Government Relations

END OF SESSION REPORT

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CNA
2014 GOVERNMENT RELATIONS
END OF SESSION REPORT

The 2014 Legislative Session convened on February 5th and adjourned at midnight on May 7th. At the beginning of session, Governor Malloy delivered his State of the State address along with his proposed state budget adjustments. Highlights from his address included some minor tax relief; adding to the state's rainy day fund as well as long term debt reduction and education spending on both K-12 and higher education. The Governor's call for reform in these areas were just some of the issues that the legislature had to address during this "short" three month session.

The General Assembly considered over 1,000 bills during this brief and challenging session. Bills that affected the nursing industry were considered in the Public Health, Education, Environment, Children's and Insurance and Real Estate Committees. Several bills were passed by the legislature that affect the nursing industry. Some of those bills include: allowing APRNs to practice independently, changes in the definition and requirements of medical spas and aligning the vision, hearing and postural screening requirements in schools with those of the American Academy of Pediatrics (AAP). Several other less significant bills with some interest to CNA were also passed during this legislative session.

Listed below is a summary of the bills referenced above that were passed during the 2014 session. If you would like additional information on any of the summaries that follow, or more information on bills that may not have been included, please do not hesitate to contact us.

As always, we appreciate the relationship between Brown Rudnick and CNA and we look forward to continuing to advocate on your behalf.

Bills of Importance to CNA which passed the General Assembly:

SB 36 (as amended by Senate "A")* ***AN ACT CONCERNING THE GOVERNOR'S RECOMMENDATIONS TO IMPROVE ACCESS TO HEALTH CARE—Public Act 14-12, Signed by Governor***

SUMMARY: This bill allows advanced practice registered nurses (APRNs) who have been licensed and practicing in collaboration with a physician for at least three years to practice independently. Current law requires APRNs to work in collaboration with a physician, including having a written agreement regarding the APRN's prescriptive authority.

The bill generally requires APRNs, when applying for their annual license renewal, to attest in writing that they have earned at least 50 contact hours of continuing education (CE) in the previous 24 months. The requirement applies to registration periods beginning on and after October 1, 2014. Among other things, the bill (1) specifies qualifying CE activities and (2) exempts from the CE requirement APRNs applying for their first license renewal or who are not actively practicing.

Starting in 2015, the bill requires manufacturers of covered drugs, devices, biologicals, and medical supplies to report to the Department of Public Health (DPH) information concerning payments or other transfers of value they make to APRNs. Manufacturers who fail to comply are subject to civil penalties.

The bill also makes technical and conforming changes.

***Senate Amendment "A"** (1) specifies that an APRN must have practiced in collaboration with a physician for three years, not just been licensed for three years, in order to practice independently; (2) adds the continuing education provisions; and (3) adds the manufacturers' disclosure provisions.

EFFECTIVE DATE: July 1, 2014 for the provisions on APRNs' collaboration and independent practice, upon passage for the continuing education provisions, and October 1, 2014 for the manufacturers' disclosure provisions.

APRN COLLABORATION WITH PHYSICIANS AND INDEPENDENT PRACTICE

Under the bill, the current requirement for an APRN to work in collaboration with a physician continues to apply for the first three years after the APRN becomes licensed in the state. After that, collaboration is optional and the APRN can practice independently, as long as he or she has actively practiced as an APRN in collaboration with a physician for at least three years. The bill also specifically permits APRNs, after that three-year period, to collaborate with other licensed health care providers.

By law, collaboration is defined as a mutually agreed upon relationship between an APRN and a physician whose education, training, or relevant experience is related to the APRN's work. The collaboration must address (1) a reasonable and appropriate level of consultation and referral, (2) patient coverage in the APRN's absence, (3) methods to review patient outcomes and disclose the

relationship to the patient, and (4) what schedule II and III controlled substances the APRN can prescribe. (APRNs can also prescribe schedule IV and V controlled substances.)

By law, unchanged by the bill, nurse anesthetists (one category of APRNs) must work under a physician's direction.

CONTINUING EDUCATION FOR APRNS

Qualifying Activities

Under the bill, an APRN's CE must be in his or her practice area and reflect his or her professional needs in order to meet the public's health care needs. It must include at least five contact hours of training or education in pharmacotherapeutics. (A contact hour is at least 50 minutes of continuing education and activities.)

The CE can include courses, including online courses, offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association, Connecticut League for Nursing, a specialty nursing society, or an equivalent organization in another jurisdiction. The CE can also include (1) educational offerings sponsored by a hospital or other health care institution or (2) courses offered by a regionally accredited academic institution or a state or local health department.

The bill allows the DPH commissioner to waive up to 10 contact hours of CE for an APRN who (1) engages in activities related to his or her service as a member of the state Board of Examiners for Nursing or (2) helps DPH with its duties to its professional boards and commissions.

Recordkeeping

The bill requires APRNs to attest on a DPH form their compliance with these CE requirements, when applying to renew their licenses. They also must (1) keep records of attendance or completion for at least three years after the year they complete the CE activities and (2) submit these records to DPH within 45 days of its asking for them.

Exemptions

The bill exempts from its CE requirements first-time license renewal applicants and those not engaged in active professional practice. An APRN who is not practicing must submit a notarized exemption application, plus any other documentation DPH requires, before the license expires. The exemption application, which must be on a DPH form, must state that the individual may not practice until he or she has met the bill's CE requirements. The bill specifies that an APRN who is exempt for less than two years must complete 25 contact hours of CE within the 12 months immediately before returning to practice.

