General Assembly **Substitute Bill No. 1**

February Session, 2024

SB00001APP 050124

AN ACT CONCERNING THE HEALTH AND SAFETY OF CONNECTICUT RESIDENTS.

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

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

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

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

(3) The location where the employee will provide services, including, if known to the agency, the (A) crime rate for the municipality in which the employee will provide services, as determined by the most recent

Crime in Connecticut annual report issued by the Department of Emergency Services and Public Protection, (B) presence of any hazardous materials at the location, including, but not limited to, used syringes, (C) presence of firearms or other weapons at the location, (D) status of the location's fire alarm system, and (E) presence of any other safety hazards at the location, including, but not limited to, electrical hazards.

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

Sec. 3. (NEW) (*Effective October 1, 2024*) (a) Each home health care agency and home health aide agency, as such terms are defined in section 19a-490 of the general statutes, and each staff member of any such agency shall report each instance of verbal abuse that is perceived as a threat or danger to the staff member, physical abuse, sexual abuse or any other abuse by an agency client against a staff member in a form and manner prescribed by the Commissioner of Public Health.

(b) Not later than January 1, 2025, and annually thereafter, the

commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the number of reports received pursuant to subsection (a) of this section and the actions taken to ensure the safety of the staff member about whom the report was made.

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

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

Sec. 6. (NEW) (*Effective January 1, 2025*) Each group 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.

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

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

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

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

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

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

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

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

(6) One representative of a police department; and

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

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

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

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

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

Sec. 9. (*Effective July 1, 2024*) The sum of one million dollars is appropriated to the Department of Public Health from the General Fund, for the fiscal year ending June 30, 2025, for the purposes of establishing and administering the home care staff safety grant program established pursuant to section 7 of this act.

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

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

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

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

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

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

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

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

(b) A graduate physician shall be subject to the supervision requirements established in any controlling federal law, the supervision requirements adopted pursuant to sections 12 to 18, inclusive, of this act

and any supervision requirements established by the National Board of Medical Examiners. A graduate physician shall not be subject to any additional supervision requirements.

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

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

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

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

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

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

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

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

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

(b) Only a physician licensed pursuant to chapter 370 of the general statutes may enter into a graduate physician collaborative practice arrangement with a graduate physician. A graduate physician collaborative practice arrangement shall take the form of a written agreement, including mutually agreed-upon protocols or standing orders, for the delivery of primary care services. A graduate physician collaborative practice arrangement may delegate to a graduate physician the authority to administer or dispense drugs, except a controlled substance, and provide treatment, provided the delivery of the primary care services is within the scope of the graduate physician's practice and is consistent with the graduate physician's skill, training and competence and the skill, training and competence of the collaborating physician. The collaborating physician shall be board certified in the specialty that the graduate physician is practicing, which

shall only include pediatrics, internal medicine, family medicine, obstetrics and gynecology or psychiatry.

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

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

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

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

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

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

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

(B) Maintain geographic proximity to a hospital, provided the graduate physician collaborative practice arrangement may allow for geographic proximity to be waived for not more than twenty-eight days per calendar year for the provision of primary care services in health care services in a rural health clinic. As used in this subparagraph, "rural health clinic" means (i) an independent health clinic, (ii) provider-based health clinic, if the provider is a critical access hospital, as defined in 42 USC 1395i-4, as amended from time to time, or (iii) a provider-based health clinic, if the primary location of the hospital sponsor is more than

twenty-five miles from the clinic, which clinic is located in a town that has either seventy-five per cent or more of its population classified as rural in the 1990 federal decennial census of population, or in the most recent such census used by the State Office of Rural Health to determine rural towns, or a town that is not designated as a metropolitan area on the list maintained by the federal Office of Management and Budget, used by the State Office of Rural Health to determine rural towns. The collaborating physician shall maintain documentation related to the geographic proximity requirement and present the documentation to the Connecticut Medical Examining Board upon request;

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

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

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

(9) A provision describing the time and manner of the collaborating physician's review of the graduate physician's delivery of primary care services and requiring the graduate physician to submit to the collaborating physician every fourteen days after the initial observation year a minimum of twenty-five per cent of the charts documenting the graduate physician's delivery of primary care services for review by the collaborating physician or by any other physician designated in the graduate physician collaborative practice arrangement. For the first three months of the initial observation year, the collaborating physician shall review one hundred per cent of the charts documenting the graduate physician's delivery of primary care services. For months four to twelve, inclusive, of the initial observation year, the collaborating

physician shall review seventy-five per cent of the charts documenting the graduate physician's delivery of primary care services; and

