Final Report of the
Task Force to Study the Comprehensive Needs of Children in the State

November 2023

Table of Contents

Charges to the Task Force to Study the Comprehensive Needs of Children in the State

The Connecticut General Assembly (2022), through Public Act 22-81, Section 24, charged this task force, which first had been established under Public Act 21-46, "to continue to study the comprehensive needs of children in the state and the extent to which such needs are being met by educators, community members and local and state agencies" (p. 18). Specifically, the Task Force was assigned to:

> (1) address subdivisions (1) to (6), inclusive, of subsection (a) of section 30 of public act 21-46, (2) provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand, and (3) study the feasibility of adjusting school start times to improve students' mental and physical well-being.

Subsections (1) through (6) of section 30 of Public Act 21-46, referenced above, directs the Task Force to:

> (1) identify the needs of children using the following tenets of the whole child initiative developed by the Association for Supervision and Curriculum Development: (A) Each student enters school healthy and learns about and practices a healthy lifestyle, (B) each student learns in an environment that is physically and emotionally safe for students and adults, (C) each student is actively engaged in learning and is connected to the school and broader community, (D) each student has access to personalized learning and is supported by qualified, caring adults, and (E) each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment; (2) recommend new programs or changes to existing programs operated by educators or local or state agencies to better address the needs of children in the state; (3) recognize any exceptional efforts to meet the comprehensive needs of children by educators, community members or local or state agencies; (4) identify and advocate for resources, including, but not limited to, funds, required to meet the needs of children in the state; (5) identify redundancies in existing services or programs for children and advocate for the elimination of such redundancies; and (6) assess all publicly available data concerning the comprehensive needs of children identified pursuant to subdivision (1) of this subsection and collect, or make recommendations to the state to collect, any data that is not being collected by educators, community members or local or state agencies. (p. 40)

The charges of Public Act 21-46 were first addressed by the Task Force in a report dated December 2021.

Section 24 of Public Act 22-81, further states that:

> Not later than January 1, 2023, and January 1, 2024, the task force shall update the report issued pursuant to subsection (g) of section 30 of public act 21-46, and submit such updated report and any additional findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to children, in accordance with the provisions of section 11-4a of the general statutes.

The pages that follow identify the individuals who currently comprise the Task Force as well as the organizations or agencies that they represent. They also articulate the process that the Task Force followed to review and update the 2021 recommendations, and to consider the two additional charges.

2022-2023 Membership of the Task Force to Study the Comprehensive Needs of Children in the State

Anne Marie Cullinan, Executive Director, Connecticut ASCD
Dr. Linda Dixon, Commissioner of Children and Families
Michael Duggan, Executive Director, Domus
Tracy Duran, Program Manager, Clinical & Educational Services, Judicial Branch
(designee of Judge Patrick L. Carroll, III, Chief Court Administrator)
Katie Durand, Housing Specialist, Connecticut Department of Housing
(designee of Seila Mosquera-Bruno, Commissioner of Housing)
Dr. Alice M. Forrester, CEO, Clifford Beers Community Health Partners
Tanya A. Hughes, Esq., Executive Director, Commission on Human Rights and Opportunities
Jennifer Jones, Education Consultant in the Office of Early Childhood
Tekowa Omara-Otunnu, Program Associate, Arts in Education, Department of Economic and Community Development
Irene Parisi, Chief Academic Officer, Connecticut State Department of Education
(designee of Charlene Russell-Tucker, Commissioner of Education)
Mark Polzella, Deputy Commissioner, Department of Labor
(designee of Danté Bartolomeo, Interim Commissioner of Labor)
Dr. Alicia M. Roy (CO-CHAIR), Principal, North Canaan Elementary School
Dr. Kayleigh Royston, Legislative Liaison, Connecticut Department of Agriculture
(designee of Bryan Hurlburt, Commissioner of Agriculture)
Pam Sucato, Director of Government Relations, Department of Transportation
Dr. Christopher E. Trombly (CO-CHAIR), Associate Professor, Southern Connecticut State University
Mark Vanacore, Department of Mental Health and Addiction Services
(designee of Nancy Navarretta, Commissioner of Mental Health and Addiction Services)
Tammy Venenga, Department of Developmental Services
Christine Velazquez, Health Program Associate, Department of Public Health
(designee of Dr. Manisha Juthani, Commissioner of Public Health)
Rose-Ann Wanczyk-Karp, Licensed Clinical Social Worker

Process followed by the
Task Force to Study the Comprehensive Needs of Children in the State

Task Force members were first notified in late October 2022 that they had been either appointed or reappointed to the Task Force to Study the Comprehensive Needs of Children in the State. The co-chairs called the first virtual meeting on Friday, November 4, 2022. The Task Force met virtually every month beginning November 2022 and continuing through December 2023, with the exception of the months of June through August 2023.

At the first meeting in November, Task Force members introduced themselves, the charges of the Task Force were discussed, the five tenets of the Whole Child Framework (healthy, safe, engaged, supported, and challenged) were quickly reviewed, and Task Force members agreed that they would each choose one of the two new charges on which to focus primarily: (1) to "provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand," or (2) to "study the feasibility of adjusting school start times to improve students' mental and physical well-being." Furthermore, members agreed to provide overviews of the progress made in each subgroup at the end of each meeting, seeking input and feedback from all members regarding the information presented.

Co-Chair Dr. Roy gathered the findings of the members who chose to focus primarily on infant and toddler care in the state, and Co-Chair Dr. Trombly gathered the findings of the members who chose to focus primarily on studying the feasibility of adjusting school start times. Before and between meetings, members submitted documents and notes to consider and review. Documents used to write our report can be found on the Connecticut General Assembly webpage for the Task Force (CGA webpage.)

Guests were invited to meetings to both present to Task Force members and also to respond to their questions. The initial report of this Task Force was presented at the end of December 2022. To create this final report, all members discussed and reviewed the updated findings presented in this report before voicing a vote in favor of the findings at the November 2023 meeting, the final meeting of the Task Force to Study the Comprehensive Needs of Children in the State.

Consolidated Recommendations and Findings

Recommendations and Findings Associated with the Task Force's Charges from 2022

To provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand.
Continue to allocate funds to provide affordable, high-quality child care and preschool for all children in Connecticut.
Continue to meet the needs of multi language learners.
Offer children with disabilities who are ages birth-5 the same access to child care as all children.
Provide the Office of Early Childhood with a robust team to meet the demands of overseeing and evaluating all of the new spaces awarded funding to ensure high-quality care is the standard.
Review and implement the final recommendations of the Blue-Ribbon Panel, a panel whose work is in alignment with this Task Force.

To study the feasibility of adjusting school start times to improve students' mental and physical well-being.
• In any/all discussions, the phrase "adjusting school start times" must be expanded to reflect the changes to school dismissal times that such adjustments necessitate, as it is at the end of the school day that many of the challenges associated with such changes materialize. • Changes to start/end times for a district's schools serving adolescents frequently necessitate changes to the start/end times of schools serving elementary-aged children in that same district. • Having middle and high schools within a district begin and end their days later than elementary schools do frequently creates childcare issues for younger students, who

will be dismissed from school before the older siblings/cousins/ neighbors who would otherwise care for them will now be available to do so.

- Having elementary schools begin or end their days either earlier or later than they currently do, in order to accommodate changes to the start/end times of middle and high schools, requires younger students to walk to, wait at, and/or walk home from bus stops at times when it is darker than when they currently do. Moreover, in many communities, not all streets/roads include sidewalks; neither are all streets/roads well-lit.
- Changes to start/end times for schools serving adolescents frequently require changes to the scheduling of bus runs. In some instances, they have required the addition of buses at considerable expense. (Given the labor market for the past several years, many school districts and/or the transportation companies with which they contract have found it impossible to recruit and retain sufficient numbers of drivers for their school bus fleets.)
- Changes to start/end times for schools serving adolescents almost invariably trigger changes in the availability of playing fields and other facilities within a community, as high school athletics are given priority. Scheduling high school practices and games later in the day automatically means that younger children on youth teams/in recreation leagues will not have access to fields/facilities until even later than they currently do. (This is especially so, since volunteer coaches are unlikely to be available any earlier in the day than they currently are.) As a consequence, middle school students – themselves adolescents – would be required to attend practices/games still later than they currently are.
- School districts that have managed successfully to achieve later school start/end times for adolescents have partnered proactively with other community agencies and organizations in order to mitigate many of the issues (e.g., demand for childcare for upper elementary-aged students) in which such schedule changes have resulted.
- School districts that have sought to achieve a full one-hour delay in school start/end times for adolescents have tended to encounter greater numbers of issues (e.g., significant changes to start/end times for younger children; bus-related expenses; childcare issues for families), and therefore more political opposition, proving the wisdom behind Voltaire's admonition against making the perfect the enemy of the good.
- Because of the varied times at which different districts' high schools begin and end their school days, students from schools with later dismissal times are often required to miss instructional time on game days in order to travel to competitions against schools with earlier dismissal times. This creates additional burdens for the student-athletes, themselves, as well as for their teachers.
- Given how politically fraught discussions have been in numerous communities that have considered changing school start/end times, it has been suggested that such

decisions should be made at a regional or state level. The already obvious disparities between the resources enjoyed by different communities prevent such wide-scale mandates, as they would pose outsized burdens upon districts with fewer resources.

- Regional issues, and issues of urbanicity, likewise render regional or state-level mandates unfeasible. (Traffic issues in lower Fairfield County prolong travel, not only between school districts, but within them, with implications – and associated expenses – for numbers of bus routes and drivers. Rural school districts tend to have fewer illuminated playing fields, fewer streets/roads with sidewalks, and fewer well-lit streets/roads; consequently, what may work well for districts in communities that are more developed or that have greater infrastructure would pose challenges in more rural, less developed communities.)
- The fact that Norwalk, to our knowledge, is the only urban community in the state to have actively considered – let alone attempted to implement – later school start/end times for adolescents highlights the vast inequities that already exist between communities in Connecticut. (Indeed, much of the literature on school districts across the country that have implemented such schedule changes center around more affluent, suburban districts.) Not only do urban districts serve greater numbers of students, they also have greater concentrations of students with higher needs (i.e., students from families with low socioeconomic status; students who are English learners; students who receive Special Education and related services).

Recommendations Associated with the Task Force's Charge from 2021, organized according to the five tenets of the Whole Child framework – that each child be *healthy*, *safe*, *engaged*, *challenged*, and *supported*

HEALTHY
H.1. Increase children's access to preventative care to promote their medical, dental, and social-emotional health.
H.2. Make health care costs – including the costs of behavioral and mental health care – affordable for families.
H.3. Increase availability of settings (telehealth, out-patient, and in-patient) for mental health preventive care, treatment, and crisis intervention for individuals of all ages.
H.4. Expand access to treatment services for addiction for individuals of all ages.

H.5. Enhance – and provide sufficient resources, including personnel and training for – schools' efforts to promote students' social and emotional health; to teach social-emotional and relationship skills; and to implement disciplinary policies and practices that are educative and restorative.

H.6. Address payment/reimbursement issues for pay-for-service in the school setting. (Statutory language allowing five sessions before parental notification prevents those sessions from being eligible for reimbursement.)

Waive elements of the comprehensive psychosocial assessment or timeline for completion: Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document all of the psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.

Extend deadlines for service or treatment plan: Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.

Consider eliminating the requirement that the treatment plan be a separate document: Update treatment plans as part of the clinical documentation in each session, as is done in primary health care. Standard medical care integrates the treatment plan into the body of the visit note, allowing the plan to be reviewed and updated at each visit.

Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.

H.7. Increase the number of individuals seeking to become mental health and behavioral health providers, and retain those professionals already in the field, by:

- increasing the rates paid for services;
- providing tuition reimbursement to those entering or already serving in these roles; and
- providing reimbursement for the costs of licensure and renewal.

H.8. Attend to the wellness of educators and other personnel who serve children and adolescents – both in school and out.

H.9. Increase awareness of nutrition programs offered through the Connecticut Department of Agriculture and the Connecticut Department of Public Health, including but not limited to, the Farmer's Market Nutrition Program.
H.10. Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics.
H.11. Increase funding to expand parents' and caregivers' access to the Connecticut Department of Labor's various job-training and workforce development programs.
H.12. Create a Connecticut Child Tax Credit
H.13. Expand access to affordable, high-quality child care and preschool; and ensure that the professionals who staff those programs are paid at competitive rates that reflect their levels of education and training, and the responsibility that they hold.
H.14. Address homelessness among adolescents – particularly those who identify as LGBTQIA+.
H.15. Establish a reimbursement mechanism (e.g. under Medicaid) for Occupational Therapy/ Executive Function supports, and ensure that such services are made more broadly available to children in all settings.
SAFE
Sa.1. Increase families' access to safe, affordable housing by: ● increasing the stock of affordable housing; ● increasing housing subsidies, so that families are not required to spend more than 30% of their income on housing.
Sa.2. Enact zoning reform to ensure that safe, affordable housing is available in <u>all</u> communities.
Sa.3. Increase children's and adolescents' access to mentoring programs and after-school programs.
Sa.4. Increase Access to Public Transportation

ENGAGED
E.1. Fully fund the Education Cost Sharing formula passed by the CGA in October 2017 in advance of the projected FY 2028 date.
E.2. Increase the number of individuals seeking to become educators (teachers, school counselors, school psychologists, school nurses, speech/language pathologists, social workers, occupational therapists, etc.), and retain those professionals already in the field, by: • increasing the salaries for these roles; • subsidizing the costs of tests and fees that individuals incur in the process of preparing to become educators; • providing tuition reimbursement to those entering or already serving in these roles; and • providing reimbursement for the costs of certification and renewal.
E.3. Enhance families' knowledgeable, confident engagement in their children's and adolescents' social, emotional, and academic development.
E.4. Significantly reduce the number of mandates for schools – especially those serving students with the greatest need, who therefore most require genuinely engaging, culturally responsive instructional practices. While accountability is inarguably necessary, many of the current mechanisms for ensuring it have served to narrow the curriculum, stifle innovation, and render school less engaging for students and educators.
E.5. Enhance the instructional and therapeutic capacity of all staff in schools through funding for ongoing, job-embedded professional development, and for additional full-day professional development opportunities beyond the scheduled academic year.
E.6. Increase access to hands-on job-training programs, leadership development opportunities, and civic engagement opportunities for adolescents, especially those from families with limited means.
SUPPORTED
Su.1. Increase the diversity of professionals in both the mental/behavioral health and education fields. (Tuition reimbursement in both areas, coupled with strategic, long-term recruiting beginning in high school, will contribute to achieving this goal.)
Su.2. Provide greater supports – in school and out – for children and adolescents who have been disconnected from school due to social-emotional concerns, academic delays, suspensions/expulsions.

CHALLENGED
C.1. Offer all children the ability to attend preschool free-of-charge beginning at age 3.
C.2. Expand CSCU's PACT (Pledge to Advance Connecticut) program to cover: • students already enrolled in community colleges; • students who need to enroll part-time, due to family or work obligations.
C.3. Return Connecticut's funding for state colleges and universities to pre-recession levels in order to increase access for young people whose families have limited means.

Task Force's Work to Address Each of Its Two Specific Charges

The first charge of the 2022-2023 Task Force is the same as that of the Task Force as explained in our 2021 Report: "To (1) address subdivisions (1) to (6), inclusive, of subsection (a) of section 30 of public act 21-46." The Task Force's original recommendations from December 2021 – annotated to reflect action taken by the C.G.A. to address those recommendations during the 2022 and 2023 legislative sessions – follows its reports of its work to address each of the two specific charges that were assigned to the Task Force in 2022:

> (1) to provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand, and
>
> (2) to study the feasibility of adjusting school start times to improve students' mental and physical well-being.

CHARGE: To provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand.

Through Public Act 22-118 (HB 5506) and effective July 2, 2022, the legislature made great strides by allocating $25 million annually in general funding in the Office of Early Childhood, Early Care and Education line item, to increase infant and toddler funding. Reimbursement rates per child for existing Child Day Care (CDC) providers that offer infant and

toddler care was increased to $13,500 per child annually, a significant per child increase from the previous average CDC infant toddler rate of $8,500 annually. Funds are also being used to create 1,300 new infant and toddler spaces throughout the state. Both existing CDC-funded providers and new providers were eligible to receive funding for these new spaces. Eligible providers include child care centers, group child care homes, and family child care homes. (The legislative language that increases the rates is found in P.A. 22-80, Sec. 2.)

Funding to increase wages for child care staff, including new infant and toddler care providers, was also provided through Public Act 22-118 (HB 5506): a total of $70 million will be distributed to state-funded, private pay center-based, and family child care providers this fiscal year.

In Fall 2022, the Office of Early Childhood developed guidelines and a three-tiered application process for 1) current CDC providers, 2) current School Readiness and Smart Start providers and 3) all eligible providers statewide.

July 2022: P.A. 22-80 (S.B. 1) allocates $25 million in General Funding in the OEC Early Care and Education line item to increase infant and toddler per-child rate to $13,500 annually within the Child Day Care (CDC) Contracts program, and additionally, to create 1,300 new subsidized infant and toddler spaces statewide. This funding will be available to licensed child care centers, group child care homes, and family child care homes. Funding is for July 1, 2022 – June 30, 2024.

October 2022: OEC released the Phase 1 application for CDC Contracts Infant Toddler Expansion funding. This application was open only to existing CDC Contractors, as they are currently state-funded: 216 spaces were awarded $2,916,000 to fund service spaces and $3,375,000 for one-time classroom enhancements.

December 2022: OEC released the Phase 2 application for CDC Contracts Infant Toddler Expansion funding. This application was open only to existing School Readiness and Smart Start programs who did not receive funding in Phase 1: 291 spaces were awarded $3,928,500 to fund service spaces and $3,000,000 for one-time classroom enhancements.

February 2023: OEC released the Phase 3 state-wide application for CDC Contracts Infant Toddler Expansion funding. This application was open to all licensed child care centers, group child care homes, and family child care homes: 783 spaces were awarded from the 1,754 applicants. Of the spaces awarded, 570 are child care centers, 20 are group child care homes, and 193 are family child care homes. The amount awarded was $10,219,500 to fund service spaces and $7,171,875 for one-time classroom enhancements. The Phase 3 money was not allocated until July 1, 2023, which is the beginning of fiscal year 2024. These funds are in addition to the previously discussed 25 million dollars in fiscal year 2023.

Family child care homes are receiving assistance through staffed family child care networks that assist family child care providers by offering ongoing support services and resources to help licensed providers reduce the amount of time and effort they spend managing their business, enabling them to focus more on learning and communicating with children and families. Ongoing support will be needed to continue to maintain the family child care networks. Family child care network support helps providers stabilize their family child care home-based businesses, which provide critical service for families with infants and toddlers, and who work non-traditional hours: a family-friendly approach is required to maintain and increase the number of family child care homes in Connecticut.

Two organizations are intermediaries for the approved family child care homes to help support providers as they become state-funded programs and serve infants and toddlers: the City

of Hartford, which will support 47 family child care homes in 147 spaces, and Hope for New Haven, which will support nine family child care homes in 34 spaces.

Additionally, as noted in our 2022 Task Force Report, resources are needed to support new and existing infant and toddler programs. The following free professional learning opportunities are available:

Basic Training for All Providers: The Child Care Education Institute (CCEI) is providing training specifically on safety, development and curriculum, ensuring that developmentally appropriate practices are employed.

State-Funded Infant and Toddler Programs: To support the state-funded infant and toddler providers, the Office of Early Childhood (OEC) Child Day Care (CDC) program managers are holding office hours for providers to focus on targeted areas including technical assistance. The OEC-created user manual and video instructions are available at all times.

Infusing Infant and Toddler Professional Learning into Office of Early Childhood Consulting Supports: A series of sessions covering six Program for Infant and Toddler Care (PITC) policies will be offered across existing OEC-supported quality improvement initiatives.

Intensive Professional Learning for a Limited Number of Providers: The Infant Mental Health Training series for English and Spanish providers will be offered with an option to receive facilitated support to gain the endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®.

On March 17, 2023, Governor Lamont established the Connecticut Blue Ribbon Panel on Child Care. The State of Connecticut website shares that "This panel will be responsible for providing the governor with a data-driven, actionable, strategic plan that supports optimal child development, family needs, business needs, and prioritizes equitable access to early care and education" (August 11, 2023). This Task Force supports the extensive work of the Blue Ribbon Panel.

The charge of the Panel is to create a five-year strategic plan to provide continuity of care for children from birth to age five until the child enters public school. Child care affects not only the children who receive the care, but the families who rely on high quality, affordable care to enter the labor force and the businesses who need the workers. Effective and ongoing child care is the backbone of a strong Connecticut. The recommendations of this Task Force should be considered in addition to those of the Blue Ribbon Panel, whose recommendations will be made at the same time the recommendations of this Task Force are due.

In further support of increasing access to high-quality early care and education for infants and toddlers, in July 2023, through Public Act 23-160 (H.B. 6882) Sec. 35 and 37, the legislature changed the age of eligibility for children attending an OEC-funded School Readiness provider. School Readiness providers can now serve children six weeks to five years of age, as opposed to only 3 and 4 year olds that were eligible in the past. This legislative change will provide access to additional infant and toddler spaces throughout the state.

Once again we would like to applaud the great strides made in providing affordable, high-quality child care for all infants and toddlers through age 5. The following are the Task Force recommendations to continue and sustain child care access to meet the demand for infant and toddler care in Connecticut:

31. Continue to allocate funds to provide affordable, high-quality child care and preschool for all children in Connecticut.

The dollars allocated for care for infants and children who are not age 5 by January 1st and are not able to attend free public school have increased dramatically. This funding needs to continue and to be expanded until all children have access to affordable, high-quality child care, especially in light of the change in start age for kindergarten. During spring 2023, the state legislature voted to change the cutoff date for kindergarten entry from January 1 to September. 1, requiring that all students be 5 years old before entering school, starting during the 2024-25 academic year. This change will leave children and families without the free public education they had expected beginning with the upcoming school year.

32. Continue to meet the needs of multi language learners.

Multilingual learners are students with a primary or home language other than English who are in the process of acquiring English. Children learn best in their native language. These learners are an asset who can help all students to learn a second language. Children who learn two languages simultaneously go through the same processes and progress at the same rate as children who learn only one language. They begin to start talking and say their first words or first sentences within the same time frame. Multi language learners need support to be successful in school.

33. Offer children with disabilities who are ages birth-5 the same access to child care as all children.

Finding child care is more difficult for families with children with disabilities. The special care required often also needs additional staff members with specialized training. Seats at child care centers could be designated for students with disabilities to ensure equal access.

34. Provide the Office of Early Childhood with a robust team to meet the demands of overseeing and evaluating all of the new spaces awarded funding to ensure high-quality care is the standard.

With the creation of 1,300 new infant and toddler spaces, the Office of Early Childhood is in need of additional staff to support the demands of ensuring all new spaces meet the standards expected.

35. Review and implement the final recommendations of the Blue-Ribbon Panel, a panel whose work is in alignment with this Task Force.

The Blue-Ribbon Panel was created by Governor Lamont in 2023 and charged with developing a five-year strategic plan for a child care system that works for families, providers, and Connecticut's economy. The Task Force to Study the Comprehensive Needs of Children in the State has been in consultation with members of the Blue-Ribbon Panel and supports their recommendations: both groups share similar charges with regard to child care.

CHARGE: To study the feasibility of adjusting school start times to improve students' mental and physical well-being.

Introduction

The members of the working group who examined the feasibility of adjusting school start times approached our task already familiar – and in agreement – with the extensive literature on adolescents' unique sleep needs, the insufficient amount (and inadequate quality) of sleep that so many adolescents currently enjoy, and the contributions of many schools' early start times to adolescents' lack of sleep. We were familiar, for example, with the American Academy of Pediatrics' (2014) position statement supporting "the efforts of school districts to optimize sleep in students and [urging] high schools and middle schools to aim for start times that allow students the opportunity to achieve optimal levels of sleep (8.5-9.5 [hours]) and to improve physical…and mental…health, safety…, academic performance, and quality of life" (p. 642). The members of the working group undertook our charge likewise cognizant of – and, in several cases, having had professional experience seeking to negotiate – the complex and wide-ranging challenges that attend efforts to alter the times at which school days begin and end.

As our charge from the Connecticut General Assembly was to study the *feasibility* of adjusting school start times in the state, the working group elected to employ the time available to us by meeting with a variety of stakeholders. At four successive monthly meetings in Spring 2023, the working group met with educational leaders from numerous districts, to learn about their experiences having considered and/or implemented changes to the start times in their districts; with high school students, to learn their perceptions of their schools' current start times, as well as their views about potential changes to those start times; and representatives from the

Connecticut Association of Schools and the Connecticut Interscholastic Athletics Conference (CASCIAC) about their views and/or experiences with adjustments to school start times.

- At our meeting on February 27th, the working group heard from Jason Beaudin, Assistant Superintendent for Operations of the **Guilford Public Schools**; Sandra Faioes, Assistant Superintendent of Business and Operations, Johanna Zanvettor, Director of Transportation, and Colin Hosten (former member of the Task Force to Study the Comprehensive Needs of Children in the State), Board of Education member, of the **Norwalk Public Schools**; and Kevin Smith, superintendent of the **Wilton Public Schools**.
- At our meeting on March 27th, the working group heard from six high school students from across the state – four young women and two young men – who serve on **CAS's Student Advisory Council**, under the supervision of Cherese Odukwek, CAS's Director of Student Activities.
- At our meeting on April 24th, the working group heard from Glenn Lungarini and Gregg Simon – respectively, the executive director of **CASCIAC** and associate executive director of **CIAC**.
- At our meeting on May 22nd, the working group heard from Bobby Rushton, Athletic Director in Wilton, formerly of the **New Canaan Public Schools**.

Two members of the working group – Irene Parisi of the Connecticut State Department of Education, and Christopher Trombly of Southern Connecticut State University – described their own experiences serving as educational administrators in districts – **Greenwich Public Schools** and ***Duxbury (MA) Public Schools*** (respectively) – as they adjusted their schools' start times.

Additionally, the working group reached out to the California Legislature's Legislative Analyst's Office for information on how the implementation of that state's recent statute

mandating later start times has played out, only to learn that the California Legislature had not required that data associated with the change in start times be collected or reported by districts.

Meetings with Stakeholders

Students

The members of the working group were honored to meet with six members of CAS' Student Advisory Council. These four young women and two young men, who attend districts from across the state (some suburban, some urban), were not only forthcoming about their own views about their schools' current start times, but were also cognizant of the many logistical challenges associated with adjusting school start times so that adolescents might begin their days later, including how such a change would almost certainly impact younger students.

The Rationale for Later School Start Times. Three of the six students spoke explicitly of the rationale for later school start times for adolescents. One expressed simply, "It helps me to get up with the sun." Two others spoke of the implications of the mismatch between current start times and adolescents' circadian rhythms. One, who attends a regional school district, explained that later start times "would lower stress" and reduce "tardiness – especially among kids who live far away." Another concurred, expressing, "Schools need to start later, because of when kids get there."

How Much Change is Necessary. All of the students were of like mind as to the need for a later start time for adolescents, but they varied to a small degree as to how much of a change they felt was necessary. One student expressed that the ideal would be for school start times for adolescents to be delayed "by at least one hour." He and his peers acknowledged, though, that that degree of change would likely not be practicable. Another student expressed that, although "a small change wouldn't help, a not-too-drastic change would be better, and easier to adjust to."

Another expressed, “just having 30 extra minutes would help.” A consensus seemed to form around eight o’clock: “An 8:00 am start time would be fair.”

Factors for Decisionmakers to Consider. As expressed above, the six representatives from CAS’ Student Advisory Council were thoughtful about the complexity associated with adjusting school start times, especially as adjustments to start times for adolescents would have impacts beyond middle and high schools.

Regional School Districts. One student who attends such a district explained, “Keeping regional districts in mind is important. Busing has been a big problem anyway.” Another student who attends a regional district concurred: “Districts with multiple towns are a big problem.”

Students Who Drive to School. One student – who, it should be pointed out, did not attend a regional school district – expressed, “Kids who drive to school need to be taken into account.” Morning darkness, fatigue, and traffic are all encountered by adolescents who drive themselves to school.

Multiple Demands on Adolescents. Numerous students reminded the working group that adolescents face multiple demands, over and above arriving punctually for school, irrespective of when their school day begins. Pointing out that adolescents’ time is also occupied by “extracurricular [activities] and sports,” one student suggested that attention should be paid by policymakers and educators to “lessen homework and other pressures.”

Ripple Effects of Changing Middle and High School Start Times. One student expressed particular concern that adjusting the times when middle and high schools begin and end their days would have an “impact on elementary students,” not least those requiring “child care, et cetera” after school.

What the COVID-19 Pandemic Had Taught Them. When one working group member asked what the experience of having lived through the COVID-19 pandemic had taught them,

and which (if any) changes resulting from the pandemic they would like to see continue, several students offered responses.

One student expressed regret that "online learning wasn't great – or enforced in a lot of schools." Another shared that they had appreciated, not only the "shorter school days" that the pandemic had necessitated, but also the "bagged lunches" the district provided to all students. A third expressed gratitude that, during the pandemic, their school instituted "academic support [on] Tuesdays and Thursdays for 45-minute periods" – a practice that they wish had continued.

Educational Administrators

Working group members are grateful to the five educational administrators representing four school districts from across the state who accepted our invitations and gave of their time to discuss with us their experiences considering and implementing adjustments to their schools' start times. While representatives from other districts that had considered, but opted against making such adjustments, declined our invitation to meet; and while, due to time constraints, more districts that have made school start time adjustments were not invited to meet with us, the working group members nevertheless feel that we have acquired a more robust (although admittedly non-exhaustive) understanding of the challenges faced by districts who undertake to meet adolescents' unique sleep needs by adjusting the times at which the schools that those youngsters attend begin and end their days.

The working group members are likewise grateful to the Connecticut Association of Public School Superintendents for having provided us with information about which districts had considered and/or made adjustments to their school start times.

School District	Change to Start Times	Duration of Change
Duxbury (MA)	40-minute delay to the high school (achieved by switching start times with the upper elementary school) * Cost-neutral	13 years – ongoing
Greenwich	1-hour delay to high school; 15-minute delay to schedules middle school; minor adjustments to elementary schools * Significant costs associated with the addition of buses	6 years – ongoing
Guilford	15-minute delay to high school; minor adjustments to schedules of middle and elementary schools. * Cost-neutral	5 years – ongoing
New Canaan	30-minute delay to 7th-12th grades; smaller changes to the schedules at the elementary level * Costs associated with buses	1 year – ongoing
Norwalk	1-hour delay to high school; no change to middle school schedules; minor changes to elementary school	1 year (hybrid); 1.5 months (in person) – REVERSED
Wilton	40-minute delay to the high school (achieved by switching start times with the upper elementary school) * Cost-neutral	20 years – ongoing

Guilford. Assistant Superintendent Beaudin shared that, a number of years ago, in response to interest in the community for changing the schools' start times to accommodate adolescents' sleep needs, a task force – including parents, teachers, and coaches – was established. He likewise explained that the district had commissioned the District Management Council to undertake a traffic study to identify the likely implications of a delayed start time.

According to Assistant Superintendent Beaudin, the task force had identified three options, but there was no consensus in the community as to which should be pursued. As the district weighed its decision, strong concern was expressed in the community about the following issues:

- that shifting which group of students began and end their school day at which time would require younger children to wait for buses or walk home from bus stops in the dark, either before school or after dismissal;
- that high school athletic teams would be competing against schools with earlier dismissal times;
- that childcare issues would result from beginning and ending the schools in a different order than they had been.

"Still," Assistant Superintendent Beaudin explained, the community recognized that "the evidence is the evidence"; that adolescents' need for more sleep could not be ignored. Ultimately, Guilford – whose buses have three runs each, in the morning and the afternoon – elected to shift Guilford High School's start time to begin fifteen minutes later (i.e., from 7:25 to 7:40am), with the other schools being pushed back by 10 minutes each (with the two Middle Schools now beginning at 8:10am and the elementary schools beginning at 9:05am). This change has been cost-neutral.

Norwalk. Norwalk – *the only urban district in Connecticut that the working group found to have actively considered, let alone attempted, to implement a change in school start times* – implemented a one-hour change in the start times of the four (4) high schools; no change to the start times of the four (4) middle schools; and only a minimal change to the start times of the thirteen (13) elementary schools for the 2020/2021 academic year. The district reversed that change six weeks into the Fall semester of the 2021/2022 academic year.

During the 2018/2019 academic year, the district had established a committee of 17 individuals, who worked for 18 months to hold focus groups, and field – and analyze data from – surveys, to consider adjusting school start times to accommodate adolescents' unique sleep needs. No traffic study was undertaken. (School buses in Norwalk have three runs in the morning, and three in the afternoon.)

Mr. Hosten – who had previously served on this task force, and who, as a member of the Norwalk School Board, was present when decisions were made to change start times – explained, "With so many moving parts [8,000 students across 23 buildings; arrangements with parochial schools, as well as well as with vocational/technical and vocational/agricultural schools], and despite years and years of planning, we knew that there'd be bumps in the road."

Assistant Superintendent Faioes, and Director Zanvettor joined Mr. Hosten in explaining that the first year of the school start time change in Norwalk had gone largely smoothly. They pointed out, though, that during the 2020/2021 academic year – the first full year of school since the start of the COVID-19 pandemic – the district was operating in a hybrid mode, with more than 50% of families electing for their children to attend school remotely.

