Public Acts Effective from Passage

PUBLIC ACT 15-4: AN ACT CONCERNING REPORTING OF PAYMENTS BY MANUFACTURERS TO INDEPENDENTLY PRACTICING ADVANCED PRACTICE REGISTERED NURSES

Public Act 15-4 (P.A. 15-4) revises a law enacted in 2014 that mandates certain manufacturers to report payments or other transfers of value to advanced practice registered nurses (APRNs). The current law is modeled on the federal Physician Payments Sunshine Act (Sunshine Act), which requires annual reporting of certain payments or other transfers of value to physicians by certain manufacturers.

Currently, manufacturers of drugs, devices, biologicals, or medical supplies payable under Medicare or Medicaid are required to report to the Department of Consumer Protection (DCP) certain payments or other transfers of value provided to APRNs. Such reports must provide the same information as required under the Sunshine Act, including, but not limited to, the amount, date, nature, and form (that is, cash, in-kind items or services, stocks or other ownership interests, or any other form of payment or transfer of value) of the payment or value conferred to the APRN. The current law requires that manufacturers submit reports to DCP quarterly, with the first report due by July 1, 2015; however, as noted below, P.A. 15-4 has modified this requirement.

P.A. 15-4 significantly reduces the reporting burden on manufacturers by limiting the scope of the current law. Pursuant to P.A. 15-4, manufacturers must only report payments or other transfers of value made to APRNs practicing “not in collaboration” with a physician. P.A. 15-4 also revises the statutory definition of “payment or other transfer of value” to exempt from reporting all payments or other transfers of value excluded from reporting under the Sunshine Act, such as transfers of less than $10 in value and product samples intended for patient use. P.A. 15-4 postpones by two years the initial reporting deadline to July 1, 2017, and only requires annual reporting. Finally, P.A. 15-4 requires the Department of Public Health (DPH) to publish on its website by December 1, and annually thereafter, a list of all APRNs authorized in Connecticut to practice not in collaboration with a physician, which manufacturers may use to determine whether certain payments or other transfers of value to an APRN must be reported to DCP.

SPECIAL ACT 15-8: AN ACT CONCERNING SUPPLEMENTAL FIRST RESPONDERS

Special Act 15-8 (S.A. 15-8) establishes a certification program for supplemental first responders, separate from the licensure and certification program for emergency medical service organizations. “Supplemental first responders” are emergency medical services providers certified to respond to a victim of sudden illness or injury, when available and only when called upon, but are not certified to offer transportation to patients or operate an ambulance service or paramedic intercept service. The act defines “emergency medical services personnel” to include those certified to practice as emergency medical responders, emergency medical technicians, advanced emergency medical technicians or emergency medical services instructors, and individuals licensed as paramedics. The terms “emergency medical services personnel” and “emergency medical services provider” are used interchangeably throughout S.A. 15-8.

Pursuant to this new legislation, DPH may issue a certificate of authorization to any emergency medical services provider who (1) operates only in a municipality with a population of at least 105,000 but not more than 115,000; (2) meets the minimum standards of the DPH commissioner (Commissioner) in the areas of training, equipment, and other standards applicable to emergency medical services personnel; and (3) maintains liability insurance of at least one million dollars. Certificates of authorization to serve as a supplemental first responder are effective for two years and renewable biennially. An applicant who
is denied is provided with written notice, including a statement of reasons for the denial, and has 30 days to request a hearing on the denial. If the denial is sustained, the applicant can reapply one year after the date on which the denial was sustained. The Commissioner may suspend or revoke a certificate of authorization if the holder does not maintain the initial minimum standards for authorization or violates the Connecticut standards governing emergency medical services. The certificate holder will have an opportunity to show compliance with all requirements in response to a suspension or revocation action.

S.A. 15-8 also states that, if a primary service area responder and a supplemental first responder are both on the scene of an emergency medical call, the primary service area responder will control and direct emergency activities. A “primary service area responder” is defined elsewhere in the Connecticut statutes as an emergency medical services provider designated to respond to a victim of sudden illness or injury in a specific geographic area.

Public Acts Effective July 1, 2015

PUBLIC ACT 15-102: AN ACT CONCERNING STATE PAYMENT TO CERTAIN FACILITIES FOR RESERVED BEDS

This legislation clarifies that the Department of Social Services (DSS) is not required to pay for beds otherwise not available at residential care homes and housing facilities during a resident's short-term absence. DSS currently pays State Supplement Program benefits to licensed residential care homes or rated housing facilities on behalf of recipients. By law, DSS must make such payments for periods when the recipient is absent from the facility, provided the recipient can reasonably be expected to return to the facility before the end of the month following the month in which the recipient leaves the facility. The bill clarifies that, if the recipient’s bed is unavailable during the absence, payment does not have to be made to the facility for such period.