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

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

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

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

(3) Specify, in consultation with the deans of medical schools and primary care residency program directors in the state, the educational methods and programs to be implemented by the collaborating physician during graduate physician collaborative practice service arrangements, to facilitate the advancement of the graduate physician's medical knowledge and capabilities and the successful completion of which may lead to credit toward a future residency program that accepts the documented educational achievements of the graduate physician through such methods and programs; and

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

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

Sec. 17. (NEW) (*Effective January 1, 2025*) (a) The Connecticut Medical Examining Board shall promulgate rules applicable to graduate physicians that are consistent with the federal guidelines established for

federally qualified health centers. The rulemaking authority granted to said board under this subsection shall not extend to any graduate physician collaborative practice arrangement governing a hospital employee providing inpatient care within a hospital.

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

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

(d) No contract or other agreement shall require a physician to act as a collaborating physician for a graduate physician against the physician's will. A physician may refuse to act as a collaborating physician, without penalty, for a particular graduate physician. No contract or other agreement shall limit the collaborating physician's authority over any protocols or standing orders or delegate the physician's authority to a graduate physician. Nothing in this subsection shall be construed to authorize a physician, in implementing protocols, standing orders or delegation to violate any standards for safe medical practice established by a hospital's medical staff.

(e) No contract or other agreement shall require a graduate physician to serve as a graduate physician for any collaborating physician against the graduate physician's will. A graduate physician may refuse to

collaborate, without penalty, with a particular physician.

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

Sec. 18. (NEW) (*Effective January 1, 2025*) (a) A collaborating physician shall complete a certification course approved by the Connecticut Medical Examining Board that shall include material on the laws pertaining to the professional relationship of a collaborating physician with a graduate physician prior to entering into a collaborative practice arrangement with a graduate physician.

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

Sec. 19. (NEW) (*Effective July 1, 2024*) On or before January 1, 2025, the Commissioner of Public Health, in consultation with the Commission on Community Gun Violence Intervention and Prevention, established pursuant to section 19a-112j of the general statutes, and the Connecticut chapters of a national professional association of physicians, a national professional association of advanced practice registered nurses and a national professional association of physician assistants, shall develop or procure educational material concerning gun safety practices to be provided by primary care providers to patients who are eighteen years of age or older during the patient's appointment with such patient's primary care provider. On or before February 1, 2025, the Department of Public Health shall make the educational material available to all primary care providers of persons eighteen years of age or older in the

state, at no cost to the provider, and make recommendations to such primary care providers for the effective use of such educational material. Such primary care providers shall provide such educational material to each patient who is eighteen years of age or older on an annual basis at the patient's appointment with the primary care provider.

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

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

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

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

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

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

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

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

(8) The creation of patient advocacy and support networks to assist

persons living with such disease; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to study health issues experienced by nail salon workers as a result of such workers' exposure to health hazards in a nail salon. Such study shall include, but need not be limited to, (1) an identification of health hazards in a nail salon, (2) mechanisms to reduce nail salon workers' exposure to such health hazards, (3) best practices for preventing nail salon workers from acquiring health issues from exposure to health hazards in a nail salon, and (4) assessing the strengths of policies protecting nail salon workers' health that have been implemented in other states.

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

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

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

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

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

(5) An expert in occupational safety;

(6) An expert in environmental health;

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

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

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

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

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

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

Sec. 22. (*Effective from passage*) The Commissioner of Public Health, in

collaboration with the Commissioner of Consumer Protection, shall study incidences of prescription drug shortages in the state and whether the state has a role in alleviating such shortages. Not later than January 1, 2025, the Commissioners of Public Health and Consumer Protection shall jointly report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and consumer protection regarding such study and any recommendations for legislation that would help alleviate or prevent such shortages.

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

(b) When the Commissioner of Children and Families, or the commissioner's designee, conducts a visit to, or evaluation of, a home pursuant to a safety plan, such visit or evaluation shall be conducted in person if such safety plan indicates that a parent or guardian in such home has a substance use disorder, as defined in section 20-74s of the general statutes.

