

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 19-118—sSB 920
Public Health Committee

**AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S
RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE PUBLIC
HEALTH STATUTES**

TABLE OF CONTENTS:

**§ 1 — SCHOOL-BASED HEALTH CENTER (SBHC) ADVISORY
COMMITTEE**

Requires the DPH commissioner to make an appointment to the SBHC advisory committee if there is a spot that is vacant for at least one year and decreases the committee's reporting frequency from annually to biennially

§ 2 — DRINKING WATER STATE REVOLVING FUND (DWSRF) LOANS

Allows DPH to disregard the priority funding list when awarding DWSRF loans for an emergency that requires an eligible drinking water project to immediately be undertaken to protect public health and safety

§§ 3, 4 & 23 — MODEL FOOD CODE

Extends by one year, from January 1, 2019, to January 1, 2020, the date by which DPH must implement the FDA's Model Food Code and makes minor and technical changes related to these laws

§ 5 — CHANGES IN FACILITY OWNERSHIP

Expands the scope of a requirement for facilities to obtain DPH approval for certain ownership transfers and extends the deadline for notifying the department

§§ 5 & 6 — MULTI-CARE INSTITUTIONS

Modifies the definition of multi-care institution and requires hospitals to provide DPH with a list of their satellite units when applying for licensure

§§ 5 & 42 — OUTPATIENT CLINIC INSPECTIONS

Generally extends, from three to four years, how often an accredited outpatient clinic must be inspected

§ 7 — HEALTH CARE PRACTITIONER DISCIPLINE

Allows DPH and health care practitioner licensing boards or commissions to take disciplinary action against a practitioner who voluntarily surrendered or entered into an agreement not to renew or reinstate his or her license or permit in another jurisdiction

**§§ 8-12 — CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM
(CADAP) AND CONNECTICUT INSURANCE PREMIUM ASSISTANCE
PROGRAM (CIPA)**

Makes technical changes to reflect the transfer of administration of CADAP and CIPA from DSS to DPH; generally requires program participants to enroll in Medicare Part D and allows DPH to pay Part D premium and coinsurance costs for participants

OLR PUBLIC ACT SUMMARY

§§ 13-18 & 26 — DPH REGULATIONS

Modifies DPH regulatory requirements by permitting, rather than requiring, DPH to adopt regulations on various topics, including radon in drinking water and indoor air and medication administration by unlicensed personnel in residential care homes, among others

§ 19 — ANNUAL EMS SYSTEM REPORT

Eliminates the requirement that DPH annually report to the Public Health Committee on quantifiable outcome measures for the state's emergency medical system

§ 20 — CHILD POVERTY AND PREVENTION COUNCIL REPORT

Eliminates the requirement that budgeted state agencies providing prevention services to children annually report to the Appropriations, Children's, and Human Services committees

§ 21 — DPH CHRONIC DISEASE PLAN

Modifies the content of DPH's statewide chronic disease plan

§ 22 — PRIVATE RESIDENTIAL WELLS AND WELLS FOR SEMI-PUBLIC USE

Modifies the definitions of "water supply well" and related terms in DPH statutes regulating private residential wells and wells for semi-public use; allows DPH to adopt regulations on the nonresidential construction of wells

§ 24 — MANDATED REPORTERS OF CHILD ABUSE AND NEGLECT

Removes DPH employees from the list of mandated reporters of child abuse and neglect to reflect the transfer of child care facility and youth camp licensure from DPH to the Office of Early Childhood

§ 25 — BACKGROUND CHECK FOR DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS) JOB APPLICANTS

Requires DDS to conduct fingerprint and state and national background checks on job applicants who have been made a conditional employment offer, instead of only applicants who would provide direct care to individuals with intellectual disability

§§ 27-40 & 78 — REPEALERS

Repeals provisions (1) requiring DSS to administer CADAP and CIPA, (2) establishing a Health Care Access Commission, and (3) requiring DMHAS to evaluate community residences twice per year

§ 41 — BEHAVIORAL HEALTH FACILITY REPORTABLE EVENTS

Requires behavioral health facilities to report "reportable events" to DPH

§§ 43 & 44 — FORENSIC NURSE EXAMINERS

Specifies when nurses can refer to themselves as a "sexual assault nurse examiner" or "sexual assault forensic examiner"

§ 45 — TECHNICAL CHANGE

Makes a technical change conforming to a statute being repealed

§§ 46-61 — EMERGENCY MEDICAL SERVICES

Makes various changes to EMS statutes, such as requiring EMS personnel to meet national training and examination requirements starting in 2020

