General Assembly

Committee Bill No. 1

February Session, 2024

LCO No. **2860**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2024*) Each home health care
2 agency and home health aide agency, as such terms are defined in
3 section 19a-490 of the general statutes, shall, during intake of a
4 prospective client, collect and provide to any employee assigned to
5 provide services to such client, information regarding:

6 (1) The client, including, if applicable, the client's (A) psychiatric
7 history, (B) history of violence, (C) history of substance use, (D) history
8 of domestic abuse, (E) current infections, if any, and the treatment the
9 client has received for such infections, and (F) whether the client's
10 diagnoses or symptoms have remained stable over time;

11 (2) Other persons present or anticipated to be present at the location
12 where the employee will provide services, including, if known to the
13 agency, each person's (A) name and relationship to the client, (B)
14 psychiatric history, (C) history of violence or domestic abuse, (D)
15 criminal record, and (E) history of substance use; and

16 (3) The location where the employee will provide services, including,
17 if known to the agency, the (A) crime rate for the municipality in which
18 the employee will provide services, as determined by the most recent
19 Crime in Connecticut annual report issued by the Department of
20 Emergency Services and Public Protection, (B) presence of any
21 hazardous materials at the location, including, but not limited to, used
22 syringes, (C) presence of firearms or other weapons at the location, (D)
23 status of the location's fire alarm system, and (E) presence of any other
24 safety hazards at the location, including, but not limited to, electrical
25 hazards.

26 Sec. 2. (NEW) (*Effective October 1, 2024*) Each home health care agency
27 and home health aide agency, as such terms are defined in section 19a-
28 490 of the general statutes, shall (1) provide staff training consistent with
29 the health and safety training curriculum for home care workers
30 endorsed by the Centers for Disease Control and Prevention's National
31 Institute for Occupational Safety and Health and the Occupational
32 Safety and Health Administration, including, but not limited to, training
33 to recognize hazards commonly encountered in home care workplaces
34 and applying practical solutions to manage risks and improve safety; (2)
35 conduct monthly safety assessments with each staff member; and (3)
36 provide staff with a mechanism to perform safety checks, which may
37 include, but need not be limited to, (A) a mobile application that allows
38 staff to access safety information relating to a client, including
39 information collected pursuant to section 1 of this act, and a method of
40 communicating with local police or other staff in the event of a safety
41 emergency, and (B) a global positioning system-enabled, wearable
42 device that allows staff to contact local police by pressing a button or
43 through another mechanism.

44 Sec. 3. (NEW) (*Effective October 1, 2024*) (a) Each home health care
45 agency and home health aide agency, as such terms are defined in
46 section 19a-490 of the general statutes, and each staff member of any
47 such agency shall report each instance of verbal abuse that is perceived
48 as a threat or danger to the staff member, physical abuse, sexual abuse

49 or any other abuse by an agency client against a staff member in a form
50 and manner prescribed by the Commissioner of Public Health.

51 (b) Not later than January 1, 2025, and annually thereafter, the
52 commissioner shall report, in accordance with the provisions of section
53 11-4a of the general statutes, to the joint standing committee of the
54 General Assembly having cognizance of matters relating to public
55 health regarding the number of reports received pursuant to subsection
56 (a) of this section and the actions taken to ensure the safety of the staff
57 member about whom the report was made.

58 Sec. 4. Subsection (a) of section 17b-242 of the 2024 supplement to the
59 general statutes is repealed and the following is substituted in lieu
60 thereof (*Effective from passage*):

61 (a) The Department of Social Services shall determine the rates to be
62 paid to home health care agencies and home health aide agencies by the
63 state or any town in the state for persons aided or cared for by the state
64 or any such town. The Commissioner of Social Services shall establish a
65 fee schedule for home health services to be effective on and after July 1,
66 1994. The commissioner may annually modify such fee schedule if such
67 modification is needed to ensure that the conversion to an
68 administrative services organization is cost neutral to home health care
69 agencies and home health aide agencies in the aggregate and ensures
70 patient access. Utilization may be a factor in determining cost neutrality.
71 The commissioner shall increase the fee schedule for home health
72 services provided under the Connecticut home-care program for the
73 elderly established under section 17b-342, effective July 1, 2000, by two
74 per cent over the fee schedule for home health services for the previous
75 year. On and after January 1, 2024, the commissioner shall increase the
76 fee schedule for complex care nursing services provided to individuals
77 over the age of eighteen such that the rate of reimbursement is equal to
78 the rate for such services provided to individuals age eighteen and
79 under. There shall be no differential in fees paid for such services based
80 on the age of the patient. The commissioner may increase any fee

payable to a home health care agency or home health aide agency upon the application of such an agency evidencing extraordinary costs related to (1) serving persons with AIDS; (2) high-risk maternal and child health care; or (3) **[**escort services; or (4)**]** extended hour services. On and after July 1, 2024, the commissioner shall increase the fee payable to a home health care agency or home health aide agency that provides escorts for safety purposes to staff conducting a home visit. In no case shall any rate or fee exceed the charge to the general public for similar services. A home health care agency or home health aide agency which, due to any material change in circumstances, is aggrieved by a rate determined pursuant to this subsection may, within ten days of receipt of written notice of such rate from the Commissioner of Social Services, request in writing a hearing on all items of aggrievement. The commissioner shall, upon the receipt of all documentation necessary to evaluate the request, determine whether there has been such a change in circumstances and shall conduct a hearing if appropriate. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. The commissioner may implement policies and procedures to carry out the provisions of this subsection while in the process of adopting regulations, provided notice of intent to adopt the regulations is posted on the eRegulations System not later than twenty days after the date of implementing the policies and procedures. Such policies and procedures shall be valid for not longer than nine months. For purposes of this subsection, "complex care nursing services" means intensive, specialized nursing services provided to a patient with complex care needs who requires skilled nursing care at home.

Sec. 5. (NEW) (*Effective January 1, 2025*) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state, shall provide coverage for escorts for the safety of home health care agency or home health aide agency staff, as deemed necessary by such staff or agency.

115 Sec. 6. (NEW) (*Effective January 1, 2025*) Each group health insurance
116 policy providing coverage of the type specified in subdivisions (1), (2),
117 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
118 issued for delivery, renewed, amended or continued in this state, shall
119 provide coverage for escorts for the safety of home health care agency
120 or home health aide agency staff, as deemed necessary by such staff or
121 agency.

122 Sec. 7. (*Effective July 1, 2024*) On or before October 1, 2024, the
123 Commissioner of Public Health shall establish and administer a home
124 care staff safety grant program. Such program shall provide grants to
125 home health care and home health aide agencies for the purposes of
126 purchasing staff safety technology, which may include, but need not be
127 limited to, (1) a mobile application that allows staff to access safety
128 information relating to a client, including information collected
129 pursuant to section 1 of this act, and a method of communicating with
130 either local police or other staff in the event of a safety emergency, and
131 (2) a global positioning system-enabled, wearable device that allows
132 staff to contact local police by pressing a button or through another
133 mechanism. The commissioner shall establish eligibility requirements,
134 priority categories, funding limitations and the application process for
135 the grant program. Not later than January 1, 2025, and annually
136 thereafter, the commissioner shall report, in accordance with the
137 provisions of section 11-4a of the general statutes, to the joint standing
138 committee of the General Assembly having cognizance of matters
139 relating to public health regarding the grant program.

