

**JOINT MEETING OF THE
KANSAS BOARD OF NURSING
AND THE
KANSAS STATE BOARD OF
HEALING ARTS**

**Monday, February 8, 2016 at 2:00
p.m.**

JOINT PAIN MANAGEMENT POLICY

2002 JOINT POLICY

Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense drugs. The boards adopt this statement to help assure health care providers and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain. Guidelines by individual boards are appropriate to address issues related to particular professions.

The appropriate application of current knowledge and treatment modalities improves the quality of life for those patients who suffer from pain, and reduces the morbidity and costs associated with pain that is inappropriately treated. All health care providers who treat patients in pain, whether acute or chronic, and whether as a result of terminal illness or non-life-threatening injury or disease, should become knowledgeable about effective methods of pain treatment. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the appropriate assessment and management of pain while retaining the right to refuse treatment. A person's report of pain is the optimal standard upon which all pain management interventions are based. The goal of pain management is to reduce the individual's pain to the lowest level possible, while simultaneously increasing the individual's level of functioning to the greatest extent possible. The exact nature of these goals is determined jointly by the patient and the health care provider.

Prescribing, administering or dispensing controlled substances, including opioid analgesics, to treat pain is considered a legitimate medical purpose if based upon sound clinical grounds. Health care providers authorized by law to prescribe, administer or dispense drugs, including controlled substances, should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

A board is under a duty to make an inquiry when it receives information contending that a health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board.

The following guidelines are not intended to define complete or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of the healthcare provider's profession.

Section II: Principles

The boards approve the following principles when evaluating the use of controlled substances for pain control:

1. Assessment of the Patient

Pain should be assessed and reassessed as clinically indicated. Interdisciplinary communications regarding a patient's report of pain should include adoption of a standardized scale for assessing pain.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the drug therapy plan should be adjusted to the individual medical needs of each patient. The nurse's skill is best utilized when an order for drug administration uses dosage and frequency parameters that allow the nurse to adjust (titrate) medication dosage. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. If, in a healthcare provider's sound professional judgement, pain should not be treated as requested by the patient, the healthcare provider should inform the patient of the basis for the treatment decisions and document the substance of this communication.

3. Informed Consent

The physician retains the ultimate responsibility for obtaining informed consent to treatment from the patient. All health care providers share the role of effectively communicating with the patient so that the patient is apprised of the risks and benefits of using controlled substances to treat pain.

4. Agreement for Treatment of High-Risk Patients

If the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, the health care provider should consider requiring a written agreement by the patient outlining patient responsibilities, including:

- Submitting to screening of urine/serum medication levels when requested;
- Limiting prescription refills only to a specified number and frequency;
- Requesting or receiving prescription orders from only one health care provider;
- Using only one pharmacy for filling prescriptions; and
- Acknowledging reasons for which the drug therapy may be discontinued (i.e., violation of agreement).

5. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the course of treatment and any new information about the etiology of the pain should be evaluated. Communication among health care providers is essential to review of the medical plan of care. The health care providers involved with the management of pain should evaluate progress toward meeting treatment objectives in light of improvement in patient's pain intensity and improved physical or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved despite medication adjustments, the health care provider's should reevaluate the appropriateness of continued treatment.

6. Consultation

The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

7. Medical Records

The medical record should document the nature and intensity of the pain and contain pertinent information concerning the patient's health history, including treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

8. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable federal and state laws.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiction, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic pain is a pain state which is persistent beyond the usual course of an acute disease or a reasonable time for an injury to heal, or that is associated with a chronic pathologic process that causes continuous pain or pain that recurs at intervals for months or years.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPROVALS

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 1st day of June, 2002.

Lance E. Malmstrom, D.C.

President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing, on the 17th day of July, 2002.

Karen Gilpin, R.N.

President.

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy, on the 10th day of June, 2002.

Max Heidrick, RPh

President

APPROVALS

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 1st day of JUNE, 2002.

Lance E. Malinowski, D.C.
President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing, on the 17th day of July, 2002.

Laura Gilpin, RN
President.

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy, on the 10 day of June, 2002.

M. J. McPherson
President

CURRENT DRAFT OF JOINT POLICY

Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense prescription medications. The Boards adopt this Statement to help assure the citizens of Kansas that it is the policy of this state to encourage competent comprehensive pain care. For chronic pain, such care is best provided by person-centered treatment teams, where they are available, in which disparate health care providers regulated by these boards work together in partnership with people with pain and their families to achieve optimal, patient-centered outcomes. This statement addresses issues that may be encountered by all team members, while guidelines issued by individual Boards and professional societies are appropriate to address issues related to particular professions.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the prompt and appropriate assessment of pain and function and the initiation of pain management while retaining the right to refuse treatment. The experience of pain is always subjective, requiring that health care providers rely heavily on self-reported data in completing a pain assessment. The primary goal of pain management is to increase the individual's level of functioning to the greatest extent possible; functional improvement often correlates with reduced pain, but these two outcomes may be unrelated in some individuals. The exact goals of care and the treatment plan used to achieve those goals should be determined jointly by the patient, family, and the health care team.

The appropriate application of available treatment modalities in a manner supported by the best available evidence improves the quality of life for people with pain, and reduces the morbidity and costs associated with inadequate or inappropriate pain care. All health care providers who treat people with pain, whether acute or chronic, and regardless of cause, should be knowledgeable about effective methods of pain treatment and indications for appropriate referral to other health care providers. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities in an integrated biopsychosocial plan of care.

Prescribing, dispensing, or administering controlled substances, including opioid analgesics, to treat pain and improve function is considered a legitimate medical purpose for the use of these medications if based upon a sound clinical evaluation and treatment plan. As in all other areas of health care, it is incumbent upon providers to recognize the risks and benefits inherent in providing pain care, and to seek to optimize the risk-benefit ratio in formulating a plan of care. High-dose and/or long-term opioid therapy is associated with an increased risk of various

adverse outcomes, which may include physical complications and substance misuse, abuse, diversion, overdose, and death. Health care providers authorized by law to prescribe, administer or dispense medications, including controlled substances, should recognize the risks associated with this type of therapy and take appropriate action to minimize such risks. These providers should be knowledgeable about the safe use of opioid analgesics; their role in an integrated, biopsychosocial treatment plan; risk factors for adverse opioid-related outcomes and ways to screen for them; and the signs and symptoms of substance use disorders. They also should understand that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

All boards have a duty to make an inquiry when they receive information contending that a licensed health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this and other relevant policy statements. Health care providers who competently treat pain should not fear disciplinary action from their licensing boards.

The following guidelines are not intended to define a standard of care or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of that healthcare provider's profession.

Section II: Principles for treating chronic pain

The boards approve the following principles when evaluating the use of controlled substances for the treatment of chronic pain:

1. Assessment of the Patient

Pain and function should be assessed and reassessed as clinically indicated. Interdisciplinary communications regarding a patient's report of pain should include adoption of a standardized protocol for assessing pain. A complete pain assessment should evaluate not only the intensity of a patient's pain, but also the impact of that pain on the patient's physical, emotional, and social functioning, as well as expectations for treatment outcomes. A number of standardized instruments are available to assist in this assessment, and clinicians should consider their use [REFS]. Assessment also should include evaluation of the individual's risk of substance misuse and abuse, ideally involving use of an evidence-based standardized instrument [REFS]. If controlled substances are, or may be, part of the individual's plan of care, obtaining a prescription monitoring program report and baseline urine/serum/saliva drug screen are strongly encouraged.

2. Treatment Plan

A written treatment plan should be strongly considered for all episodes of pain care. Such a plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or treatments involving other health care professionals are planned. After treatment begins, the treatment plan, especially the medication regimen, should be adjusted to the individual medical needs of each patient. The plan may include specific directions for adjusting medication doses or schedules between evaluations by the prescriber. Other treatment modalities may be necessary, depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. If, in a healthcare provider's sound professional judgment, pain should not be treated as requested by the patient, the healthcare provider should discuss the basis for the treatment decisions with the patient and document the substance of this communication.

3. Informed Consent and Agreement for Controlled Substance Treatment

Each patient should have one health care provider who coordinates the pain care plan. That provider retains the ultimate responsibility for obtaining informed consent to treatment from the patient. All health care providers share the role of effectively communicating with the patient so that he or she is apprised of the risks and benefits of using controlled substances to treat pain.

If controlled substances are part of the individual's pain treatment plan, use of a written controlled substance treatment agreement should be strongly considered. The purposes of such an agreement are to ensure clarity on the part of both the patient and the health care provider regarding the role of controlled substances in the overall treatment plan and to establish parameters governing their provision as part of a comprehensive treatment plan. Such an agreement should outline patient responsibilities, including:

- Submitting to testing of medication levels when requested;
- Limiting prescription refills only to a specified number and frequency;
- Requesting and receiving prescription orders from only specified health care providers;
- Using only one pharmacy or pharmacy chain for filling prescriptions;
- Storing medications securely, not sharing them with anyone else, using them only as directed, and disposing of excess supplies in a safe and effective manner; and
- Acknowledging reasons for which the drug therapy may be modified or discontinued (e.g., violation of agreement).

It also should list the health care provider's responsibilities, including:

- [LIST TO BE DETERMINED]

4. Periodic Review

At reasonable intervals based on the individual circumstances of the patient, the course of

treatment and any new information about the etiology of the pain should be evaluated. Communication among health care providers is an essential part of reviewing the plan of care. The health care providers involved in providing pain care should evaluate progress toward meeting treatment objectives in terms of physical and psychosocial outcomes (e.g., ability to work or attend school; emotional, cognitive, and behavioral functioning; need for health care resources; activities of daily living; and quality of social life). Such periodic reviews should include an evaluation of the patient's current prescription monitoring program report, testing for medication levels, pill counts, and other monitoring techniques, at a frequency determined by the health care provider based on the patient's evaluated risk for substance misuse, abuse, and/or diversion. If treatment goals are not being achieved despite medication adjustments and the use of other treatment modalities, the health care providers should reevaluate the diagnosis and the appropriateness of continued controlled substance treatment. If it is determined that controlled substances are not providing expected benefits and/or are causing adverse outcomes, their doses should be tapered and/or discontinued, in a manner that minimizes the risk of producing withdrawal and appropriately treats any emerging symptoms of withdrawal. Other changes to the treatment plan, as indicated by the results of the evaluation, should be made as needed.

5. Consultation

The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with co-morbid psychiatric disorders, those who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder can be challenging, and extra care, monitoring, documentation, and consultation with or referral to an expert(s) in the management of such patients may be appropriate.

6. Medical Records

The medical record should document the results of the pain assessment and contain pertinent information concerning the patient's health history, including previous treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance. The results of periodic reviews, including findings from the patient examination, the prescription monitoring program report, drug testing, and consultations with, or treatments provided by, other health care providers should be documented to assist in evaluating the patient's progress toward the goals set out in the plan of care.

7. Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable

federal and state laws.

Section III: Principles for treating acute pain

[To be added]

Section IV: Definitions

For the purposes of these guidelines, these terms are defined as follows:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Acute pain is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and is associated with invasive procedures, trauma and acute illness. It is generally time-limited, and resolves as the identified cause resolves.

Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury. It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years.

Misuse (also called *nonmedical use*) encompasses all uses of a prescription medication other than those that are directed by a health care provider and used by a patient within the law and the requirements of good medical practice.

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiction, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Diversion is defined as the intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution.

Physical dependence on a controlled substance is a state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist. Physical dependence

is an expected result of extended opioid use. Physical dependence, by itself, does not equate with addiction.

Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance is common in opioid treatment, has been demonstrated following a single dose of opioids, and is not the same as addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Opioid is any compound that binds to an opioid receptor in the central nervous system. The class includes both naturally-occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides.

Prescription Monitoring Program is a state-operated program that facilitates the collection, analysis, and reporting of information on the prescribing and dispensing of controlled substances. The Kansas Tracking and Reporting of Controlled Substances (K-TRACS) program employs electronic data transfer systems, under which prescription information is transmitted from the dispensing pharmacy to the Kansas Board of Pharmacy, which collates and analyzes the information, and makes it available to authorized parties.

PARAMEDIC MOBILE INTEGRATED HEALTHCARE

Paramedic/Mobile Integrated Health Care Course

Diane Glynn

From: Cannon, Chris [cannon@cowley.edu]
Sent: Friday, August 21, 2015 12:21 PM
To: Diane Glynn
Subject: RE: Course Syllabus and Requirements

Hey Diane,

The course instructor is going to email me the syllabus today (he is at his full-time job right now); I will forward it on when I receive it. The syllabus will have a list of skills that will be taught in the course, and the didactic content is based on the course procedure objectives at the link I sent previously.

The textbook for the course is *Mobile Integrated Healthcare: Approach to Implementation* from Jones and Bartlett. You can find it on their website at this link: <http://www.iblearning.com/catalog/9781449690168/>.

I'd be glad to help out with anything else you need, just send me an email or call me on my cell (316-323-4580) with any questions. Thank you!

Regards,

Chris Cannon

Chair, Health and Human Services
EMS Program Director
Cowley College Allied Health Center

406 E. 8th Street
Winfield, KS 67156

620-229-5985

620-229-5989 Fax

www.cowley.edu/paramedic

www.facebook.com/cowleyems

ABOUT COWLEY	NEWS & EVENTS	ACADEMICS	LOCATIONS	ALUMNI & FRIENDS
FUTURE STUDENTS	CURRENT STUDENTS	CAMPUS LIFE	TIGER ATHLETICS	STUDENT LOGINS

July 27, 2015

Cowley Home

NEWS & EVENTS

NEWS

What's New!

- New Courses, Programs, & Degrees
- New Quality Projects for Student Success

What's Happening

Events Calendar

Cowley Press

Calendars

Photo Gallery

Alumni & Friends' News

Speakers Bureau

Performances

Campus Security & Public Safety

Cowley first in the state to offer Community Paramedic Mobile Integrated Healthcare program

Expanding the roles of EMS workers to provide health services where access to physicians, clinics or hospitals is difficult or may not exist, Cowley College is the first school in the state of Kansas to offer the Community Paramedic/Mobile Integrated Healthcare program.

The Community Paramedic Mobile Integrated Healthcare program closes the gap by expanding the role of EMS personnel beyond just responding to emergencies. The program isn't a replacement for home health or other services that already exist; instead it supplements existing services and expands the knowledge of EMS personnel on how to best help patients. And that best help may not always be an ambulance trip to the emergency room. The CP/MIH program is about maximizing resource usage while minimizing costs.

The 14-credit hour course will run from August 2015 to May 2016. The course will consist of weekly online meetings and a Skills Lab the first Saturday of each month. There will also be clinical rotations.

"This is the next step in the evolution of EMS," Chris Cannon, Cowley College Allied Health Department Chair/Director of EMS Education said. "This class will equip students with the ability to connect patients in need with local resources." Cannon said.

Malachi Winters, former lead paramedic instructor at Cowley College, modeled the curriculum off of the North Central EMS Institute. The emphasis of the course will be on items not covered in depth in the Paramedic Program.

Those interested in the program must have two years of experience as a paramedic and have a reference letter from an EMS Service Director and Physician Medical Director.

The program will prepare students to take the BCCTPC (Board for Critical Care Transport Paramedic Certification) exam.

For more information contact Chris Cannon at cannon@cowley.edu.

COWLEY COLLEGE	What's the Cost?	Future Students	Contact Cowley	College Catalog	Site Map	Video Gallery
-----------------------	-------------------------	------------------------	-----------------------	------------------------	-----------------	----------------------

Copyright © Cowley County Community College and Area Vocational Technical School. Legal Notices

Mobile Path

Text Only

Online Quick Links

Search

ABOUT COWLEY

NEWS & EVENTS

ACADEMICS

LOCATIONS

ALUMNI & FRIENDS

FUTURE
STUDENTSCURRENT
STUDENTSCAMPUS
LIFETIGER
ATHLETICSSTUDENT
LOGINS

Cowley Home

ACADEMICS

Academic Departments

- Health & Human Services
- EMS (Emergency Medical Services)
- Academic Programs
 - Paramedic (PMT)
 - EMT-Basic
 - CCENTP
 - The Difficult Airway
 - EMS Leadership
 - EMS Educator
 - EMS Other
- Courses & Degrees
- News & Events
- Photo Gallery
- Faculty & Staff
- Department Business
- Special Offerings
- Scholarships
- High School Students
- Tell Us Your Needs

Cowley College
EMS Education

- Allied Health
- Criminal Justice
- Cosmetology

Faculty Profiles

Distance Learning

Online College

Business & Industry
Training

Academic Affairs

Degrees & Programs

Transfer Credits Info

Graduation
Requirements

Class Schedules

Academic Calendar

College Catalog

Speakers Bureau

Forms Index

Campus Security
& Public Safety

Community Paramedic Course Application

Personal Information

First Name: _____ (required)

Middle Name: _____

Last Name: _____ (required)

E-mail Address: _____ (required)

Home Phone Number: _____ (required)

Cell Phone Number: _____

Address: _____ (required)

City: _____ (required)

State: _____ (required)

Zip: _____ (required)

Course Prerequisites

Are you licensed as a paramedic with at least 2 years ALS experience? ☐ Yes ☐ No (required)

Have you met the reading assessment?

☐ Yes☐ No, but will test prior to start of class (required)

- o Compass score - 63 / ACT reading score - 18
- o Hold an Associate's Degree or higher

Do you have personal health insurance (you are required to carry insurance during clinical rotation) ☐ Yes ☐ No (required)

Required Documentation:

- o One letter reference from your EMS service director
- o One letter of reference from your medical director
- o Completed immunization form
- o Completed physical exam form
- o Completed personal health insurance form

Work Experience:

Describe your work experience, particularly any experience you might have in pre-hospital care, public safety or healthcare:

☐ I verify that all of the information provided is, to the best of my knowledge, accurate. I also acknowledge that a criminal record check will be required in the future before clinical rotations.

*Incomplete applications will not be considered.

Please click the submit button only once. It may take a few minutes for a confirmation message to appear.

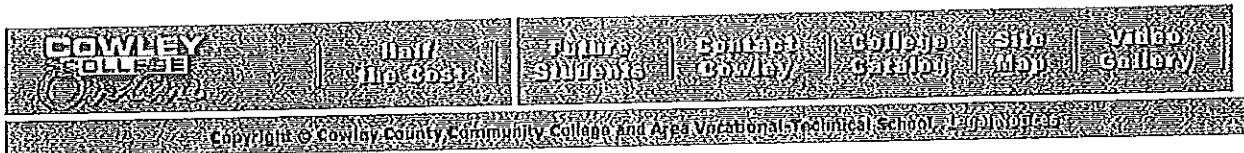
SUBMISSION: After submitting this application please mail or email the following documents to the EMS Program Director:

BE SURE TO INCLUDE YOUR NAME AND CLASS APPLIED FOR WHEN SUBMITTING DOCUMENTATION.

If you have never taken a Cowley class – you will need complete a short admissions application prior to enrollment: <http://www.cowley.edu/admissions/apps.html>

Submit the above to:

Chris Cannon, EMS Program Director
cannon@cowley.edu
Cowley College
1406 E. 8th Street
Winfield, KS 67156
620.229.5985





**COWLEY COLLEGE
& Area Vocational Technical School**

COURSE PROCEDURE FOR

**COMMUNITY PARAMEDIC / MOBILE INTEGRATED HEALTHCARE
EMS 5685 14 Credit Hours**

Student Level:

This course is open to students on the college level in the freshman or sophomore year.

Prerequisites:

Student must have a completed background check on file, meet or exceed minimum reading score of 63 according to the COMPASS Reading test or ACT Reading score of 18 or higher; Associate degree or higher to waive the COMPASS test. Student must currently be certified and/or licensed as a Paramedic (or equivalent) by a recognized state governing body or the National Registry of Emergency Medical Technicians (NREMT). Student must have two years of experience as a street level provider in a service that provides advanced life support (ALS) care of patients.

Controlling Purpose:

This course is designed to help the student increase his or her knowledge concerning the level of responsibility that clinicians will be expected to know in order to perform as a Community Paramedic.

Learner Outcomes:

Upon completion, the training program aims to produce clinicians who have the competencies, knowledge, and professional skills to function as a Community Paramedic in a mobile integrated healthcare system. Course completers will receive a certificate of completion from Cowley College in Community Paramedic/Mobile Integrated Healthcare. The qualifications will be nationally and internationally recognized as an established system of care serving urban, rural, and frontier communities.

