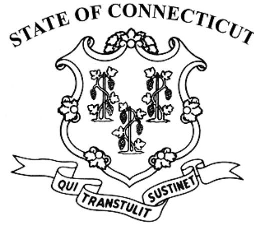

Substitute Senate Bill No. 1

Public Act No. 21-35

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

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

Section 1. (NEW) (*Effective from passage*) It is hereby declared that racism constitutes a public health crisis in this state and will continue to constitute a public health crisis until the goal set forth in subsection (c) of section 3 of this act is attained.

Sec. 2. (NEW) (*Effective from passage*) (a) There is established a Commission on Racial Equity in Public Health, to document and make recommendations to decrease the effect of racism on public health. The commission shall be part of the Legislative Department.

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

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of a nonprofit organization that focuses on racial equity issues and one of whom shall be a representative of Health Equity Solutions;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a representative of a violence intervention program using

a health-based approach to examine individuals post-incarceration and policies for integration and one of whom shall be a representative of the Connecticut Health Foundation;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the Katal Center for Equity, Health, and Justice;

(4) One appointed by the majority leader of the Senate, who shall be a representative of the Connecticut Children's Office for Community Child Health;

(5) Two appointed by the minority leader of the House of Representatives, one of whom shall be a physician educator associated with The University of Connecticut who has experience and expertise in infant and maternal care and who has worked on diversity and inclusion policy and one of whom shall be a representative of the Partnership for Strong Communities;

(6) Two appointed by the minority leader of the Senate, one of whom shall be a medical professional with expertise in mental health and one of whom is a representative of the Open Communities Alliance;

(7) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(8) Two members of the Black and Puerto Rican Caucus, appointed by the caucus chairperson;

(9) One appointed by the Governor, who shall be a representative of the Diversity, Equity, and Inclusion Committee of the Connecticut Bar Association;

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

(11) The Commissioner of Children and Families, or the commissioner's designee;

(12) The Commissioner of Early Childhood, or the commissioner's designee;

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

(14) The Commissioner of Economic and Community Development, or the commissioner's designee;

(15) The Commissioner of Education, or the commissioner's designee;

(16) The Commissioner of Housing, or the commissioner's designee;

(17) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

(18) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

(19) The executive director of the Office of Health Strategy, or the executive director's designee;

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

(21) The Commissioner of Energy and Environmental Protection, or the commissioner's designee; and

(22) The Commissioner of Correction, or the commissioner's designee.

(c) Any member of the commission appointed under subdivisions (1) to (8), inclusive, of subsection (b) of this section may be a member of the General Assembly. All initial appointments to the commission made

under subdivisions (1) to (9), inclusive, of subsection (b) of this section shall be made not later than sixty days after the effective date of this section. Appointed members shall serve a term that is coterminous with the appointing official and may serve more than one term.

(d) The Secretary of the Office of Policy and Management, or the secretary's designee, and the representative appointed under subdivision (1) of subsection (b) of this section as a representative of Health Equity Solutions, shall serve as chairpersons of the commission. Such chairpersons shall schedule the first meeting of the commission, which shall be held not later than sixty days after the effective date of this section. If appointments under subsection (b) of this section are not made within such sixty-day period, the chairpersons may designate individuals with the required qualifications stated for the applicable appointment to serve on the commission until appointments are made pursuant to subsection (b) of this section.

(e) Members shall continue to serve until their successors are appointed. Any vacancy shall be filled by the appointing authority. Any vacancy occurring other than by expiration of term shall be filled for the balance of the unexpired term.

(f) A majority of the membership shall constitute a quorum for the transaction of any business and any decision shall be by a majority vote of those present at a meeting, except the commission may establish such committees, subcommittees or other entities as it deems necessary to further the purposes of the commission. The commission may adopt rules of procedure.

(g) The members of the commission shall serve without compensation, but shall, within the limits of available funds, be reimbursed for expenses necessarily incurred in the performance of their duties.

(h) The commission, by majority vote, shall hire an executive director to serve as administrative staff of the commission, who shall serve at the pleasure of the commission. The commission may request the assistance of the Joint Committee on Legislative Management in hiring the executive director. The executive director may hire not more than two executive assistants to assist in carrying out the duties of the commission.