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

(a) As used in this section, (1) "board eligible" means eligible to take a qualifying examination administered by a medical specialty board after having graduated from a medical school, completed a residency program and trained under supervision in a specialty fellowship program, (2) "board certified" means having passed the qualifying

examination administered by a medical specialty board to become board certified in a particular specialty, and (3) "board recertification" means recertification in a particular specialty after a predetermined time period prescribed by a medical specialty board, including, but not limited to, through participation in any required maintenance of certification program, after having passed the qualifying examination administered by the medical specialty board to become board certified in a particular specialty.

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

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

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

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

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

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

(b) No insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that

delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes in this state on or after January 1, 2025, shall (1) deny reimbursement to such health care provider, or prevent any health care provider from participating in any provider network based solely on such health care provider's decision not to maintain a specialty certification through any maintenance of certification program, or (2) require any health care provider to maintain a specialty certification through a maintenance of certification program as a prerequisite for obtaining professional liability insurance or other indemnity against liability for professional malpractice in accordance with section 20-11b of the general statutes, provided that such health care provider does not hold such health care provider out to be a specialist under such specialty certification.

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

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

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

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

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

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

(b) (1) Except as provided in subdivision (2) of this subsection, each pharmacist who dispenses an opioid drug to a patient in this state shall provide to such patient, at the time such pharmacist dispenses such

drug to such patient, a personal opioid drug deactivation and disposal system. No pharmacy or pharmacist shall charge any fee to, or impose any cost on, any patient for a personal opioid drug deactivation and disposal system that a pharmacist provides to a patient pursuant to this subdivision.

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

(c) The Commissioner of Consumer Protection may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section.

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

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

(1) State-wide, regional or community substance use disorder needs

assessments to identify structural gaps and needs to inform expenditures from the fund;

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

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

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

(5) Evaluation of effectiveness and outcomes reporting for substance use disorder abatement infrastructure, programs, services, supports and resources for which moneys from the fund have been disbursed, including, but not limited to, impact on access to harm reduction services or treatment for substance use disorders or reduction in drug-related mortality;

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

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

enforcement;

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

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

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

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

(12) Documented expenses incurred by pharmacies and pharmacists in providing personal opioid drug deactivation and disposal systems to patients pursuant to section 26 of this act.

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

(7) "Employer" means any person acting directly or indirectly in the interest of an employer in relation to an employee, but shall not include any person engaged in farming, or any person subject to the provisions of the National Labor Relations Act, unless the National Labor Relations Board has declined to assert jurisdiction over such person, or any person subject to the provisions of the Federal Railway Labor Act, or the state or any political or civil subdivision thereof or any religious agency or

corporation, or any labor organization, except when acting as an employer, or any one acting as an officer or agent of such labor organization. An employer licensed by the Department of Public Health under section 19a-490 shall be subject to the provisions of this chapter with respect to all its employees except those licensed under **[**chapters 370 and**]** chapter 379, unless such employer is the state or any political subdivision thereof;

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

(b) 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 and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall provide coverage for coronary calcium scans.

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

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

(b) Each group 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 and delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2025, shall provide coverage for coronary calcium scans.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 32. (*Effective July 1, 2024*) The sum of twenty-five thousand dollars is appropriated to the Department of Emergency Services and Public Protection, for each of the fiscal years ending June 30, 2025, June 30, 2026, June 30, 2027, and June 30, 2028, for an annual meeting focused on prevention, identification and management of a cyber security event, as defined in section 31 of this act. The annual meeting shall (1) include, but need not be limited to, representatives of the Department of Public Health, the Division of Emergency Management and Homeland Security within the Department of Emergency Services and Public Protection, the state National Guard and other local, regional and state-wide law enforcement agencies dealing with cyber security events, and (2) consider the (A) creation of cyber security event command scenarios;

(B) functioning and training of individuals within hospitals working with pharmaceuticals while without technology to ensure medication administration and documentation in a safe manner; (C) functioning and training of individuals within hospitals working with laboratory samples and testing and reporting regarding such samples and test results for patients while without technology to ensure safe and accurate documentation and communication; and (D) functioning and training of individuals within hospitals performing imaging studies and testing and reporting results for patients while working without technology to ensure safe and accurate documentation and communication.

