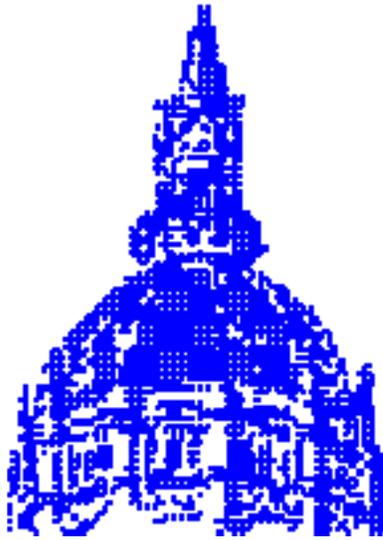


2000
ACTS AFFECTING

HEALTH PROFESSIONS



Prepared for members of the

Connecticut General Assembly

by

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2000-R-0604 (Revised)

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NOTICE TO READERS

This report provides brief highlights of the 2000 public acts affecting health professions. Not all provisions of the acts are included. Readers are encouraged to obtain the full text of acts that interest them from the Connecticut State Library or the House Clerk's office. *Highlights of the Revised FY 01 Budget* is available from the Office of Fiscal Analysis. Complete summaries of all public acts passed during the 2000 session will be available in early fall when OLR's Public Act Summary book is published, and some are now available on the OLR website.

This is a revision of OLR Report 2000-R-0604, originally issued June 2, 2000, to reflect actions taken by the General Assembly during the June 19 Special Session.

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ATHLETIC TRAINERS

A new law requires the Department of Public Health (DPH) to license athletic trainers. Previously, athletic trainers certified by the National Athletic Trainer Associations (NATA) could practice in Connecticut.

Under this law, licensed athletic trainers can work only with people who belong to sports teams or who participate in sports or recreation activities at least three times a week and then only to treat injuries they sustain in those activities.

The law establishes two classes of trainers, those who practice under a physician's orders and those who do not. The latter can perform initial evaluations and provide temporary help, but they must immediately refer an injured athlete to certain providers. The former can treat injured athletes for up to four days and then, if the symptoms do not improve, must refer them to a provider.

The law establishes educational requirements for licensure, allows certain people to be licensed without examination, and allows others to practice without a license. It sets the fee for an initial license at \$150, and renewals at \$100. **(PA 00-226, effective October 1, 2000 or when the DPH commissioner publishes notice in the Connecticut Law Journal that he is implementing the law's licensing provisions, whichever is later)**

DENTISTS/DENTAL COVERAGE

Outpatient Coverage

Existing law requires individual and group health insurance policies to cover general anesthesia, nursing, and related hospital services provided in conjunction with inpatient dental services if certain conditions are met. A new law extends this coverage requirement to outpatient or one-day dental services that meet the same conditions. These are: (1) the anesthesia, nursing, and related services are deemed medically necessary by the treating dentist or oral surgeon and the patient's primary care physician according to the health insurance policy's requirements for prior authorization of services and (2) the patient is either (a) a child under age four with a dental condition or significant complexity requiring that certain procedures be done in a hospital as determined by a licensed dentist, in conjunction with a licensed primary care physician specialist or (b) a person with a developmental disability, as determined by a physician specializing in primary care, that places him at serious risk. **(PA 00-135, effective upon passage)**

Pilot Dental Program

A new law requires the DPH and Department of Social Services (DSS) commissioners

and the chief executive officer of the University of Connecticut (UConn) Health Center to establish a pilot program for delivering dental services to children in low-income families in two regions of the state. The program must provide for the design and implementation of a “model integrated system” of children’s dental care, including disease prevention, service intervention, and measurable outcomes. **(PA 00-2, June Special Session, effective July 1, 2000)**

Dental Advisory Council

A new law establishes a 10-member Dental Advisory Council to examine dental care access for Medicaid recipients. The council must:

1. review the fees that Medicaid pays for dental services to determine their adequacy and recommend adjustments to these fees based on experience and access to dental services and dental utilization as reflected in federal utilization reports;
2. monitor the effects of Medicaid dental fee increases on the number of people eligible for Medicaid who obtain these services and the number of participating providers;
3. recommend dental service capacity assessments;
4. identify private foundation support for public or

- nonprofit health care entities providing dental services;
5. evaluate dental care pilot programs;
6. enhance public and medical community awareness of dental access issues; and
7. recommend ways to expand access and increase utilization, including, at a minimum, state utilization goals.