(i) The commission shall have the following powers and duties: To (1) support collaboration by bringing together partners from many different sectors to recognize the links between health and other issues and policy areas and build new partnerships to promote health and equity and increase government efficiency; (2) create a comprehensive strategic plan to eliminate health disparities and inequities across sectors, in accordance with section 3 of this act; (3) study the impact that the public health crisis of racism has on vulnerable populations within diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, including, but not limited to, Black American descendants of slavery; (4) obtain from any legislative or executive department, board, commission or other agency of the state or any organization or other entity such assistance as necessary and available to carry out the purposes of this section; (5) accept any gift, donation or bequest for the purpose of performing the duties described in this section; (6) establish bylaws to govern its procedures; and (7) perform such other acts as may be necessary and appropriate to carry out the duties described in this section, including, but not limited to, the creation of subcommittees.

(j) The commission shall engage with a diverse range of community members, including people of color who identify as members of diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, who experience inequities in health, to make recommendations to the relevant state

agencies or other entities on an ongoing basis concerning the following: (1) Structural racism in the state's laws and regulations impacting public health, where, as used in this subdivision, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color; (2) racial disparities in the state's criminal justice system and its impact on the health and well-being of individuals and families, including overall health outcomes and rates of depression, suicide, substance use disorder and chronic disease; (3) racial disparities in access to the resources necessary for healthy living, including, but not limited to, access to adequate fresh food and physical activity, public safety and the decrease of pollution in communities; (4) racial disparities in health outcomes; (5) the impact of zoning restrictions on the creation of housing disparities and such disparities' impact on public health; (6) racial disparities in state hiring and contracting processes; and (7) any suggestions to reduce the impact of the public health crisis of racism within the vulnerable populations studied under subdivision (3) of subsection (i) of this section.

(k) Not later than January 1, 2022, and every six months thereafter, the commission shall submit a report to the Secretary of the Office of Policy and Management and the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with the provisions of section 11-4a of the general statutes, concerning (1) the activities of the commission during the prior six-month period; (2) any progress made in attaining the goal described in subsection (c) of section 3 of this act; (3) any recommended changes to such goal based on the research conducted by the commission, any disparity study performed by any state agency or entity, or any community input received; (4) the status of the comprehensive strategic plan required under section 3 of this act; and (5) any recommendations for policy changes or amendments to state law.

Sec. 3. (NEW) (*Effective from passage*) (a) The Commission on Racial Equity in Public Health, established under section 2 of this act, shall develop and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors, including consideration of the following: Air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, access to quality health care, social services, sustainable communities and the impact of climate change.

(b) Such plan shall address the incorporation of health and equity into specific policies, programs and government decision-making processes including, but not limited to, the following: (1) Disparities in laws and regulations impacting public health; (2) disparities in the criminal justice system; (3) disparities in access to resources, including, but not limited to, healthy food, safe housing, public safety and environments free of excess pollution; and (4) disparities in access to quality health care.

(c) Not later than January 1, 2022, as part of such plan, the commission shall determine, using available scientifically based measurements, the percentages of disparity in the state based on race, in the following areas: (1) Education indicators, including kindergarten readiness, third grade reading proficiency, scores on the mastery examination, administered pursuant to section 10-14n of the general statutes, rates of school-based discipline, high school graduation rates and retention rates after the first year of study for institutions of higher education in the state, as defined in section 3-22a of the general statutes; (2) health care utilization and outcome indicators, including health insurance coverage rates, pregnancy and infant health outcomes, emergency room visits and deaths related to conditions associated with exposure to environmental pollutants, including respiratory ailments, quality of life, life expectancy, lead poisoning and access to adequate healthy nutrition and self-reported well-being surveys; (3) criminal justice indicators, including rates of involvement with the justice

system; and (4) economic indicators, including rates of poverty, income and housing insecurity. It shall be the goal of the state to attain at least a seventy per cent reduction in the racial disparities set forth in subdivisions (1) to (4), inclusive, of this subsection from the percentage of disparities determined by the commission on or before January 1, 2022.