§ 62 — BOARD OF EXAMINERS FOR PHYSICAL THERAPISTS

OLR PUBLIC ACT SUMMARY

Adds a third physical therapist and removes the physician member from the Board of Examiners for Physical Therapists

§ 63 — TECHNICAL CORRECTION TO PA 19-19

Makes a technical correction to PA 19-19 on epinephrine auto-injectors

§§ 64-69 — MOBILE INTEGRATED HEALTH

Prohibits EMS organizations from providing mobile integrated health care programs without DPH approval, allows EMS organizations to transport patients to destinations other than emergency departments, and allows paramedics to provide telehealth services

§§ 70-75 — TECHNICAL AND CONFORMING CHANGES TO LAWS RELATED TO NURSING HOMES

Makes technical and conforming changes to certain laws related to nursing homes to conform to PA 16-66

§ 76 — VETERINARY LICENSURE EXEMPTIONS

Specifies when certain faculty and students of accredited veterinary schools are exempt from the veterinary medicine licensure requirements

§ 77 — HEALTH SYSTEMS PLANNING UNIT AND DATA RELEASE

Allows OHS's Health Systems Planning Unit, under certain conditions, to release patient-identifiable data to consultants or independent professionals contracted by OHS

EFFECTIVE DATE: July 1, 2019, unless otherwise noted.

§ 1 — SCHOOL-BASED HEALTH CENTER (SBHC) ADVISORY COMMITTEE

Requires the DPH commissioner to make an appointment to the SBHC advisory committee if there is a spot that is vacant for at least one year and decreases the committee's reporting frequency from annually to biennially

Under existing law, the SBHC advisory committee includes (1) several public officials or their designees and (2) 11 members appointed by the governor, legislative leaders, and the Department of Public Health (DPH) commissioner.

This act requires the DPH commissioner to make an appointment to the committee if a spot is vacant for at least one year. If this occurs, the commissioner must notify the appointing authority of her choice at least 30 days before making the appointment.

By law, the advisory committee must report to the Public Health and Education committees. The act decreases the required reporting frequency from annually to every other year. As under prior law, the next report is due January 1, 2020.

§ 2 — DRINKING WATER STATE REVOLVING FUND (DWSRF) LOANS

Allows DPH to disregard the priority funding list when awarding DWSRF loans for an emergency that requires an eligible drinking water project to immediately be undertaken to protect public health and safety

OLR PUBLIC ACT SUMMARY

By law, DPH awards DWSRF program loans equal to 100% of eligible project costs to eligible drinking water projects based on a priority list for funding it establishes and maintains.

The act allows DPH to disregard the priority list for an emergency, including an unanticipated infrastructure failure, water contamination, or a water shortage, that requires an eligible project to immediately be undertaken in order to protect the public's health and safety. Prior law allowed DPH to disregard the priority list only if a public water supply emergency existed.

§§ 3, 4 & 23 — MODEL FOOD CODE

Extends by one year, from January 1, 2019, to January 1, 2020, the date by which DPH must implement the FDA's Model Food Code and makes minor and technical changes related to these laws

The act extends by one year, from January 1, 2019, to January 1, 2020, the date by which DPH must adopt the federal Food and Drug Administration's (FDA) Model Food Code as the state's food code for regulating food establishments. The act also makes minor and technical changes related to the model food code laws.

§ 5 — CHANGES IN FACILITY OWNERSHIP

Expands the scope of a requirement for facilities to obtain DPH approval for certain ownership transfers and extends the deadline for notifying the department

Under prior law, certain changes in facility ownership were subject to prior DPH approval after a scheduled inspection by the department. (This formerly applied to nursing homes and residential care homes (RCHs); a 2016 law updated the laws defining these facilities and appears to have inadvertently applied this requirement to RCHs only.)

The act expands the types of facilities subject to this requirement to include all DPH-licensed facilities (e.g., hospitals, behavioral health facilities, and nursing homes). The prior approval is needed for:

1. a change in ownership for any such facility or institution owned by an individual, partnership, or association or
2. a change in ownership or beneficial ownership of 10% or more of the stock of a corporation that owns, conducts, operates, or maintains the facility or institution.

As under prior law for RCHs, the approval is conditioned on the facility or institution showing that it has complied with all the law's requirements, the licensure regulations, and all applicable public health code requirements. The act extends the deadline for providing notice to the department from 90 to 120 days in advance of the effective date for the proposed change in ownership.