140 Sec. 8. (*Effective from passage*) (a) The chairpersons of the joint standing
141 committee of the General Assembly having cognizance of matters
142 relating to public health shall convene a working group to study staff
143 safety issues affecting home health care and home health aide agencies,
144 as such terms are defined in section 19a-490 of the general statutes.

145 (b) The working group shall include, but need not be limited to, the
146 following members:

147 (1) Three employees of a home health care or home health aide
148 agency;

149 (2) Two representatives of a home health care or home health aide
150 agency;

151 (3) One representative of a collective bargaining unit representing
152 home health care or home health aide agency employees;

153 (4) One representative of a mobile crisis response services provider;

154 (5) One representative of an assertive community treatment team;

155 (6) One representative of a police department; and

156 (7) One representative of an association of hospitals in the state.

157 (c) The chairpersons of the joint standing committee of the General
158 Assembly having cognizance of matters relating to public health shall
159 schedule the first meeting of the working group, which shall be held not
160 later than sixty days after the effective date of this section.

161 (d) The members of the working group shall select two
162 cochairpersons from among the members of the working group.

163 (e) The administrative staff of the joint standing committee of the
164 General Assembly having cognizance of matters relating to public
165 health shall serve as administrative staff of the working group.

166 (f) Not later than January 1, 2025, the working group shall submit a
167 report on its findings and recommendations to the joint standing
168 committee of the General Assembly having cognizance of matters
169 relating to public health, in accordance with the provisions of section 11-
170 4a of the general statutes. The working group shall terminate on the date
171 that it submits such report or January 1, 2025, whichever is later.

172 Sec. 9. (*Effective July 1, 2024*) The sum of one million dollars is
173 appropriated to the Department of Public Health from the General

174 Fund, for the fiscal year ending June 30, 2025, for the purposes of
175 establishing and administering the home care staff safety grant program
176 established pursuant to section 7 of this act.

177 Sec. 10. (NEW) (*Effective January 1, 2025*) (a) As used in this section
178 and sections 11 to 18, inclusive, of this act:

179 (1) "Graduate physician" means a medical school graduate who:

180 (A) Is a resident and citizen of the United States or a resident alien in
181 the United States; and

182 (B) Has successfully completed step 1 and step 2 of the United States
183 Medical Licensing Examination, or the equivalent of step 1 and step 2 of
184 any other medical licensing examination or combination of
185 examinations that is approved by the National Board of Medical
186 Examiners or National Board of Osteopathic Medical Examiners, within
187 the two-year period immediately preceding the date of the person's
188 application for licensure as a graduate physician, but not more than
189 three years after graduation from a medical school or a school of
190 osteopathic medicine;

191 (2) "Graduate physician collaborative practice arrangement" means
192 an agreement between a physician licensed pursuant to chapter 370 of
193 the general statutes and a graduate physician who meets the
194 requirements of sections 11 to 18, inclusive, of this act;

195 (3) "Medical school graduate" means a person who has graduated
196 from a medical school accredited by the Liaison Committee on Medical
197 Education or the Commission on Osteopathic College Accreditation or
198 a medical school listed in the World Directory of Medical Schools, or its
199 equivalent; and

200 (4) "Primary care services" means medical services in pediatrics,
201 internal medicine, family medicine, obstetrics and gynecology or
202 psychiatry.

203 Sec. 11. (NEW) (*Effective January 1, 2025*) (a) A graduate physician
204 collaborative practice arrangement shall limit the graduate physician to
205 providing primary care services.

206 (b) A graduate physician shall be subject to the supervision
207 requirements established in any controlling federal law, the supervision
208 requirements adopted pursuant to sections 12 to 18, inclusive, of this act
209 and any supervision requirements established by the National Board of
210 Medical Examiners. A graduate physician shall not be subject to any
211 additional supervision requirements.

212 Sec. 12. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical
213 Examining Board, established pursuant to section 20-8a of the general
214 statutes, shall promulgate rules to:

215 (1) Establish the process for licensure of graduate physicians,
216 supervision requirements for graduate physicians and additional
217 requirements for graduate physician collaborative practice
218 arrangements;

219 (2) Set fees for licensure, including, but not limited to, a requirement
220 that the total fees collected each year shall be greater than or equal to the
221 total costs necessary to facilitate the graduate physician collaborative
222 practice arrangement each year; and

223 (3) Address any other matters necessary to protect the public and
224 take disciplinary action against participants in graduate physician
225 collaborative practice arrangements.

226 (b) A graduate physician's license issued pursuant to sections 11 to
227 18, inclusive, of this act and the rules promulgated by the Connecticut
228 Medical Examining Board concerning graduate physician collaborative
229 practice arrangements shall be valid for two years from the date of
230 issuance and are not subject to renewal. Said board may deny an
231 application for licensure as a graduate physician or suspend or revoke
232 the license of a graduate physician for violation of any provision of

233 sections 11 to 18, inclusive, of this act, as applicable, or for a violation of
234 the rules or standards of conduct established by said board.

235 (c) Any rule promulgated under the authority delegated to said
236 board under this section shall become effective upon promulgation,
237 provided such rule complies with the Uniform Administrative
238 Procedures Act, sections 4-166 to 4-189, inclusive of the general statutes.

239 Sec. 13. (NEW) (*Effective January 1, 2025*) A graduate physician shall
240 clearly identify as a graduate physician and may use the identifiers
241 "doctor" or "Dr.". A graduate physician shall not practice or attempt to
242 practice without a graduate physician collaborative practice
243 arrangement, except as otherwise provided in sections 11 to 18,
244 inclusive, of this act or permitted under rules promulgated by the
245 Connecticut Medical Examining Board pursuant to section 12 of this act.

246 Sec. 14. (NEW) (*Effective January 1, 2025*) A licensed physician
247 collaborating with a graduate physician shall be responsible for
248 supervising the activities of the graduate physician and shall accept full
249 responsibility for the primary care services provided by the graduate
250 physician.

251 Sec. 15. (NEW) (*Effective January 1, 2025*) (a) The provisions of sections
252 11 to 18, inclusive, of this act shall apply to all graduate physician
253 collaborative practice arrangements. To be eligible to practice as a
254 graduate physician, a licensed graduate physician shall enter into a
255 graduate physician collaborative practice arrangement with a licensed
256 physician not later than six months after the date on which the graduate
257 physician obtains initial licensure as a graduate physician.

258 (b) Only a physician licensed pursuant to chapter 370 of the general
259 statutes may enter into a graduate physician collaborative practice
260 arrangement with a graduate physician. A graduate physician
261 collaborative practice arrangement shall take the form of a written
262 agreement, including mutually agreed-upon protocols or standing
263 orders, for the delivery of primary care services. A graduate physician

264 collaborative practice arrangement may delegate to a graduate
265 physician the authority to administer or dispense drugs, except a
266 controlled substance, and provide treatment, provided the delivery of
267 the primary care services is within the scope of the graduate physician's
268 practice and is consistent with the graduate physician's skill, training
269 and competence and the skill, training and competence of the
270 collaborating physician. The collaborating physician shall be board
271 certified in the specialty that the graduate physician is practicing, which
272 shall only include pediatrics, internal medicine, family medicine,
273 obstetrics and gynecology or psychiatry.