The council is composed of the DSS and DPH commissioners and the dean of the UCONN School of Dentistry, or their designees, and representatives from the following:

1. a mobile dental clinic, whom the governor appoints;
2. the Connecticut State Dental Association, whom the House Speaker appoints;
3. a managed care company, whom the Senate President Pro Tem appoints;
4. the Connecticut Dental Hygiene Association, whom the Senate majority leader appoints;
5. the Children’s Health Council, whom the House minority leader appoints;
6. a community health center or school-based health center, whom the House majority leader appoints;
7. and a faculty member or administrator of a dental hygiene school located in Connecticut, whom the

Senate minority leader appoints.

The council must submit an interim report of its analysis and recommendations to the Public Health and Human Services committees by April 15, 2001. A final report is due by January 1, 2002. **(PA 00-2, June Special Session, effective July 1, 2000)**

EMERGENCY MEDICAL SERVICES

EMS System

The legislature made a number of changes in the emergency medical services (EMS) system including:

1. requiring licensed and certified ambulance services and EMS-related entities to submit specific data to DPH on a quarterly basis, requiring DPH to prepare an annual report based on it, and allowing DPH to penalize those not submitting data;
2. requiring each public safety answering point (PSAP) to submit information quarterly to the Office of State-Wide Emergency Telecommunications on EMS calls received and requiring the office to provide DPH with this information annually;
3. requiring each PSAP, by July 1, 2004, to provide emergency medical dispatch (EMD) or arrange for its provision by a public

or private safety agency or regional telecommunications center, for 9-1-1 calls the PSAP receives that require EMS;

4. requiring the emergency telecommunications office to provide or approve an EMD training course and to assist PSAPs or center with EMD training;
5. providing funding through the enhanced emergency 9-1-1 program funding mechanism for DPH data collection and certain EMD costs;
6. requiring (a) DPH to develop EMS system outcome measures, (b) each municipality to establish a local EMS plan, and (c) the Office of Emergency Medical Services to develop model local EMS plans;
7. allowing any municipality to petition the DPH commissioner to remove a primary service responder not meeting certain performance standards and requiring DPH to develop a primary service assignment pilot program; and
8. requiring DPH to adopt regulations addressing procedures and conditions for filing rate increase requests and to study an expedited approval or waiver process for additional EMS vehicles

and locations. (**PA 00-151**,
effective July 1, 2000)

Paramedics

Another new law restricts licensed paramedics' scope of practice to those activities authorized in DPH regulations governing emergency medicine. By law, those activities must be performed under the supervision, control, and responsibility of a licensed physician. Paramedics operating within this scope of practice are exempt from the prohibition against practicing medicine without a physician's license. Prior law permitted paramedics to practice paramedicine outside the emergency medical system under a doctor's supervision.

This law allows paramedics to administer controlled substances (e.g., morphine, demerol, and valium) under a licensed physician's written protocols or standing orders. Prior law required them to be in simultaneous communication with a supervising doctor when administering these drugs.

Finally, it specifies that paramedics do not have to be in simultaneous communication with a supervising doctor to use an automatic external defibrillator. (**PA 00-47**, *effective October 1, 2000*)

Administration Of Epinephrine

A new law allows an EMT to administer epinephrine using

automatic prefilled cartridge injectors or similar automatic injectable equipment if he has been trained to do so according to national standards recognized by DPH. Epinephrine must be administered according to written protocols and standing orders of a licensed physician serving as an emergency department director.

It requires all EMTs to receive this training and requires all licensed or certified ambulances to have epinephrine in such injectors or equipment for administration.