Objection to the implemented start time change emerged only after the start of the 2021/2022 academic year, when all students were attending school in person, and, consequently, factors underlying those objections (i.e., athletics, child care, high school students' after-school

jobs, and, especially, traffic) materialized – and at a time when families were still negotiating the stressors associated with the ongoing pandemic.

Assistant Superintendent Faioes, Director Zanvettor, and Mr. Hosten explained that, with all students back in school physically, all of the districts' school buses were on the road at times when they hadn't previously been. This impacted everyone in the community, not only students or the families of school-aged children.

Moreover, the change in high school start and end times – coupled with the priority given to the schools in using the city's playing fields – triggered decreased access to field times for the city's numerous recreational sports leagues and teams. The high schools' athletic teams were also negatively impacted by the change in the time at which their school day ended, as they were now traveling to other communities for interscholastic games later than they had previously been. (As Director Zanvettor succinctly put it: "In lower Fairfield County, athletic transportation is <u>always</u> a problem because of traffic on I-95.")

The leaders from Norwalk expressed that there is hope among some members of the community to revisit the topic of school start times at a later date. Indeed, as one of them put it, the reversal in 2021/22 was "not an *abandonment* of the idea of a later start time."

The leaders from Norwalk pointed out that the numerous unions representing the school district's various employees had been very involved in the decision-making processes, both to change – and then to reverse the change – to school start times. (They identified that the unions had worked with the school board so that Collective Bargaining Agreements could be amended to accommodate the change to school start times.)

More than one of the leaders from Norwalk expressed that, both politically and practically, a more universal/uniform, large-scale – i.e., either state-wide or county-wide – change to school start times would likely have mitigated the challenges that the district

experienced at the start of the 2021/2022 academic year, compelling it to reverse the later high school start times that had been implemented.

Wilton. Not unlike Guilford or Norwalk, the Wilton Public Schools have three bus runs, both in the morning and in the afternoon. In Wilton, one run accommodates the middle school and high school students; another serves students attending the upper elementary school; and the third services students at the district's early childhood school.

As Superintendent Smith explained, the 2022/2023 academic year represented the 20th anniversary of Wilton's having secured later start times for middle and high school students. The district had achieved this by having 6th-12th graders begin their day when 3rd-5th Graders at Cider Mill School previously had (i.e., at 8:20), and 3rd-5th Graders begin their day at the earlier time (i.e., 7:40am). No change had been made to when youngsters at the early childhood school began or ended their day. The adjustment was cost-neutral. Superintendent Smith expressed that, while there was no correlation between the later start time and any increase in academic achievement among middle and high school students, those youngsters were getting more sleep, came to school on time more often than previously, were less irritable, and came to school better fed (having had time to eat something before leaving their homes). He also indicated that there had been no negative impacts to 3rd-5th Graders at Cider Mill as a result of having to begin their day earlier than before.

Superintendent Smith emphasized that partnering with local community members and organizations has been key to the success of the time change in Wilton. He points out, for example, that numerous after-school activities have evolved in the community for upper elementary school-aged students, since they now get out of school earlier than middle and high school-aged siblings who might otherwise have been tasked with watching them after school.

Superintendent Smith acknowledged that high school athletes regularly need to leave school early during game days – both to allow for ever-present Fairfield County traffic, and because they are competing against teams whose schools dismiss earlier than they do.

Athletic Director Rushton – formerly of New Canaan – explained that the last period at Wilton High School (which dismisses at 2:55) is impacted regularly by student-athletes needing to leave school at 2 or 2:15 for varsity games, in order to account for the traffic that they invariably encounter getting to other districts in lower Fairfield County. (He indicated that juniors and seniors at Wilton High School have been largely good about fulfilling their academic obligations, but acknowledged that this also creates more of a burden for teachers.) He explained that colleagues in Greenwich have reported that that district's change in start times has doubled the number of student-athletes missing their last class to leave early for games.

Mr. Rushton pointed out that by no means all districts have pools or ice rinks, which presents yet another challenge for schools that offer sports requiring the use of such facilities.

Reporting that high school athletic teams are given priority for use of playing fields (especially those that are well-lit), and that "youth sports get what's left over," Director Rushton identified that many 7th and 8th graders involved in youth sports – themselves emerging adolescents – regularly do not get off of the fields until 9pm. He expressed that leaders of the high school league in the southwest portion of the state have discussed pushing games later (to account for the aforementioned traffic issues) but that they are aware that, by so doing, they'd be pushing youth leagues' games still later.

Athletic Director Rushton – echoing a point made by one of the leaders in Norwalk – conveyed that some consistency of school start and end times across districts would be helpful from an athletics perspective. He added that it would also benefit teachers, many of whom teach in communities other than those in which they live and where their own children attend school.

New Canaan. Wilton Athletic Director Rushton, who had previously worked for a number of years in New Canaan, explained that that district had instituted a slightly later start time and end time for its adolescents. He added that there were some budget implications to this, though, due to an accompanying change in bus transportation.

Duxbury, MA. Working group member Christopher Trombly's experience in Duxbury, Massachusetts closely resembles what Superintendent Smith expressed about Wilton's change in school start times. Both districts serve similar numbers of students, and have three buildings with identical grade configurations. As Wilton had, Duxbury accomplished its later school start time for middle and high school students by having the upper elementary school – where Christopher served as principal – begin and end its day first. Also as Wilton had, school leaders in Duxbury had worked closely with community members and organizations well in advance of the time change to ensure that there would be after-school activities available (at a sliding scale) to families for whom the change would pose child care issues (as 3rd-5th Graders would now be dismissed from school forty-five minutes before their 6th-12th Grade siblings would be dismissed).

Unlike Norwalk, whose Collective Bargaining Agreements had needed to be amended, the CBA between the district and the teachers' union in Duxbury required no such amendment. First of all, the start or end times of individual schools were not codified in the CBA. Additionally, while explaining that teachers were required to work on-site for forty-five minutes beyond when students were present, the document did not specify that those forty-five minutes needed to begin immediately after dismissal. District leaders and the teachers' union merely confirmed their mutual understanding that those teachers from the upper elementary school who wished to offer programming through the community organization, which had arranged to provide after-school activities on campus for upper elementary school students, could do so

beginning at dismissal (so that no students would ever be unsupervised), and that the forty-five minutes that such teachers were contractually obliged to work on-site beyond the school day would begin upon completion of the after-school activity.

Christopher explained that Duxbury's first attempt, six years earlier, at changing start times to accommodate the unique sleep needs of adolescents had never come to fruition, as the one proposal that was presented to the district's elected school committee had been roundly rejected by that body.

Despite the extensive research undertaken, and deliberations engaged in, by members of an ad hoc committee that had been empaneled to study the issue and make recommendations, the two individuals who chaired the panel – one administrator, and one representative of the local PTA – had opted to recommend to the school committee a proposal to which the rest of the committee's members had unanimously objected. While the proposal that the chairs put forward would have given middle and high school students a delay to the start of their school day of slightly more than one hour, it would also have necessitated that one of the district's two elementary schools begin a full hour earlier than it had, and that the other would dismiss somewhat later in the afternoon than it already did – raising concerns about elementary-aged children waiting for or being dropped off by their school buses in the dark. Moreover, this proposal made no efforts to address any childcare issues for families that might result from it.

As the other members of the ad hoc committee had earlier done, the district's elected school committee rejected this proposal out of hand – to the conspicuous relief of most members of the community. Over one-half of a decade elapsed before the district would even consider the matter, again. When it ultimately did, it adopted a slight variation of the very proposal that most members of the earlier ad hoc committee (except for its two chairs) had espoused.

Greenwich. Working group member Irene Parisi shared her experiences as an

administrator in Greenwich, when that district made a change to its school start times approximately five years before – a decision that had been under discussion for the previous three years.

Ms. Parisi reported that interscholastic high school athletics became a significant issue, as high school students needed to leave school early to compete against other schools that dismissed earlier than Greenwich did. She reported, also, that the variability of the facilities in different communities likewise posed a problem. (Some communities' playing fields are far better lit than those in others, for example.) She added – similar to what the leaders in Norwalk did – that the changes in schools' use of fields negatively impacted on the availability of those same fields for use by other leagues and teams (since the schools are given priority).

CASCIAC Associate Executive Director Gregg Simon reported that when Greenwich changed its high school start and end times, the sub-varsity teams' games experienced problems because of insufficient buses and fields with lights. He explained that some districts have made such limitations work by holding games – even double-headers – on Saturdays.

Ms. Parisi indicated that, due to greater than foreseen issues with traffic and length of bus runs, the district ultimately needed to add buses – a considerable expense that was covered through cuts to other areas of the school district's budget (e.g., curricular materials).

CASCIAC

As the working group had heard from others, CASCIAC Executive Director Lungarini shared that resources – field time, field space, lighting – are issues in communities. (He pointed out that many schools in eastern Connecticut, and rural schools across the state, have few if any

fields with any lighting at all.) As others also had, he explained that changes made by school districts for their high school athletic teams impact park and recreation programs, which use the facilities once the school teams have finished with them.

As the working group had also heard from others, Executive Director Lungarini expressed that transportation in lower Fairfield County is always a significant issue, with Route 95 and the Merritt Parkway always experiencing heavy traffic – not least in the afternoons and evenings when high school teams are traveling to or from games.

Executive Director Lungarini reported having attended a national conference during which he spoke with educators from California, who were responding to that state's new statutorily mandated change in start times. He shared that districts' experiences have varied considerably, depending upon their disparate resources. (Some districts had additional buses, or space on buses, available, so have been minimally impacted. Others had no available space on buses, or extra buses, so were really challenged to make this work.) California had provided some funding for transportation and childcare, but different districts had different needs, and different availability (e.g., of childcare slots). He reported one California administrator as having explained that high school students in his district were having difficulty getting after-school jobs, because of the more limited time in the afternoon when they were available to work.

Citing a "joint venture" of which CAS had previously been a part (along with CEA) to advocate for a change in the start date for kindergarten students, Executive Director Lungarini recalls having discovered that childcare would be an enormous impediment: There were far too few available childcare slots to accommodate the need that such a change would create.

Identifying, as others had, the myriad complexities associated with changing schools' start and end times, but acknowledging what the literature says about the unique sleep needs of adolescents, Executive Director Lungarini suggested that policymakers give serious

consideration to the annual toggling back and forth that is done between Daylight Savings time and Standard time, given that the latter exacerbates the already shorter amount of daylight enjoyed in the New England states, compared with states in other parts of the country.

Reminding the working group that our collective aim is to better circumstances for adolescents – not merely to "change the clock" – Executive Director Lungarini expressed that, while changing start times is certainly one step to be considered, there are many other ways that policymakers could help children, adolescents, and their families, and by which they could help educators to help their students.

Brief Review of the Literature

Adolescent Sleep Needs

Citing extensive research about what the fields of medicine and psychology have learned about the unique sleep needs of adolescents, and the inadequate sleep that many adolescents get, the American Academy of Pediatrics (2014) made numerous recommendations for addressing the issue. Among these was that, "In most districts, middle and high schools should aim for a starting time of no earlier than 8:30am" (p. 647). The AAP added, "individual school districts also need to take average commuting times and other exigencies into account in setting a start time that allows for adequate sleep opportunity for students" (p. 647).

Kelly et al. (2022) studied "reciprocal relations between sleep and symptoms of depression, anxiety, and externalizing behaviors" – that is, adjustment problems – of adolescents at three different times, when participating adolescents were aged 16, 17, and 18. The researchers studied participants' average sleep duration, variability in sleep duration, average sleep efficiency, and variability in sleep efficiency over seven consecutive nights. The participants, themselves, reported on their sleepiness, while "Cross-lagged panel models tested reciprocal relations and whether sleep more robustly predicted adjustment or vice versa" (p. 542).

The authors found that "adjustment problems predicted sleepiness to a greater degree than" did the research-documented amount of sleep that the participants had actually received. They explain that the literature in this area has long shown that "youth with anxiety disorders often report daytime sleepiness, yet actigraphy-derived duration and poor sleep quality are less evident…" Echoing other scholars, the authors suggested, "Adjustment problems may require adolescents to exert more energy each day to navigate ordinary daily challenges. Consequently, adolescents with adjustment problems may need more sleep than those with better psychological health and therefore experience more daytime sleepiness…It is also possible that adjustment problems compromise particular sleep stages…that lead to feelings of sleepiness…" (Kelly et al., 2022, p. 13).

Reminding that the American Academy of Pediatrics (2014) had recommended a nation-wide delay in when middle and high schools begin their days, Dunster et al. (2019) asserted that insufficient sleep in many adolescents is largely due to early school start times. To underscore the importance of sleep for teenagers, the authors explained that lack of sleep in adolescents is associated with increased rates of depression, anxiety, and suicidal thoughts; substance use/abuse; delinquent behaviors; car accidents; sports injuries; obesity; and difficulty acquiring and storing knowledge. Explaining, "Studies from around the world indicate that later school start times benefit students" (p. 576), the authors echoed the American Academy of Pediatrics' (2014) recommendation that middle and high schools "start no earlier than 8:30[am]" (p. 577).

Acknowledging the challenges associated with achieving later school start times for adolescents, Dunster et al. (2019) suggested that districts might reorder when their constituent schools start: "A somewhat earlier (e.g., 8:00) start for primary schools and later (no earlier than 8:30) start for middle/high schools may require minimal extra investment in school transportation

and yet result in schedules more in tune with the biology of young children and teenagers" (p. 577).

Impacts of Delayed School Start Times on Adolescent Sleep Hygiene

Dunster et al. (2018) undertook a study of the effects of a nearly one-hour delayed start time for Seattle's secondary schools, finding an increase in students' daily median sleep duration (of 34 minutes); an increase (of 4.5%) in students' academic performance; and better student attendance.

Berry et al. (2021) compared sleep patterns and sleep-wake problems (e.g., oversleeping, feeling sleepy daily) in adolescents who attended schools that had delayed their start times with those of adolescents attending schools that had retained their earlier start times. The authors found that the students in schools that had delayed their start times had a five percent decrease in the prevalence of oversleeping, and a six percent decrease in the prevalence of feeling sleepy daily. Acknowledging that these changes may seem minor, the authors nevertheless asserted that, "when applied across a school district with thousands of high school students," the percentages "correspond to a large number of adolescents that have less sleep-wake problems if schools do not start so early" (p. 834).

Adolescent Social, Emotional, and Academic Development

For several years prior to the start of the recent COVID-19 pandemic, educators and clinicians had begun describing an uptick in the mental health challenges of the children and adolescents whom they served. Not only did these professionals report increased numbers of impacted youngsters, they also highlighted the increased intensity and, in some cases, earlier onset of the mental health challenges with which those youngsters were presenting (U.S. Department of Education, 2021).

The pandemic served to exacerbate what was already a serious problem. Being unable physically to attend school for extended periods of time contributed to the increased loneliness that so many children and adolescents had already been experiencing. Additionally, the pandemic triggered young people's worries about their own health and that of their loved ones; introduced myriad challenges associated with online learning; and created the conditions for increased tension between young people and their parents (U.S. Department of Education, 2021).

Meherali et al. (2021) assert that, despite the relatively low percentage of children and adolescents who were actually infected with COVID-19 at the pandemic's height, those young people were nevertheless "highly vulnerable" to stress – including that caused by "school closure, isolation, limited physical activities, social distancing, and imposition of a restriction of liberty" (p. 14).

Indeed, the stress that they experienced during the pandemic is thought by some scholars to have resulted in structural changes to young people's brains. Gotlib et al. (2022), for example, explain,

> Compared with carefully matched peers assessed before the pandemic, adolescents assessed during the pandemic showed signs of advanced cortical thinning and had larger bilateral hippocampal and amygdala volumes…It appears…that the pandemic not only has adversely affected mental health of adolescents, but also has accelerated their brain maturation…[T]he pandemic appears to have altered adolescent mental health and neurodevelopment, at least in the short term… (p. 5)

Gotlib et al.'s (2022) finding – while certainly sobering – reinforces what has long been understood about the dynamic relationship between stress, the brain, and learning. Stress "activates brain regions associated with fear and escape rather than with academic thinking"; it depletes the "cognitive resources" required for learning (National Academies of Sciences, Engineering, and Medicine, 2018, p. 30).

Immordino-Yang et al. (2018) explain,

> The brains of children and adolescents who experience persistent adversity respond by strengthening circuits that promote aggressive and anxious tendencies at the expense of circuits for cognition, reasoning, and memory. The hormonal signaling molecules responsible for these shifts in neural development are toxic in large amounts, making individuals more likely to develop health problems, including mental health disorders such as addiction, anxiety, and depression, and physical health problems, such as heart disease, obesity, and cancer. (p. 3)

Those authors identify numerous "physiological preconditions" that policymakers, parents, educators, clinicians, and others must ensure for young people:

> Adequate physical activity, social connection, nutrition, and sleep are particularly important in adolescence, as these buffer the effects of stress on the brain and improve well-being, emotion regulation, cognition, and decision-making. (Immordino-Yang et al., 2018, p. 8)

Education Policy

Economic Inequality. Drawing upon data from four "well-documented" and "psychometrically linked data sets" [namely, the Long-Term Trend assessment administered by the National Assessment of Educational Progress (LTT-NAEP), the main NAEP assessment, the Trends in International Mathematics and Science Study (TIMSS), and the Programme for International Student Assessment (PISA)], Hanushek et al. (2020) conducted an analysis of the performance of cohorts of American students born between 1961 and 2001. The authors' aim was to identify any long-term trends in achievement gaps between youngsters from families of low socioeconomic status and those with greater means.

The authors found that there has been "little change in the SES-achievement relationship across the past close to fifty years" (Hanushek et al., 2020, p. 2). They conclude that, notwithstanding five decades' worth of education policy ostensibly designed to level the playing field for youngsters born into families and communities with limited resources,

> the gap in achievement between children from high- and low-SES backgrounds has not changed. If the goal is to reduce the dependence of students' achievement on the socio-economic status of their families, re-evaluating the design and foci of existing policy programs seems appropriate. As long as cognitive skills remain

> critical for the income and economic well-being of U.S. citizens, the unwavering achievement gaps across the SES spectrum do not bode well for future improvements in intergenerational mobility. (Hanushek et al., 2020, p. 28)

Hanushek et al.'s (2020) finding comes as no surprise to scholars who study – or, still less, to practitioners employed in – schools and districts that predominantly serve youngsters of low socioeconomic status.

> Counterproductive, if well-intended, accountability measures have governed education policy in many jurisdictions for the better part of the last two decades. With their overemphasis on the results of annual standardized tests, these regimes have effectively shifted onto educators accountability for policy-makers' perennial failure to remedy long-standing societal injustice (Anyon, 2010; Berliner, 2013; Gorski, 2012). Moreover, these policies have served to narrow the curriculum to only those subjects that are formally tested and to denude teaching and learning – not least, in the tested subjects – of creativity and curiosity for students and teachers alike (Berliner, 2013; MacDonald & Shirley, 2009; Ravitch, 2010; Schneider, 2017)…
>
> Particularly cruel, students whose annual test scores capture the lack of opportunity and resources available in the neighborhoods in which they live and attend school, and who therefore most require educators who are pedagogically creative, conscientious and culturally sustaining, are instead taught by educators who – precisely because of the high stakes associated with such testing – face the harshest sanctions for exercising their own professional judgment…(Anyon, 2010; Berliner, 2013; Garcia & Weiss, 2017; Hargreaves et al., 2014; Ravitch, 2010; Sahlberg, 2010; Schneider, 2017; Tienken et al., 2017; Tienken & Orlich, 2013).
>
> (Trombly, 2020, p. 353)

It was for all of these reasons that the Task Force to Study the Comprehensive Needs of Children in the State had made the following recommendation in its initial report to the Connecticut General Assembly in 2021:

> ***E.1. Fully fund the Education Cost Sharing formula passed by the CGA in October 2017 in advance of the projected FY 2028 date.***

We are gratified that, in 2023, the CGA added $150 million to Education Cost Sharing for FY 2025, in addition to the planned $45 million increase; and that it now has the goal of fully funding Education Cost Sharing by FY 2026.

Counterproductive Mandates. Empirically examining the choices that people across disciplines make, Adams et al. (2021) found that individuals tend to overlook subtractive change; that they more often make additions to situations in order to improve them, rather than seek to improve matters by eliminating redundancies. While acknowledging that "defaulting to a search for additive ideas often serves its users well," the authors cautioned, "the tendency to overlook subtraction may be implicated in a variety of costly modern trends, including overburdened minds and schedules, including red tape in institutions" (p. 261). The authors concluded,

> If people default to additive transformations – without considering comparable (and sometimes superior) subtractive alternatives – they may be missing opportunities to make their lives more fulfilling [or] their institutions more effective… (p. 261)

It was, in part, with this in mind that the Task Force had made the following recommendation in its initial report to the CGA in 2021 (and subsequently identified in its 2022 Report that the CGA had not yet taken any steps to address it):

> ***E.4. Significantly reduce the number of mandates for schools – especially those serving students with the greatest need, who therefore most require genuinely engaging, culturally responsive instructional practices. While accountability is inarguably necessary, many of the current mechanisms for ensuring it have served to narrow the curriculum, stifle innovation, and render school less engaging for students and educators.***

We appreciate that the CGA has directed the Connecticut Association of Boards of Education to convene a working group to review mandates on the State Department of Education and local Boards of Education; to make recommendations on what mandates should be repealed; and to develop a biennial process to review mandates.

We feel strongly that such a review should attend, not only to the intended outcomes of those mandates, but also to their actual (if unintended) impacts upon students and the educators who serve them. In this way, this important exercise could result in relieving children and adolescents in Connecticut's schools – particularly in districts serving large numbers of

youngsters from families with limited resources – from much of the needless but harmful stress that they currently endure.

Conclusion

The Task Force to Study the Comprehensive Needs of Children in the State was charged, among other things, to "study the *feasibility* of adjusting school start times to improve students' mental and physical well-being" (emphasis added). Members of the Task Force, across both working groups, undertook this charge mindful and in agreement with the vast body of literature emphasizing the particular importance of sleep during adolescence. We likewise approached the task fully cognizant that schools and their schedules are intricately interwoven with the schedules of the families and communities whom they serve, and that any effort to alter the former would necessarily have implications for the latter.

What follows are the Task Force's key findings as they relate to "the feasibility of adjusting school start times":

- In any/all discussions, the phrase "adjusting school start times" must be expanded to reflect the changes to school dismissal times that such adjustments necessitate, as it is at the end of the school day that many of the challenges associated with such changes materialize.
- Changes to start/end times for a district's schools serving adolescents frequently necessitate changes to the start/end times of schools serving elementary-aged children in that same district.
- Having middle and high schools within a district begin and end their days later than elementary schools do frequently creates childcare issues for younger students, who will be dismissed from school before the older siblings/cousins/ neighbors who would otherwise care for them will now be available to do so.

- Having elementary schools begin or end their days either earlier or later than they currently do, in order to accommodate changes to the start/end times of middle and high schools, requires younger students to walk to, wait at, and/or walk home from bus stops at times when it is darker than when they currently do. Moreover, in many communities, not all streets/roads include sidewalks; neither are all streets/roads well-lit.
- Changes to start/end times for schools serving adolescents frequently require changes to the scheduling of bus runs. In some instances, they have required the addition of buses at considerable expense. (Given the labor market for the past several years, many school districts and/or the transportation companies with which they contract have found it impossible to recruit and retain sufficient numbers of drivers for their school bus fleets.)
- Changes to start/end times for schools serving adolescents almost invariably trigger changes in the availability of playing fields and other facilities within a community, as high school athletics are given priority. Scheduling high school practices and games later in the day automatically means that younger children on youth teams/in recreation leagues will not have access to fields/facilities until even later than they currently do. (This is especially so, since volunteer coaches are unlikely to be available any earlier in the day than they currently are.) As a consequence, middle school students – themselves adolescents – would be required to attend practices/games still later than they currently are.
- School districts that have managed successfully to achieve later school start/end times for adolescents have partnered proactively with other community agencies and organizations in order to mitigate many of the issues (e.g., demand for

childcare for upper elementary-aged students) in which such schedule changes have resulted.

- School districts that have sought to achieve a full one-hour delay in school start/end times for adolescents have tended to encounter greater numbers of issues (e.g., significant changes to start/end times for younger children; bus-related expenses; childcare issues for families), and therefore more political opposition, proving the wisdom behind Voltaire's admonition against making the perfect the enemy of the good.
- Because of the varied times at which different districts' high schools begin and end their school days, students from schools with later dismissal times are often required to miss instructional time on game days in order to travel to competitions against schools with earlier dismissal times. This creates additional burdens for the student-athletes, themselves, as well as for their teachers.
- Given how politically fraught discussions have been in numerous communities that have considered changing school start/end times, it has been suggested that such decisions should be made at a regional or state level. The already obvious disparities between the resources enjoyed by different communities prevent such wide-scale mandates, as they would pose outsized burdens upon districts with fewer resources.
- Regional issues, and issues of urbanicity, likewise render regional or state-level mandates unfeasible. (Traffic issues in lower Fairfield County prolong travel, not only between school districts, but within them, with implications – and associated expenses – for numbers of bus routes and drivers. Rural school districts tend to have fewer illuminated playing fields, fewer streets/roads with sidewalks, and

fewer well-lit streets/roads; consequently, what may work well for districts in communities that are more developed or that have greater infrastructure would pose challenges in more rural, less developed communities.)

- The fact that Norwalk, to our knowledge, is the only urban community in the state to have actively considered – let alone attempted to implement – later school start/end times for adolescents highlights the vast inequities that already exist between communities in Connecticut. (Indeed, much of the literature on school districts across the country that have implemented such schedule changes center around more affluent, suburban districts.) Not only do urban districts serve greater numbers of students, they also have greater concentrations of students with higher needs (i.e., students from families with low socioeconomic status; students who are English learners; students who receive Special Education and related services).

Adolescents endure many challenges to their emotional and physical health. While altering school start/end times for these young people to afford them more and better-quality sleep is one option to which every consideration should be given, it is by no means the only one. Other, more immediately practicable options – including building more opportunities for exercise and fresh air into adolescents' school days; engaging them more actively and authentically in the learning process; relieving them of time-intensive homework assignments that do not contribute meaningfully to their learning, or to teachers' diagnoses of how to further that learning; ensuring that their schools employ numbers of nurses, school counselors, social workers, and other support professionals commensurate with the needs of the students who attend those schools; and guaranteeing that students' and families' basic needs for safe, affordable housing, nutritious food, adequate income, and accessible/affordable healthcare – must also be prioritized, if Connecticut is indeed serious about improving adolescents' mental and physical well-being.

Updated Recommendations of the Task Force

Connecticut should take to heart and act upon what Frederick Douglass articulated over one hundred sixty-five years ago: "It is easier to build strong children than to repair broken men."

The recommendations of the 2021 Task Force report were designed to build strong children in Connecticut by ensuring that all youngsters in the state are *healthy* (recommendations H.1 through H.15), *safe* (recommendations Sa.1 through Sa.4), *engaged* (recommendations E.1 through E.6), *supported* (recommendations Su.1 and Su.2), and *challenged* (recommendations C.1 through C.3).

Abraham Maslow (1943) identified individuals' physiological needs as pre-potent to all of their other needs (i.e., their needs for safety, belongingness and love, esteem, and self-actualization). Similarly, when enumerating the five component tenets of the Whole Child framework, ASCD identified the need for children to be healthy as foundational to their being safe, engaged, supported, and challenged.

As the Department of Public Health (2021) explains in its compelling report *Healthy Connecticut 2025 – State Health Improvement Plan*, four elements are critical to ensuring that individuals and communities are healthy: Access to Health Care, Economic Stability, Healthy Food and Housing, and Community Strength and Resilience. These 'Social Drivers of Health' – the conditions in which people live, attend school, and work – "disproportionately impact vulnerable or disadvantaged populations, such as children and young people; people with disabilities; seniors; veterans; immigrants regardless of status; People of Color; current and recently incarcerated people; the poor; the homeless and those experiencing housing insecurity; people with Substance Use Disorders; and Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and other Queer-identifying (LGBTQIA+) people" (p. 20).

Because health disparities – which are preventable differences "in health status, risk factors, and/or health outcomes among subgroups of the population"(DPH, 2021, p. 20) – often stem from the social, economic, and/or environmental disadvantages that people experience, all four Social Drivers of Health are reflected in the Task Force's recommendations.

Many of the recommendations offered by the Task Force to Study the Comprehensive Needs of Children in the State 2021 have also been – or are being – made by other agencies and organizations in Connecticut. The following pages list the recommendations from 2021 and 2023 and provide a status update on the legislative actions that have been taken. Recommendations that have been addressed have been highlighted in green with a description of the legislative actions taken. The recommendations not yet addressed – including several new recommendations emerging from the charges assigned to us in 2022 – have been highlighted in gold.

Task Force recommendations highlighted in green have been addressed to some degree by the CGA, either in the 2022 or the 2023 legislative session. **(Specific actions taken are identified.)**

Task Force recommendations highlighted in gold have not yet been addressed by the legislature to the best of our knowledge. Some of these recommendations were included in our first report in December 2021; some have been added subsequently, either in our second report, or pursuant to the two specific charges that were assigned to us in 2022.

Healthy: ***Each student enters school healthy and learns about and practices a healthy lifestyle.***

H.1. Increase children's access to preventative care to promote their medical, dental, and social-emotional health.

The Task Force endorses the Department of Social Services' (2021) *State Action Plan for Fiscal Year 2022*, which, among other things, calls for increases in:

- the number of children who receive well-child exams annually;
- the number of children who receive dental visits annually; and
- the number of DPH funded School Based Health Center sites that conduct Adverse Childhood Experiences (ACEs) screenings, and make necessary referrals.

Likewise, this recommendation reflects the Task Force's appreciation of the efforts of the task force that had been established under Public Act 21-35 to examine strategies to expand access to school-based health centers (SBHCs) or expand SBHC sites.

2022 Session

Senate Bill 1 section 10 established the Task Force to Combat Ableism. The task force shall identify (1) current efforts to educate all students on disability and combat ableism in the public school curriculum and classrooms, and (2) opportunities to expand such efforts and integrate them into social-emotional learning.

Senate Bill 2 section 1 made mental health and addiction services available 24/7.

Senate Bill 2 section 2 created the Social Determinants of Mental Health Fund to offer funding for mental health care to those impacted by social determinants.

Senate Bill 2 sections 11-12 established the Get Outside and Play for Children's Mental Health Day.

Senate Bill 2 section 17 creates a cost sharing program for pediatric providers to hire LCSWs and Counselors in-office.

2023 Session

No action taken.

H.2. Make health care costs – including the costs of behavioral and mental health care – affordable for families.

As the U.S. Department of Education (2021a) explains, "Nearly one in five children in the United States live in poverty, and youth from lower income households are less likely to access health care…and more likely to experience significant mental health systems" (p. 10).

The Task Force endorses the Connecticut Department of Public Health's (2021) *Healthy Connecticut 2025 - State Health Improvement Plan*, which, among other things, calls for a decrease in the number of Connecticut residents who are at risk of spending more than 10% of their net income on health care services and coverage.

2022 Session

Senate Bill 1 section 12 established a School Based Health Center expansion program.

Senate Bill 2 section 2 created the Social Determinants of Mental Health Fund to offer funding for mental health care to those impacted by social determinants.

2023 Session

No action taken.

H.3. Increase availability of settings (telehealth, out-patient, and in-patient) for mental health preventive care, treatment, and crisis intervention for individuals of all ages.

This recommendation reflects the Connecticut Department of Public Health's (2021) priorities - expressed in *Healthy Connecticut 2025 - State Health Improvement Plan* - that there be an increase in "the number of traditional and alternative (community- and technology-based) places people can access health care" (p. 45), and that there be an increase in "the availability and diversity of primary care providers, community partners, and care management services" (p. 46).

Additionally, this recommendation echoes that of the Centers for Disease Control and Prevention (2019), which advocates interventions to lessen the immediate and long-term harms to youngsters of Adverse Childhood Experiences (ACEs). Among the interventions that the CDC recommends are: enhanced primary care, victim-centered services, treatment to lessen the harms of ACEs, treatment to prevent problem behavior and future involvement in violence, and family-centered treatment for substance use disorders.

This recommendation likewise reflects the aim, expressed in the *Connecticut Children's Behavioral Health Plan - 2021 Annual Report*, that the state invest in collaborative activities that will allow for the provision of services and supports needed by children.

The Sandy Hook Advisory Commission explained in 2015:

> Many of our students and their families live under persistent and pervasive stress that interferes with learning and complicates the educational process. There are many potential resources such as school

based health centers that should provide a locus of preventive care, including screenings and referrals for developmental and behavioral difficulties, exposure to toxic stress, and other risk factors, as well as treatment offerings that can address crisis, grief and other stressors.

2022 Session

Senate Bill 1 sections 3-5 offered a grant and program to hire mental health workers in schools with highest unmet need.

Senate Bill 2 section 1 made mental health and addiction services available 24/7.

Senate Bill 2 sections 3-4 creates a mental health plan for student athletes.

2023 Session

No action taken.

H.4. Expand access to treatment services for addiction for individuals of all ages.

This recommendation reflects the Department of Social Services' (2021) goal, articulated in its *State Action Plan for FY 2022,* of reducing the number of adolescents who report using substances.

Moreover, this recommendation reinforces the CDC's (2019) promotion of family-centered treatment for substance use disorders as one mechanism by which to mitigate the impacts of Adverse Childhood Experiences.

2022 Session

Senate Bill 2 section 1 made mental health and addiction services available 24/7.