§§ 5 & 6 — MULTI-CARE INSTITUTIONS

OLR PUBLIC ACT SUMMARY

Modifies the definition of multi-care institution and requires hospitals to provide DPH with a list of their satellite units when applying for licensure

The act modifies the definition of “multicare institution” to include hospitals that provide behavioral and other health care services (e.g., walk-in clinic). It also requires these hospitals to provide DPH with a list of their satellite units or locations when completing an initial or renewal license application. The act defines a “satellite unit” as a location where the multi-care institution provides a segregated unit of services.

By law, multi-care institution refers to specified institutions that (1) have more than one facility or one or more satellite units owned and operated by a single licensee and (2) offer complex patient health care services at each facility or satellite unit. Under existing law, these institutions include psychiatric outpatient clinics for adults, free-standing facilities for substance abuse treatment, psychiatric hospitals, or general acute care hospitals that provide outpatient behavioral health services. The act specifies that complex patient health care services may include methadone delivery and related substance use treatment services to individuals in a nursing home.

§§ 5 & 42 — OUTPATIENT CLINIC INSPECTIONS

Generally extends, from three to four years, how often an accredited outpatient clinic must be inspected

The act extends, from every three years to every four years, how frequently DPH must inspect certain outpatient clinics. This applies to clinics that have (1) obtained accreditation from a national accrediting organization in the immediately preceding 12 months and (2) not committed any violation that the commissioner determines would pose an immediate threat to the patients’ health, safety, or welfare.

The act’s provisions do not limit the commissioner’s authority to inspect any outpatient clinic for initial licensure or renewal, suspend or revoke any such clinic’s license, or take any other authorized legal action against the clinic.

§ 7 — HEALTH CARE PRACTITIONER DISCIPLINE

Allows DPH and health care practitioner licensing boards or commissions to take disciplinary action against a practitioner who voluntarily surrendered or entered into an agreement not to renew or reinstate his or her license or permit in another jurisdiction

The act allows a health care practitioner licensing board or commission or DPH to take disciplinary action against a practitioner’s license or permit if the individual was subject to voluntary surrender or an agreement not to renew or reinstate his or her license or permit in another jurisdiction. It applies to individuals subject to these actions by an authorized professional disciplinary agency of any state, the federal government, the District of Columbia, a U.S. possession or territory, or a foreign country.

OLR PUBLIC ACT SUMMARY

As under existing law, the board, commission, or DPH can rely on the findings and conclusions made by the other jurisdiction's agency in taking the disciplinary action.

§§ 8-12 — CONNECTICUT AIDS DRUG ASSISTANCE PROGRAM (CADAP) AND CONNECTICUT INSURANCE PREMIUM ASSISTANCE PROGRAM (CIPA)

Makes technical changes to reflect the transfer of administration of CADAP and CIPA from DSS to DPH; generally requires program participants to enroll in Medicare Part D and allows DPH to pay Part D premium and coinsurance costs for participants

PA 18-168 transferred administration of CADAP and CIPA from the Department of Social Services (DSS) to DPH. This act effectuates that transfer by removing references to CADAP in DSS-related statutes.

The act also reinstates the requirement that program applicants and beneficiaries enroll in Medicare Part D or demonstrate their ineligibility to do so. (PA 18-168 eliminated this requirement.) It allows the DPH commissioner to pay the premium and coinsurance costs of Medicare Part D coverage for these individuals.

By law, CADAP is a pharmaceutical drug assistance program that pays for certain FDA-approved medications to treat HIV and HIV-related conditions for eligible low-income residents. CIPA, which is funded through CADAP, provides health insurance premium assistance to eligible CADAP participants who have private insurance.

§§ 13-18 & 26 — DPH REGULATIONS

Modifies DPH regulatory requirements by permitting, rather than requiring, DPH to adopt regulations on various topics, including radon in drinking water and indoor air and medication administration by unlicensed personnel in residential care homes, among others

The act permits, rather than requires, DPH to adopt regulations:

1. concerning radon in drinking water that are consistent with the federal Environmental Protection Agency's (EPA) national primary drinking water regulations (§ 13);
2. establishing radon measurement requirements and procedures for evaluating radon in indoor air and reducing elevated levels detected in public schools (§ 14);
3. requiring home health agencies, residential care homes, assisted living services agencies, and licensed hospice care organizations to provide training on Alzheimer's disease and dementia to direct care staff (§ 16);
4. ensuring the safe provision of auricular acupuncture as an adjunct therapy to treat alcohol and drug abuse (§ 26); and
5. requiring residential care homes to designate unlicensed personnel to obtain certification to administer medication to residents who require such assistance (§ 15).