This law defines EMT, for these purposes, as (1) any class of EMT certified under DPH regulations including EMT-intermediate and (2) any licensed paramedic. Epinephrine is used therapeutically as a vasoconstrictor, a cardiac stimulant, and to relax bronchioles. It is used to check local hemorrhage and to relieve asthmatic attacks. (**PA 00-135**, *effective January 1, 2001*)

Certification Regulations

Prior law required DPH to adopt regulations on statewide standardization or certification for "emergency medical technician-intermediate." A new law instead requires regulations on state-wide certification standardization for each class of (1) emergency medical technicians (EMTs), including paramedics; (2) EMS instructors; and (3) medical response

technicians. **(PA 00-135, effective upon passage)**

HOSPITAL STAFF

Legislation exempts a parent of a newborn from criminal liability for abandonment or risk of injury to a minor if he voluntarily leaves a baby with designated hospital emergency room nursing staff. A parent can leave a baby anonymously, but the act permits the hospital staff to give him a numbered bracelet that can serve as identification if, in the future, he wishes to be reunified with the child. The Department of Children and Families (DCF) assumes custody of a baby left under these circumstances. A court must approve a parent's attempt to reunify. **(PA 00-207, effective October 1, 2000)**

HYPERTRICHOLOGISTS

A new law requires hypertrichologists seeking license renewal to participate in continuing education. DPH must adopt regulations (1) defining basic requirements for continuing education, (2) specifying qualifying programs, (3) establishing a control and reporting system, and (4) providing for a waiver of continuing education for good cause. **(PA 00-135, effective upon passage)**

MARITAL AND FAMILY THERAPISTS

Legislation requires licensed marital and family therapists to participate in continuing education and provide DPH with satisfactory evidence of such participation in order to renew their licenses. DPH must adopt regulations (1) defining basic requirements for continuing education, (2) specifying qualifying programs, (3) establishing a control and reporting system, and (4) providing for a waiver of continuing education for good cause. **(PA 00-135, effective upon passage)**

MENTAL RETARDATION WORKERS

Existing law requires the Department of Mental Retardation (DMR) to create and maintain a registry of people terminated or separated from employment because of substantiated abuse or neglect of a DMR client. It applies to people employed by DMR or by an agency, organization, or individual licensed or funded by DMR. A new law directs DMR to notify these employers at least semiannually of the names, addresses, and Social Security numbers of people placed on the registry and the type of abuse or neglect.

It also allows, rather than requires, DMR to respond to initial inquiries about whether a

person has been separated or terminated from employment by using telephone voice mail or other automated response. (**PA 00-37**, *effective upon passage*)

NATUREOPATHY

A new law allows a state-approved natureopathic medicine college or program to include in its curriculum the didactic and clinical training necessary for it to qualify for Council on Naturopathic Medical Education accreditation. This can include training outside of the scope of naturopathy practice.

The act allows the program's students and licensed faculty members to do all procedures that are part of the program's curriculum if (1) they are incidental to the course of study and (2) the students are under the direct supervision of a faculty member who is licensed to perform such procedures in the state. (**PA 00-52**, *effective October 1, 2000*)

NURSES

Nurse Staffing

A new law directs DPH to undertake a number of activities concerning nursing in Connecticut. It must:

1. develop a single, uniform method for collecting and analyzing standardized data on the linkage between nurse staffing levels and the quality of

- acute, long-term, and home care, including patient outcomes;
2. conduct an ongoing study of the relationship between nurse staffing patterns in hospitals and quality of health care, including patient outcomes;
3. obtain relevant licensure and demographic data that may be available from other state agencies and make it available to the public in a standardized form; and
4. collaborate with hospitals and the nursing profession concerning the collection of standardized data on patient care outcomes at hospitals and make it available to the public in a report card format. (**PA 00-216**, *effective October 1, 2000*)

Nursing Shortage

That same new law also requires DPH to study the nursing shortage in the state. The study must address (1) the causes of the shortage and recommendations for its alleviation; (2) make recommendations for implementing methods of collecting uniform data on nurse-to-patient ratios in hospitals, nursing homes, and home health agencies, including the feasibility of getting the data from other state and federal agencies; and (3) make recommendations for

supplementing nursing care in response to the shortage, including recommendations on the feasibility of developing criteria for the certification, training, and supervision of medication technicians in long-term care facilities.