2023 Session

PA 23-97
Increases treatment for opioid addiction by:

- Creating a harm reduction pilot to prevent overdoses – allowing people to access fentanyl and xylazine tests, receive counseling and other services - under the care of licensed providers
- Establishing a dedicated funding source for the bulk purchase of Narcan for towns, schools, local police and health departments and EMS companies
- Encouraging people to obtain Narcan when they are prescribed an opioid

H.5. Enhance – and provide sufficient resources, including personnel and training for – schools' efforts to promote students' social and emotional health; to teach social-emotional and relationship skills; and to implement disciplinary policies and practices that are educative and restorative.

The Task Force agrees with the CDC's (2019) expression of the importance of teaching young people to "handle stress, manage emotions, and tackle everyday challenges."

The Sandy Hook Advisory Commission identified in 2015:

> For many children schools offer the only real possibility of accessing services, so districts should increase the availability of school guidance counselors, social workers, psychologists, and other school health and behavioral health professionals during and after school as well as potentially on Saturdays.

The Task Force likewise endorses Connecticut Voices for Children's (2021) recommendation that the Connecticut General Assembly:

> Increase funding for behavioral health support staff in schools including counselors, psychologists, and social workers. Behavioral health support staff spend years in higher education learning to support positive school environments, connect with and support families, and identify when children are struggling and intervene before crises emerge. (p. 16)

Darling-Hammond and Podolsky (2019) report that policymakers in nations with histories of high academic achievement provide resources necessary for "ongoing time and support for professional learning and collaboration" (p. 29). Persistently inequitable school funding in Connecticut inhibits these kinds of supports from being available in schools and districts that serve communities with the greatest concentrations of need.

"Because Connecticut does not fund school districts based on the complete learning needs of the students they serve," the School + State Finance Project (2020) explains, "districts serving the highest-need students often do not receive funding that reflects the needs of their student population, making it difficult for those districts to provide their students with educational opportunities equal to those of their non-need peers" (p. 18).

2022 Session

Senate Bill 1 section 10 established the Task Force to Combat Ableism. The task force shall identify (1) current efforts to educate all students on disability and combat ableism in the public school curriculum and classrooms, and (2) opportunities to expand such efforts and integrate them into social-emotional learning.

2023 Session

PA 23-167 secs. 47-71 reforms current school climate reporting and plan development practices and includes requirements to incorporate restorative practices. BOEs will provide training resources to schools, open to all employees, on social and emotional learning, school climate and restorative practices. This act also requires boards of education to adopt a restorative practices response policy for incidents of challenging behavior that is nonviolent and does not constitute a crime. Such policy may not include SROs unless the behavior escalates to violence or is a crime. SDE will establish a working group under the CT School Discipline Collaborative to study current school discipline practices, including those that lead to students becoming involved with the justice system. SDE will also evaluate and monitor districts that have high levels of suspensions/expulsions as they work to reduce the use of these interventions, and will provide recommendations for districts to use to evaluate students' mental health and suicide risk.

PA 23-159 deals with professional development provided to paraeducators and requires it to integrate social-emotional learning and restorative practices.

H.6. Address payment/reimbursement issues for pay-for-service in the school setting. (Statutory language allowing five sessions before parental notification prevents those sessions from being eligible for reimbursement.)

Waive elements of the comprehensive psychosocial assessment or timeline for completion: Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document all of the psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.

Extend deadlines for service or treatment plan: Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.

Consider eliminating the requirement that the treatment plan be a separate document: Update treatment plans as part of the clinical documentation in each session, as is done in primary health care. Standard medical care integrates the treatment plan into the body of the visit note, allowing the plan to be reviewed and updated at each visit.

Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.

Heinrich, Camacho, Henderson, Hernández, and Joshi (2021) explain of administrative burdens:

> They not only appear to impede children's and families' access to public benefits and social service support that affect their healthy development and well-being, but they also place additional strain on the capacity of public and private nonprofit organizations that serve as the health and social safety net for those in most need, particularly in communities with more limited resources and social service infrastructure. (p. 29)

The Task Force underscores the following recommendations made by the Sandy Hook Advisory Commission in 2015:

- To promote healthy child development and foster robust communities, our systems of care must attend to the factors affecting family welfare. Current funding structures must thus be revamped. The Commission recommends support for models of integrated care driven by family needs in which all providers focus on family strength, address their risk factors, and accept the family as a partner in treatment.
- Inadequate reimbursement rates combined with high utilization rates at many outpatient behavioral health clinics have made this model of care financially unsustainable. In addition, overall Medicaid rates for adult inpatient care have not increased in at least eight years. Recent increases in rates for inpatient child and adolescent care have been coupled with decreases in other Medicaid reimbursement rates to the same hospitals. The Commission recommends that higher reimbursement rates in both outpatient and inpatient settings, which better reflect the costs of care, be a core component of a redesigned behavioral health care system.
- Connecticut has significant problems with system fragmentation resulting from diverse payment systems and a lack of coordination or consistency among state agencies. A fragmented system yields unequal access to effective treatment, discontinuities of care for those

receiving service, and unsustainable financial burdens for individuals, families and communities.

H.7. Increase the number of individuals seeking to become mental health and behavioral health providers, and retain those professionals already in the field, by:

- **increasing the rates paid for services;**
- **providing tuition reimbursement to those entering or already serving in these roles; and**
- **providing reimbursement for the costs of licensure and renewal.**

RECOMMENDATION (December 2022): Take immediate steps to retain existing skilled behavioral health professionals and expand the pool of qualified clinicians from all disciplines.

- Adjust grant funding levels and reimbursement rates to support competitive compensation packages.
- Eliminate regulatory requirements that create barriers to entry not necessary to maintain clinical integrity: for example, the Mastery Test for LMSW, which has evidence of racial bias, until a new test has been agreed upon by the state.
- Request that the relevant administrative agencies investigate social workers' progression to the LCSW and the associated implications (e.g., requirements for ongoing supervision).

This recommendation echoes that articulated in the 2021 Annual Report of the Connecticut Children' Behavioral Health Plan:

> Take immediate steps to retain existing skilled behavioral health professionals and expand the pool of qualified clinicians from all disciplines. Suggested actions include:
>
> a) Adjust grant funding levels and reimbursement rates to support competitive compensation packages.
>
> b) Eliminate regulatory requirements that create barriers to entry not necessary to maintain clinical integrity.

Explaining, "Inadequate reimbursement rates have…impacted the behavioral health workforce which remains insufficient to meet the needs of many Connecticut residents," the Sandy Hook Advisory Commission (2015) recommended, "in addition to addressing reimbursement rates, Connecticut identify and take measures to increase the behavioral health workforce. These might include educational incentives such as loan forgiveness programs."

In some states, individuals are allowed to sit for their initial Social Work license exam during their last semester of matriculation, rather than waiting until after they have graduated to take the exam. This allows them, if they successfully pass their exam, to have their Social Work license issued upon graduation - i.e., several months earlier than if they had been required already to have graduated.

2022 Session

House Bill 5001 section 1 requires DPH and DCF to develop and implement a plan to waive licensure requirements for mental or behavioral health providers licensed in other states.

House Bill 5001 section 2 expands existing law on expedited licensure for health care providers licensed in other states.

2023 Session

Related - SB 2 updated licensing fees for LCSW, LMSW, LMFT, LMFT-A, LPC and LPC-A. All renewals will now be annual with the same fees for every license.

H.8. Attend to the wellness of educators and other personnel who serve children and adolescents – both in school and out.

Recommending that "Wellness for Each and Every Child, Student, Educator, and Provider" be prioritized, the U.S. Department of Education (2021) explains:

> Educator wellness is associated with child and student wellness…Educators who provide emotional support and establish positive relationships influence children's and students' health, overall wellness, and life satisfaction (Steward & Suldo, 2011). Wellness is multidimensional and may include medical, emotional, environmental, occupational, physical, intellectual, spiritual, and financial components…Educators' wellness is an important component to ensuring a healthy school climate, and educator wellness programs are associated with greater workplace satisfaction and lower rates of absenteeism…Promoting staff wellness benefits staff, children, and students. (p. 20)

2022 Session

Senate Bill 1 section 14 placed in statute a guaranteed uninterrupted duty-free lunch period for educators.

2023 Session

No action taken.

H.9. Increase awareness of nutrition programs offered through the Connecticut Department of Agriculture and the Connecticut Department of Public Health, including but not limited to, the Farmer's Market Nutrition Program.

The task force is very appreciative of the ongoing and evolving partnerships between Connecticut's Departments of Agriculture and of Public Health in the area of nutrition. In an effort to support increased utilization of the nutrition programs offered through state agencies, the task force recommends additional support for outreach and awareness of these programs.

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its priority areas "Healthy Food and Housing." DPH explains:

> Many of our health outcomes are influenced by what, how much, and how often we eat. Yet for many, making the healthy food choice is not the easy choice. For some CT residents, healthy and affordable foods are not as readily available in their communities as are places that prepare or sell processed pre-packaged foods that are more likely to be high in salt, sugars, and fats. Children within these communities are especially vulnerable since they are subject to the food choices made by their parents…[H]ealthy food access, which is influenced by the affordability and availability of food and household income is an important factor that impacts population health both immediately and with lasting effects. (p. 55)

To meet this priority, DPH (2021) recommends that Connecticut:

- "Increase the utilization of available housing and food programs by eligible residents…" (p. 57), and
- "Increase the number of access points where people can obtain affordable, healthy, and nutritious food…" (p. 57).

H.10. Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics.

In making this recommendation, the Task Force repeats verbatim one of the aims put forth by the Department of Public Health.

Edelman (2012) urges that policymakers not "forget the underlying issues of jobs and income and the closely connected and still-important issues of race and gender" (p. 141). He continues:

> The poverty-related activities that can be conducted within schools and by using schools as a base are worthwhile, but people should not confuse them with the policies that are necessary to reduce poverty meaningfully. Quality education is a core strategy in fighting poverty, but unless we fight poverty on all fronts, the schools will not succeed in helping all children have the chance to achieve their full potential. (p. 141)

H.11. Increase funding to expand parents' and caregivers' access to the Connecticut Department of Labor's various job-training and workforce development programs.

The Task Force underscores the Department of Public Health's (2021) aims that Connecticut:

- Increase the amount of capital investment in communities and local businesses to support workforce development, community development, and entrepreneurship... (p. 51)
- Increase the number of employers who invest in employment retention and wellness programs/policies that support the continuity of their work... (p. 51)
- Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance… (p. 52)

H.12. Create a Connecticut Child Tax Credit

The Task Force bases this recommendation on recommendations from both the Centers for Disease Control and Prevention and Connecticut Voices for Children.

In its publication *Preventing Adverse Experiences (ACEs): Leveraging the Best Available Evidence*, the CDC (2019) reports, "The evidence tells us that ACEs can be prevented by…strengthening household financial security" (p. 11). It continues by explaining that Child Tax Credits "help increase income for working families while offsetting the costs of childcare," and that they "have also been shown to reduce child behavioral problems (e.g. physical aggression, anxiety, and hyperactivity) - factors that are linked to later perpetration of violence toward peers and intimate partners" (p. 11).

Connecticut Voices for Children (2021) advocates a Connecticut Child Tax Credit, explaining that such a measure "would provide financial support for working and middle-class families, make Connecticut's tax system fairer, and make Connecticut more competitive" (p. 5).

2022 Session

There was a Child Tax Rebate in 2022.

2023 Session

No action taken.

H.13. Continue to expand access to affordable, high-quality child care and preschool until universal preschool is available for all; and ensure that the professionals who staff those programs are paid at competitive rates that reflect their levels of education and training, and the responsibility that they hold.

This recommendation echoes the suggestion made by the Hunt/Kean Leadership Fellows (2021) that the early childhood workforce - those women and men who care for and teach our communities' youngest members - be supported to become credentialed, to provide high quality care and education, and to be compensated in accordance with the importance of their work.

This recommendation likewise echoes the Centers for Disease Control and Prevention's (2019) priority of "Ensuring a strong start for children and paving the way for them to reach their full potential" through such measures as "early childhood home visitation," "high-quality child care," and "preschool enrichment with family engagement" (p. 9).

Connecticut Voices for Children (2021) explains that, during the COVID-19 pandemic, "Lack of available and affordable child care forced many people to choose between working and keeping their children safe and learning" (p. 16).

2022 Session

Senate Bill 1 sections 1 and 2 offered a grant for early childhood education program operators and child care service providers.

Senate Bill 2 section 12 increased GAP payments for children with IEPs

Senate Bill 2 section 13 offered municipalities the opportunity to abate property taxes for early childhood educators.

2023 Session

Continued Smart Start and increased per-child funding for school readiness.

H.14. Address homelessness among adolescents – particularly those who identify as LGBTQIA+.

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its aims to "[d]ecrease the number of persons experiencing or at risk of homelessness and increase opportunities to obtain affordable and sustainable housing…" (p. 58).

The Task Force appreciates the Department of Housing's ongoing efforts in this area, and it urges the Connecticut General Assembly to make more funding available to support those efforts as well as those of local agencies and organizations that work to support homeless and housing insecure adolescents - particularly those who identify as LGBTQIA+.

The Task Force likewise appreciates the work of the Statewide Minor Homelessness Task Force, co-chaired by the Center for Children's Advocacy and the Connecticut Youth Services Association, which includes the Department of Housing, Department of Children and Families, Connecticut State Department of Education, and other youth-serving organizations and advocates. That panel has been reviewing the limited available data regarding this population, existing resources, and working with the National Coalition for Juvenile Justice, the Court Support Services Division of the Judicial Branch, and other organizations and agencies on a Collaboration for Change pilot project in the greater Stamford region that is establishing a coordinated system - including

multi-sector case conferencing - that assists unaccompanied youth experiencing homelessness. Two additional pilots are being launched, which will help inform the work necessary to address unaccompanied minor homelessness across the state.

2022 Session

No action taken.

2023 Session

In PA 23-167, the CGA required that when Boards of Education develop policies and procedures related to youth suicide prevention, they base their assessment of risk factors on the plan developed by the Connecticut Suicide Advisory Board, including at least:

- Those who have lost someone to suicide.
- Those with disabilities or chronic health conditions, including mental or substance use disorders.
- Those who are involved in the juvenile justice system.
- Those who are homeless or in foster care.
- LGBTQ students.

H.15. Establish a reimbursement mechanism (e.g. under Medicaid) for Occupational Therapy/ Executive Function supports, and ensure that such services are made more broadly available to children in all settings.

Executive functioning skills are needed for children and adults to "focus on multiple streams of information at the same time, monitor errors, make decisions in light of available information, revise plans as necessary, and resist the urge to let frustration lead to hasty actions" (Center on the Developing Child, 2011, p. 1). These skills are coordinated in the brain through the development of working memory, mental flexibility, and self-control. In children exposed to "toxic stress" the skill development in the brain is delayed (p. 7). Occupational therapy can develop executive functioning skills by focusing on daily real-life situations.

The Task Force understands that Medicaid, operated by the Department of Social Services in Connecticut, reimburses for health-care services as stated in the Department's publication entitled *Medicaid School Based Child Health Program* (2017). In addition, although occupational therapy services are included in those services that are reimbursable, services exclusively to develop executive functioning skills are not included as reimbursable. Children who need occupational therapy support to develop executive function skills for life and learning should have the opportunity to receive these services and be included among those that are reimbursable.

SAFE: ***Each student learns in an environment that is physically and emotionally safe for students and adults.***

Sa.1. Increase families' access to safe, affordable housing by:

- **increasing the stock of affordable housing;**
- **increasing housing subsidies, so that families are not required to spend more than 30% of their income on housing.**

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its priority areas "Healthy Food and Housing." DPH explains:

> Households are considered cost burdened when they spend more than 30% of their gross income on housing. In 2017, an estimated 27% of owners and 48% of renters in Connecticut were cost-burdened. When families have to spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress, mental health problems, and an increased risk of disease. (p. 56)

To meet this priority, DPH (2021) recommends that Connecticut:

- "Adopt and begin to implement a Connecticut property maintenance code that includes a statewide definition for safe and quality housing…" (p. 58), and
- "Increase the percentage of owner-occupied housing in CT…" (p. 59).

The Task Force appreciates the Connecticut Department of Housing's (2020) ongoing "Work to Ensure That All of the State's Residents Live in a Suitable Living Environment":

> A suitable living environment includes improving the safety and livability of neighborhoods; increasing access to quality public and private facilities and services; reducing the isolation of income groups within a community or geographical area through the spatial de-concentration of housing opportunities for persons of lower income and the revitalization of deteriorating or deteriorated neighborhoods; restoring and preserving properties of special historic, architectural, or aesthetic value; and conservation of energy resources and consideration of potential impacts of climate change on existing and future development. (p. 3)

2022 Session

House Bill 5205 requires towns with at least 14,000 people to create fair rent commissions.

2023 Session

No action taken.

Sa.2. Enact zoning reform to ensure that safe, affordable housing is available in <u>all</u> communities.

The Department of Public Health (2021) explains:

> Low-income families may be more likely to live in poor-quality housing that can damage health. Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located…[T]he quality of a home's neighborhood is

> shaped in part by how well individual homes are maintained; living in a poor quality home and widespread residential deterioration in a neighborhood can both negatively affect mental health. (p. 55)

The Task Force appreciates the work of Connecticut's Commission on Human Rights and Opportunities in addressing issues housing discrimination, in improving access to affordable housing, and in advocating for zoning reform.

The Task Force echoes Connecticut Voices for Children's (2021) recommendations that the Connecticut General Assembly "continue efforts toward residential zoning reform and the development of more affordable housing in future legislative sessions" (p. 11); and that the CGA ask "Connecticut towns to plan and zone for their fair share of the state's affordable housing needs" (p. 12).

DeLuca & Clampet-Lundquist (2016) explain, "Policies that offer low-income families affordable housing in opportunity-rich neighborhoods, provide youth with a range of programs in schools and other settings so they can pursue their interests, and give low-income young adults affordable post-secondary education with concrete avenues to stable jobs can help launch youth out of poverty as they move into adulthood" (p. 16).

2022 Session

No action taken.

2023 Session

While the CGA did not pass a major zoning reform bill this year, it included in the budget funding for the Municipal Redevelopment Agency (MRDA) in sections 203-207.

The MRDA will create incentives for municipalities to create more affordable housing by adopting "housing growth zones", which will need to include zoning changes. This is a change that is entirely voluntary for municipalities, so it isn't entirely clear how large of an impact this will ultimately have in increasing affordable housing stock, and it certainly won't be in all communities.

The CGA also created a "workforce housing" incentive program for municipalities in SB 998. Like the MRDA it is voluntary for municipalities and creates more state incentives to create more "affordable housing" (which are deed restricted units where lower income residents pay less than 30% of their income in rent). But we'll need to see how many municipalities take advantage of this program.

PA 23-142 forces municipalities to change their zoning codes to make it easier to open group and family childcare homes. This has been a perennial bill that we finally passed this year that expands access to childcare.

Sa.3. Increase children's and adolescents' access to mentoring programs and after-school programs.

In its publication *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*, the Centers for Disease Control and Prevention (2019) recommends "Connecting youth to caring adults and activities" through such approaches as "mentoring programs" and "after-school programs" (p. 9).

2022 Session

Senate Bill 2 section 45 offers an opportunity for Youth Service Bureaus to receive grants for their programs.

2023 Session

No action taken.

Sa.4. Increase Access to Public Transportation.

As was memorably said to one of the Task Force co-chairs 27 years ago by a young mother who had just explained the time required and logistical challenges associated with getting her small children to their early morning medical appointments and herself to the mid-afternoon meeting at which the conversation occurred, "Being poor is a full-time job." Not having sufficient financial resources to own a vehicle of her own, and living in a region of the state where public transportation was limited, added significantly to the burdens and stresses of this mother and her family.

Connecticut's Judicial Branch provides cards and vouchers that families whose children are involved with the courts may use for transportation. Regrettably, these enormously valuable supports cease when these children and adolescents exit the system.

Investments in expanding public transportation in Connecticut, and in increasing access to that expanded system, will go a long way to reducing stresses on children and families with low incomes. Moreover, given what is now all-too-clear about climate change and its impact on public health (particularly for children and families with low incomes), expanded public transportation will serve to reduce carbon emissions by decreasing people's reliance upon personal vehicles.

This recommendation underscores the Department of Public Health's (2021) priority that Connecticut "Increase the number of policies and systems that address environmental and social justice, health disparities, and community safety as a result of meaningful community engagement…" (p. 64).

2022 Session

House Bill 5506 suspended the 25-cent-per-gallon motor vehicle fuels tax on gasoline. It also allocated funding to the DOT for free public bus transportation.

2023 Session

The housing growth zones created through the MRDA are supposed to be in downtowns or areas with public transit, so if they are adopted, they would increase access to public transit for those households.

ENGAGED: ***Each student is actively engaged in learning and connected to the school and broader community.***

E.1. Fully fund the Education Cost Sharing formula passed by the CGA in October 2017 in advance of the projected FY 2028 date.

"Because Connecticut does not fund school districts based on the complete learning needs of the students they serve," the School + State Finance Project (2020) explains, "districts serving the highest-need students often do not receive funding that reflects the needs of their student population, making it difficult for those districts to provide their students with educational opportunities equal to those of their non-need peers" (p. 18).

As the National Commission on Social, Emotional, and Academic Development (2018) explains,

> Balanced and equitable preK-12 learning systems require balanced and equitable distribution of resources, which should include a diverse and stable cadre of effective educators, reasonable class sizes, appropriate ratios of counselors and other support staff to students, and access to health and mental health services. Federal, state and local leaders should account for the differing needs of students by supporting weighted school funding formulas that provide more resources for students with greater needs… (p. 36)

The necessity for schools and districts serving greater numbers of students with significant needs to receive funding commensurate with those numbers and needs has been underscored by the challenges posed by the COVID-19 pandemic.

2022 Session

No action taken.

2023 Session

The CGA put an additional $150m into ECS for FY 25 on top of the planned $45m increase. Goal is to fully fund by FY 26.

E.2. Increase the number of individuals seeking to become educators (teachers, school counselors, school psychologists, school nurses, speech/language pathologists, social workers, occupational therapists, etc.), and retain those professionals already in the field, by:

- **increasing the salaries for these roles;**
- **subsidize the costs of tests and fees that individuals incur in the process of preparing to become educators;**
- **providing tuition reimbursement to those entering or already serving in these roles; and**
- **providing reimbursement for the costs of certification and renewal.**

The U.S. Department of Education (2021) explains that - after over a year and one-half of operating during the COVID-19 pandemic, "many school districts, straining under logistical challenges and uncertain budgets, have pointed to staffing shortages as an ongoing challenge in supporting students who are struggling" (p. 4). The Department goes on to report, "According to the National Association of Elementary School Principals, nearly

70% of school principals who participated in a survey conducted in early 2021 said they could not meet their students' mental health needs with the staff they had" (p. 4).

The task force agrees with the National Commission on Social, Emotional and Academic Development (2018), which writes:

> In order to attract a highly qualified and diverse educator workforce, state leaders can leverage opportunities and partnerships to expand and strengthen the recruitment mechanisms for future educators. Along with expanded recruitment, there should be a complementary focus on retention connected to ongoing professional support and growth. (p. 29).

Darling-Hammond and Podolsky (2019) report that policymakers in nations with histories of high academic achievement provide resources necessary to ensure

- Teacher compensation competitive with other college-educated professions and
- High-quality preparation available at little or no cost to entering teachers. (p. 29)

2022 Session

Senate Bill 1 section 23 will review obsolete provisions, evaluate requirements, and analyze regulation for teacher candidates.

In June, 2022, Governor Lamont and Commissioner Russell-Tucker announced a time-limited (two-year), $2,000,000 grant of federal American Rescue Plan, Elementary and Secondary School Emergency Relief (ARP-ESSER) funds to off-set the costs that pre-service educators incur in order to become certified (e.g., basic skills assessments, culminating content assessments, performance assessments, application fees).
https://news.southernct.edu/2022/06/03/new-grants-will-offset-test-costs-for-aspiring-teachers/

2023 Session

PA 23-167 removes the requirement that school nurses have the equivalent of one year full-time work as an RN during the five years prior to their employment, and requires school nurses employed by BOEs to complete at least fifteen hours of professional development every two years.

PA 23-159 restricts edTPA to an accountability tool to evaluate teacher prep programs; it will no longer be used to deny certificates to teachers.

E.3. Enhance families' knowledgeable, confident engagement in their children's and adolescents' social, emotional, and academic development.

In its publication *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*, the Centers for Disease Control and Prevention (2019) recommends, "Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges" (p. 9).

The Judicial Branch's Department of Probation oversees an invaluable family engagement initiative. This initiative should continue, and it should be replicated by other agencies, so that families of youth who are no longer involved with the court system may continue to benefit, and the families of youth who have never had

such involvement may likewise learn to knowledgeably, confidently engage in their children's and adolescents' social, emotional, and academic development.

E.4. Significantly reduce the number of mandates for schools – especially those serving students with the greatest need, who therefore most require genuinely engaging, culturally responsive instructional practices. While accountability is inarguably necessary, many of the current mechanisms for ensuring it have served to narrow the curriculum, stifle innovation, and render school less engaging for students and educators.

"Administrative burdens," Heinrich, Camacho, Henderson, Hernández, and Joshi (2021) explain, "may have far-reaching individual and systemic consequences – they generate substantial negative externalities…"

> They not only appear to impede children's and families' access to public benefits and social service support that affect their healthy development and well-being, but they also place additional strain on the capacity of public and private nonprofit organizations that serve as the health and social safety net for those in most need, particularly in communities with more limited resources and social service infrastructure. (p. 29)

Moreover, the sociologist Donald T. Campbell (1979) famously explained, "The more any quantitative social indicator is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor…" (p. 84).

Nowhere, perhaps, has Campbell's Law been more evident than in education policy. With good intentions of ensuring equitable outcomes for youngsters from traditionally under-resourced and under-served backgrounds, policymakers have for decades employed stagnant or decreasing scores as justification, not to address underlying societal inequities, but to impose still more prescriptions on the educators who serve these youngsters.

> The consequence of holding everyone accountable to low level tests in reading and math, without building any of the supporting structures, climate, or culture that would enable those results, is that schools serving disadvantaged students **narrowed the curriculum** and focused disproportionately on **test prep**, whereas more advantaged public schools and private schools had flexibility to continue offering a **richer and more holistic educational approach**.
> (Mehta, 2019 - emphasis in the original)

Education scholar Andy Hargreaves (2015) writes,

> Some of America's leading educational academics…repeatedly remind us that most of the variance in student achievement is explained by factors outside the school and beyond the ambit of educational policy and strategy. Poverty, poor infant care, lack of statutory maternity or paternity support, environmental toxins, neighborhood violence, financial insecurity and resulting instability among the working poor – these are the kinds of factors that are the greatest predictors of student underachievement in the United States. (p. 276)

Ironically, the very report that catalyzed the education reforms that have served to exacerbate societal inequities identified this issue nearly four decades ago. In *A Nation at Risk: The Imperative for Educational Reform*, the National Commission on Excellence in Education (1983) explained,

> That we have compromised [the] commitment [to schools and colleges of high quality] is, upon reflection, hardly surprising, given the multitude of often conflicting demands we have placed on our Nation's schools and colleges. They are routinely called on to provide solutions to personal, social, and political problems that the home and other institutions either will not or cannot resolve. We must

> understand that these demands on our schools and colleges often exact an educational cost as well as a financial one. (p. 1)

"If the goal in the long run is not simply to hold schools accountable but to enable them to consistently produce at higher levels of practice," Harvard's Jal Mehta (2013) explains, "the United States will need to move away from its recurring emphasis on scientific methods of control from above and embrace the more professional path characteristic of top-performing nations" (p. 13). The Task Force believes that there is no better place for this movement to begin than Connecticut.

The U.S. Department of Education (2021) recommends the following action steps:
Action Steps:

- Eliminate ineffective or redundant efforts such as non-instructional administrative duties and non-critical meetings so educators can direct their attention and energy toward better and sustained implementation of high-quality practices for all children or students, especially those with high risk. (p. 20)
- Establish a realistic workload, child or student to teacher ratio, and a manageable approach to teaching an aligned and integrated curriculum for academics and social-emotional, and behavioral health instruction. Feeling competent is part of wellness. When educators feel like they have the skills, resources, and supports to do their job well, they feel less stressed and are able to better meet the needs of their children, students and families… (p. 20)
- Integrate wellness into professional development approaches by providing adequate planning time for staff that includes opportunities for collaboration, training, peer coaching, and supportive performance feedback. (p. 21)
- Prioritize collaborative planning time for delivery of instruction…[P]rovide collaborative opportunities to engage in group learning focused on a common issue and grade level/core/department team meetings to create small systems of support for staff…" (p. 21)

2022 Session

No action taken.

2023 Session

PA 23-160 directs CABE to convene a working group to review mandates on SDE and Boards of Ed. They'll make recommendations on what mandates should be repealed and on the development of a biennial process to review mandates.

E.5. Enhance the instructional and therapeutic capacity of all staff in schools through funding for ongoing, job-embedded professional development, and for additional full-day professional development opportunities beyond the scheduled academic year.

The National Commission on Social, Emotional, and Academic Development (2018) explains:

> The understanding that learning is social, emotional, and cognitive should be applied to both adults' and students' learning experiences. However, today's educators typically receive limited pre-service or in-service training on how to promote the development of these skills or how to construct learning environments that promote their development or practice. To ensure young people gain the broad set of skills necessary for success requires comprehensively training and developing the educators who support them. (p. 28)

Darling-Hammond and Podolsky (2019) report that policymakers in academically high-achieving nations provide "readily available support from trained mentors for beginning teachers" and "ongoing time and support for professional learning and collaboration" (p. 29). School leaders in Connecticut's public schools endeavor to provide these supports to their faculty and staff members, but persistently inequitable funding inhibits this in the schools and districts that serve communities with the greatest concentrations of need.

The Task Force endorses Connecticut Voices for Children's (2021) recommendation that the Connecticut General Assembly:

> Increase funding for behavioral health support staff in schools including counselors, psychologists, and social workers. Behavioral health support staff spend years in higher education learning to support positive school environments, connect with and support families, and identify when children are struggling and intervene before crises emerge. (p. 16)

Citing the long-term impacts of what has already been a protracted COVID-19 pandemic, the U.S. Department of Education (2021) explains:

> There is a critical need for **all staff** in schools (e.g., administrators, educators, school nurses, community health workers, family advocates, family resource developers, school liaisons, teacher aides, teacher assistants, student aides, class aides, behavior coaches, behavior interventionists, behavior aides) to be trained to fully support schools' Tier 1 (promotion prevention) and Tier 2 (early intervention) programming…[S]chools and programs are and will be contending with significantly elevated child and student social, emotional, and behavioral concerns as well as addressing the lost instructional time associated with the pandemic. (p. 31 - emphasis in the original)

The U.S. Department of Education (2021) goes on to recommend that we:

- Modify or extend pre- and in-service professional development to include mental health training. Ensure that teacher pre-service programs include mental health training. Offer blended professional development for teachers and other service providers so evidence-based practices can be implemented effectively and with high fidelity… (p. 32); and
- Implement coaching models to further strengthen teachers' mental health knowledge and capacity…" (p. 32)

2022 Session

No action taken.

2023 Session

PA 23-159 requires boards of education to add at least one paraeducator to the professional development and evaluation committee. SDE, in collaboration with the School Paraeducator Advisory Council, will annually develop and update guidance and best practices for programs of professional development for paraeducators and distribute such resources to each BOE. The same act requires play-based learning to be included in professional development for teachers and administrators, and professional development for principals and vice principals must include training on the management of school personnel.

PA 23-167 Requires BOEs to provide professional development opportunities for school nurses, including training on the implementation of IEPs and 504 plans.

E.6. Increase access to hands-on job-training programs, leadership development opportunities, and civic engagement opportunities for children and adolescents, especially those from families with limited means.

Connecticut's Judicial Branch and the Connecticut Department of Children and Families both provide these kinds of opportunities to children and adolescents who are involved with their respective systems. These programs should continue, and they should be expanded and extended so that youth who are no longer involved with these systems may continue to access them, and so that youth who have had no such involvement may benefit from them.

This recommendation reinforces that made by the Department of Public Health (2021) in its publication *Healthy Connecticut 2025 - State Health Improvement Plan*:

> Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance… (p. 52)

The Commission on Human Rights and Opportunities has a robust internship program available to high school students, college students, and students in law or graduate programs. These students have the opportunity to engage in a variety of civil rights issues including the planning of a summer symposium and the mediation of discrimination complaints. Funding for financial stipends for students would allow the CHRO to expand the program, particularly to those students who may not be able to afford to work an unpaid internship.

2022 Session

Senate Bill 1 section 24 offers boards of education the option to issue instructor permits to those in manufacturing, allied health, computer technology, engineering, or construction.

Senate Bill 2 section 5 moved the Pipeline for Connecticut's Future Program to the DOE and DOL, where local BOEs can participate, and redefined components of the program.

2023 Session

PA 23-70 addresses workforce shortages through our higher education system, including:

- Extending CHESLA student loan subsidy programs to paraeducators and school counselors in alliance districts, police officers in distressed municipalities, and emergency medical service personnel.
- Creating a task force to develop a plan to establish clinical placements for nursing students at state facilities.
- Requiring the Commissioner of Insurance to work on growing the state's insurance industry.

PA 23-55 created prosecutor apprenticeships for legal interns

SB 998 created tax credits and incentives for towns and businesses that build workforce housing, including for teachers, police officers, and firefighters

PA 23-97:
Encouraging careers in our K-12 schools, offering nursing licenses at our colleges, and creating opportunities among our existing personal care attendant workforce

Streamlined licensing for nurses and physical therapists that move to CT
Partnering with other states for clinical training opportunities

PA 23-61 The CT Clean Economy Council will be developing a training plan to expand opportunities for apprenticeships, certificates and degree programs for green jobs with workforce shortages.