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

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

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

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

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

(5) Establishing a disease management program to promote early

diagnosis of such health conditions and develop protocols for providing education, care consultation and referrals for medical and social services to persons with such health conditions and such persons' caregivers, including, but not limited to, through collaborations among teaching hospitals in the state and partnerships with nonprofit organizations that deliver a range of support services promoting the mental and physical health of persons with such health conditions and their caregivers and family members; and

(6) Creating a program that is specific to persons with dementia, including, but not limited to (A) community-based opportunities for exercise, self-care and caregiver education, (B) peer support groups and social gatherings for such persons and their caregivers, family members and friends, (C) the provision of information on the department's Internet web site regarding dementia and support for persons with dementia and their caregivers, family members and friends, (D) the development of mobile applications that allow caregivers and family members of persons with dementia to track such persons using personal global positioning system units or mobile telephones with a global positioning system, (E) adult day care networks, and (F) transportation services.

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

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

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

(2) "Hospital" has the same meaning as provided in section 19a-490

of the general statutes.

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

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

(d) The data contained in such registry may be used by the department and authorized researchers as specified in such regulations, provided personally identifiable information in such registry concerning any such patient with Parkinson's disease or Parkinsonism shall be held confidential pursuant to section 19a-25 of the general statutes. The data contained in the registry shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes. The commissioner may enter into a contract with a nonprofit association in this state concerned with the prevention and treatment of Parkinson's disease and Parkinsonism to provide for the implementation and administration of the registry established pursuant to this section.

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

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

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

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

(i) Said committee shall include, but need not be limited to, the following members, who shall be appointed by the Commissioner of Public Health not later than June 1, 2025: (1) A neurologist; (2) a movement disorder specialist; (3) a primary care provider; (4) a neuropsychiatrist who treats Parkinson's disease; (5) a patient living with Parkinson's disease; (6) a public health professional; (7) a population health researcher with experience in state-wide registries of health condition data; (8) a patient advocate; (9) a family caregiver of a person with Parkinson's disease; (10) a representative of a nonprofit organization related to Parkinson's disease; (11) a physical therapist with experience working with persons with Parkinson's disease; (12) an occupational therapist with experience working with persons with Parkinson's disease; (13) a speech therapist with experience working with persons with Parkinson's disease; (14) a social worker with experience providing services to persons with Parkinson's disease; (15) a geriatric specialist; and (16) a palliative care specialist. Each member shall serve a term of two years. The commissioner shall appoint, from among the members of the oversight committee, a chairperson who shall schedule the first meeting of the oversight committee on or before July 1, 2025. The Department of Public Health shall assist said committee in its work and provide any information or data that the committee deems necessary to fulfil its duties, unless the disclosure of such information or data is prohibited by state or federal law. Not later than

January 1, 2026, and annually thereafter, the chairperson of the committee shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding the work of the committee. Not later than January 1, 2026, and at least annually thereafter, such chairperson shall report to the Commissioner of Public Health regarding the work of the committee.

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

Sec. 35. (NEW) (*Effective from passage*) (a) The Commissioner of Mental Health and Addiction Services, in consultation with the Commissioner of Children and Families, shall establish a program for persons diagnosed with recent-onset schizophrenia spectrum disorder, at a hospital in the state, for specialized treatment early in such persons' psychosis. Such program shall serve as a hub for the state-wide dissemination of information regarding best practices for the provision of early intervention services to persons diagnosed with a recent-onset schizophrenia spectrum disorder. Such program shall address (1) the limited knowledge of (A) region-specific needs in treating such disorder, (B) the prevalence of first-episode psychosis in persons diagnosed with such disorder, and (C) disparities across different regions in treating such disorder, (2) uncertainty regarding the availability and readiness of clinicians to implement early intervention services for persons diagnosed with such disorder and such persons' families, and (3) funding of and reimbursement for early intervention services available to persons diagnosed with such disorder.

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

(1) Develop structured curricula, online resources and videoconferencing-based case conferences to disseminate information for the development of knowledge and skills relevant to patients with

first-episode psychosis and such patients' families;

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

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

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

(5) Serve as an incubator for new evidence-based treatment approaches and pilot such approaches for deployment across the state;

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

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

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

Sec. 36. (*Effective from passage*) (a) The cochairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall establish a working group to study and make recommendations concerning methods of addressing

loneliness and isolation experienced by persons in the state and to improve social connection among such persons. The working group shall perform the following functions:

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

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

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

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

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

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

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

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

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

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

(6) A student of a school of social work at an institution of higher

education in the state;

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

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

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

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

(11) A representative of an organization serving children in an urban area of the state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Not later than January 1, 2025, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date 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

PH *Joint Favorable Subst. -LCO*

APP *Joint Favorable*