OLR PUBLIC ACT SUMMARY

For the latter, if the department implements regulations on medication administration by unlicensed personnel, the act requires, rather than allows, DPH to adopt policies and procedures while adopting the regulations.

Additionally, the act permits DPH, in consultation with the Department of Mental Health and Addiction Services (DMHAS), to (1) amend its substance abuse treatment regulations, (2) implement a dual licensure program for behavioral health providers who provide mental health and substance abuse services, or (3) permit the use of saliva and urine drug screens at DPH-licensed facilities (§ 17). Prior law required DPH to implement all three of the above listed actions.

Lastly, the act eliminates the requirement that DPH, in consultation with the Connecticut Examining Board for Barbers, Hairdressers and Cosmeticians, adopt regulations establishing minimum curriculum requirements for hairdressing and cosmetology schools. It instead requires the commissioner to adopt a curriculum and procedures for approving these schools and post the curriculum on the DPH website (§ 18).

§ 19 — ANNUAL EMS SYSTEM REPORT

Eliminates the requirement that DPH annually report to the Public Health Committee on quantifiable outcome measures for the state's emergency medical system

The act eliminates the requirement that DPH annually research, develop, track, and report to the Public Health Committee quantifiable outcome measures for the state's emergency medical service (EMS) system.

Existing law, unchanged by the act, requires DPH to develop an EMS data collection system through which EMS service professionals submit quarterly data to the department. DPH must annually report on the data it collects to the EMS Advisory Board (CGS § 19a-177(8)).

§ 20 — CHILD POVERTY AND PREVENTION COUNCIL REPORT

Eliminates the requirement that budgeted state agencies providing prevention services to children annually report to the Appropriations, Children's, and Human Services committees

The act eliminates a requirement that budgeted state agencies providing prevention services to children report to the Appropriations, Children's, and Human Services committees annually by November 1. Under prior law, agencies had to submit this report through 2020. The report had to include (1) the number of families and children served, for at least two prevention services; (2) a description of the preventive purposes of the services; and (3) performance-based standards and outcomes included in relevant contracts, among other things.

The reporting requirement was enacted when the Child Poverty and Prevention Council was established. The council terminated in June 2015.

§ 21 — DPH CHRONIC DISEASE PLAN

OLR PUBLIC ACT SUMMARY

Modifies the content of DPH's statewide chronic disease plan

By law, DPH must consult with the Office of Health Strategy and local health departments to develop and implement a statewide chronic disease plan. The act requires that the plan reduce the incidence of tobacco use, high blood pressure, health care-associated infections, asthma, unintended pregnancy, and diabetes.

Prior law required that the plan reduce the incidence of chronic disease, including chronic cardiovascular disease, cancer, lupus, stroke, chronic lung disease, diabetes, arthritis or another metabolic disease, and the effects of behavioral health disorders.

As under prior law, the plan must be consistent with (1) DPH's Healthy Connecticut 2020 health improvement plan and (2) the state healthcare innovation plan developed under the State Innovation Model Initiative by the federal Centers for Medicare and Medicaid Services Innovation Center.

§ 22 — PRIVATE RESIDENTIAL WELLS AND WELLS FOR SEMI-PUBLIC USE

Modifies the definitions of "water supply well" and related terms in DPH statutes regulating private residential wells and wells for semi-public use; allows DPH to adopt regulations on the nonresidential construction of wells

The act makes minor changes to several definitions concerning the regulation of private residential wells and wells for semi-public use. It expands the definition of "water supply well" to include an artificial excavation to obtain or provide water for industrial, commercial, agricultural, recreational, irrigation, or other outdoor water use, in addition to domestic use or drinking as under existing law. In doing so, the act conforms to the statutory definition used by the Department of Consumer Protection to regulate well drilling, thus subjecting all water supply wells to Public Health Code requirements.

The act also allows the DPH commissioner to adopt regulations on the nonresidential construction of new water supply wells (e.g., an office building with fewer than 25 employees), in addition to the residential construction of such wells as under existing law.