The commissioner must report his findings and recommendations to the Public Health Committee by December 31, 2000. **(PA 00-216, effective upon passage)**

APRNs

A new law permits advanced practice registered nurses (APRNs) to issue emergency certificates authorizing people with mental illness to be taken to a general hospital for examination (see section on “Social Workers” for more detail). **(PA 00-147, effective October 1, 2000)**

Under existing law, APRNs providing direct patient care services must have professional liability insurance or other indemnity against professional malpractice liability. The act exempts from this requirement any APRN maintaining current certification from the American Association of Nurse Anesthetists and providing services under a physician’s direction. **(PA 00-135, effective upon passage)**

Under that same new law, an APRN licensee must be “eligible” for a registered nurse (RN)

license instead of “maintaining” such a license. **(PA 00-135, effective upon passage)**

NURSE’S AIDES

Nurse’s Aide Training

A new law increases training for nurse’s aides from 75 to 100 hours and requires the extra 25 hours to cover specialized training in understanding and responding to challenging behaviors related to physical, psychiatric, psychological, and cognitive disorders. (These kinds of disorders can be caused by Alzheimer’s disease, senile dementia, or other diseases that disproportionately affect seniors.) But it lets trainees enrolled in a training program before October 1, 2000 complete the program as it existed when they enrolled, regardless of changes the DPH commissioner makes to implement these new requirements. **(PA 00-59, effective October 1, 2000)**

PEDIATRIC ASTHMA

A new law directs DPH, in consultation with the Department of Social Services (DSS), to establish a pilot program for early identification and treatment of pediatric asthma. The program is subject to available appropriations. DPH must make grants-in-aid for projects in two towns to identify, screen, and refer children with asthma for treatment. The

projects must work cooperatively with maternal and child health providers such as local health departments, community health centers, Healthy Start, and Healthy Families to target for early asthma identification (1) children who were born prematurely, (2) premature infants, or (3) pregnant women at risk of premature delivery.

The projects can use private resources through public-private partnerships to establish public awareness programs and outreach initiatives targeting urban areas to encourage early screening of children with asthma risks.

DPH must evaluate the pilot program and report to the Public Health, Human Services, and Appropriations committees by October 1, 2001. **(PA 00-216, effective July 1, 2000)**

PHARMACY

Temporary Permits

A new law allows the Department of Consumer Protection (DCP), when authorized by the Pharmacy Commission, to issue a temporary permit to practice pharmacy to someone who:

1. is licensed in good standing in another state or jurisdiction that grants reciprocal privileges to Connecticut pharmacists,
2. has applied to the Pharmacy Commission for a license based on the fact

he is licensed in another jurisdiction, and

3. has no actions pending against him by another jurisdiction's pharmacy board or commission.

It requires a temporary permit holder to work under the direct supervision of a licensed pharmacist. The permit expires when the pharmacist receives a Connecticut license or three months from the date the permit is issued, whichever is sooner. The permit fee is \$100. An individual may obtain only one temporary permit, but the Pharmacy Commission may, in its discretion, authorize a three-month extension. **(PA 00-182, effective October 1, 2000)**

Expiration Dates on Prescription Drugs

Existing law requires pharmacists to include on each prescription container's label a prominently printed expiration date that can be read and understood by the ordinary individual. A new law requires that the date be based on the manufacturer's recommended conditions of use and storage rather than on customary conditions of purchase, use, and storage based on the manufacturer's recommended guidelines. **(PA 00-182, effective October 1, 2000)**

Controlled Substance Practitioner Registration

By law, medical practitioners who distribute, administer, or dispense controlled substances must register with DCP. A new law requires them to register annually rather than biennially and reduces the renewal fee from \$25 to \$10. **(PA 00-182, effective October 1, 2000)**