PA 23-167 requires SDE to develop an educator apprenticeship initiative to enable students in educator preparation programs and other routes to certification to gain classroom teaching experience. It expands school-based apprenticeship opportunities in aviation and aerospace, training for future paraeducators, and dual credit/enrollment opportunities.

SUPPORTED: ***Each student has access to personalized learning and is supported by qualified, caring adults.***

Su.1. Increase the diversity of professionals in both the mental/behavioral health and education fields. (Tuition reimbursement in both areas, coupled with strategic, long-term recruiting beginning in high school, will contribute to achieving this goal.)

This recommendation echoes the aim articulated in the 2021 Annual Report for the Connecticut Children's Behavioral Health Plan to "develop new partnerships and strategies to increase behavioral health workforce diversity to be more reflective of the children and families seeking services."

The Department of Public Health (2021) asserts, "Access to health care impacts one's overall physical, social, and mental health status and quality of life. It is important to recognize that comfort and trust in a health care provider may mean finding a provider who is not only culturally humble but who looks like the patients he or she serves" (p. 43).

The same can be said of the educators by whom students and families are supported, which is why the ongoing work of Connecticut's Commission on Human Rights and Opportunities and the Connecticut State Department of Education to increase minority teacher recruitment and retention are so crucial.

Citing the fact that "Connecticut has the fifth highest [racial and ethnic] education disparity in the United States, and the highest of the six New England states," Troyer (2019) suggests, "One possible explanation for the disparity is a lack of representation. Until 2018, 23 school districts didn't have a single person of color on staff" (p. 63).

2022 Session

Senate Bill 1 sections 15-22 worked to create a minority teacher candidate program and rename the Task Force to Diversify the Educator Workforce.

2023 Session

PA 23-167 did this for the education field. Schools are currently required to have an increasing educator diversity plan. This bill required SDE to review and approve plans before they are implemented. It will allow students to apply for the scholarship program early if they will be enrolled in a teacher prep program in the following fall semester.

Su.2. Provide greater supports – in school and out – for children and adolescents who have been disengaged in or disconnected from school due to social-emotional concerns, academic delays, suspensions/expulsions.

The Task Force recommends that greater resources be invested in supporting children and adolescents who are disengaged in or disconnected from school. These additional resources could be allocated to state and local agencies, as well as to not-for-profit organizations that train and employ Youth Development Professionals who facilitate children's and adolescents' access to school and the requisite supports.

"**Disengaged youth** are enrolled in school, but show at least one of three signs of not being effectively connected to their education" – that is, they miss approximately 25 or more days of school per year; they have two or more

suspensions or expulsions; and/or they have failed two or more courses per year (Parthenon - EY Education Practices, 2016, p. 8 – emphasis added).

"**Disconnected youth** have not received a high school diploma or equivalent and are not enrolled in high school despite being 21 or younger" (Parthenon - EY Education Practices, 2016, p. 21 – emphasis added).

"Finding ways to keep young people engaged in high school, and to re-engage young people who are disconnected, is an urgent need not just for the public education system, but also for the whole state" (Parthenon - EY Education Practices, 2016, p. 16).

Public Health - "Disconnected youth in Connecticut aged 18-24 are more than twice as likely to experience health challenges as peers their age, and 33% more likely to be struggling with substance abuse" (Parthenon - EY Education Practices, 2016, p. 15).

Racial Equity - "Disengaged and disconnected youth are more than twice as likely to be black or Hispanic versus all other students in the state, and nearly three times as likely to be boys of color" (Parthenon - EY Education Practices, 2016, p. 15).

Economic Development - "Disconnected youth in Connecticut aged 18-24 have a 34% unemployment rate, 2.5 times the rate of all other young people in the state" (Parthenon - EY Education Practices, 2016, p. 15).

School to Prison Pipeline - "Disconnected youth in Connecticut aged 18-24 are five times more likely to be incarcerated than their peers who completed high school, at an annual cost of more than $50,000 per inmate" (Parthenon - EY Education Practices, 2016, p. 15).

Fiscal Sustainability - "On average, Connecticut spends almost four times more on health care, corrections and welfare programs or a high school dropout than for other citizens" (Parthenon - EY Education Practices, 2016, p. 15).

"Once a student disconnects from high school in Connecticut, the odds that he or she effectively re-engages and earns a diploma are low. Of all students who dropped out of a Connecticut high school between 2012 and 2014:

- Only 12% ever re-enrolled in any public high school (including alternative schools).
- Only 1% ever attained a high school diploma.
- Only 9% achieved a GED or credit diploma through the adult education system.

(Parthenon - EY Education Practices, 2016, p. 17)

"These findings pose a dual challenge: the need for more high-quality supports for the 14,000 disconnected youth in Connecticut today that are at risk of falling into a cycle of poverty, absent help to get back on track; and the need for creative thinking and deeper investment in new strategies, collaborations and program approaches to more effectively engage students while they are enrolled in school. The incentive is clear to focus on preventing disengaged youth from becoming disconnected in the first place" (p. 17).

"Helping disengaged and disconnected youth connect to success would spark a virtuous cycle for both these young people and the state as a whole: stronger schools, higher employment, fewer individuals becoming involved with incarceration or addiction, healthier and more prosperous communities, and more rapid and sustainable economic growth…" (Parthenon - EY Education Practices, 2016, p. 5).

2022 Session

Senate Bill 1 sections 3-5 offered a grant and program to hire mental health workers in schools with highest unmet need.

Senate Bill 1 section 30 launched a study into Unified School District #1.

Senate Bill 2 section 9 banned the removal of recess as a punishment in most circumstances.

2023 Session

LEAP, the Learner Engagement and Attendance Program, went into effect this past school year and has had success at reducing chronic absence at the 15 school districts using the program.

CHALLENGED: ***Each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment.***

C.1. Offer all children the ability to attend preschool free-of-charge beginning at age 3.

The Task Force recognizes that children's earliest years are critical to their cognitive, behavioral, social, and emotional development. High-quality early childhood educational opportunities serve to mitigate against Adverse Childhood Experiences (CDC, 2019, p. 15), and are crucial to youngsters' future academic, social, and vocational success.

Furthermore, the Task Force understands that gaps in preschool access exist between children whose parents have higher income and educational attainment and those whose parents have lower income and less educational attainment. This differential access to, and utilization of, early childhood programs exacerbates existing inequalities in childhood development and eventual academic and economic outcomes (Council of Economic Advisers, 2014).

Moreover, the Task Force appreciates that investments in early childhood programs have been shown to yield financial dividends, not only for participating children themselves (in the form of higher eventual earnings) but also for the economy as a whole (Council of Economic Advisers, 2014; Liebtag, 2018).

2022 Session

No action taken.

2023 Session

Smart Start was extended indefinitely, extending eligibility for School Readiness to "from birth" (both in PA 23-160) and increased funding for School Readiness (PA 23-150).

C.2. Expand CSCU's PACT (Pledge to Advance Connecticut) program to cover:

- **students already enrolled in community colleges;**
- **students who need to enroll part-time, due to family or work obligations.**

The PACT program is laudable. Regrettably, though, it ignores the fact that many students who begin their higher education experiences in community colleges, rather than in four-year colleges or universities, do so because of limited resources and/or the need to balance their studies with work, child care, and/or other family obligations by enrolling part-time rather than full-time. Expanding eligibility for the PACT program to students who are already enrolled in community colleges, as well as to students who need to enroll on a part-time basis, will better serve the needs of a great many students and families in Connecticut, and will better reflect the historic mission of the state's community colleges.

2022 Session

No action taken.

2023 Session

PA 23-204 (budget) expanded PACT eligibility to returning students. Students will no longer have to be attending community college for the first time or remain continuously enrolled to be eligible. Part-time students are already eligible.

C.3. Return Connecticut's funding for state colleges and universities to pre-recession levels in order to increase access for young people whose families have limited means.

Adjusted for inflation, Connecticut's funding for public higher education remains 21% below what it had been before the onset of the Great Recession (Mitchell, Leachman, & Saenz, 2019).

The failure of the state government to adequately fund higher education negatively impacts students, both by adding to their out-of-pocket costs and by compromising the quality of their learning experiences. Still worse, they exacerbate existing inequality, by making higher education less accessible to low-income students and students of color (Mitchell, Leachman, & Saenz, 2019).

Students who attend Connecticut's state colleges and universities – particularly the community college campuses and the four regional state universities (i.e., the CSUs) – come disproportionately from communities whose school districts had been assigned to the lowest three District Reference Groups (DRGs). **[44% of students who attend the four CSUs attended school in DRGs G, H, or I – the districts with the fewest resources but the highest concentrations of need.]** The CGA, to its credit, has recently taken steps to address the longstanding disparities in funding for districts that serve large percentages of students with high needs and whose families have low incomes and limited means. The CGA should take similar measures to ensure that, when students who had attended poorly resourced K-12 schools/districts in Connecticut matriculate in the state's public community colleges and regional universities, those institutions have sufficient resources to meet their needs.

SPECIFIC CHARGE: **To provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand.**

31. Continue to allocate funds to provide affordable, high-quality child care and preschool for all children in Connecticut.

The dollars allocated for care for infants and children who are not age 5 by January 1st and are not able to attend free public school have increased dramatically. This funding needs to continue and to be expanded until all children have access to affordable, high-quality child care, especially in light of the change in start age for kindergarten. During spring 2023, the state legislature voted to change the cutoff date for kindergarten entry from January 1 to September. 1, requiring that all students be 5 years old before entering school, starting during the 2024-25 academic year. This change will leave children and families without the free public education they had expected beginning with the upcoming school year.

32. Continue to meet the needs of multi language learners.

Multilingual learners are students with a primary or home language other than English who are in the process of acquiring English. Children learn best in their native language. These learners are an asset who can help all students to learn a second language. Children who learn two languages simultaneously go through the same processes and progress at the same rate as children who learn only one language. They begin to start talking and say their first words or first sentences within the same time frame. Multi language learners need support to be successful in school.

33. Offer children with disabilities who are ages birth-5 the same access to child care as all children.

Finding child care is more difficult for families with children with disabilities. The special care required often also needs additional staff members with specialized training. Seats at child care centers could be designated for students with disabilities to ensure equal access.

34. Provide the Office of Early Childhood with a robust team to meet the demands of overseeing and evaluating all of the new spaces awarded funding to ensure high-quality care is the standard.

With the creation of 1,300 new infant and toddler spaces, the Office of Early Childhood is in need of additional staff to support the demands of ensuring all new spaces meet the standards expected.

35. Review and implement the final recommendations of the Blue-Ribbon Panel, a panel whose work is in alignment with this Task Force.

The Blue-Ribbon Panel was created by Governor Lamont in 2023 and charged with developing a five-year strategic plan for a child care system that works for families, providers, and Connecticut's economy. The Task Force to Study the Comprehensive Needs of Children in the State has been in consultation with members of the Blue-Ribbon Panel and supports their recommendations: both groups share similar charges with regard to child care.

Review of The Whole Child Framework

"Who deserves our intention more than children?"

Jason Reynolds, National Ambassador for Young People's Literature

Convinced that no one is more deserving of our intention than our young people, we on the Task Force to Study the Comprehensive Needs of Children in the State continue to urge Connecticut's elected and appointed leaders to gauge each policy measure that they consider according to the degree to which it comports with the Whole Child framework – with a view to how well it would serve to keep children healthy, safe, engaged, supported, and/or challenged.

Source: ASCD Whole Child Network (2020)

ASCD – formerly, the Association for Curriculum Development and Supervision – enumerated these five tenets a decade and one-half ago, when it first set forth the Whole Child Framework. Based on research in child development, these tenets articulate that each and every child deserves to be – and, therefore, that society must ensure that each child is – healthy, safe, engaged, supported, and challenged. As Slade and Griffith (2013) explain, "This framework does not seek to divorce itself from academic development but it does seek to expand what constitutes academic development in the 21st century and aims to refocus attention on all attributes required for educational and societal success" (p. 21).

We ask that everyone in the state – residents and officials, alike – take a long view of matters of public policy, recognizing both that the consequences (positive and negative) of decisions made in the short term will last well into the future, and that the effects of choices that individual families and communities make for themselves are invariably (if unintentionally) felt by others – with the most negative effects too often being felt by families and communities least able to withstand them.

Despite having among the highest per capita income and the highest per capita wealth of any state in the nation, Connecticut is also distinguished as having among the greatest gaps in both household income and household wealth – and, by extension, in health outcomes, access to healthcare, and academic achievement.

In its *Kids Count Profile*, the Annie E. Casey Foundation (2021) reported that – even before the onset of the COVID-19 pandemic – 14% of children in Connecticut were living in poverty, and that 27% of children in our state had parents who did not have secure employment.

In their publication *ALICE in Connecticut: A Financial Hardship Study*, the Connecticut United Ways (2020) report data on households in the state that can be assigned the ALICE designation, indicating that they are Asset Limited, Income Constrained [and] Employed. The authors explain, "ALICE households earn too much to qualify as 'poor' but are still unable to make ends meet" (p. 5). In short, ALICE households do not earn enough income to cover the costs of housing, child care, food, transportation, health care, and other necessities.

In 2018, well before the onset of the COVID-19 pandemic, 11% of Connecticut households were below the federal poverty level. That same year, 27% of households in Connecticut qualified as ALICE – a 40% increase in such households from 2007 until that date (Connecticut United Ways, 2020).

That same publication – whose findings, it bears repeating, pre-date the onset of COVID-19 – makes plain that the state's income and wealth disparities are not proportionately distributed across all racial and ethnic groups. As of 2018, 38% of all households in Connecticut fell below the ALICE threshold, but 57% of Black households in the state – and 63% of Hispanic households – fell below that threshold. Put differently, while Black households represent 10% of all households in the state, they represent 15% of Connecticut's ALICE households. Despite representing only 13% of Connecticut's total households, Hispanic households represent 22% of the state's ALICE households (Connecticut United Ways, 2020).

Actions taken by the legislature in recent years have begun to address the inequities. Ongoing efforts are required to continue to meet the needs of the whole child.

References

Adams, G.S., Converse, B.A., Hales, A.H., & Klotz, L.E. (2021). People systematically overlook subtractive changes. *Nature, 592*, 258-271.

American Academy of Pediatrics. (2014). Policy statement: School start times for adolescents. *Pediatrics, 134*(3), 642-649.

Annie E. Casey Foundation. *2021 Kids Count Data Book: State Trends in Child Well-Being*. Author.

ASCD Whole Child Network (2020). *The Learning Compact Renewed: Whole Child for the Whole World.* Author.

Berry, K.M., Erickson, D.J., Berger, A.T., Wahlstrom, K., Iber, C., Full, K.M., Redline, S., & Widome, R. (2021). Association of delaying school start time with sleep-wake behaviors among adolescents. *Journal of Adolescent Health, 69*, 831-837.

Center on the Developing Child, Harvard University (2011). *Building the Brain's "Air Traffic Control" System: How Early Experiences Shape the Development of Executive Function: Working Paper 11.* Author.

Connecticut Children's Behavioral Health Plan Implementation Advisory Board (2021). *Connecticut Children's Behavioral Health Plan: 2021 Annual Report.* Author.

Connecticut Department of Housing (2020). *State of Connecticut 2020-24 Consolidated Plan for Housing and Community Development*. Author.

Connecticut Department of Public Health (2021). *Healthy Connecticut 2025: State Healthy Improvement Plan.* Author.

Connecticut Department of Social Services (2017). *Medicaid School Based Child Health Program: User Guide.* Author.

Connecticut United Ways (2020). *ALICE in Connecticut: A Financial Hardship Study*.

Connecticut Voices for Children (2021). *2021 Legislative Session Review: Legislative Brief June 2021 by Connecticut Voices for Children Staff*. Author.

Council of Economic Advisers (2014). *The Economics of Early Childhood Investments.* Author.

Darling-Hammond, L. & Podolsky, A. (2019). Breaking the cycle of teacher shortages: What kind of policies can make a difference? *Education Policy Analysis Archives, 27*(34).

DeLuca, S. & Clampet-Lundquist, S. (2016). *The Cycle of Poverty Is Not Inevitable: Lessons from Baltimore's Resilient Youth.* The Century Foundation.

Dunster, G.P., de la Ingleasia, L., Ben-Hamo, M., Nave, C., Fleischer, J.G., Satchidananda Panda, & de la Inglesia, H.O. (2018). Sleepmore in Seattle: Later school start times are associated with more sleep and better performance in high school students. *Science Advances, 4*(12).

Edelman, P. (2012). *So Rich, So Poor: Why It's So Hard to End Poverty in America*. New Press.

Gotlib, I.H., Miller, J.G., Borchers, L.R., Coury, S.M., Costello, L.A., Garcia, J.M., & Ho, T.C. (2022). Effects of the COVID-19 pandemic on mental health and brain maturation in adolescents: Implications for analyzing longitudinal data. *Biological Psychiatry: Global Open Science.*

Hanushek, E.A., Peterson, P.E., Talpey, L.M., Woessmann, L. (2020). *Long-run trends in the U.S. SES-achievement gap.* (EdWorkingPaper: 20-207). Retrieved from Annenberg Institute at Brown University: https://www.edworkingpapers.com/ai20-207

Hargreaves, A. (2015). The iniquity of inequity: And some international clues about ways to address it. (In Blankstein, A.M. & Noguera, P., eds.) *Excellence through Equity: Five principles of courageous leadership to guide achievement for every student*. ASCD.

Immordino-Yang, M.H., Darling-Hammond, L., & Krone, C. (2018). *The brain basis for integrated social, emotional, and academic development: How emotions and social relationships drive learning.* Aspen Institute.

Hunt / Kean Leadership Fellows. (2021). *Childhood Education: Issue Brief 2021.* The Hunt Institute.

Kantor, H. & Lowe, R. (2013). Educationalizing the welfare state and privatizing education: The evolution of social policy since the new deal. In Carter, P.L. & Welner, K.G. (Eds.) *Closing the Opportunity Gap: What America Must Do to Give Every Child an Even Chance* (pp. 25-39). Oxford University Press.

Liebtag, E. (2018). Early childhood: What we know, and what's possible. *Getting Smart*, January 30, 2018. Retrieved from: https://www.gettingsmart.com/2018/01/30/early-learning-what-we-know-and-where-we-are-headed/

Mapp, S. & Gabel, S.G. (2019). It is easier to build strong children than to repair broken men. *Journal of Human Rights and Social Work, 4*, 145-146.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396.

Meherali, S., Punjani, N., Louie-Poon, S., Rahim, K.A., Das, J.K., Salam, R.A., & Lassi, Z.S. (2021). Mental health of children and adolescents amidst COVID-19 and past pandemics: A rapid systematic review. *International Journal of Environmental Research and Public Health, 18,* 3432.

Mehta, J. (2013). The penetration of technocratic logic into the educational field: Rationalizing schooling from the progressives to the present. *Teachers College Record, 115*(5), 1-36.

Mehta, J. (2019). Why equity has been a conservative force in American education – and how that could change. *Education Week's Blogs,* February 14, 2019.

Mitchell, M., Leachman, M., and Saenz, M. (2019). *State higher education funding cuts have pushed costs to students, worsened inequality.* Center for Budget and Policy Priorities.

National Academies of Sciences, Engineering, Medicine (2018). *How people learn II: Learners, contexts, and cultures.* National Academies Press.

National Commission on Excellence in Education (1983). *A Nation at Risk: The Imperative for Educational Reform, A Report to the Nation and the Secretary of Education.* United States Department of Education.

National Commission on Social, Emotional, and Academic Development (2018). *A Policy Agenda in Support of How Learning Happens.* Aspen Institute.

Parthenon-EY Education Practice (2016). *Untapped Potential: Engaging all Connecticut Youth.* Dalio Foundation.

Reynolds, J. (2021). *The Late Show with Stephen Colbert (12/3/21).* https://www.youtube.com/watch?v=nNzYE_4DdtA

Sandy Hook Advisory Commission (2015). *Final Report of the Sandy Hook Advisory Commission*. Author.

School + State Finance Project (2020). *Mismatch Between Funding & Student Needs in CT: Policy Brief, July 28, 2020.* Retrieved from: www.schoolstatefinance.org

Slade., S., & Griffith, D. (2013). A whole child approach to student success. *KEDI Journal of Educational Policy*, Special Issue (2013), 21-35.

Trombly, C.E. (2020). Learning in the time of COVID-19: capitalizing on the opportunity presented by the pandemic. *Journal of Professional Capital and Community, 5*(3/4), 351-358.

Troyer, M. (2019). States with the worst education disparity. (January 26, 2019.) Retrieved from: https://stacker.com/stories/2398/states-worst-education-disparity

U.S. Department of Education, Office of Civil Rights (2021). *Education in a Pandemic: The Disparate Impacts of COVID-19 on America's Students.* Author.

U.S. Department of Education, Office of Special Education and Rehabilitative Services (2021a). *Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs.* Author.

Appendices

Substitute Senate Bill No. 2

Public Act No. 21-46

AN ACT CONCERNING SOCIAL EQUITY AND THE HEALTH, SAFETY AND EDUCATION OF CHILDREN.

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

Section 1. (NEW) (*Effective July 1, 2021*) (a) As used in this section, (1) "evidence-based" describes a training program that (A) incorporates methods demonstrated to be effective for the intended population through scientifically based research, including statistically controlled evaluations or randomized trials, (B) can be implemented with a set of procedures to allow successful replication in the state, (C) achieves sustained, desirable outcomes, and (D) when possible, has been determined to be cost-beneficial, and (2) "Question, Persuade and Refer (QPR) Institute Gatekeeper Training" means an educational program designed to teach lay and professional persons who work with youth the warning signs of a suicide crisis and how to respond.

(b) The Youth Suicide Advisory Board, established pursuant to section 17a-52 of the general statutes, and the Office of the Child Advocate, shall jointly administer an evidence-based youth suicide prevention training program in each local health department and district department of health formed pursuant to section 19a-241 of the general statutes. The training program shall provide certification in QPR Institute Gatekeeper Training, utilizing a training model that will enable

participants to provide QPR Institute Gatekeeper Training to other individuals upon completion of the training program. Such training program shall be offered not later than July 1, 2022, and at least once every three years thereafter.

(c) The director of health for each local health department and district department of health shall determine the eligibility criteria for participation in the youth suicide prevention training program. Participants shall be members of the following groups within such district: (1) Employees of such local health department and district department of health, (2) employees of youth service bureaus established pursuant to section 10-19m of the general statutes, (3) school employees, as defined in section 10-222d of the general statutes, (4) employees and volunteers of youth-serving organizations, (5) employees and volunteers of operators of youth athletic activities, as defined in section 21a-432 of the general statutes, (6) employees of municipal social service agencies, (7) members of paid municipal or volunteer fire departments, and (8) members of local police departments. With respect to school employees, such training program may be included as part of an in-service training program provided pursuant to section 10-220a of the general statutes, as amended by this act.

(d) Any individual who has received certification in QPR Institute Gatekeeper Training through the training program administered pursuant to subsection (b) of this section may, during the period in which such certification is valid, provide QPR Institute Gatekeeper Training to any member of a group described in subdivisions (1) to (8), inclusive, of subsection (c) of this section and members of the public.

(e) The Youth Suicide Advisory Board and the Office of the Child Advocate may contract with a nongovernmental entity that provides evidence-based suicide prevention training to carry out the provisions of this section.

Sec. 2. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

(1) "Contact hour" means a minimum of fifty minutes of continuing education and activities; and

(2) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 of the general statutes and is current and valid.

(b) For registration periods beginning on and after January 1, 2022, a physician assistant licensed pursuant to chapter 370 of the general statutes applying for license renewal shall, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education administered by the American Association of Physician Assistants, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training.

(c) Each physician assistant applying for license renewal pursuant to section 19a-88 of the general statutes shall sign a statement attesting that he or she has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the Department of Health. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education was completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

Sec. 3. Subsection (a) of section 20-73b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Except as otherwise provided in this section, each physical therapist licensed pursuant to this chapter shall complete a minimum of twenty hours of continuing education during each registration period. For purposes of this section, registration period means the twelve-month period for which a license has been renewed in accordance with section 19a-88 and is current and valid. The continuing education shall be in areas related to the individual's practice, except, on and after January 1, 2022, shall include not less than two hours of training or education on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training, during the first registration period in which continuing education is required and not less than once every six years thereafter. The requirement described in subdivision (2) of this subsection may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act. Qualifying continuing education activities include, but are not limited to, courses offered or approved by the American Physical Therapy Association or any component of the American Physical Therapy Association, a hospital or other licensed health care institution or a regionally accredited institution of higher education.

Sec. 4. Section 20-74h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

Licenses for occupational therapists and occupational therapy assistants issued under this chapter shall be subject to renewal once every two years and shall expire unless renewed in the manner prescribed by regulation upon the payment of two times the professional services fee payable to the State Treasurer for class B as defined in section 33-182*l*, plus five dollars. The department shall notify any person or entity that fails to comply with the provisions of this section that the person's or entity's license shall become void ninety days after the time for its renewal unless it is so renewed. Any such license

shall become void upon the expiration of such ninety-day period. The commissioner shall establish additional requirements for licensure renewal which provide evidence of continued competency, which, on and after January 1, 2022, shall include not less than two hours of training or education, offered or approved by the Connecticut Occupational Therapy Association, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training during the first renewal period and not less than once every six years thereafter. The requirement described in subdivision (2) of this section may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act. The holder of an expired license may apply for and obtain a valid license only upon compliance with all relevant requirements for issuance of a new license. A suspended license is subject to expiration and may be renewed as provided in this section, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order or judgment by which the license was suspended. If a license revoked on disciplinary grounds is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee.

Sec. 5. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

(1) "Contact hour" means a minimum of fifty minutes of continuing education and activities; and

(2) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 of the general statutes and is current and valid.

(b) For registration periods beginning on and after January 1, 2022, a registered nurse licensed pursuant to chapter 378 of the general statutes

who is actively practicing in this state, and a licensed practical nurse licensed pursuant to chapter 378 of the general statutes who is actively practicing in this state, applying for license renewal shall, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education on (1) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training. For purposes of this section, qualifying continuing education activities include, but are not limited to, in-person and online courses offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association, Connecticut League for Nursing, a specialty nursing society or an equivalent organization in another jurisdiction, an educational offering sponsored by a hospital or other health care institution or a course offered by a regionally accredited academic institution or a state or local health department.

(c) Each registered nurse and licensed practical nurse applying for license renewal pursuant to section 19a-88 of the general statutes shall sign a statement attesting that he or she has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the Department of Public Health. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education was completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

Sec. 6. Subsection (a) of section 20-102ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The Commissioner of Public Health shall adopt regulations, in

accordance with the provisions of chapter 54, concerning the regulation of nurse's aides. Such regulations shall require a training program for nurse's aides of not less than one hundred hours. Not less than seventy-five of such hours shall include, but not be limited to, basic nursing skills, personal care skills, care of cognitively impaired residents, recognition of mental health and social service needs, basic restorative services and residents' rights. Not less than twenty-five of such hours shall include, but not be limited to, specialized training in understanding and responding to challenging behaviors related to physical, psychiatric, psychosocial and cognitive disorders. On and after January 1, 2022, not less than two of such hours shall include (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association or Connecticut League for Nursing, a specialty nursing society or equivalent organization in another jurisdiction, a hospital or other health care institution, a regionally accredited academic institution, or a state or local health department. The requirement described in subdivision (2) of this section may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 7. Subsection (b) of section 20-185k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) A license issued under this section may be renewed annually. The license shall be renewed in accordance with the provisions of section 19a-88, for a fee of one hundred seventy-five dollars. Each behavior analyst applying for license renewal shall furnish evidence satisfactory to the commissioner of (1) having current certification with the Behavior Analyst Certification Board, and (2) on and after January 1, 2022,

completing not less than two hours of training or education, offered or approved by the Connecticut Association for Behavior Analysis, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (A) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (B) suicide prevention training, during the first renewal period and not less than once every six years thereafter. The requirement described in subparagraph (B) of this subdivision may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 8. Subsection (f) of section 20-195ttt of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(f) A certification issued under this section may be renewed every three years. The license shall be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred dollars. Each certified community health worker applying for license renewal shall furnish evidence satisfactory to the commissioner of having completed a minimum of thirty hours of continuing education requirements, including two hours focused on cultural competency, systemic racism or systemic oppression, **[**and**]** two hours focused on social determinants of health and on and after January 1, 2022, two hours of training on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention, provided by the Community Health Worker Advisory Body or training or education providers approved by the Community Health Worker Advisory Body. The requirement described in subdivision (2) of this subsection may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 9. Section 20-206mm of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Except as provided in subsections (b) and (c) of this section, an applicant for a license as a paramedic shall submit evidence satisfactory to the Commissioner of Public Health that the applicant has successfully (1) completed a paramedic training program approved by the commissioner, (2) for applicants applying on and after January 1, 2020, completed mental health first aid training as part of a program provided by an instructor certified by the National Council for Behavioral Health, and (3) passed an examination prescribed by the commissioner.

(b) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a paramedic in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that the applicant has no pending disciplinary action or unresolved complaint against him or her, or (2) (A) is currently licensed or certified as a paramedic in good standing in any New England state, New York or New Jersey, (B) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the paramedic scope of practice model conducted by an organization offering a program that is recognized by the national emergency medical services program accrediting organization, (C) for applicants applying on or after January 1, 2020, has completed mental health first aid training as part of a program provided by an instructor certified by the National Council for Behavioral Health, and (D) has no pending disciplinary action or unresolved complaint against him or her.

(c) Any person who is certified as an emergency medical technician-paramedic by the Department of Public Health on October 1, 1997, shall be deemed a licensed paramedic. Any person so deemed shall renew his license pursuant to section 19a-88 for a fee of one hundred fifty-five

dollars.

(d) On or after January 1, 2020, each person seeking certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician shall apply to the department on forms prescribed by the commissioner. Applicants for certification shall comply with the following requirements: (1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the emergency medical responder, emergency medical technician or advanced emergency medical technician curriculum, (B) has passed the examination administered by the national organization for emergency medical certification for an emergency medical responder, emergency medical technician or advanced emergency medical technician as necessary for the type of certification sought by the applicant or an examination approved by the department, and (C) has no pending disciplinary action or unresolved complaints against such applicant, (2) a certificate issued under this subsection shall be renewed once every two years in accordance with the provisions of section 19a-88 upon presentation of evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education for an emergency medical responder, emergency medical technician or advanced emergency medical technician as required by the national organization for emergency medical certification or as approved by the department, or (B) presents a current certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician from the national organization for emergency medical certification, or (3) for certification by endorsement from another state, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified as an emergency medical responder, emergency

medical technician or advanced emergency medical technician in good standing by a state that maintains certification or licensing requirements that the commissioner determines are equal to or greater than those in this state, or (B) holds a current certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician from the national organization for emergency medical certification.

(e) On or after January 1, 2022, each person seeking renewal of a certification as an emergency medical responder or emergency medical technician under subdivision (2) of subsection (d) of this section, shall present evidence satisfactory to the commissioner that such person has, in the previous six year period, completed (1) the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act, or (2) not less than two hours of training or education, approved by the Commissioner of Public Health, on (A) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (B) suicide prevention.

[(e)**]** (f) On or after January 1, 2020, each person seeking certification as an emergency medical services instructor shall apply to the department on forms prescribed by the commissioner. Applicants for certification shall comply with the following requirements: (1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified by the department as an emergency medical technician or advanced emergency medical technician or licensed by the department as a paramedic, (B) has completed a program of training as an emergency medical instructor based on current national education standards within the prior two years, (C) has completed twenty-five hours of teaching activity under the supervision of a currently certified emergency medical services instructor, (D) has completed written and practical examinations as prescribed by the commissioner, (E) has no

pending disciplinary action or unresolved complaints against the applicant, and (F) effective on a date prescribed by the commissioner, presents documentation satisfactory to the commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the national organization for emergency medical certification, or (2) for renewal certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education and teaching activity as required by the department, which, on and after January 1, 2022, shall include not less than two hours of training or education, approved by the Commissioner of Public Health, on (i) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (ii) suicide prevention training, during the first renewal period and not less than once every six years thereafter, (B) maintains current certification by the department as an emergency medical technician, advanced emergency medical technician or licensure by the department as a paramedic, and (C) effective on a date as prescribed by the commissioner, presents documentation satisfactory to the commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the national organization for emergency medical certification.

[(f)**]** (g) A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall document the completion of his or her continuing educational requirements through the continuing education platform Internet web site. A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor who is not engaged in active professional practice in any form during a certification period shall be exempt from the continuing education requirements of this section, provided the emergency medical responder, emergency medical

technician, advanced emergency medical technician or emergency medical services instructor submits to the department, prior to the expiration of the certification period, an application for inactive status on a form prescribed by the department and such other documentation as may be required by the department. The application for inactive status pursuant to this subsection shall contain a statement that the emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor may not engage in professional practice until the continuing education requirements of this section have been met.

[(g)**]** (h) The commissioner may issue a temporary emergency medical technician certificate to an applicant who presents evidence satisfactory to the commissioner that (1) the applicant was certified by the department as an emergency medical technician prior to becoming licensed as a paramedic pursuant to section 20-206*ll*, or (2) the applicant's certification as an emergency medical technician has expired and the applicant's license as a paramedic has become void pursuant to section 19a-88. Such temporary certificate shall be valid for a period not to exceed one year and shall not be renewable.