Units Outcomes and Criterion Based Evaluation Key for Core Content:

The following defines the minimum core content not including the final examination period. Instructors may add other content as time allows.

Evaluation Key:

- A = All major and minor goals have been achieved and the achievement level is considerably above the minimum required for doing more advanced work in the same field.
- B = All major goals have been achieved, but the student has failed to achieve some of the less important goals. However, the student has progressed to the point where the goals of work at the next level can be easily achieved.
- C = All major goals have been achieved, but many of the minor goals have not been achieved. In this grade range, the minimum level of proficiency represents a person who has achieved the major goals to the minimum amount of preparation necessary for taking more advanced work in the same field, but without any major handicap of inadequacy in his background.
- D = A few of the major goals have been achieved, but the student's achievement is so limited that he is not well prepared to work at a more advanced level in the same field. or training in this area.
- F = Failing, will be computed in GPA and hours attempted.
- N = No Instruction

UNIT 1: Role of the Community Paramedic in the Health Care System						
Outcomes: The Community Paramedic will understand and analyze their role in the health care system.						
A	B	C	D	F	N	Specific Competencies
						Demonstrate the ability to:
						The Community Paramedic will be able to define Community Paramedic.
						The Community Paramedic will be able to define his or her role within a distinct community.
						The Community Paramedic will demonstrate the ability to navigate and establish systems to better serve communities and clients.
						The Community Paramedic will be able to define his or her role as a direct service provider.
						The Community Paramedic will be able to define his or her role as a mentor and stakeholder empowerment advocate.
						The Community Paramedic will be able to discuss the history and future of their role.
						The Community Paramedic will be able to discuss rural and remote medical care dilemma in the United States.
						The Community Paramedic will be familiar with the 2004 Rural and Frontier EMS Agenda of the Future.
						The Community Paramedic will be familiar with the Community Healthcare and Emergency Cooperative (CHEC).
						The Community Paramedic will be familiar with the International Roundtable on Community Paramedics (IRCP).
						The Community Paramedic will be able to explain the "scope of practice" to stakeholders.
						The Community Paramedic will be able to define the current paramedic scope of practice and how it drives the Community Paramedic scope of practice.
						The Community Paramedic will assess and identify gaps between community needs and services
						The Community Paramedic will develop solutions to improve quality of life and health.
						The Community Paramedic will defend the importance of providing services only where and when there are no others to provide them.
						The Community Paramedic will predict how to establish and navigate systems to better serve citizens.

							The Community Paramedic will defend the roles of advocate, facilitator, liaison, and resource coordinator.
							The Community Paramedic will explain the need for expanded services.
							The Community Paramedic will be able to discuss the different relationship they will have with members of the healthcare team, including EMS, nursing, and social workers.
							The Community Paramedic will be able to compare and contrast the strategies of advocacy and liaison work.
							The Community Paramedic will be able to identify common local, regional, state, and national organizations that can provide support for clients.
UNIT 2: Social Determinants of Health							
Outcomes: The Community Paramedic will understand the social determinants of health.							
A	B	C	D	F	N	Specific Competencies	
						Demonstrate the ability to:	
						The Community Paramedic will be able to define the social ecology model and the determinants of health.	
						The Community Paramedic will be able to describe the correlation between health status indicators and individual characteristics.	
						The Community Paramedic will describe age as an individual health factor determinant.	
						The Community Paramedic will describe gender as an individual health factor determinant.	
						The Community Paramedic will describe educational level as an individual health factor determinant.	
						The Community Paramedic will describe economic status as an individual health factor determinant.	
						The Community Paramedic will describe race as an individual health factor determinant.	
						The Community Paramedic will be able to identify social characteristics that are correlated with health status indicators.	
						The Community Paramedic will describe race as a social health status indicator.	
						The Community Paramedic will describe ethnicity as a social health status indicator.	
						The Community Paramedic will describe relationship status as a social health indicator.	

							The Community Paramedic will be able to identify environmental determinants of health.
							The Community Paramedic will describe environmental triggers as an environmental determinate of health.
							The Community Paramedic will describe urban blight as an environmental determinate of health.
							The Community Paramedic will be able to identify the impact of organizational policies, societal regulations and laws on health behaviors.
							The Community Paramedic will discuss the impact of drunk driving laws on health behaviors.
							The Community Paramedic will discuss the impact of seat belt use on health status.
							The Community Paramedic will discuss the influence of culture and spirituality on health status indicators.
							The Community Paramedic will be able to define social margin.
							The Community Paramedic will identify high risk and high need populations.
							The Community Paramedic will identify factors that lead to inequalities of healthcare.
							The Community Paramedic will be able to describe the role documentation plays in assessing the gaps in patient's healthcare needs and in providing resources to the patient.
UNIT 3: Public Health and the Primary Care Role of the Community Paramedic							
Outcomes: The Community Paramedic will understand their role in public health and primary care.							
A	B	C	D	F	N	Specific Competencies	
						Demonstrate the ability to:	
						The Community Paramedic will be able to describe health promotion activities in public health.	
						The Community Paramedic will be able to defend the role of Health Risk Appraisals (HRAs) in public health.	
						The Community Paramedic will be able to defend the role of biometric screening in public health.	
						The Community Paramedic will be able to defend the role of immunizations in public health.	
						The Community Paramedic will be able to defend the role of community education in public health.	

						The Community Paramedic will be able to describe primary and secondary injury prevention activities in public health.
						The Community Paramedic will be able to list examples of Injury prevention efforts by life-stage.
						The Community Paramedic will be able to describe chronic disease management in public health.
						The Community Paramedic will be able to describe and apply appropriate risk mitigation strategies based on the social determinants of health.
						The Community Paramedic will identify and apply individual level behavior modification strategies.
						The Community Paramedic will describe and apply methods to improve Health Literacy.
						The Community Paramedic will describe and apply methods to reduce social, environmental, and economic risks to health.
						The Community Paramedic will be able to discuss financial impact of the Community Paramedic upon healthcare payers.
						The Community Paramedic will describe public and private insurance programs.
						The Community Paramedic will identify common barriers to enrollment in public programs.
						The Community Paramedic will demonstrate how to assist in completing applications for public and private programs.
						The Community Paramedic will identify other potential financial stakeholders.
						The Community Paramedic will be able to describe and apply the appropriate evaluation techniques, including formative, process, outcome, and impact evaluations, to measure the success of a program.
UNIT 4: Developing Cultural Competence						
Outcomes: The Community Paramedic will become culturally competent.						
A	B	C	D	F	N	Specific Competencies
						Demonstrate the ability to:
						The Community Paramedic will be able to provide a broad definition of culture.
						The Community Paramedic will be able to specifically define culture, ethnic group, and acculturation.
						The Community Paramedic will be able to recognize the divide between culture and individual identity.
						The Community Paramedic will assess factors that affect an individual's experience with culture of origin.

							The Community Paramedic will gauge the degree of acculturation of an individual.
							The Community Paramedic will be able to describe how cultural barriers and stereotypes impact health.
							The Community Paramedic will be able to recognize the risks of stereotyping, including the patient as an individual, inappropriate conclusions, and eroding trust.
							The Community Paramedic will develop a process for becoming culturally competent, including factors for considering race, ethnicity, religion, spirituality, sexual identity, and age.
							The Community Paramedic will be able to incorporate cultural competence into community paramedic work.
							The Community Paramedic will describe the role of cultural consideration when utilizing a Needs Assessment, Web of Resources, and Referrals.
							The Community Paramedic will be able to discuss how culture can impact the Web of Resources, outreach, the individual, and the community in the EMS system.
UNIT 5: The Community Paramedic's Role Within the Community							
Outcomes: The Community Paramedic will understand their role within the community.							
A	B	C	D	F	N	Specific Competencies	
						Demonstrate the ability to:	
						The Community Paramedic will be able to define and use a community needs assessment.	
						The Community Paramedic will be able to develop potential patient profiles based upon EMS call volume.	
						The Community Paramedic will extrapolate client profiles based on use of EMS, populations, morbidity, mortality, perception, and call acuity.	
						The Community Paramedic will develop profiles for other needs of the community based on high risk and high need populations, as well as societal and institutional gaps.	
						The Community Paramedic will be able to discuss how mapping plays a role, as part of a community needs assessment.	
						The Community Paramedic will demonstrate use of GIS mapping to track frequent use, creating a map of unmet community needs, and add to the map based on challenges of individual service areas.	
						The Community Paramedic will be able to describe different types of safety nets, including specifically: organizations, non-profit safety nets, private safety nets, and public safety nets.	

						The Community Paramedic will be able to discuss the role financing plays on the types of clients an agency will serve and how to refer clients for assistance in applying for benefits.
						The Community Paramedic will describe the process for taking referrals, receiving referrals, and evaluating receipt of assistance.
						The Community Paramedic will be able to discuss the different types and levels of care available to address a client's health, mental health, substance abuse, and social service (both outpatient and hospital based) needs.
						The Community Paramedic will be able to create a resource map with types of services and types of clients specified on the map.
						The Community Paramedic will define and explain the web of resources.
						The Community Paramedic will be able to translate client/community need into a web of resources based on client profiles and types and trajectories of care.
						The Community Paramedic will be able to use pathways to care for clients, including levels of care, client populations, assisting programs, and follow-up on referrals.
						The Community Paramedic will be able to discuss the concept of negative consequences in working with clients.
						The Community Paramedic will integrate the concepts of parallel web of resources, behavioral paradigms, behavior change, utilization, individual client situation, and goals when discussing negative consequences.
						The Community Paramedic will be able to apply negative consequences to modify behavior while maintaining credibility with the client.
						The Community Paramedic will differentiate between threat of negative consequences and use of negative consequences.
						The Community Paramedic will be able to discuss the types of resources needed to apply negative consequences as a means of modifying unhealthy behavior.
						The Community Paramedic will be able to define outreach.
						The Community Paramedic will be able to conduct outreach to a variety of programs for the purpose of engaging their services into the web of resources.
						The Community Paramedic will be able to establish an ongoing relationship and structure a relationship with an agency that becomes part of the web of resources.
						The Community Paramedic will be able to evaluate the effectiveness of the relationship with an agency based on number of clients, difficulties, and amount of assistance.

						The Community Paramedic will be able to identify, use, and discuss the purpose of community outreach with stakeholders.
						The Community Paramedic will be able to use evaluation, deployment, follow-up, and interventions to translate a needs assessment into a community outreach strategy.
						The Community Paramedic will be able to use case findings, safely approaching a client, introductions, biopsychosocial assessment, and resource identification in individual outreach.
						The Community Paramedic will be able to discuss case finding from multiple sources of information for both housed and homeless clients.
						The Community Paramedic will be able to discuss basic safety principles associated with individual outreach, including concerns with working alone, de-escalation, and staffing issues.
						The Community Paramedic will be able to approach a client and introduce them in a manner that sets the tone for effective outreach.
						The Community Paramedic will be able to conduct a biopsychosocial assessment, a psycho-psychosocial assessment, and a bio-medical assessment.
						The Community Paramedic will be able to identify resources that could address unmet or under met needs of a client, factoring in resistance and the web of resources.
						The Community Paramedic will be able to discuss the HOME (Homeless Outreach and Medical Emergency) Team Interventional Technique.
						The Community Paramedic will be able to apply Johnson Intervention, motivational interviewing, and a positive approach as steps involved in the HOME Team Interventional technique.
						The Community Paramedic will integrate system navigation and utilization of other sources of care into the web of resources to motivate clients to change.
						The Community Paramedic will be able to explain the different forms of client referrals (phone and written).
						The Community Paramedic will discuss factors involved with the physical transportation of a client to a resource provider, including client condition, safety, structuring of transports, and receiving agencies.
						The Community Paramedic will be able to identify and provide medical interventions aimed at bridging the gap between field and other sources of care including factors such as: basis for medical care, psychosocial concerns, length of care, and specific types of care.
						The Community Paramedic will be able to provide adequate tracking and follow-up for a client, including: tracking clients, documenting client visits, follow-ups, waivers, information sharing, a Memorandum of Understanding, and moving of clients.

							The Community Paramedic will be able to explain how to reconnect a client to the web of resources.
							The Community Paramedic will be able to discuss appropriate documentation, documentation mechanisms, research and tracking trends.
							The Community Paramedic will be able to discuss the types of documentation to use when a client is contacted through the 911 system, including planning with local and state EMS authorities and local protocols.
							The Community Paramedic will be able to structure documentation during an initial outreach contact.
							The Community Paramedic will be able to conduct ongoing documentation for a client.
							The Community Paramedic will be able to compare and contrast between different types of documentation, including electronic documentation, paper documentation, and forms used for data collection.
UNIT 6: The Community Paramedic's Personal Safety and Wellness							
Outcomes: The Community Paramedic will understand the importance of balancing stress and wellness while ensuring their personal safety.							
A	B	C	D	F	N	Specific Competencies	
						Demonstrate the ability to:	
						The Community Paramedic will be able to define Key terms associated with wellness and safety.	
						The Community Paramedic will be able to discuss physical, mental, emotional, and spiritual components of well-being.	
						The Community Paramedic will be able to discuss the causes of stress, general adaptation syndrome, physiologic responses, to stress, psychological manifestations of stress, and reactions to stress.	
						The Community Paramedic will be able to discuss the development of burnout, the role of distress and beliefs in burnout, as well as symptoms of burnout and guidelines for managing burnout.	
						The Community Paramedic will be able to identify the warning signs of stress and burnout.	
						The Community Paramedic will be able to identify strategies to manage stress.	
						The Community Paramedic will be able to discuss the role of nutrition, exercise and relaxation, sleep, disease prevention, and balance in the context of personal wellness.	

						The Community Paramedic will be able to discuss the stages of grief, working with family members, dealing with a grieving child, working with the patient, patient reactions, anxiety, mental health problems, and receiving unrelated bad news in the context of death and dying.
						The Community Paramedic will be able to discuss caring for critically ill and injured adult patients, including informing the patient, communication, orientation, refusal of care, allowing for hope, and dealing with family members.
						The Community Paramedic will be able to discuss caring for critically ill and injured pediatric patients as well as dealing with the death of a child.
						The Community Paramedic will be able to identify professional demeanor, compassion, expression of fears and concerns, religious customs, death and DNRs as actions that can reduce stressful situations during patient/family interactions.
						The Community Paramedic will be able to discuss characteristics of professional boundaries such as setting limits, negotiating boundaries, drawing the boundary line, and preventing the crossing of boundaries.
						The Community Paramedic will be able to define key terms associated with personal safety.
						The Community Paramedic will be able to defend self-care, recognition of hazards, and self-control as aspects of personal safety.
						The Community Paramedic will illustrate the knowledge of the spread of infectious disease, transmission.
						The Community Paramedic will be able to discuss and implement OSHA Blood-Borne Pathogens standard, including CDC, universal precautions, engineering controls, environmental controls, textiles and laundry, soiled patient care equipment, and post-exposure management.
						The Community Paramedic will identify how to minimize risks of infection utilizing preventative measures, respiratory hygiene/cough etiquette, communication, and infection control routine.
						The Community Paramedic will be able to identify and mitigate work environment hazards, physical hazards, sanitation hazards, violence and personal safety while working in a home visit environment.
						The Community Paramedic will be able to define, describe, and evaluate behavioral emergencies.
						The Community Paramedic will be able to explain potential injuries, training and practice, special techniques, body mechanics, and special equipment for safe movement and positioning of a patient.

UNIT 7: The Clinical Experience

Outcomes: The Community Paramedic will understand and provide the clinical care of the identified population.

A	B	C	D	F	N	Specific Competencies
						Demonstrate the ability to:
						The Community Paramedic will be able to interviewing techniques, approach to an interview, and discussion of sensitive topics, societal aspects, and medication reconciliation to compile a history on a non-acute patient.
						The Community Paramedic will be able to perform a focused physical examination and comprehensive physical examination through a review of systems and document an appropriate patient history, using a standardized form, of a sub-acute, semi-chronic patient.
						The Community Paramedic will be able to recognize the clinical differences between the newborn, pediatric, adult, and geriatric populations while monitoring high risk populations, observing for end of life issues, and assessing for use of CAM and communication with a primary medical doctor.
						The Community Paramedic will be able to interpret results and reports obtained through laboratory procedures, radiological testing, health promotion studies and diagnostic imaging and be able to identify red flags.
						The Community Paramedic will be able to discuss regulation of point of care testing/CLIA.
						The Community Paramedic will be able to obtain specimens and samples for laboratory testing using proper specimen collection techniques and utilization of bedside lab diagnostics.
						The Community Paramedic will utilize specialty equipment in the gathering of a history and physical of a sub-acute, semi-chronic patient, including: digital equipment, cameras, computers, telemedicine, otoscope, and Bluetooth stethoscope.
						The Community Paramedic will be able to demonstrate use of common home health equipment and devices, including: medical equipment, ambulatory assist devices, commodes, in home hospital beds, patient transfer devices and ergonomics.
						The Community Paramedic will be able to access and maintain proper care of ports, central lines, catheters, ileostomy, colostomy, and peg tubes.
						The Community Paramedic will be able to identify the need for Psychological First Aid (PFA) as it pertains to the individual experiencing a crisis situation, including: signs of stress, defense mechanisms, pre-existing conditions, and the development and implementation of PFA.
						The Community Paramedic will be able to assist patients and families with end-of-life issues including hospice and palliative care.

						The Community Paramedic will be able to collaborate with other healthcare professionals to provide care within the public health system including immunizations, transportation and access to resources, health promotion and injury prevention clinical opportunities, and disease prevention activities.
						The Community Paramedic will be able to manage patients with heart failure.
						The Community Paramedic will be able to manage patients with asthma.
						The Community Paramedic will be able to manage patients with COPD.
						The Community Paramedic will be able to manage patients with diabetes.
						The Community Paramedic will be able to manage patients with neurological conditions.
						The Community Paramedic will be able to manage patients with hypertension.
						The Community Paramedic will be able to manage patients with wounds.
						The Community Paramedic will be able to manage patients with infections.
						The Community Paramedic will be able to manage patients' oral health.
						The Community Paramedic will be able to manage patients' mental health.

Projects Required:

As assigned. A project may be required and will be explained by the instructor.

Textbook:

Contact Bookstore for current textbook.

Materials/Equipment Required:

- Liability Insurance: Required by the field internship sites. This provides you with malpractice insurance coverage while performing required clinicals. \$25.00
- Background check: Required for all students who have direct contact with the public. \$45.00
- Uniforms for Field Rotations: Cost will vary
- Immunizations: Cost will vary
- Travel and Transportation: Field clinicals are completed at a variety of sites. Because of this, students must have adequate transportation and should be aware of the costs involved in this travel. Cost will vary
- Stethoscope (optional): \$15-\$180
- Meals Away from Home during Field Training: Cost will vary

Attendance Policy:

Students should adhere to the attendance policy outlined by the instructor in the course syllabus.

Grading Policy:

The grading policy will be outlined by the instructor in the course syllabus.

Maximum class size:

Based on classroom occupancy

Course Timeframe:

The U.S. Department of Education, Higher Learning Commission and the Kansas Board of Regents define credit hour and have specific regulations that the college must follow when developing, teaching and assessing the educational aspects of the college. A credit hour is an amount of work represented in intended learning outcomes and verified by evidence of student achievement that is an institutionally-established equivalency that reasonably approximates not less than one hour of classroom or direct faculty instruction and a minimum of two hours of out-of-class student work for approximately fifteen weeks for one semester hour of credit or an equivalent amount of work over a different amount of time. The number of semester hours of credit allowed for each distance education or blended hybrid courses shall be assigned by the college based on the amount of time needed to achieve the same course outcomes in a purely face-to-face format.

Although this is a competency-based program, the following guidelines for hours shall be utilized:

Classroom: 100 hours

Skills Laboratory: 80 hours

Clinicals: 120 hours

Catalog Description:

EMS 5685 - Community Paramedic/Mobile Integrated Healthcare (14 hrs)

This course is designed to help the student increase his or her knowledge concerning the level of responsibility that clinicians will be expected to know in order to perform as a Community Paramedic. Upon completion, the training program aims to produce clinicians who have the competencies, knowledge, and professional skills to function as a Community Paramedic in a mobile integrated healthcare system. Course completers will receive a certificate of completion from Cowley College in Community Paramedic/Mobile Integrated Healthcare. The qualifications will be nationally and internationally recognized as an established system of care serving urban, rural, and frontier communities.