PUBLIC ACT 15-36: AN ACT EXTENDING COST REPORTING DEADLINES FOR LONG-TERM CARE FACILITIES

Public Act 15-36 extends the deadline for long-term care facilities to submit their annual cost reports. Long-term care facilities include, but are not limited to, nursing homes, residential care homes, and residential facilities for persons with intellectual disabilities. Current law requires long-term care facilities to file cost reports with DSS by December 31 of each year. This legislation extends this deadline to February 15 of each year.

PUBLIC ACT 15-50: AN ACT CONCERNING REQUIREMENTS FOR FACILITIES THAT COMPLETE MEDICARE OR MEDICAID APPLICATIONS FOR PATIENTS

Current law sets forth a bill of rights for all patients of nursing home facilities, residential care homes, and chronic disease hospitals. The patients’ bill of rights ensures respect for patients’ autonomy and safeguards their well-being. It includes the right for patients to be fully informed about their medical condition and the services available in the facility, as well as the right to confidential treatment of personal and medical records, quality care, and freedom from mental and physical abuse.

This legislation adds a new right to the patients’ bill of rights, providing that every patient of a nursing home facility, residential care home, or chronic disease hospital is entitled to receive a copy of any Medicare or Medicaid application completed by the facility on behalf of the patient or to designate a family member or other representative to receive a copy of any such application.
Public Act 15-174: An Act Concerning Childhood Vaccinations
Under current law, each local or regional board of education or similar body governing a nonpublic school must confirm that each student has been immunized against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, hemophilus influenzae type B, and any other vaccine required by DPH’s childhood immunization schedule prior to the child’s enrollment in any public or nonpublic school program, subject to certain exceptions. Under current law, this immunization requirement is waived if a child presents a statement from the child’s parents or guardian that such immunization is contrary to the child’s religious beliefs.

This legislation changes the exception to immunization requirements due to religious beliefs. Under this legislation, a child who presents a statement that such immunization is contrary to the religious beliefs of the child or the child’s parents or guardian is exempt from immunization requirements. Additionally, this legislation requires that the statement be acknowledged in accordance with Connecticut law by a judge, family support magistrate, clerk, or deputy clerk of a court having a seal; a town clerk; a notary public; a justice of the peace; or an attorney admitted to the Connecticut bar. Further, to remain enrolled in the school program, the parents or guardian of a child exempt from immunization requirements on religious grounds must annually present such a statement to the school.

This legislation also directs that state regulations governing immunization requirements for children prior to attending child day care centers, group day care homes, or family day care homes must include appropriate exemptions for children whose parents or guardian objects to immunization on religious grounds and that any objection must be accompanied by a statement from such parents or guardian that such immunization is contrary to the religious beliefs of the child or the child’s parents or guardian. This statement of opposition due to religious beliefs must be acknowledged in the same manner as statements of religious exemptions in schools, as described above.

PUBLIC ACT 15-129: AN ACT CONCERNING HOSPITAL TRAINING AND PROCEDURES FOR PATIENTS WITH SUSPECTED DEMENTIA

Public Act 15-129 requires hospitals, beginning on October 1, 2015, to include the symptoms of dementia as part of regular training of hospital staff who provide direct patient care.

Public Acts Effective October 1, 2015

PUBLIC ACT 15-32: AN ACT CONCERNING PATIENT-DESIGNATED CAREGIVERS

Public Act 15-32 (P.A. 15-32) establishes requirements for hospitals regarding patient designation of a caregiver to provide post-discharge assistance to the patient. The term “caregiver” is defined as an individual designated by the patient to provide assistance with basic activities of daily living and other support tasks following discharge from a hospital. A caregiver can include a relative, spouse, partner, friend, or neighbor “who has a significant relationship with the patient” and is not compensated for performing caregiving tasks. The term is limited to assistance provided in the patient’s home and generally does not include post-discharge care provided in a rehabilitation facility, nursing home, or similar setting.

As of October 1, 2015, hospitals will be required to (1) allow patients to designate a caregiver prior to or at the time the patient receives a written copy of the patient’s discharge plan; (2) include the designated caregiver’s name, contact information, and relationship to the patient in the patient’s discharge plan; (3) make reasonable attempts to notify the caregiver of the patient's
discharge to the patient’s home as soon as practicable; (4) provide training and instructions for caregivers in all post-discharge assistance tasks described in the discharge plan; and (5) document in the patient’s medical record any training provided to the caregiver, patient, or patient representative and any instructions regarding post-discharge assistance.