Waiver or Extension for Medical Reasons

The bill allows the DPH commissioner or her designee to grant a CE waiver or an extension of time for an ARPN who has a medical disability or illness. A licensee seeking a waiver or extension must submit to DPH (1) an application, on a form the commissioner prescribes; (2) a

certification of the disability or illness, by a licensed physician, APRN, or physician assistant; and (3) any other documentation the commissioner may require.

The bill allows the commissioner or designee to grant a waiver or extension for up to a single one-year registration period, but they can grant additional waivers or extensions if the disability or illness continues beyond the waiver period and the licensee reapplies to DPH.

License Reinstatement

The bill requires an APRN whose license became void due to failure to timely renew it and who is seeking reinstatement to submit evidence documenting successful completion of 25 hours of CE within the year immediately preceding his or her application for reinstatement.

MANUFACTURERS' DISCLOSURE REQUIREMENTS

The bill requires manufacturers of covered drugs, devices, biologicals, and medical supplies to report on payments or other transfers of value they make to APRNs practicing in Connecticut. They must report the information to DPH quarterly in the form and manner the commissioner prescribes, with the first report due by January 1, 2015. The bill allows the commissioner to publish the information on the department's website.

The bill applies to manufacturers of drugs, devices, biologicals, or medical supplies that are covered by (1) Medicare or (2) the state Medicaid or Children's Health Insurance Program plan, including a plan waiver. It applies to such manufacturers operating in the U.S. (including a territory, possession, or commonwealth) who make such transfers. The bill does not apply to transfers made indirectly to an APRN through a third party, in connection with an activity or service in which the manufacturer is unaware of the APRN's identity.

Required Reporting

The bill requires these manufacturers to report the same information required by federal law to be reported for payments or transfers of value to physicians or teaching hospitals. (The federal law is known as the Physician Payments Sunshine Act.)

This information includes:

1. the recipient's name and business address;

2. the amount and date of the payment or other transfer of value;

3. the form of the payment or transfer (e.g., cash, in-kind items);

4. the nature of the payment or transfer (e.g., consulting fees, gifts, entertainment, food);

5. if the payment or other transfer is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered product; and

6. any other information determined appropriate by the federal Health and Human Services secretary.

Civil Penalty for Noncompliance

Under the bill, a manufacturer required to report that fails to do so is subject to a civil penalty. The penalty is $1,000 to $4,000 for each payment or transfer not reported

SB 418, *AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS CONCERNING MEDICAL SPAS—Public Act 14-119, Signed by Governor*

SUMMARY: This bill sets certain requirements and limitations for medical spas (i.e., establishments where cosmetic medical procedures are performed). Among other things, it:

1. requires medical spas to employ or contract for the services of a physician, physician assistant (PA), or advanced practice registered nurse (APRN) with specified training and experience;

2. requires such a provider to perform an initial physical assessment of a person before he or she can undergo a cosmetic medical procedure at the medical spa;

3. allows only such providers, or registered nurses (RNs), to perform cosmetic medical procedures at medical spas; and

4. requires medical spas to provide information, in various formats, regarding their providers' names and specialties.

The bill requires cosmetic medical procedures at medical spas to be performed in accordance with the statutes pertaining to public health (Title 19a) and professional and occupational licensing (Title 20). Among other things, these statutes prohibit anyone from performing procedures outside his or her scope of practice.

The bill applies to all facilities where cosmetic medical procedures are performed, including unlicensed facilities and hospitals or other licensed health care facilities.

EFFECTIVE DATE: October 1, 2014

COSMETIC MEDICAL PROCEDURE AT MEDICAL SPAS

Definition

Under the bill, a “cosmetic medical procedure” is a procedure directed at improving the person's appearance and that does not meaningfully promote proper body function or prevent or treat illness or disease. These procedures may include cosmetic surgery, hair transplants, cosmetic injections or soft tissue fillers, dermaplaning, dermastamping, dermarolling, dermabrasion that removes cells beyond the stratum corneum, chemical peels using modification solutions exceeding 30% concentration with a pH value lower than 3.0, laser hair removal, laser skin resurfacing, laser treatment of leg veins, sclerotherapy and other laser procedures, intense pulsed light, injection of cosmetic filling agents and neurotoxins (e.g., Botox), and the use of class II medical devices designed to induce deep skin tissue alteration. (The U.S. Food and Drug

Administration classifies medical devices into three classes, with regulatory control increasing from class I to class III.)

Qualifications of Physicians, PAs, or APRNs

Under the bill, a physician, PA, or APRN employed by or under contract with a medical spa must:

1. be licensed in Connecticut,

2. be actively practicing in the state,

3. have education or training from a higher education institution or professional organization in performing cosmetic medical procedures, and

4. have experience performing these procedures.

(The bill does not set specific standards for RNs performing procedures at medical spas.)

Provider Information

The bill requires medical spas to post notice in a conspicuous place accessible to customers of the names and any specialty of the physicians, PAs, APRNs, or RNs performing cosmetic medical procedures at the spa. This same information must be (1) posted on the spa's website and (2) provided in a written notice to people undergoing procedures at the facility, before the procedure. Any spa advertisements must also contain this information or indicate that it is available on the facility's website and list that address.

HB 5566, ***AN ACT CONCERNING MINOR REVISIONS TO THE EDUCATION STATUTES—Public Act 14-230***

SUMMARY: This bill makes numerous changes to the education statutes including:

1. changing the title of “special master” for a district under state supervision and control to “district improvement specialist”;

2. changing the number and schedule of required vision, hearing, and postural screenings for public school students;

3. indemnifying teacher mentors and reviewers against lawsuits;

4. changing the terms for appointments to an administrator professional standards council;

5. changing standards for allowable nutritional drinks in schools;

6. specifying that agricultural science (vo-ag) center equipment and facilities purchased with state grants must be used exclusively by the vo-ag centers; and

7. requiring parents to notify a student's home district when the student is accepted to or placed on the waiting list for an interdistrict magnet school.