(d) Upon completion of the initial comprehensive strategic plan, and thereafter of any update to such plan, the commission shall submit the plan 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, and to any other joint standing committee of the General Assembly having cognizance of matters relevant to what is contained in such plan, as determined by the commission.

Sec. 4. (*Effective from passage*) (a) As used in this section, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color, and "state agency" has the same meaning as provided in section 1-79 of the general statutes. The Commission on Racial Equity in Public Health, established under section 2 of this act, shall determine best practices for state agencies to (1) evaluate structural racism within their own policies, practices, and operations, and (2) create and implement a plan, which includes the establishment of benchmarks for improvement, to ultimately eliminate any such structural racism within the agency.

(b) Not later than January 1, 2023, the commission shall submit a 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 government administration. Such report shall include the best practices established by the commission under this section and a recommendation on any legislation

to implement such practices within state agencies.

Sec. 5. (*Effective from passage*) The Commissioner of Public Health shall study the development and implementation of a recruitment and retention program for health care workers in the state who are people of color. Not later than February 1, 2022, the commissioner shall report the results of such study, 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. Such report shall include any legislative recommendations to improve the recruitment and retention of people of color in the health care sector, including, but not limited to, recommendations for the implementation of such recruitment and retention program.

Sec. 6. (*Effective from passage*) The Department of Energy and Environmental Protection shall perform an assessment of racial equity within environmental health quality programs administered by said department. Not later than January 1, 2022, the department shall submit a 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 the environment. Such report shall include the results of such assessment and any legislative recommendations to improve racial equity within such programs.

Sec. 7. (*Effective from passage*) (a) As used in this section, "cultural humility" means a continuing commitment to (1) self-evaluation and critique of one's own worldview with regard to differences in cultural traditions and belief systems, and (2) awareness of, and active mitigation of, power imbalances between cultures.

(b) The Office of Higher Education, in collaboration with the Board of Regents for Higher Education and the Board of Trustees of The University of Connecticut, shall evaluate the recruitment and retention of people of color in health care preparation programs offered by the

constituent units of the state system of higher education and the inclusion of cultural humility education in such programs. Not later than January 1, 2022, the office shall submit a 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 higher education. Such report shall include the results of such evaluation and any legislative recommendations to improve the recruitment and retention of people of color in such programs and include additional cultural humility education in such programs.

Sec. 8. Subsection (b) of section 2-128 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Not later than January first, annually, the executive director of the commission shall submit a status report, organized by subcommission, concerning its efforts in promoting the desired results listed in subdivision (1) of subsection (a) of this section to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a. <u>On and after January 1, 2022, such report shall include the status of amendments to the joint rules of the House of Representatives and the Senate concerning the preparation of racial and ethnic impact statements pursuant to section 2-24b.</u>

Sec. 9. (*Effective from passage*) (a) There is established a gun violence intervention and prevention advisory committee for the purpose of advising the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level

gun violence in the state. The committee shall: (1) Consult with community outreach organizations, victim service providers, victims of community violence and gun violence, community violence and gun violence researchers and public safety and law enforcement representatives regarding strategies to reduce community violence and gun violence; (2) identify effective, evidence-based community violence and gun violence reduction strategies; (3) identify strategies to align the resources of state agencies to reduce community violence and gun violence; (4) identify state, federal and private funding opportunities for community violence and gun violence reduction initiatives; and (5) develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

(b) The committee shall be composed of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut Hospital Association and one of whom shall be a representative of Compass Youth Collaborative;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a representative of the Connecticut Violence Intervention Program and one of whom shall be a representative of Regional Youth Adult Social Action Partnership;

(3) Two appointed by the majority leader of the House of Representatives, one of whom shall be a representative of Hartford Communities That Care, Inc. and one of whom shall be a representative of CT Against Gun Violence;

(4) Two appointed by the majority leader of the Senate, one of whom shall be a representative of Project Longevity and one of whom shall be a representative of Saint Francis Hospital and Medical Center;

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

Representatives, who shall be a representative of Yale New Haven Hospital;

(6) One appointed by the minority leader of the Senate, who shall be a representative of Hartford Hospital;

(7) One appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of You Are Not Alone (YANA);

(8) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of Mothers United Against Violence;

(9) One appointed by the executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, who shall be a representative of the Health Alliance for Violence Intervention; and

(10) Two appointed by the Commissioner of Public Health, who shall be representatives of the Department of Public Health's Injury and Violence Surveillance Unit.