Hospitals have discretion to provide training and instructions for caregivers either in person or by video technology as long as the hospital provides the following as part of the instruction: (1) a live or recorded demonstration of the post-discharge assistance tasks performed by an individual designated by the hospital who is authorized to perform the tasks, (2) an opportunity for the caregiver to ask questions about the tasks, and (3) answers to the caregiver’s questions. P.A. 15-32 requires individuals providing demonstrations and responding to caregiver questions to do so in a culturally competent manner and with appropriate language access services as required under state and federal law. In addition, all training and instruction should use nontechnical language to the extent possible.

P.A. 15-32 is explicit that it does not create a private right of action against a hospital or its employees, consultants, or contractors and that the same will not be held liable, in any way, for services rendered or not rendered by a caregiver to a patient at the patient’s home. The bill also specifies that it should not be construed to affect a health insurer’s benefit plans or reimbursement obligations, to delay patient discharges or transfers from a hospital to another facility, or to take precedence over a patient’s proxy health care rights. Caregivers are not entitled to reimbursement by any government or commercial payor for post-discharge assistance provided in accordance with P.A. 15-32.

PUBLIC ACT 15-34: AN ACT CONCERNING LANGUAGE INTERPRETERS IN HOSPITALS

Public Act 15-34 (P.A. 15-34) revises a current Connecticut law regarding patient access to interpreters in acute care hospitals. Previously, acute care hospitals in Connecticut were required to make interpreter services available to certain patients “to the extent possible” for the hospital. P.A. 15-34 removes the “to the extent possible” condition from the current law to now mandate that all acute care hospitals in Connecticut “ensure the availability of interpreter services to patients whose primary language is spoken by a group comprising not less than five per-cent of the population residing in the geographic area served by the hospital.”

PUBLIC ACT 15-49: AN ACT CONCERNING PRESCRIPTION DRUGS

Current law prohibits any person from knowingly purchasing for resale, selling, offering for sale, or delivering in any manner a counterfeit drug or device. A counterfeit drug or device is a drug or device, or the container or labeling of which, that without authorization bears the trademark, trade name, or other identifying mark, imprint, number or device, or any likeness of a manufacturer, distributor, or dispenser other than the person who actually manufactured, distributed, or dispensed such drug or device and thereby falsely purports or is represented to be the drug or device of, or to have been distributed by, such other manufacturer, distributor, or dispenser.

This legislation expands the scope by prohibiting any person from knowingly importing or reimporting into the state, or dispensing a counterfeit drug or device, in addition to the current prohibitions listed above. For the purposes of this prohibition, “dispensing” includes processing a drug or device for delivery or for administration for a patient pursuant to a prescription and consists of (1) comparing the label’s directions to the prescription’s directions to determine accuracy; (2) selecting the drug or device from stock to fill the prescription; (3) counting, measuring, compounding, or preparing the drug or device; (4) placing the
drug or device in the proper container; (5) affixing the label to the container; and (6) adding to a written prescription any required notations. Dispense does not include delivering or administering a drug or device to a patient.

Any physician, dentist, podiatrist, optometrist, physician assistant, advanced practice registered nurse, or nurse-midwife licensed by the state of Connecticut and authorized to prescribe medication within the scope of such person's practice who violates any of the above-described prohibitions will be subject to disciplinary action by DPH or the applicable board or commission having jurisdiction over such a prescribing practitioner.

PUBLIC ACT 15-59: AN ACT CONCERNING SCHOOL-BASED HEALTH CENTERS

Public Act 15-59 (P.A. 15-59) defines a “school-based health center” (SBHC) as a health center that meets the following standards: (1) it is located in or on the grounds of a school facility of a school district, school board, Indian tribe, or tribal organization; (2) it is organized through school, community, and health provider relationships; (3) it is administered by a “sponsoring facility”; and (4) it provides comprehensive, on-site medical and behavioral health services to children and adolescents. A “sponsoring facility” may be a hospital, public health department, community health center, nonprofit health or human services agency, school or school system, or a program administered by the Indian Health Service, the Bureau of Indian Affairs, an Indian tribe, or a tribal organization. The legislation prohibits use of the term “school-based health center” by any person or entity not meeting the above definition. P.A. 15-59 also authorizes DPH to issue regulations that set minimum quality standards for SBHCs. Furthermore, the legislation creates a new term, “expanded school health site,” whose definition is almost the same as that of an SBHC; however, expanded school health sites provide a more limited set of services.