EFFECTIVE DATE: July 1, 2014, except for the provisions regarding indemnity, appointments to the administrator standards council, and due date for the racial minority enrollment report, which are effective on passage.

§§ 1-3 — SPECIAL MASTER TITLE CHANGED TO DISTRICT IMPROVEMENT SPECIALIST

The bill changes the title of a person assigned by the State Board of Education (SBE) to administer education operations in a low-performing district and work collaboratively with the district's board from "special master" to "district improvement specialist" (see BACKGROUND). New London is currently the only district that has such a person assigned. In addition, under the commissioner's network of schools law, in certain situations the education commissioner may appoint a special master to implement a school turnaround plan. The bill changes this person to a school improvement specialist, which presumably is someone different than a district improvement specialist.

§ 4 — VISION, HEARING AND POSTURAL SCREENINGS

The bill reduces the number of mandatory annual vision, hearing, and postural screenings for public school students and eliminates the requirement for annual postural screenings. Table 1 lists the changes by type of screening and grade. By law, the school superintendent must contact the parents of any student found to have any impairment, disease, or defect of vision or hearing or evidences a postural problem.

Table 1: Vision, Hearing, and Postural Screenings

Screening	***Current Grades***	***Grades under the Bill***
Vision	K, 1-6 inclusive, & grade 9	K, 1, & 3-5 inclusive
Hearing	K-3 inclusive, 5 & 8	K, 1, & 3-5 inclusive
Postural	5 – 9	Female students: 5 and 7, Male students: 8 or 9

§ 5 — INDEMNITY FOR TEACHER MENTORS OR REVIEWERS

The bill extends the legal indemnity currently given to teachers, administrators, school board members, and others to teacher mentors and teacher reviewers. This means these employees are held harmless by their employer for acts or omissions that cause death or injury to another person or property if the employee's acts where (1) not wanton, reckless, or malicious and (2) within the

scope of his or her employment. Employers covered are local or regional boards of education, the governing council of a charter school, SBE, the Board of Regents for Higher Education or the board of trustees of each state institution of higher education, and each state agency that employs teachers.

§ 6 — APPOINTMENTS TO THE ADVISORY COUNCIL FOR SCHOOL ADMINISTRATOR PROFESSIONAL STANDARDS

The bill extends, from two to four years, the terms of all appointments to the Advisory Council for School Administrators that take place on or after the bill's passage.

§ 7 — NATIONAL EXAM AS PART OF SUBSTITUTE FOR STANDARD GRADUATION REQUIREMENTS

Current law requires the State Department of Education (SDE) to establish a program that allows boards of education to permit 11th and 12th grade students to substitute certain evidence of academic achievement for existing high school graduation requirements in order to receive a high school diploma. One of three required pieces is a passing score on a national examination that SDE determines. The bill changes this to a nationally recognized exam that SBE approves.

§ 8 — NUTRITIONAL DRINK STANDARDS IN SCHOOLS

The bill changes the standards for allowable nutritional drinks in schools. Table 2 shows the changes.

Table 2: Allowable Nutritional Drinks in Schools

Beverage	*Current Law*	*Bill*
Milk	May be flavored but cannot contain artificial sweeteners or more than four grams of sugar per ounce	Only low-fat or skimmed milk; bans nonnutritive sweetening agents, sugar alcohols, or added sodium; keeps the existing artificial sweetener ban and sugar limit
Nondairy Milks (such as soy or rice milk)	May be flavored but cannot (1) contain artificial sweeteners or more than four grams of sugar per ounce or (2) have a high amount of calories from fat.	Bans nonnutritive sweetening, sugar alcohols, or added sodium; keeps the artificial sweeteners ban, sugar limit, and low amount of calories from fat.
Fruit or vegetable juice (100%)	Bans added sugars, sweeteners, and artificial sweeteners	Bans added sodium
Water, fruit, or vegetable juice combinations	Bans added sugars, sweeteners, and artificial sweeteners	Bans added sodium; must meet the nutrition requirements of the Healthy, Hunger Free Kids Act of 2010 (P.L. 111-296); keeps

		the artificial sweeteners, sweeteners, and sugar ban.
Water only	Bans sugars, sweeteners, artificial sweeteners, and caffeine	Bans added sodium; keeps the sugar, sweetener, artificial sweetener, and caffeine bans.

The bill also limits the portion size for drinks other than water to no more than eight ounces for K-5 grade students. Current law permits up to 12 ounces a serving for K-5 students. The bill keeps the sixth grade through high school limit at 12 ounces.

§ 9 — USE OF AGRICULTURAL SCIENCE CENTER EQUIPMENT

Under the bill, any facility, facility renovation, or equipment at a regional vo-ag center that receives a state grant must be used exclusively by the vo-ag center. Vo-ag centers are hosted by local school districts but serve a region of many districts.

§ 10 — MAGNET SCHOOL ENROLLMENT NOTIFICATION

The bill requires the parents or guardian of a student who enrolls in a magnet school for the coming year or of a student on a waiting list for a magnet school to notify the student's home school district of the upcoming enrollment or status on a waiting list. This must be done within two weeks after the enrollment lottery for the magnet school (which are usually held in March or April). Enrollment lotteries are held when a magnet school has more students interested in attending than it has available seats.

By law and unchanged by the bill, a magnet school operator must, by May 15 annually, notify a student's home district that the student is enrolled in the magnet school for the coming school year and what the tuition will be. All magnet schools, except Sheff host magnets, are allowed to charge the tuition to a student's home (i.e., sending) district.