274 (c) A graduate physician collaborative practice arrangement shall
275 contain the following provisions:

276 (1) The complete names, home and business addresses and
277 telephone numbers of the collaborating physician and the graduate
278 physician;

279 (2) A requirement that the graduate physician practice at the same
280 location as the collaborating physician;

281 (3) A requirement that the graduate physician or collaborating
282 physician prominently display, in every office where the graduate
283 physician is authorized to prescribe, a disclosure statement informing
284 patients that they may be seen by a graduate physician and advising
285 patients that they have the right to see the collaborating physician;

286 (4) A list of each specialty and board certification of the collaborating
287 physician and each certification of the graduate physician;

288 (5) The manner of collaboration between the collaborating physician
289 and the graduate physician, including, but not limited to, a description
290 of the manner in which the collaborating physician and the graduate
291 physician shall:

292 (A) Engage in collaborative practice consistent with each
293 professional's skill, training, education and competence; and

294 (B) Maintain geographic proximity to a hospital, provided the
295 graduate physician collaborative practice arrangement may allow for
296 geographic proximity to be waived for not more than twenty-eight days
297 per calendar year for the provision of primary care services in health
298 care services in a rural health clinic. As used in this subparagraph, "rural
299 health clinic" means (i) an independent health clinic, (ii) provider-based
300 health clinic, if the provider is a critical access hospital, as defined in 42
301 USC 1395i-4, as amended from time to time, or (iii) a provider-based
302 health clinic, if the primary location of the hospital sponsor is more than
303 twenty-five miles from the clinic, which clinic is located in a town that
304 has either seventy-five per cent or more of its population classified as
305 rural in the 1990 federal decennial census of population, or in the most
306 recent such census used by the State Office of Rural Health to determine
307 rural towns, or a town that is not designated as a metropolitan area on
308 the list maintained by the federal Office of Management and Budget,
309 used by the State Office of Rural Health to determine rural towns. The
310 collaborating physician shall maintain documentation related to the
311 geographic proximity requirement and present the documentation to
312 the Connecticut Medical Examining Board upon request;

313 (6) A requirement that the graduate physician shall not provide
314 primary care services to a patient during the absence of the collaborating
315 physician from the practice location for any reason;

316 (7) A list of all other graduate physician collaborative practice
317 arrangements of (A) the collaborating physician with another graduate
318 physician, and (B) the graduate physician with another collaborating
319 physician;

320 (8) The duration of the graduate physician collaborative practice
321 arrangement between the collaborating physician and the graduate
322 physician;

323 (9) A provision describing the time and manner of the collaborating
324 physician's review of the graduate physician's delivery of primary care
325 services and requiring the graduate physician to submit to the

326 collaborating physician every fourteen days after the initial observation
327 year a minimum of twenty-five per cent of the charts documenting the
328 graduate physician's delivery of primary care services for review by the
329 collaborating physician or by any other physician designated in the
330 graduate physician collaborative practice arrangement. For the first
331 three months of the initial observation year, the collaborating physician
332 shall review one hundred per cent of the charts documenting the
333 graduate physician's delivery of primary care services. For months four
334 to twelve, inclusive, of the initial observation year, the collaborating
335 physician shall review seventy-five per cent of the charts documenting
336 the graduate physician's delivery of primary care services; and

337 (10) A requirement that a collaborating physician be on premises if
338 the graduate physician performs primary care services in a hospital or
339 emergency department.

340 Sec. 16. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical
341 Examining Board shall promulgate rules regulating the use of graduate
342 physician collaborative practice arrangements for graduate physicians.
343 The rules shall:

344 (1) Specify the geographic areas to be covered by graduate physician
345 collaborative practice arrangements;

346 (2) Specify the methods of treatment that may be covered by
347 graduate physician collaborative practice arrangements;

348 (3) Specify, in consultation with the deans of medical schools and
349 primary care residency program directors in the state, the educational
350 methods and programs to be performed during graduate physician
351 collaborative practice service arrangements, which methods and
352 programs shall facilitate the advancement of the graduate physician's
353 medical knowledge and capabilities and the successful completion of
354 which may lead to credit toward a future residency program that deems
355 acceptable the documented educational achievements of the graduate
356 physician through such methods and programs; and

357 (4) Require a review of the primary care services provided under a
358 graduate physician collaborative practice arrangement.

359 (b) A collaborating physician shall not enter into a graduate
360 physician collaborative practice arrangement with more than three
361 graduate physicians at the same time.

362 Sec. 17. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical
363 Examining Board shall promulgate rules applicable to graduate
364 physicians that are consistent with the guidelines established for
365 federally qualified health centers. The rulemaking authority granted to
366 said board under this subsection shall not extend to any graduate
367 physician collaborative practice arrangement governing a hospital
368 employee providing inpatient care within a hospital.

369 (b) The board shall not deny, revoke, suspend or otherwise take
370 disciplinary action against a collaborating physician for primary care
371 services delegated to a graduate physician, provided the provisions of
372 this section and any applicable rule promulgated by said board are
373 satisfied.

374 (c) Not later than thirty days after any licensure change of a
375 physician, the board shall require the physician to identify whether the
376 physician is engaged in a graduate physician collaborative practice
377 arrangement, and to report to the board the name of each graduate
378 physician with whom the physician has entered into such an
379 arrangement. The board may make the information regarding such
380 arrangement available to the public. The board shall track the reported
381 information and may routinely conduct reviews or inspections to ensure
382 that the arrangements are being carried out in compliance with this
383 chapter.

384 (d) No contract or other agreement shall require a physician to act as
385 a collaborating physician for a graduate physician against the
386 physician's will. A physician may refuse to act as a collaborating
387 physician, without penalty, for a particular graduate physician. No

388 contract or other agreement shall limit the collaborating physician's
389 authority over any protocols or standing orders or delegate the
390 physician's authority to a graduate physician. Nothing in this subsection
391 shall be construed to authorize a physician, in implementing protocols,
392 standing orders or delegation to violate any standards for safe medical
393 practice established by a hospital's medical staff.

394 (e) No contract or other agreement shall require a graduate physician
395 to serve as a graduate physician for any collaborating physician against
396 the graduate physician's will. A graduate physician may refuse to
397 collaborate, without penalty, with a particular physician.

398 (f) Each collaborating physician and graduate physician that is party
399 to a graduate physician collaborative practice arrangement shall wear
400 an identification badge while acting within the scope of the
401 arrangement. The identification badge shall prominently display the
402 licensure status of the collaborating physician and the graduate
403 physician.

404 Sec. 18. (NEW) (*Effective January 1, 2025*) (a) A collaborating physician
405 shall complete a certification course approved by the Connecticut
406 Medical Examining Board that shall include material on the laws
407 pertaining to the professional relationship of a collaborating physician
408 with a graduate physician.

409 (b) A graduate physician collaborative practice arrangement shall
410 supersede any hospital licensing regulation concerning hospital
411 medication orders under a protocol or standing order for the purpose of
412 delivering inpatient or emergency care within a hospital if the protocol
413 or standing order has been approved by the hospital's medical staff and
414 pharmaceutical therapeutics committee.

415 Sec. 19. (NEW) (*Effective July 1, 2024*) On or before January 1, 2025, the
416 Commissioner of Public Health, in consultation with the Commission
417 on Community Gun Violence Intervention and Prevention, established
418 pursuant to section 19a-112j of the general statutes, and the Connecticut

419 chapters of a national professional association of physicians, a national
420 professional association of advanced practice registered nurses and a
421 national professional association of physician assistants, shall develop
422 or procure educational material concerning gun safety practices to be
423 provided by primary care providers to patients who are eighteen years
424 of age or older during the patient's appointment with such patient's
425 primary care provider. On or before February 1, 2025, the Department
426 of Public Health shall make the educational material available to all
427 primary care providers of persons eighteen years of age or older in the
428 state, at no cost to the provider, and make recommendations to such
429 primary care providers for the effective use of such educational
430 material. Such primary care providers shall provide such educational
431 material to each patient who is eighteen years of age or older on an
432 annual basis.