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

(d) The president pro tempore of the Senate shall select the chairperson of the committee from among the members of the committee. Such chairperson shall schedule the first meeting of the committee, which shall be held not later than sixty days after the effective date of this section. The committee shall meet not less than bimonthly.

(e) The administrative staff of the Commission on Women, Children, Seniors, Equity and Opportunity shall serve as administrative staff of the committee.

(f) Not later than January 1, 2022, the committee shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services, in accordance with the provisions of section 11-4a of the general statutes. The committee shall terminate on the date that it submits such report or January 1, 2022, whichever is later.

Sec. 10. (*Effective from passage*) The Department of Public Health shall conduct a study on the state's COVID-19 response. Not later than February 1, 2022, the Commissioner of Public Health shall submit a preliminary 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 findings of such study. Such report may include the commissioner's recommendations for (1) any policy changes and amendments to the general statutes necessary to improve the state's response to future pandemics, including, but not limited to, recommendations regarding provisions of the general statutes or the regulations of Connecticut state agencies that should automatically be waived in the event of an occurrence or imminent threat of an occurrence of a communicable disease, except a sexually transmitted disease, or a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes in response to an epidemic or pandemic, and (2) how to improve administration of mass vaccinations, reporting and utilization of personal protective equipment supply during a public health emergency, cluster outbreak investigation and health care facilities' care for patients. As used in this section, "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any

related mutation thereof recognized by said organization as a communicable respiratory disease.

Sec. 11. (NEW) (*Effective from passage*) (a) On and after January 1, 2022, any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose shall:

(1) Collect such data in a manner that allows for aggregation and disaggregation of data;

(2) Expand race and ethnicity categories to include subgroup identities as specified by the Community and Clinical Integration Program of the Office of Health Strategy and follow the hierarchical mapping to align with United States Office of Management and Budget standards;

(3) Provide the option to individuals of selecting one or more ethnic or racial designations and include an "other" designation with the ability to write in identities not represented by other codes;

(4) Provide the option to individuals to refuse to identify with any ethnic or racial designations;

(5) Collect primary language data employing language codes set by the International Organization for Standardization; and

(6) Ensure, in cases where data concerning an individual's ethnic origin, ethnicity or race is reported to any other state agency, board or commission, that such data is neither tabulated nor reported without all of the following information: (A) The number or percentage of individuals who identify with each ethnic or racial designation as their sole ethnic or racial designation and not in combination with any other

ethnic or racial designation; (B) the number or percentage of individuals who identify with each ethnic or racial designation, whether as their sole ethnic or racial designation or in combination with other ethnic or racial designations; (C) the number or percentage of individuals who identify with multiple ethnic or racial designations; and (D) the number or percentage of individuals who do not identify or refuse to identify with any ethnic or racial designations.

(b) Each health care provider with an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange as specified in section 17b-59e of the general statutes shall, collect and include in its electronic health record system self-reported patient demographic data including, but not limited to, race, ethnicity, primary language, insurance status and disability status based upon the implementation plan developed under subsection (c) of this section. Race and ethnicity data shall adhere to standard categories as determined in subsection (a) of this section.

(c) Not later than August 1, 2021, the Office of Health Strategy shall consult with consumer advocates, health equity experts, state agencies and health care providers, to create an implementation plan for the changes required by this section.

(d) The Office of Health Strategy shall (1) review (A) demographic changes in race and ethnicity, as determined by the U.S. Census Bureau, and (B) health data collected by the state, and (2) reevaluate the standard race and ethnicity categories from time to time, in consultation with health care providers, consumers and the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 12. Section 19a-59i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is established a maternal mortality review committee within the department to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths.