§ 11 — DUE DATE FOR RACIAL MINORITY ENROLLMENT REQUIREMENT REPORT

The bill extends, from January 1, 2013 to January 1, 2015, the deadline for SDE to submit a report to the Education Committee recommending legislation to amend the racial minority enrollment requirements for magnet schools to conform with changes in federal law. The recommendations must reflect the regional demographics of the magnet school programs and the diverse populations attending the magnet schools.

HB 5521 (as amended by House "A")* ***AN ACT CONCERNING THE STORAGE AND ADMINISTRATION OF EPINEPHRINE AT PUBLIC SCHOOLS—Public Act 14-176***

SUMMARY: This bill requires schools to designate and train nonmedical staff to administer emergency epinephrine in cartridge injectors ("epipens") to students having allergic reactions who were not previously known to have serious allergies. It authorizes the emergency use of

epipens by nonmedical staff only if (1) the school nurse is not present or available and (2) certain conditions are met.

The bill permits the following individuals (i.e., "qualified school employees") to be trained and authorized: principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by a school district, coach of school intramural or interscholastic athletics, and school paraprofessional. By law, (1) all of these individuals can, under specific circumstances, administer glucagon via injection to a student with diabetes and (2) a specifically designated paraprofessional can administer an epipen to a student with a known allergy.

The bill requires the school nurse or school principal to select qualified school employees to be trained and administer epipens under the bill's provisions. The professionals must meet training and other requirements before being allowed to administer epipens. Schools must (1) have at least one qualified professional on the school grounds during regular school hours and (2) maintain a store of epipens for emergency use.

The bill also:

1. extends the existing immunity from liability for employees and local boards provided under the existing glycogen and epipen law to the epinephrine provisions:

2. requires the departments of Education (SDE) and Public Health (DPH) to jointly develop an annual training program for emergency epipen administration, and

3. requires SDE to adopt the necessary regulations to carry out the bill's provisions.

***House Amendment "A":**

1. requires SDE and DPH to jointly develop an annual training with specific elements for nonmedical staff to administer epipens in emergencies to students who were not previously known to have severe allergies,

2. removes the provisions that (a) broaden the types of drugs a school-based health center nurse can administer and (b) permits only Connecticut licensed physicians or dentists to authorize the existing asthma and epipen provisions,

3. deletes dentists from the list of personnel authorized to administer emergency epipens, and

4. makes conforming and technical changes.

EFFECTIVE DATE: July 1, 2014

STUDENTS WITH ALLERGIES

Administering Emergency Epinephrine

The bill requires a school nurse or principal to select qualified school professionals to, under certain conditions, give an emergency epipen injection to a student having an allergic reaction without a prior written authorization from a parent or guardian or a written order from a qualified

medical professional for the administration of epinephrine. It defines "qualified medical professional" as a Connecticut-licensed physician, optometrist, advanced practice registered nurse, physician assistant, or podiatrist.

Current law only allows (1) nonmedical staff to give emergency glucagon injections to diabetic students requiring prompt treatment to avoid serious harm or death and (2) a specifically designated paraprofessional to administer an epipen to a student with a known allergy. In both scenarios, nonmedical staff can administer injections if there is written authorization from the student's parents and a written order from a physician.

The bill applies the same conditions and training requirements to employees administering epinephrine as currently exist for glucagon, except the new provisions do not require that the employee volunteer to become an epipen administrator.

Nonmedical staff can administer the injections only if the:

1. school nurse is absent or unavailable;

2. employee has completed any annual training in how to administer epinephrine that the school nurse and school medical advisor require; and

3. nurse and medical advisor attest, in writing, that the employee has completed the training.

The school nurse must provide general supervision to the qualified employee.

Maintaining Store of Emergency Epinephrine

The bill requires the school nurse or, in the nurse's absence a qualified school employee, to maintain a store of epinephrine cartridge injectors for emergency use. The bill defines cartridge injector as an automatic prefilled cartridge injector or similar automatic injectable equipment used to deliver epinephrine in a standard dose for emergency first aid response to allergic reactions.

REQUIREMENTS ON LOCAL AND REGIONAL BOARDS OF EDUCATION

As with glucagon, the bill requires local and regional boards of education to adopt policies and procedures allowing emergency administration of epinephrine. The policies and procedures must (1) conform with the bill's provisions and with State Board of Education (SBE) regulations and (2) be approved by the local board's medical advisor, or it there is none, a qualified licensed physician.

Each school that administers medication under the bill must record the administration as required by state law and store the medication as prescribed by Department of Consumer Protection regulations.

SBE REGULATIONS

The bill requires SBE, in consultation with DPH, to adopt regulations that specify the conditions and procedures for the storage and administration of epinephrine for emergency first aid for

students having allergic reactions who do not have a prior written parental authorization or a prior written order of a qualified medical professional for epinephrine administration.

IMMUNITY FROM LIABILITY

The bill extends the existing immunity from liability for employees and local boards provided under the glycogen law to the epinephrine provisions.

It bars anyone from making a claim against a town, board of education, or school employee for damages resulting from administration of medication under the bill. The immunity covers the qualified school personnel. It does not apply to acts or omissions that constitute gross, wilful, or wanton negligence.

The bill also extends immunity to those acting under an existing statute that allows specified school employees, other than the school nurse, to administer medicinal preparations, including controlled drugs the consumer protection commissioner designates, to a student pursuant to a written medical order. The specified employees are a principal, teacher, licensed nurse, licensed athletic trainer, licensed physical or occupational therapist employed by the school board, or coach

REQUIRED TRAINING

By December 31, 2014, the bill requires SDE and DPH to jointly develop, in consultation with the School Nurse Advisory Council, an annual training program for emergency first aid to students who experience allergic reactions.