433 Sec. 20. (*Effective from passage*) (a) The cochairpersons of the joint
434 standing committee of the General Assembly having cognizance of
435 matters relating to public health shall establish a working group to
436 study nonalcoholic fatty liver disease, including nonalcoholic fatty liver
437 and nonalcoholic steatohepatitis. Such study shall include, but need not
438 be limited to, an examination of the following:

439 (1) The incidences of such disease in the state compared to incidences
440 of such disease throughout the United States;

441 (2) The population groups most affected by and at risk of being
442 diagnosed with such disease and the main risk factors contributing to
443 its prevalence in such groups;

444 (3) Strategies for preventing such disease in high-risk populations
445 and how such strategies can be implemented state-wide;

446 (4) Methods of increasing public awareness of such disease,
447 including, but not limited to, public awareness campaigns educating the
448 public regarding liver health;

449 (5) Whether implementation of a state-wide screening program for
450 such disease in at-risk populations is recommended;

451 (6) Policy changes necessary to improve care and outcomes for
452 patients with such disease;

453 (7) Insurance coverage and affordability issues that affect access to
454 treatments for such disease;

455 (8) The creation of patient advocacy and support networks to assist
456 persons living with such disease; and

457 (9) The manner in which social determinants of health influence the
458 risk and outcomes of such disease and interventions needed to address
459 such determinants.

460 (b) The working group shall include, but need not be limited to, the
461 following members:

462 (1) A physician with expertise in hepatology and gastroenterology
463 representing an institution of higher education in the state;

464 (2) Three persons in the state living with nonalcoholic fatty liver
465 disease;

466 (3) A representative of a patient advocacy organization in the state;

467 (4) A social worker with experience working with communities in
468 underserved areas in the state and addressing social determinants of
469 health;

470 (5) An expert in health care policy in the state with experience in
471 advising on regulatory frameworks, health care access and insurance
472 issues;

473 (6) A nutritionist and dietician in the state with experience in
474 providing guidance on preventative measures and dietary interventions
475 related to nonalcoholic fatty liver disease;

476 (7) A community health worker who works directly with
477 underserved communities in the state in addressing social determinants
478 of health;

479 (8) A representative of a nonprofit organization in the state focused
480 on liver health; and

481 (9) The Commissioner of Public Health, or the commissioner's
482 designee.

483 (c) The cochairpersons of the joint standing committee of the General
484 Assembly having cognizance of matters relating to public health shall
485 convene the first meeting of the working group, which shall be held not
486 later than sixty days after the effective date of this section.

487 (d) The members of the working group shall select two
488 cochairpersons from among the members of the working group.

489 (e) The administrative staff of the joint standing committee of the
490 General Assembly having cognizance of matters relating to public
491 health shall serve as administrative staff of the working group.

492 (f) Not later than January 1, 2025, the working group shall submit a
493 report on its findings and recommendations to the joint standing
494 committee of the General Assembly having cognizance of matters
495 relating to public health, in accordance with the provisions of section 11-
496 4a of the general statutes. The working group shall terminate on the date
497 that it submits such report or January 1, 2025, whichever is later.

498 Sec. 21. (*Effective from passage*) (a) The cochairpersons of the joint
499 standing committee of the General Assembly having cognizance of
500 matters relating to public health shall convene a working group to study
501 health issues experienced by nail salon workers as a result of such
502 workers' exposure to health hazards in a nail salon. Such study shall
503 include, but need not be limited to, (1) an identification of health
504 hazards in a nail salon, (2) mechanisms to reduce nail salon workers'
505 exposure to such health hazards, (3) best practices for preventing nail

506 salon workers from acquiring health issues from exposure to health
507 hazards in a nail salon, and (4) assessing the strengths of policies
508 protecting nail salon workers' health that have been implemented in
509 other states.

510 (b) The working group shall include, but need not be limited to, the
511 following members:

512 (1) Three nail technicians, each employed by a different nail salon in
513 the state;

514 (2) Three owners or managers of three different nail salons in the
515 state;

516 (3) A health care professional licensed in the state with experience
517 treating patients experiencing symptoms of an illness attributable to
518 such patients' exposure to health hazards while working in a nail salon;

519 (4) A representative of a labor union in the state;

520 (5) An expert in occupational safety;

521 (6) An expert in environmental health;

522 (7) A director of a municipal health department in the state with more
523 than three nail salons in the department's jurisdiction; and

524 (8) The Commissioner of Public Health, or the commissioner's
525 designee.

526 (c) The cochairpersons of the joint standing committee of the General
527 Assembly having cognizance of matters relating to public health shall
528 convene the first meeting of the working group, which shall occur not
529 later than sixty days after the effective date of this section.

530 (d) The members of the working group shall select two
531 cochairpersons from among the members of the working group.

532 (e) The administrative staff of the joint standing committee of the
533 General Assembly having cognizance of matters relating to public
534 health shall serve as administrative staff of the working group.

535 (f) Not later than January 1, 2025, the working group shall submit a
536 report on its findings and recommendations to the joint standing
537 committee of the General Assembly having cognizance of matters
538 relating to public health, in accordance with the provisions of section 11-
539 4a of the general statutes. The working group shall terminate on the date
540 that it submits such report or January 1, 2025, whichever is later.

541 Sec. 22. (*Effective from passage*) The Commissioner of Public Health, in
542 collaboration with the Commissioner of Consumer Protection, shall
543 study incidences of prescription drug shortages in the state and whether
544 the state has a role in alleviating such shortages. Not later than January
545 1, 2025, the Commissioners of Public Health and Consumer Protection
546 shall jointly report, in accordance with the provisions of section 11-4a of
547 the general statutes, to the joint standing committees of the General
548 Assembly having cognizance of matters relating to public health and
549 consumer protection regarding such study and any recommendations
550 for legislation that would help alleviate or prevent such shortages.

551 Sec. 23. (NEW) (*Effective July 1, 2024*) (a) For the purposes of this
552 section, "safety plan" means any plan established by the Department of
553 Children and Families to address or mitigate behaviors of a parent or
554 guardian or conditions or circumstances in a home that may render such
555 home unsafe for a child, by (1) identifying actions that have been or will
556 be taken to address or mitigate such behaviors, conditions or
557 circumstances, and (2) specifying the individuals or providers
558 responsible for taking such actions, and timeframes for review of such
559 actions by the department.

560 (b) When the Commissioner of Children and Families, or the
561 commissioner's designee, conducts a visit to, or evaluation of, a home
562 pursuant to a safety plan, such visit or evaluation shall be conducted in
563 person if such safety plan indicates that a parent or guardian in such

564 home has a substance use disorder, as defined in section 20-74s of the
565 general statutes.

566 Sec. 24. Section 19a-490ff of the 2024 supplement to the general
567 statutes is repealed and the following is substituted in lieu thereof
568 (*Effective from passage*):

569 (a) As used in this section, (1) "board eligible" means eligible to take
570 a qualifying examination administered by a medical specialty board
571 after having graduated from a medical school, completed a residency
572 program and trained under supervision in a specialty fellowship
573 program, (2) "board certified" means having passed the qualifying
574 examination administered by a medical specialty board to become
575 board certified in a particular specialty, and (3) "board recertification"
576 means recertification in a particular specialty after a predetermined time
577 period prescribed by a medical specialty board, including, but not
578 limited to, through participation in any required maintenance of
579 certification program, after having passed the qualifying examination
580 administered by the medical specialty board to become board certified
581 in a particular specialty.