§ 24 — MANDATED REPORTERS OF CHILD ABUSE AND NEGLECT

Removes DPH employees from the list of mandated reporters of child abuse and neglect to reflect the transfer of child care facility and youth camp licensure from DPH to the Office of Early Childhood

The act removes DPH employees from the list of mandated reporters of child abuse and neglect to reflect the transfer of licensing child care facilities and youth camps from DPH to the Office of Early Childhood under PA 14-39.

§ 25 — BACKGROUND CHECK FOR DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS) JOB APPLICANTS

OLR PUBLIC ACT SUMMARY

Requires DDS to conduct fingerprint and state and national background checks on job applicants who have been made a conditional employment offer, instead of only applicants who would provide direct care to individuals with intellectual disability

The act requires DDS to conduct fingerprint and state and national background checks on any job applicant who has been made a conditional employment offer. Prior law required DDS to do this only for applicants who would provide direct services to people with intellectual disability.

Existing law allows DDS to subject private providers licensed or funded by the state to Connecticut criminal background checks if they will have direct contact with individuals with intellectual disability and their families. The act specifies that this requirement applies only to private providers that have been made a conditional employment offer by the department.

§§ 27-40 & 78 — REPEALERS

Repeals provisions (1) requiring DSS to administer CADAP and CIPA, (2) establishing a Health Care Access Commission, and (3) requiring DMHAS to evaluate community residences twice per year

The act repeals the following provisions and makes related technical and conforming changes:

1. requiring DSS to administer CADAP and CIPA, which provide prescription medication assistance to eligible low-income residents with HIV or HIV-related conditions (the programs are now administered by DPH, see §§ 8-12) (CGS §17b-256);
2. establishing a Health Care Access Commission to develop programs needed to ensure appropriate health care access by all residents (the commission is defunct and its duties are now performed by the Office of Health Strategy's Health Care Cabinet) (CGS §19a-7b); and
3. requiring DMHAS to evaluate community residences for individuals with mental illness twice a year and send the review to DPH upon request (CGS §19a-507c).

§ 41 — BEHAVIORAL HEALTH FACILITY REPORTABLE EVENTS

Requires behavioral health facilities to report "reportable events" to DPH

Existing law requires DPH to (1) develop a system for nursing homes to electronically report "reportable events" to the department and (2) nursing homes to report these events using the electronic system. The act extends these requirements to behavioral health facilities.

For these purposes, "reportable events" are events occurring at these facilities that DPH deems to require immediate notification.

§§ 43 & 44 — FORENSIC NURSE EXAMINERS

OLR PUBLIC ACT SUMMARY

Specifies when nurses can refer to themselves as a “sexual assault nurse examiner” or “sexual assault forensic examiner”

PA 19-114 makes various changes to the Office of Victim Services’ Sexual Assault Forensic Examiner (SAFE) program. For example, it expands the types of health care providers that may become sexual assault forensic examiners (which includes nurses) and requires them to successfully complete certification requirements implemented by the chief court administrator.

This act specifies that a registered nurse or advanced practice registered nurse who provides care and treatment to a sexual assault victim may not use the title of “sexual assault nurse examiner” unless he or she completed the chief court administrator’s training and certification.

§ 45 — TECHNICAL CHANGE

Makes a technical change conforming to a statute being repealed

The act removes a statutory reference to a provision being repealed (see § 78).

§§ 46-61 — EMERGENCY MEDICAL SERVICES

Makes various changes to EMS statutes, such as requiring EMS personnel to meet national training and examination requirements starting in 2020

The act makes various changes to the statutes on emergency medical services (EMS). Among other things, it:

1. requires emergency medical technicians (EMTs), advanced EMTs, and emergency medical responders (EMRs), starting January 1, 2020, to obtain and renew their state certification by completing national training and examination requirements (§§ 57 & 58);
2. requires EMS instructors to obtain and renew their state certification in this manner by a date DPH determines (§ 58); and
3. allows a volunteer, hospital-based, or municipal ambulance service to apply to DPH to add a branch location to their primary service area, and makes corresponding changes to application requirements (previously, they had to undergo a hearing process through the department) (§ 50).

The act also makes minor and technical changes to various EMS statutes, including (1) requiring EMS organizations to submit required data to DPH in electronic format, instead of also allowing written submissions; (2) requiring DPH to establish minimum training standards for all EMS personnel, instead of only EMTs; and (3) modifying the definition of “EMS organization” and substituting this term for “EMS provider” to update terminology.