[(h)**]** (i) An applicant who is issued a temporary emergency medical technician certificate pursuant to subsection **[**(g)**]** (h) of this section may, prior to the expiration of such temporary certificate, apply to the department for: (1) Renewal of such person's paramedic license, giving such person's name in full, such person's residence and business address and such other information as the department requests, provided the application for license renewal is accompanied by evidence satisfactory to the commissioner that the applicant was under the medical oversight of a sponsor hospital, as those terms are defined in section 19a-175, on the date the applicant's paramedic license became void for nonrenewal; or (2) recertification as an emergency medical technician, provided the application for recertification is accompanied by evidence satisfactory

to the commissioner that the applicant completed emergency medical technician refresher training approved by the commissioner not later than one year after issuance of the temporary emergency medical technician certificate. The department shall recertify such person as an emergency medical technician without the examination required for initial certification specified in regulations adopted by the commissioner pursuant to section 20-206oo.

[(i)] (j) Any person certified as an emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor pursuant to this chapter and the regulations adopted pursuant to section 20-206oo whose certification has expired may apply to the Department of Public Health for reinstatement of such certification, provided such person completes the requirements for renewal certification specified in this section. Any certificate issued pursuant to this section shall remain valid for ninety days after the expiration date of such certificate and become void upon the expiration of such ninety-day period.

[(j)] (k) The Commissioner of Public Health shall issue an emergency medical technician certification to an applicant who is a member of the armed forces or the National Guard or a veteran and who (1) presents evidence satisfactory to the commissioner that such applicant holds a current certification as a person entitled to perform similar services under a different designation by the National Registry of Emergency Medical Technicians, or (2) satisfies the regulations promulgated pursuant to subdivision (3) of subsection (a) of section 19a-179. Such applicant shall be exempt from any written or practical examination requirement for certification.

[(k)] (l) For the purposes of this section, "veteran" means any person who was discharged or released under conditions other than dishonorable from active service in the armed forces and "armed forces" has the same meaning as provided in section 27-103.

Sec. 10. Section 19a-14c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) For the purposes of this section, "outpatient mental health treatment" means the treatment of mental disorders, emotional problems or maladjustments with the object of (1) removing, modifying or retarding existing symptoms; (2) improving disturbed patterns of behavior; and (3) promoting positive personality growth and development. Treatment shall not include prescribing or otherwise dispensing any medication which is a legend drug as defined in section 20-571.

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, an independent social worker certified pursuant to chapter 383b or a marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) **[**he**]** the minor is voluntarily seeking such treatment; (B) **[**he**]** the minor has discussed with the provider the possibility of involving his or her parent or guardian in the decision to pursue such treatment; (C) **[**he**]** the minor has determined it is not in his or her best interest to involve his or her

parent or guardian in such decision; and (D) [he] the minor has been given adequate opportunity to ask the provider questions about the course of his or her treatment.

(c) [After the sixth session of outpatient mental health treatment provided to a minor pursuant to this section, the provider of such treatment shall notify the minor that the consent, notification or involvement of a parent or guardian is required to continue treatment, unless such a requirement would be seriously detrimental to the minor's well-being. If the provider determines such a requirement would be seriously detrimental to the minor's well-being, he shall document such determination in the minor's clinical record, review such determination every sixth session thereafter and document each such review. If the provider determines such a requirement would no longer be seriously detrimental to the minor's well-being, he shall require the consent, notification or involvement of a parent or guardian as a condition of continuing treatment.] (1) Except as otherwise provided in subdivision (2) of this subsection, a minor may request and receive as many outpatient mental health treatment sessions as necessary without the consent or notification of a parent or guardian. No provider shall notify a parent or guardian of treatment provided pursuant to this section or disclose any information concerning such treatment to a parent or guardian without the consent of the minor.

(2) A provider may notify a parent or guardian of treatment provided pursuant to this section or disclose certain information concerning such treatment without the consent of the minor who receives such treatment provided (A) such provider determines such notification or disclosure is necessary for the minor's well-being, (B) the treatment provided to the minor is solely for mental health and not for a substance use disorder, and (C) the minor is provided an opportunity to express any objection to such notification or disclosure. The provider shall document his or her determination concerning such notification or disclosure and any

objections expressed by the minor in the minor's clinical record. A provider may disclose to a minor's parent or guardian the following information concerning such minor's outpatient mental health treatment: (i) Diagnosis; (ii) treatment plan and progress in treatment; (iii) recommended medications, including risks, benefits, side effects, typical efficacy, dose and schedule; (iv) psychoeducation about the minor's mental health; (v) referrals to community resources; (vi) coaching on parenting or behavioral management strategies; and (vii) crisis prevention planning and safety planning. A provider shall release a minor's entire clinical record to another provider upon the request of the minor or such minor's parent or guardian.

(d) A parent or guardian who is not informed of the provision of outpatient mental health treatment for his or her minor child pursuant to this section shall not be liable for the costs of the treatment provided.

Sec. 11. Subsection (a) of section 10-148a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) For the school year commencing July 1, **[**2019**]** 2021, and each school year thereafter, each certified employee shall participate in a program of professional development. Each local and regional board of education shall make available, annually, at no cost to its certified employees, a program of professional development that is not fewer than eighteen hours in length, of which a preponderance is in a small group or individual instructional setting. Such program of professional development shall (1) be a comprehensive, sustained and intensive approach to improving teacher and administrator effectiveness in increasing student knowledge achievement, (2) focus on refining and improving various effective teaching methods that are shared between and among educators, (3) foster collective responsibility for improved student performance, (4) be comprised of professional learning that (A) is aligned with rigorous state student academic achievement standards,

(B) is conducted among educators at the school and facilitated by principals, coaches, mentors, distinguished educators, as described in section 10-145s, or other appropriate teachers, (C) occurs frequently on an individual basis or among groups of teachers in a job-embedded process of continuous improvement, and (D) includes a repository of best practices for teaching methods developed by educators within each school that is continuously available to such educators for comment and updating, and (5) include training in culturally responsive pedagogy and practice. Each program of professional development shall include professional development activities in accordance with the provisions of subsection (b) of this section. The principles and practices of social-emotional learning shall be integrated throughout the components of such program of professional development described in subdivisions (1) to (5), inclusive, of this subsection.

Sec. 12. Subsection (b) of section 10-220a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) Not later than a date prescribed by the commissioner, each local and regional board of education shall establish a professional development and evaluation committee. Such professional development and evaluation committee shall consist of (1) at least one teacher, as defined in subsection (a) of section 10-144d, selected by the exclusive bargaining representative for certified employees chosen pursuant to section 10-153b, (2) at least one administrator, as defined in subsection (a) of section 10-144e, selected by the exclusive bargaining representative for certified employees chosen pursuant to section 10-153b, and (3) such other school personnel as the board deems appropriate. The duties of such committees shall include, but not be limited to, participation in the development or adoption of a teacher evaluation and support program for the district, pursuant to section 10-151b, and the development, evaluation and annual updating of a

comprehensive local professional development plan for certified employees of the district. Such plan shall: (A) Be directly related to the educational goals prepared by the local or regional board of education pursuant to subsection (b) of section 10-220, as amended by this act, (B) on and after July 1, [2011] 2021, be developed with full consideration of the priorities and needs related to student social-emotional learning, in accordance with the provisions of section 10-148a, as amended by this act, and student academic outcomes as determined by the State Board of Education, [and] (C) provide for the ongoing and systematic assessment and improvement of both teacher evaluation and professional development of the professional staff members of each such board, including personnel management and evaluation training or experience for administrators, [shall] and (D) be related to regular and special student needs and may include provisions concerning career incentives and parent involvement. The State Board of Education shall develop guidelines to assist local and regional boards of education in determining the objectives of the plans and in coordinating staff development activities with student needs and school programs.

Sec. 13. Subsection (b) of section 10-220 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) The board of education of each local or regional school district shall, with the participation of parents, students, school administrators, teachers, citizens, local elected officials and any other individuals or groups such board shall deem appropriate, prepare a statement of educational goals for such local or regional school district. The statement of goals shall be consistent with state-wide goals pursuant to subsection (c) of section 10-4 and include goals for the integration of principles and practices of social-emotional learning in the program of professional development for the school district, in accordance with the provisions of section 10-148a, as amended by this act, and career

placement for students who do not pursue an advanced degree immediately after graduation. Each local or regional board of education shall annually establish student objectives for the school year which relate directly to the statement of educational goals prepared pursuant to this subsection and which identify specific expectations for students in terms of skills, knowledge and competence.

Sec. 14. Section 10-221 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

[(a)**]** (b) Boards of education shall prescribe rules for the management, studies, classification and discipline of the public schools and, subject to the control of the State Board of Education, the textbooks to be used; shall make rules for the control, within their respective jurisdictions, of school library media centers, including Internet access and content, and approve the selection of books and other educational media therefor, and shall approve plans for public school buildings and superintend any high or graded school in the manner specified in this title.

[(b) Not later than July 1, 1985, each**]** (c) Each local and regional board of education shall develop, adopt and implement written policies concerning homework, attendance, promotion and retention. The Department of Education shall make available model policies and guidelines to assist local and regional boards of education in meeting the responsibilities enumerated in this subsection.

[(c)**]** (d) Boards of education may prescribe rules to impose sanctions against pupils who damage or fail to return textbooks, library materials or other educational materials. Said boards may charge pupils for such damaged or lost textbooks, library materials or other educational

materials and may withhold grades, transcripts or report cards until the pupil pays for or returns the textbook, library book or other educational material.

[(d) Not later than July 1, 1991, each**]** (e) Each local and regional board of education shall develop, adopt and implement policies and procedures in conformity with section 10-154a for (1) dealing with the use, sale or possession of alcohol or controlled drugs, as defined in subdivision (8) of section 21a-240, by public school students on school property, including a process for coordination with, and referral of such students to, appropriate agencies, and (2) cooperating with law enforcement officials.

[(e) Not later than July 1, 1990, each**]** (f) Each local and regional board of education shall adopt a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts. Each such board of education may establish a student assistance program to identify risk factors for youth suicide, procedures to intervene with such youths, referral services and training for teachers and other school professionals and students who provide assistance in the program.

[(f) Not later than September 1, 1998, each**]** (g) (1) Each local and regional board of education shall develop, adopt and implement written policies and procedures to encourage parent-teacher communication. These policies and procedures may include monthly newsletters, required regular contact with all parents, flexible parent-teacher conferences, drop-in hours for parents, home visits and the use of technology such as homework hot lines to allow parents to check on their children's assignments and students to **[**get**]** receive assistance if needed. **[**For the school year commencing July 1, 2010, and each school year thereafter, such**]** Such policies and procedures shall require the district to conduct two flexible parent-teacher conferences for each school year.

(2) For the school year commencing July 1, 2021, and each school year thereafter, the policies and procedures described in subdivision (1) of this subsection shall require the district to (A) offer parents the option of attending any parent-teacher conference by telephonic, video or other conferencing platform, (B) conduct one parent-teacher conference, in addition to those required pursuant to subdivision (1) of this subsection, during periods when such district provides virtual learning for more than three consecutive weeks, and one additional parent-teacher conference every six months thereafter for the duration of such period of virtual learning, and (C) request from each student's parent the name and contact information of an emergency contact person who may be contacted if the student's parent cannot be reached to schedule a parent-teacher conference required pursuant to subparagraph (B) of this subdivision.

(3) On and after January 1, 2022, such policies and procedures shall require (A) a teacher conducting a parent-teacher conference required pursuant to subparagraph (B) of subdivision (2) of this subsection to provide a copy of the document developed pursuant to section 15 of this act to the parent prior to the parent-teacher conference, and (B) if a teacher is unable to make contact with a student's parent in order to schedule a parent-teacher conference required pursuant to subparagraph (B) of subdivision (2) of this subsection after making three attempts, such teacher shall report such inability to the school principal, school counselor or other school administrator designated by the local or regional board of education. Such principal, counselor or administrator shall contact any emergency contact person designated by the student's parent pursuant to subparagraph (C) of subdivision (2) of this subsection to ascertain such student and family's health and safety.

Sec. 15. (NEW) (*Effective from passage*) Not later than December 1, 2021, the Department of Education shall develop, and annually update, a document for use by local and regional boards of education that

provides information concerning educational, safety, mental health and food insecurity resources and programs available for students and their families. Such document shall contain, but need not be limited to, (1) providers of such resources and programs, including, but not limited to, the Departments of Education, Children and Families and Mental Health and Addiction Services, the United Way of Connecticut and local food banks, (2) descriptions of the relevant resources and programs offered by each provider, including, but not limited to, any program that provides laptop computers, public Internet access or home Internet service to students, (3) contact information for each provider, resource and program, and (4) relevant Internet web sites. The Department of Education shall annually distribute such document electronically to each local and regional board of education.

Sec. 16. (NEW) (*Effective from passage*) (a) As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

(b) Not later than January 1, 2022, the Commissioner of Education shall develop, and update as necessary, standards for virtual learning. The standards shall not be deemed to be regulations, as defined in section 4-166 of the general statutes.

(c) For the school year commencing July 1, 2022, and each school year thereafter, a local or regional board of education may authorize virtual learning to students in grades nine to twelve, inclusive, provided such board (1) provides such instruction in compliance with the standards developed pursuant to subsection (b) of this section, and (2) adopts a policy regarding the requirements for student attendance during virtual learning, which shall (A) be in compliance with the Department of Education's guidance on student attendance during virtual learning, and (B) count the attendance of any student who spends not less than one-half of the school day during such instruction engaged in (i) virtual

classes, (ii) virtual meetings, (iii) activities on time-logged electronic systems, and (iv) the completion and submission of assignments.

Sec. 17. Section 10-16 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

Each school district shall provide in each school year no less than one hundred and eighty days of actual school sessions for grades kindergarten to twelve, inclusive, nine hundred hours of actual school work for full-day kindergarten and grades one to twelve, inclusive, and four hundred and fifty hours of half-day kindergarten, provided school districts shall not count more than seven hours of actual school work in any school day towards the total required for the school year. Virtual learning shall be considered an actual school session for purposes of this section, provided such virtual learning is conducted in compliance with the standards developed pursuant to subsection (b) of section 16 of this act. If weather conditions result in an early dismissal or a delayed opening of school, a school district which maintains separate morning and afternoon half-day kindergarten sessions may provide either a morning or afternoon half-day kindergarten session on such day. As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

Sec. 18. Section 10-198b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[On or before July 1, 2012, the] The State Board of Education shall define "excused absence", [and] "unexcused absence" [, and on or before January 1, 2016, the State Board of Education shall define] and "disciplinary absence" for use by local and regional boards of education for the purposes of carrying out the provisions of section 10-198a, reporting truancy, pursuant to subsection (c) of section 10-220, and calculating the district chronic absenteeism rate and the school chronic

absenteeism rate pursuant to section 10-198c. On or before July 1, 2021, the State Board of Education shall amend the definitions of "excused absence" and "unexcused absence" to exclude a student's engagement in (1) virtual classes, (2) virtual meetings, (3) activities on time-logged electronic systems, and (4) the completion and submission of assignments, if such engagement accounts for not less than one-half of the school day during virtual learning authorized pursuant to section 16 of this act. As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

Sec. 19. (NEW) (*Effective July 1, 2021*) (a) As used in this section and section 10-198b of the general statutes, as amended by this act, "mental health wellness day" describes a school day during which a student attends to such student's emotional and psychological well-being in lieu of attending school.

(b) For the school year commencing July 1, 2021, and each school year thereafter, a local or regional board of education shall permit any student enrolled in grades kindergarten to twelve, inclusive, to take two mental health wellness days during the school year, during which day such student shall not be required to attend school. No student shall take mental health wellness days during consecutive school days.

Sec. 20. Section 10-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Any local or regional board of education may establish and operate a school lunch program for public school children, may operate lunch services for its employees, may establish and operate a school breakfast program, as provided under federal laws governing said programs, or may establish and operate such other child feeding programs as it deems necessary. Charges for such lunches, breakfasts or other such feeding may be fixed by such boards and shall not exceed the

cost of food, wages and other expenses directly incurred in providing such services. When such services are offered, a board shall provide free lunches, breakfasts or other such feeding to children whose economic needs require such action under the standards promulgated by said federal laws. Such board is authorized to purchase equipment and supplies that are necessary, to employ the necessary personnel, to utilize the services of volunteers and to receive and expend any funds and receive and use any equipment and supplies which may become available to carry out the provisions of this section. Any town board of education may vote to designate any volunteer organization within the town to provide a school lunch program, school breakfast program or other child feeding program in accordance with the provisions of this section.

(b) For the school year commencing July 1, 2021, and each school year thereafter, a local or regional board of education shall include in any policy or procedure for the collection of unpaid charges for school lunches, breakfasts or other such feeding applicable to employees and third-party vendors of such school lunches, breakfasts or such feeding (1) a prohibition on publicly identifying or shaming a child for any such unpaid charges, including, but not limited to, delaying or refusing to serve a meal to such child, designating a specific meal option for such child or otherwise taking any disciplinary action against such child, (2) a declaration of the right for any child to purchase a meal, which meal may exclude any a la carte items or be limited to one meal for any school lunch, breakfast or other such feeding, and (3) a procedure for communicating with the parent or legal guardian of a child for the purpose of collecting such unpaid charges. Such communication shall include, but not be limited to, (A) information regarding local food pantries, (B) applications for the school district's program for free or reduced priced meals and for the supplemental nutrition assistance program administered by the Department of Social Services, and (C) a link to the Internet web site maintained by the town for such school

district listing any community services available to the residents of such town. In the event the unpaid charges for school lunches, breakfasts or other such feeding due from any parent or legal guardian are equal to or more than the cost of thirty meals, the local or regional board of education shall refer such parent or legal guardian to the local homeless education liaison designated by such board, pursuant to Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act, 42 USC 11431 et seq., as amended from time to time.

(c) A local or regional board of education may accept gifts, donations or grants from any public or private sources for the purpose of paying off any unpaid charges for school lunches, breakfasts or other such feeding.

Sec. 21. Section 17a-10a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The Commissioner of Children and Families shall ensure that a child placed in the care and custody of the commissioner pursuant to an order of temporary custody or an order of commitment is provided visitation with such child's parents and siblings, unless otherwise ordered by the court.

(b) The commissioner shall ensure that such child's visits with his or her parents, or opportunities to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in accordance with the provisions of subsection (a) of this section, shall occur as frequently as reasonably possible, based upon consideration of the best interests of the child, including the age and developmental level of the child, and shall be sufficient in number and duration to ensure continuation of the relationship.

(c) If such child has an existing relationship with a sibling and is separated from such sibling as a result of intervention by the

commissioner including, but not limited to, placement in a foster home or in the home of a relative, the commissioner shall, based upon consideration of the best interests of the child, ensure that such child has access to and visitation rights with such sibling throughout the duration of such placement. In determining the number, frequency and duration of sibling visits, the commissioner shall consider the best interests of each sibling, given each child's age and developmental level and the continuation of the sibling relationship. If the child and his or her sibling both reside within the state and within fifty miles of each other, the commissioner shall, within available appropriations, ensure that such child's visits with his or her sibling occur, on average, not less than once per week, unless the commissioner finds that the frequency of such visitation is not in the best interests of each sibling.

(d) In the event of a pandemic or outbreak of a communicable disease resulting in a declaration of a public health emergency by the Governor pursuant to section 19a-131a, or a declaration of a national emergency by the President of the United States, such child shall be provided opportunities to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in lieu of in-person visitation, for the duration of any such declaration. Not later than January 1, 2022, the commissioner shall develop a policy that requires the temporary cessation of in-person visitation provided pursuant to this section, on a case-by-case basis, in the event that a child or such child's parent or sibling is seriously ill due to a communicable disease, and visitation could result in the contraction of such disease by one or more participants in the visitation. Such policy shall require that such child be provided an opportunity to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in lieu of such visitation. The commissioner shall define "seriously ill" and "communicable disease" for the purposes of carrying out this subsection.

[(d)**]** (e) The commissioner shall include in each child's case record information relating to the factors considered in making visitation determinations pursuant to this section. If the commissioner determines that such visits are not in the best interests of the child, that the occurrence of, on average, not less than one visit per week with his or her sibling is not in the best interests of each sibling, or that the number, frequency or duration of the visits requested by the child's attorney or guardian ad litem is not in the best interests of the child, the commissioner shall include the reasons for such determination in the child's case record.

[(e)**]** (f) On or before October first of each year, the commissioner shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children, data sufficient to demonstrate compliance with subsections (a), (c) and **[**(d)**]** (e) of this section. Such data shall include the total annual number of children in out-of-home placements who have siblings, the total number of child cases with documented sibling visitation and the number of individual siblings involved in each case.

Sec. 22. (NEW) (*Effective July 1, 2021*) Not later than February 1, 2022, the Commissioner of Children and Families shall develop and maintain a software application for use on computers and mobile devices to facilitate (1) the reporting of nonemergent incidents to the Department of Children and Families by mandated reporters, and (2) communication between children in the care and custody of the commissioner and social workers assigned to such children.

Sec. 23. Section 17a-103d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Upon receiving a complaint of abuse or neglect of a child, the Department of Children and Families shall, at the time of any initial

face-to-face contact with the child's parent or guardian on or after October 1, [2011] 2021, provide the parent or guardian with (1) written notice, in plain language, that: [(1)] (A) The parent or guardian is not required to permit the representative of the department to enter the residence of the parent or guardian; [(2)] (B) the parent or guardian is not required to speak with the representative of the department at that time; [(3)] (C) the parent or guardian is entitled to seek the representation of an attorney and to have an attorney present when the parent or guardian is questioned by a representative of the department, including at any meeting conducted to determine whether the parent or guardian's child should be removed from the home; [(4)] (D) any statement made by the parent, guardian or other family member may be used against the parent or guardian in an administrative or court proceeding; [(5)] (E) the representative of the department is not an attorney and cannot provide legal advice to the parent or guardian; [(6)] (F) the parent or guardian is not required to sign any document presented by the representative of the department, including, but not limited to, a release of claims or a service agreement, and is entitled to have an attorney review such document before agreeing to sign the document; and [(7)] (G) a failure of the parent or guardian to communicate with a representative of the department may have serious consequences, which may include the department's filing of a petition for the removal of the child from the home of the parent or guardian, and therefore it is in the parent's or guardian's best interest to either speak with the representative of the department or immediately seek the advice of a qualified attorney; and (2) a list of providers of free and low-cost legal services through which the parent or guardian may obtain legal advice.

(b) The department shall make reasonable efforts to ensure that the notice and list provided to a parent or guardian pursuant to this section [is] are written in a manner that will be understood by the parent or guardian, which reasonable efforts shall include, but not be limited to,

ensuring that the notice [is] and list are written in a language understood by the parent or guardian.

(c) The representative of the department shall request the parent or guardian to sign and date the notice described in subsection (a) of this section as evidence of having received the notice and list. If the parent or guardian refuses to sign and date the notice upon such request, the representative of the department shall specifically indicate on the notice that the parent or guardian was requested to sign and date the notice and refused to do so and the representative of the department shall sign the notice as witness to the parent's or guardian's refusal to sign the notice. The department shall provide the parent or guardian with a copy of the signed notice at the time of the department's initial face-to-face contact with the parent or guardian.

Sec. 24. Section 17a-248g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Subject to the provisions of this section, funds appropriated to the lead agency for purposes of section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall not be used to satisfy a financial commitment for services that would have been paid from another public or private source but for the enactment of said sections, except for federal funds available pursuant to Part C of the Individuals with Disabilities Education Act, 20 USC 1431 et seq., except that whenever considered necessary to prevent the delay in the receipt of appropriate early intervention services by the eligible child or family in a timely fashion, funds provided under said sections may be used to pay the service provider pending reimbursement from the public or private source that has ultimate responsibility for the payment.

(b) Nothing in section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall be construed to permit the Department of Social Services or any other state

agency to reduce medical assistance pursuant to this chapter or other assistance or services available to eligible children. Notwithstanding any provision of the general statutes, costs incurred for early intervention services that otherwise qualify as medical assistance that are furnished to an eligible child who is also eligible for benefits pursuant to this chapter shall be considered medical assistance for purposes of payments to providers and state reimbursement to the extent that federal financial participation is available for such services.

(c) Providers of early intervention services shall, in the first instance and where applicable, seek payment from all third-party payers prior to claiming payment from the birth-to-three system for services rendered to eligible children, provided, for the purpose of seeking payment from the Medicaid program or from other third-party payers as agreed upon by the provider, the obligation to seek payment shall not apply to a payment from a third-party payer who is not prohibited from applying such payment, and who will apply such payment, to an annual or lifetime limit specified in the third-party payer's policy or contract.

(d) The commissioner, in consultation with the Office of Policy and Management and the Insurance Commissioner, shall adopt regulations, pursuant to chapter 54, providing public reimbursement for deductibles and copayments imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.

(e) **[**The commissioner shall establish and periodically revise, in accordance with this section, a schedule of fees based on a sliding scale for early intervention services. The schedule of fees shall consider the cost of such services relative to the financial resources of the state and the parents or legal guardians of eligible children, provided that on and after October 6, 2009, the commissioner shall (1) charge fees to such parents or legal guardians that are sixty per cent greater than the amount of the fees charged on the date prior to October 6, 2009; and (2)

charge fees for all services provided, including those services provided in the first two months following the enrollment of a child in the program. Fees may be charged to any such parent or guardian, regardless of income, and shall be charged to any such parent or guardian with a gross annual family income of forty-five thousand dollars or more, except that no fee may be charged to the parent or guardian of a child who is eligible for Medicaid. Notwithstanding the provisions of subdivision (8) of section 17a-248, as used in this subsection, "parent" means the biological or adoptive parent or legal guardian of any child receiving early intervention services. The lead agency may assign its right to collect fees to a designee or provider participating in the early intervention program and providing services to a recipient in order to assist the provider in obtaining payment for such services. The commissioner may implement procedures for the collection of the schedule of fees while in the process of adopting or amending such criteria in regulation, provided the commissioner posts notice of intention to adopt or amend the regulations on the eRegulations System, established pursuant to section 4-173b, within twenty days of implementing the policy. Such collection procedures and schedule of fees shall be valid until the time the final regulations or amendments are effective**]** The commissioner shall not charge a fee for early intervention services to the parents or legal guardians of eligible children.

(f) **[**The**]** With respect to early intervention services rendered prior to the effective date of this section, the commissioner shall develop and implement procedures to hold a recipient harmless for the impact of pursuit of payment for **[**early intervention**]** such services against lifetime insurance limits.

(g) Notwithstanding any provision of title 38a relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made

pursuant to section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a. Except as provided in this subsection, nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of section 10-94f, subsection (a) of section 10-94g, subsection (a) of section 17a-219b, subsection (a) of section 17a-219c, sections 17a-248, 17a-248b to 17a-248f, inclusive, this section, and sections 38a-490a and 38a-516a.

Sec. 25. Subdivision (10) of subsection (a) of section 10-76d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(10) (A) Each local and regional board of education responsible for providing special education and related services to a child or pupil shall notify the parent or guardian of a child who requires or who may require special education, a pupil if such pupil is an emancipated minor or eighteen years of age or older who requires or who may require special education or a surrogate parent appointed pursuant to section 10-94g, in writing, at least five school days before such board proposes to, or refuses to, initiate or change the child's or pupil's identification, evaluation or educational placement or the provision of a free appropriate public education to the child or pupil.

(B) Upon request by a parent, guardian, pupil or surrogate parent, the responsible local or regional board of education shall provide such parent, guardian, pupil or surrogate parent an opportunity to meet with a member of the planning and placement team designated by such board prior to the referral planning and placement team meeting at which the assessments and evaluations of the child or pupil who requires or may require special education is presented to such parent, guardian, pupil or surrogate parent for the first time. Such meeting shall be for the sole purpose of discussing the planning and placement team process and any concerns such parent, guardian, pupil or surrogate parent has regarding the child or pupil who requires or may require

special education.

(C) Such parent, guardian, pupil or surrogate parent shall (i) be given at least five school days' prior notice of any planning and placement team meeting conducted for such child or pupil, (ii) have the right to be present at and participate in all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, [and] (iii) have the right to have (I) advisors of such person's own choosing and at such person's own expense, [and to have] (II) the school paraprofessional assigned to such child or pupil, if any, [to be present at and to] and (III) such child or pupil's birth-to-three service coordinator, if any, attend and participate in all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, and (iv) have the right to have each recommendation made in such child or pupil's birth-to-three individualized transition plan, as required by section 17a-248e, as amended by this act, if any, addressed by the planning and placement team during such meeting at which an educational program for such child or pupil is developed.

(D) Immediately upon the formal identification of any child as a child requiring special education and at each planning and placement team meeting for such child, the responsible local or regional board of education shall inform the parent or guardian of such child or surrogate parent or, in the case of a pupil who is an emancipated minor or eighteen years of age or older, the pupil of (i) the laws relating to special education, (ii) the rights of such parent, guardian, surrogate parent or pupil under such laws and the regulations adopted by the State Board of Education relating to special education, including the right of a parent, guardian or surrogate parent to (I) withhold from enrolling such child in kindergarten, in accordance with the provisions of section 10-184, and (II) have advisors and the school paraprofessional assigned to such child or pupil [to be present at, and to] attend and participate in [,]

all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, in accordance with the provisions of subparagraph (C) of this subdivision, and (iii) any relevant information and resources relating to individualized education programs created by the Department of Education, including, but not limited to, information relating to transition resources and services for high school students. If such parent, guardian, surrogate parent or pupil does not attend a planning and placement team meeting, the responsible local or regional board of education shall mail such information to such person.

(E) Each local and regional board of education shall have in effect at the beginning of each school year an educational program for each child or pupil who has been identified as eligible for special education.

(F) At each initial planning and placement team meeting for a child or pupil, the responsible local or regional board of education shall inform the parent, guardian, surrogate parent or pupil of (i) the laws relating to physical restraint and seclusion pursuant to section 10-236b and the rights of such parent, guardian, surrogate parent or pupil under such laws and the regulations adopted by the State Board of Education relating to physical restraint and seclusion, and (ii) the right of such parent, guardian, surrogate parent or pupil, during such meeting at which an educational program for such child or pupil is developed, to have (I) such child or pupil's birth-to-three service coordinator attend and participate in all portions of such meeting, and (II) each recommendation made in the transition plan, as required by section 17a-248e, as amended by this act, by such child or pupil's birth-to-three service coordinator addressed by the planning and placement team.

(G) Upon request by a parent, guardian, pupil or surrogate parent, the responsible local or regional board of education shall provide the results of the assessments and evaluations used in the determination of eligibility for special education for a child or pupil to such parent,

guardian, surrogate parent or pupil at least three school days before the referral planning and placement team meeting at which such results of the assessments and evaluations will be discussed for the first time.

(H) Each local or regional board of education shall monitor the development of each child who, pursuant to subsection (a) of section 17a-248e, as amended by this act, has been (i) referred for a registration on a mobile application designated by the Commissioner of Early Childhood, in partnership with such child's parent, guardian or surrogate parent, or (ii) provided a form for such child's parent, guardian or surrogate parent to complete and submit to such local or regional board of education that screens for developmental and social-emotional delays using a validated screening tool, such as the Ages and Stages Questionnaire and the Ages and Stages Social-Emotional Questionnaire, or its equivalent. If such monitoring results in suspecting a child of having a developmental delay, the board shall schedule a planning and placement team meeting with such child's parent, guardian or surrogate parent for the purposes of identifying services for which such child may be eligible, including, but not limited to, a preschool program under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq. If a parent, guardian or surrogate parent of any child referred for a registration on the mobile application or provided a form to complete and submit pursuant to subsection (a) of section 17a-248e, as amended by this act, fails to complete such registration or complete and submit such form after a period of six months from the date of such referral or provision of such form, the board shall send a reminder, in the form and manner determined by the board, to such parent, guardian or surrogate parent to complete such registration or complete and submit such form. The board shall send another reminder after a period of one year from such referral or provision of such form if such registration remains incomplete or such form is not submitted.

Sec. 26. Subsection (i) of section 10-76d of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(i) (1) No local or regional board of education shall discipline, suspend, terminate or otherwise punish any member of a planning and placement team employed by such board who discusses or makes recommendations concerning the provision of special education and related services for a child during a planning and placement team meeting for such child.

(2) No birth-to-three service coordinator or qualified personnel, as those terms are defined in section 17a-248, who discusses or makes recommendations concerning the provision of special education and related services for a child during a planning and placement team meeting for such child or in a transition plan, as required by section 17a-248e, as amended by this act, shall be subject to discipline, suspension, termination or other punishment on the basis of such recommendations.

Sec. 27. Subsection (a) of section 17a-248e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Each eligible child and his or her family shall receive (1) a multidisciplinary assessment of the child's unique needs and the identification of services appropriate to meet such needs, (2) a written individualized family service plan developed by a multidisciplinary team, including the parent, within forty-five days after the referral, **[**and**]** (3) review of the individualized family service plan with the family at least every six months, with evaluation of the individualized family service plan at least annually, and (4) not later than two months after the date on which any child is determined to be ineligible for participation in preschool programs under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq., a referral to register for a mobile application designated by the Commissioner of Early Childhood

for the purpose of continued screening for developmental and social-emotional delays in partnership with the local or regional board of education for the school district in which such child resides pursuant to subparagraph (H) of subdivision (10) of subsection (a) of section 10a-76d, as amended by this act, provided a form used for screening for developmental and social-emotional delays using a validated screening tool, such as the Ages and Stages Questionnaire and the Ages and Stages Social-Emotional Questionnaire, or its equivalent, is provided to any family upon the request of such family for the purpose of completing and submitting such form to the local or regional board of education for the school district in which such child resides.