The program must include instruction in:

1. cardiopulmonary resuscitation (CPR),

2. first aid,

3. food allergies,

4. signs and symptoms of anaphylaxis,

5. prevention and risk-reduction strategies regarding allergic reactions,

6. emergency management and administration of epinephrine,

7. follow-up and reporting procedures after a student has experienced an allergic reaction,

8. carrying out the bill's provisions, and

9. any other relevant issues related to emergency first aid for students with allergic reactions.

SDE must make the training program available to local and regional boards of education.

HB 5537, AN *ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES—Public Act 14-231*

SUMMARY: This bill makes numerous substantive, minor, and technical changes to Department of Public Health (DPH)-related statutes and programs.

Please review the attached summary of HB 5537, LCO 5588. In particular, see sections 4 (School Nurse Access to Immunization Registry), 52 (APRN Independent Practice Requirements), 53 (APRN Continuing Education Requirements), 69 (Naturopathy) and 70 (Physician Assistants). If you would like more information on this bill, please let me know.

HB 5597, *AN ACT IMPLEMENTING PROVISIONS OF THE STATE BUDGET FOR THE FISCAL YEAR ENDING JUNE 30, 2015—Public Act 14-217*

Please see sections of interest to CNA below:

§ 75 — MANUFACTURERS' DISCLOSURE REQUIREMENTS FOR PAYMENTS TO APRNS

PA 14-12 requires manufacturers of covered drugs, devices, biologicals, and medical supplies to report on payments or other transfers of value they make to advanced practice registered nurses (APRNs) practicing in Connecticut. The bill requires manufacturers to report the information to DCP, not DPH, quarterly in the form and manner the commissioner prescribes. The bill makes the first report due by July 1, 2015, instead of January 1, 2015. It also allows the DCP commissioner, instead of the DPH commissioner, to publish the information on his department's website.

Unchanged by the bill, the law applies to manufacturers of drugs, devices, biologicals, or medical supplies that are covered by (1) Medicare or (2) the state Medicaid or Children's Health Insurance Program plan, including a plan waiver. The law does not apply to transfers made indirectly to an APRN through a third party, in connection with an activity or service in which the manufacturer is unaware of the APRN's identity.

EFFECTIVE DATE: October 1, 2014

§ 131 — DISPOSAL OF UNWANTED MEDICATION

The bill requires the Consumer Protection Department (DCP), in consultation with the Connecticut Pharmacists Association and Connecticut Police Chiefs Association, to develop and implement a program to collect and dispose of unwanted pharmaceuticals (medication). The program must provide for (1) a secure locked box accessible to the public 24 hours a day to drop off unwanted medication anonymously at all local police stations and (2) transporting the medication to a biomedical waste treatment facility for incineration.

The bill requires DCP, within available appropriations, to organize a public awareness campaign to educate the public about the program and the dangers of unsafe medication disposal. It also allows DCP to adopt implementing regulations.

EFFECTIVE DATE: October 1, 2014

§ 158 — PHYSICIAN AND APRN PROFILES

Current law requires DPH, within available resources, to collect certain information to create individual profiles for health care providers for dissemination to the public. The bill eliminates the "within available appropriations" restriction with regard to collecting information on physicians and APRNs. The bill also adds to the profile information (1) whether or not the practitioner provides primary care services and (2) for an APRN, whether he or she is practicing independently or in collaboration with a physician to the list of collected information.

Collected information includes, among other things, the practitioner's specialty, primary practice location, and any hospitals at which he or she has admitting privileges. Unchanged by the bill, DPH must also collect such information on dentists, chiropractors, optometrists, podiatrists, naturopaths, dental hygienists, and physical therapists within available appropriations.

EFFECTIVE DATE: October 1, 2014

§§ 169-175 & 259 — REPEAL OF HITE-CT; ELECTRONIC HEALTH INFORMATION

The bill repeals the statutes establishing the Health Information Technology Exchange of Connecticut (HITE-CT) and makes conforming changes.

Under current law, HITE-CT is a quasi-public agency designated as the state's lead agency for health information exchange. It is responsible for, among other things, (1) developing a statewide health information exchange to share health information electronically among health care facilities and professionals, public and private payers, government agencies, and patients and (2) providing grants to advance health information technology and exchange in the state, within available resources. It is governed by a 20-member board of directors.

Transfer of Certain Responsibilities to DSS

The bill transfers, from HITE-CT to the DSS commissioner, the responsibility to (1) implement and periodically revise the statewide health information technology plan and (2) establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding. The DSS commissioner must do this in consultation with DPH and DMHAS.

The bill requires the DSS commissioner, when complying with certain existing requirements regarding the plan's contents, to take into consideration advice that human services advisory boards and councils may provide to him.

The bill requires the DSS commissioner to develop uniform electronic health information technology standards for use throughout DDS, DPH, DOC, DCF, and DMHAS. Under the bill, if one of these agencies plans to revise the health information technology plan, it must submit the revision plan to the DSS commissioner for his approval before implementation. If the commissioner grants an approval that requires additional funding, he must submit the revisions to the OPM secretary.

The bill requires the DSS commissioner to annually submit the statewide health information technology plan, as revised, to the Appropriations, Human Services, and Public Health committees. (This applies regardless of whether the plan was revised since it was last submitted.) The first submission is due by January 1, 2015.