(b) The cochairpersons of the maternal mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut State Medical Society. The cochairpersons shall convene a meeting of the maternal mortality review committee upon the request of the Commissioner of Public Health.

(c) The maternal mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on the maternal death case being reviewed:

(1) A physician licensed pursuant to chapter 370 who specializes in obstetrics and gynecology, appointed by the Connecticut State Medical Society;

(2) A physician licensed pursuant to chapter 370 who is a pediatrician, appointed by the Connecticut State Medical Society;

(3) A community health worker, appointed by the Commission on Women, Children, Seniors, Equity and Opportunity;

(4) A nurse-midwife licensed pursuant to chapter 377, appointed by the Connecticut Nurses Association;

(5) A clinical social worker licensed pursuant to chapter 383b, appointed by the Connecticut Chapter of the National Association of Social Workers;

(6) A psychiatrist licensed pursuant to chapter 370, appointed by the

Connecticut Psychiatric Society;

(7) A psychologist licensed pursuant to chapter 20-136, appointed by the Connecticut Psychological Association;

(8) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(9) A member of the Connecticut Hospital Association;

(10) A representative of a community or regional program or facility providing services for persons with psychiatric disabilities or persons with substance use disorders, appointed by the Commissioner of Public Health;

(11) A representative of The University of Connecticut-sponsored health disparities institute; or

(12) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.

(d) Whenever a meeting of the maternal mortality review committee takes place, the committee shall consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section 19a-59h and make recommendations regarding the prevention of maternal deaths. Not later than ninety days after such meeting, the committee shall report, to the Commissioner of Public Health, any recommendations and findings of the committee in a manner that complies with section 19a-25.

(e) Not later than January 1, 2022, and annually thereafter, the maternal mortality review committee shall submit a report of disaggregated data, in accordance with the provisions of section 19a-25, regarding the information and findings obtained through the committee's investigation process 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. Such report may include recommendations to reduce or eliminate racial inequities and other public health concerns regarding maternal mortality and severe maternal morbidity in the state.

[(e)**]** (f) All information provided by the department to the maternal mortality review committee shall be subject to the provisions of section 19a-25.

Sec. 13. Section 19a-490u of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[On or after October 1, 2015, each**]** (a) Each hospital, as defined in section 19a-490, shall **[**be required to**]** include training in the symptoms of dementia as part of such hospital's regularly provided training to staff members who provide direct care to patients.

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

Sec. 14. (*Effective from passage*) 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 advance breast health and breast cancer awareness and promote greater understanding of the importance of early breast cancer detection in the state. The working group shall (1) identify organizations that provide

outreach to individuals, including, but not limited to, young women of color and high school students, regarding the importance of breast health and early breast cancer detection; and (2) examine payment options for early breast cancer detection services available to such individuals. Not later than February 1, 2022, the working group shall submit, in accordance with the provisions of section 11-4a of the general statutes, recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding appropriations or legislative proposals that will improve breast cancer awareness and early detection of breast cancer.

Sec. 15. (*Effective from passage*) (a) As used in this section, "doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person before, during and after birth.

(b) The Commissioner of Public Health shall conduct a scope of practice review pursuant to sections 19a-16d to 19a-16f, inclusive, of the general statutes to determine whether the Department of Public Health should establish a state certification process by which a person can be certified as a doula. The commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, the findings of such committee and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health on or before February 1, 2022.

Sec. 16. (*Effective from passage*) (a) There is established a working group to develop recommendations for the strategic expansion of school-based health center services in the state. The working group shall consider, but need not be limited to, the following: (1) Specific geographical regions of the state where additional school-based health centers may be needed, (2) options to expand or add services at existing school-based health centers, (3) methods for providing additional support for school-based health centers to expand telehealth services,

(4) options for expanding insurance reimbursement for school-based health centers, and (5) options to expand access to school-based health centers or expand school-based health center sites, which may include establishing school-based mental health clinics. As used in this subsection, "school-based mental health clinic" means a clinic that (A) is located in or on the grounds of a school facility of a school district or school board or of an Indian tribe or tribal organization, (B) is organized through school, community and health provider relationships, (C) is administered by a sponsoring facility, and (D) provides on-site mental, emotional or behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

