Robinson+Cole

Health Law *Pulse*

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Connecticut Enacts New Legislation Concerning Telehealth, Nurse Staffing Level Reports, and Other Health Care-Related Issues

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PUBLIC ACT 15-88: AN ACT CONCERNING THE FACILITATION OF TELEHEALTH

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

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

Requirements for Telehealth Services

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

The new requirements include certain patient protections. During the first telehealth interaction, providers must inform their patients about the treatment methods and limitations of providing treatment via telehealth and obtain the patient's consent to using telehealth, to be documented in the patient's health

record. At the time of each telehealth interaction, telehealth providers must request patient consent to disclose records relating to the telehealth session to the patient's primary care provider. If the patient does consent, such records shall be shared with the patient's primary care provider. The provision of telehealth services and maintenance and disclosure of related records must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Telehealth providers must provide patients with their license number and contact information. Facility fees may not be charged for telehealth services.

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

These requirements are effective as of October 1, 2015.

Requirements for Insurance Coverage

Effective January 1, 2016, individual and group health insurance policies that cover basic hospital expenses, basic medical-surgical expenses, major medical expenses, or hospital or medical services in Connecticut must provide coverage for medical advice, diagnosis, care, or treatment provided via telehealth to the extent the same is covered under the policy when provided in person. Telehealth coverage must be subject to the same terms and conditions that apply to all other benefits under the respective policy. Policies cannot exclude coverage solely because a service is provided via telehealth, provided that telehealth services are appropriate for the context of care, and insurers cannot be required to reimburse a treating or consulting provider for technical fees or costs associated with providing services via telehealth.

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

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

Public Act 15-91 (P.A. 15-91) revises the current law to require each hospital licensed by DPH to report annually its nurse staffing plan to DPH, effective as of July 1, 2015. This legislation also requires nurse staffing plans implemented after January 1, 2016, to include the following elements in addition to those described above: (1) the number of registered nurses, licensed practical nurses, and assistive personnel providing direct patient care and the ratio of patients to such providers by patient care unit; (2) the hospital's method for determining and adjusting direct patient care staffing levels; and (3) a description of each patient care unit's supporting personnel. This legislation further requires that all nurse staffing plans implemented after January 1, 2017, describe any differences between the staffing levels included in the staffing plan and each patient care unit's actual staffing levels, and any actions the hospital will take to adjust staffing levels or address such differences.

P.A. 15-91 also revises a current law regarding reports of workplace violence incidents. Currently, a health care employer (defined as a health care institution with 50 or more employees) must report to DPH, upon request, the number of workplace violence incidents occurring on the employer's premises and the specific area or department where each incident occurred. P.A. 15-91 requires health care employers to report such incidents annually to DPH. This provision is effective as of October 1, 2015, and

the first report is due by January 1, 2016.

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

Effective October 1, 2015, P.A. 15-120 makes several changes to the Department of Mental Health and Addiction Services' (DMHAS) statutes regarding data collection and the role of the DMHAS commissioner, as well as other technical changes. DMHAS is currently charged with establishing uniform methods for keeping statistical information for both public and private agencies, including a client identifier system. This legislation specifies that these data collection requirements apply to all public and private agencies providing care or treatment for psychiatric disabilities or for alcohol or drug abuse or dependence, regardless of whether they are operated or funded by the state. This legislation requires all such agencies to collect and make available the relevant statistical information, including the number of persons treated, their demographic and clinical information, admission and readmission rates, the frequency and duration of treatment, the level of care provided, and discharge and referral information. Agencies must provide this information to DMHAS upon request. In the event an agency fails to do so, DMHAS is required to report the agency to the Department of Public Health or another licensing authority.

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

Effective July 1, 2015, P.A. 15-102 clarifies that the Department of Social Services (DSS) is not required to pay for beds otherwise not available at residential care homes and housing facilities during a resident's short-term absence. DSS currently pays State Supplement Program benefits to licensed residential care homes or rated housing facilities on behalf of recipients. By law, DSS must make such payments for periods when the recipient is absent from the facility, provided the recipient can reasonably be expected to return to the facility before the end of the month following the month in which the recipient leaves the facility. The bill clarifies that, if the recipient's bed is unavailable during the absence, payment does not have to be made to the facility for such period.

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

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

Pursuant to this new legislation, DPH may issue a certificate of authorization to any emergency medical services provider who (1) operates only in a municipality with a population of at least 105,000 but not more than 115,000; (2) meets the minimum standards of the DPH commissioner (Commissioner) in the areas of training, equipment, and other standards applicable to emergency medical services personnel; and (3) maintains liability insurance of at least one million dollars. Certificates of authorization to serve as

a supplemental first responder are effective for two years and renewable biennially. An applicant who is denied will be provided with written notice, including a statement of reasons for the denial, and will have 30 days to request a hearing on the denial. If the denial is sustained, the applicant can reapply one year after the date on which the denial was sustained. The Commissioner may suspend or revoke a certificate of authorization if the holder does not maintain the initial minimum standards for authorization or violates the Connecticut standards governing emergency medical services. The certificate holder will have an opportunity to show compliance with all requirements in response to a suspension or revocation action.

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

If you have any questions, please contact a member of Robinson+Cole’s Health Law Group:

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