EFFECTIVE DATE: July 1, 2014

Other Bills of Interest to CNA Which Passed the General Assembly:

HB 5040 (as amended by House "A")* ***AN ACT CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES AND THE PROTECTION OF CHILDREN—Public Act 14-186***

SUMMARY: This bill expands the circumstances in which the departments of Children and Families (DCF) and Social Services (DSS) must disclose the names and records of certain individuals to specific entities. The circumstances affecting DCF include:

1. disclosing the names and records of people being investigated and prosecuted for falsely reporting child abuse and neglect,

2. determining a person's suitability for working in a state-licensed child care facility,

3. placing a public school employee on the child abuse and neglect registry, and

4. protecting a DCF employee being threatened by a client or coworker.

The bill expands the circumstances in which DSS must disclose information to DCF about a child receiving DSS services or the child's immediate family.

The bill also requires DCF to disclose information to help the Judicial Branch track juvenile offender recidivism and the Birth-to-Three program provided services.

The bill expands the actions DCF can take to help children it identifies or believes are victims of trafficking to include (1) providing services, (2) forming multidisciplinary teams to review trafficking cases, and (3) providing training to law enforcement officers about trafficking. It also expands the category of children or youths a court may find to be "uncared for" to include child-trafficking victims.

Additionally, the bill (1) expands the mandated reporter list and (2) aligns some of the procedural aspects for suspending an employee suspected of child abuse and neglect who works at a (a) public school or (b) private school or public or private child care facility or institution.

***House Amendment "A"** removes a provision that exempted certain social workers from mandated reporter responsibilities in limited circumstances.

EFFECTIVE DATE: October 1, 2014

HB 5113 (as amended by House "A" and "B")* ***AN ACT CONCERNING YOUTH ATHLETICS AND CONCUSSIONS—Public Act 14-66, Signed by Governor***

SUMMARY: This bill makes several changes and additions to the laws regarding concussion prevention.

It narrows the scope, from concussions and head injuries to just concussions, of the (1) initial training course and subsequent information review that intramural and interscholastic athletics coaches must complete and (2) training and refresher courses the State Board of Education (SBE) must develop in consultation with several entities. It also specifies that a concussion is a type of brain injury.

The bill broadens the (1) list of entities SBE must consult when developing the training and refresher courses and information review to include the Department of Public Health (DPH) commissioner and (2) information required in the refresher course.

It (1) requires SBE to develop a concussion education plan and (2) prohibits school boards from allowing a student athlete to participate in any intramural or interscholastic athletic activity unless the athlete and his or her parent or guardian complete certain requirements pertaining to the plan.

It also requires (1) SBE to develop or approve an informed consent form on concussions to distribute to parents and legal guardians of student athletes involved in intramural and interscholastic athletic activities and (2) schools to provide the form to each student athlete's parent or guardian and get his or her signature authorizing the student to participate in the athletic activity.

The bill additionally requires:

1. SBE to annually collect and report to DPH information from all school districts on concussion occurrences and

2. coaches or other qualified school employees to notify a student athlete's parent or guardian when the student is removed from play for a concussion or suspected concussion.

Finally, the bill establishes a 20-member task force to study concussion occurrences in youth athletics and recommend possible legislative initiatives to address such concussions. The task force must report its findings and recommendations to the Public Health and Children's committees by January 1, 2015.

***<u>House Amendment "A"</u>:**

1. eliminates a requirement that the refresher course include updates on coaching best practices for all coaches and instead requires the refresher course to include football-specific best practice information for football coaches;

2. requires school boards, instead of the governing authority for intramural and interscholastic athletics, to (a) implement the concussion education plan and (b) prohibit students from

participating in athletic activities unless the student and his or her parent or guardian meets certain requirements regarding the plan;

3. removes language expanded the types of activities from which a student athlete is barred following a concussion or suspected concussion; and

4. makes other minor changes.

***House Amendment "B"** establishes the concussion task force.

EFFECTIVE DATE: July 1, 2014, except for the task force provision, which is effective upon passage.

HB 5146 (as amended by House "A")* ***AN ACT CONCERNING THE USE OF PUBLIC SCHOOL HEALTH ASSESSMENT FORMS BY YOUTH CAMPS AND DAY CARE CENTERS—Public Act 14-15, Signed by Governor***

SUMMARY: This bill allows licensed youth camps, child or group daycare facilities, and family day care homes to use a child's physical examination required for school purposes and either his or her school health assessment form or State Department of Education early childhood health assessment record form to satisfy any physical examination or health status certification they require. It requires that the physical examination be completed within a time the Office of Early Childhood (OEC) commissioner establishes (See BACKGROUND).

The bill also requires the OEC commissioner to adopt regulations to allow a child's school health assessment form, in addition to a physical examination, to satisfy a youth camp's health examination or certification requirement. Under current law, the public health commissioner adopts regulations on youth camp health forms.

***House Amendment "A"** requires the OEC commissioner, not the public health commissioner, to (1) adopt the regulations on school health assessment forms and youth camps, and (2) set the time to complete a physical examination.

EFFECTIVE DATE: July 1, 2014

HB 5305 (as amended by House "A")* ***AN ACT CONCERNING CADMIUM LEVELS IN CHILDREN'S JEWELRY—Public Act 14-140, Signed by Governor***

SUMMARY: This bill delays, for two years, the ban on manufacturing, selling, offering for sale, or distributing in Connecticut children's jewelry containing more than .0075% (by weight) of elemental cadmium, or compounds or alloys containing it. Under current law, the ban begins July 1, 2014.

By law, children's jewelry means jewelry designed or intended to be worn or used by children under age 13. It includes charms, bracelets, pendants, necklaces, earrings, or rings, and any of their components.