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

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

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

(3) The Commissioner of Children and Families, or the commissioner's designee;

(4) The Commissioner of Education, or the commissioner's designee;

(5) The Insurance Commissioner, or the commissioner's designee;

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

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

(8) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or the chairpersons' designees;

(9) The ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or the ranking members' designees;

(10) Two persons designated by the Connecticut Association of School Based Health Centers;

(11) One person designated by the Community Health Center Association of Connecticut;

(12) One person designated by the Connecticut Association of Healthcare Plans;

(13) One person designated by Connecticut Health Center, Inc.; and

(14) One person who is a children's mental health service provider, appointed by the Commissioner of Children and Families.

(c) The cochairpersons of the working group shall be the Commissioner of Public Health, or the commissioner's designee, and a member of the working group appointed pursuant to subdivisions (6) to (9), inclusive, of subsection (b) of this section, elected by the members of the working group. The cochairpersons shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) Not later than February 1, 2022, the working group shall submit a report on its findings and any recommendations for the strategic expansion of school-based health center services, in accordance with 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 appropriations. The working group shall terminate on the date that it submits such report or February 1, 2022, whichever is later.

Sec. 17. (*Effective from passage*) (a) For the fiscal years ending June 30, 2022, and June 30, 2023, the Department of Mental Health and Addiction Services shall, within available appropriations, increase access to mobile crisis services throughout the state by expanding such services' hours of operation to include nights and weekends.

(b) The Department of Mental Health and Addiction Services shall develop a plan to increase access to mobile crisis services throughout the state by making such services available twenty-four hours per day and seven days per week. Not later than January 1, 2022, the Commissioner of Mental Health and Addiction Services shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations, regarding such plan. Such report shall include any legislative recommendations necessary to implement such plan.

Sec. 18. (*Effective from passage*) (a) As used in this section:

(1) "Peer support services" means all nonmedical mental health care services and substance use services provided by peer support specialists; and

(2) "Peer support specialist" means an individual providing peer support services to another individual in the state.

(b) There is established a task force to study peer support services and to encourage health care providers to use such peer support services when providing care to patients. Such study shall include, but need not be limited to, an examination of methods available for the delivery and certification of peer support services and payment mechanisms for such services.

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

(1) Two appointed by the speaker of the House of Representatives, one of whom has personal experience with psychiatric or substance use disorders;

(2) Two appointed by the president pro tempore of the Senate, one of whom has personal experience with psychiatric or substance use disorders;

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

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

(5) One appointed by the minority leader of the House of Representatives, who has personal experience with psychiatric or substance use disorders;

(6) One appointed by the minority leader of the Senate, who has personal experience with psychiatric or substance use disorders;

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

(8) Two persons appointed by the Governor, one of whom has personal experience with psychiatric or substance use disorders.

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

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

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

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

(h) Not later than January 1, 2022, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2022, whichever is later.

Sec. 19. (NEW) (*Effective from passage*) The Department of Mental Health and Addiction Services shall develop a mental health toolkit to help employers in the state address employee mental health needs that arise as a result of COVID-19. Such toolkit shall (1) identify common mental health issues that employees experience as a result of COVID-19, (2) identify symptoms of such mental health issues, and (3) provide information and other resources regarding actions that employers may take to help employees address such mental health issues. Not later than October 1, 2021, the Department of Mental Health and Addiction Services shall post such mental health toolkit on its Internet web site. As used in this section, "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by said organization as a communicable respiratory disease.

Sec. 20. Section 19a-200 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The mayor of each city, the chief executive officer of each town and the warden of each borough shall, unless the charter of such city, town or borough otherwise provides, nominate some person to be director of health for such city, town or borough. **[**, which**]** Such person shall possess the qualifications specified in subsection (b) of this section. Upon approval of the Commissioner of Public Health, such nomination shall be confirmed or rejected by the board of selectmen, if there be such a board, otherwise by the legislative body of such city or town or by the burgesses of such borough within thirty days thereafter.