National Certification for Certain EMS Personnel

Starting January 1, 2020, the act generally requires applicants for EMR, EMT, or advanced EMT certification to obtain certification from a national organization

OLR PUBLIC ACT SUMMARY

for emergency medical certification in place of current state certification and licensure requirements. It requires applicants for EMS instructor certification to do so starting at a date the DPH commissioner prescribes.

The act defines the national organization for emergency medical certification (“national organization”) as a national organization, or its successor, that (1) DPH approves and identifies on its website and (2) tests and certifies EMS personnel. (DPH approved and identified the National Registry of Emergency Medical Technicians, a nonprofit organization that tests and certifies all levels of EMS personnel.)

Previously, applicants for state certification had to meet specified training requirements and pass written and practical examinations, as listed in the table below.

Initial Certification. Under the act, applicants for initial certification as an EMR, EMT, or advanced EMT must (1) complete an initial training program consistent with the National Highway Traffic Safety Administration’s National EMS Education Standards for their respective profession and (2) pass the national organization’s examination for their respective profession or a DPH-approved examination. In addition, as under prior law, applicants must have no pending disciplinary action or complaint against them.

The act requires applicants for EMS instructor initial certification to:

1. hold a current EMT or advanced EMT certification or paramedic license in Connecticut;
2. complete an EMT instructor training program based on current national education standards within the prior two years;
3. complete 25 hours of teaching under the supervision of a certified EMS instructor;
4. complete written and practical examinations prescribed by DPH;
5. have no pending disciplinary action or complaints; and
6. by a date the DPH commissioner prescribes, maintain current EMT, advanced EMT, or paramedic certification from the national organization.

Previously, applicants had to meet the initial certification requirements listed in the table below.

Prior Initial Certification Requirements for EMRs, EMTs, Advanced EMTs, and EMS Instructors

<i>Profession</i>	<i>Prior Education and Training Requirements For Initial Certification</i>
EMR	(1) complete 60-hour DPH-approved training that includes written and practical examinations or (2) be currently certified as an EMT, advanced EMT, or paramedic and pass the examination required for an initial EMR training program
EMT	(1) complete 150-hour DPH-approved training that includes written and practical examinations or (2) be currently licensed as a physician, registered or advanced practice registered nurse, or physician assistant and complete a 30-hour DPH-approved refresher course and pass written and practical examinations
Advanced EMT	(1) complete 150-hour DPH-approved training that includes written and practical examinations or meets or exceeds the 2009 National EMS Education

OLR PUBLIC ACT SUMMARY

	Standards for the profession and (2) be currently certified as an EMT
EMS Instructor	(1) be currently certified in good standing as an EMT; (2) document his or her qualifications, referencing national education standards; (3) submit a letter of endorsement from two certified EMS instructors; and (4) successfully complete written and practical examinations

Certification Renewals. The act requires applicants seeking to renew certification as an EMR, EMT, or advanced EMT to (1) successfully complete the continuing education required by the national organization or approved by DPH or (2) be currently certified in their respective professions by the national organization.

Prior law required EMRs, EMTs, and advanced EMTs seeking certification renewal to complete a DPH-approved refresher course. Applicants currently certified in another state could complete a refresher course in that state if DPH determined it was equal to Connecticut's.

For EMS instructors, the act requires applicants for certification renewal to:

1. successfully complete the continuing education and teaching required by DPH;
2. maintain a current Connecticut EMT or advanced EMT certification or paramedic license; and
3. by a date the DPH commissioner prescribes, maintain current EMT, advanced EMT, or paramedic certification by the national organization.

Additionally, the act requires EMRs, EMTs, and advanced EMTs to renew their certifications every two years, rather than three years as under prior law.

Certification by Endorsement. As under prior law, the act requires EMR, EMT, and advanced EMT applicants for certification by endorsement (i.e., those currently certified in another state) to present satisfactory evidence to the DPH commissioner that they are currently certified in good standing in their respective profession by a state with requirements DPH determines are at least as strict as Connecticut's. The act alternatively grants certification to such applicants who are currently certified by the national organization.

Continuing Education. The act requires EMRs, EMTs, advanced EMTs, and instructors (i.e., EMS personnel) to document completion of their continuing education requirements through an online database approved by the DPH commissioner. The database must allow EMS personnel to enter, track, and reconcile continuing education hours and topics.

The act exempts from the continuing education requirement EMS personnel who are not engaged in professional practice in any form during the certification period. But the act requires such EMS personnel to apply to DPH for inactive status before their certification expires and submit any documentation the department requires. The application must include a statement that the EMS personnel cannot engage in professional practice until meeting the act's continuing education requirements.