This legislation also makes technical amendments to existing Connecticut statutes that apply only to SBHCs to now include SBHCs and expanded school health sites.

PUBLIC ACT 15-120: AN ACT CONCERNING VARIOUS REVISIONS TO THE MENTAL HEALTH AND ADDICTION STATUTES

Public Act 15-120 makes several changes to the Department of Mental Health and Addiction Services’ (DMHAS) statutes regarding data collection and the role of the DMHAS commissioner, as well as other technical changes. DMHAS is currently charged with establishing uniform methods for keeping statistical information for both public and private agencies, including a client identifier system. This legislation specifies that these data collection requirements apply to all public and private agencies providing care or treatment for psychiatric disabilities or for alcohol or drug abuse or dependence, regardless of whether they are operated or funded by the state. This legislation requires all such agencies to collect and make available the relevant statistical information, including the number of persons treated, their demographic and clinical information, admission and readmission rates, the frequency and duration of treatment, the level of care provided, and discharge and referral information. Agencies must provide this information to DMHAS upon request. In the event an agency fails to do so, DMHAS is required to report the agency to DPH or other licensing authority.
PUBLIC ACT 15-223: AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH’S RECOMMENDATIONS REGARDING EMERGENCY MEDICAL SERVICES

This legislation makes changes to various emergency medical services (EMS) laws by adding a new provision regarding decision-making responsibility at the scene of an emergency medical call, revising EMS data reporting requirements, and making various changes to the licensure and certification of EMS providers.

Responsibility for Decision Making at the Scene of an Emergency Medical Call

This legislation implements a new provision regarding responsibility for decision making by EMS providers responding on the scene of an emergency medical call. Under this legislation, the provider at the scene of an emergency call who holds the highest classification of licensure or certification is responsible for making patient care decisions. This legislation classifies licensure or certification as follows from highest to lowest: paramedic, advanced emergency medical technician (AEMT), emergency medical technician (EMT), and emergency medical responder (EMR). If two or more providers hold the same licensure or certification, the provider for the primary service area responder, which is the EMS provider designated to respond to a certain geographic area, is responsible for making decisions. If all providers on the scene are EMTs or EMRs, the EMS organization providing transportation services is responsible for making patient care decisions. The provider exercising patient care decision making must transfer patient care to a provider with a higher licensure or certification classification upon the arrival of such a provider on the scene. This legislation requires all providers on the scene to ensure that this transfer takes place in a timely and orderly manner. It does not limit the authority of a fire chief or fire officer in charge to control or direct emergency activities at the scene.

Collection of Emergency Services Data

Current law requires DPH to collect EMS data from ambulance and paramedic intercept services on a quarterly basis, including the total number of calls received through the 911 system; the level of services required for each call; response times; the number of past, cancelled, and mutual aid calls; and prehospital data for the nonscheduled transport of patients. This legislation grants DPH discretion to collect additional information and requires that the number of past, cancelled, and mutual aid calls include calls both made and received during the reporting period. Under this legislation, an organization that fails to comply with these reporting requirements is subject to a civil penalty of up to $100 per day for each failure to report the required EMS data to DPH. Prior to assessing a civil penalty, DPH must provide written notice of the deficiency to the organization. The organization has 15 business days to respond to the notice. This legislation exempts all state agencies licensed or certified as EMS organizations from these civil penalties. This legislation also permits DPH to adopt regulations concerning the collection of EMS data.

Licensure and Certification Requirements

This legislation expands a series of current laws concerning paramedic licensure to also encompass the certification of EMRs, EMTs, AEMTs, and emergency medical services instructors (EMS Instructors). Under current law, a paramedic license is not required for an individual furnishing services within the scope of practice of a Connecticut license or certification, or for a student, intern, or other trainee studying paramedicine in an accredited institution or within a DPH-approved EMS program, provided that the activities are supervised and part of a course of study. This legislation expands these exemptions to other EMS provider classifications. Under this legislation, certification as an EMR, EMT, AEMT, or EMS Instructor is not required for any individual furnishing services within the scope of practice of a Connecticut license or certification or for a student, intern, or other trainee studying EMS in an accredited institution or within a DPH-approved EMS program, provided that the activities are supervised and part of a course of study.
Under current law, DPH is permitted to issue an EMT or EMR certificate to any applicant currently certified in any New England state, New York, or New Jersey, provided that the applicant has no pending disciplinary actions or unresolved complaints and completes an initial training program. This legislation permits DPH to issue an AEMT certificate to an applicant who meets these requirements. Under current law, DPH is also allowed to issue EMR certification to an individual certified as an EMR by a state whose licensure requirements are equal to or greater than Connecticut’s, provided that the applicant has no pending disciplinary actions or unresolved complaints and completes an initial training program. This legislation permits DPH to issue an EMT or AEMT certificate to an applicant that meets these requirements.