Prerequisites: Student must have a completed background check on file, meet or exceed minimum reading score of 63 according to the COMPASS Reading test or ACT Reading score of 18 or higher; Associate degree or higher to waive the COMPASS test. Student must currently be certified and/or licensed as a Paramedic (or equivalent) by a recognized state governing body or

the National Registry of Emergency Medical Technicians (NREMT). Student must have two years of experience as a street level provider in a service that provides advanced life support (ALS) care of patients.

Refer to the following policies:

402.00 Academic Code of Conduct

263.00 Student Appeal of Course Grades

403.00 Student Code of Conduct

Disability Services Program:

Cowley College, in recognition of state and federal laws, will accommodate a student with a documented disability. If a student has a disability which may impact work in this class and which requires accommodations, contact the Disability Services Coordinator.

Diane Glynn

From: Cannon, Chris [cannon@cowley.edu]
Sent: Monday, August 24, 2015 11:19 AM
To: Diane Glynn
Subject: RE: Course Syllabus and Requirements
Attachments: EMS5685 151S CP_MIH Syllabus.pdf

Hi Diane,

I've attached the syllabus for the Community Paramedic/MIH course to this message.

Thank you, and please don't hesitate to contact me with any questions!

Regards,

Chris Cannon
Chair, Health and Human Services
EMS Program Director
Cowley College Allied Health Center
1406 E. 8th Street
Winfield, KS 67156
620-229-5985
620-229-5989 Fax
www.cowley.edu/paramedic
www.facebook.com/cowleyems



Course Syllabus
Community Paramedic/Mobile Integrated Healthcare
EMS5658_HW01151S

August 18th 2015 – May 13th 2016

Credit Hours: 14
Instructor: Malachi Winters
Phone: 316-640-8681
E-Mail: Please use Blackboard Messages

Office Hours/Hours of Availability: You may call me at (316) 640-8681 or email me to set up an appointment.

Textbook: Mobile Integrated Healthcare: Approach to Implementation. MedStar Mobile Healthcare. Jones & Bartlett. 2016 ISBN: 978-1-4496-9016-8

Link to Cowley College Bookstore: <http://www.cowley.edu/bookstore/index.html>

Last Day to Withdraw with a "W" - November 15, 2015

If you need to drop or withdraw from any course, please talk to your instructor and/or advisor first. If an athlete, notify your coach to avoid impacting eligibility. Dropping or withdrawing from a class may impact your financial aid, scholarship, or eligibility status.

Communication: Communication regarding this course will take place via **Blackboard Messages**. Communication from Cowley administration or advisors will be delivered to student C-mail.
<http://www.cowley.edu/cmail.html>

Blackboard Messages is a private and secure text-based communication system which occurs within a course among its Course members. Users must log on to Blackboard to send, receive, or read messages. The *Blackboard Messages* tool is located on the Course Menu, on the left side of the course webpage. It is recommended that students check their messages routinely to ensure up-to-date communication. This is the best way to communicate with your instructor privately. I will respond to your messages within 48 HOURS. Please do not resend your email if 48 HOURS have not passed.

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Instructors teaching online, hybrid, or using Blackboard to web enhance their face-to-face classes may also require students to correspond using the Blackboard Messages within their Blackboard course.

All student academic reports and current grades can be accessed through Campus Connect. Even though the Blackboard grade book may be used to help students track their academic progress, the official grade is posted in Campus Connect.

Computer Requirements: It is the student's responsibility to have (or have access to) a working computer with reliable broadband Internet access. Computer assignments may be required by the instructor to access course materials or to submit assignments using appropriate software. The college offers computers for student use at the Cowley Wichita Center, Cowley Mulvane Center, and the Cowley Arkansas City Campus.

Purpose or Goal of the Class: This course is designed to help the student increase his or her knowledge concerning the level of responsibility that clinicians will be expected to know in order to perform as a Community Paramedic.

Objectives of this Course: Upon completion, the training program aims to produce clinicians who have the competencies, knowledge, and professional skills to function as a Community Paramedic in a mobile integrated healthcare system. Course completers will receive a certificate of completion from Cowley College in Community Paramedic/Mobile Integrated Healthcare. The qualifications will be nationally and internationally recognized as an established system of care serving urban, rural, and frontier communities.

Expectations of this Course: This is an hybrid online course, which means most of the course work will be conducted online. Expectations for performance in an online course are the same for a traditional course. In fact, online courses require a degree of self-motivation, self-discipline, and technology skills which can make these courses more demanding for some students.

Students are expected to:

- Review the How to Get Started information in the course content.
- Introduce yourself to your instructors and classmates during the first week by posting a self-introduction in the appropriate discussion forum.
- Interact online with the instructor and peers and keep up with all assignments and activities.
- Log in to the course a minimum of twice per week.
- Respond to discussion boards within the designated timeframe.
- Respond to messages from your instructor.
- Submit assignments and activities by corresponding deadline(see course schedule for deadlines).

Course Grade/Points Possible:

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Education 224

Course Grade		Letter Grade Scale	
Homework	20%	86-93%	= B
Fall Project	20%	80-85%	= C
Clinical Participation	20%	70-79%	= D
Capstone Project	20%	Below 70%	= F
Exams (2)	20%		

Tutoring and Remediation:

If student needs tutoring or assistance with course material, Cowley College offers tutoring for specific courses online via Tutor.com and on campus in Mulvane and Arkansas City.

Refer to the following preferred link

On campus <http://www.cowley.edu/academics/tutoring/tutorschedule.html>

Online <http://www.cowley.edu/academics/tutoring/tutorschedule.html>

Homework: Homework assignments include writing assignments and online quizzes assigned throughout the course. Homework will count as 20% of the final course grade.

Exams/Final Exam: Two cumulative exams, one at the end of the Fall Semester and one at the end of the Spring Semester will be administered. These exams together will count for 20% of the final course grade.

Projects Required: During the 2015 Fall Semester, the student will complete a community needs assessment of his or her community to identify gaps in healthcare within the system he or she operates in. This needs assessment will count as the Fall Project and will count for 20% of the entire grade of the course. The community needs assessment will be used to drive clinical placement and as the backbone for the Capstone Project.

During the 2016 Spring Semester, the student will complete a Capstone Project which will address one of the needs identified during the Community Needs Assessment. The Capstone Project must have instructor, physician medical director, and service director approval before implementation. The Capstone Project will count for 20% of the entire grade of the course.

Skills Verification: To complete the course, the student must successfully* perform all designated skills found in the Community Paramedic specific course requirements while evaluated by faculty, peers, or clinical preceptors (as indicated)

*successfully is defined as:

A. Skill is performed accurately.

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

- B. No main steps of skill are omitted.
- C. Skill performance would not cause patient harm (if applicable).
- D. No critical criteria were committed/omitted (as applicable).
- E. Score the necessary points for a passing performance on the check sheet as designated (if applicable) for each skill.

<u>Clinical Competency</u>	<u>Lab</u>	<u>Clinical</u>
Adult History Gathering	2	20
Pediatric History Gathering from Parent	2	20
Medication Reconciliation	1	7
Electronic Medical Review	0	7
Comprehensive History and Physical Exam – Pediatric	2	20
Comprehensive History and Physical Exam – Adult	2	20
Patient Documentation	2	20
Prenatal Physical Examination	0	5
Direct verbal report to provider	0	10
Newborn Assessment	0	5
Pediatric Assessment	0	20
Children with Special Needs Assessment	0	10
Adult Assessments	0	20
Geriatric Assessment	0	20
Well Baby Checks 2-12 mos.	0	20
Well Baby Checks 1-5 yr.	0	15
Well Baby Checks 6-13 yr.	0	10
Well Baby Checks 13-18 yr.	0	10

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Weights	0	5
Lengths	0	5
Vitals	0	2
Developmental assessment	0	5
Head Circumference	0	5
Hospice/End of life visits	0	5
Communication with Primary Referring Provider	0	3
Radiological diagnostic preparation instructions – CT	0	2
Radiological diagnostic preparation instructions – MRI	0	2
Radiological diagnostic preparation instructions – US	0	2
Radiological diagnostic preparation instructions – Nuclear	0	2
Results from diagnostic lab testing	0	15
Identification of “red flags” and high risk results	0	5
Identifying required further diagnostic testing needs	0	5
Specimen collection techniques – serum	0	5
Specimen collection techniques – urine	1	3
Specimen collection techniques – wound, throat, nasal or related culture	1	5
Health promotion studies education (Cholesterol, HA1C, Colonoscopy, etc)	0	5
Bedside diagnostics performance – Fecal occult	0	3
Bedside diagnostics performance – FSBG	0	3
Bedside chemistry strips	3	3
Handheld point of care analyzers – BGL	0	3
Handheld point of care analyzers – PT/INR	0	3

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Handheld point of care analyzers – other blood tests	0	3
Digital Equipment (Sonogram)	0	5
Cameras	0	5
Computers/medical records	0	5
Telemedicine/Skype/Facetime	1	5
Otoscope	3	30
Bluetooth Stethoscope	2	5
Oxygen Delivery	1	5
CPAP	1	5
Bi-PAP	0	5
Walkers	1	5
Canes	1	5
Crutches	3	5
Commodes	1	5
Hospital beds	1	5
Hoyer lifts	1	5
Slide boards	1	5
Air lift cushions	1	5
Wheel chairs	1	5
Ports	3	5
Central lines	3	5
Ileostomy	2	5
Foley Catheters	2	5

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Straight urinary catheters	2	5
Colostomy care	2	5
Peg tubes	2	5
Wound management	2	5
Assessment of Mental Health	5	0
Identify the signs of stress	5	0
Recognize defense mechanisms	5	0
Determine Pre-existing conditions (psychological)	5	0
Establish goals of the intervention (psychological)	5	0
Provide psychological first aid	0	10
Pain and pain management	0	5
Hospice referral criteria	0	5
Understands palliative care	0	5
Immunization techniques	2	20
Immunization schedule	0	20
TB medication administration	0	5
Home safety inspections	0	5
Overview to reporting communicable diseases	0	5
Participation in community health activity	0	4
Assessment and management plan of a sub-acute patient with heart failure	0	10
Assessment and management plan of a sub-acute patient with asthma	0	10
Peak flow assessment for asthma	1	5
Assessment and management plan of a sub-acute patient with COPD	0	10

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Chest Physiotherapy	1	3
Assessment and management plan of a sub-acute patient with diabetes	0	10
Assessment and management plan of a sub-acute patient with TBI	0	10
Assessment and management plan of a sub-acute patient with spinal cord injury	0	10
Assessment and management plan of a sub-acute patient with MS/MD	0	10
Assessment and management plan of a sub-acute patient with hypertension	0	5
Assessment and management plan of a sub-acute patient with a wound	0	10
Demonstration of surgical asepsis	1	3
Assessment and management plan of a sub-acute patient with an infection	0	10
Assessment and management plan of a sub-acute patient with regard to oral health	0	5
Assessment and management plan of a sub-acute / semi-chronic psychiatric patient	0	10

Clinical Experience:

In order to complete the course, the student will complete the minimum of 120 hours in the clinical setting under the direct supervision and with voice contact of a physician, or, with physician approval, an advanced practice registered nurse or a physician assistant. Per KSA 65-6119 and KS AG Opinion 2014-20, a Kansas certified paramedic may:

(1) Perform all the authorized activities identified in K.S.A. 65-6120, 65-6121, 65-6144, and amendments thereto;

(2) when voice contact or a telemetered electrocardiogram is monitored by a physician, physician assistant where authorized by a physician or an advanced practice registered nurse where authorized by a physician or licensed professional nurse where authorized by a physician and direct communication is maintained, and upon order of such person, may administer such medications or procedures as may be deemed necessary by a person identified in subsection (d)(2);

(3) perform, during an emergency, those activities specified in subsection (d)(2) before contacting a person identified in subsection (d)(2) when specifically authorized to perform such activities by medical protocols; and

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

(4) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.

Students will have a 40 hour core set of clinical rotations that they must complete, including rotations through a primary care physician's practice, a wound care clinic, hospice, a cardiology clinic, and behavioral health.

Community Paramedic programs vary widely across the country. In order to be successful, a Community Paramedic program must be built to fit the needs of a community. As such, it is not reasonable to expect that any standardized clinical rotation will fit the needs of every community. The remaining 80 hours of clinical time, (henceforth referred to as "Elective Clinicals") not covered in the core rotation will be arranged by the student with faculty assistance.

The placement of students in Elective Clinical environments will be dependent on the Needs Assessment project that the student will complete during the 2015 Fall Semester. Based on the local needs identified in the Needs Assessment, the student will coordinate with local physician(s) to arrange for focused Elective Clinical time to address the specific needs of the community that the student will be operating in.

Attendance Policy:

Hybrid Courses – You will be required to log into the class a minimum of 2-3 times weekly and complete work both online and in the classroom.

Pay close attention to deadlines, and allow yourself plenty of time to complete assignments, discussion questions, quizzes, and exams.

Weekly attendance for the online class runs from 00:00 Tuesday, until Monday at 23:59.

You MUST complete at least one online assignment (i.e. discussion board post, quiz, exam, or an assignment submission) at least once during that week, or you will be counted absent.

<http://www.cowley.edu/policy/policy257.html> (Institutional Policies: Academic Affairs Council: Series 200.00: 257.00 Attendance and Classwork)

Notification of Tardiness or Absences: At times, the adult student will have legitimate reasons for being late or absent from class. We ask that these students contact the instructor via telephone or e-mail during the didactic session of the program. Other requirements during clinical and field training will be discussed during those class orientations.

Instructor Class Policies: Due to the intense pace of the program, attendance is essential for a student to be successful. Students must also observe the following requirements:

1. Due to the intensity and rapid pace of Community Paramedic training, attendance at all scheduled activities is mandatory. Students may miss up to a total of 10% of the didactic classes, and up to a total of 5% of the clinical without makeup time. Faculty may counsel (in

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

which make-up activities may be required), or may recommend dismissal in the case of absences in excess of the specified percentages.

2. Students are obligated to achieve a specified number of hours for completion of clinicals. Therefore, the student must work all scheduled hours. Students must complete at least 120 hours of clinicals. Students may only miss 5% of the clinical training without makeup time.
3. Assigned asynchronous online lectures (recorded lectures) count towards the general attendance requirements noted above for classes. Failure to view assigned content will result in an absence being recorded for those hours.
4. Military reserves will be allowed to attend required training sessions and make up time, as required by law. Reserves that are called to active duty status will be allowed to complete the program if possible at a later date, as required by law.

Late Work: Homework is due at the start of class when due. A maximum of 10% will be deducted from the homework that is handed in after the start of class.

Make-up work/tests: Any make-up work must be arranged with the instructor. It is the student's responsibility to contact the instructor and initiate conversation about make-up assignments. Note that the instructor reserves the right not to accept late or make-up work.

Emergency Preparedness: In the case of an event that causes disruptions to normal campus functions, go to the college website at www.cowley.edu for emergency notifications.

Use of Student Photographs: Student photographs or video taken during the paramedic class may be used by the college for fliers, brochures, bulletin boards, presentations, WWW pages or other appropriate methods decided by the Director of EMS Education.

Social Media: Social Media (Twitter, facebook, LinkedIn, etc.) is a convenient and valuable communication tool for paramedic students. However, care must be taken to maintain professionalism when posting about the Community Paramedic/MIH program. At NO TIME will any patient identifying information, unprofessional photographs of students in uniform, and/or comments about clinical/preceptors be posted on a social media website. Violation of this policy is taken seriously, and may result in:

- A. counseling.
- B. remediation.
- C. immediate temporary suspension
- D. recommended permanent suspension.

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Dress Code: Students are perceived as potential practitioners; therefore, strict attention to professionalism must be maintained. All students are expected to exercise good personal hygiene prior to class, and during clinicals. Tasteful casual dress is acceptable for classroom activities. Specific dress code requirements for the clinical setting will be addressed by clinical site preference.

Disability Services Program: Cowley College, in recognition of state and federal laws, will accommodate a student with a documented disability. If you have a disability which may impact your work in this class and for which you require accommodations, please contact James Brown, the Disability Services Coordinator. Phone number: Arkansas City Campus: 620.441.5557, E-mail: jim.brown@cowley.edu

Grade Change/Appeal: <http://www.cowley.edu/policy/policy263.html> (Institutional Policies: Academic Affairs Council: Series 200.00: 263.00 Student Appeal of Course Grade)

Student Code of Conduct: <http://www.cowley.edu/policy/policy403.html> (Institutional Policies: Student Affairs Council: Series 400.00: 403.00 Student Code Of Conduct)

Academic Code of Conduct: Cowley College is committed to instilling in its students a high level of academic integrity. Integrity in the classroom is a definite expectation. Students who compromise the integrity of the academic process are subject to disciplinary action by the college.

Review the academic code of conduct policy at: <http://www.cowley.edu/policy/policy402.html> (Institutional Policies: Student Affairs 400:402 Academic Code of Conduct)

Credit Hour Definition: <http://www.cowley.edu/policy/policy280.html> (Institutional Policies: Academic Affairs 200:280 Credit Hour Definition)

Semester schedule:

Week	Dates	Topic	
Week 1	August 18 th -24 th	Module 1.1 – Introduction to the Community Paramedic Module 1.2 - Understanding the Health Care System	
Week 2	August 25 th -31 st	Module 2.1 – Social Determinants of Health	

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Week 3	September 1 st – 7 th	Module 3.1 – Promotion and Prevention	
Week 4	September 8 th – 14 th	Module 3.2 – Patient Support Techniques and the Impact of the Community Paramedic on the Healthcare System	
Week 5	September 15 th – 21 st	Module 4.1 - Developing Cultural Competence	
Week 6	September 22 nd – 28 th	Module 5.1 – Community Needs Assessment Module 5.2 – Systems of Care Module 5.3 – Pathways of Care	
Week 7	September 29 th – October 5 th	Module 5.4 – Negative Resources Module 5.5 – Introduction to Outreach Module 5.6 - Community Outreach Module 5.7 - Principles of Individual Outreach	
Week 8	October 6 th – 12 th	Module 5.8 - The HOME Team Interventional	

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

		Technique	
Week 9	October 13 th – 19 th	Module 5.9 – System Navigation Module 5.10 - Documentation	
Week 10	October 20 th – 26 th	Module 6.1 – Personal Safety and Wellness	In person lab to be scheduled.
Week 11	October 27 th – November 2 nd	Module 7.1 – Aspects of Behavioral Health	
Week 12	November 2 nd – 9 th	Module 8.1 – Assessment Skills	In person lab to be scheduled.
Week 13	November 10 th – 16 th	Module 8.2 – Care Plan Writing	
Week 14	November 17 th – 23 rd	Module 8.3 – Medication Reconciliation	
Week 15	November 24 th – 30 th	Thanksgiving Break	
Week 16	December 1 st – 7 th	Clinical Schedule and Capstone Workshop	
Week 17	December 10 th	Final Exam	LIVE ONLINE

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.

Diane Glynn

From: Jason White [jason.white3254@gmail.com]
Sent: Monday, July 13, 2015 4:07 PM
To: Glynn, Diane M [BON]; Blubaugh, Mary I [BON]
Subject: Fwd: [kansas-ems] Community Paramedic/Mobile Integrated Healthcare Course

just wanted to make sure you knew what was going on

Jason

----- Forwarded message -----

From: Cannon, Chris <cannon@cowley.edu>
Date: Mon, Jul 13, 2015 at 3:59 PM
Subject: [kansas-ems] Community Paramedic/Mobile Integrated Healthcare Course
To: Kansas EMS discussion <kansas-ems@list.da.ks.gov>

Cowley College is offering a Community Paramedic/Mobile Integrated Healthcare course starting on August 18, 2015. The course curriculum is based on the North Central EMS Institute national Community Paramedic curriculum, and will help prepare participants to develop and manage CP/MIH programs in their communities. Flexibility is stressed during the course, with an emphasis placed on local needs and resources. The course will also help prepare participants to challenge the upcoming BCCTPC Certified Community Paramedic (CP-C) exam. The CP/MIH course includes asynchronous online assignments, live online weekly meetings, monthly skills labs, and clinical rotations.