Certified EMT-Paramedics. The act increases, from \$150 to \$155, the license renewal fee for paramedics who were certified EMT-paramedics on October 1, 1997. (Prior DPH regulations established three levels of EMT certification, including EMT-paramedic.)

OLR PUBLIC ACT SUMMARY

§ 62 — BOARD OF EXAMINERS FOR PHYSICAL THERAPISTS

Adds a third physical therapist and removes the physician member from the Board of Examiners for Physical Therapists

The act adds a third physical therapist and removes the physician member from the five-member Board of Examiners for Physical Therapists. (The other two members are public members.) In practice, the physician spot is currently vacant.

Under existing law and the act, the governor appoints the board's members.

§ 63 — TECHNICAL CORRECTION TO PA 19-19

Makes a technical correction to PA 19-19 on epinephrine auto-injectors

PA 19-19 allows authorized entities to acquire and maintain a supply of epinephrine auto-injectors and contains related provisions. This act makes a technical correction to PA 19-19, specifying that its definitions apply throughout that act.

EFFECTIVE DATE: Upon passage

§§ 64-69 — MOBILE INTEGRATED HEALTH

Prohibits EMS organizations from providing mobile integrated health care programs without DPH approval, allows EMS organizations to transport patients to destinations other than emergency departments, and allows paramedics to provide telehealth services

The act makes various changes regarding mobile integrated health care programs. Specifically, it:

1. allows DPH, starting January 1, 2020, and within available appropriations, to authorize an EMS organization to establish a mobile integrated health program under the organization's existing license or certification;
2. prohibits EMS organizations from providing a mobile integrated health program without DPH approval;
3. requires DPH to adopt regulations setting minimum program standards, including (a) standards to ensure patients' health, safety, and welfare and (b) data collection and reporting requirements;
4. allows the DPH commissioner to implement policies and procedures to administer these programs and requires her to post them on the DPH website and the state's e-regulation system within 20 days after they are implemented;
5. generally makes patients liable for reasonable and necessary service costs if they receive nonemergency services from a mobile integrated health care program;
6. allows a licensed or certified EMS organization or provider to transport patients by ambulance to alternate destinations (i.e., medically appropriate

OLR PUBLIC ACT SUMMARY

- facilities other than emergency departments) in consultation with the medical director of a sponsor hospital;
7. allows certain ambulance services assigned as a primary service area responder by September 1, 2019, to be deemed as the primary service area's authorized mobile integrated health care program;
 8. requires DPH to establish rates for licensed or certified EMS organizations or providers that treat and release patients without transporting them to an emergency department when such treatment is not part of a mobile integrated health program; and
 9. adds paramedics to the list of health care providers authorized to provide telehealth services.

Under the act, a "mobile integrated health care program" is a DPH-approved program in which a licensed or certified ambulance service or paramedic intercept service provides services, including clinically appropriate medical evaluations, treatment, transport, or referrals to other health care providers under nonemergency conditions by a paramedic acting within his or her scope of practice as part of an EMS organization within the EMS system.

Additionally, the act makes technical and conforming changes.

Mobile Integrated Health Programs (§§ 68 & 69)

Program Authorization (§ 68). The act allows the DPH commissioner, starting January 1, 2020, and within available appropriations, to authorize an EMS organization to establish a mobile integrated health care program under the organization's current license or certification. To do so, the EMS organization must apply to DPH using forms the commissioner prescribes, and provide satisfactory evidence that it meets the law's licensure or certification requirements.

The act prohibits anyone from advertising or producing printed materials that hold themselves out to be a mobile integrated health care program provider unless they are licensed, certified, or authorized by law.

However, the act allows an ambulance service that is assigned as the primary service area responder for a primary service area (PSA) on or before September 1, 2019, to be deemed authorized by DPH as the PSA's licensed mobile integrated health care program. The ambulance service must notify DPH's Office of Emergency Medical Services in writing by October 1, 2019, (1) of its assignment as a PSA responder and (2) attesting to its compliance with laws and regulations on the operation of an ambulance service.

The act extends existing laws to mobile integrated health care programs. For example, as is already the case for other requests by EMS organizations to offer new or expanded EMS services:

1. DPH generally must hold a hearing to determine the need for a mobile integrated health care program before granting a permit approving one and
2. if the application is approved, the organization must acquire the necessary equipment within six months, or the approval is void.