This legislation requires EMTs, EMRs, AEMTs and EMS Instructors to be recertified every three years. In connection with this requirement, each EMT must complete 30 hours of DPH-approved refresher training, including in Alzheimer’s disease and dementia symptoms and care, or meet such other requirements established by DPH.

Public Act Effective January 1, 2016

PUBLIC ACT 15-11: AN ACT CONCERNING PERSONS WHO DECONTAMINATE REUSABLE MEDICAL INSTRUMENTS OR DEVICES

Public Act 15-11 (PA 15-11) applies to outpatient surgical facilities and hospitals, other than chronic disease hospitals, and requires central service technicians (CSTs) to meet certain certification requirements. PA 15-11 defines a CST as a person who “decontaminates, inspects, assembles, packages and sterilizes reusable medical instruments or devices in a health care facility, whether such person is employed by the health care facility or provides services pursuant to a contract with the health care facility.”

Under PA 15-11, CSTs are required to pass a nationally accredited central service exam and be credentialed by either the International Association of Healthcare Central Service Materiel Management or the Certification Board for Sterile Processing and Distribution, Inc. Alternatively, a person may obtain either of the above credentials within two years from the date of hire or contracting with a health care facility.

Certain individuals who perform services similar to a CST are exempt from the CST exam and certification requirements. These include individuals employed by or contracted with a health care facility as a CST before January 1, 2016; health care providers licensed in Connecticut; and students and interns supervised by a health care provider. PA 15-11 also exempts from the CST requirements individuals who act in consultation with a certified CST to decontaminate or sterilize reusable medical instruments or devices but do not work in a central service department; however, such individuals must receive training and be deemed competent in decontaminating and sterilizing based on the health care facility’s standards and in accordance with the manufacturer’s instructions. CSTs and exempt individuals must annually complete at least 10 hours of continuing education. Health care facilities must submit to DPH, upon request, documentation that each of its CSTs meets the requirements of PA 15-11.

PA 15-11 also requires health care facilities to retain a list of the names and job titles of exempt individuals, including all licensed health care providers, other than those employed by or contracted with a health care facility as a CST before January 1, 2016.
PUBLIC ACT 15-88: AN ACT CONCERNING THE FACILITATION OF TELEHEALTH

Public Act 15-88 is the first comprehensive law in Connecticut to address telemedicine (also referred to as “telehealth”) and to establish regulatory requirements for providing telehealth services and mandates certain insurance coverage for such services. Telehealth is a mode of delivering health services to patients via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management, and self-management of the patient’s physical and mental health.

Under the new law, any of the following licensed professionals acting within their scope of practice and in accordance with applicable standards of care can provide services via telehealth: physicians, physical therapists, chiropractors, naturopaths, podiatrists, occupational therapists, optometrists, advanced practice registered nurses, physician assistants, psychologists, marital and family therapists, clinical or master social workers, alcohol and drug counselors, professional counselors, and certified dietician-nutritionists.

Requirements for Telehealth Services

Telehealth services must be conducted using real-time, interactive two-way communication technology and/or transmitting images and data recorded with a camera or other technology from the patient to the remote provider. The definition of telehealth expressly excludes the use of fax, audio-only telephone, text messaging, and e-mail. Telehealth providers must have access to or knowledge of the patient’s medical history, as provided by the patient, and health record, including the name and address of the patient’s primary care provider. Health care services rendered via telehealth must conform to the standard of care applicable to the provider’s profession that would be expected for in-person care, and if the relevant standard requires the use of certain tests or a physical exam, such tests or exam may be carried out using appropriate peripheral devices. Providers are prohibited from prescribing schedule I, II, or III controlled substances via telehealth.

The new requirements include certain patient protections. During the first telehealth interaction, providers must inform their patients about the treatment methods and limitations of providing treatment via telehealth, obtain the patient’s consent to using telehealth, and document their consent in the patient’s health record. At the time of each telehealth interaction, telehealth providers must request patient consent to disclose records related to the telehealth session to the patient’s primary care provider. If the patient does consent, such records are shared with the patient’s primary care provider. The provision of telehealth services and maintenance and disclosure of related records must comply with the Health Insurance Portability and Accountability Act of 1996, as amended. Telehealth providers must provide patients with their license number and contact information. Facility fees may not be charged for telehealth services.