Dates: 8/18/15 – 5/12/16

Live Online Meetings: Thursday evenings, 6-10 PM

Lab Sessions: One Saturday per month

Credit: 14 credit hours

Lead Instructor: Malachi Winters

Requirements for Admission:

- Current paramedic licensure/certification
- Minimum 2 years of experience as a paramedic
- Letter of reference from your current EMS service director

Education 236

- Letter of reference from your current EMS medical director
- Current immunizations (form at link below)
- Current physical exam (form at link below)
- Current health insurance (form at link below)

Please submit your course application at the following link:

http://www.cowley.edu/community_paramedic/

Cost: Tuition Information + \$100 lab fee

Thank you for your interest, and please don't direct all questions OFF LISTSERV to cannon@cowley.edu.

Regards,

Chris Cannon

Chair, Health and Human Services

EMS Program Director

Cowley College Allied Health Center

1406 E. 8th Street
Winfield, KS 67156

620-229-5985

620-229-5989 Fax

www.cowley.edu/paramedic

www.facebook.com/cowleyems

You are currently subscribed to kansas-ems as: jason.white3254@gmail.com.
To unsubscribe send a blank email to leave-203154-
193819.d7a2e7cbf373f14d8a64c24742530736@list.da.ks.gov

[Home](#)
[Communities](#)
[Colleges](#)
[Paramedics](#)
[Program Handbook](#)
[2014JEMS](#)
[NCCCP](#)

[About CHEC](#)



[Login](#)

YOU ARE HERE: [Home](#)

Coming Soon...

Welcome to the Community Paramedic Program Web site. We hope you take time to learn more about an innovative program with the potential to improve the health of millions living in rural and remote regions of the United States and around the world.

It's a simple concept: Connect underutilized resources to underserved populations. In this case, we're expanding the roles of EMS workers to provide health services where access to physicians, clinics and/or hospitals is difficult or may not exist.

The Community Paramedic Program is organic. It exists for the sole purpose of serving the needs of a particular community. Its success relies heavily on collaboration among local stakeholders:

- the people who live or travel in medically underserved rural and remote locales;
- elected officials whose charge it is to maintain the physical and fiscal health of a community;
- health department officials, clinic and hospital administrators, who assess needs and manage resources in order to provide the range of services to meet those needs.

Last but not least, colleges and universities that train our nation's first responders are core to the Community Paramedic Program.

Similar initiatives in the United States and around the world have generated remarkable results. We visited many of them. Today's Community Paramedic Program combines all of the best practices and lessons learned from these programs.

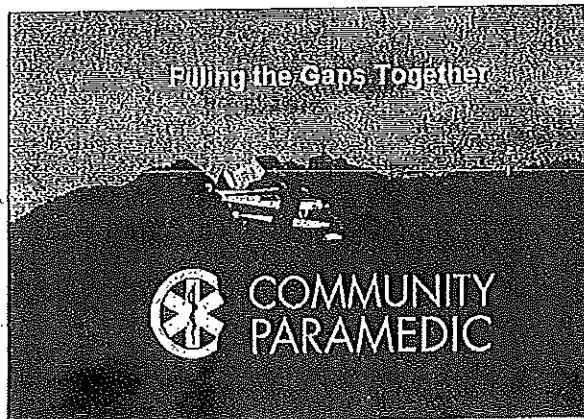
Once you've had a chance to learn more about the Community Paramedic Program, we'd like to hear your thoughts. If you are interested in finding out how you can initiate a Community Paramedic program where you are, or have questions about the program, please e-mail me.



From



North Central EMS Institute
 P.O. Box 2286
 St. Cloud, Minnesota 56302
 888.603.4426
 320.251.8154 (fax)
[Contact Us](#)



The Community Paramedic Program—A New Way of Thinking

For nearly 76 million people living in rural areas of the United States, health care needs far outnumber health care options. These communities already include disproportionate numbers of elderly citizens, immigrants, impoverished families and those in poor health.

Residents often must travel great distances—incurring great expenses—to receive even the most basic care. Or worse, they receive no care at all.

The Community Paramedic Program closes the gap by expanding the role of EMS personnel. Through a standardized curriculum, accredited colleges and universities will train first responders at the appropriate level to serve communities more broadly in the areas of:

- Primary care
- Public health
- Disease management
- Prevention and wellness
- Mental health
- Oral health

The Community Paramedic Program adapts to the specific needs and resources of each community. It will succeed through the combined efforts of those that have a stake in maintaining the health and well-being of its residents.

Gary Winarove, Project Director
Community Healthcare
Emergency Cooperative
(CHEC)

copyright 2005-2014 communityparamedic.org

[Privacy Statement](#) [Terms Of Use](#)

Community Paramedic™ Program Handbook

Western Eagle County Health Services District



Fall 2011
Version 1.2



North Central
EMS Institute



COMMUNITY™
PARAMEDIC

360 Eby Creek Rd.
PO Box 1809
Eagle, CO 81631
Phone: 970-328-1130
www.wecadems.com/cp.html

Education 241

Community Paramedic Program Handbook

Ownership of copyright

The copyright in this document and the material herein (including without limitation the text, computer code, artwork, photographs, images, music, audio material, video material and audio-visual material in this document) is owned by Western Eagle County Health Services District [and its licensors].

Copyright license

Western Eagle County Health Services District grants to you a worldwide non-exclusive royalty-free revocable license to:

- ⊙ view this document and the material on this website on a computer or mobile device via a web browser or other such manner;
- ⊙ copy and store this document and the material in your computer hard drive; and
- ⊙ print pages from this document for your own [personal and non-commercial] use.

Western Eagle County Health Services District does not grant you any other rights in relation to this document or the material herein. You may not distribute this document via email, fax, or other electronic means. If a second copy is needed, please request to download it from the www.communityparamedic.org website. In other words, all other rights are reserved.

For the avoidance of doubt, you must not adapt, edit, change, transform, publish, republish, distribute, redistribute, broadcast, rebroadcast or show or play in public this document or the material herein (in any form or media) without Western Eagle County Health Services District prior written permission.

Data mining

The automated and/or systematic collection of data from this document is prohibited.

Permissions

You may request permission to use the copyright materials in this document by writing to emontera@wecadems.com or PO Box 1809, Eagle, CO 81631.

Enforcement of copyright

Western Eagle County Health Services District takes the protection of its copyright very seriously.

If Western Eagle County Health Services District discovers that you have used its copyright materials in contravention of the license above, Western Eagle County Health Services District may bring legal proceedings against you seeking monetary damages and an injunction to stop you using those materials. You could also be ordered to pay legal costs.

If you become aware of any use of Western Eagle County Health Services District's copyright materials that contravenes or may contravene the license above, please report this by email to wecadems@wecadems.com or by post to PO Box 1809, Eagle, CO 81631.

Infringing material

If you become aware of any material in this document that you believe infringes your or any other person's copyright, please report this by email to wecadems@wecadems.com or by post to PO Box 1809, Eagle, CO 81631.

Community Paramedic™ Program Handbook

This handbook was developed by:

Silver Street Consulting, LLC
Jill Hunsaker Ryan, MPH, Principal
silverstreetconsulting@gmail.com
www.silverstreetconsulting.net

Under the direction of:

Christopher A. Montera, Chief
Lisa Ward, Community Paramedic Coordinator
Kevin Creek, Community Paramedic
Christopher Berdoulay, Community Paramedic
Western Eagle County Health Service District (WECAD)
cmontera@wecadems.com
www.wecadems.com

In cooperation with:

Anne Robinson, RN, BSN, President of Caring Anne Consulting, LLC
Community Paramedic Curriculum Developer, North Central EMS Institute
ar@caringanne.com
www.caringanne.com

This handbook has been reviewed and approved by
Gary Wingrove, Strategic Affairs, North Central EMS Institute

Funding provided by Colorado Department of Public Health and Environment, Emergency Medical Services Division and Western Eagle County Health Services District.

Community Paramedic™ Program Handbook

TABLE OF CONTENTS

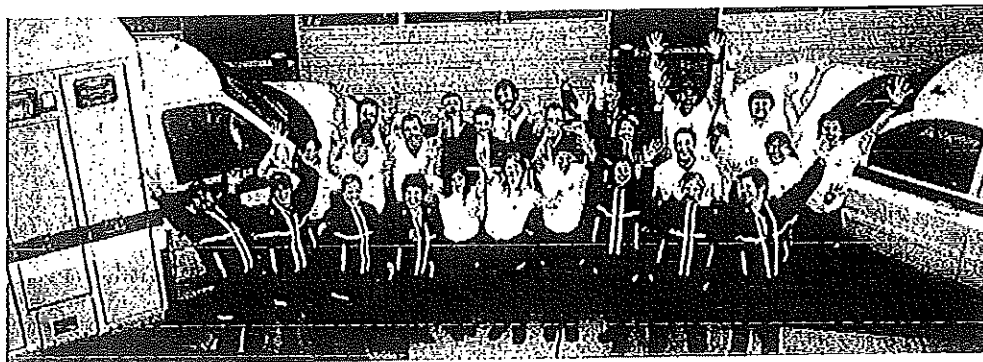
Background	1
The WECAD Model	2
Primary Care Services	
Community-Based Services	
The Global View	3
History	
Value	
Programs	
Program Development	8
Plan to Plan	8
Assess Program Feasibility	8
State Regulations	
Internal Commitment	
Key Partner Commitment	
Determine how to Provide Medical Direction	10
Assess Community Needs	11
Determine Program Scope	11
Services	
Personnel	
Budget	
Engage the Community	15
Develop Policies and Procedures	16
Plan and Implement Training	17
Develop an Evaluation Plan	18
Begin Operations	20
Evaluate the Pilot Phase	21
Appendices	23
A. Community Paramedic Program Resources	23
B. Work Plan	24
C. Example of a Memorandum of Understanding	26
D. Client Satisfaction Survey	31
E. National Community Paramedic Fact Sheet	32
F. WECAD's Community Paramedic Fact Sheet	33
G. Community Paramedic Patient Referral Procedures	35
H. Release of Information Form	36
I. Procedure for Physician Contact While on Visit	37
J. Home Safety Assessment	38
K. Social Support Evaluation	42
L. Sample Clinical Services Policies (Wounds/Medication Reconciliation)	43
M. Physician Order Form	44

BACKGROUND

Eagle County, Colorado is a rural resort community of approximately 54,000 residents located in the Rocky Mountains, over two hours west of Denver. Thirty percent of residents are uninsured, as are 54 percent of ambulance patients. Social supports are limited, especially for the elderly or those with mental health issues. And, the county is subject to extreme weather conditions, which can geographically isolate residents on any given day. These dynamics create service gaps, many of which are filled by a call to Dispatch to request an ambulance, which has become the service provider of last resort.

The Western Eagle County Health Services District (WECAD), similar to other rural EMS systems, experiences calls that aren't true emergencies, but rather of a social service or home health nature. The District also receives emergency calls of health issues gone awry because medication wasn't taken or an individual waited too long to seek medical attention. Some emergency calls are in response to patients just released from the hospital that were either prone to complications or didn't understand their discharge instructions. These patients are likely re-admitted.

WECAD's daily experiences with these types of cases prompted it to explore ways that paramedics could be more proactive in helping vulnerable residents maintain their health in order to prevent an ambulance transport. In 2009, WECAD joined with the Eagle County Public Health Agency, local physicians, and the International Roundtable on Community Paramedicine to plan and implement Colorado's first Community Paramedic (CP) program. This handbook is designed to help other organizations start such an endeavor.



The WECAD Model

The goals of WECAD's Community Paramedic Program are twofold: to improve health outcomes among medically vulnerable populations; and to save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions. WECAD's Community Paramedic model has two components: 1) primary care services, ordered by a physician and conducted in a patient's home, and 2) community-based prevention services planned and provided in concert with the local public health department.

Primary Care Services

As a way to increase availability and continuity of health care for vulnerable populations, specially-trained paramedics provide specific primary care services in the patient's home, working through a physician's order. The services are within the paramedic's legal scope of practice, and the paramedics have been trained and evaluated on their ability to provide such care. This type of care is not of

In-home care that is delivered by a Community Paramedic is not of an ongoing nature, but rather each visit requires a discreet order from the patient's physician.

an ongoing nature, such as that of a home health agency, but rather each visit necessitates a discreet order with instructions for that one visit. If the provider believes the patient requires additional follow up by the Community Paramedic, they must issue another order.

While in the home, the Community Paramedic takes a patient history, assesses the chief complaint, and then confers with the treating provider on next steps. The paramedic may also conduct a home safety check and assess the need for referral to a social service agency or other community resource. A patient care report is developed and faxed to the ordering provider to be placed in the patient's chart. This in-home type of care is perfect for many vulnerable populations including:

- ✓ The chronically ill who have a hard time getting to their medical provider's office and frequently cancel appointments.
- ✓ Patients recently hospitalized that would benefit from a few in-home monitoring sessions to prevent complications.
- ✓ Patients in need of social supports who frequently call 9-1-1.

Community-Based Prevention Services

Community Paramedics also assist the local public health department with community-based services such as immunizations, disease investigations, blood draws at health fairs, mass vaccination clinics, and fluoride varnish applications to children. This assistance helps to increase the capacity of the department. In this two-way partnership, public health personnel also play a role in linking uninsured patients to a primary care provider, thus assisting with the physician order process described above.

The Global View

Community paramedicine is a relatively new field with local programs emerging as a response to the health care crisis. The CP model increases access to basic health care services through the use of specially trained Emergency Medical Service (EMS) personnel in an expanded role. These so-called Community Paramedics provide care in a non-urgent setting, consistent with the Medical Home Model (defined as patient-centered medical care led by a physician coordinating all aspects of preventive, acute and chronic care, using the best available evidence and technology), and under the supervision of an ordering physician or advance practice provider.

Community Paramedics expand the reach of primary care services by using a paramedic to perform procedures already in their skill set, such as: assessment (vital signs, blood pressure, labs: glucose levels, medication compliance), treatment (wound care, medication reconciliation), prevention (immunizations, fall assessment), and referral (medical and social services). Specific roles and services are determined by each community's unique health needs, within the paramedic's legal scope of practice, and consistent with medical direction. International programs have had success in reducing emergency transports and hospital readmissions by using the paramedic in this expanded role.

History

The term "community paramedicine" was first described in the U.S. in 2001, as a means of improving rural EMS and community healthcare; however, it is not a new concept in practice.¹ Increasingly EMS personnel are caring for patients with non-emergent medical problems in their day-to-day role as emergency responder. For example, studies place the number of low-acuity transports (e.g., sprains or

¹ Joint Committee on Rural Emergency Care (JCREC): National Association of State Emergency Medical Services Officials & National Organization of State Offices of Rural Health, "State Perspectives Discussion Paper on Development of Community Paramedic Programs," (2010).

flu-like systems) at 10–40%.² Thus, it is not surprising that the field is moving toward a more community-based approach. National organizations have written about this progression for years. In 1996, a National Highway Traffic Safety Administration report described an EMS of the future with the ability not only to provide acute care, but also identify health risks, provide follow-up care, treat chronic conditions and monitor community health (Delbridge).³

The 2004 article, "Rural and Frontier EMS Agenda of the Future," provided a vision of EMS personnel providing not only a rapid response, but also filling roles in prevention, evaluation, triage, and referral (McGinnis, National Health Association Press).⁴ In 2010, the Joint Committee on Rural Emergency Care (JCREC), which is comprised of members from the National Association of State Emergency Medical Services Officials (NASEMSO) and the National Organization of State Offices of Rural Health (NOSORH), issued a discussion paper which called the community paramedicine model "One of the most progressive and historically-based evolutions available to community-based healthcare," further praising its potential to decrease emergency department utilization, save healthcare dollars and improve patient outcomes.⁵

Value

According to the American Academy of Family Physicians (AAFP) a health system that focuses on primary care is more effective, more efficient, and more equitable among patient populations. These benefits are demonstrated by reduced mortality rates, less frequent use of ERs and hospitals, better preventive care, higher patient satisfaction, and a reduction in health disparities.⁶ In communities all across America, provider shortages are reducing access to this basic level of care (Figure 1). In fact, the AAFP reports that the number of medical school students entering primary care has dropped 51.8 percent since 1997. According to a 2010 University of Michigan Health System study, the country may not be ready to shift to a Medical Home model because there aren't enough primary-care doctors to handle the workload.⁷ Demand for primary care physicians is only going to increase with the 2010

² Krumpalman, K. "History of Community Paramedicine," *Journal of Emergency Medical Services*; June 22, 2010.

³ Joint Committee on Rural Emergency Care (JCREC): National Association of State Emergency Medical Services Officials, National Organization of State Offices of Rural Health State Perspectives, "Discussion Paper on Development of Community Paramedic Programs." (2010)

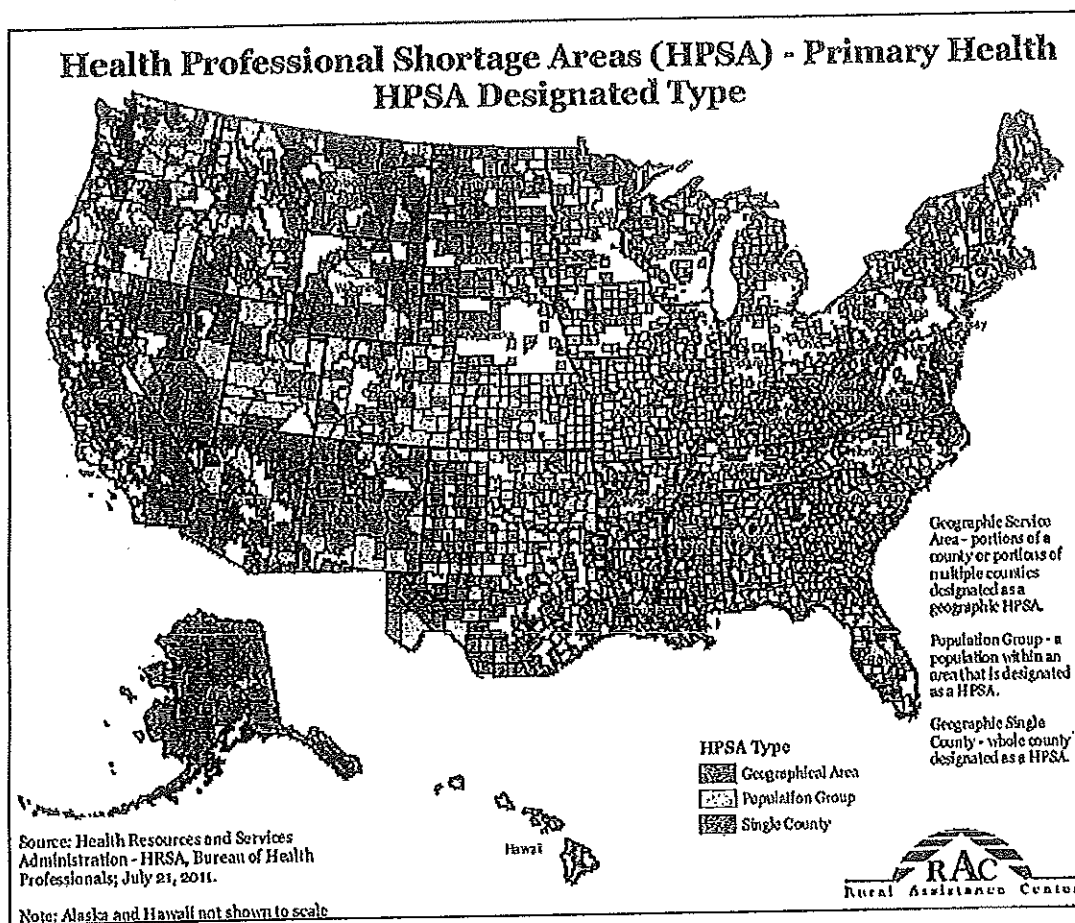
⁴ *Ibid.*

⁵ *Ibid.*

⁶ American Academy of Family Physicians, "Responses To Medical Students' Frequently Asked Questions About Family Medicine," *American Family Physician*; July 1, 2007.

⁷ American Public Health Association, "Specialty Care and the Patient-Centered Medical Home," *Medical Care: Official Journal of the Medical Section*; January 2011, Vol. 49, Issue 1.

Figure 1. passage of health care reform that will vastly extend insurance coverage.