(b) Notwithstanding the charter provisions of any city, town or borough with respect to the qualifications of the director of health, on and after October 1, 2010, any person nominated to be a director of health shall (1) be a licensed physician and hold a degree in public health from an accredited school, college, university or institution, or (2) hold a graduate degree in public health from an accredited institution of higher education. The educational requirements of this section shall not apply to any director of health nominated or otherwise appointed as director of health prior to October 1, 2010.

(c) In cities, towns or boroughs with a population of forty thousand or more for five consecutive years, according to the estimated population figures authorized pursuant to subsection (b) of section 8-159a, such director of health shall serve in a full-time capacity, except where a town has designated such director as the chief medical advisor for its public schools under section 10-205. **[**, and**]**

(d) No director shall, **[**not,**]** during such director's term of office, have any financial interest in or engage in any employment, transaction or professional activity that is in substantial conflict with the proper discharge of the duties required of directors of health by the general statutes or the regulations of Connecticut state agencies or specified by the appointing authority of the city, town or borough in its written agreement with such director. A written agreement with such director

shall be submitted to the Commissioner of Public Health by such appointing authority upon such director's appointment or reappointment.

(e) Such director of health shall have and exercise within the limits of the city, town or borough for which such director is appointed all powers necessary for enforcing the general statutes, provisions of the regulations of Connecticut state agencies relating to the preservation and improvement of the public health and preventing the spread of diseases therein.

(f) In case of the absence or inability to act of a city, town or borough director of health or if a vacancy exists in the office of such director, the appointing authority of such city, town or borough may, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of health during the period of such absence or inability or vacancy and such person's start date. **[**, provided the**]** The commissioner may appoint such acting director if the city, town or borough fails to do so. The person so designated, when sworn, shall have all the powers and be subject to all the duties of such director.

(g) In case of vacancy in the office of such director, if such vacancy exists for **[**thirty**]** sixty days, said commissioner may appoint a director of health for such city, town or borough. The person so designated, when sworn, shall (1) be considered an employee of the city, town or borough, and (2) have all the powers and be subject to all the duties of such director.

(h) In case of the absence or inability to act of a city, town or borough director of health during a public health emergency declared pursuant to section 19a-131a, the appointing authority of such city, town or borough shall, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of

health during the period of such absence or inability or vacancy and such person's start date. If the city, town or borough fails to appoint such acting director of health, or fails to notify the commissioner of such appointment within thirty days, the commissioner shall appoint an acting director who meets the qualifications specified in subsection (b) of this section. The person designated as acting director of health pursuant to this subsection, when sworn, shall (1) be considered an employee of the city, town or borough, and (2) have all the powers and be subject to all the duties of such director.

(i) Said commissioner, may, for cause, remove an officer the commissioner or any predecessor in said office has appointed, and the common council of such city, town or the burgesses of such borough may, respectively, for cause, remove a director whose nomination has been confirmed by them, provided such removal shall be approved by said commissioner; and, within two days thereafter, notice in writing of such action shall be given by the clerk of such city, town or borough, as the case may be, to said commissioner, who shall, within ten days after receipt, file with the clerk from whom the notice was received, approval or disapproval.

(j) Each such director of health shall hold office for the term of four years from the date of appointment and until a successor is nominated and confirmed in accordance with this section.

(k) Each director of health shall, annually, at the end of the fiscal year, [of the city, town or borough, file with the Department of Public Health a report of the doings as such director for the year preceding] submit a report to the Department of Public Health detailing the activities of such director during the preceding fiscal year.

[(b)] (l) On and after July 1, 1988, each city, town and borough shall provide for the services of a sanitarian licensed under chapter 395 to work under the direction of the local director of health. Where practical,

the local director of health may act as the sanitarian.

[(c)**]** (m) As used in this chapter, "authorized agent" means a sanitarian licensed under chapter 395 and any individual certified for a specific program of environmental health by the Commissioner of Public Health in accordance with the general statutes and regulations of Connecticut state agencies.

Sec. 21. (*Effective from passage*) For the fiscal year ending June 30, 2022, the Department of Public Health shall, within available appropriations, implement the state loan repayment program for community-based health care providers in primary care settings.

Approved June 14, 2021