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

590 Sec. 25. (NEW) (*Effective January 1, 2025*) (a) For purposes of this
591 section:

592 (1) "Health care provider" has the same meaning as provided in
593 section 38a-477aa of the general statutes;

594 (2) "Maintenance of certification" means any process requiring
595 periodic recertification examinations or other professional development
596 activities to maintain specialty certification;

597 (3) "Professional liability insurance" has the same meaning as
598 provided in section 38a-393 of the general statutes; and

599 (4) "Specialty certification" means any certification by a medical
600 board that specializes in one area of medicine and has requirements in
601 addition to licensing requirements in this state.

602 (b) No insurer, health care center, hospital service corporation,
603 medical service corporation, fraternal benefit society or other entity that
604 delivers, issues for delivery, renews, amends or continues an individual
605 or group health insurance policy providing coverage of the type
606 specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of
607 the general statutes in this state on or after January 1, 2025, shall (1) deny
608 reimbursement to such health care provider, or prevent any health care
609 provider from participating in any provider network based solely on
610 such health care provider's decision not to maintain a specialty
611 certification through any maintenance of certification program, or (2)
612 require any health care provider to maintain a specialty certification
613 through a maintenance of certification program as a prerequisite for
614 obtaining professional liability insurance or other indemnity against
615 liability for professional malpractice in accordance with section 20-11b
616 of the general statutes, provided that such health care provider does not
617 hold such health care provider out to be a specialist under such specialty
618 certification.

619 Sec. 26. (NEW) (*Effective October 1, 2024*) (a) As used in this section:

620 (1) "Dispense" has the same meaning as provided in section 21a-240
621 of the general statutes;

622 (2) "Opioid drug" has the same meaning as provided in section 20-
623 14o of the general statutes;

624 (3) "Personal opioid drug deactivation and disposal system" means a
625 product that is designed for personal use and enables a patient to
626 permanently deactivate and destroy an opioid drug;

627 (4) "Pharmacist" has the same meaning as provided in section 21a-240
628 of the general statutes; and

629 (5) "Pharmacy" has the same meaning as provided in section 21a-240
630 of the general statutes.

631 (b) (1) Except as provided in subdivision (2) of this subsection, each
632 pharmacist who dispenses an opioid drug to a patient in this state shall
633 provide to such patient, at the time such pharmacist dispenses such
634 drug to such patient, a personal opioid drug deactivation and disposal
635 system. No pharmacy or pharmacist shall charge any fee to, or impose
636 any cost on, any patient for a personal opioid drug deactivation and
637 disposal system that a pharmacist provides to a patient pursuant to this
638 subdivision.

639 (2) Any pharmacy or pharmacist may seek reimbursement from the
640 Opioid Settlement Advisory Committee established pursuant to section
641 17a-674d of the general statutes for documented expenses incurred by
642 such pharmacy or pharmacist in providing personal opioid drug
643 deactivation and disposal systems to patients pursuant to subdivision
644 (1) of this subsection. No such pharmacy or pharmacist shall be required
645 to bear any documented expense for providing personal opioid drug
646 deactivation and disposal systems to patients pursuant to subdivision
647 (1) of this subsection and, if there are insufficient funds in the Opioid
648 Settlement Fund established pursuant to section 17a-674c of the general
649 statutes, as amended by this act, to cover such documented expenses or
650 such funds are otherwise unavailable, no pharmacist shall be required
651 to provide a personal opioid drug deactivation and disposal system
652 pursuant to subdivision (1) of this subsection.

653 (c) The Commissioner of Consumer Protection may adopt
654 regulations, in accordance with the provisions of chapter 54 of the

655 general statutes, to implement the provisions of this section.

656 Sec. 27. Subsection (f) of section 17a-674c of the 2024 supplement to
657 the general statutes is repealed and the following is substituted in lieu
658 thereof (*Effective October 1, 2024*):

659 (f) Moneys in the fund shall be spent only for the following substance
660 use disorder abatement purposes, in accordance with the controlling
661 judgment, consent decree or settlement, as confirmed by the Attorney
662 General's review of such judgment, consent decree or settlement and
663 upon the approval of the committee and the Secretary of the Office of
664 Policy and Management:

665 (1) State-wide, regional or community substance use disorder needs
666 assessments to identify structural gaps and needs to inform
667 expenditures from the fund;

668 (2) Infrastructure required for evidence-based substance use disorder
669 prevention, treatment, recovery or harm reduction programs, services
670 and supports;

671 (3) Programs, services, supports and resources for evidence-based
672 substance use disorder prevention, treatment, recovery or harm
673 reduction;

674 (4) Evidence-informed substance use disorder prevention, treatment,
675 recovery or harm reduction pilot programs or demonstration studies
676 that are not evidence-based, but are approved by the committee as an
677 appropriate use of moneys for a limited period of time as specified by
678 the committee, provided the committee shall assess whether the
679 evidence supports funding such programs or studies or whether it
680 provides a basis for funding such programs or studies with an
681 expectation of creating an evidence base for such programs and studies;

682 (5) Evaluation of effectiveness and outcomes reporting for substance
683 use disorder abatement infrastructure, programs, services, supports and
684 resources for which moneys from the fund have been disbursed,

685 including, but not limited to, impact on access to harm reduction
686 services or treatment for substance use disorders or reduction in drug-
687 related mortality;

688 (6) One or more publicly available data interfaces managed by the
689 commissioner to aggregate, track and report data on (A) substance use
690 disorders, overdoses and drug-related harms, (B) spending
691 recommendations, plans and reports, and (C) outcomes of programs,
692 services, supports and resources for which moneys from the fund were
693 disbursed;

694 (7) Research on opioid abatement, including, but not limited to,
695 development of evidence-based treatment, barriers to treatment,
696 nonopioid treatment of chronic pain and harm reduction, supply-side
697 enforcement;

698 (8) Documented expenses incurred in administering and staffing the
699 fund and the committee, and expenses, including, but not limited to,
700 legal fees, incurred by the state or any municipality in securing
701 settlement proceeds, deposited in the fund as permitted by the
702 controlling judgment, consent decree or settlement;

703 (9) Documented expenses associated with managing, investing and
704 disbursing moneys in the fund;

705 (10) Documented expenses, including legal fees, incurred by the state
706 or any municipality in securing settlement proceeds deposited in the
707 fund to the extent such expenses are not otherwise reimbursed pursuant
708 to a fee agreement provided for by the controlling judgment, consent
709 decree or settlement; **[**and**]**

710 (11) Provision of funds to municipal police departments for the
711 purpose of equipping police officers with opioid antagonists, with
712 priority given to departments that do not currently have a supply of
713 opioid antagonists; and

714 (12) Documented expenses incurred by pharmacies and pharmacists

715 in providing personal opioid drug deactivation and disposal systems to
716 patients pursuant to section 26 of this act.