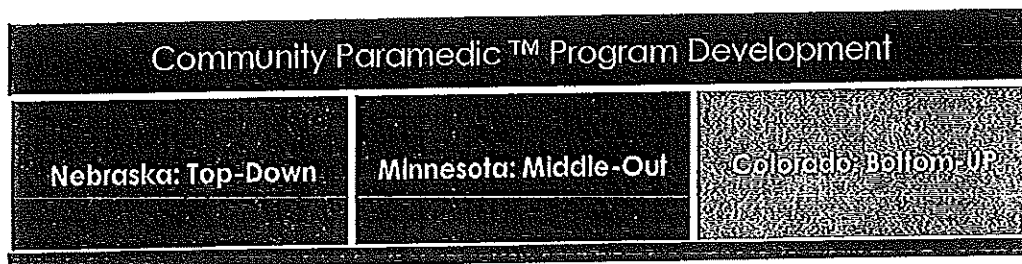


Additionally, one quarter of the U.S. population lives in rural and remote regions, and only 10 percent of the country's physicians practice in these areas. Compounding the problem are widespread hospital and clinic closures, an aging population, increasing cultural diversity, and the fact that rural residents are often economically disadvantaged and less healthy than their metropolitan counterparts. Many in the medical field are calling for the use of mid-level providers as a strategy to extend the reach of the physician. It makes sense to tap into EMS personnel that already live and work in these communities, in order to augment services and extend health care access.⁸

⁸ Wingrove, G., Laine, S. "Community Paramedic: A New Expanded EMS Model," Domain 3, National Association of EMS Educators, official publication. Fall 2008, 32-37.

Programs

Today, various forms of community paramedicine programs are operating both nationally and internationally. According to the Joint Committee on Rural Emergency Care, the expanded role of EMS personnel has already occurred on a wide scale in countries such as England, Australia and Canada. In the United States, paramedics with community-based functions are being used locally in states like Colorado, Minnesota, Texas, Nebraska, California, Pennsylvania and North Carolina. However, program services and operations vary. Community Paramedic programs are born out of necessity and as such, are based on specific community needs. The Joint Committee aptly states, "If you have seen one community paramedic program, you've seen one community paramedic program."



For example, the state of Nebraska has used a "top-down" approach to develop a community paramedicine system. The effort was led by the state's EMS Office and Office of Rural Health, which jointly advocated for state legislation as a means to provide standards for the development of local programs. Minnesota used a "middle-out" approach by developing a training program through a collaboration of partners, which was then offered to any interested paramedic within the state. Colorado used a "bottom-up" approach that began at the grass-roots level through a partnership between a local ambulance service and public health department, and in cooperation with the state EMS Office. The intent was to pilot this local program with the goal of replication. These programs, along with additional background on the community paramedicine field, are described in the Joint Committee on Rural Emergency Care article, "State Perspectives: Discussion Paper on Development of Community Paramedic Programs" (2010), which is available online at:

<http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf>

Community Paramedic™ Program Handbook

7

Work is being conducted on a national level too. The Community Health Care Emergency Cooperative, which is representative of local programs and national organizations, has developed a standard curriculum for college credit that includes a 12-week classroom and Internet course, hands on lab sessions, and clinical rotations with oversight by medical providers. The aim of curriculum is to be portable so local programs can use their own academic institutions and community medical providers. Information can be found online at: www.communityparamedic.org/Colleges.aspx. Another good resource is the International Roundtable on Community Paramedicine, which provides an up-to-date, informational website and holds annual conferences on advances in the field: www.ircp.org.

Program Development

This handbook is based on the Colorado model, which is a grass-roots approach, led by an ambulance service, in partnership with the local public health department, and with guidance from the state EMS regulatory agency. The following is an overview of recommended steps for this "bottom-up" approach. Steps can be modified to fit local needs and aren't necessarily linear in their time frame, in fact some may need to occur simultaneously.

② Plan to Plan

The first step in developing a Community Paramedic program is to learn all you can about this up-and-coming field, the various programs in operation today, and the scope of training required for this new type of paramedic. Doing your homework upfront will allow you to begin formulating the vision and scope of your program, so that you may effectively propose the idea to stakeholders. This handbook will provide you with most of the background you will need to begin. Appendix A provides a list of resources for additional guidance during your information gathering process. Developing a Community Paramedic program requires the ongoing management of multiple logistics requiring significant legwork. To help plan and track all of the tasks, develop a work plan and fill it in to the best of your ability now, and update it as you go. A sample work plan has been attached as Appendix B.

③ Assess Program Feasibility and Engage Key Partners

You should determine early in the process whether such a program is even feasible in your area, given state EMS laws and the level of commitment needed internally, from local medical providers, and from a community college or university. The following section provides a list of initial contacts and commitments you will need.

Program Feasibility Checklist:

- ✓ Are there any state regulatory barriers that need to be dealt with first?
- ✓ Does internal buy-in exist among EMS Personnel, Medical Director and Board?
- ✓ Are local physician practices willing to participate? Train paramedics?
- ✓ Is a local college or university available to teach the Community Paramedic course?

State Regulatory Agency

Once you have formed your initial program vision, begin by talking with your state EMS regulatory agency to see if there are any issues that either precludes a CP program from operating in your state or that need to be dealt with first, such as licensing. Because formal Community Paramedic programs are new, the agency may not be sure where the program fits regulations-wise. Your education and input may be needed to help resolve the issue.

Ambulance Service

Next, propose the idea internally. You will need commitments from everyone within the organization including the agency director, EMS personnel, board members and medical director. The paramedics will be required to participate in a fairly rigorous training program, both up front and in an ongoing manner. Make sure personnel are willing to take on this additional role. Obtain assurances from the board of directors that: 1) they will support the organization in focusing on program development, which could take 1-2 years to operationalize; and 2) they understand that internal resources, including funding, may need to be shifted toward program support. Finally, gain a commitment from the medical director that they will provide the medical oversight, including the development of quality assurance mechanisms, advising the clinical training process, and evaluating the competency of the Community Paramedic's skills.

Medical Providers

Next, approach medical providers to make sure there is enough physician buy-in to make the program worth developing. The participation of primary care physicians is key to the success of the grass roots model since they have a major role in training the Community Paramedics during clinical rotations, and providing the orders to use them. Physician commitment will be one of the greatest determinants of program feasibility. If your program wishes to also make clinical assistance available to the local public health department or assist them with prevention activities, they should also be engaged at this step. Note that not all public health departments offer client-level medical services, but they are a good partner nonetheless, and may be able to help you recruit physicians for the program. Eventually, you will want to formalize relationships with these entities through a legal agreement such as a memorandum of understanding (MOU). (See Appendix C for an example.)

College or University

In order to utilize the Community Health Care Emergency Cooperative's Community Paramedic Curriculum, training must occur thorough a community college or university willing to teach the curriculum, coordinate the clinical rotations, and provide academic credit *(available in 2012)*. You should gain commitment from an academic institution early in the process, to make sure that training is available for the program. The director of the EMS division at the institution will be the best contact and should also be the person to request the curriculum from the Cooperative.

The college or university will need to employ and pay for the faculty member that will be teaching the course. Ideally, the course instructor will have an understanding of the EMS system, the roles of the various levels of providers (EMT, paramedic, public health nurse, social worker, etc.) plus, experience working within the health care system, and familiarity with community resources. Because the course is set up to have online sessions, the institution should also have a system that can accommodate this, like an online "Blackboard." Note that a legal agreement (e.g., MOU) with the institution is critical to have in place before training begins.

@ Determine How to Provide Medical Direction

The program's Medical Director will have specific duties related to the Community Paramedic program. For example, they will evaluate the Community Paramedics after completion of training, annually, and as needed. A sample evaluation tool is provided within the Community Paramedic Curriculum. They will also perform chart reviews and provide feedback to the paramedics. This process should be rigorous at first, by potentially looking at all clients during the program's pilot phase (for example, the first 50 patients), and then determining the criteria for regular reviews after that. During chart reviews, the medical director can evaluate whether the CPs are assessing the patients appropriately, documenting appropriately, communicating adequately with the ordering physician, making referrals, following policies and procedures, and meeting general patient and provider needs. Client satisfaction surveys are one tool that can help the Medical Director assess patient care on many levels. A sample tool is provided as Appendix D. Patient case studies performed with the paramedics for a high-risk type of visit will help to build judgment and continue the learning process. The medical director may also be part of call down list if the ordering physician is not available when the home visit is conducted.

In WECAD's program, a local primary care physician has agreed to share the medical oversight with the organization's medical director. Additionally, ordering physicians that are participating in the program are teaching and evaluate skill competencies during clinical rotations (All of these roles are clarified through a Memorandum of Understanding with each physician practice).

@ Assess Community Health Needs

The Community Paramedic program will be better able to make the case for its existence, obtain resources, and have more of an impact on community health overall, if services are based on a needs assessment. A community needs assessment can determine:

- The leading causes of preventable morbidity and mortality
- Gaps in health care services
- Demographics of the populations most impacted by the gaps
- Characteristic of those who most frequently use the ambulance service
- Most frequent conditions requiring hospital readmission
- The greatest health care needs as seen by local medical providers

Your local public health agency has experience conducting health assessments and could be a good resource for this activity. The department regularly tracks community health outcomes such as death, injury, and disease rates, which could be used for program planning and evaluation. For example, areas with a high rate of senior falls may wish to add a safety check to Community Paramedic home visits. Patient databases at the hospital and ambulance services are two sources of queryable data. The ambulance service database can provide the medical description and demographics of patients that place frequent 9-1-1 calls. The hospital database may be able to provide a list of the conditions most frequently requiring hospital readmission that could be targeted for a CP visit. Finally, one-on-one medical provider interviews can provide qualitative information about how a CP program can best help them fill health care gaps and serve their most vulnerable patients

@ Determine the Scope of the Program

During this phase, you will want to determine the types of services to be offered, personnel needs and program budget, based on the results of the community needs assessment, services provided in the Community Paramedic Curriculum, and the level of funding your agency either has or will be able to raise toward this program.

Services

The first step is to determine whether your Community Paramedics will provide in-home patients visits and/or community-based services, as both require a different type of clinical training. Be sure that the services you are envisioning are within the legal scope of practice for your paramedics, based on state regulations. Eventually, the program's medical director will need to approve these. Common services include: assessment (vital signs, blood pressure, labs such as glucose levels, medication compliance), treatment (wound care, medication administration), prevention (immunizations, in-home fall prevention) and referral (medical and social services).

Personnel Needs

Each program will need to determine the number of Community Paramedics and their schedule, based on the needs assessment, frequency of ambulance calls, and population size. Community Paramedics can be scheduled based on a couple of different scenarios: 1) If the agency has enough EMS personnel, the Community Paramedic could be assigned discreet and prescheduled times to see clients when they are not designated as an emergency responder; 2) If the Community Paramedic has a dual role of emergency response, consider scheduling them on the second response team at pre-determined times to allow more prescheduled opportunities to see clients.



In terms of other types of personnel, the program will require programmatic and medical oversight, program coordination, scheduling, fundraising, and evaluating. Agency personnel or contractors may be used to fill these functions, and a single position may fill more than one function; for example, the program coordinator may also schedule patients. The following are examples of positions used within the WECAD program:

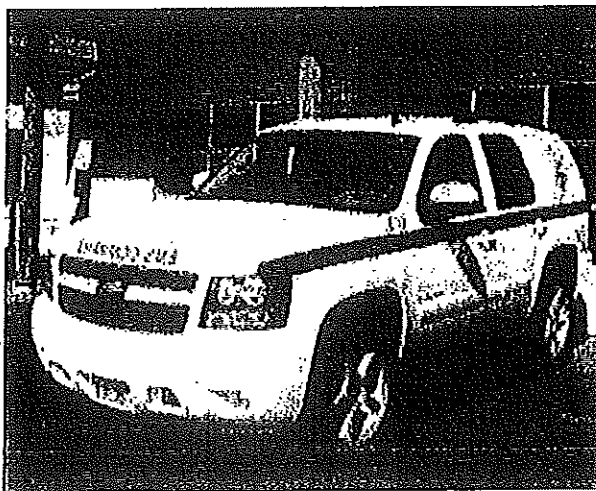
- | | |
|-----------------------|-----------------------|
| ■ Medical Director | ■ Program Coordinator |
| ■ Program Director | ■ Scheduler |
| ■ Community Paramedic | ■ Evaluator |
| | ■ Grant Writer |

▪ Quality Assurance Coordinator

Budget and Fundraising Needs

Based on the services you plan to offer and the staffing patterns necessary to support them, develop a program budget and fundraising plan. Determining whether new personnel need to be hired will depend on the scope of the program and population of the service area. In some cases, it may be possible to shift in-house personnel. For intermittent functions like grant writing, a contractor may make the most sense dollar-wise. For the operational budget, the need for new items such as a daily means of transportation (non-ambulance vehicle) and primary care equipment will need to be determined. Tuition costs and training supplies will also need to be quantified for the Community Paramedic course provided by the local community college or university, if the agency will be the entity to pay for such training. Examples of potential line item budget expenses are provided as Figure 2.

After developing a budget, it may be necessary to create a fundraising plan with targets set by dollar amount and deadlines. A multi-year budget can inform fundraising targets for consecutive years. Sources of funding may include local, state and federal governments, foundation grants, and donations from community partners. In the future, it may be possible to bill Medicaid and Medicare.



CP Program Tip

In WECAD's experience, patients of the Community Paramedic program are uncomfortable with an ambulance pulling up to their house for a home visit, because it causes unnecessary concern to neighbors. WECAD obtained an SUV through a grant and then outfitted it with lighting, sirens, lettering and radio, for use by the CP Program.

Figure 2: Sample Budget Items

■ PERSONNEL	■ Program Director
	■ Community Paramedic(s)
	■ Quality Assurance Coordinator
	■ Program Coordinator/Scheduler
■ CONSULTANT/CONTRACTUAL	■ Medical Oversight (Licensed physician)
	■ Evaluation
	■ Grant Writing
■ EQUIPMENT	■ Otoscope (with camera to send to physician)
	■ Stethoscope (digital to send read-out to physician)
	■ Temporal thermometer
	■ Pulse oximeter
	■ Digital camera (to send pictures to physician, e.g. wounds, cellulitis, home safety risks)
	■ Portable adult and baby scales
	■ EKG/defibrillators
■ LAB SUPPLIES	■ Dressing changes
	■ Blood draw
■ TRAVEL	■ Non-emergency vehicle (lettering, lights, radio if new)
	■ Motor vehicle insurance/gas
■ INSURANCE	■ Additional malpractice insurance (Check with insurance company)
■ UNIFORMS	■ Community Paramedic uniforms
■ TRAINING	■ Tuition, text books and supplies

© Engage the Community

A community engagement process is a good way to assess the level of community support, build advocates for the program, identify community resources, and determine potential barriers. Strategically anticipate how you will use different entities and who needs to know about the program early, in order to support it. Begin the process by developing key messages for specific audiences and determining how to target them.

CP Program Tip

Before approaching stakeholders, prepare the following materials:

- Local community health assessment
- Program vision
- Fact sheet (National Sample: Appendix E; WECAD Sample: Appendix F).

Prepare to make the argument that the Community Paramedic program is not meant to replace a primary care provider, public health nurse or home health agency, but rather is intended to be complimentary to the health care system in breaking down silos and filling gaps.

It is particularly important to build relationships with the public health department and social service agencies early in the process, as these types of organizations can assist with community needs assessment, client referrals, and are likely to become champions for the program. Whether your program provides community-based services or not, the local public health department can also play a supporting role by helping to conduct a community health assessment to determine the population's health status and gaps within the health care system. Since a Community Paramedic program can be a good strategy to fill gaps and promote public health values such as the Medical Home Model and reducing barriers to care, partnering can benefit both entities. The health department also probably has strong partnerships with key medical providers and help to get them on board. Additionally, the department likely has experts in the realm of program evaluation and can suggest different methodologies and assist with the CP Program's process.

Social service agencies offer programs that may benefit the Community Paramedic client. Because the Community Paramedics get a first-hand look at the client's home environment, they are in the perfect position to assess the types of referrals that may benefit the client such as Medicaid enrollment, mental health treatment, case management, and assistance with food and home utilities. Social service agencies will be integral in educating Community Paramedics during the training phase, about the types of community resources available and how to make referrals.

Buy-in is also beneficial from other medical providers like home health agencies and physician practices that are not participating in the CP program, so that they understand the niche of a Community Paramedic and so-called turf issues can be avoided. Other types of organizations that should be engaged include local governments, foundations, civic groups, the state's Office of Rural Health and other organizations that may provide funding, advocacy or other types of support.

Another way to engage stakeholders is to develop a community advisory committee that meets regularly. This group can be the eyes and ears of the community, providing insight, feedback and direction. The committee may have representation from medical providers, health and human service agencies, gatekeepers to underserved communities, consumers, elected officials and other community leaders.

© Develop Policies and Procedures

Because Community Paramedics are working in an expanded role and with new community partners, it will be important to develop policies and procedures that provide explicit boundaries around the program, clarifying what it is and what it is not. Community Paramedics should always follow the policies and procedures of their larger organization; however, P&Ps specific to the Community Paramedicine program will also need to be developed. In general, policies and procedures can:

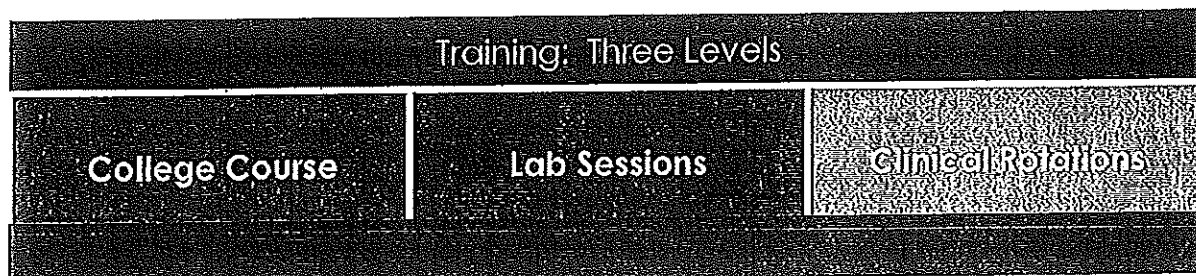
- Outline the new role of the paramedic, stating that a paramedic is not to provide a service out of their scope of practice, and for which they have not been trained and evaluated.
- Define program services and operational policies such as response time.
- Outline the process for receiving requests to utilize Community Paramedics (Appendix G). (Providers should also be trained on the process.)

- Require the use of a Release of Information Form to protect patient confidentiality before a Community Paramedic begins care (Appendix H).
- Define the conditions under which the Community Paramedic may practice (within a specific service area, serving only providers with an MOU agreement in place, and in which settings—home or public health clinic).
- Provide the steps for when physician contact is needed during a visit and the ordering physician is not available (Appendix I).
- Define service-specific procedures such as:
 - Home safety assessment (Appendix J)
 - Evaluation for social support (Appendix K)
 - Clinical services (wound care, medication compliance and reconciliation, etc.) (Appendix L)

The Community Paramedic Curriculum provides general guidelines to the paramedics about these types of policies during training. Individual organizations should develop their own policies, which can stand alone or be woven into procedures, job descriptions, legal agreements, etc.

④ Plan and Implement Training

There are three levels of training to prepare a paramedic to provide primary care through a physician's order: 1) a 12-week didactic college course, 2) hands-on lab sessions, and 3) clinical rotations. The curriculum used for the didactic course is available through the Community Health Care Emergency Cooperative (<http://communityparamedic.org/Colleges.aspx>) and must be taught through a college or university. The course consists of approximately six classroom presentations and 2-3 hours of weekly online sessions.



In order to pass the course, the individual paramedic must perform 32 hours of lab sessions and 100-150 hours of clinical time, depending on the specialties chosen. The clinical time is organized into two levels of training: The first focuses on the general clinic setting; the second concentrates in specialty areas, depending on the community's needs and program's scope. The college or university will coordinate the matching of the students with clinical sites; however, the Community Paramedic program should have already done the legwork in identifying and engaging local providers, to assure the clinical rotations are successful. Whenever possible, it will help to make the program successful if medical practices that plan to use Community Paramedic services provide training during the clinical rotation phase, so a level of trust can be established between the paramedic and ordering physician.

Before the clinical rotations can be arranged, the scope of Community Paramedic services will need to be determined, including the skills and procedures to be taught by the providers. Services need to be within the legal scope of practice and should be approved by the ambulance service's medical director. Training and lab time should focus exclusively on the procedures that are going to be offered by the program. The Curriculum highlights primary care services already being performed by Community Paramedics. Local programs will need to make sure these fall within their state regulatory guidelines before including them in the scope of services.

② Develop An Evaluation Plan

Developing an evaluation plan during the planning process will provide many benefits to the program. First, it will assure that client databases are in place and collecting the right data, beginning with the first patient. Also, program evaluation at its basic level, will be required in any grant application for future funding, and an evaluation plan will make grant writing easier.