The legislation is clear that it should not be construed to prohibit (1) a provider from providing on-call coverage or consulting with another provider regarding a patient’s care or (2) orders of health care providers for hospital outpatients or inpatients.

Effective October 1, 2015

Requirements for Insurance Coverage

Individual and group health insurance policies that cover basic hospital expenses, basic medical-surgical expenses, major medical expenses, or hospital or medical services in Connecticut must provide coverage for medical advice, diagnosis, care, or treatment provided via telehealth to the extent the same is covered under the policy when provided in person. Telehealth coverage must be subject to the same terms and conditions that apply to all other benefits under the respective policy. Policies
cannot exclude coverage solely because a service is provided via telehealth, provided that telehealth services are appropriate for the context of care, and insurers cannot be required to reimburse a treating or consulting provider for technical fees or costs associated with providing services via telehealth.

*Effective January 1, 2016*

**PUBLIC ACT 15-91: AN ACT CONCERNING REPORTS OF NURSE STAFFING LEVELS**

Currently, each hospital licensed by DPH is required to make a prospective nurse staffing plan available to DPH upon request. The nurse staffing plan must contain a written certification that the staffing described in the plan is sufficient to provide adequate and appropriate health care services and must also (1) include each patient care unit’s minimum professional skill mix, (2) identify hospital employment practices concerning temporary and traveling nurses, (3) set forth each patient care unit’s administrative staffing level, (4) explain the hospital’s nurse staffing plan review process, and (5) describe how the hospital obtains input from direct care staff when developing the nurse staffing plan.

Public Act 15-91 (P.A. 15-91) revises the current law to require each hospital licensed by DPH to report annually its nurse staffing plan to DPH. This legislation also requires nurse staffing plans implemented after January 1, 2016, to include the following elements in addition to those described above: (1) the number of registered nurses, licensed practical nurses, and assistive personnel providing direct patient care and the ratio of patients to such providers by patient care unit; (2) the hospital’s method for determining and adjusting direct patient care staffing levels; and (3) a description of each patient care unit’s supporting personnel. This legislation further requires that all nurse staffing plans implemented after January 1, 2017, describe any differences between the staffing levels included in the staffing plan and each patient care unit’s actual staffing levels, and any actions the hospital will take to adjust staffing levels or address such differences.

*Effective July 1, 2015*

P.A. 15-91 also revises a current law regarding reports of workplace violence incidents. Currently, a health care employer (defined as a health care institution with 50 or more employees) must report to DPH, upon request, the number of workplace violence incidents occurring on the employer’s premises and the specific area or department where each incident occurred. P.A. 15-91 requires health care employers to report such incidents annually to DPH. The first report is due by January 1, 2016.

*Effective October 1, 2015*

**PUBLIC ACT 15-142: AN ACT IMPROVING DATA SECURITY AND AGENCY EFFECTIVENESS**

Robinson+Cole’s Data Privacy Team previously published a summary of Public Act 15-142, which can be found [here](#).

**PUBLIC ACT 15-146: AN ACT CONCERNING HOSPITALS, INSURERS AND HEALTH CARE CONSUMERS**

Robinson+Cole previously published a summary of Public Act 15-146, which can be found [here](#).
PUBLIC ACT 15-198: AN ACT CONCERNING SUBSTANCE ABUSE AND OPIOID OVERDOSE PREVENTION

Existing law provides licensed health care professionals immunity from civil damages and criminal prosecution related to lawfully prescribing, dispensing, or administering an opioid antagonist to treat or prevent a drug overdose as long as the licensed health care professional acts with reasonable care. This legislation removes the “reasonable care” condition to the immunity.

Public Act 15-198 (P.A. 15-198) permits licensed pharmacists to prescribe an opioid antagonist in good faith, provided that the pharmacist (1) has been trained and certified by a program approved by DCP, (2) trains the recipient regarding proper administration of the opioid antagonist, and (3) maintains proper records of such dispensing and instruction. P.A. 15-198 specifically states that a licensed health care professional or pharmacist who complies with the above will be deemed not to have violated the applicable standard of care.

Effective from Passage

Prescription Drug Monitoring Program

Under current law, practitioners who prescribe controlled substances (such as physicians, advance practice registered nurses, and physician assistants) must provide certain prescription-related information to DCP as part of Connecticut’s prescription drug monitoring program (PMP). P.A. 15-198 requires a prescribing practitioner, or the prescriber’s agent who is a licensed health care professional, to review a patient’s PMP record prior to prescribing that patient more than a 72-hour supply of a controlled substance. The legislation provides an exception that permits a practitioner to prescribe more than a 72-hour supply of a controlled substance on any occasion that the PMP is not operational. To satisfy the exception, the practitioner, or the practitioner’s agent who is a licensed health care professional, must check the patient’s PMP record within 24 hours of regaining access. P.A. 15-198 also provides that a practitioner who prescribes a controlled substance to a patient for continuous or prolonged treatment must review the patient’s PMP record once every 90 days.