Reimbursement Formula for Hemophilia Drugs

A new law sets the maximum that the state will pay for Factor VIII pharmaceuticals (drugs used to treat Hemophilia A) in the Medicaid, General Assistance (GA), state-administered GA (SAGA) and ConnPACE programs at the actual acquisition cost plus 8%. DSS currently pays pharmacies the estimated acquisition cost for these drugs, which is the average wholesale price minus 12% plus a dispensing fee for each prescription. This law permits the DSS commissioner to designate specific suppliers from which pharmacists must order these drugs; the supplier bills DSS directly. If the commissioner designates such suppliers, she must pay the dispensing pharmacy a handling fee equal to the 8%. **(PA 00-2, June Special Session, effective July 1, 2000)**

Generic Substitutions

Under a new law, health care professionals prescribing brand name (i.e., non-generic) drugs for Medicaid, GA, SAGA, and

ConnPACE recipients must specify to pharmacists why the brand name drug is medically necessary. The prescriber may do this in writing, by telephone, or electronically. Existing law, unchanged by this law, requires prescribers who do not want pharmacists to substitute chemically equivalent generics to hand-write on Medicaid recipients' prescriptions "Brand Medically Necessary." If they phone in the prescription, they must send the pharmacist a handwritten certification within 10 days. The act extends these requirements to prescriptions for SAGA, GA and ConnPACE recipients.

The act makes a similar change to the law permitting pharmacists to dispense generic drugs. They must currently substitute generics for medical assistance participants unless the prescription contains the handwritten phrase "No Substitution" or for Medicaid recipients, "Brand Medically Necessary."

The act also requires DSS to establish a procedure requiring pharmacists to get prior approval to initially dispense a brand name drug when there is a chemically equivalent generic substitute.

It requires DSS to hire an independent pharmacy consultant under an "administrative services only" contract to act on its behalf to make approval decisions. It specifies that the prior approval

procedure can only be required for initial prescriptions, and it deems requests for approval granted if the consultant does not either grant or deny them within two hours. It permits pharmacists denied reimbursement for failing to substitute a generic to appeal to DSS.

The act requires prescribers to disclose to DSS or its pharmacy consultant, on request, the reason why a brand name drug product and dosage form is medically necessary compared to a chemically equivalent generic product. It requires DSS to establish a procedure for practitioners to appeal its determination that generic substitution is required for a Medicaid, GA, SAGA, or ConnPACE prescription. **(PA 00-2, June Special Session, effective July 1, 2000)**

Prior Authorization for Prescription Drugs

A new law permits DSS to establish a prior authorization plan for some prescription drugs covered under the Medicaid, GA, SAGA, and ConnPACE programs. It applies to (1) initial prescriptions for drugs costing \$500 or more for a 30-day supply and (2) any early refill request. It requires DSS to develop a procedure by which prior authorizations are obtained from an independent pharmacy consultant acting on behalf of DSS under an administrative

services only contract. It deems an authorization granted if a request is not denied within two hours of after DSS receives it.

DSS must also establish a plan to increase cost effectiveness or enhance access to a particular prescription drug. The plan may designate suppliers from which pharmacies must order certain drugs and require the suppliers to deliver the drug to the pharmacy and submit their bills to DSS. DSS must pay the dispensing pharmacy a handling fee for each prescription it fills. The fee cannot exceed 400% of the dispensing fee DSS pays pharmacists under the Medicaid program (This fee was \$4.10, but the act reduces it to \$3.60 on July 1, 2000.) The act also permits DSS to review utilization patterns and establish a schedule of maximum quantities of "oral dosage units" (medication taken by mouth) to be dispensed at one time to Medicaid, SAGA, and GA program participants. **(PA 00-2, June Special Session, effective July 1, 2000)**

Return of Prescriptions By Nursing Homes

A new law requires long-term care facilities to return to the pharmacy, for repackaging and reimbursement to DSS, drugs that were dispensed to a patient but not used if they are:

1. prescription drugs but not controlled substances,

2. sealed in individually packaged units,
3. returned to the vendor pharmacy for redispensing during the product's recommended shelf life, and determined to be of acceptable integrity by a licensed pharmacist,
4. in single-dose sealed containers approved by the federal Food and Drug Administration (FDA) if they are oral or parenteral products,
5. in FDA-approved units-of-use containers if they are topical or inhalant drug products, or
6. in multiple-dose sealed FDA-approved containers from which no doses have been withdrawn if parenteral medications.