Sec. 28. (NEW) (*Effective from passage*) Not later than July 1, 2022, the Commissioner of Early Childhood shall develop and implement a plan to expand the birth-to-three program, established pursuant to section 17a-248b of the general statutes, as amended by this act, to provide early intervention services to any child who is (1) enrolled in the program, (2) turns three years of age on or after May first and not later than the first day of the next school year commencing July first, and (3) is eligible for participation in preschool programs under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq., provided such services shall terminate upon such child's participation in such a preschool program. The commissioner may adopt regulations in accordance with chapter 54 of the general statutes to implement the provisions of this section.

Sec. 29. (NEW) (*Effective July 1, 2021*) For the school year commencing July 1, 2022, and each school year thereafter, in any school district that serves a town that has not convened or established a local or regional school readiness council pursuant to section 10-16r of the general statutes, the local or regional board of education for such school district shall designate a school readiness liaison. Such liaison shall (1) be an existing employee of such school district, and (2) serve as an informational resource for parents of children transitioning from the

birth-to-three program established pursuant to section 17a-248 of the general statutes, to enrollment in a public elementary school in such school district.

Sec. 30. (*Effective from passage*) (a) There is established a task force to study the comprehensive needs of children in the state and the extent to which such needs are being met by educators, community members and local and state agencies. The task force shall (1) identify the needs of children using the following tenets of the whole child initiative developed by the Association for Supervision and Curriculum Development: (A) Each student enters school healthy and learns about and practices a healthy lifestyle, (B) each student learns in an environment that is physically and emotionally safe for students and adults, (C) each student is actively engaged in learning and is connected to the school and broader community, (D) each student has access to personalized learning and is supported by qualified, caring adults, and (E) each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment; (2) recommend new programs or changes to existing programs operated by educators or local or state agencies to better address the needs of children in the state; (3) recognize any exceptional efforts to meet the comprehensive needs of children by educators, community members or local or state agencies; (4) identify and advocate for resources, including, but not limited to, funds, required to meet the needs of children in the state; (5) identify redundancies in existing services or programs for children and advocate for the elimination of such redundancies; and (6) assess all publicly available data concerning the comprehensive needs of children identified pursuant to subdivision (1) of this subsection and collect, or make recommendations for the state to collect, any data that is not being collected by educators, community members or local or state agencies. As used in this section, "community member" means any individual or private organization that provides services or programs for children.

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

(1) Two appointed by the speaker of the House of Representatives, one of whom is an educator employed by a local or regional board of education and one of whom is a social worker licensed pursuant to chapter 383b of the general statutes who works with children;

(2) Two appointed by the president pro tempore of the Senate, one of whom is a representative of the board of directors of the Association for Supervision and Curriculum Development affiliate in the state, and one of whom is representative of an institution of higher education in the state;

(3) One appointed by the majority leader of the House of Representatives, who is a school administrator employed by a local or regional board of education;

(4) One appointed by the majority leader of the Senate, who is a chairperson of a local or regional board of education;

(5) One appointed by the minority leader of the House of Representatives, who is a director or employee of a private nonprofit organization in the state that provides services or programs for children;

(6) One appointed by the minority leader of the Senate, who is a director or employee of a private nonprofit organization in the state that provides health-related services or programs for children;

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

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

(9) The Healthcare Advocate, or the advocate's designee;

(10) The Labor Commissioner, or the commissioner's designee;

(11) The executive director of the Commission on Human Rights and Opportunities, or the executive director's designee;

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

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

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

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

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

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

(18) The Commissioner of Transportation, or the commissioner's designee;

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

(20) The superintendent of the Technical Education and Career System, or the superintendent's designee;

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

(22) The Chief Court Administrator, or the Chief Court Administrator's designee; and

(23) The director of Special Education Equity for Kids of Connecticut, or the director's designee.

(c) Any member of the task force appointed under subdivisions (1) to (6), inclusive, of subsection (b) of this section may be a member of the General Assembly.

(d) 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 not later than thirty days after the vacancy occurs. If a vacancy is not filled by the appointing authority, the chairpersons of the task force may fill such vacancy.

(e) 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.

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

(g) 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 children, 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.

Approved June 16, 2021

Substitute Senate Bill No. 2

Public Act No. 22-81

AN ACT EXPANDING PRESCHOOL AND MENTAL AND BEHAVIORAL SERVICES FOR CHILDREN.

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

Section 1. (NEW) (*Effective July 1, 2022*) For the fiscal year ending June 30, 2023, and each fiscal year thereafter, the Department of Mental Health and Addiction Services shall make mobile crisis response services available twenty-four hours a day, seven days per week, to the public.

Sec. 2. (NEW) (*Effective July 1, 2022*) (a) There is established a Social Determinants of Mental Health Fund, which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account, the resources of which shall be used by the Commissioner of Children and Families to assist families in covering the cost of mental health services and treatment for their children. The commissioner shall establish eligibility criteria for families to receive such assistance based on social determinants of mental health, with a goal toward reducing racial, ethnic, gender and socioeconomic mental health disparities. As used in this section, "social determinants of mental health" includes, but is not limited to, discrimination and social exclusion, adverse early life experiences, low educational attainment, poor educational quality and

educational inequality, poverty, income inequality and living in socioeconomically deprived neighborhoods, food insecurity, unemployment, underemployment and job insecurity, poor housing quality and housing instability, impact of climate change, adverse features of the structures and systems in which persons live or work and poor access to health care.

(b) The commissioner may accept on behalf of the fund any federal funds or private grants or gifts made for purposes of this section. The commissioner shall use such funds to make grants to families for the purposes described in this section.

Sec. 3. (NEW) (*Effective July 1, 2022*) Not later than July 1, 2023, the Department of Education, in collaboration with the governing authority for intramural and interscholastic athletics, shall develop a mental health plan for student athletes to raise awareness of mental health resources available to student athletes. Such plan shall be made available to local and regional boards of education and implemented in accordance with the provisions of section 4 of this act. Such plan shall include, but need not be limited to, provisions relating to (1) access to the mental health services team for the school district, (2) screening and recognizing appropriate referrals for student athletes, (3) communication among members of the mental health services team, (4) the management of administration of student athlete medications, (5) crisis intervention services, (6) the mitigation of risk to student athletes, and (7) transition care for those student athletes leaving intramural or interscholastic athletics by means of graduation, dismissal or suspension. The department shall make such plan available on its Internet web site and provide technical assistance to local and regional boards of education in the implementation of the plan.

Sec. 4. (NEW) (*Effective July 1, 2022*) For the school year commencing July 1, 2023, and each school year thereafter, each local and regional board of education shall implement the mental health plan for student

athletes, developed pursuant to section 3 of this act, for the school district.

Sec. 5. Section 10-21k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

[A local or regional board of education may establish a**]** The Department of Education, in collaboration with the Labor Department, shall administer the Pipeline for Connecticut's Future program. Under the program, **[**a local or regional board of education shall partner with**]** the department shall (1) assist local and regional boards of education in enhancing existing partnerships or establishing new partnerships with providers of child care services, early childhood education programs or mental health services, as well as any additional fields such as manufacturing, computer programming or the culinary arts, and one or more local businesses, to offer a pathways program (A) that assists students in (i) obtaining occupational licenses, (ii) participating in apprenticeship opportunities, and (iii) gaining immediate job skills, (B) that provides (i) industry-specific class time and cooperative work placements, (ii) on-site and apprenticeship training, and (iii) course credit and occupational licenses to students upon completion, and (C) that may lead to a diploma, credential, certificate or license upon graduation in early child care, education or mental health services, and any additional fields, such as manufacturing, computer programming or the culinary arts, and (2) provide incentives to local and regional boards of education for establishing such partnerships.

Sec. 6. (*Effective July 1, 2022*) The Neag School of Education at The University of Connecticut shall conduct a study of the impact of social media and mobile telephone usage on the mental health of students in grades kindergarten to twelve, inclusive. Such study shall include, but need not be limited to, an evaluation of the mental health of students related to social media and phone usage across the elementary, middle and high school levels and how such usage impacts the educational

experience for students and the school climate. Not later than January 1, 2024, the Neag School of Education shall submit a report on its findings and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to children and public health, in accordance with the provisions of section 11-4a of the general statutes.

Sec. 7. Subdivision (3) of subsection (a) of section 19a-77 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(3) A "family child care home" which consists of a private family home **[**caring**]** providing care (A) for (i) not more than six children, including the provider's own children not in school full time, **[**where the children are cared**]** without the presence or assistance of an assistant or substitute staff member approved by the Commissioner of Early Childhood, pursuant to section 19a-87b, present and assisting the provider, or (ii) not more than nine children, including the provider's own children, with the presence and assistance of such approved assistant or substitute staff member, and (B) for not less than three or more than twelve hours during a twenty-four-hour period and where care is given on a regularly recurring basis except that care may be provided in excess of twelve hours but not more than seventy-two consecutive hours to accommodate a need for extended care or intermittent short-term overnight care. During the regular school year, for providers described in subparagraph (A)(i) of this subdivision, a maximum of three additional children who are in school full time, including **[**the**]** such provider's own children, shall be permitted, except that if **[**the**]** such provider has more than three children who are such provider's own children and in school full time, all of **[**the**]** such provider's own children shall be permitted. During the summer months when regular school is not in session, for providers described in subparagraph (A)(i) of this subdivision, a maximum of three additional

children who are otherwise enrolled in school full time **[**, including the provider's own children,**]** shall be permitted if there is such an approved assistant or substitute staff member **[**approved by the Commissioner of Early Childhood, pursuant to section 19a-87b,**]** present and assisting **[**the**]** such provider, except that **[**(A)**]** (i) if **[**the**]** such provider has more than three such additional children who are **[**the**]** such provider's own children, all of **[**the**]** such provider's own children shall be permitted, and **[**(B)**]** (ii) such approved assistant or substitute staff member shall not be required if all of such additional children are **[**the**]** such provider's own children;

Sec. 8. (NEW) (*Effective July 1, 2022*) For the school year commencing July 1, 2022, and each school year thereafter, each local and regional board of education shall hire or designate an existing employee to serve as the family care coordinator for the school district. The family care coordinator shall work with school social workers, school psychologists and school counselors in the schools under the jurisdiction of the board. The family care coordinator shall serve as a liaison for the school system with mental health service providers for the purposes of providing students with access to mental health resources within the community bringing mental health services to students inside of the school.

Sec. 9. Section 10-221o of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Each local and regional board of education shall require each school under its jurisdiction to (1) offer all full day students a daily lunch period of not less than twenty minutes, and (2) include in the regular school day for each student enrolled in elementary school time devoted to physical exercise of not less than twenty minutes in total, except that a planning and placement team may develop a different schedule for a child requiring special education and related services in accordance with chapter 164 and the Individuals With Disabilities Education Act, 20 USC 1400 et seq., as amended from time to time. In the event of a

conflict with this section and any provision of chapter 164, such other provision of chapter 164 shall be deemed controlling. Nothing in this subsection shall prevent a local or regional board of education from including an additional amount of time, beyond the twenty minutes required for physical exercise, devoted to undirected play during the regular school day for each student enrolled in elementary school.

(b) **[**Not later than October 1, 2019, each local and regional board of education shall adopt a policy, as the board deems appropriate, concerning the issue regarding any school employee being involved in preventing a student from participating in the entire time devoted to physical exercise or undirected play in the regular school day, pursuant to subsection (a) of this section, as a form of discipline.**]** For the school year commencing July 1, 2022, and each school year thereafter, each local and regional board of education shall adopt a policy, as the board deems appropriate, concerning the circumstances when a school employee may prevent or otherwise restrict a student from participating in the entire time devoted to physical exercise in the regular school day, pursuant to subsection (a) of this section, as a form of discipline. Such policy shall (1) permit such prevention or restriction (A) when a student poses a danger to the health or safety of other students or school personnel, or (B) when such prevention or restriction is limited to the period devoted to physical exercise that is the shortest in duration if there are two or more periods devoted to physical exercise in a school day, provided the period of time devoted to physical exercise that such student may participate in during such school day is at least twenty minutes in duration, (2) only permit such prevention or restriction once during a school week, unless such student is a danger to the health or safety of other students or school personnel, (3) not include any provisions that such board determines are unreasonably restrictive or punitive, (4) distinguish between (A) discipline imposed prior to the start of such time devoted to physical exercise and discipline imposed during such time devoted to physical exercise, and (B) discipline that (i)

prevents or otherwise restricts a student from participating in such time devoted to physical exercise prior to such time devoted to physical exercise, and (ii) methods used to redirect a student's behavior during such time devoted to physical exercise, and (5) not permit such prevention or restriction if a student does not complete such student's work on time or for such student's academic performance. For purposes of this section, "school employee" means **[**(1)**]** (A) a teacher, substitute teacher, school administrator, school superintendent, guidance counselor, school counselor, psychologist, social worker, nurse, physician, school paraprofessional or coach employed by a local or regional board of education or working in a public elementary, middle or high school; or **[**(2)**]** (B) any other individual who, in the performance of his or her duties, has regular contact with students and who provides services to or on behalf of students enrolled in a public elementary, middle or high school, pursuant to a contract with the local or regional board of education.

Sec. 10. Subsection (a) of section 10-29a of the 2022 supplement to the general statutes is amended by adding subdivision (104) as follows (*Effective October 1, 2022*):

(NEW) (104) The Governor shall proclaim May twenty-sixth of each year to be Get Outside and Play for Children's Mental Health Day to raise awareness about issues relating to children's mental health and the positive effect that being outdoors has on children's mental health and wellness. Suitable exercises shall be held in the State Capitol and in the public schools on the day so designated or, if that day is not a school day, on the school day preceding, or on any such other day as the local or regional board of education prescribes.

Sec. 11. (NEW) (*Effective July 1, 2022*) For the school year commencing July 1, 2022, and each school year thereafter, the Department of Education shall provide annual notice to local and regional boards of education about Get Outside and Play for Children's Mental Health

Day, as proclaimed pursuant to subdivision (104) of subsection (a) of section 10-29a of the general statutes, as amended by this act, and include with such notice any suggestions or materials for suitable exercises that may be held in observance of such day.

Sec. 12. Section 17a-248g of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) Subject to the provisions of this section, funds appropriated to the lead agency for purposes of section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall not be used to satisfy a financial commitment for services that would have been paid from another public or private source but for the enactment of said sections, except for federal funds available pursuant to Part C of the Individuals with Disabilities Education Act, 20 USC 1431 et seq., except that whenever considered necessary to prevent the delay in the receipt of appropriate early intervention services by the eligible child or family in a timely fashion, funds provided under said sections may be used to pay the service provider pending reimbursement from the public or private source that has ultimate responsibility for the payment.

(b) Nothing in section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall be construed to permit the Department of Social Services or any other state agency to reduce medical assistance pursuant to this chapter or other assistance or services available to eligible children. Notwithstanding any provision of the general statutes, costs incurred for early intervention services that otherwise qualify as medical assistance that are furnished to an eligible child who is also eligible for benefits pursuant to this chapter shall be considered medical assistance for purposes of payments to providers and state reimbursement to the extent that federal financial participation is available for such services.

(c) Providers of early intervention services shall, in the first instance and where applicable, seek payment from all third-party payers prior to claiming payment from the birth-to-three system for services rendered to eligible children, provided, for the purpose of seeking payment from the Medicaid program or from other third-party payers as agreed upon by the provider, the obligation to seek payment shall not apply to a payment from a third-party payer who is not prohibited from applying such payment, and who will apply such payment, to an annual or lifetime limit specified in the third-party payer's policy or contract.

(d) The commissioner, in consultation with the Office of Policy and Management and the Insurance Commissioner, shall adopt regulations, pursuant to chapter 54, providing public reimbursement for deductibles and copayments imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.

(e) The commissioner shall not charge a fee for early intervention services to the parents or legal guardians of eligible children.

(f) With respect to early intervention services rendered prior to June 16, 2021, the commissioner shall develop and implement procedures to hold a recipient harmless for the impact of pursuit of payment for such services against lifetime insurance limits.

(g) Notwithstanding any provision of title 38a relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a. Except as provided in this subsection, nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of section 10-94f, subsection (a) of section 10-94g, subsection (a) of section 17a-219b, subsection (a) of section 17a-219c, sections 17a-248, 17a-248b

to 17a-248f, inclusive, this section, and sections 38a-490a and 38a-516a.

(h) For the fiscal years ending June 30, 2023, and June 30, 2024, the commissioner shall make a general administrative payment to providers in the amount of two hundred dollars for each child with an individualized family service plan on the first day of the billing month and whose plan accounts for less than nine hours of service during such billing month, provided at least one service is provided by such provider during such billing month.

Sec. 13. (NEW) (*Effective October 1, 2022, and applicable to assessment years commencing on or after October 1, 2022*) Any municipality may, by vote of its legislative body or, in a municipality where the legislative body is a town meeting, by vote of the board of selectmen, abate up to one hundred per cent of the property taxes due for any tax year, for not more than five tax years, for any property or portion of a property (1) used in the operation of a child care center or group child care home licensed pursuant to section 19a-80 of the general statutes, or a family child care home licensed pursuant to section 19a-87b of the general statutes, as amended by this act, and (2) owned by the person, persons, association, organization, corporation, institution or agency holding such license.

Sec. 14. Subsection (a) of section 19a-79 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) The Commissioner of Early Childhood shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the purposes of sections 19a-77 to 19a-80, inclusive, as amended by this act, and 19a-82 to 19a-87, inclusive, and to assure that child care centers and group child care homes meet the health, educational and social needs of children utilizing such child care centers and group child care homes. Such regulations shall (1) specify that before being permitted to attend

any child care center or group child care home, each child shall be protected as age-appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section 19a-7f, (2) specify conditions under which child care center directors and teachers and group child care home providers may administer tests to monitor glucose levels in a child with diagnosed diabetes mellitus, and administer medicinal preparations, including controlled drugs specified in the regulations by the commissioner, to a child receiving child care services at such child care center or group child care home pursuant to the written order of a physician licensed to practice medicine or a dentist licensed to practice dental medicine in this or another state, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a, or a physician assistant licensed to prescribe in accordance with section 20-12d, and the written authorization of a parent or guardian of such child, (3) specify that an operator of a child care center or group child care home, licensed before January 1, 1986, or an operator who receives a license after January 1, 1986, for a facility licensed prior to January 1, 1986, shall provide a minimum of thirty square feet per child of total indoor usable space, free of furniture except that needed for the children's purposes, exclusive of toilet rooms, bathrooms, coatrooms, kitchens, halls, isolation room or other rooms used for purposes other than the activities of the children, (4) specify that a child care center or group child care home licensed after January 1, 1986, shall provide thirty-five square feet per child of total indoor usable space, (5) establish appropriate child care center staffing requirements for employees certified in cardiopulmonary resuscitation by the American Red Cross, the American Heart Association, the National Safety Council, American Safety and Health Institute, Medic First Aid International, Inc. or an organization using guidelines for cardiopulmonary resuscitation and emergency cardiovascular care published by the American Heart Association and International Liaison

Committee on Resuscitation, (6) specify that a child care center or group child care home (A) shall not deny services to a child on the basis of a child's known or suspected allergy or because a child has a prescription for an automatic prefilled cartridge injector or similar automatic injectable equipment used to treat an allergic reaction, or for injectable equipment used to administer glucagon, (B) shall, not later than three weeks after such child's enrollment in such a center or home, have staff trained in the use of such equipment on-site during all hours when such a child is on-site, (C) shall require such child's parent or guardian to provide the injector or injectable equipment and a copy of the prescription for such medication and injector or injectable equipment upon enrollment of such child, and (D) shall require a parent or guardian enrolling such a child to replace such medication and equipment prior to its expiration date, (7) specify that a child care center or group child care home (A) shall not deny services to a child on the basis of a child's diagnosis of asthma or because a child has a prescription for an inhalant medication to treat asthma, and (B) shall, not later than three weeks after such child's enrollment in such a center or home, have staff trained in the administration of such medication on-site during all hours when such a child is on-site, **[**and**]** (8) establish physical plant requirements for licensed child care centers and licensed group child care homes that exclusively serve school-age children, (9) specify that a child care center or group child care home shall immediately notify the parent or guardian of a child enrolled in such center or home if such child exhibits or develops an illness or is injured while in the care of such center or home, (10) specify that a child care center or group child care home shall create a written record of any such illness or injury, which shall, (A) include, but not be limited to, (i) a description of such illness or injury, (ii) the date, time of occurrence and location of such illness or injury, (iii) any responsive action taken by an employee of such center or home, and (iv) whether such child was transported to a hospital emergency room, doctor's office or other medical facility as a result of such illness or injury, (B) be provided to

the parent or guardian of such child not later than the next business day, and (C) be maintained by such center or home for a period of not less than two years and be made immediately available upon the request of the Office of Early Childhood, and (11) specify that a child care center or group child care home shall maintain any video recordings created at such center or home for a period of not less than thirty days, and make such recordings immediately available upon the request of the Office of Early Childhood. When establishing such requirements, the Office of Early Childhood shall give consideration to child care centers and group child care homes that are located in private or public school buildings. With respect to **[**this**]** subdivision **[**only**]** (8) of this subsection, the commissioner shall implement policies and procedures necessary to implement the physical plant requirements established pursuant to this subdivision while in the process of adopting such policies and procedures in regulation form. Until replaced by policies and procedures implemented pursuant to this subdivision, any physical plant requirement specified in the office's regulations that is generally applicable to child care centers and group child care homes shall continue to be applicable to such centers and homes that exclusively serve school-age children. The commissioner shall post notice of the intent to adopt regulations pursuant to this subdivision on the eRegulations System not later than twenty days after the date of implementation of such policies and procedures. Policies and procedures implemented pursuant to this subdivision shall be valid until the time final regulations are adopted. For purposes of this subsection, "illness" means fever, vomiting, diarrhea, rash, headache, persistent coughing, persistent crying or any other condition deemed an illness by the Commissioner of Early Childhood.

Sec. 15. Subsection (f) of section 19a-87b of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(f) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to ensure that family child care homes, as described in section 19a-77, meet the health, educational and social needs of children utilizing such homes. Such regulations shall (1) ensure that the family child care home is treated as a residence, and not an institutional facility, **[**. Such regulations shall**]** (2) specify that each child be protected as age-appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type B and any other vaccine required by the schedule of active immunization adopted pursuant to section 19a-7f, **[**. Such regulations shall also**]** (3) specify conditions under which family child care home providers may administer tests to monitor glucose levels in a child with diagnosed diabetes mellitus, and administer medicinal preparations, including controlled drugs specified in the regulations by the commissioner, to a child receiving child care services at a family child care home pursuant to a written order of a physician licensed to practice medicine in this or another state, an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, and the written authorization of a parent or guardian of such child, **[**. Such regulations shall**]** (4) specify appropriate standards for extended care and intermittent short-term overnight care, (5) specify that a family child care home shall immediately notify the parent or guardian of a child enrolled in such home if such child exhibits or develops an illness or is injured while in the care of such home, (6) specify that a family child care home shall create a written record of any such illness or injury, which shall, (A) include, but not be limited to, (i) a description of such illness or injury, (ii) the date, time of occurrence and location of such illness or injury, (iii) any responsive action taken by an employee of such home, and (iv) whether such child was transported to a hospital emergency room, doctor's office or other medical facility as a result of such illness or injury, (B) be provided to the parent or guardian of such child not later

than the next business day, and (C) be maintained by such home for a period of not less than two years and be made immediately available upon the request of the Office of Early Childhood, and (7) specify that a family child care home shall maintain any video recordings created at such home for a period of not less than thirty days, and make such recordings immediately available upon the request of the Office of Early Childhood. The commissioner shall inform each licensee, by way of a plain language summary provided not later than sixty days after the regulation's effective date, of any new or changed regulations adopted under this subsection with which a licensee must comply. For purposes of this subsection, "illness" means fever, vomiting, diarrhea, rash, headache, persistent coughing, persistent crying or any other condition deemed an illness by the Commissioner of Early Childhood.

Sec. 16. (NEW) (*Effective July 1, 2022*) (a) Not later than January 1, 2023, the Department of Children and Families shall establish a policy concerning the management and expenditure of Social Security disability insurance benefit payments received by, or on behalf of, children and youths in the care and custody of the Commissioner of Children and Families. Such policy shall include, but not be limited to, (1) a requirement that any such payments be deposited into a trust account maintained for the purpose of receiving such deposits, (2) a requirement that records be maintained concerning the total sum and remaining balance of such payments deposited on behalf of each child or youth receiving such payments, and (3) guidelines concerning the management and oversight of such account and permissible and impermissible withdrawals from such account by children or youths or the guardians of such children or youths.

(b) The Department of Children and Families may employ personnel to implement the provisions of subsection (a) of this section.

(c) No Social Security disability insurance benefit received by a child or youth in the care and custody of the Commissioner of Children and

Families shall be utilized by the Department of Children and Families to offset the cost of such child or youth's care.

Sec. 17. (NEW) (*Effective July 1, 2022*) (a) Not later than July 1, 2023, the Commissioner of Public Health, in consultation with the Commissioner of Social Services, shall establish a pilot grant program to expand behavioral health care offered to children by providers of pediatric care in private practices.

(b) The Commissioner of Public Health, within available appropriations, shall establish a grant program to provide such providers with a fifty per cent match for costs associated with paying the salaries of licensed social workers providing counseling and other services to children receiving primary health care from such providers. The commissioner shall (1) prescribe forms and criteria for such providers to apply and qualify for grant funds; and (2) require such providers to report to the commissioner on use of the funds to expand behavioral health care for children.

Sec. 18. (NEW) (*Effective July 1, 2022*) Not later than December 1, 2022, the Department of Consumer Protection shall develop documents concerning the safe storage by consumers of (1) prescription drugs, as defined in section 19a-754b of the general statutes, and (2) cannabis, as defined in section 21a-420 of the general statutes, and cannabis products, as defined in section 21a-420 of the general statutes. Such documents shall contain, but need not be limited to, information concerning best practices for (A) storing prescription drugs and cannabis and cannabis products in a manner that renders such items inaccessible to children, and (B) disposal of unused and expired prescription drugs and cannabis and cannabis products. Not later than December 15, 2022, the department shall publish such documents on its Internet web site.

Sec. 19. (NEW) (*Effective July 1, 2022*) Not later than January 1, 2023,

each pharmacy, as defined in section 20-635 of the general statutes, shall post a sign in a conspicuous place on the premises of such pharmacy, notifying consumers that they may visit the Internet web site of the Department of Consumer Protection for information concerning the safe storage of prescription drugs and disposal of unused and expired prescription drugs.

Sec. 20. (NEW) (*Effective July 1, 2022*) Not later than January 1, 2023, each retailer, as defined in section 21a-420 of the general statutes, and hybrid retailer, as defined in section 21a-420 of the general statutes, shall post a sign in a conspicuous place on the premises of such retailer or hybrid retailer notifying consumers that they may visit the Internet web site of the Department of Consumer Protection for information concerning the safe storage of cannabis and cannabis products and disposal of unused and expired cannabis and cannabis products.

Sec. 21. (NEW) (*Effective October 1, 2022*) Each hospice and hospice care program licensed under section 19a-122b of the general statutes that provides hospice home care services for terminally ill persons shall dispose of any controlled substance, as defined in section 21a-240 of the general statutes, that such hospice or hospice care program dispensed or administered to a terminally ill person (1) as soon as practicable after the death of such person, and (2) in the manner described in subsection (d) of section 21a-262 of the general statutes, and in accordance with any other applicable state or federal law.

Sec. 22. (*Effective from passage*) The Commissioner of Revenue Services shall conduct a study to identify options for establishing a tax credit against the personal income tax for taxpayers with dependent children enrolled in child care. Not later than January 1, 2023, the commissioner 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 children. Such report shall include the findings of such study and any legislative

recommendations.

Sec. 23. (*Effective from passage*) (a) For the purposes of this section, "child care facilities" means child care centers, group child care homes and family child care homes that provide "child care services", as described in section 19a-77 of the general statutes, as amended by this act, and "out-of-pocket costs" has the same meaning as provided in section 19a-755b of the general statutes.

(b) The Commissioner of Social Services, in consultation with the Office of the State Comptroller, shall conduct a study to identify ways in which the state may provide financial assistance to employees of child care facilities for out-of-pocket costs associated with the provision of medical care to such employees. Not later than January 1, 2024, the commissioner of Social Services 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 children. Such report shall include the findings of such study, including, but not limited to, an analysis of whether such employees may be eligible for participation in any state employee health insurance plan under development, and any legislative recommendations.

Sec. 24. (*Effective from passage*) (a) There is established a task force to continue to study the comprehensive needs of children in the state and the extent to which such needs are being met by educators, community members and local and state agencies. The task force shall (1) address subdivisions (1) to (6), inclusive, of subsection (a) of section 30 of public act 21-46, (2) provide recommendations to meet the demand for infant and toddler care in the state by increasing access to and enrollment in child care centers, group child care homes and family child care homes, and identify resources to assist such centers and homes in meeting such demand, and (3) study the feasibility of adjusting school start times to improve students' mental and physical well-being.

(b) The task force shall consist of the members appointed to the task force to study the comprehensive needs of children pursuant to subsection (b) of section 30 of public act 21-46, except that if any member declines such appointment, a new appointee shall be selected by the appointing authority pursuant to said subsection.

(c) Any member of the task force appointed under subdivisions (1) to (6), inclusive, of subsection (b) of section 30 of public act 21-46 may be a member of the General Assembly.

(d) 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 not later than thirty days after the vacancy occurs. If a vacancy is not filled by the appointing authority, the chairpersons of the task force may fill such vacancy.

(e) 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.

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

(g) Not later than January 1, 2023, and January 1, 2024, the task force shall update the report issued pursuant to subsection (g) of section 30 of public act 21-46, and submit such updated report and any additional findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to children, 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, 2024, whichever is later.

Sec. 25. Section 17b-28e of the general statutes is amended by adding subsection (d) as follows (*Effective July 1, 2022*):

(NEW) (d) (1) Not later than October 1, 2022, the Commissioner of Social Services shall provide Medicaid payments to an enrolled independent licensed behavioral health clinician in private practice for covered services performed by an associate licensed behavioral health clinician working within such associate clinician's scope of practice under the supervision of such independent clinician, provided such independent clinician is (A) authorized under state law to supervise such associate clinician, and (B) complies with any supervision and documentation requirements required by law. Nothing in this subsection shall be construed to alter any requirement concerning such services, including, but not limited to, scope of practice, supervision and documentation requirements.

(2) For purposes of this subsection, (A) "independent licensed behavioral health clinician" means a psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker licensed under chapter 383b of the general statutes or professional counselor licensed under chapter 383c of the general statutes, (B) "associate licensed behavioral health clinician" means a marital and family therapy associate licensed under chapter 383a of the general statutes, master social worker licensed under chapter 383b of the general statutes or professional counselor associate licensed under chapter 383c of the general statutes, and (C) "private practice" means a practice setting that does not require a facility or institutional license and includes both solo and group practices of independent licensed behavioral health clinicians.

Sec. 26. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health, in consultation with the Commissioner of Early Childhood, shall develop and implement a plan to establish licensure by reciprocity or

endorsement of a person who (1) is (A) a speech and language pathologist licensed or certified to provide speech and language pathology services, or entitled to provide speech and language pathology services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, or (B) an occupational therapist licensed or certified to provide occupational therapy services, or entitled to provide occupational therapy services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in force in this state, (2) has no disciplinary action or unresolved complaint pending against such person, and (3) intends to provide early intervention services under the employment of an early intervention service program participating in the birth-to-three program established pursuant to section 17a-248b of the general statutes. When developing and implementing such plan, the Commissioner of Public Health shall consider eliminating barriers to the expedient licensure of such persons in order to immediately address the needs of children receiving early intervention services under the birth-to-three program. The provisions of any interstate licensure compact regarding a speech and language pathologist or occupational therapist adopted by the state shall supersede any program of licensure by reciprocity or endorsement implemented under this section for such speech and language pathologist or occupational therapist.

(b) On or before January 1, 2023, the Commissioner of Public Health shall (1) implement the plan to establish licensure by reciprocity or endorsement, and (2) 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 children regarding such plan and recommendations for any necessary legislative changes related to such plan.

Sec. 27. Section 17a-667 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) There is established a Connecticut Alcohol and Drug Policy Council which shall be within the Department of Mental Health and Addiction Services.

(b) The council shall consist of the following members: (1) The Secretary of the Office of Policy and Management, or the secretary's designee; (2) the Commissioners of Children and Families, Consumer Protection, Correction, Education, Mental Health and Addiction Services, Public Health, Emergency Services and Public Protection, Aging and Disability Services and Social Services, and the Insurance Commissioner, or their designees; (3) the Chief Court Administrator, or the Chief Court Administrator's designee; (4) the chairperson of the Board of Regents for Higher Education, or the chairperson's designee; (5) the president of The University of Connecticut, or the president's designee; (6) the Chief State's Attorney, or the Chief State's Attorney's designee; (7) the Chief Public Defender, or the Chief Public Defender's designee; **[**and**]** (8) the Child Advocate, or the Child Advocate's designee; and (9) the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health, criminal justice and appropriations, or their designees. The Commissioner of Mental Health and Addiction Services and the Commissioner of Children and Families shall be cochairpersons of the council and may jointly appoint up to seven individuals to the council as follows: (A) Two individuals in recovery from a substance use disorder or representing an advocacy group for individuals with a substance use disorder; (B) a provider of community-based substance abuse services for adults; (C) a provider of community-based substance abuse services for adolescents; (D) an addiction medicine physician; (E) a family member of an individual in recovery from a substance use disorder; and (F) an emergency medicine

physician currently practicing in a Connecticut hospital. The cochairpersons of the council may establish subcommittees and working groups and may appoint individuals other than members of the council to serve as members of the subcommittees or working groups. Such individuals may include, but need not be limited to: (i) Licensed alcohol and drug counselors; (ii) pharmacists; (iii) municipal police chiefs; (iv) emergency medical services personnel; and (v) representatives of organizations that provide education, prevention, intervention, referrals, rehabilitation or support services to individuals with substance use disorder or chemical dependency.