717 Sec. 28. Subdivision (7) of section 31-101 of the general statutes is
718 repealed and the following is substituted in lieu thereof (*Effective October*
719 *1, 2024*):

720 (7) "Employer" means any person acting directly or indirectly in the
721 interest of an employer in relation to an employee, but shall not include
722 any person engaged in farming, or any person subject to the provisions
723 of the National Labor Relations Act, unless the National Labor Relations
724 Board has declined to assert jurisdiction over such person, or any person
725 subject to the provisions of the Federal Railway Labor Act, or the state
726 or any political or civil subdivision thereof or any religious agency or
727 corporation, or any labor organization, except when acting as an
728 employer, or any one acting as an officer or agent of such labor
729 organization. An employer licensed by the Department of Public Health
730 under section 19a-490 shall be subject to the provisions of this chapter
731 with respect to all its employees except those licensed under **[**chapters
732 370 and**]** chapter 379, unless such employer is the state or any political
733 subdivision thereof;

734 Sec. 29. (NEW) (*Effective January 1, 2025*) (a) As used in this section,
735 "coronary calcium scan" means a computed tomography scan of the
736 heart that looks for calcium deposits in the heart arteries.

737 (b) Each individual health insurance policy providing coverage of the
738 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
739 of the general statutes and delivered, issued for delivery, renewed,
740 amended or continued in this state on or after January 1, 2025, shall
741 provide coverage for coronary calcium scans.

742 (c) The provisions of this section shall apply to a high deductible
743 health plan, as such term is used in subsection (f) of section 38a-493 of
744 the general statutes, to the maximum extent permitted by federal law,
745 except if such plan is used to establish a medical savings account or an

746 Archer MSA pursuant to Section 220 of the Internal Revenue Code of
747 1986, as amended from time to time, or any subsequent corresponding
748 internal revenue code of the United States, as amended from time to
749 time, or a health savings account pursuant to Section 223 of said Internal
750 Revenue Code of 1986, as amended from time to time, the provisions of
751 this section shall apply to such plan to the maximum extent that (1) is
752 permitted by federal law, and (2) does not disqualify such account for
753 the deduction allowed under said Section 220 or 223 of said Internal
754 Revenue Code of 1986, as applicable.

755 Sec. 30. (NEW) (*Effective January 1, 2025*) (a) As used in this section,
756 "coronary calcium scan" means a computed tomography scan of the
757 heart that looks for calcium deposits in the heart arteries.

758 (b) Each group health insurance policy providing coverage of the
759 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469
760 of the general statutes and delivered, issued for delivery, renewed,
761 amended or continued in this state on or after January 1, 2025, shall
762 provide coverage for coronary calcium scans.

763 (c) The provisions of this section shall apply to a high deductible
764 health plan, as such term is used in subsection (f) of section 38a-493 of
765 the general statutes, to the maximum extent permitted by federal law,
766 except if such plan is used to establish a medical savings account or an
767 Archer MSA pursuant to Section 220 of the Internal Revenue Code of
768 1986, as amended from time to time, or any subsequent corresponding
769 internal revenue code of the United States, as amended from time to
770 time, or a health savings account pursuant to Section 223 of said Internal
771 Revenue Code of 1986, as amended from time to time, the provisions of
772 this section shall apply to such plan to the maximum extent that (1) is
773 permitted by federal law, and (2) does not disqualify such account for
774 the deduction allowed under said Section 220 or 223 of said Internal
775 Revenue Code, as applicable.

776 Sec. 31. (NEW) (*Effective from passage*) (a) As used in this section:

777 (1) "Cyber security event" means any observable occurrence of action
778 that could potentially affect the security of computer systems, networks
779 or data; and

780 (2) "Health care facility" means any institution, as defined in section
781 19a-490 of the general statutes, that is licensed pursuant to chapter 368v
782 of the general statutes.

783 (b) Not later than January 1, 2025, the Department of Public Health's
784 Office of Public Preparedness and Response, in collaboration with the
785 state's Chief Information Security Officer, shall include in the state's
786 public health emergency response plan an initiative for health care
787 facility readiness during a cyber security event. Such initiative shall
788 include, but need not be limited to, the acquisition or establishment of
789 the following by each health care facility for use during a cyber security
790 event, as necessary or appropriate for each health care facility:

791 (1) A radio communication system to enable the various units of the
792 health care facility to continue to function;

793 (2) A separate intranet system for secure communications within the
794 health care facility;

795 (3) Facsimile machines, local printers or local laptops for printing and
796 intranet communications;

797 (4) Medical devices that are not connected to the Internet;

798 (5) An intranet-based emergency management information system to
799 document routine and emergency events or incidents;

800 (6) A diversion management system for hospital emergency
801 departments to communicate to emergency medical services
802 organizations, other first responders and patients the need to divert
803 patients seeking emergency medical services to another emergency
804 department or health care facility; and

805 (7) Methods of communicating and coordinating with the
806 Department of Social Services and health carriers to reduce the risk of a
807 sudden reduction in cash flow from the inability to bill for health care
808 services.

809 Sec. 32. (*Effective July 1, 2024*) The sum of twenty-five thousand
810 dollars is appropriated to the Department of Emergency Services and
811 Public Protection, for each of the fiscal years ending June 30, 2025, June
812 30, 2026, June 30, 2027, and June 30, 2028, for an annual meeting focused
813 on prevention, identification and management of a cyber security event,
814 as defined in section 31 of this act. The annual meeting shall (1) include,
815 but need not be limited to, representatives of the Department of Public
816 Health, the Division of Emergency Management and Homeland
817 Security within the Department of Emergency Services and Public
818 Protection, the state National Guard and other local, regional and state-
819 wide law enforcement agencies dealing with cyber security events, and
820 (2) consider the (A) creation of cyber security event command scenarios;
821 (B) functioning and training of individuals within hospitals working
822 with pharmaceuticals while without technology to ensure medication
823 administration and documentation in a safe manner; (C) functioning
824 and training of individuals within hospitals working with laboratory
825 samples and testing and reporting regarding such samples and test
826 results for patients while without technology to ensure safe and accurate
827 documentation and communication; and (D) functioning and training
828 of individuals within hospitals performing imaging studies and testing
829 and reporting results for patients while working without technology to
830 ensure safe and accurate documentation and communication.

831 Sec. 33. (NEW) (*Effective from passage*) (a) Not later than January 1,
832 2025, the Department of Public Health, in collaboration with the Office
833 of Health Strategy, shall establish a healthy brain initiative by
834 developing a plan to address health conditions affecting the brain,
835 including, but not limited to, Alzheimer's disease, dementia,
836 Parkinson's disease, stroke and epilepsy. Such plan shall include, but
837 need not be limited to, the following objectives:

838 (1) Strengthening (A) policies concerning the prevention and
839 treatment of such health conditions, and (B) partnerships with
840 organizations and health care providers to develop such policies;

841 (2) Evaluating and utilizing data regarding such health conditions;

842 (3) Building a skilled and diverse health care workforce to engage in
843 prevention efforts and provide treatment to persons with such health
844 conditions, including, but not limited to, through obtaining grant
845 funding and using data to estimate and address the gap between the
846 health care workforce capacity and the anticipated demand for health
847 care services from persons with such health conditions;

848 (4) Educating the public regarding such health conditions, methods
849 to prevent such health conditions and treatment options for persons
850 with such health conditions;

851 (5) Establishing a disease management program to promote early
852 diagnosis of such health conditions and develop protocols for providing
853 education, care consultation and referrals for medical and social services
854 to persons with such health conditions and such persons' caregivers,
855 including, but not limited to, through collaborations among teaching
856 hospitals in the state and partnerships with nonprofit organizations that
857 deliver a range of support services promoting the mental and physical
858 health of persons with such health conditions and their caregivers and
859 family members; and

860 (6) Creating a program that is specific to persons with dementia,
861 including, but not limited to (A) community-based opportunities for
862 exercise, self-care and caregiver education, (B) peer support groups and
863 social gatherings for such persons and their caregivers, family members
864 and friends, (C) the provision of information on the department's
865 Internet web site regarding dementia and support for persons with
866 dementia and their caregivers, family members and friends, (D) the
867 development of mobile applications that allow caregivers and family
868 members of persons with dementia to track such persons using personal

869 global positioning system units or mobile telephones with a global
870 positioning system, (E) adult day care networks, and (F) transportation
871 services.