The first part of the evaluation plan should include a method for tracking patients in a queryable manner. If the organization already has a client database, such as an electronic medical record, this could be used; otherwise a spreadsheet program such as Excel or Access would also work if client information were entered after each visit. The database should track variables such as client demographics (age, gender, ethnicity, language, insurance status), services requested on an order, patient diagnosis, referring physician, time and date of call, chief complaint, referrals to other services by a Community Paramedic, and outcomes (e.g., ambulance transport, physician follow-up, re-

admission, no follow-up necessary). Collecting and analyzing this type of information will meet most types of grant requirements. This information can also inform programming in terms of staffing patterns, budget, training needs, gaps in service, and types of patients served. Descriptive statistics can then be used to illustrate the program such as:

- Percentage of uninsured, Medicaid and Medicare patients
- Percentage of Spanish-speaking patients
- Age range of patients
- Number of visits (total and average per patient)
- Leading types of chief complaints (tracked by number of events)
- Leading outcomes of visits (tracked by number of events)

Patient databases at the hospital or within the ambulance service can also illustrate program outcomes such as a change in the level of non-emergency transports and hospital readmission rates. The reduction in non-emergency transports can be targeted as a program goal by using the ambulance patient database to determine frequent callers to 9-1-1 for non-emergency transports, then coordinating with their physician to provide an intervention, which may include linking to social service agencies. Non-emergency transports can also be a baseline measure for the program, to determine CP program impact over time.

The hospital may have data that shows the most prevalent conditions likely to cause a readmission. The CP program, in cooperation with the discharging physician, can then target patients with these conditions. This can also be a baseline measure for the program to determine impact over time. If the program serves enough patients to impact county-level health outcomes, such as a reduction in injury or death rates, these indicators could be tracked and measured with the help of public health data sites.

Also, qualitative information can supplement the quantitative data by documenting case studies to illustrate outcomes and the value of the Community Paramedic program. In its most basic form, this is a narrative, which tells the story of particular CP cases. Case studies should meet certain criteria such as those where a negative outcome for the patient was either clearly or possibly avoided, due to the intervention of the Community Paramedic. Information can be elicited through an interview with the

Community Paramedic and/or ordering physician, to document the case. Case studies can include patient demographics, presenting problem, the CP intervention and resulting outcomes. Names should not be used to protect patient confidentiality.

@ Begin Operations

Once legal agreements are in place with providers, and paramedics have been clinically trained and evaluated, the scheduler can begin accepting orders from the physician or requests from the public health department. An example of a Physician's Order Form is provided as Appendix M. Patients are served in one of two ways: 1) during a home visit through the medical provider's order; 2) in a community or clinic setting through a partnership with the local public health department.

Physician's Office

Physicians order home visits through the agency scheduler, who then arranges the appointment with the patient. The visit is set up as a medical provider consultation. The ordering provider will fax the scheduler a packet to include medication list, medical history, supporting documents, and other pertinent medical information. The Community Paramedic will respond to the order between 8:00 am and 5:00 pm within 24 – 48 hours of receipt, based on urgency. During the home visit, the Community Paramedic takes a patient history, assesses the chief complaint, and then confers with the treating provider on next steps. If the treating provider is unavailable for consultation, a call-down list triggered to assist the CP in getting the medical recommendations from either another physician within the practice or alternative physician according to policy (Appendix I.)

Once the visit has occurred, the Community Paramedic communicates to the physician through the patient care report, which then becomes a permanent part of the permanent medical record. Physicians may only order services, which are in within the program's scope of services (services within the paramedic's scope of practice, for which they have been trained and evaluated as able to perform satisfactorily). Visits are scheduled during regular business hours and initial visits are scheduled for one hour.

Local Public Health Department

Community Paramedics may assist a local public health department with such services as immunizations, fluoride varnish application, blood draws for screenings, blood pressure checks and communicable disease investigations. The paramedic works with a registered nurse and the health department has oversight from the department's medical director, who should be a licensed physician. Community Paramedics may be of particular use for surge capacity during a disease outbreak when mass vaccination/prophylaxis and investigation is needed or when a clinic is short staffed. The Community Paramedic's agency and public health department should agree on a process for requesting the services of a Community Paramedic, to be coordinated through the scheduler.

© Evaluate the Pilot Phase

The program should plan to have a 1-2 month pilot phase to test how all of the systems are working. At the end of the pilot phase, the systems should be evaluated and mid-course corrections made. An evaluation of the pilot period can assess the following:

- How the referral process is working for medical providers (interviews)
- Response time of the Community Paramedics (tracking forms or EMR)
- Client satisfaction (surveys or interviews) (Appendix D)
- Quality assurance (case/chart reviews)
- Program evaluation: Does patient database capture all the variables? (Database query)

Different aspects of this evaluation can be woven into an ongoing quality assurance plan and conducted on a regular basis.

APPENDICES

Appendix A

Community Paramedicine Resources

Additional information and connections to national organizations, literature and other resources are provided below.

- **International Roundtable on Community Paramedicine:** www.IRCP.org
- **Joint Committee on Rural Emergency Care:**
National Association of State EMS Officials & National Organization of State Offices of Rural Health
 - *Policy Brief on Integration of EMS into the Healthcare Delivery System, November 2009:* www.nosorh.org/policy/files/jcrec_policy_brief.pdf
 - *State Perspectives: Discussion Paper on Development of Community Paramedic Programs, 2010:*
www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf
- **Community Health Care Emergency Cooperative's Community Paramedic Curriculum:** www.communityparamedic.org/Colleges.aspx
- **WECAD Community Paramedic Program Development:**
 - Chris Montero, Chief, Western Eagle County Health Services District
E-mail: cmontera@wecadems.com
Website: www.wecadems.com/cp.html
 - Caring Anne Consulting, Anne Robinson, RN, President
Public Health Nurse Consultant
E-mail: ar@caringanne.com
Website: www.caringanne.com
 - Silver Street Consulting, Jill Hunsaker Ryan, MPH, Principal
Public Health Consultant
E-mail: www.silverstreetconsulting.net
Website: silverstreetconsulting@gmail.com

Appendix B: Work Plan Template, Months 1-12															
Step	Activities	Person(s) Responsible	Activity Due Date Place X by Month(s)												Done (X)
			1	2	3	4	5	6	7	8	9	10	11	12	
Plan to Plan	Background materials														
	Work plan														
Determine Program Feasibility/Begin to Engage Key Partners	State EMS Office														
	Internal Leadership, Staff														
	Medical Community														
	College/University														
Determine Medical Direction/Quality Assurance	Develop a plan														
Assess Community Health Needs	Engage health department														
	Develop an assessment plan														
Determine Program Scope	Services														
	Personnel Needs														
	Budget														
	Need for Fundraising														
Engage Stakeholders	Identify														
	Engage														
	Form advisory committee														
Develop Policies/Procedures	Identify needed policies/procedures														
	Develop, incorporate into training														
Plan for Training	Commitments for clinical rotations from providers														
	Plan training with college/university														

©2011

Appendix B: Work Plan Template, Months 13-24														
Step	Activities	Person(s) Responsible	Activity Dates Place X by Month(s)											
			13	14	15	16	17	18	19	20	21	22	23	24
Implement Training	Implement classroom training													
	Clinical rotations													
	Health Dept. trainings													
	Evaluate paramedics													
Develop an Evaluation Plan	Client database tracking													
	Outcomes and how to measure													
	Case study procedures													
Begin Operations	MOUs in place with providers													
	Scheduling procedures in place, providers trained													
	Begin accepting patients													
	Conduct chart reviews													
Evaluate the Pilot Phase	Referral process													
	Response time													
	Patient satisfaction													
	Quality assurance procedures													
	Patient database tracking													
	Make corrections to systems													

APPENDIX C: Sample Provider Agreement

MEMORANDUM OF UNDERSTANDING
COMMUNITY PARAMEDIC PROGRAM

This Community Paramedic Program Agreement ("Agreement") is entered this ____ day of _____, 20____, between (COMMUNITY PARAMEDIC PROGRAM) and (MEDICAL PROVIDER), herein being referred to collectively as, the "Participants."

WHEREAS, the Participants share a mission to improve the health of residents in (NAME OF SERVICE AREA); and

WHEREAS, community paramedics are specially trained to conduct in-home patient assessments and provide specific primary health care and preventive services, by acting through a physician's order and within a defined scope of practice; and

WHEREAS, the community paramedic model helps physicians monitor the health of vulnerable patients, thereby producing better health outcomes and reducing the number of ambulance transports, visits to the emergency department, and hospital readmissions; and

WHEREAS, medical providers are key to the community paramedic program in terms of providing clinical training and issuing orders; and

WHEREAS, (MEDICAL PROVIDER) desires to participate in (PROGRAM'S) community paramedic program.

NOW, THEREFORE, in consideration of the terms and conditions of this MOU, the receipt and sufficiency of which is jointly acknowledged, the Participants agree as follows:

I. Scope of Work

- a. (MEDICAL PROVIDER) agrees to provide a clinical rotation for a mutually agreed upon number of community paramedics, in the areas of family practice and pediatrics, based on the attached clinical rotation guidelines (Attachment A). Activities will include training then evaluating the community paramedic's ability to correctly perform each procedure. (MEDICAL PROVIDER) may provide additional training hours if both parties agree that it would be mutually beneficial to the program.
- g. Participants agree to share patient records as is necessary to provide care, and will follow corresponding confidentiality policies. The patient record created by the community paramedic will be sent to the ordering physician at (MEDICAL PROVIDER).
- h. Participants agree to run data requests on certain measurable outcomes for use by both parties. Data will be presented in aggregate without patient identifiers. (CP PROGRAM) will share program evaluation results with (MEDICAL PROVIDER).
- i. (MEDICAL PROVIDER) providers shall formally request a home visit by the community paramedic through a physician order, based on services that are within the scope and expertise of the paramedic. A community paramedic will act on the order between 8:00 am and 5:00 pm within 24 – 48 hours of receipt, and based on urgency and availability, unless otherwise agreed upon by the issuing provider. (MEDICAL PROVIDER'S) physicians and medical providers shall provide medical oversight and have ultimate responsibility regarding their patients in the program.

Appendix C: Sample Provider Agreement, Continued

- f. (MEDICAL PROVIDER) shall provide a representative to the Community Paramedic Advisory Committee, which meets quarterly.
- g. (MEDICAL PROVIDER) shall participate in case reviews when appropriate, in order to improve the quality of the program and document specific outcomes for evaluation purposes.
- h. (CP PROGRAM) shall provide the medical oversight for the program through its Medical Directors, Colorado-licensed physicians.
- i. (MEDICAL PROVIDER'S) participating physicians shall sign Attachment B agreeing that they understand the program and the procedures available to be performed. Attachment B can be amended with additions or deletions of physician's signatures on an as needed basis without the need to change this agreement.
- j. (MEDICAL PROVIDER) shall provide proof of a certificate of liability insurance for Medical Malpractice listing all physicians participating in the program.

II. Insurance

Each party, shall, at no cost or expense to the other party, carry a policy or policies of professional liability insurance, comprehensive general insurance, and workers compensation insurance issued by an insurance carrier or self insurance mechanism authorized by the State of Colorado in such amounts as are reasonably acceptable to each other, provided that such amounts are not less than the liability limitations under the Colorado Governmental Immunity Act, Section 24-10-101, et seq., C.R.S. ("CGIA"). Said insurance policies shall cover officers, employees, agents and volunteers of the Participants. If the liability insurance required by this section is on a "claims made" basis and at any time prior to the expiration of any statute of limitation period which might apply to acts, errors or omissions of a party during the term of this Agreement, or a party shall cease to maintain liability insurance required by this section or should switch insurance carriers, that party shall purchase from an insurance carrier acceptable to the other, a "tail" policy covering acts, errors or omissions during the term of this Agreement as to which claims may then still be asserted. If a party fails to purchase such tail coverage within 30 days after the termination of this Agreement, the other party shall have the right to purchase such coverage and bill the other for the premium.

Upon request, each party shall provide the other with certificate(s) of such insurance coverage and statement(s) from the insurance carrier that the certificate holder will be notified at least 30 days prior to any cancellation, non-renewal or change in such coverage. Failure by either party to maintain proper insurance coverage shall, at the option of either party, be grounds to immediately terminate this Agreement.

III. Compensation

The Participants understand that no compensation will occur for community paramedic services or the training they receive, unless a modification is made to this contract.

IV. Term of Agreement

The term of this Agreement shall be through the end of the year in which it is entered, and this Agreement shall be automatically renewed for additional one (1) year terms in perpetuity.

V. Termination of Agreement

Either party may terminate this Agreement at any time and for any reason in writing with thirty (30) days notice.

VI. Amendment

This Agreement shall be binding on the Participants and represents the final and complete understanding of the Participants as regards the subject matter. This Agreement shall not be modified or amended unless in writing, executed by Participants.

VII. Waiver of Breach

No waiver by either party of any term, covenant, condition or agreement contained herein, shall be deemed as a waiver of any other term, covenant, condition or agreement, nor a waiver of breach thereof deemed to constitute a waiver of any subsequent breach, whether of the same or a different provision of this Agreement.

VIII. Counterparts

This Agreement may be executed in counterparts, each of which will be an original, but all of which together shall constitute one and the same instrument.

IX. Enforcement, Jurisdiction and Venue

This Agreement shall be governed and construed in accordance with the laws of the (STATE OF PROGRAM, and in addition to any other remedy, may be specifically enforced. Jurisdiction and venue for any suit, right or cause of action arising under, or in connection with this Agreement shall be exclusive in (LOCATION OF PROGRAM, STATE).

X. Responsibility for Acts of Employees and Promise to Indemnify

Each party will be solely responsible for its acts and omissions and the acts and omissions of its employees, agents, officers and volunteers in the performance of its obligations under this Agreement, and shall indemnify and hold the other party harmless from and against any and all demands, losses, liabilities, claims, or judgments, costs and expenses, including but not limited to reasonable attorney's fees, arising out of any act or omission of the party, its employees, agents, officers and volunteers in the performance of its obligations under this Agreement.

XI. Third Party Beneficiary

Nothing herein expressed or implied is intended or should be construed to confer or give to any person or entity other than (CP PROGRAM) or (MEDICAL PROVIDER) and their respective successors and assigns, any right, remedy or claim under or by reason hereof of by reason of any covenant or condition herein contained.

XII. Notices

Any formal notice, demand or request pursuant to this Agreement shall be in writing and shall be deemed properly served, given or made, if delivered in person or sent by certified mail postage prepaid to the Participants at the following addresses or as otherwise modified pursuant to this section:

If to (CP PROGRAM):
(ADDRESS)

with a copy to:
(LEGAL COUNSEL)

If to (MEDICAL PROVIDER):
(ADDRESS)

with a copy to:
(LEGAL COUNSEL)

XIII. Severability

In the event that any of the terms, covenants or conditions of this Agreement or their application shall be held invalid as to any person, entity or circumstance by any court having competent jurisdiction, the remainder of this Agreement and the application in effect of its terms, covenants or conditions to such persons, entities or circumstances shall not be effected thereby.

XIV. Section Headings

The section headings in this Agreement are inserted for convenience and are not intended to indicate completely or accurately the contents of the sections they introduce and shall have no bearing on the construction of the sections they introduce.

XV. Duly Authorized Signatories

By execution of this Agreement, the undersigned each individually represent that he or she is duly authorized to execute and deliver this Agreement and that the subject party shall be bound by the signatory's execution of this Agreement.

IN WITNESS WHEREOF the Participants have caused this Agreement to be executed as of the day and year written above.

(PROGRAM)

By: _____

Title: _____

ATTEST: _____

(MEDICAL PROVIDER)

By: _____

Title: _____

ATTEST: _____

Sample MOU: Attachment A Continued
Community Paramedic Clinical Procedures

Family Practice Clinical Rotation

40 Hours Clinical Time (L1)

PROCEDURES LEVEL 1	# Performed	Clinical Site
Blood Pressure checks	2	FP
Medical Equipment		FP
Otoscope	30	FP
Blue Tooth Stethoscope	5	FP
Home Medication		FP
Compliance	7	FP
Medication Reconciliation	7	FP
Pt Documentation		FP
SOAP Notes	5	FP
Chart Review	15	FP
History & Physical	20	FP
Assessment	20	FP
Results from Tests/Diagnostic tools	15	FP
Identifying Red Flags	5	FP
Identifying further testing needs	5	FP
Prenatal		FP
Doppler	5	FP
Measurements	5	FP
Urine for Protein	5	FP
Acute Illness Management		FP
0-1 years	5	FP
1-5 years	5	FP
6-13 years	5	FP
14-18 years	5	FP
18 + years	5	FP
65 + years	5	FP



Appendix D

31

**WESTERN EAGLE COUNTY
HEALTH SERVICES DISTRICT**785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689

F: 970-524-1771

Client Satisfaction Survey

Western Eagle County Health Services District (WECAD) is committed to providing you with excellent service and care. We are a community organization that is tax supported by our residents and home owners. It is our goal to maintain the highest level of customer service, training, skills, and compassion to all of our patients and families. Please take a few moments and complete this short survey. Your responses will be assured confidentiality.

Reason for Service: 911 Call ☐ Community Paramedic Visit ☐ Transferred from Clinic to Hospital ☐

Please rate the following areas on a scale of 1 – 5 (1 Strongly Dissatisfied to 5 Very Satisfied)
Circle only one answer per line.

	Strongly Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	
Courtesy of the 911 call operator	1	2	3	4	5	N/A
Usefulness of instruction provided by the 911 call operator prior to the arrival of Paramedics	1	2	3	4	5	N/A
Professionalism / appearance of Paramedics	1	2	3	4	5	N/A
Quality of care provided by Paramedics	1	2	3	4	5	N/A
Cleanliness of ambulance and equipment	1	2	3	4	5	N/A
Overall satisfaction with WECAD	1	2	3	4	5	N/A
Satisfaction with care you received at Emergency Room after we ended our care	1	2	3	4	5	N/A

If you do have a concern about our services provided, please contact our office and speak with Chief Christopher Montera or Deputy Chief Christopher Dick or we will call you back at the number you provide.

Name: _____ Phone: _____
Please provide name and phone number. (Optional and Confidential)

Additional Comments:

Thank you for your time and comments about our service.

Version 09/2011

Office Use Only:	
DOS: _____	
ID: _____	
<input type="checkbox"/> Ref	<input type="checkbox"/> Trans
<input type="checkbox"/> In	<input type="checkbox"/> Out
<input type="checkbox"/> VMC	<input type="checkbox"/> VVH

Community Focused Emergency Medical Services
www.wecadems.com



Opportunity Statement

- Severe Primary Care Shortage currently exists and is on the rise
- Vulnerable populations with new health insurance plans will not have access to a provider because of the increase in demand
- Cost of healthcare continues to rise with Emergency Rooms being the most available alternative
- Access to care problems are exacerbated in rural areas due to higher healthcare provider shortages, a larger elderly population than urban, and transportation barriers

Community Paramedic Solution

The Community Paramedic model is an innovative, proven solution to provide high quality primary care and preventative services by employing a currently available and often underutilized healthcare resource.

How Does it Work?

A primary care partner refers a patient to Emergency Medical Services (EMS) personnel to provide services in the home that are within their current scope of practice including: hospital discharge follow-up, fall prevention in the home, blood draws, medication reconciliation or wound care. The Community Paramedic provides care and communicates health records back to the referring physician to ensure quality of care and appropriate oversight. In addition works with Public Health to provide preventative services throughout the community.

Advantages

- Decreases workload and increases quality and efficiency of managing patients in a primary care and public health settings by utilizing EMS Personnel through non-traditional methods
- EMS personnel are integrated throughout the healthcare system, improving access and decreasing healthcare cost
- Community Paramedic certification provides a job opportunity where EMS volunteer work is often the only sustainable model in rural areas
- EMS personnel currently have the training, expertise and scope of practice to provide essential primary care services
- The program has a proven track record locally and internationally

Frequently Asked Questions

Q: Does a Community Paramedic replace current healthcare systems like home health care or primary care physicians?

A: No. Community Paramedic is an extension of the primary care provider to provide care to patients without access, and does not replace the specialized services available in a home health care model or physician office.

Q: Does a Community Paramedic have the right training to provide primary care?