Effective October 1, 2015

Reporting Exemption for Dispensing and Administering Opioid Agonists

Current law generally requires that pharmacies report weekly to DCP information about the controlled substance prescriptions the pharmacies dispensed. Institutional pharmacies and pharmacists’ drug rooms operated by DPH-licensed facilities (Pharmacists’ Drug Rooms) are exempt from this reporting requirement with respect to dispensing or administering an opioid antagonist to a patient to treat a substance use disorder. This new legislation revises this exception to apply instead to institutional pharmacies and Pharmacists’ Drug Rooms that dispense or administer an opioid agonist to treat a substance use disorder. An opioid agonist is a chemical compound that elicits a reaction similar to that of an opioid.

Continuing Education

Current law generally requires physicians, APRNs, and physician assistants licensed in Connecticut to receive a certain amount of continuing education to be eligible to renew their licenses. P.A. 15-198 specifies that such continuing education must include training related to prescribing controlled substances and pain management.
PUBLIC ACT 15-242: AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES

Public Act 15-242 makes a number of substantive and technical changes to Connecticut’s public health statutes.

Under current law, hospitals are required to file annually with the Office of Health Care Access (OHCA) their policies regarding charity care and reduced cost services for the indigent and debt collection. Hospitals are also required to submit audited financial statements to OHCA by February 28 of each year in connection with OHCA’s review of the uncompensated care level provided by each hospital to the indigent. The new legislation specifies that a health system may make a single filing containing audited financial statements for each hospital within the system rather than making separate filings for each hospital.

Effective July 1, 2015

This legislation establishes new requirements for the maintenance and retention of medical records by chronic disease hospitals and children’s hospitals. Specifically, these facilities must maintain medical records on-site in an accessible manner and keep each patient’s medical records on-site for a minimum of 10 years after discharge. In terms of record keeping for children’s hospitals only, nurses’ notes do not need to be maintained as medical records. Original medical records may be destroyed prior to the expiration of the 10-year period if the facility maintains a copy of the records in a manner consistent with its current standards and provides DPH with a description of the process it uses for preserving such copies. Chronic disease hospitals are required to complete a patient’s medical records not more than 30 days after the patient’s discharge, except in unusual circumstances, which must be specified in the hospital’s medical staff rules and regulations.

This legislation amends existing law to require that all orders written by a physician assistant include the physician assistant’s signature and printed name. The signature requirement had been inadvertently removed by previous legislation.

Under current law, qualified registered nurses and qualified licensed practical nurses from other states are required to obtain temporary permits from DPH to provide care to Connecticut patients on a temporary basis. This legislation allows such nurses to provide this care for up to 72 hours without a DPH permit. For care beyond 72 hours, a temporary permit still needs to be obtained. The legislation preserves the requirement that such nurses must not hold themselves out as licensed in Connecticut.

Under current law, various professionals are required to notify DSS within 72 hours of when they reasonably suspect an elderly person has been abused, neglected, exploited, or abandoned or is in need of protective services. The legislation specifically states that the list of “mandatory reporters” includes employees of home health care agencies and homemaker and companion agencies.

Under current law, DPH and its professional licensing boards and commissions can take disciplinary action against a practitioner’s license or permit on the basis of disciplinary actions taken by other states, the District of Columbia, U.S. possessions or territories, or foreign jurisdictions. This legislation includes disciplinary actions taken by federal governmental agencies among those that can form the basis of an action by DPH or the board or commission. As with the other jurisdictions, DPH or the applicable board or commission is entitled to rely on the federal governmental agency’s findings and conclusions when taking a disciplinary action.

Under current law, a “medical spa” is defined as an establishment in which cosmetic medical procedures are performed. This legislation explicitly excludes hospitals and other licensed health care facilities from the definition of medical spa. Currently, medical spas must employ or contract with a physician, physician assistant, or advanced practice registered
nurse to perform an initial physical assessment of a person prior to any cosmetic medical procedure. The legislation specifies that this initial assessment must be performed in person.