872 (b) Not later than January 1, 2025, the Commissioner of Public Health
873 shall report, in accordance with the provisions of section 11-4a of the
874 general statutes, to the joint standing committee of the General
875 Assembly having cognizance of matters relating to public health
876 regarding the plan developed pursuant to subsection (a) of this section
877 and the department's anticipated implementation date of such plan.

878 Sec. 34. (NEW) (*Effective from passage*) (a) As used in this section:

879 (1) "Health care provider" means any person or organization that
880 furnishes health care services to persons with Parkinson's disease or
881 Parkinsonism and is licensed or certified to furnish such services
882 pursuant to chapters 370 and 378 of the general statutes; and

883 (2) "Hospital" has the same meaning as provided in section 19a-490
884 of the general statutes.

885 (b) Not later than July 1, 2025, the Department of Public Health shall
886 maintain and operate a state-wide registry of data on Parkinson's
887 disease and Parkinsonism.

888 (c) Each hospital and each health care provider shall make available
889 to the registry such data concerning each patient with Parkinson's
890 disease or Parkinsonism admitted to such hospital or treated by such
891 health care provider for such patient's Parkinson's disease or
892 Parkinsonism as the Commissioner of Public Health shall require by
893 regulations adopted in accordance with chapter 54 of the general
894 statutes. Each hospital and health care provider shall provide each such
895 patient with notice of, and the opportunity to opt out of, such disclosure.

896 (d) The data contained in such registry may be used by the
897 department and authorized researchers as specified in such regulations,
898 provided personally identifiable information in such registry

899 concerning any such patient with Parkinson's disease or Parkinsonism
900 shall be held confidential pursuant to section 19a-25 of the general
901 statutes. The data contained in the registry shall not be subject to
902 disclosure under the Freedom of Information Act, as defined in section
903 1-200 of the general statutes. The commissioner may enter into a contract
904 with a nonprofit association in this state concerned with the prevention
905 and treatment of Parkinson's disease and Parkinsonism to provide for
906 the implementation and administration of the registry established
907 pursuant to this section.

908 (e) Each hospital shall provide access to its records to the Department
909 of Public Health, as the department deems necessary, to perform case
910 finding or other quality improvement audits to ensure completeness of
911 reporting and data accuracy consistent with the purposes of this section.

912 (f) The Department of Public Health may enter into a contract for the
913 receipt, storage, holding or maintenance of the data or files under its
914 control and management for the purpose of implementing the
915 provisions of this section.

916 (g) The Department of Public Health may enter into reciprocal
917 reporting agreements with the appropriate agencies of other states to
918 exchange Parkinson's disease and Parkinsonism care data.

919 (h) The Department of Public Health shall establish a Parkinson's
920 disease and Parkinsonism data oversight committee to (1) monitor the
921 operations of the state-wide registry established pursuant to subsection
922 (b) of this section, (2) provide advice regarding the oversight of such
923 registry, (3) develop a plan to improve quality of Parkinson's disease
924 and Parkinsonism care and address disparities in the provision of such
925 care, and (4) develop short and long-term goals for improvement of such
926 care.

927 (i) Said committee shall include, but need not be limited to, the
928 following members, who shall be appointed by the Commissioner of
929 Public Health not later than June 1, 2025: (1) A neurologist; (2) a

930 movement disorder specialist; (3) a primary care provider; (4) a
931 neuropsychiatrist who treats Parkinson's disease; (5) a patient living
932 with Parkinson's disease; (6) a public health professional; (7) a
933 population health researcher with experience in state-wide registries of
934 health condition data; (8) a patient advocate; (9) a family caregiver of a
935 person with Parkinson's disease; (10) a representative of a nonprofit
936 organization related to Parkinson's disease; (11) a physical therapist
937 with experience working with persons with Parkinson's disease; (12) an
938 occupational therapist with experience working with persons with
939 Parkinson's disease; (13) a speech therapist with experience working
940 with persons with Parkinson's disease; (14) a social worker with
941 experience providing services to persons with Parkinson's disease; (15)
942 a geriatric specialist; and (16) a palliative care specialist. Each member
943 shall serve a term of two years. The commissioner shall appoint, from
944 among the members of the oversight committee, a chairperson who
945 shall schedule the first meeting of the oversight committee on or before
946 July 1, 2025. The Department of Public Health shall assist said committee
947 in its work and provide any information or data that the committee
948 deems necessary to fulfil its duties, unless the disclosure of such
949 information or data is prohibited by state or federal law. Not later than
950 January 1, 2026, and annually thereafter, the chairperson of the
951 committee shall report, in accordance with the provisions of section 11-
952 4a of the general statutes, to the joint standing committee of the General
953 Assembly having cognizance of matters relating to public health,
954 regarding the work of the committee. Not later than January 1, 2026, and
955 at least annually thereafter, such chairperson shall report to the
956 Commissioner of Public Health regarding the work of the committee.

957 (j) The Commissioner of Public Health may adopt regulations, in
958 accordance with the provisions of chapter 54, to implement the
959 provisions of this section.

960 Sec. 35. (NEW) (*Effective from passage*) (a) The Commissioner of Mental
961 Health and Addiction Services, in consultation with the Commissioner
962 of Children and Families, shall establish a program for persons

963 diagnosed with recent-onset schizophrenia spectrum disorder, at a
964 hospital in the state, for specialized treatment early in such persons'
965 psychosis. Such program shall serve as a hub for the state-wide
966 dissemination of information regarding best practices for the provision
967 of early intervention services to persons diagnosed with a recent-onset
968 schizophrenia spectrum disorder. Such program shall address (1) the
969 limited knowledge of (A) region-specific needs in treating such
970 disorder, (B) the prevalence of first-episode psychosis in persons
971 diagnosed with such disorder, and (C) disparities across different
972 regions in treating such disorder, (2) uncertainty regarding the
973 availability and readiness of clinicians to implement early intervention
974 services for persons diagnosed with such disorder and such persons'
975 families, and (3) funding of and reimbursement for early intervention
976 services available to persons diagnosed with such disorder.

977 (b) The program established pursuant to subsection (a) of this section
978 shall perform the following functions:

979 (1) Develop structured curricula, online resources and
980 videoconferencing-based case conferences to disseminate information
981 for the development of knowledge and skills relevant to patients with
982 first-episode psychosis and such patients' families;

983 (2) Assess and improve the quality of early intervention services
984 available to persons diagnosed with a recent-onset schizophrenic
985 spectrum disorder across the state;

986 (3) Provide expert input on complex cases of a recent-onset
987 schizophrenic spectrum disorder and launch a referral system for
988 consultation with persons having expertise in treating such disorders;

989 (4) Share lessons and resources from any campaigns aimed at
990 reducing the duration of untreated psychosis to improve local pathways
991 to care for persons with such disorders;

992 (5) Serve as an incubator for new evidence-based treatment

993 approaches and pilot such approaches for deployment across the state;

994 (6) Advocate for policies addressing the financing, regulation and
995 provision of services for persons with such disorders; and

996 (7) Collaborate with state agencies to improve outcomes for persons
997 diagnosed with first-episode psychosis in areas including, but not
998 limited to, crisis services and employment services.