The bill also establishes a 16-member task force to study the threshold at which cadmium is safe in children's jewelry. The task force must report to the Children's, General Law, and Public Health committees by January 15, 2015.

***House Amendment "A"** establishes the task force.

EFFECTIVE DATE: Upon passage

HB 5386, AN ACT CONCERNING CARE COORDINATION FOR CHRONIC DISEASE— Public Act 14-148, Signed by governor

SUMMARY: This act requires the public health (DPH) commissioner to develop and implement a plan to (1) reduce the incidence and effects of chronic disease, (2) improve chronic disease care coordination in Connecticut, and (3) improve outcomes for conditions associated with chronic disease. She must develop the plan (1) within available resources and (2) in consultation with the lieutenant governor or her designee and local and regional health departments.

The plan must address chronic cardiovascular disease, cancer, lupus, stroke, chronic lung disease, diabetes, arthritis or another metabolic disease, and the effects of behavioral health disorders. It 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 Centers for Medicare and Medicaid Services Innovation Center.

The act also requires the commissioner to report biennially on chronic diseases and the plan's implementation. The report must include several matters, such as a description of the diseases most likely to cause death or disability and recommendations for what health care providers and patients can do to reduce the diseases' incidence and effects.

EFFECTIVE DATE: October 1, 2014

REPORTING REQUIREMENT

The act requires the DPH commissioner, by January 15, 2015 and biennially thereafter, to report to the Public Health Committee on chronic disease and implementing the plan described above. She must do so in consultation with the lieutenant governor or her designee. The commissioner must post the reports on the department's website within 30 days after she submits them. The reports must include:

1. a description of the chronic diseases most likely to cause death or disability, the approximate number of people affected by them, and an assessment of each such disease's financial effect on the state, hospitals, and health care facilities;

2. a description and assessment of programs and actions that DPH and health care providers have implemented to improve chronic disease care coordination and prevent chronic disease;

3. the sources and amount of funding DPH receives to treat people with multiple chronic diseases and to treat or reduce the most prevalent chronic diseases in the state;

4. a description of care coordination between DPH and health care providers to prevent and treat chronic disease; and

5. recommendations on actions health care providers and people with chronic diseases can take to reduce the incidence and effects of these diseases

HB 5528, (As amended by House "A") ***AN ACT CONCERNING ESSENTIAL PUBLIC HEALTH SERVICES—Public Act 14-226.***

SUMMARY: This bill requires municipal health departments, as well as local health districts with populations of 50,000 or more or that serve three or more municipalities, to provide a basic health program as a prerequisite to receiving annual funding from the Department of Public Health (DPH). The program must include:

1. monitoring the community's health status to identify and solve problems;

2. investigating and diagnosing health problems and hazards in the community;

3. informing, educating, and empowering people in the community regarding health issues;

4. mobilizing community partnerships and action to identify and solve health problems for people in the community;

5. developing policies and plans that support individual and community health efforts;

6. enforcing laws and regulations to ensure health and safety;

7. connecting people to health care when appropriate;

8. assuring a competent public health and personal care workforce;

9. evaluating the effectiveness, accessibility, and quality of personal and population-based health services; and

10. researching to find innovative solutions to health problems.

EFFECTIVE DATE: October 1, 2014.

House Amendment "A" specifies that requirements in the underlying bill be met within available appropriations, making the cost to DPH a potential one. It also expands euthanization requirement exemptions to any animal euthanized in a facility subject to regulation by the United State Department of Agriculture.

SB 10, AN ACT CONCERNING COPAYMENTS FOR BREAST ULTRASOUND SCREENINGS AND OCCUPATIONAL THERAPY SERVICES—Public Act 14-97, Signed by Governor

SUMMARY: This act prohibits certain health insurance policies from imposing a copayment of more than $20 for a breast ultrasound screening for which the policies are required to provide coverage. By law, policies must cover a comprehensive breast ultrasound screening if a (1) mammogram shows heterogeneous or dense breast tissue based on the American College of Radiology's Breast Imaging Reporting and Data System or (2) woman is at an increased risk for breast cancer because of family history, her own breast cancer history, positive genetic testing, or other indications her physician or advanced practice registered nurse determine.

The act also prohibits certain health insurance policies from imposing a copayment of more than $30 per visit for in-network occupational therapy services performed by a state-licensed occupational therapist. Effective January 1, 2015, PA 13-307 similarly limits copayments for in-network physical therapy services performed by a state-licensed physical therapist.

The act applies to individual and group policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. The copayment limitation for breast ultrasound screening also applies to individual policies that cover limited benefits. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2015

SB 35, AN ACT CONCERNING NOTICE OF ACQUISITIONS, JOINT VENTURES AND AFFILIATIONS OF GROUP MEDICAL PRACTICES—Public Act 14-168, Signed by Governor

SUMMARY: The bill results in state cost, a potential state cost, and General Fund revenue. It expands Certificates of Need (CON) requirements to include transfers of ownership of a group practice of eight or more physicians to any entity other than a physician or group of physicians, with an exemption in FY 15. This results in an anticipated cost to the Department of Public Health (DPH) of less than $53,452 in FY 15 and less than $71,220 in FY 16, an anticipated cost to the State Comptroller Fringe Benefits of less than $19,192 in FY 15 and less than $26,073 in FY 16 and an anticipated revenue gain to the General Fund of less than $4,000 in FY 15 and FY 16. The requirement under the bill that all CON deliberations by DPH's Office of Health Care Access (OHCA) take into consideration and include in its written findings: (1) whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region and (2) whether the applicant has satisfactorily demonstrated that any consolidation of market share resulting from the proposal will not adversely affect health care costs or accessibility to care may result in a cost to OHCA to the extent that the Office needs additional resources to meet these requirements.