The act prohibits returning drugs dispensed in a bulk dispensing container.

If the drugs are packaged in the manufacturer's unit-dose packages, they must be returned for redispensing and reimbursement to DSS if they can be redispensed for use before the expiration date, if any, stated on the package. If they are repackaged in the manufacturer's unit-dose or multiple-dose blister packs, they must be returned if (1) the package clearly indicates (a) the date of repackaging, (b) the drug's lot number, and (c) the product's expiration date; (2) 90 or fewer days have elapsed since the drug was repackaged; and (3)

the pharmacy keeps a repackaging log in the case of drugs that are repackaged before needed.

The act requires long-term care facilities to establish procedures for returning drugs to the pharmacy from which they were purchased. It requires the Department of Consumer Protection commissioner, in consultation with DSS, to adopt implementing regulations concerned with the repackaging and labeling of returned drugs. It allows him to implement the program through January 1, 2002, while in the process of adopting the regulations, provided he publishes notice in the *Connecticut Law Journal* within 20 days of implementation.

The act (1) requires DSS to reimburse the pharmacy for the reasonable cost of services incurred in operating such a program, as the commissioner determines and (2) allows it to establish procedures for reimbursing non-Medicaid payors for returned products, if feasible. **(PA 00-2, June Special Session, effective July 1, 2000)**

Pharmacy Review Board Panel

A new law adds two representatives of pharmacies serving long-term care facilities to the DSS pharmacy review panel. This panel advises DSS in the operation of its pharmacy benefits programs. **(PA 00-2,**

June Special Session, *effective July 1, 2000*)

PHYSICAL THERAPIST ASSISTANTS

A new law requires DPH to license physical therapy assistants (PTAs). Previously, PTAs had to register with the department. This law establishes educational requirements for licensure, allows certain people to be licensed without examination, and permits others to practice without a license. A PTA must pay \$150 to take the licensing exam or to obtain a license without an exam and must pay a \$30 annual professional services fee. PTAs must work on referral from a physician, physician assistant, podiatrist, natureopath, chiropractor, dentist, or APRN licensed in Connecticut or bordering state whose licensing requirements meet Connecticut standards. **(PA 00-226, effective October 1, 2000 or when the DPH commissioner publishes notice in the Connecticut Law Journal that he is implementing the law's licensing provisions, whichever is later)**

PHYSICIANS

Existing law requires managed care organizations to obtain information from active Connecticut physicians who practice in the relevant specialty area before implementing new medical protocols or

substantially altering existing ones. This law was amended to specify that "medical protocol" includes drug formularies or lists of covered drugs. **(PA 00-216, effective July 1, 2000)**

Beginning January 1, 2001, a new law requires certain individual and group health insurance policies that are delivered, issued for delivery, renewed, amended, or continued in Connecticut to provide access to pain management specialists and coverage for pain management treatment ordered by such specialists. Coverage includes the use of whatever means a specialist finds necessary to (1) make a diagnosis and (2) develop a treatment plan, including the use of medications and procedures. It defines "pain" to mean a localized sensation of severe discomfort, distress, or suffering, and it defines "pain management specialist" as a physician credentialed by the American Academy of Pain Management or a board-certified anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in pain management.

The requirement applies to hospital and medical service plans offered by HMOs and health insurance policies that offer the following types of coverage: (1) basic hospital expense, (2) basic medical-surgical expense, (3) major medical expense, (4) limited benefit expense, and (5) hospital

or medical expense. (**PA 00-216**, effective January 1, 2000)

PHYSICIANS ASSISTANTS

Prescriptive Authority

A new law expands the prescriptive authority of physicians assistants (PAs).