(c) The council shall review policies and practices of state agencies and the Judicial Department concerning substance abuse treatment programs, substance abuse prevention services, the referral of persons to such programs and services, and criminal justice sanctions and programs and shall develop and coordinate a state-wide, interagency, integrated plan for such programs and services and criminal sanctions.

(d) Such plan shall be amended not later than January 1, 2017, to contain measurable goals, including, but not limited to, a goal for a reduction in the number of opioid-induced deaths in the state.

Sec. 28. Section 19a-7d of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) **[**Not later than January 1, 2022, the**]** <u>The</u> Commissioner of Public Health shall establish, within available resources, a program to provide three-year grants to community-based providers of primary care services in order to expand access to health care for the uninsured. The grants may be awarded to community-based providers of primary care for (1) funding for direct services, (2) recruitment and retention of primary care clinicians and registered nurses through subsidizing of salaries or through a loan repayment program, and (3) capital

expenditures. The community-based providers of primary care under the direct service program shall provide, or arrange access to, primary and preventive services, behavioral health services, referrals to specialty services, including rehabilitative and mental health services, inpatient care, prescription drugs, basic diagnostic laboratory services, health education and outreach to alert people to the availability of services. Primary care clinicians and registered nurses participating in the state loan repayment program or receiving subsidies shall provide services to the uninsured based on a sliding fee schedule, provide free care if necessary, accept Medicare assignment and participate as Medicaid providers, or provide nursing services in school-based health centers and expanded school health sites, as such terms are defined in section 19a-6r. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish eligibility criteria, services to be provided by participants, the sliding fee schedule, reporting requirements and the loan repayment program. For the purposes of this section, "primary care clinicians" includes family practice physicians, general practice osteopaths, obstetricians and gynecologists, internal medicine physicians, pediatricians, dentists, certified nurse midwives, advanced practice registered nurses, physician assistants, **[**and**]** dental hygienists, psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists and licensed professional counselors.

(b) Funds appropriated for the state loan repayment program shall not lapse until fifteen months following the end of the fiscal year for which such funds were appropriated. For the fiscal year ending June 30, 2023, the department shall expend at least one million six hundred thousand dollars of the funds appropriated for the state loan repayment program for repayments for physicians. Any remaining funds may be expended for other health care providers. For purposes of this section, "physician" means any physician licensed pursuant to chapter 370 who (1) graduated from a medical school in the state or completed his or her

medical residency program at a hospital licensed under chapter 368v, and (2) is employed as a physician in the state.

Sec. 29. (*Effective July 1, 2022*) (a) On or before January 1, 2023, the Commissioner of Public Health shall convene a working group to advise the commissioner regarding methods to enhance physician recruitment in the state. The working group shall examine issues that include, but need not be limited to, (1) recruiting, retaining and compensating primary care, psychiatric and behavioral health care providers; (2) the potential effectiveness of student loan forgiveness; (3) barriers to recruiting and retaining physicians as a result of covenants not to compete, as defined in section 20-14p of the general statutes; (4) access to health care providers; (5) the effect, if any, of the health insurance landscape on limiting health care access; (6) barriers to physician participation in health care networks; and (7) assistance for graduate medical education training.

(b) The working group convened pursuant to subsection (a) of this section shall include, but need not be limited to, the following members: (1) A representative of a hospital association in the state; (2) a representative of a medical society in the state; (3) a physician licensed under chapter 370 of the general statutes with a small group practice; (4) a physician licensed under chapter 370 of the general statutes with a multisite group practice; (5) one representative each of at least three different schools of medicine; (6) a representative of a regional physician recruiter association; (7) the human resources director of at least one hospital in the state; (8) a member of a patient advocacy group; and (9) four members of the general public. The working group shall elect chairpersons from among its members. As used in this subsection, "small group practice" means a group practice comprised of less than eight full-time equivalent physicians and "multisite group practice" means a group practice comprised of over one hundred full-time equivalent physicians practicing throughout the state.

(c) On or before January 1, 2024, the working group shall report, in accordance with the provisions of section 11-4a of the general statutes, its findings to the commissioner and to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

Sec. 30. Subdivision (12) of subsection (a) of section 19a-906 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(12) "Telehealth provider" means (A) any physician licensed under chapter 370, physical therapist licensed under chapter 376, chiropractor licensed under chapter 372, naturopath licensed under chapter 373, podiatrist licensed under chapter 375, occupational therapist licensed under chapter 376a, optometrist licensed under chapter 380, registered nurse or advanced practice registered nurse licensed under chapter 378, physician assistant licensed under chapter 370, psychologist licensed under chapter 383, marital and family therapist licensed under chapter 383a, clinical social worker or master social worker licensed under chapter 383b, alcohol and drug counselor licensed under chapter 376b, professional counselor licensed under chapter 383c, dietitian-nutritionist certified under chapter 384b, speech and language pathologist licensed under chapter 399, respiratory care practitioner licensed under chapter 381a, audiologist licensed under chapter 397a, pharmacist licensed under chapter 400j or paramedic licensed pursuant to chapter 384d who is providing health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession, and (B) on and after July 1, 2024, an appropriately licensed, certified or registered physician, naturopath, registered nurse, advanced practice registered nurse, physician assistant, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, nurse-midwife,

behavior analyst, music therapist or art therapist, in another state or territory of the United States or the District of Columbia, who (i) provides telehealth services under any relevant order issued pursuant to section 33 of this act, (ii) provides mental or behavioral health care through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession, and (iii) maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut mental or behavioral health care providers.

Sec. 31. Subsection (h) of section 19a-906 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(h) No telehealth provider or hospital shall charge a facility fee for telehealth services. Such prohibition shall apply to hospital telehealth services whether provided on campus or otherwise. For purposes of this subsection, "hospital" has the same meaning as provided in section 19a-490 and "campus" has the same meaning as provided in section 19a-508c.

Sec. 32. Section 1 of public act 21-9, as amended by section 3 of public act 21-133, is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(2) "Connecticut medical assistance program" means the state's Medicaid program and the Children's Health Insurance program administered by the Department of Social Services.

(3) "Facility fee" has the same meaning as provided in section 19a-508c of the general statutes.

(4) "Health record" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(5) "Medical history" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(6) "Medication-assisted treatment" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(7) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(8) "Peripheral devices" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(9) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(10) "Store and forward transfer" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(11) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act.

(12) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical, oral and mental health, and includes interaction between the patient at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through **[**(A)**]**

facsimile, texting or electronic mail. **[**, or (B) audio-only telephone unless the telehealth provider is (i) in-network, or (ii) a provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.**]**

(13) "Telehealth provider" means any person who is (A) **[**an in-network provider or a provider enrolled in the Connecticut medical assistance program**]** providing health care or other health services **[**to a Connecticut medical assistance program recipient**]** through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 378 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes, dietitian-nutritionist certified under chapter 384b of the general statutes, speech and language pathologist licensed under chapter 399 of the general statutes, respiratory care practitioner licensed under chapter 381a of the general statutes, audiologist licensed under chapter 397a of the general statutes, pharmacist licensed under chapter 400j of the general statutes, paramedic licensed pursuant to chapter 384d of the general statutes,

nurse-midwife licensed under chapter 377 of the general statutes, dentist licensed under chapter 379 of the general statutes, behavior analyst licensed under chapter 382a of the general statutes, genetic counselor licensed under chapter 383d of the general statutes, music therapist certified in the manner described in chapter 383f of the general statutes, art therapist **[**certified**]** licensed in the manner described in chapter 383g of the general statutes or athletic trainer licensed under chapter 375a of the general statutes, or (ii) an appropriately licensed, certified or registered physician, physician assistant, physical therapist, physical therapist assistant, chiropractor, naturopath, podiatrist, occupational therapist, occupational therapy assistant, optometrist, registered nurse, advanced practice registered nurse, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, speech and language pathologist, respiratory care practitioner, audiologist, pharmacist, paramedic, nurse-midwife, dentist, behavior analyst, genetic counselor, music therapist, art therapist or athletic trainer, in another state or territory of the United States or the District of Columbia, that provides telehealth services pursuant to his or her authority under any relevant order issued by the Commissioner of Public Health and maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(b) (1) Notwithstanding the provisions of section 19a-906 of the general statutes, as amended by this act, during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, a telehealth provider may only provide a telehealth service to a patient when the telehealth provider:

(A) Is communicating through real-time, interactive, two-way

communication technology or store and forward transfer technology;

(B) Has determined whether the patient has health coverage that is fully insured, not fully insured or provided through **[**Medicaid or the Children's Health Insurance Program**]** the Connecticut medical assistance program, and whether the patient's health coverage, if any, provides coverage for the telehealth service;

(C) Has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the name and address of the patient's primary care provider, if any;

(D) Conforms to the standard of care applicable to the telehealth provider's profession and expected for in-person care as appropriate to the patient's age and presenting condition, except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition; and

(E) Provides the patient with the telehealth provider's license number, if any, and contact information.

(2) Notwithstanding the provisions of section 19a-906 of the general statutes, as amended by this act, if a telehealth provider provides a telehealth service to a patient during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, the telehealth provider shall, at the time of the telehealth provider's first telehealth interaction with a patient, inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform, including, but not limited to, the limited duration of the relevant provisions of this section and sections 3 to 7, inclusive, of **[**this act**]** public act 21-9, as amended by this act, and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice

and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.

(c) Notwithstanding the provisions of this section or title 20 of the general statutes, no telehealth provider shall, during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, prescribe any schedule I, II or III controlled substance through the use of telehealth, except a schedule II or III controlled substance other than an opioid drug, as defined in section 20-14o of the general statutes, in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time, for the treatment of a person with a psychiatric disability or a person with a substance use disorder, as defined in section 17a-458 of the general statutes, including, but not limited to, medication-assisted treatment. A telehealth provider using telehealth to prescribe a schedule II or III controlled substance pursuant to this subsection shall electronically **[**submit**]** transmit the prescription pursuant to section 21a-249 of the general statutes, as amended by **[**this act**]** public act 21-9.

(d) During the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions during such period to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive, of the general statutes.

(e) During the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, any consent or

revocation of consent under this section shall be obtained from or communicated by the patient, or the patient's legal guardian, conservator or other authorized representative, as applicable.

(f) (1) The provision of telehealth services and health records maintained and disclosed as part of a telehealth interaction shall comply with all provisions of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and the rules and regulations adopted thereunder, that are applicable to such provision, maintenance or disclosure.

(2) Notwithstanding the provisions of section 19a-906 of the general statutes, as amended by this act, and subdivision (1) of this subsection, a telehealth provider that is an in-network provider or a provider enrolled in the Connecticut medical assistance program that provides telehealth services to a Connecticut medical assistance program recipient, may, during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, use any information or communication technology in accordance with the directions, modifications or revisions, if any, made by the Office for Civil Rights of the United States Department of Health and Human Services to the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191, as amended from time to time, or the rules and regulations adopted thereunder.

(g) Notwithstanding any provision of the general statutes, nothing in this section shall, during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, prohibit a health care provider from: (1) Providing on-call coverage pursuant to an agreement with another health care provider or such health care provider's professional entity or employer; (2) consulting with another health care provider concerning a patient's care; (3) ordering care for hospital outpatients or inpatients; or (4) using telehealth for a hospital inpatient, including for the purpose of ordering medication or treatment

for such patient in accordance with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time. As used in this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375, 376 to 376b, inclusive, 378, 379, 380, 381a, 383 to 383c, inclusive, 384b, 397a, 399 or 400j of the general statutes or licensed or certified pursuant to chapter 368d or 384d of the general statutes.

(h) Notwithstanding any provision of the general statutes, no telehealth provider shall charge a facility fee for a telehealth service provided during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024.

(i) (1) Notwithstanding any provision of the general statutes, no telehealth provider shall provide health care or health services to a patient through telehealth during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, unless the telehealth provider has determined whether or not the patient has health coverage for such health care or health services.

(2) Notwithstanding any provision of the general statutes, a telehealth provider who provides health care or health services to a patient through telehealth during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, shall:

(A) Accept as full payment for such health care or health services:

(i) An amount that is equal to the amount that Medicare reimburses for such health care or health services if the telehealth provider determines that the patient does not have health coverage for such health care or health services; or

(ii) The amount that the patient's health coverage reimburses, and any coinsurance, copayment, deductible or other out-of-pocket expense

imposed by the patient's health coverage, for such health care or health services if the telehealth provider determines that the patient has health coverage for such health care or health services. If the patient's health coverage uses a provider network, the amount of such reimbursement, and such coinsurance, copayment, deductible or other out-of-pocket expense, shall not exceed the in-network amount regardless of the network status of such telehealth provider.

(3) If a telehealth provider determines that a patient is unable to pay for any health care or health services described in subdivisions (1) and (2) of this subsection, the provider shall offer to the patient financial assistance, if such provider is otherwise required to offer to the patient such financial assistance, under any applicable state or federal law.

(j) Subject to compliance with all applicable federal requirements, notwithstanding any provision of the general statutes, state licensing standards or any regulation adopted thereunder, a telehealth provider may provide telehealth services pursuant to the provisions of this section from any location.

(k) Notwithstanding the provisions of section 19a-906 of the general statutes, as amended by this act, during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, any Connecticut entity, institution or health care provider that engages or contracts with a telehealth provider that is licensed, certified or registered in another state or territory of the United States or the District of Columbia to provide health care or other health services shall verify the credentials of such provider in the state in which he or she is licensed, certified or registered, ensure that such **[**a**]** provider is in good standing in such state, and confirm that such provider maintains professional liability insurance or other indemnity against liability for professional malpractice in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(l) Notwithstanding sections 4-168 to 4-174, inclusive, of the general statutes, from the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, the Commissioner of Public Health may temporarily waive, modify or suspend any regulatory requirements adopted by the Commissioner of Public Health or any boards or commissions under chapters 368a, 368d, 368v, 369 to 381a, inclusive, 382a, 383 to 388, inclusive, 397a, 398, 399, 400a, 400c, 400j and 474 of the general statutes as the Commissioner of Public Health deems necessary to reduce the spread of COVID-19 and to protect the public health for the purpose of providing residents of this state with telehealth services from out-of-state practitioners.

Sec. 33. (NEW) (*Effective July 1, 2022*) The Commissioner of Public Health may issue an order authorizing telehealth providers who are not licensed, certified or registered to practice in this state to provide telehealth services to patients in this state. Such order may be of limited duration and limited to one or more types of providers described in subdivision (13) of subsection (a) of section 1 of public act 21-9, as amended by this act, or subdivision (12) of subsection (a) of section 19a-906 of the general statutes, as amended by this act. The commissioner may impose conditions including, but not limited to, a requirement that any telehealth provider providing telehealth services to patients in this state pursuant to such order shall submit an application for licensure, certification or registration, as applicable. The commissioner may suspend or revoke any authorization provided pursuant to this section to a telehealth provider who violates any condition imposed by the commissioner or applicable requirements for the provision of telehealth services under the law. Any such order issued pursuant to this section shall not constitute a regulation, as defined in section 4-166 of the general statutes.

Sec. 34. Subsection (c) of section 21a-249 of the 2022 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective from passage*):

(c) A licensed practitioner shall not be required to electronically transmit a prescription when:

(1) Electronic transmission is not available due to a temporary technological or electrical failure. In the event of a temporary technological or electrical failure, the practitioner shall, without undue delay, reasonably attempt to correct any cause for the failure that is within his or her control. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record as soon as practicable, but in no instance more than seventy-two hours following the end of the temporary technological or electrical failure that prevented the electronic transmittal of the prescription. For purposes of this subdivision, "temporary technological or electrical failure" means failure of a computer system, application or device or the loss of electrical power to such system, application or device, or any other service interruption to such system, application or device that reasonably prevents the practitioner from utilizing his or her certified application to electronically transmit the prescription in accordance with subsection (b) of this section;

(2) The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by an electronically transmitted prescription in a timely manner and that such delay would adversely impact the patient's medical condition, provided if such prescription is for a controlled substance, the quantity of such controlled substance does not exceed a five-day supply for the patient, if the controlled substance was used in accordance with the directions for use. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically

transmit the prescription in the patient's medical record;

(3) The prescription is to be dispensed by a pharmacy located outside this state. A practitioner who issues a prescription, but fails to electronically transmit the prescription, as permitted by this subsection, shall document the reason for the practitioner's failure to electronically transmit the prescription in the patient's medical record;

(4) Use of an electronically transmitted prescription may negatively impact patient care, such as a prescription containing two or more products to be compounded by a pharmacist, a prescription for direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion, a prescription that contains long or complicated directions, a prescription that requires certain elements to be included by the federal Food and Drug and Administration, or an oral prescription communicated to a pharmacist by a health care practitioner for a patient in a chronic and convalescent nursing home, licensed pursuant to chapter 368v; or

(5) The practitioner demonstrates, in a form and manner prescribed by the commissioner, that such practitioner does not have the technological capacity to issue an electronically transmitted **[**prescriptions**]** prescription. For the purposes of this subsection, "technological capacity" means possession of a computer system, hardware or device that can be used to electronically transmit controlled substance prescriptions consistent with the requirements of the federal Controlled Substances Act, 21 USC 801, as amended from time to time. The provisions of this subdivision shall not apply to a practitioner when such practitioner is prescribing as a telehealth provider, as defined in section 19a-906, as amended by this act, section 1 of public act 20-2 of the July special session or section 1 of public act 21-9, as amended by this act, as applicable, pursuant to subsection (c) of section 19a-906, subsection (c) of section 1 of public act 20-2 of the July special session or subsection (c) of section 1 of public act 21-9, as amended by this act, as

applicable.

Sec. 35. Section 3 of public act 21-9 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For the purposes of this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(2) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(3) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(4) "Store and forward transfer" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(5) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(6) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of an insured's physical, oral and mental health, and includes interaction between the insured at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through (A) facsimile, texting or electronic mail, or (B) audio-only telephone if the policy described in subsection (b) of this section uses a provider network and the telehealth provider is out-of-network; and

(7) "Telehealth provider" means any person who (A) provides health care or other health services through the use of telehealth within such

person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) is (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 378 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes, dietitian-nutritionist certified under chapter 384b of the general statutes, speech and language pathologist licensed under chapter 399 of the general statutes, respiratory care practitioner licensed under chapter 381a of the general statutes, audiologist licensed under chapter 397a of the general statutes, pharmacist licensed under chapter 400j of the general statutes, paramedic licensed pursuant to chapter 384d of the general statutes, nurse-midwife licensed under chapter 377 of the general statutes, dentist licensed under chapter 379 of the general statutes, behavior analyst licensed under chapter 382a of the general statutes, genetic counselor licensed under chapter 383d of the general statutes, music therapist certified in the manner described in chapter 383f of the general statutes, art therapist **[**certified**]** licensed in the manner described in chapter 383g of the general statutes or athletic trainer licensed under chapter 375a of the general statutes, or (ii) an in-network and appropriately licensed, certified or registered physician, physician assistant, physical therapist, physical therapist assistant, chiropractor,

naturopath, podiatrist, occupational therapist, occupational therapy assistant, optometrist, registered nurse, advanced practice registered nurse, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional counselor, dietitian-nutritionist, speech and language pathologist, respiratory care practitioner, audiologist, pharmacist, paramedic, nurse-midwife, dentist, behavior analyst, genetic counselor, music therapist, art therapist or athletic trainer, in another state or territory of the United States or the District of Columbia, that provides telehealth services pursuant to his or her authority under any relevant order issued by the Commissioner of Public Health and maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(b) Notwithstanding any provision of the general statutes, each individual health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is effective at any time during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, shall, at all times that the policy remains in effect during such period, provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the same extent coverage is provided for such advice, diagnosis, care or treatment when provided to the insured in person. The policy shall not, at any time during such period, exclude coverage for a service that is appropriately provided through telehealth because such service is provided through telehealth or a telehealth platform selected by an in-network telehealth provider.

(c) Notwithstanding any provision of the general statutes, no telehealth provider who receives a reimbursement for a covered service

provided through telehealth in accordance with subsection (b) of this section shall seek any payment for such service from the insured who received such service, except for any coinsurance, copayment, deductible or other out-of-pocket expense set forth in the insured's policy. Such amount shall be deemed by the telehealth provider to be payment in full.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service. Except as provided in subsection (b) or (c) of this section, the coverage required under subsection (b) of this section shall be subject to the same terms and conditions applicable to all other benefits under the policy providing such coverage.

(e) The provisions of this section shall apply to a high deductible health plan, as that 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 said Section 220 or 223, as applicable.

Sec. 36. Section 4 of public act 21-9 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For the purposes of this section:

(1) "Asynchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(2) "Originating site" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(3) "Remote patient monitoring" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(4) "Store and forward transfer" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(5) "Synchronous" has the same meaning as provided in section 19a-906 of the general statutes, as amended by this act;

(6) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of an insured's physical, oral and mental health, and includes interaction between the insured at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through (A) facsimile, texting or electronic mail, or (B) audio-only telephone if the policy described in subsection (b) of this section uses a provider network and the telehealth provider is out-of-network; and

(7) "Telehealth provider" means any person who (A) provides health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to such person's profession, and (B) is (i) a physician or physician assistant licensed under chapter 370 of the general statutes, physical therapist or physical therapist assistant licensed under chapter

376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist or occupational therapy assistant licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, registered nurse or advanced practice registered nurse licensed under chapter 378 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes, dietitian-nutritionist certified under chapter 384b of the general statutes, speech and language pathologist licensed under chapter 399 of the general statutes, respiratory care practitioner licensed under chapter 381a of the general statutes, audiologist licensed under chapter 397a of the general statutes, pharmacist licensed under chapter 400j of the general statutes, paramedic licensed pursuant to chapter 384d of the general statutes, nurse-midwife licensed under chapter 377 of the general statutes, dentist licensed under chapter 379 of the general statutes, behavior analyst licensed under chapter 382a of the general statutes, genetic counselor licensed under chapter 383d of the general statutes, music therapist certified in the manner described in chapter 383f of the general statutes, art therapist **[**certified**]** licensed in the manner described in chapter 383g of the general statutes or athletic trainer licensed under chapter 375a of the general statutes, or (ii) an in-network and appropriately licensed, certified or registered physician, physician assistant, physical therapist, physical therapist assistant, chiropractor, naturopath, podiatrist, occupational therapist, occupational therapy assistant, optometrist, registered nurse, advanced practice registered nurse, psychologist, marital and family therapist, clinical social worker, master social worker, alcohol and drug counselor, professional

counselor, dietitian-nutritionist, speech and language pathologist, respiratory care practitioner, audiologist, pharmacist, paramedic, nurse-midwife, dentist, behavior analyst, genetic counselor, music therapist, art therapist or athletic trainer, in another state or territory of the United States or the District of Columbia, that provides telehealth services pursuant to his or her authority under any relevant order issued by the Commissioner of Public Health and maintains professional liability insurance, or other indemnity against liability for professional malpractice, in an amount that is equal to or greater than that required for similarly licensed, certified or registered Connecticut health care providers.

(b) Notwithstanding any provision of the general statutes, each group health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is effective at any time during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, shall, at all times that the policy remains in effect during such period, provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the same extent coverage is provided for such advice, diagnosis, care or treatment when provided to the insured in person. The policy shall not, at any time during such period, exclude coverage for a service that is appropriately provided through telehealth because such service is provided through telehealth or a telehealth platform selected by an in-network telehealth provider.

(c) Notwithstanding any provision of the general statutes, no telehealth provider who receives a reimbursement for a covered service provided through telehealth in accordance with subsection (b) of this section shall seek any payment for such service from the insured who received such service, except for any coinsurance, copayment, deductible or other out-of-pocket expense set forth in the insured's

policy. Such amount shall be deemed by the telehealth provider to be payment in full.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service. Except as provided in subsection (b) or (c) of this section, the coverage required under subsection (b) of this section shall be subject to the same terms and conditions applicable to all other benefits under the policy providing such coverage.

(e) The provisions of this section shall apply to a high deductible health plan, as that term is used in subsection (f) of section 38a-520 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 said Section 220 or 223, as applicable.

Sec. 37. Section 5 of public act 21-9 is repealed the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Insured" has the same meaning as provided in section 38a-1 of the general statutes;

(3) "Telehealth" has the same meaning as provided in sections 3 and 4 of **[**this act**]** public act 21-9, as amended by this act; and

(4) "Telehealth provider" has the same meaning as provided in sections 3 and 4 of **[**this act**]** public act 21-9, as amended by this act.

(b) Notwithstanding any provision of the general statutes, no health carrier shall reduce the amount of a reimbursement paid to a telehealth provider for covered health care or health services that the telehealth provider appropriately provided to an insured through telehealth during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, because the telehealth provider provided such health care or health services to the patient through telehealth and not in person.

Sec. 38. Section 7 of public act 21-9 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Advanced practice registered nurse" means an advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes;

(2) "Physician" has the same meaning as provided in section 21a-408 of the general statutes;

(3) "Qualifying patient" has the same meaning as provided in section 21a-408 of the general statutes; and

(4) "Written certification" has the same meaning as provided in section 21a-408 of the general statutes.

(b) Notwithstanding the provisions of sections 21a-408 to 21a-408n,

inclusive, of the general statutes, or any other section, regulation, rule, policy or procedure concerning the certification of medical marijuana patients, a physician or advanced practice registered nurse may issue a written certification to a qualifying patient and provide any follow-up care using telehealth services during the period beginning on **[**the effective date of this section**]** May 10, 2021, and ending on June 30, **[**2023**]** 2024, provided all other requirements for issuing the written certification to the qualifying patient and all recordkeeping requirements are satisfied.

Sec. 39. Section 38a-499a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) As used in this section, "telehealth" has the same meaning as provided in section 19a-906, as amended by this act.

(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 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider licensed in the state. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider licensed in the state, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Sec. 40. Section 38a-526a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2024*):

(a) As used in this section, "telehealth" has the same meaning as provided in section 19a-906, as amended by this act.

(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 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider licensed in the state. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider licensed in the state for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service

corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Sec. 41. (*Effective from passage*) The executive director of the Office of Health Strategy, established under section 19a-754a of the general statutes, shall conduct a study regarding the provision of, and coverage for, telehealth services in this state. Such study shall include, but need not be limited to, an examination of (1) the feasibility and impact of expanding access to telehealth services, telehealth providers and coverage for telehealth services in this state beginning on July 1, 2024, and (2) any means available to reduce or eliminate obstacles to patient access to telehealth services, telehealth providers and coverage for telehealth services in this state, including, but not limited to, any means available to reduce patient costs for telehealth services and coverage for telehealth services in this state. Not later than January 1, 2023, the executive director shall submit a report on the findings of such study, 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, human services and insurance.

Sec. 42. (*Effective October 1, 2022*) The Psychology Interjurisdictional Compact is hereby enacted into law and entered into by the state of Connecticut with any and all states legally joining therein in accordance with its terms. The compact is substantially as follows:

"PSYCHOLOGY INTERJURISDICTIONAL COMPACT

ARTICLE I

PURPOSE

Whereas, states license psychologists in order to protect the public

through verification of education, training and experience and ensure accountability for professional practice; and

Whereas, the compact is intended to regulate the day-to-day practice of telepsychology, including, but not limited to, the provision of psychological services using telecommunication technologies, by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, the compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for thirty days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, the compact is intended to authorize state psychology regulatory authorities to afford legal recognition, in a manner consistent with the terms of the compact, to psychologists licensed in another state; and

Whereas, the compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state licensing and regulation will best protect public health and safety; and

Whereas, the compact shall not apply when a psychologist is licensed in both the home and receiving states; and

Whereas, the compact shall not apply to permanent in-person, face-to-face practice, it shall allow for authorization of temporary psychological practice.

Consistent with such principles, the compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines and temporary in-person, face-to-face services in a state which the psychologist is not licensed to practice psychology;

(2) Enhance the states' ability to protect the public's health and safety, especially client or patient safety;

(3) Encourage the cooperation of compact states in the areas of psychology licensure and regulation;

(4) Facilitate the exchange of information between compact states regarding licensure, adverse actions and disciplinary history of psychologists;

(5) Promote compliance with the laws governing psychological practice in each compact state; and

(6) Invest all compact states with the authority to hold licensed psychologists accountable through the mutual recognition of compact state licenses.

ARTICLE II

DEFINITIONS

(1) "Adverse action" means any action taken by a state psychology regulatory authority that finds a violation of a statute or regulation that is identified by the state psychology regulatory authority as discipline and is a matter of public record.

(2) "Association of State and Provincial Psychology Boards" means the recognized membership organization composed of state and provincial psychology regulatory authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) "Authority to practice interjurisdictional telepsychology" means a licensed psychologist's authority to practice telepsychology, within the limits authorized under the compact, in another compact state.

(4) "Bylaws" means the bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to Article X of the compact for the governance of said commission, or for directing and controlling the actions and conduct of said commission.

(5) "Client or patient" means the recipient of psychological services, whether psychological services are delivered in the context of healthcare, corporate, supervision or consulting services.

(6) "Commissioner" means the voting representative appointed by each state psychology regulatory authority pursuant to Article X of the compact.

(7) "Compact" means the Psychology Interjurisdictional Compact.

(8) "Compact state" means a state, the District of Columbia or United States territory that has enacted the compact and that has not withdrawn pursuant to subsection (c) of Article XIII of the compact, or been terminated pursuant to subsection (b) of Article XII of the compact.

(9) "Coordinated licensure information system" or "coordinated database" means an integrated process for collecting, storing and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, that is administered by the recognized membership organization composed of state and provincial psychology regulatory authorities.

(10) "Confidentiality" means the principle that data or information is not made available or disclosed to unauthorized persons or processes.

(11) "Day" means any part of a day in which psychological work is

performed.

(12) "Distant state" means the compact state where a psychologist is physically present, not through the use of telecommunications technologies, to provide temporary in-person, face-to-face psychological services.

(13) "E.Passport" means the certificate issued by the Association of State and Provincial Psychology Boards that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(14) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(15) "Home state" means a compact state where a psychologist is licensed to practice psychology, provided (A) if the psychologist is licensed in more than one compact state and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the home state is the compact state where the psychologist is physically present when delivering telepsychological services, and (B) if the psychologist is licensed in more than one compact state and is practicing under the temporary authorization to practice, the home state is any compact state where the psychologist is licensed.

(16) "Identity history summary" means a summary of information retained by the Federal Bureau of Investigation, or said bureau's designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(17) "In-person, face-to-face" (A) means interactions in which the psychologist and the client or patient are in the same physical space, and (B) does not include interactions that may occur through the use of

telecommunication technologies.

(18) "IPC" means the Interjurisdictional Practice Certificate issued by the Association of State and Provincial Psychology Boards that grants temporary authority to practice based on notification to the state psychology regulatory authority of intention to practice temporarily, and verification of one's qualifications for such practice.

(19) "License" means authorization by a state psychology regulatory authority to engage in the independent practice of psychology, which practice would be unlawful without the authorization.

(20) "Noncompact state" means any state that is not a compact state.

(21) "Psychologist" means an individual licensed for the independent practice of psychology.

(22) "Psychology Interjurisdictional Compact Commission" or "commission" means the national administration of which all compact states are members.

(23) "Receiving state" means a compact state where the client or patient is physically located when the telepsychological services are delivered.

(24) "Rule" means a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to Article XI of the compact that is of general applicability, implements, interprets or prescribes a policy or provision of the compact, or an organizational, procedural or practice requirement of the commission, and has the force and effect of statutory law in a compact state, including, but not limited to, the amendment, repeal or suspension of an existing rule.

(25) "Significant investigatory information" means:

(A) Investigative information that a state psychology regulatory authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

(B) Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified or had an opportunity to respond.

(26) "State" means a state, commonwealth, territory or possession of the United States, or the District of Columbia.

(27) "State psychology regulatory authority" means the board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

(28) "Telepsychology" means the provision of psychological services using telecommunication technologies.

(29) "Temporary authorization to practice" means a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under the compact, in another compact state.

(30) "Temporary in-person, face-to-face practice" means the practice of psychology by a psychologist who is physically present, not through the use of telecommunications technologies, in the distant state for not more than thirty days in a calendar year and based on notification to the distant state.

ARTICLE III

HOME STATE LICENSURE

(a) The home state shall be a compact state where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more compact state licenses at a time. If the psychologist is licensed in more than one compact state, the home state is the compact state where the psychologist is physically present when the services are delivered as authorized by the authority to practice interjurisdictional telepsychology under the terms of the compact.

(c) Any compact state may require a psychologist not previously licensed in a compact state to obtain and retain a license to be authorized to practice in the compact state under circumstances not authorized by the authority to practice interjurisdictional telepsychology under the terms of the compact.

(d) Any compact state may require a psychologist to obtain and retain a license to be authorized to practice in a compact state under circumstances not authorized by a temporary authorization to practice under the terms of the compact.