In 2013, 31 new CON applications were filed with OHCA and 37 decisions were rendered OHCA estimates that there were approximately 23 transfers of ownership of a group practice over the past three years or approximately eight annually. It is unknown of these approximate eight transfers how many parties to a transfer will sign a sale agreement on or before 9/1/14 (exempted from CON requirements under the bill). Further, it is unknown how many transfers involve group practices of eight or more physicians and how many of these are transferred to physicians or physician groups. As such, state costs and General Fund revenue detailed below may be less than what is currently estimated, as these factors may reduce the number of CON applications required and decided by OHCA under the bill.

Senate Amendment "A" expanded CON requirements to include transfers of ownership of a group practice and resulted in a similar fiscal impact.

Senate Amendment "B" struck the language of the underlying bill and the provisions of Senate "A" and replaced both with the new language of the amendment, which results in the fiscal impact described above.

SB 45 (as amended by Senate "A")* AN ACT CONCERNING THE DEPARTMENT OF CHILDREN AND FAMILIES AND THE EDUCATION OF CHILDREN—Public Act 14-99, Signed by Governor

SUMMARY: This bill requires the superintendent of each school district providing education to a neglected or abused child committed to the custody of the Department of Children and Families (DCF) to provide certain education-related information to (1) DCF, (2) the student's foster parent, and (3) the student's attorney.

It requires DCF and the Judicial Branch's Court Support Services Division (CSSD) to promptly review the educational files of any child or youth when he or she enters a facility or school program they run or contract with to determine if the child or youth may be eligible for special education and related services under state law.

***Senate Amendment "A"** removes a provision increasing the number of children under DCF supervision for whom the education commissioner may appoint a surrogate parent.

EFFECTIVE DATE: October 1, 2014

SB 229 (as amended by Senate "B")* *AN ACT CONCERNING SUDDEN CARDIAC ARREST PREVENTION—Public Act 14-93, Signed by Governor*

SUMMARY: This bill requires the State Board of Education (SBE), for school years beginning July 1, 2015 and in consultation with specified organizations, to develop or approve a sudden cardiac arrest awareness education program for use by local and regional boards of education. Sudden cardiac arrest occurs when the heart suddenly and unexpectedly stops beating.

It requires coaches of intramural and interscholastic athletics to:

1. obtain the written consent of a student's parent or legal guardian before allowing a student to participate in such athletic activities;

2. annually review the sudden cardiac arrest awareness program before beginning their coaching assignments;

3. immediately remove from athletic activities a student who shows the warning signs of sudden cardiac arrest; and

4. bar such a student from resuming participation in athletic activities unless the student has received written clearance from a Connecticut-licensed doctor, physician assistant, or advanced practice registered nurse.

The bill immunizes coaches from personal and professional civil liability for their actions or omissions concerning the above requirements, except for grossly negligent, reckless, or wilful misconduct. Existing law already requires school boards to indemnify school employees and volunteers, including coaches, against financial loss and expense resulting from alleged negligence or other acts arising from their duties, subject to similar exceptions (CGS § 10-235).

The bill does not relieve coaches of their duties or obligations under state law, regulation, or a collective bargaining agreement. And it allows SBE to revoke the permit of a coach who fails to annually review the sudden cardiac arrest awareness education program.

***Senate Amendment "B"** (1) restores provisions on consent forms eliminated in the file copy (File 664); (2) limits the violations for which SBE may revoke a coaching permit; (3) delays, from October 1, 2014 until July 1, 2015, the date certain provisions of the bill take effect; (4) expands coaches' liability protection; and (5) adds provisions (a) specifying symptoms of sudden cardiac arrest, (b) requiring an organization of national, state, or local medical associations, rather than county medical associations, to help develop the program, and (c) declaring that it does not relieve coaches of certain duties or obligations.

EFFECTIVE DATE: October 1, 2014

SB 413, ***AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS REGARDING MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT—Special Act 14-5, Signed by Governor***

SUMMARY: The bill would allow the Department of Public Health (DPH) commissioner to establish a pilot program for the use of medical orders for life-sustaining treatment (MOLST). It would also allow her to establish an advisory committee to make recommendations regarding the MOLST pilot program. If the commissioner adopts such a program, she must implement policies and procedures on various matters.

EFFECTIVE DATE: Upon passage

SB 417 (as amended by Senate "A")* ***AN ACT CONCERNING THE PROVISION OF PSYCHIATRIC AND SUBSTANCE USE TREATMENT SERVICES—Public Act 14-211***

SUMMARY: This bill allows a "multi-care institution" to offer certain health services at locations not listed on its license. It does so by eliminating the requirement that the Department of Public Health (DPH) issue a license only for the premises and persons named in the application. The bill also specifies a multi-care institution license application process and allows DPH to adopt regulations to implement its provisions.

The bill also broadens the licensure requirements for certain institutions. The law requires licensure of home health care agencies, homemaker-home health aide agencies, and homemaker-home health aide services only if they are not otherwise required to be licensed by the state. The bill broadens this provision to also include other health care institutions, including hospitals, nursing homes, residential care homes, mental health facilities, and alcohol or drug treatment facilities.

***Senate Amendment "A"** (1) broadens the bill's (File 458) scope from facilities providing outpatient psychiatric services to multi-care institutions offering a range of services, (2) adds the licensing provisions, (3) allows DPH to adopt regulations, and (4) increases the types of health care facilities required to be licensed if not otherwise licensed by the state.

EFFECTIVE DATE: October 1, 2014

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