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

Reporting Requirement

The bill requires the task force to report its findings and recommendations to the Public Health Committee by January 1, 2024. The task force terminates when it submits the report or on January 1, 2024, whichever is later.

Background — Related Bill

sSB 1210 (File 524), reported favorably by the Public Health Committee, has similar provisions on a rural health task force.

§ 38 — HEALTH CARE MAGNET SCHOOL STUDY

Requires the education commissioner, in consultation with the labor and DPH commissioners, to study the feasibility of establishing an interdistrict magnet school program focused on training students for health care professions

The bill requires the education commissioner, in consultation with the labor and DPH commissioners, to study the feasibility of creating an interdistrict magnet school program to educate and train students interested in health care professions. This must include pathways for students to (1) graduate with a certification, license, or registration allowing them to practice in a health care field and (2) complete a curriculum designed to prepare them for pre-medicine or nursing higher education programs.

By February 1, 2024, the education commissioner must report on the study to the Public Health Committee.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 1228 (File 524, § 1), reported favorably by the Public Health Committee, has identical provisions on an interdistrict magnet school program.

§ 39 — DELETED BY SENATE AMENDMENT "C"

§ 40 — COMMUNICATION ACCESS STUDY

Requires the aging and disability services commissioner, in consultation with the Advisory Board for Persons Who are Deaf, Hard of Hearing or Deafblind, to evaluate gaps in these individuals' access to communication with medical providers

The bill requires the aging and disability services commissioner, in consultation with the Advisory Board for Persons Who are Deaf, Hard of Hearing or Deafblind, to (1) conduct a study evaluating gaps in these individuals' access to communication with medical providers and (2) develop recommendations to improve this access, including interpreting through American Sign Language or Spanish Sign Language as applicable. By October 1, 2023, the commissioner must report on the study to the Aging, Human Services, and Public Health committees.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 1228 (File 471, § 6), reported favorably by the Public Health Committee, has similar provisions on a communication access study.

§§ 41 & 42 — DENTAL ASSISTANTS

Provides an alternate way for dental assistants to qualify to take dental x-rays, by passing a competency assessment rather than a national exam, and requires UConn's School of Dental Medicine to develop the assessment by January 1, 2025

Existing law allows dentists to delegate certain procedures to dental assistants if they are performed under the dentist's direct supervision. Under current law, these include dental x-rays, but only if the assistant has passed the Dental Assisting National Board's dental radiation health and safety exam.

The bill allows dentists to also delegate these procedures to dental assistants who have passed a radiation health and safety competency assessment. That assessment must be administered by an in-state dental education program accredited by the American Dental Association's Commission on Dental Accreditation.

By January 1, 2025, the bill requires UConn's School of Dental Medicine to (1) develop this competency assessment, reflecting current industry practices on dental x-rays, and (2) report on its development to the Public Health Committee.

EFFECTIVE DATE: Upon passage, except October 1, 2023, for the provision on dental assistants' eligibility to take dental x-rays after passing the assessment.

Background — Related Bill

sSB 1228 (File 471, §§ 7 & 8), reported favorably by the Public Health Committee, has identical provisions on dental assistants and the UConn-developed assessment.

§ 43 — EPINEPHRINE ADMINISTRATION BY EMS PERSONNEL

Requires EMS personnel, under specified conditions, to administer epinephrine using automatic prefilled cartridge injectors, similar automatic injectable equipment, or prefilled vials and syringes

The bill requires EMS personnel to administer epinephrine using automatic prefilled cartridge injectors, similar automatic injectable equipment, or prefilled vials and syringes when the following conditions are met:

1. the EMS professional has been trained to do so in accordance with DPH-recognized national standards;

2. the medication is administered according to written protocols and standing orders of a licensed physician serving as an emergency department director; and

3. the EMS professional determines administering epinephrine is necessary to treat the person.

Current law allows, but does not require, EMTs and paramedics to do this using automatic prefilled cartridge injectors or similar equipment.

The bill requires all EMS personnel to receive this training from a DPH-designated organization; current law requires EMTs and paramedics to receive this training.

Current law requires licensed or certified ambulances to have epinephrine in injectors or equipment for administration. The bill requires them to have epinephrine in injectors, similar equipment, or

prefilled vials and syringes for this purpose.

Under the bill, "EMS personnel" include EMTs, advanced EMTs, paramedics, and emergency medical responders.

EFFECTIVE DATE: October 1, 2023

Background — Related Bill

SB 1073 (File 558, § 1), reported favorably by the Public Health Committee, has similar provisions on the administration of epinephrine by EMS personnel.