Liability for Service Costs (§ 69). The act generally makes anyone who

OLR PUBLIC ACT SUMMARY

receives nonemergency medical or transport services from a mobile integrated health program liable for the reasonable and necessary cost of those services.

The provision does not apply to anyone receiving services for injuries arising out of and in the course of his or her employment, as defined in the workers' compensation law.

Transportation to Alternate Destinations (§ 66)

The act allows a licensed or certified EMS organization or provider to transport a patient by ambulance to an alternate destination (i.e., medically appropriate facilities other than emergency departments) in consultation with a sponsor hospital's medical director. An ambulance that does so must meet state regulatory requirements for a basic level ambulance, including those regarding medically necessary supplies and services.

Rate Setting (§ 65)

The act requires the DPH commissioner to establish rates for licensed or certified EMS organizations or providers that treat and release patients without transporting them to an emergency department. EMS organizations and providers must provide these services within their scope of practice and following protocols approved by their sponsor hospital.

Existing law also requires the DPH commissioner to establish rates for licensed or certified ambulance services and paramedic intercept services.

The act specifies that these new and existing rates do not apply to treatment provided to patients through mobile integrated health care programs.

Telehealth Providers (§ 67)

The act adds licensed paramedics to the list of health care providers authorized to provide health care services using telehealth. They must do so within their profession's scope of practice and standard of care, just as other telehealth providers must under existing law. By law, telehealth means delivering healthcare services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's physical and mental health.

Existing law already allows the following providers to provide health care services using telehealth: licensed physicians, advanced practice registered nurses, registered nurses, physician assistants, pharmacists, occupational and physical therapists, naturopaths, chiropractors, optometrists, podiatrists, psychologists, marital and family therapists, clinical or master social workers, alcohol and drug counselors, professional counselors, dietician-nutritionists, speech and language pathologists, respiratory care practitioners, and audiologists.

§§ 70-75 — TECHNICAL AND CONFORMING CHANGES TO LAWS RELATED TO NURSING HOMES

OLR PUBLIC ACT SUMMARY

Makes technical and conforming changes to certain laws related to nursing homes to conform to PA 16-66

The act makes technical changes to conform to PA 16-66, which created a definition for “nursing home facility” that is separate from the definition of “residential care home” for institutional licensing purposes.

EFFECTIVE DATE: Upon passage

§ 76 — VETERINARY LICENSURE EXEMPTIONS

Specifies when certain faculty and students of accredited veterinary schools are exempt from the veterinary medicine licensure requirements

Existing law specifies certain entities that are exempt from the prohibition against practicing veterinary medicine without a license. Previously, this included hospitals, educational institutions, laboratories, or state or federal institutions, or any employee, student, or person associated with those facilities, while they were engaged in research or studies involving the use of medical, surgical, or dental procedures. The act instead exempts these entities and individuals while they are engaged in research or studies involving the administration of these procedures to an animal or livestock within the facility.

The act also provides an exemption from the veterinary licensure laws for faculty members, residents, students, and interns employed by an American Veterinary Medical Association-accredited school of veterinary medicine, surgery, or dentistry. The exemption applies while they are engaged in clinical practice, research, or studies involving the use of veterinary medical, surgical, or dental procedures within a hospital, clinic, or laboratory that the school owns.

The act also makes technical changes.

§ 77 — HEALTH SYSTEMS PLANNING UNIT AND DATA RELEASE

Allows OHS's Health Systems Planning Unit, under certain conditions, to release patient-identifiable data to consultants or independent professionals contracted by OHS

By law, the Office of Health Strategy's (OHS) Health Systems Planning Unit generally must keep confidential any patient-identifiable data it receives. Existing law provides certain exceptions, such as data the unit provides to state or federal agencies under certain conditions and for certain purposes.

The act allows the Health Systems Planning Unit to also release patient-identifiable data to consultants or independent professionals contracted by OHS to carry out the unit's functions, including collecting, managing, or organizing the data.

As with the existing exceptions, the act prohibits these consultants or professionals from releasing this data in any manner that could lead to the identification of an individual patient, physician, provider, or payer.

EFFECTIVE DATE: Upon passage

OLR PUBLIC ACT SUMMARY

BACKGROUND

Related Act

PA 19-191, § 10, contains similar provisions on licensing EMS personnel and requires such licensure applicants to also complete mental health first aid training.

OTHER ACTS AMENDED:

INDEX SUGGESTIONS:

PUBLIC HEALTH, DEPT. OF

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