Currently, PAs can prescribe Schedule II through V controlled substances, but prescribing Schedules II and III is limited to short-term hospital settings. This law expands PAs' prescriptive authority by allowing them to (1) prescribe Schedule IV and V controlled substances in all settings; (2) renew prescriptions for Schedule II and III controlled substances in outpatient settings; and (3) prescribe Schedule II and III to an inpatient in a short-term hospital, chronic disease hospital, emergency room satellite of a general hospital, or in a chronic and convalescent nursing home after a physician's admission evaluation.

As under current law, the PA's supervising physician must cosign the prescription order for a Schedule II or III controlled substance within 24 hours. (**PA 00-205**, effective October 1, 2000)

Medical Hearing Panels

Under prior law, the public health commissioner had to establish a list of 16 individuals who could serve as members of medical hearing panels in

conjunction with the state Medical Examining Board. The legislature increased the number to 18 by (1) requiring that one of the panel members be a licensed PA and (2) increasing public members from eight to nine. The remaining eight members must be licensed physicians in the state, with at least one being a graduate of an American Osteopathic Association accredited medical education program. (**PA 00-205**, effective October 1, 2000)

PHYSICAL RESTRAINTS

Existing law prohibits anyone who cares for or supervises people in state-operated or -licensed institutions from using involuntary physical restraint on a person, except in an emergency or as necessary to transport someone under the jurisdiction of the Department of Mental Health and Addiction Services' (DMHAS) Whiting Forensic Division.

A new law expands the permitted use of mechanical restraints when transporting people to include those in the criminal justice system who are committed to or receiving services from DMHAS. It applies to people:

1. committed to DMHAS who face a criminal charge and have not posted bail or bond,
2. whose competency to stand trial must be examined,
3. ordered to undergo a presentence psychiatric

exam after conviction for serious felonies and violent sex offenses,

4. who are inmates in a Department of Correction facility and need confinement in a psychiatric hospital, and
5. who were found not guilty by reason of insanity and are under the jurisdiction of the Psychiatric Review Board.

Each use of restraints must be documented in the person's medical record. The documentation must (1) state the reason the restraint was used, including the person's clinical condition, the risk of his fleeing, and the danger he posed to the public and (2) describe the nature of the restraint and how long it lasted. (**PA 00-55**, effective October 1, 2000)

PROFESSIONAL COUNSELORS

Privileged Communications

A new law, with several specified exceptions, makes confidential and not subject to disclosure, communications between a patient and his licensed professional counselor or between the patient's family and the counselor. The patient or his authorized representative may, however, give the counselor written consent to disclose the information. This consent may be withdrawn at any time, but withdrawal has no effect on information already disclosed.

It defines "authorized representative" as (1) a person the patient authorizes to assert the information's confidentiality, (2) a deceased patient's personal representative or next of kin, (3) an incompetent patient's court-appointed guardian or conservator, or (4) the incompetent patient's nearest relative who may act until a guardian or conservator is appointed.

Professional counselors do not need consent to disclose a patient's diagnosis and treatment:

1. in court-ordered mental health assessment cases if the patient knew that his communications would not be confidential and if the disclosure is limited to issues about his mental health;
2. in civil proceedings where the patient or, in the event of his death, someone representing him or his beneficiary introduces the patient's mental health into evidence and the judge finds that the interest in disclosure outweighs the privilege;
3. when statutorily mandated to do so;
4. if they believe in good faith that failure to disclose would present a clear and present danger to someone's health or safety;
5. if they believe in good faith that a patient poses a risk

- of imminent personal injury to himself or to others or their property;
6. if they know, or in good faith suspect, that a child, elderly adult, or disabled or incompetent person is being abused; or
 7. when making a claim to collect fees for services rendered.