(e) A home state's license authorizes a psychologist to practice in a receiving state under the authority to practice interjurisdictional telepsychology only if the compact state:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the commission, in compliance with the terms of the compact, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an identity history summary of all applicants at initial licensure, including, but not limited to, the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, or said bureau's designee with similar authority, not later than ten years after activation of the compact; and

(5) Complies with the bylaws and rules of the commission.

(f) A home state's license grants a temporary authorization to practice to a psychologist in a distant state only if the compact state:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the commission, in compliance with the terms of the compact, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an identity history summary of all applicants at initial licensure, including, but not limited to, the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, or said bureau's designee with similar authority, not later than ten years after activation of the compact; and

(5) Complies with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE TO PRACTICE TELEPSYCHOLOGY

(a) Compact states shall recognize the right of a psychologist, licensed in a compact state in conformance with Article III of the compact, to

practice telepsychology in receiving states in which the psychologist is not licensed, under the authority to practice interjurisdictional telepsychology as provided in the compact.

(b) To exercise the authority to practice interjurisdictional telepsychology under the terms and provisions of the compact, a psychologist licensed to practice in a compact state shall:

(1) Hold a graduate degree in psychology from an institution of higher education that was, at the time the degree was awarded:

(A) Regionally accredited by an accrediting body recognized by the United States Department of Education to grant graduate degrees, or authorized by provincial statute or royal charter to grant doctoral degrees; or

(B) A foreign college or university deemed to be equivalent to an institution of higher education described in subparagraph (A) of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology from a psychology program that meets the following criteria:

(A) The program, wherever it may be administratively housed, shall be clearly identified and labeled as a psychology program. Such program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(B) The psychology program shall stand as a recognizable, coherent, organizational entity within the institution;

(C) There shall be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across

administrative lines;

(D) The program shall consist of an integrated, organized sequence of study;

(E) There shall be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

(F) The designated director of the program shall be a psychologist and a member of the core faculty;

(G) The program shall have an identifiable body of students who are matriculated in such program for a degree;

(H) The program shall include supervised practicum, internship or field training appropriate to the practice of psychology;

(I) The curriculum shall encompass a minimum of three academic years of full-time graduate study for a doctoral degree and a minimum of one academic year of full-time graduate study for a master's degree; and

(J) The program shall include an acceptable residency, as defined by the rules of the commission.

(3) Possess a current, full and unrestricted license to practice psychology in a home state that is a compact state;

(4) Have no history of adverse action that violates the rules of the commission;

(5) Have no criminal record history reported on an identity history summary that violates the rules of the commission;

(6) Possess a current, active E.Passport;

(7) Provide (A) attestations regarding areas of intended practice,

conformity with standards of practice, competence in telepsychology technology, criminal background and knowledge and adherence to legal requirements in the home and receiving states, and (B) a release of information to allow for primary source verification in a manner specified by the commission; and

(8) Meet other criteria as defined by the rules of the commission.

(c) The home state maintains authority over the license of any psychologist practicing in a receiving state under the authority to practice interjurisdictional telepsychology.

(d) A psychologist practicing in a receiving state under the authority to practice interjurisdictional telepsychology shall be subject to the receiving state's scope of practice. A receiving state may, in accordance with such state's due process law, limit or revoke a psychologist's authority to practice interjurisdictional telepsychology in the receiving state and may take any other necessary actions under the receiving state's applicable law to protect the health and safety of the receiving state's citizens. If a receiving state takes action, the state shall promptly notify the home state and the commission.

(e) If a psychologist's license in any home state, another compact state or any authority to practice interjurisdictional telepsychology in any receiving state, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and the psychologist shall not be eligible to practice telepsychology in a compact state under the authority to practice interjurisdictional telepsychology.

ARTICLE V

COMPACT TEMPORARY AUTHORIZATION TO PRACTICE

(a) Compact states shall recognize the right of a psychologist, licensed in a compact state in conformance with Article III of the compact, to

practice temporarily in other compact states in which the psychologist is not licensed, as provided in the compact.

(b) To exercise the temporary authorization to practice under the terms and provisions of the compact, a psychologist licensed to practice in a compact state shall:

(1) Hold a graduate degree in psychology from an institution of higher education that was, at the time the degree was awarded:

(A) Regionally accredited by an accrediting body recognized by the United States Department of Education to grant graduate degrees, or authorized by provincial statute or royal charter to grant doctoral degrees; or

(B) A foreign college or university deemed to be equivalent to an institution of higher education described in subparagraph (A) of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

(A) The program, wherever it may be administratively housed, shall be clearly identified and labeled as a psychology program. Such program shall specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

(B) The psychology program shall stand as a recognizable, coherent, organizational entity within the institution;

(C) There shall be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

(D) The program shall consist of an integrated, organized sequence of study;

(E) There shall be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

(F) The designated director of the program shall be a psychologist and a member of the core faculty;

(G) The program shall have an identifiable body of students who are matriculated in such program for a degree;

(H) The program shall include supervised practicum, internship or field training appropriate to the practice of psychology;

(I) The curriculum shall encompass a minimum of three academic years of full-time graduate study for a doctoral degree and a minimum of one academic year of full-time graduate study for a master's degree; and

(J) The program includes an acceptable residency, as defined by the rules of the commission;

(3) Possess a current, full and unrestricted license to practice psychology in a home state that is a compact state;

(4) No history of adverse action that violates the rules of the commission;

(5) No criminal record history that violates the rules of the commission;

(6) Possess a current, active IPC;

(7) Provide attestations regarding areas of intended practice and work experience and provide a release of information to allow for

primary source verification in a manner specified by the commission; and

(8) Meet other criteria, as defined by the rules of the commission.

(c) A psychologist practicing in a distant state under the temporary authorization to practice shall practice within the scope of practice authorized by the distant state.

(d) A psychologist practicing in a distant state under the temporary authorization to practice shall be subject to the distant state's authority and law. A distant state may, in accordance with such state's due process law, limit or revoke a psychologist's temporary authorization to practice in the distant state and may take any other necessary actions under the distant state's applicable law to protect the health and safety of the distant state's citizens. If a distant state takes action, the state shall promptly notify the home state and the commission.

(e) If a psychologist's license in any home state or another compact state, or any temporary authorization to practice in any distant state, is restricted, suspended or otherwise limited, the IPC shall be revoked and the psychologist shall not be eligible to practice in a compact state under the temporary authorization to practice.

ARTICLE VI

CONDITIONS OF TELEPSYCHOLOGY PRACTICE IN A RECEIVING STATE

A psychologist may practice in a receiving state under the authority to practice interjurisdictional telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate state psychology regulatory authority, as defined in the rules of the commission, and under the following circumstances:

(1) The psychologist initiates a client or patient contact in a home state via telecommunications technologies with a client or patient in a receiving state; and

(2) The psychologist complies with any other conditions regarding telepsychology that are set forth in the rules promulgated by the commission.

ARTICLE VII

ADVERSE ACTIONS

(a) A home state shall have the power to impose adverse action against a psychologist's license issued by the home state. A distant state shall have the power to take adverse action on a psychologist's temporary authorization to practice in such distant state.

(b) A receiving state may take adverse action on a psychologist's authority to practice interjurisdictional telepsychology in such receiving state. A home state may take adverse action against a psychologist based on an adverse action taken by a distant state regarding temporary in-person, face-to-face practice.

(c) If a home state takes adverse action against a psychologist's license, the psychologist's (1) authority to practice interjurisdictional telepsychology is terminated, (2) E.Passport is revoked, (3) temporary authorization to practice is terminated, and (4) IPC is revoked. All home state disciplinary orders that impose adverse action shall be reported to the commission in accordance with the rules promulgated by the commission. A compact state shall report adverse actions in accordance with the rules of the commission. If discipline is reported on a psychologist, the psychologist shall not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the rules of the commission. Other actions may be imposed as determined by the rules promulgated by the commission.

(d) A home state's psychology regulatory authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee that occurred in a receiving state as it would if such conduct had occurred by a licensee in the home state. In such cases, the home state's law shall control in determining any adverse action against a psychologist's license.

(e) A distant state's psychology regulatory authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under temporary authorization to practice that occurred in that distant state as it would if such conduct had occurred by a licensee within the home state. In such cases, the distant state's law shall control in determining any adverse action against a psychologist's temporary authorization to practice.

(f) Nothing in the compact shall override a compact state's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the compact state's law. Compact states shall require psychologists who enter any alternative programs to not provide telepsychology services under the authority to practice interjurisdictional telepsychology or provide temporary psychological services under the temporary authorization to practice in any other compact state during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist if the compact state imposes an adverse action pursuant to subsection (c) of this article.

ARTICLE VIII

ADDITIONAL AUTHORITIES INVESTED IN A COMPACT STATE'S PSYCHOLOGY REGULATORY AUTHORITY

(a) In addition to any other powers granted under state law, a

compact state's psychology regulatory authority shall have the authority under the compact to do the following:

(1) Issue subpoenas, for both hearings and investigations, that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a compact state's psychology regulatory authority for the attendance and testimony of witnesses or the production of evidence from another compact state shall be enforced in the latter compact state by any court of competent jurisdiction, according to such court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state psychology regulatory authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses are or evidence is located; and

(2) Issue cease and desist or injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology or temporary authorization to practice.

(b) During the course of any investigation, a psychologist may not change the psychologist's home state licensure. A home state psychology regulatory authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The home state psychology regulatory authority shall promptly report the conclusions of such investigations to the commission. Once an investigation has been completed, and pending the outcome of such investigation, the psychologist may change his or her home state licensure. The commission shall promptly notify the new home state of any such decisions as provided in the rules of the commission. All information provided to the commission or distributed by compact states pursuant to the psychologist shall be confidential, filed under seal and used for investigatory or disciplinary matters. The commission may create additional rules for mandated or discretionary sharing of information by compact states.

ARTICLE IX

COORDINATED LICENSURE INFORMATION SYSTEM

(a) The commission shall provide for the development and maintenance of a coordinated licensure information system and reporting system containing licensure and disciplinary action information on all psychologists to whom the compact is applicable in all compact states as defined by the rules of the commission.

(b) Notwithstanding any other provision of the general statutes, a compact state shall submit a uniform data set to the coordinated database on all licensees as required by the rules of the commission, including, but not limited to, the following:

(1) Identifying information;

(2) Licensure data;

(3) Significant investigatory information;

(4) Adverse actions against a psychologist's license;

(5) An indicator that a psychologist's authority to practice interjurisdictional telepsychology or temporary authorization to practice is revoked;

(6) Nonconfidential information related to alternative program participation information;

(7) Any denial of application for licensure, and the reasons for such denial; and

(8) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(c) The coordinated database administrator shall promptly notify all

compact states of any adverse action taken against, or significant investigative information on, any licensee in a compact state.

(d) Compact states reporting information to the coordinated database may designate information that may not be shared with the public without the express permission of the compact state reporting the information.

(e) Any information submitted to the coordinated database that is subsequently required to be expunged by the law of the compact state reporting the information shall be removed from the coordinated database.

ARTICLE X

ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION

(a) The compact states hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The commission is a body politic and an instrumentality of the compact states.

(2) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in the compact shall be construed to be a waiver of sovereign immunity.

(b) (1) The commission shall consist of one voting representative

appointed by each compact state who shall serve as such state's commissioner. The state psychology regulatory authority shall appoint its delegate. The delegate shall be empowered to act on behalf of the compact state. The delegate shall be limited to the following:

(A) An executive director, executive secretary or similar executive;

(B) A current member of the state psychology regulatory authority of a compact state; or

(C) A designee empowered with the appropriate delegate authority to act on behalf of the compact state.

(2) Any commissioner may be removed or suspended from office as provided by the law of the state from which the commissioner is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compact state in which the vacancy exists.

(3) Each commissioner shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. A commissioner shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for commissioners' participation in meetings by telephone or other means of communication.

(4) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article XI of the compact.

(6) The commission may convene in a closed, nonpublic meeting if

the commission has to discuss the following:

(A) Noncompliance of a compact state with its obligations under the compact;

(B) The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

(C) Current, threatened or reasonably anticipated litigation against the commission;

(D) Negotiation of contracts for the purchase or sale of goods, services or real estate;

(E) Accusation against any person of a crime or formally censuring any person;

(F) Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

(G) Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(H) Disclosure of investigatory records compiled for law enforcement purposes;

(I) Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact; or

(J) Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to the provisions of subdivision (6) of this subsection, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including, but not limited to, a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(c) The commission shall, by a majority vote of the commissioners, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including, but not limited to:

(1) Establishing the fiscal year of the commission;

(2) Providing reasonable standards and procedures for the following:

(A) The establishment and meetings of other committees; and

(B) Governing any general or specific delegation of any authority or function of the commission;

(3) Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals at such meetings and proprietary information, including, but not limited to, trade secrets. The commission may meet in closed session only after a majority of the commissioners vote to close a meeting to the public in whole or in part.

As soon as practicable, the commission shall make public a copy of the vote to close the meeting revealing the vote of each commissioner with no proxy votes allowed;

(4) Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service law or other similar law of any compact state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

(6) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees;

(7) Providing a mechanism for concluding the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment or reserving of all of its debts and obligations;

(8) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compact states;

(9) The commission shall maintain its financial records in accordance with the bylaws; and

(10) The commission shall meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(d) The commission may:

(1) Promulgate uniform rules to facilitate and coordinate implementation and administration of the compact, which rules shall have the force and effect of law and shall be binding in all compact

states;

(2) Bring and prosecute legal proceedings or actions in the name of the commission, provided the standing of any state psychology regulatory authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) Purchase and maintain insurance and bonds;

(4) Borrow, accept or contract for services of personnel, including, but not limited to, employees of a compact state;

(5) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

(6) Accept any appropriate donations and grants of money, equipment, supplies, materials and services and to receive, utilize and dispose of the same; provided the commission shall strive at all times to avoid any appearance of impropriety or conflict of interest;

(7) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed, provided the commission shall strive at all times to avoid any appearance of impropriety;

(8) Sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property real, personal or mixed;

(9) Establish a budget and make expenditures;

(10) Borrow money;

(11) Appoint committees, including, but not limited to, advisory committees comprised of members, state regulators, state legislators or their representatives and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws;

(12) Provide and receive information from, and to cooperate with, law enforcement agencies;

(13) Adopt and use an official seal; and

(14) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

(e) (1) The elected officers shall serve as the executive board, which shall have the power to act on behalf of the commission according to the terms of the compact. The executive board shall be comprised of the following six members:

(A) Five voting members who are elected from the membership of the commission by the commission; and

(B) One ex-officio, nonvoting member from the recognized membership organization composed of state and provincial psychology regulatory authorities.

(2) The ex-officio member shall have served as staff or member on a state psychology regulatory authority and shall be selected by its respective organization.

(3) The commission may remove any member of the executive board as provided in the bylaws.

(4) The executive board shall meet at least annually.

(5) The executive board shall have the following duties and responsibilities:

(A) Recommend to the entire commission changes to the rules or bylaws, changes to the compact legislation, fees paid by compact states, including, but not limited to, annual dues, and any other applicable fees;

(B) Ensure compact administration services are appropriately provided, contractually or otherwise;

(C) Prepare and recommend the budget;

(D) Maintain financial records on behalf of the commission;

(E) Monitor compact compliance of member states and provide compliance reports to the commission;

(F) Establish additional committees as necessary; and

(G) Other duties as provided in rules or bylaws.

(f) The commission:

(1) Shall pay, or provide for the payment of the reasonable expenses of its establishment, organization and ongoing activities.

(2) May accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

(3) May levy on and collect an annual assessment from each compact state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessment and fees shall be in a total amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the commission.

The commission shall promulgate a rule under this subdivision that is binding upon all compact states.

(4) Shall not incur obligations of any kind prior to securing the funds adequate to meet such obligations, or pledge the credit of any of the compact states, except by and with the authority of the compact state.

(5) Shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the commission.

(g) (1) The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or wilful or wanton misconduct of such person.

(2) The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities,

provided (A) nothing in this subdivision shall be construed to prohibit such person from retaining his or her own counsel, and (B) the actual or alleged act, error or omission did not result from such person's intentional or wilful or wanton misconduct.

(3) The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against such person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided the actual or alleged act, error or omission did not result from the intentional or wilful or wanton misconduct of such person.

ARTICLE XI

RULEMAKING

(a) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the compact states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the compact, then such rule shall have no further force and effect in any compact state.

(c) Rules, or amendments to the rules, shall be adopted at a regular or special meeting of the commission.

(d) Prior to promulgation and adoption of a final rule or rules by the commission, and at least sixty days prior to the scheduled date of the

meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking as follows:

(1) On the Internet web site of the commission; and

(2) On the Internet web site of each compact state's psychology regulatory authority or the publication in which each state would otherwise publish proposed rules.

(e) The notice of proposed rulemaking shall include the following:

(1) The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit to the commission (A) notice of their intention to attend the public hearing, and (B) written comments.

(f) Prior to adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(g) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by the following:

(1) At least twenty-five persons who submit written comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least twenty-five members.

(h) If a hearing is held on the proposed rule or amendment, the commission shall publish the location, time and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days prior to the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. The provisions of this subdivision shall not preclude the commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this subsection shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required under this subsection.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(j) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the

rule, if any, based on the rulemaking record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with promulgation of the proposed rule without a public hearing.

(l) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided the usual rulemaking procedures described in the compact and in this subsection shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety days after the effective date of the rule. For the purposes of this subsection, "emergency rule" means a rule that shall be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety or welfare;

(2) Prevent a loss of commission or compact state funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The commission, or an authorized committee of the commission, may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the Internet web site of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the commission prior to the end of the notice period. If no challenge is made, the revision shall take effect without further action. If the revision is challenged, the revision may not

take effect without the approval of the commission.

ARTICLE XII

OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

(a) (1) The executive, legislative and judicial branches of state government in each compact state shall enforce the compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated under the compact shall have standing as statutory law.

(2) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a compact state pertaining to the subject matter of the compact that may affect the powers, responsibilities or actions of the commission.

(3) The commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such proceeding for all purposes. Failure to provide service of process to the commission shall render a judgment or order void as to the commission, the compact or promulgated rules.

(b) (1) If the commission determines that a compact state has defaulted in the performance of its obligations or responsibilities under the compact or the promulgated rules, the commission shall perform the following actions:

(A) Provide written notice to the defaulting state and other compact states of the nature of the default, the proposed means of remedying the default or any other action to be taken by the commission; and

(B) Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state

may be terminated from the compact upon an affirmative vote of a majority of the compact states, and all rights, privileges and benefits conferred by the compact shall be terminated on the effective date of termination of the defaulting state. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the compact states.

(4) A compact state that has been terminated shall be responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including, but not limited to, obligations that extend beyond the effective date of termination.

(5) The commission shall not bear any costs incurred by the state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(6) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the State of Georgia or the federal district where the compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including, but not limited to, reasonable attorney's fees.

(c) (1) Upon request by a compact state, the commission shall attempt to resolve disputes related to the compact that arise among compact states and between compact and noncompact states.

(2) The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before

the commission.

(d) (1) The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(2) By majority vote, the commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the compact has its principal offices against a compact state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including, but not limited to, reasonable attorney's fees.

(3) The remedies set forth in the compact shall not be the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XIII

DATE OF IMPLEMENTATION OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL AND AMENDMENTS

(a) The compact shall come into effect on the date on which the compact is enacted into law in the seventh compact state. The provisions that become effective at such time shall be limited to the powers granted to the commission relating to assembly and the promulgation of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

(b) Any state that joins the compact subsequent to the commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in such state. Any rule that has been previously adopted by the commission shall have the full force

and effect of law on the day the compact becomes law in such state.

(c) Any compact state may withdraw from the compact by enacting a statute repealing the same.

(1) A compact state's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing state's psychology regulatory authority to comply with the investigative and adverse action reporting requirements set forth in Article VII of this section prior to the effective date of withdrawal.

(d) Nothing contained in the compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a compact state and a noncompact state that does not conflict with the provisions of the compact.

(e) The compact may be amended by the compact states. No amendment to the compact shall become effective and binding upon any compact state until it is enacted into the law of all compact states.

ARTICLE XIV

CONSTRUCTION AND SEVERABILITY

The compact shall be liberally construed so as to effectuate the purposes thereof. If the compact is held contrary to the constitution of any state member of the compact, the compact shall remain in full force and effect as to the remaining compact states."

Sec. 43. (NEW) (*Effective October 1, 2022*) The Interstate Medical Licensure Compact is hereby enacted into law and entered into by the state of Connecticut with any and all states legally joining therein in accordance with its terms. The compact is substantially as follows:

"INTERSTATE MEDICAL LICENSURE COMPACT

SECTION 1. PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing licensure requirements for physicians. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in such state issued to a physician through the procedures in the compact.

SECTION 2. DEFINITIONS

As used in section 1, this section, and sections 3 to 24, inclusive, of the compact:

(1) "Bylaws" means those bylaws established by the Interstate Commission pursuant to section 11 of the compact.

(2) "Commissioner" means the voting representative appointed by each member board pursuant to section 11 of the compact.

(3) "Compact" means the Interstate Medical Licensure Compact.

(4) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(5) "Expedited license" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

(6) "Interstate Commission" means the interstate commission created pursuant to section 11 of the compact.

(7) "License" means authorization by a member state for a physician to engage in the practice of medicine, which would be unlawful without authorization.

(8) "Medical Practice Act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(9) "Member board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation and education of physicians as directed by the state government.

(10) "Member state" means a state that has enacted the compact.

(11) "Practice of medicine" means the clinical prevention, diagnosis or treatment of human disease, injury or condition requiring a physician to obtain and maintain a license in compliance with the Medical Practice Act of a member state.

(12) "Physician" means any person who:

(A) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic

College Accreditation or a medical school listed in the International Medical Education Directory or its equivalent;

(B) Passed each component of the United States Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination within three attempts, or any of said examination's predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(C) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(D) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(E) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(F) Has never been convicted, received adjudication, deferred adjudication, community supervision or deferred disposition for any offense by a court of appropriate jurisdiction;

(G) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(H) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(I) Is not under active investigation by a licensing agency or law

enforcement authority in any state, federal or foreign jurisdiction.

(13) "Offense" means a felony, gross misdemeanor or crime of moral turpitude.

(14) "Rule" means a written statement by the Interstate Commission promulgated pursuant to section 12 of the compact that is of general applicability, implements, interprets or prescribes a policy or provision of the compact, or an organizational, procedural or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal or suspension of an existing rule.

(15) "State" means any state, commonwealth, district or territory of the United States.

(16) "State of principal license" means a member state where a physician holds a license to practice medicine and that has been designated as such by the physician for purposes of registration and participation in the compact.

SECTION 3. ELIGIBILITY

(a) A physician shall meet the eligibility requirements set forth in subparagraphs (A) to (I), inclusive, of subdivision (12) of section 2 of the compact to receive an expedited license under the terms and provisions of the compact.

(b) A physician who does not meet the requirements set forth in subparagraphs (A) to (I), inclusive, of subdivision (12) of section 2 of the compact may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the compact, relating to the issuance of a license to practice medicine in such state.

SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in such state, and the state is:

(1) The state of principal residence for the physician;

(2) The state where at least twenty-five per cent of the practice of medicine occurs;

(3) The location of the physician's employer; or

(4) If no state qualifies under subdivision (1), (2) or (3) of this subsection, the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, provided the state meets the requirements of subsection (a) of this section.

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(a) A physician seeking licensure through the compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure

and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(1) Static qualifications, including, but not limited to, verification of medical education, graduate medical education, results of any medical or licensing examination and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

(2) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including, but not limited to, the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with 5 CFR 731.202.

(3) Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of such state.

(c) Upon verification in subsection (b) of this section, a physician eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a) of this section, including, but not limited to, the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) of this section and any fees under subsection (c) of this section, a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license in the member state.

(f) An expedited license obtained through the compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a nondisciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process, including, but not limited to, payment of any applicable fees, and the issuance of an expedited license.

SECTION 6. FEES FOR EXPEDITED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of medicine in such state may impose a fee for a license issued or renewed through the compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses.

SECTION 7. RENEWAL AND CONTINUED PARTICIPATION

(a) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of principal license;

(2) Has not been convicted or received adjudication, deferred adjudication, community supervision or deferred disposition for any offense by a court of appropriate jurisdiction;

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c) of this section, a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process shall be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the compact.

SECTION 8. COORDINATED INFORMATION SYSTEM

(a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under section 5 of the compact.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaint against a licensed physician who has applied or received an expedited license through the compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any nonpublic complaint or any disciplinary or investigatory information not required by subsection (c) of the compact to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9. JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation or compliance materials in furtherance of any joint or individual investigation initiate under the compact.

(e) Any member state may investigate actual or alleged violations of

the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10. DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct that may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in such state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until such respective member board takes action to reinstate the license in a manner consistent with the Medical Practice Act of such state.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and perform one of the following actions:

(1) Impose the same or any lesser sanction against the physician, provided such sanctions are consistent with the Medical Practice Act of such state; or

(2) Pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board shall be suspended, automatically and immediately without further action necessary by the other member board, for ninety days upon entry of the order by the disciplining board, to permit the member board to investigate the basis for the action under the Medical Practice Act of such state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety-day suspension period in a manner consistent with the Medical Practice Act of such state.

SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the Interstate Medical Licensure Compact Commission.

(b) The purpose of the Interstate Commission is the administration of the compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between separate member boards, or if the licensing and disciplinary authority is split between multiple member

boards within a member state, the member state shall appoint one representative from each member board. A commissioner shall be the following:

(1) An allopathic or osteopathic physician appointed to a member board;

(2) An executive director, executive secretary or similar executive of a member board; or

(3) A member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of such meeting shall be a business meeting to address such matters as may properly come before the commission, including, but not limited to, the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A commissioner shall not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from such state who shall meet the requirements of subsection (d) of this section.

(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it

determines by a two-thirds vote of the commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practice and procedures of the Interstate Commission;

(2) Include a discussion of matters specifically exempted from disclosure by federal statute;

(3) Include a discussion of trade secrets or commercial or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

(5) Include a discussion of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) Include a discussion of investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes of all meetings, which minutes shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including, but not limited to, a record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members and others as determined by the

bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact, including, but not limited to, enforcement and compliance with the provisions of the compact, its bylaws and rules and other such duties as necessary.

(l) The Interstate Commission shall establish other committees for governance and administration of the compact.

SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The powers and duties of the Interstate Commission are as follows:

(1) Oversee and maintain the administration of the compact;

(2) Promulgate rules that shall be binding to the extent and in the manner provided for in the compact;

(3) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules and actions;

(4) Enforce compliance with compact provisions, the rules promulgated by the Interstate Commission and the bylaws, using all necessary and proper means, including, but not limited to, the use of judicial process;

(5) Establish and appoint committees, including, but not limited to, an executive committee as required by section 11 of the compact, that shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(6) Pay, or provide for the payment of the expenses related to the

establishment, organization and ongoing activities of the Interstate Commission;

(7) Establish and maintain one or more offices;

(8) Borrow, accept, hire or contract for services of personnel;

(9) Purchase and maintain insurance and bonds;

(10) Employ an executive director who shall have such powers to employ, select or appoint employees, agents or consultants, and to determine the qualifications, define the duties and fix the compensation of such employees, agents or consultants;

(11) Establish personnel policies and programs relating to conflicts of interest, rates of compensation and qualifications of personnel;

(12) Accept donations and grants of money, equipment, supplies, materials and services, and receive, utilize and dispose of such money, equipment, supplies, material and services in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(13) Lease, purchase, accept contributions or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed;

(14) Sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

(15) Establish a budget and make expenditures;

(16) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(17) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the

preceding year. Such report shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(18) Coordinate education, training and public awareness regarding the compact, its implementation and its operation;

(19) Maintain records in accordance with the bylaws;

(20) Seek and obtain trademarks, copyrights and patents; and

(21) Perform such functions as may be necessary or appropriate to achieve the purpose of the compact.

SECTION 13. FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment shall be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed accountant and the report of the audit shall be included in the annual report of the Interstate Commission.

SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact not later than twelve months after the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers elected or appointed pursuant to subsection (b) of this section shall serve without remuneration for the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties or responsibilities, provided such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or wilful and wanton misconduct of such person.

(e) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of such

state for state officials, employees and agents. The Interstate Commission is considered to be an instrumentality of the states for the purpose of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury or liability caused by the intentional or wilful and wanton misconduct of such person.

(f) The Interstate Commission shall defend the executive director, its employees and, subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties or responsibilities, provided the actual or alleged act, error or omission did not result from intentional or wilful and wanton misconduct on the part of such person.

(g) To the extent not covered by the state involved, member state or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgment, including, but not limited to, attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error or omission that occurred within the scope of the Interstate Commission employment, duties or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties or responsibilities, provided the actual or alleged act, error or omission did not result from intentional or wilful and wanton misconduct on the part of such person.

SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purpose of the compact. Notwithstanding the foregoing, if the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted under the compact, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, as amended from time to time.

(c) Not later than thirty days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16. OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated under the compact shall have standing as statutory law, but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the compact and the rules in

any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact that may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all services of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact or promulgated rules.

SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(b) The Interstate Commission may, by majority vote of the commissioners, initiate legal action in the United States Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. If judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including, but not limited to, reasonable attorney's fees.

(c) The remedies set forth in the compact shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or regulation of a profession.

SECTION 18. DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed

upon it by the compact, or the rules and bylaws of the Interstate Commission promulgated under the compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or promulgated rules, the Interstate Commission shall take the following actions:

(1) Provide written notice to the defaulting state and other member states of the nature of the default, the means of curing the default and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state shall cure its default; and

(2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges and benefits conferred by the compact shall terminate on the effective date of termination. A cure of the default shall not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state that has been terminated is responsible for all

dues, obligations and liabilities incurred through the effective date of termination, including, but not limited to, obligations the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or that has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including, but not limited to, reasonable attorney's fees.

SECTION 19. DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes that are subject to the compact and may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member of the compact.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by not less than seven states. Thereafter, it shall become effective and binding on a state upon enactment of the compact into law by such state.

(c) The governors of nonmember states, or their designees, shall be

invited to participate in the activities of the Interstate Commission on a nonvoting basis prior to adoption of the compact by all states.

(d) The Interstate Commission may propose amendments to the compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21. WITHDRAWAL

(a) Once effective, the compact shall continue in force and remain binding upon every member state, provided a member state may withdraw from the compact by specifically repealing the statute that enacted the compact into law.

(b) Withdrawal from the compact shall be done by the enactment of a statute repealing the compact, but shall not take effect until one year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw not later than sixty days after its receipt of notice provided under subsection (c) of this section.

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including, but not limited to, obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22. DISSOLUTION

(a) The compact shall dissolve effective upon the date of the withdrawal or default of the member state that reduces the membership of the compact to one member state.

(b) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded, and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23. SEVERABILITY AND CONSTRUCTION

(a) The provisions of the compact shall be severable, and if any phrase, clause, sentence or provision of the compact is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of the compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the member states are members.

SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing in the compact prevents the enforcement of any other law of a member state that is not inconsistent with the compact.

(b) All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including, but not limited to, all rules and bylaws promulgated by said commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with the terms of such agreements.

(e) If any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in such member state."

Sec. 44. (*Effective July 1, 2022*) For the fiscal year ending June 30, 2023, the Office of Early Childhood shall hire two full-time employees to provide technical assistance and business consulting services for providers of child care services, as described in section 19a-77 of the general statutes, as amended by this act, in the state.

Sec. 45. Section 10-19q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2022*):

(a) The Department of Children and Families shall administer, within available appropriations, an enhancement grant program for youth service bureaus. The department shall annually award grants in the amounts of: (1) Three thousand three hundred dollars to youth service bureaus that serve a town with a population of not more than eight thousand or towns with a total combined population of not more than eight thousand; (2) five thousand dollars to youth service bureaus that

serve a town with a population greater than eight thousand, but not more than seventeen thousand or towns with a total combined population greater than eight thousand, but not more than seventeen thousand; (3) six thousand two hundred fifty dollars to youth service bureaus that serve a town with population greater than seventeen thousand, but not more than thirty thousand or towns with a total combined population greater than seventeen thousand, but not more than thirty thousand; (4) seven thousand five hundred fifty dollars to youth service bureaus that serve a town with a population greater than thirty thousand, but not more than one hundred thousand or towns with a total combined population greater than thirty thousand, but not more than one hundred thousand; and (5) ten thousand dollars to youth service bureaus that serve a town with a population greater than one hundred thousand or towns with a total combined population greater than one hundred thousand.

(b) (1) For the fiscal year ending June 30, 2023, if the amount appropriated for grants payable to youth service bureaus under this section exceeds the amount appropriated for such grants for the fiscal year ending June 30, 2022, the amount of such excess shall be distributed proportionately among the youth service bureaus.

[(b)**]** (2) Notwithstanding the provisions of this section, for the fiscal year ending June 30, **[**2020**]** 2024, and each fiscal year thereafter, the amount of grants payable to youth service bureaus shall be **[**(1)**]** (A) reduced proportionately if the total of such grants in such year exceeds the amount appropriated for such grants for such year, or **[**(2)**]** (B) increased proportionately if the total of such grants in such year is less than the amount appropriated for such grants in such year.

Sec. 46. (*Effective July 1, 2022*) For the fiscal year ending June 30, 2023, the Department of Public Health shall hire a health program associate for the Office of Emergency Medical Services, established pursuant to section 19a-178 of the general statutes, to administer mobile integrated

health care programs in accordance with the provisions of section 19a-180 of the general statutes.

Approved May 24, 2022