A: Additional training is provided to Community Paramedics specific to providing preventive care in the home within their current scope. However, services provided do not fall out of the currently defined scope of practice for EMS personnel.

Q: Is the quality of care compromised by using a Community Paramedic vs. a primary care provider?

A: No. A Community Paramedic provides care under the supervision of a physician, so the quality of care is consistent with care provided in a clinic setting.



WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689

F: 970-524-1771

Community Paramedic Fact Sheet

Problem Statement:

- Access to healthcare and particularly primary care services is a growing concern. Primary care providers are in short supply, and the uninsured population is on the rise.
- Uninsured patients are less likely to seek out preventive care services, and are more likely to go to the emergency room for non-urgent care, increasing the cost of healthcare.
- In rural areas, the problem is exacerbated because of a higher rate of uninsured, compared to urban settings, and shortage of healthcare providers.

Opportunity:

- To address the decrease in access to primary care services, it is necessary to evaluate current resources within communities and explore innovative solutions. The Community Paramedic model is a proven solution that provides essential primary care services for vulnerable populations.
- Paramedics have the training, expertise and scope of practice to provide primary care services such as assessments, blood draws, wound care, diagnostic cardiac monitoring, fall prevention, medication reconciliation, and post-operative follow up. They also have the experience of taking health care into the home.
- Internationally, Community Paramedic programs have demonstrated increased health outcomes and cost savings. Many countries are providing Emergency Medical Service (EMS) personnel with additional training to expand into community-based services.
- EMS personnel are already integrated throughout the healthcare system, allowing them to easily provide primary care services within their scope of practice.

What the Community Paramedic model offers:

- Enhanced utilization of a healthcare resource under the current scope of practice.
- Increased efficiency in terms of managing patients in a primary care setting.
- Coordinated and integrated care with physician's offices, hospitals, home health agencies, long term care facilities, and public health departments.

The Community Paramedic model will NOT:

- Replace current healthcare systems or positions.
- Change the current defined scope of practice of the EMS Personnel.
- Remove patient populations from healthcare providers.
- Decrease the level of care provided.

-Over-

WECAD Community Paramedic Fact Sheet
Continued

34

Health Care Statistics

Primary care shortage

- o In July 2011, 52 of Colorado's 64 counties (81%) were either fully or partially designated as a Health Professional Shortage Area.¹

Uninsured/Underinsured rates

- o In 2010, 14.7% (342,122) of Colorado residents reportedly did not see a doctor in the previous 12 months, due to costs.²
- o During 2009/2010, 22% of Eagle County residents were reportedly uninsured, compared to Colorado at 15.4%.³
- o In 2005, 68% of Eagle County's Latino households were reportedly uninsured.⁴

Access to care statistics

- o Colorado's overall population is projected to grow by 20% between 2010 and 2020, while the population ages 65+ is projected to grow at nearly twice that rate (37%) during the same time period.⁵
- o In 2005, 38% of Eagle County households reportedly had trouble accessing health care.⁴
- o In 2005, 43% of Eagle County residents reportedly were unable to access dental care.⁴

Readmission rates

- o 50.2% of patients who were readmitted to the hospital had no follow-up care with primary care physician from time of discharge to time of readmission.⁶
- o In 2009, the cost to Medicare of unplanned re-hospitalizations was \$22.9 billion nationally.⁷

Cost of healthcare in ER

- o ER costs per-visit are generally 3 times higher than comparable care in an outpatient clinic.⁶
- o According to Johns Hopkins University, between 1997 and 2007, 13 percent of trauma patients returned to the emergency room within a month of discharge for routine follow-up care such as dressing changes.⁸
- o In Colorado in 2008, 80% of ER visits were not true emergencies.⁶

Preventive services

- o In 2005, 56% of Eagle County households were reportedly affected by chronic health issues.⁴
- o In 2009/2010 32% of Eagle County residents were reportedly overweight & 10.5% were obese.³
- o According to the Centers for Disease Control, vaccination is the number one method of preventing disease, disability, and premature death.

1. Colorado Department of Public Health and Environment, Primary Care Health Professional Shortage Area Map. Website: www.cdphe.state.co.us/pp/primarycare/shortage/pchpsa.pdf

2. Henry J. Kaiser Family Foundation: www.statehealthfacts.org/profileInd.jsp?ind=747&cat=8&rqn=7

3. Colorado Health Information Dataset (CoHID), Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Website: <http://www.cdphe.state.co.us/cohid/brfss.html>

4. Healthy Eagle County 2010, A Blue Print for Improving our Community's Health (2005). Website: http://www.eaglecounty.us/HHS/Reports_and_Resources/

5. Colorado Department of Local Affairs, 2010 Census Data for Colorado by Age. Website: <http://dola.colorado.gov/dla/demog/2010censusdata.html>; U.S. Census Bureau, Population Projections (by age through 2020). Website: www.census.gov/population/www/projections/projectionsagesex.htm

6. Carl Fouts, Program Director, Colorado Rural Health Center, Presentation at the Western Eagle County Ambulance District Community Paramedic Town Hall Meeting, July 29, 2009.

7. Jake Swanton, Office of Senator Mark Udall, Presentation at the International Roundtable of Community Paramedics Conference, Vail, CO, August 9, 2010.



WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689
F: 970-524-1771

Community Paramedic Patient Referral Guide

1. Provider talks with patient about follow-up with a community paramedic from WECAD.
2. Provider requests patient sign the **consent/authorization to release health information form**.
3. Provider completes the **community paramedic patient referral form** and **lab form** if indicated.
(Use existing laboratory request form, as this is the form the lab will receive with the specimen.)
4. Provider faxes the following to the CP Patient Scheduler: Release of information form, current history and physical, medication history, hospital discharge orders, immunization records or any other medical record applicable to the community paramedic visit. *(Please include the patient's medical record number.)*
5. Scheduler will verify with physician that all information has been received.
6. The community paramedics will make every effort to see the referred patient **within 48 hours of the referral unless the patient is in urgent need of medical follow-up**.
7. Scheduler will call the patient to arrange appointment time/date.
8. Scheduler will coordinate with the community paramedics to arrange patient visit.
9. Scheduler will call or fax the appointment dates to the provider offices once a week.
10. Community Paramedic will complete patient visit at appointment time arranged.
11. Community Paramedic will complete patient care report.
12. Scheduler will fax patient care report back to provider office within 24 hours of visit.

**WESTERN EAGLE COUNTY
HEALTH SERVICES DISTRICT**785 Red Table Dr.
Gypsum, CO 81637P: 970-524-1689
F: 970-524-1771Release of Information Form

PATIENT INFORMATION		PLEASE RETURN BY FAX TO 970-524-1771	
Patient's Last Name	First	Middle	DOB
INFORMATION			
<input type="checkbox"/> Consult	<input type="checkbox"/> Labs	<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Other as specified below:	
<input type="checkbox"/> Emergency Department Report	<input type="checkbox"/> MRI Report	_____	
<input type="checkbox"/> EKG Tracings	<input type="checkbox"/> Operative Report	_____	
<input type="checkbox"/> Graphic Record	<input type="checkbox"/> X-Ray Report	_____	
<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-Ray MRI	_____	
Date of Order:	Purpose of Release:		
This consent/authorization is to release health information from and to:			
Name		Phone Number	
Address	City	State	Zip Code
This consent/authorization will remain in effect			
<input type="checkbox"/> From the date it is signed out until: _____			
<input type="checkbox"/> Until the following event occurs: _____			
Note: If neither of the above options is selected, this consent/authorization will remain in effect for 180 days from the date this is signed.			
I authorize my health information described above to be released to Western Eagle County Community Paramedic Program to send all copies of my health record back to the above named entity for the purpose of continuity of care and understand that:			
1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows:			
2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C.F.R. parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it.			
3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer at the address listed at the top left of this form with a written revocation which will not be effective until received and approved by the Privacy Officer.			
4. I may refuse to sign this Consent/Authorization and this refusal will not affect the treatment Western Eagle County Community Paramedic Program provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party.			
Signature of Patient/Parent of Legal Representative		Date	
If signed by Legal Representative, Legal Representative's authority to act on behalf of patient:			
Relationship to patient:			
For Office Use ONLY			
DATE INFORMATION RELEASED		MEDICAL RECORD NUMBER	



WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

37

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689

F: 970-524-1771

Physician Contact While at Visit

Last Revised: (Date)

Purpose: This policy is in place in the event a Community Paramedic is at a visit with a patient and a physician needs to be contacted immediately, but the ordering physician is not available.

Procedure: Always begin by calling the ordering physician first. If they are unavailable, proceed through the call down list in the order provided below.

1. Call the ordering physician's on-call service
2. Call the ambulance service's medical control at the hospital
3. Call the ambulance service's medical director on their mobile phone



WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689
F: 970-524-1771

Home Safety Assessment

Last Revised: (Date)

Purpose: The home safety assessment is designed to provide a detailed walkthrough of the client's home, identify safety hazards and make recommendations when needed.

Procedure: The paramedic will look at many factors that have been shown to cause injuries to members of the home, especially the very young and elderly. With a specially designed checklist, (Attachment A) the assessment begins at the driveway or walkway and ends at the back yard. Note, this assessment is not a mechanical inspection of the home and is not designed to look at the safety of electrical wiring, hot water heaters, plumbing or any other mechanical features of the house. Rather, it is designed to focus on things such as trip hazards, kitchen safety, adequate lighting in the home and in walk areas, grab bars and lift handles if applicable, and other notable safety features.

A Community Paramedic does not perform the role of a physical therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy. If a Community Paramedic notices the client is having difficulty moving around, they should make the necessary referrals to organizations that can provide walkers, canes and other mobility devices, and also link them with their primary care physician, so that they can be referred to a physical therapist. If hazards are found, the paramedic will recommend changes that need to be made and, if needed, refer the client to the appropriate community resources that can then provide further assistance.

Western Eagle County Health Services District

Home Safety Assessment Checklist

Date of visit: _____

Occupant name: _____ Paramedic Name: _____

OUTSIDE OF HOUSE

1. Sidewalk and/or pathway to house is level and free from any hazards. Yes ___ No ___ N/A ___
2. Driveway is free from debris/snow/ice. Yes ___ No ___ N/A ___
3. Outside stairs are stable and have sturdy handrail. Yes ___ No ___ N/A ___
4. Porch lights are working and provide adequate lighting. Yes ___ No ___ N/A ___

LIVING ROOM

1. Furniture is of adequate height and offers arm rests that assist in getting up and down. Yes ___ No ___ N/A ___
2. Floor is free from any clutter that would create tripping hazards. Yes ___ No ___ N/A ___
3. All cords are either behind furniture or secured in a manner that does not cause trip hazards. Yes ___ No ___ N/A ___
4. All rugs are secured to floor with double-sided tape. Yes ___ No ___ N/A ___
5. Lighting is adequate to light room. Yes ___ No ___ N/A ___
6. All lighting has an easily accessible on/off switch. Yes ___ No ___ N/A ___
7. Phone is readily accessible near favorite seating areas. Yes ___ No ___ N/A ___
8. Emergency numbers are printed near all phones in house. Yes ___ No ___ N/A ___

KITCHEN

1. Items used most often are within easy reach on low shelves. Yes ___ No ___ N/A ___
2. Step stool is present, is sturdy and has handrail. Yes ___ No ___ N/A ___
3. Floor mats are non-slip tread and secured to floor. Yes ___ No ___ N/A ___
4. Oven controls are within easy reach. Yes ___ No ___ N/A ___
5. Kitchen lighting is adequate and easy to reach switches. Yes ___ No ___ N/A ___
6. ABC fire extinguisher is located in kitchen. Yes ___ No ___ N/A ___

WECAD Home Safety Checklist, cont.

STAIRS

1. Carpet is properly secured to stairs and/or all wood is properly secured. Yes ___ No ___ N/A ___
2. Handrail is present and sturdy. Yes ___ No ___ N/A ___
3. Stairs are free from any clutter. Yes ___ No ___ N/A ___
4. Stairway is adequately lit. Yes ___ No ___ N/A ___

BATHROOM

1. Tub and shower have a non-slip surface. Yes ___ No ___ N/A ___
2. Tub and/or shower have a grab bar for stability. Yes ___ No ___ N/A ___
3. Toilet has a raised seat. Yes ___ No ___ N/A ___
4. Grab bar is attached near toilet for assistance. Yes ___ No ___ N/A ___
5. Pathway from bedroom to bathroom is free from clutter and well lit for ease of movement in the middle of the night. Yes ___ No ___ N/A ___

BEDROOM

1. Floor is free from clutter. Yes ___ No ___ N/A ___
2. Light is near bed and is easy to turn on. Yes ___ No ___ N/A ___
3. Phone is next to bed and within easy reach. Yes ___ No ___ N/A ___
4. Flashlight is near bed in case of emergency. Yes ___ No ___ N/A ___

GENERAL

1. Smoke detectors in all areas of the house (each floor) and tested. Yes ___ No ___ N/A ___
2. CO detectors on each floor of house and tested. Yes ___ No ___ N/A ___
3. Flashlights are handy throughout the home. Yes ___ No ___ N/A ___
4. Resident has all medical information readily available and in an area emergency providers will easily find. Yes ___ No ___ N/A ___
5. All heaters are away from any type of flammable material. Yes ___ No ___ N/A ___

WECAD Home Safety Checklist, cont.

OVERALL TIPS

1. Homeowner has good non-skid shoes to move around house. Yes ___ No ___ N/A ___
2. All assisted walking devices are readily accessible and in good condition. Yes ___ No ___ N/A ___
3. There is a phone near the floor for ease of reach in case of a fall. Yes ___ No ___ N/A ___
4. All O2 tubing is less than 50 ft. and is not a trip hazard. Yes ___ No ___ N/A ___
5. Resident has had an annual hearing and vision check by a physician. Yes ___ No ___ N/A ___
6. Resident has the proper hearing and visual aides prescribed and are in good working order. Yes ___ No ___ N/A ___
7. All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses. Yes ___ No ___ N/A ___

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

After evaluation I recommend the resident be considered for the following referrals.

Signature of resident: _____

Signature of Community Paramedic: _____

References: Centers for Disease Control and Prevention / <http://www.cdc.gov>

A. 'Check for Safety' A Home Fall Prevention Checklist for Older Adults

B. U.S. Fall Prevention Programs for Seniors – Selected Programs Using Home Assessment and Modification.

Compiled and created by Kevin Creek NREMT-P / Community Paramedic
 Western Eagle County Health Services District, 360 Eby Creek Road, P.O. Box 1809, Eagle CO 81631
 May 2011



Appendix K

**WESTERN EAGLE COUNTY
HEALTH SERVICES DISTRICT**785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689

F: 970-524-1771

SocialSupport EvaluationLast Revised: (Date)

Purpose: The social evaluation procedure is designed for use during the home visit for the Community Paramedic to determine whether the client has the social supports necessary to help maintain their health.

Procedure: The Community Paramedic will use history taking and other interview techniques to assess the client's general well being in the home, and make sure that this is a person who has all of their basic needs met. The Community Paramedic will assess such necessities as adequate food, cleanliness, clothing, shelter, companionship, supportive social network, ability to obtain prescription medications (financially and physically in terms of being able to retrieve/open them), and other important day-to-day needs. Referrals will be made to the appropriate agencies when appropriate, and a detailed report will be given to the physician after the Community Paramedic visit.



WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689
F: 970-524-1771

Wound Check/Dressing Change

Last Revised: (Date)

Purpose: To perform an evaluation of a wound and to assist the patient and family caregivers in the changing of basic dressings in the home setting.

Procedure: In caring for a patient who has a wound that needs to be evaluated and have a dressing changed, the Community Paramedic will perform a history, physical, and basic evaluation of the wound to make sure that there is no infection or other obvious signs of immediate need for physician evaluation. Basic dressing changes will be performed, however, there will be no advanced care of the wound such as draining or debriding. If during the visit it appears that the wound needs any type of advanced care, the Community Paramedic will contact the physician's office and recommend that the patient be seen as soon as possible.

Medication Compliance and Reconciliation

Last Revision: (Date)

Purpose: The purpose of this service is to evaluate the patient's medications to determine whether they are taking and storing them correctly. Elderly patients in particular may be on multiple medications, which can create confusion. The CP will evaluate whether the patient is taking each one of their prescribed medications, at the appropriate time and correct dosage, and whether they are safely and properly storing them. The goal for the Community Paramedic is to help the client organize and correctly understand how and when to take their medications.

Procedure: Before visiting with the patient, the physician's office will fax a copy of the most current medication list, history and orders to the Community Paramedic office so that the visiting paramedic knows exactly what plan the patient is supposed to be on. Through inspection of the medications, organizational containers and interview techniques, the paramedic will determine if the patient is following their prescribed medications and routine. If, during the visit, the paramedic finds that there is a discrepancy in how the patient is handling their medications, the physician will be contacted and discussions will be made on how to correct the problem. The paramedic will NOT change any medications, dose, or advise the patient on how to resume a normal schedule once the patient has gone off their prescribed meds or routine. The physician will make any and all decisions regarding the patient's medications, and the paramedic is in an assistance role only.



Appendix M

WESTERN EAGLE COUNTY HEALTH SERVICES DISTRICT

785 Red Table Dr.
Gypsum, CO 81637

P: 970-524-1689
F: 970-524-1771

Community Paramedic Patient Order Form

PATIENT INFORMATION <small>(May submit patient face sheet for demographics)</small>		PLEASE RETURN BY FAX TO 970-524-1771	
Date of Order: _____		Requested Date of Service: _____	
Primary Language: _____			
Client Name: Last _____		DOB: _____	
First _____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Middle _____			
Physical Street Address _____		City/Town _____	
		State _____	
		Zip Code _____	
Mailing Address (if different) _____		City/Town _____	
		State _____	
		Zip Code _____	
Insurance (For research purposes only): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, company: _____			
DIAGNOSIS		PREVENTION ASSESSMENTS	
Diagnosis: _____		<input type="checkbox"/> Nutrition Assessment	
Reason for Visit: _____		<input type="checkbox"/> Social Evaluation / Social Support	
		<input type="checkbox"/> Home Safety Inspection	
LABORATORY SPECIMEN COLLECTION PLEASE INCLUDE AGENCY CLINICAL LAB TESTING ORDER SHEET			
<input type="checkbox"/> Blood Draw <input type="checkbox"/> IStat Test (Coming Soon!) <input type="checkbox"/> Stool Collection <input type="checkbox"/> Urine Collection			
Requested Labs/Blood Tubes: _____			
CLINICAL CARE			
<u>Cardiovascular</u>		<u>Respiratory</u>	
<input type="checkbox"/> Blood Pressure Check		<input type="checkbox"/> Asthma Meds/Education/Compliance	
<input type="checkbox"/> EKG 12 Lead		<input type="checkbox"/> CPAP	
<input type="checkbox"/> Peripheral Intravenous Lines		<input type="checkbox"/> MDI Use	
<u>Follow-up/Post Discharge</u>		<input type="checkbox"/> Nebulizer Usage/Compliance	
<input type="checkbox"/> Diabetic Follow-up/Education		<input type="checkbox"/> Peak Flow Meter Education/Usage	
<input type="checkbox"/> Neurological Assessment		<input type="checkbox"/> Oxygen Saturation Check	
<input type="checkbox"/> Dressing Change/Wound Check/Type: _____		<u>General</u>	
<input type="checkbox"/> Discharge Follow-up/Diagnosis: _____		<input type="checkbox"/> Assessment / H&P	
		<input type="checkbox"/> Ear exams	
		<input type="checkbox"/> Medication Evaluation or Medication Compliance	
		<input type="checkbox"/> Post Injury/Illness Evaluation	
		<input type="checkbox"/> Post Stroke Assessment/Follow-up	
		<input type="checkbox"/> Weight Check	
Other Orders/Information: _____			

PUBLIC HEALTH/SOCIAL SERVICES			
<input type="checkbox"/> Bright Beginnings		<input type="checkbox"/> EHS Post Partum Visit	
<input type="checkbox"/> Disease Investigation		<input type="checkbox"/> Fluoride Varnish Clinic	
		<input type="checkbox"/> Welfare Check	
		<input type="checkbox"/> TB Meds DOT	
ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)		Disclaimer: All visits will be accomplished as soon as possible but generally within 24 - 72. All services provided must be within the scope of practice of a paramedic as described in 6 CCR 1015-3 Chapter 2, EMS Practice and Medical Director Oversight Rules. Paramedics will verify that orders fall within this scope of practice and will contact you if orders need clarification or further instruction.	
Contact Number: _____			
Referring Physician: _____			
(Please Print)			
Signature _____		Date _____	
<input type="checkbox"/> Fax report back to referring physician			
<input type="checkbox"/> Fax report to: _____			

Community Paramedic (CP)

Briefing Paper (NCSL) August, 2014)



Background

Gaps in health care services lead to excessive and sometimes unnecessary, expensive hospital admissions / readmissions. The Community Paramedic (CP) role has been suggested as a solution to vulnerable populations with chronic conditions and limited access to primary care services. With origins in rural Canada, Australia and New Zealand, the CP has been promoted in a number of communities in the US for more than a decade through an array of funding. The delivery care model garnered even more attention as Emergency Medical Services (EMS) providers noted a high incidence of non-emergent calls to which transport to an emergency room (ER) was deemed unnecessary and for which reimbursement for the home visit was not available.