When trying to collect fees, counselors may disclose to a collection agency the patient's name and address and the amount he owes. The counselor must give the patient at least 30 days advance written notice of the disclosure. If a dispute arises or additional information is needed to substantiate the claim, the counselor may disclose (1) that the patient was receiving professional counseling, and (2) the dates and types of service. **(PA 00-190, effective October 1, 2000)**

Reimbursement for Mental Health Services

By law, certain health care providers must be reimbursed under individual and group health insurance policies for mental or nervous condition diagnosis and treatment services. Providers include (1) licensed physicians or psychologists; (2) licensed clinical social workers who pass the clinical exam and complete at least 2,000 hours of post-master's social work in a tax-exempt nonprofit, municipal, state or federal agency, or a DPH-

licensed institution; (3) social workers certified as independent before October 1, 1990; (4) licensed marital and family therapists who complete at least 2,000 hours of post-master's work experience in a tax-exempt nonprofit, municipal, state, or federal agency or a DPH-licensed institution; (5) marital and family therapists certified before October 1, 1992; and (6) licensed or certified alcohol and drug counselors.

A new law adds licensed professional counselors to the list of providers who must be reimbursed for such services. Licensed professional counselors can receive reimbursement when they provide services in a residential treatment facility or provide outpatient services in a (1) nonprofit community mental health center, (2) licensed nonprofit adult psychiatric clinic operated by an accredited hospital, or (3) residential treatment facility. By law, services must be within the scope of the license issued to the center, clinic, or facility. **(PA 00-135, effective upon passage)**

Licensure Requirements

An amendment to the law on licensure of professional counselors allows an applicant for a license to meet alternative requirements. Instead of completing graduate semester hours at a regionally accredited higher education institution or receiving a degree from a

regionally accredited institution, or both, the act allows a person to apply for licensure if he (1) earned a master's degree in sociology before 1971; (2) passed the National Counselor Examination before July 1, 1999; and (3) continuously worked as a supervisor of the practitioners listed above for a minimum of 15 years immediately before applying. This alternative is available for 30 days after the act takes effect. **(PA 00-1, June Special Session, effective upon passage)**

PROVIDER PARTICIPATION IN AGENCY ACTIVITIES

Legislation allows DPH, DMR, the Department of Mental Health and Addiction Services (DMHAS), and the Office of Health Care Access to invite any provider to participate in any informal policy-making committee, task force, work group, or other ad hoc committee it establishes. Such participation is not deemed lobbying under the act. A "provider" is any independent contractor or private agency under contract with a department to provide services. **(PA 00-135, effective upon passage)**

PSYCHOLOGISTS

An amendment to the law on licensure of psychologists requires the Board of Examiners of Psychologists to approve the educational program of a license

applicant who (1) graduated from an institution in another state whose graduates can take the state psychology licensing exam in that state (2) passed the national psychology exam before January 1, 1996, (3) has been licensed to practice in that state for at least 5 years, (4) is a currently a practicing doctoral-level psychologist licensed in that state and has practiced there for at least 5 years, and (5) has had no disciplinary action anywhere. This provision expires 30 days from the act's passage. **(PA 00-216, effective upon passage)**

SOCIAL WORKERS

A new law permits certain licensed clinical social workers (LCSWs) and advanced practice registered nurses (APRNs) to issue emergency certificates authorizing people with mental illness to be taken to a general hospital for examination. To do this, they must reasonably believe, based on direct evaluation, that the person (1) has a psychiatric disability, (2) is dangerous to himself or others or gravely disabled, and (3) needs immediate care and treatment. The person must be examined within 24 hours and released within 72 hours unless he is committed to a psychiatric facility. Existing law permits police officers and psychologists to issue emergency certificates authorizing such exams under these conditions.

The act applies to LCSWs and APRNs who, as members of mobile crisis teams, jail diversion programs, or assertive case management programs operated by, or under contract with, DMHAS, have received at least eight hours of specialized training in conducting the kind of direct evaluations the act prescribes.

It requires the DHMAS commissioner to collect statistical and demographic data on emergency certificates issued by LCSWs and APRNs. (**PA 00-147**, *effective October 1, 2000*)