§ 44 — MEDICAL RECORDS REQUESTS

Generally sets deadlines for licensed health care institutions to send electronic copies of patient medical records to another institution upon request

The bill sets deadlines for licensed health care institutions to transfer an electronic copy of a patient's medical records to another institution upon receiving a medical records request directed by the patient or patient's representative. Under the bill, the transfer must occur (1) as soon as feasible, but no later than six days, for urgent requests, or (2) within seven business days, for non-urgent requests. The bill specifies that the institution is not required to get specific written consent from the patient before sending the electronic copy.

The bill exempts from these requirements (1) DMHAS-operated facilities and (2) the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center.

The bill also specifies that these provisions do not require institutions to transfer records in the following circumstances:

1. if doing so would violate the federal Health Insurance Portability and Accountability Act (HIPAA) or related regulations, which set limits and rules regarding the disclosure of protected health information;

2. in response to a direct request from another provider, unless the provider can validate that he or she has a health provider relationship with the patient; or

3. in response to a third-party request.

EFFECTIVE DATE: January 1, 2024

Background — Related Bill

sSB 958 (File 120), reported favorably by the Public Health Committee, sets deadlines for licensed health care institutions to transfer patient medical records to another institution upon receiving a patient-approved request, requiring the transfer to occur (1) immediately, for urgent requests, or (2) within two business days, for non-urgent requests.

§ 45 — PRACTITIONER SHORTAGE TASK FORCE

Creates a task force to study how to address the state's shortage of radiologic technologists, nuclear medicine technologists, and respiratory care practitioners

The bill creates a task force to study ways to address the state's shortage of radiologic technologists, nuclear medicine technologists, and respiratory care practitioners and make a plan to address this shortage.

EFFECTIVE DATE: Upon passage

Membership and Administration

Under the bill, the task force includes the Public Health Committee chairpersons and ranking members or their designees, and six appointed members as shown below.

Table: Task Force Appointed Members

Appointing Authority	*Appointee Qualifications*
House speaker	Representative of a statewide association of radiologic technologists, with expertise in that profession
Senate president pro tempore	Representative of a statewide association of nuclear medicine technologists, with expertise in that profession
House majority leader	Representative of a statewide association of respiratory care practitioners, with expertise in that profession
Senate majority leader	Representative of an association of hospitals in the

	state
House minority leader	Representative of a radiologists' society in the state
Senate minority leader	Representative of a medical society in the state, with expertise in pulmonary issues

Under the bill, any members may be legislators. Initial appointments must be made within 30 days after the bill's passage. Appointing authorities fill any vacancy.

The House speaker and Senate president pro tempore select the task force chairpersons from among its members. The chairpersons must schedule the first meeting, to be held within 60 days after the bill's passage.

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

Reporting Requirement

The bill requires the task force to report its findings and recommendations to the Public Health Committee by January 1, 2024. The task force terminates when it submits the report or on January 1, 2024, whichever is later.

§§ 46 & 47 — BACKGROUND CHECKS FOR PHYSICIAN AND PSYCHOLOGIST LICENSURE APPLICANTS

Requires psychologist licensure applicants, and physician applicants who wish to participate in interstate compacts, to submit to a state and national fingerprint-based criminal history records check by DESPP

The bill requires applicants for licensure as a (1) psychologist, or (2) physician who intends to apply for a license in another state within one year after applying for licensure, to submit to a state and national fingerprint-based criminal history records check by DESPP. It requires the DESPP commissioner to report the results of the physicians' records checks to the DPH commissioner (it does not require him to do this for psychologists).

In doing this, the bill allows physicians and psychologists to participate in the Interstate Medical Licensure Compact and the

Psychology Interjurisdictional Compact, respectively, which Connecticut joined under PA 22-81 (see *Background*). These compacts require providers to complete an FBI fingerprint background check as a condition of participation.

EFFECTIVE DATE: July 1, 2023

Background — Interstate Compacts

The Interstate Medical Licensure Compact provides an expedited licensure process for physicians seeking to practice in multiple states. The Psychology Interjurisdictional Compact provides a process authorizing psychologists to practice by telehealth (unlimited) and temporary in-person, face-to-face services (30 days per year per state) across state boundaries, without having to be licensed in each of the states.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 27 Nay 10 (03/27/2023)

Appropriations Committee

Joint Favorable
Yea 41 Nay 12 (05/08/2023)