999 (c) Not later than January 1, 2025, and annually thereafter, the
1000 Commissioner of Mental Health and Addiction Services shall report, in
1001 accordance with the provisions of section 11-4a of the general statutes,
1002 to the joint standing committee of the General Assembly having
1003 cognizance of matters relating to public health, regarding the functions
1004 and outcomes of the program for specialized treatment early in
1005 psychosis and any recommendations for legislation to address the needs
1006 of persons diagnosed with recent-onset schizophrenic spectrum
1007 disorders.

1008 Sec. 36. (*Effective from passage*) (a) The cochairpersons of the joint
1009 standing committee of the General Assembly having cognizance of
1010 matters relating to public health shall establish a working group to
1011 study and make recommendations concerning methods of addressing
1012 loneliness and isolation experienced by persons in the state and to
1013 improve social connection among such persons. The working group
1014 shall perform the following functions:

1015 (1) Evaluate the causes of and other factors contributing to the sense
1016 of isolation and loneliness experienced by persons in the state;

1017 (2) Evaluate methods of preventing and eliminating the sense of
1018 isolation and loneliness experienced by persons in the state;

1019 (3) Recommend local activities, systems and structures to combat
1020 isolation and loneliness in the state, including, but not limited to,
1021 opportunities for organizing or enhancing in-person gatherings within
1022 communities, especially for persons who have been living in isolation

1023 for extended periods of time; and

1024 (4) Explore the possibility of creating municipal-based social
1025 connection committees to address the challenges of and potential
1026 solutions for combatting isolation and loneliness experienced by
1027 persons in the state.

1028 (b) The working group shall include, but need not be limited to, the
1029 following members:

1030 (1) A high school teacher from an urban high school in the state;

1031 (2) A high school teacher from a rural high school in the state;

1032 (3) A dining hall manager of a soup kitchen in a suburban area of the
1033 state;

1034 (4) Three high school students of a high school in the state, including
1035 one student who identifies as a member of the LGBTQ+ community, one
1036 student who identifies as female and one student who identifies as male;

1037 (5) A student of a school of public health at an institution of higher
1038 education in the state;

1039 (6) A student of a school of social work at an institution of higher
1040 education in the state;

1041 (7) A resident of an assisted living facility for veterans in the state;

1042 (8) A resident of an assisted living facility in a suburban town of the
1043 state;

1044 (9) A member of the administration of a senior center in a rural area
1045 of the state;

1046 (10) A member of the administration of a senior center in an urban
1047 area of the state;

1048 (11) A representative of an organization serving children in an urban

1049 area of the state;

1050 (12) A representative of an organization that represents
1051 municipalities in the state;

1052 (13) A representative of an organization that represents small towns
1053 in the state;

1054 (14) A representative of an organization in the state that is working
1055 on policies to improve planning and zoning laws to create an inclusive
1056 society and improve access to transit-oriented development in the state;

1057 (15) A representative of an organization in the state that is working
1058 to improve and create more walkable and accessible main streets in
1059 towns and municipalities in the state;

1060 (16) A representative of an organization in the state that advocates for
1061 persons with a physical disability;

1062 (17) An expert in digital health and identifying safe digital education;

1063 (18) A representative of an organization in the state that develops
1064 mobile applications that are intended to address loneliness and
1065 isolation;

1066 (19) A psychiatrist who treats adolescents in the state;

1067 (20) A psychiatrist who treats adults in the state;

1068 (21) A librarian from a library in a rural area of the state;

1069 (22) A social worker who practices in an urban area of the state;

1070 (23) The Commissioner of Mental Health and Addiction Services, or
1071 the commissioner's designee; and

1072 (24) The Commissioner of Children and Families, or the
1073 commissioner's designee.

1074 (c) The cochairpersons of the joint standing committee of the General
1075 Assembly having cognizance of matters relating to public health shall
1076 schedule the first meeting of the working group, which shall be held not
1077 later than sixty days after the effective date of this section.

1078 (d) The members of the working group shall elect two chairpersons
1079 from among the members of the working group.

1080 (e) The administrative staff of the joint standing committee of the
1081 General Assembly having cognizance of matters relating to public
1082 health shall serve as administrative staff of the working group.

1083 (f) Not later than January 1, 2025, the working group shall submit a
1084 report on its findings and recommendations to the joint standing
1085 committee of the General Assembly having cognizance of matters
1086 relating to public health, in accordance with the provisions of section 11-
1087 4a of the general statutes. The working group shall terminate on the date
1088 that it submits such report or January 1, 2025, whichever is later.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2024*	New section
Sec. 2	*October 1, 2024*	New section
Sec. 3	*October 1, 2024*	New section
Sec. 4	*from passage*	17b-242(a)
Sec. 5	*January 1, 2025*	New section
Sec. 6	*January 1, 2025*	New section
Sec. 7	*July 1, 2024*	New section
Sec. 8	*from passage*	New section
Sec. 9	*July 1, 2024*	New section
Sec. 10	*January 1, 2025*	New section
Sec. 11	*January 1, 2025*	New section
Sec. 12	*January 1, 2025*	New section
Sec. 13	*January 1, 2025*	New section
Sec. 14	*January 1, 2025*	New section
Sec. 15	*January 1, 2025*	New section
Sec. 16	*January 1, 2025*	New section

Sec. 17	*January 1, 2025*	New section
Sec. 18	*January 1, 2025*	New section
Sec. 19	*July 1, 2024*	New section
Sec. 20	*from passage*	New section
Sec. 21	*from passage*	New section
Sec. 22	*from passage*	New section
Sec. 23	*July 1, 2024*	New section
Sec. 24	*from passage*	19a-490ff
Sec. 25	*January 1, 2025*	New section
Sec. 26	*October 1, 2024*	New section
Sec. 27	*October 1, 2024*	17a-674c(f)
Sec. 28	*October 1, 2024*	31-101(7)
Sec. 29	*January 1, 2025*	New section
Sec. 30	*January 1, 2025*	New section
Sec. 31	*from passage*	New section
Sec. 32	*July 1, 2024*	New section
Sec. 33	*from passage*	New section
Sec. 34	*from passage*	New section
Sec. 35	*from passage*	New section
Sec. 36	*from passage*	New section

Statement of Purpose:

To improve the health and safety of Connecticut residents.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. LOONEY, 11th Dist.; SEN. DUFF, 25th Dist.
SEN. ANWAR, 3rd Dist.; SEN. CABRERA, 17th Dist.
SEN. COHEN, 12th Dist.; SEN. FLEXER, 29th Dist.
SEN. GASTON, 23rd Dist.; SEN. HARTLEY, 15th Dist.
SEN. HOCHADEL, 13th Dist.; SEN. KUSHNER, 24th Dist.
SEN. LESSER, 9th Dist.; SEN. MAHER, 26th Dist.
SEN. MARONEY, 14th Dist.; SEN. MARX, 20th Dist.
SEN. MCCRORY, 2nd Dist.; SEN. MILLER P., 27th Dist.
SEN. MOORE, 22nd Dist.; SEN. NEEDLEMAN, 33rd Dist.
SEN. OSTEN, 19th Dist.; SEN. RAHMAN, 4th Dist.
SEN. SLAP, 5th Dist.; SEN. WINFIELD, 10th Dist.
REP. DELANY, 144th Dist.; REP. JOHNSON, 49th Dist.
REP. RADER, 98th Dist.

S.B. 1