+ Under current law, if a health care facility plans to terminate all of its services and those services were authorized by a Certificate of Need (CON), the facility must notify OHCA at least 60 days prior to such termination and surrender its CON at least 30 days prior to such termination. Also under current law, if a facility plans to terminate the operation of a facility or service for which a CON was not obtained, the facility must notify OHCA at least 60 days prior to such termination. This legislation clarifies that these obligations do not apply if the health care facility is required to obtain a CON in connection with such planned termination. A CON is currently required in the following contexts: termination of any inpatient or outpatient services by a hospital, termination of an emergency department by a short-term acute care general hospital, termination of surgical services (with certain exceptions) by an outpatient surgical facility or an outpatient department of a short-term acute care general hospital, and termination of any inpatient or outpatient services by a state-operated facility that serves Medicare or Medicaid beneficiaries.

+ The legislation makes a number of changes to current law regarding hospital notification to EMS organizations of possible exposure to infectious diseases. Under current law, if a hospital diagnoses a patient as having infectious pulmonary tuberculosis, it must verbally notify the EMS organization that attended, treated, assisted, handled, or transported the patient within 48 hours of making the diagnosis and must provide written notification to the organization within 72 hours of making the diagnosis. If a hospital determines that a patient who died at or before reaching the hospital had infectious pulmonary tuberculosis, it must notify the EMS organization that attended, treated, assisted, handled, or transported the patient within 48 hours of the determination. Hospitals are also required to respond to requests submitted by EMS organizations for notification regarding patient test results following possible exposure to an infectious disease.

+ Under the new legislation, notifications must occur upon a diagnosis of any “airborne infectious disease.” The legislation empowers the commissioner (Commissioner) to designate diseases as infectious diseases or airborne infectious diseases through the adoption of regulations. The notification requirements in the law apply to diseases designated as airborne infectious diseases by DPH or designated as such on the list of infectious diseases developed by the U.S. secretary of Health and Human Services (HHS).

+ The legislation also replaces the current definition of “exposure” with the term “exposed,” defined as being in circumstances in which there is a recognized risk of transmitting an infectious disease from a human source to an emergency services provider or, in the case of a disease designated by HHS as a select agent, from a contaminated surface or the environment to an emergency services provider.

+ The legislation requires hospitals to designate a hospital employee as a “hospital contact person” to be responsible for providing all requisite notifications under the law to the officers designated by EMS organizations to receive such notifications (designated officers). By January 1, 2016, EMS organizations and hospitals must provide the Commissioner with names and contact information for their designated officers and hospital contact persons respectively. The Commissioner is required to maintain and update a list of all such designated officers and hospital contact persons, along with their contact information, on or after January 1, 2016, and to make the list available on DPH’s website.

+ The legislation also specifies that, while hospitals, hospital contact persons, and designated officers are insulated from causes of action for damages and civil penalties regarding their obligations under the law, the Commissioner may take disciplinary actions as deemed appropriate under the circumstances.

+ The legislation permits certified dietician-nutritionists (CDNs) to write orders for a patient diet, including a therapeutic diet, for patients in health care facilities. Previously, CDNs could only convey a physician’s verbal order and could not directly
write patient diet orders. Nurses and physician assistants of the relevant facility can now act on a CDN’s order for a patient diet with the same authority as if the order were received directly from a physician. CDNs must document their orders in the patient’s medical record, and the orders must be countersigned by a physician within 72 hours unless state or federal law or regulations requires otherwise. The legislation also specifies that registered nurses and licensed practical nurses are permitted to execute dietary orders written in patient charts by CDNs. The legislation is explicit that it does not prohibit a physician from conveying a verbal order for a patient diet to a CDN. The definition of “dietetics or nutrition practice” has been revised to include the ordering of oral diets and enteral and parenteral nutrition support and the physical administration of oral diets. The definition does not include administering nutrition by any means other than oral administration, the administration of enteral or parenteral diets, or the issuance of orders for laboratory or other diagnostic tests intended to be implemented by an appropriately licensed nurse.

Commencing on January 1, 2016, licensed alcohol and drug counselors, chiropractors, psychologists, marital and family therapists, professional counselors, clinical and master social workers, and advanced practice registered nurses are required to participate in continuing education programs on the topic of mental health conditions common to veterans and family members of veterans. In particular, the programs must consist of at least two contact hours of training and education during the first renewal period in which continuing education is required. At least once every six years thereafter, the programs must focus on (1) determining whether a patient is a veteran or family member of a veteran; (2) screening for conditions such as posttraumatic stress disorder, risk of suicide, depression, and grief; and (3) training on suicide prevention. In addition, the legislation specifies that the continuing medical education requirements for physicians in the area of behavioral health may include the programs described in the preceding sentence.

Effective October 1, 2015