Building on the preparation and skills of the Emergency Medical Technician (EMT) and Paramedic, it is suggested CPs be used for home assessment, consultation, direct care, public health and wellness services, health teaching, chronic disease management, mental health, medication reconciliation, and oral health. Traditionally these are functions that had been delivered by home and public health nurses, but cuts in funding decimated many programs. While support was inadequate to sustain the services of public and home health nurses, CP programs have been successful in securing grants.

While there are a number of states using EMTs in an expanded role in demonstration projects without a title change, some states are seeking to legitimize these roles through legislation. Minnesota became the first state to recognize the CP in statute in 2011 (effective 2012), with CPs subsequently added to the list of Medicaid-approved services. In 2013, a similar bill was signed into law in Missouri and Pennsylvania formed a task force to make recommendations as to the best model for this role in the state. A resolution passed in the (2014) North Dakota legislature, authorizing a study of the feasibility and desirability of the practice with the request for a report and recommendations to be submitted to the next Legislative Assembly. As with North Dakota, California and Maine were also authorized by the legislature to conduct demonstration projects. Though not a true CP program, Tennessee passed a law (2014), permitting EMTs to provide non emergent services in the community under medical direction. With 232 unique EMS and mobile integrated healthcare systems in existence nationally, (per The National Association of Emergency Medical Technicians (NAEMT)), numerous challenges occur when attempting to introduce this new role (CP).

The ANA believes the focus should be on patient's timely access to safe, competent care.

Recommended considerations when advancing state legislation / regulation:

Clarity of role and functions

Practice is defined with clear parameters in statute or regulations.

The title used is consistent and clear.

There is a central repository of information (i.e. registry) providing information as to education, certification(s), and other credentials.

Competence - Appropriate education and training

There is a uniform standard for education and training, which is consistent with the defined practice.

The "higher" education program is accredited.

Competencies are measurable and reflect the minimum, not the ceiling.

Accountability

Accountability to a regulatory body and public is evident. Most importantly, the authority, power and composition of the regulating board are logical and consistent with that which governs similar health care professionals.

There is a "license" specific to the new role and title. Re-registration is required. Frequency should be reasonable and logical with consideration of actions to be performed. (Continuing Education, etc)

Criminal background checks should be conducted.

There are clearly defined grounds for disciplinary action, other violations and possible remedies.

Be sure to build in a method for evaluating the new role and impact on patient outcomes.

Interdisciplinary teamwork, reflected by cooperation, collaboration and communication

Community Paramedicine is divergent from the primary mission of Emergency Medical Services, therefore should provide for a different or additional type of medical supervision by primary care physicians, or advanced practice nurses.

Invite Registered Nurses to the table when framing this new role. Nurses have core competencies in interdisciplinary care coordination and have played integral roles in the formation and success of an inter-professional team. The Nurse Practice Act associated rules / regulations may need to be amended to permit nurses to delegate, supervise or provide oversight.



Regulatory Guide

Considerations with Newly Created / Expanded Healthcare Workforce Roles

Supplement to the Principles for Utilization of Community Paramedics (CPs)

(Reproduction / distribution without ANA permission is prohibited)

Introduction

The health care system is now and will continue to undergo a major transformation, which will require looking at the health care workforce differently.

The system will:

- Place greater emphasis on primary and preventive care,
- Seek to better integrate care across: -- specialties, home health agencies and nursing homes, community and home-based services,
- Use technology to monitor health,
- Provide payment incentives, promote accountability, move toward "risk based" and "value-based" models of care, and
- Be designed to lower cost, increase quality, and improve the patient experience.

To support the new landscape, we will need a more flexible use of workers that include:

- Existing workers taking on new roles in new models of care; shifting employment settings; and workers moving between needed specialties and changing services they offer,
- New types of health care workers performing new functions, and
- Broader implementation of true team-based models of care and education.

It is expected that registered nurses will be doing much more care coordination for different types of patients; managing transitions of care across acute, ambulatory, and community settings (including the patient's home); and continue creating care plans; engaging and educating patients and family; performing outreach and population health management; connecting patients with community-based services, as well as provide supervision and oversight for care delivered by other health care workers, whose roles are changing.

Why a regulatory guide?

The purpose of regulation is to:

1. "Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners";
2. "Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner"; and
3. "Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses." (NCSBN 2006)

Public protection should be the top priority.

With health care transformation and greater need for access, it is critical the public recognize new and changing health care roles, how they fit within the interdisciplinary team, (ROLE CLARITY) and be confident the workforce receives the appropriate education and training to perform competently. (ROLE COMPETENCE)

Given the differences between state laws, and which agencies, commissions, boards regulate professions and other health care entities, this document is intended as a broad brush guide to navigating the regulation of changing roles of the health care workforce, (such as the Community Paramedic); all in an effort to achieve the best interests and protections for the public, patients and the nursing profession.

Role Clarity (for the Public and the Interdisciplinary Team)

Role Competence

Accountability

Definitions

Scope of Practice

Defines the parameters, rules, and regulations within which an individual may practice in a specifically defined area of practice; regulated by rule, statute or court decision. In addition to representing the limits of service, it may include provisions for continuing education and professional accountability (NCSNB, 2007; NHTS, 2004).

Though subtle, a distinction has been made between "legal" scope of practice and "professional". Legal is based on state-specific practice acts, defining what service a health care worker can and cannot provide and under what conditions; while "professional" describes the services or activities a health care provider is trained and competent to perform, based on acquired knowledge, skills and abilities.

(chws.albany.edu; ANA, 2010)

Definitions Continued

Licensure

Licensure is a process by which a governmental authority grants permission to an individual health care provider to operate or engage in an occupation or profession. Licensure regulations are generally established to ensure that an individual meets minimum standards to protect public health and safety.

Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee and/or proof of continuing education. (Shroder, 2013) Traditionally, this has been a state-based function. For select health care workers, some states refer to licensure – as “certification”, conveying that the standards for that state have been met.

Certification

A “Certification” can be either a prerequisite for licensure or, in some cases, is viewed as documented entry-level competence. Certification is a process by which a nongovernmental agency validates, based upon predetermined standards, an individual’s qualifications for practice in a defined functional or clinical area. (Schmitt & Shimberg, 1996; AACN, 2014)

Registration - Re-registration

This reflects the process for submitting evidence of qualifications and making available a listing of individuals who have fulfilled the qualifications and are deemed minimally competent to practice.

Regulatory agency

For the purposed of this document, this definition applies to the human capacity – health professions. A regulatory agency is a public authority or government agency with oversight for “health professions”, ensuring that the public’s best interest is served. The agency is dedicated to consumer protection and quality.

Regulations

Regulations reflect either a rule or statute that prescribes the management, governance, or operating parameters for a given group, to ensure that the public is protected from unscrupulous, incompetent and unethical practitioners. Regulatory standards should be based upon clear definitions of professional scope, controlled acts and accountability. (Schmitt & Shimberg, 1996; Benton et. al, 2013; NHTS, 1996)

Competence

Refers to the ability of an individual to demonstrate integration of knowledge, skills, and judgment in daily practice for the benefit of the individual or community being served. (ANA, 2010; Epstein & Hundert, 2002)

Accountability

Reflects taking personal responsibility for judgments made and actions taken in the course of providing health care, irrespective of the healthcare organizations policies or directives from others. (ANA, 2011).

Definitions Continued

Collaboration

Is a process involving two or more health care professionals working together, though not necessarily in each other's presence; each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer. (ANA, 2010 pg. 64)

Supervision

There is no universally recognized "legal" definition of supervision, however ANA defines supervision to be the active process of directing, guiding, and influencing the outcome of an individual's performance of a task. Similarly, the National Council of State Boards of Nursing (NCSBN) defines supervision as the provision of guidance or direction, oversight, evaluation, and follow-up by the licensed nurse for the accomplishment of a delegated nursing task by "assistive" personnel.

Individuals engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer under federal labor law. (ANA & NCSBN, 2006)

Whether state law calls for direct, indirect, general, offsite, prescriptive, personal, close supervision or authorized supervision, it is critical to understand how the state law interprets the requirements.

(Schroder, 2013)

Delegation

Generally involves assignment of the performance of activities or tasks related to patient care. Since it involves "the transfer of responsibility" for the performance of a task from one individual to another while retaining accountability for the outcome, some state Nurse Practice Acts rules / regulations prohibit nurses from delegating to non-nurses. The registered nurse cannot delegate responsibilities related to making nursing judgments. (ANA, 2010)

Criminal background checks (CBCs)

Health care consumers are dependent upon professional licensing boards to conduct appropriate screening of applicants. In the past many (boards of nursing) included a good moral character requirement for licensure, but this term may be viewed as vague, subjective and difficult to define. The recent trend is for boards of nursing to require CBCs (i.e., state checks, federal checks or a combination.) CBCs provide validation of the information reported on applications. While a lack of criminal history is no guarantee against future criminal acts, the CBC is seen as a more objective and reliable source of information regarding an applicant's behavior and conduct and better predictor for future.

Considerations

Tension with stakeholders should not reduce the desire for standards nor derail the focus on public protection through role clarity, appropriate education & training, demonstrated competence, collaboration and cooperation with the interdisciplinary health care team, and accountability.

Role Clarity and Competence

Role Clarity:

- ✓ Practice is defined with clear parameters in statute or regulations.
- ✓ The title used is consistent and clear.
- ✓ There is a central repository of information (i.e. registry) providing information as to education, certification(s), and other credentials.

(Italicized text is specific to the Community Paramedic)

A survey in 2005, revealed 39 different licensure levels between EMTs and Paramedics within 30 states plus territories. (NHTSA, 2005). Beyond that, there is great variation as to recognition of the practice parameters of the CP. Most often the CP is following the current EMS model: protocols for engagement and care with oversight by an emergency medical director.

If expanding the EMT role to include functioning in the home care and community settings, the title should reflect that of Community Paramedic.

Appropriate education and training:

- ✓ There is a uniform standard for education and training, which is consistent with the defined practice.
- ✓ The "higher" education program is accredited.
- ✓ Competencies are measurable and reflect the minimum, not the ceiling.

Education of a CP should promote the development of skills in clinical problem solving and decision making. It has been recommended that detailed explanation of training, education levels, entry-to-practice standards and skill maintenance of CPs should be done to ensure competence in performing specific services and expanded practice roles including but not limited to knowledge of wellness, prevention, principles of health teaching, chronic disease management and roles and scope of other healthcare team members. It is recommended that successful completion of a nationally accredited Paramedic program be required. (NHTSA, 2005)

Accountability:

- ✓ There is a "license" specific to the new role and title.
- ✓ Accountability to a regulatory body and public is evident. Most importantly, the authority, power and composition of the regulating board are logical and consistent with that which governs similar health care professionals.
- ✓ Practice should not be solely tied to "medical" supervision. Evaluate "medical" protocols, if used, to be sure they are appropriate to the setting, reflecting non-emergent care and recognize there are relationships with nursing and other members of the interdisciplinary team.

- ✓ It is recommended that criminal background checks be done. The licensing or regulatory agency or board should have the discretion to grant or deny licensure based on the findings of the background check.
- ✓ There are clearly defined grounds for disciplinary action and possible remedies.
- ✓ Re-registration is required. Frequency should be reasonable and logical with consideration of actions to be performed. (Continuing Education, etc.)

There has been considerable debate within the EMS Community as to whether there should be an explicit definition of CPs in statute. This is based largely on the desire for the CP to function differently between communities based on the specific needs and demographics. Regardless, regulations must be clear to assure there are defined parameters for practice and description of needed education, licensure and certification for the protection of the public.

Sole regulatory oversight by the EMS state Board or office may not be logical when CPs' primary role is that of primary care extender. It is advisable to create a collaborative oversight by primary care providers along with the 911/Emergency based medical directors"

Interdisciplinary teamwork, reflected by cooperation, collaboration and communication

- ✓ Nurses have core competencies in interdisciplinary care coordination and have played an integral part in the formation and success of an inter-professional team. The Nurse Practice Act and associated rules and regulations permit nurses to delegate, supervise or provide oversight, as circumstances dictate. Some states explicitly or implicitly limit to whom the nurse may transfer responsibility (delegate) functions. As such, consideration should be given to changing rules to permit nurses to exercise judgment as to whom and when delegation is appropriate and be in position to provide the necessary oversight.

Because Community Paramedicine is divergent from the primary mission of Emergency Medical Service, it may require a different or additional type of medical supervision / direction by primary care physicians, or advanced practice nurses. (Kizer et al., 2013)

Presently CP's work under the supervision of an Emergency Medical Director who is a physician. However, in some situations the CP may be a part of an RN interdisciplinary team. In general CPs should be permitted to provide non emergent medical services delegated by a primary care provider (i.e. Primary Care Physicians, Advance Practice Nurses, RN) with the proviso that the service is within the CP's skill set. A CP's skill should not be utilized to extend the scope of the health care provider beyond what is reasonable and safe.

- ✓ There is a method for evaluating the new / evolving role and the impact on patient outcomes.

References

- American Nurses Association, (2011). Code of Ethics for Nurses with Interpretive Statements. New York: Author.
- American Nurses Association, (2010). Scope and Standards of Practice. 2nd Edition. Silver Spring MD.
- Benton, D. C., Gonzalez-Jurado, M. A., Benelt-Montesinos, J.V., (2013) *A structured policy review of the principles of professional self-regulation*. Journal of International Nursing Review, 60(1), 13-22.
- Epstein R.M., Hundert E.M., (2002) *Defining and assessing professional competence*. JAMA: 287(2), 226–35
- Finocchio, L. J., Dower, C. M., McMahon, T., Gragnola, C. M., and the Taskforce on Healthcare Workforce Regulation, (1995) *Reforming Healthcare Workforce Regulation: Policy Considerations for the 21st Century*. Pew Health Professions Commission: CA
- Fraher, Erin PhD, MPP, Director, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill.
- Health Resource and Services Administration. (2010) *Health Licensing Board Report to Congress*. www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf
- Kizer, Kenneth W., Karen Shore, and Almee Moulin UC Davis Institute for Population Health Improvement *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*; July 2013.
- National Highway Traffic Safety Administration (NHTSA). (2005) *EMS Education Agenda for the Future: A Systems Approach*. www.nhtsa.gov/people/injury/ems/FinalEducationAgenda.pdf
- National Council of State Boards of Nursing (NCSBN) (2006) *Changes In Healthcare Professions' Scope of Practice: Legislative Considerations* (2006) NCSBN in collaboration with five health care professional groups, including: Medicine, Pharmacy, Physical Therapy Occupational Therapy, and Social Work. https://www.ncsbn.org/ScopeofPractice_09.pdf
- National Highway Traffic Safety Administration (NHTSA) (2005) *National EMS Scope of Practice Model* www.ems.gov/education/EMSScope.pdf
- Office of Inspector General, (2008). *System of Records - Criminal Investigative Files* oig.hhs.gov/authorities/docs/08/030408frnotice.pdf - 68k - 2008-03-04
- Schmitt, K. and Shimberg, B *Demystifying Occupational and Professional Regulation: Answers to Questions You May Have Been Afraid to Ask* (1996). Council on Licensure, Enforcement, and Regulation.
- Shroder, K. (2013) *Practice laws and regulations: and how and why they change*. American Dental Hygiene Association.

6/2014



ANA's Essential Principles for Utilization of Community Paramedics

Background

Over the past decade, emergency medical services (EMS) has piloted a new role, most often referred to as the community paramedic (CP). This expanded role builds on the skills and preparation of the emergency medical technician (EMT) and paramedic, with the intention of fulfilling the healthcare needs of those populations with limited access to primary care services. Cuts in public health and community services funding have decimated programs, leaving unmet health needs. In many cases, CPs are filling a gap in services that had been performed by public health nurses and visiting nurses.

Communities have used CPs for home assessment, consultation, and direct care, purportedly reducing unnecessary hospital admissions and readmissions. The EMS community describes other possible services that could be performed by the CP as public health, disease management, prevention and wellness, mental health, and oral health. Consistent with the traditional EMS model, CPs use protocols and work under the direction of a physician (medical director).

ANA believes that every patient deserves access to safe, quality care from all healthcare providers. Health care is ever-changing and is currently undergoing a significant transformation. ANA supports initiatives which allow all members of the healthcare team to fully function consistent with their education and training in a cooperative manner.

Purpose

ANA's Essential Principles for Utilization of Community Paramedics provides overarching standards and strategies for the registered nurse and the community paramedic to apply when cooperating in various settings and across the continuum of care. This document seeks to promote common understanding of the community paramedic role and clarification of registered nurses' expectations of cooperation with this new role.

The significance of establishing the groundwork for cooperation is rooted in two major assumptions:

- There exists overlapping patient care responsibilities between healthcare team members.
- Patient-centered care coordination is a core professional standard and competency for all registered nursing practice.

These assumptions assert that registered nurses and community paramedics will need to cooperate. Successful cooperation leads to the delivery of safe, quality care and transparency with regards to roles and functions. Therefore, it is important to:

- Establish minimum standards for education and training for the community paramedic, — beyond the emergency services education and training required of EMTs and paramedics— that prepares the community paramedic to competently perform the expanded functions.
- Reduce "role confusion" by identifying the community paramedic's role within the healthcare team while distinguishing the registered nurses' responsibilities.
- Foster interdisciplinary cooperation through appropriate regulatory models.

Terminology and Basics

Notes on Terminology

The word *nurse* refers specifically to a professional registered nurse. *Nursing's Social Policy Statement: The Essence of the Profession* (ANA, 2010; pg. 7) recognizes the value of clearly identifying the recipients of professional nursing care, be they individuals, groups, families, communities, or populations. The terms *patient*, *client*, *person*, *population* and *community* most often refer to *individuals*, whereas *healthcare consumer* can represent an individual or group.

The terms *community paramedic*, *advanced practice paramedic* and *community health aide/worker** refer to an individual who lawfully engages in an expanded scope of paramedic or EMT practice to meet the needs of the local community and has successfully completed standardized education and training to competently perform those functions.

(* Variations in titles may exist between states. This document addresses those roles that build on the EMT and paramedic.)

Basics: Assuring Patient Safety

- Role competence – Clarity of functions with appropriate education and training
- Interdisciplinary teamwork – Reflected by cooperation, collaboration and communication
- Accountability – Accountable for self, to the community, and to a regulatory agency

Essential Principles

ANA recognizes that, given existing differences in regulatory structure, regulatory models will vary from state to state, but believes that at the very least, a model must incorporate some Basics for assuring patient safety.

(**For guidance in developing a suitable regulatory framework, members should contact Janet Haebler, ANA Government Affairs janet.haebler@ana.org.)

Role Competence

As with all healthcare providers, the public has a right to expect community paramedics to demonstrate competence throughout their careers and in all healthcare settings. ANA's position is that competence is definable and can be evaluated.

Competence can be evaluated by implementing tools that retrieve objective and subjective information about an individual's knowledge and performance (ANA, 2010; pg. 25, 32). There should be a mechanism for maintaining and measuring continued competence.

Uniform education and clinical training from an accredited program in the higher education setting, consistent with the functions of the community paramedic role, should be required by state statute, rules, regulations. Accredited educational programs should include core components from social and behavioral sciences and social determinants of health such as:

- Cultural competency
- Community roles and resources
- Health assessment
- Personal safety
- Professional boundaries
- Clinical components that include sub-acute and semi-chronic patient needs

Interdisciplinary Teamwork

The community paramedic must be considered part of the interdisciplinary team. Given the role of registered nurses as coordinators of patient care (ANA, 2012), it is important that community paramedics communicate and cooperate with registered nurses. Regulatory models should not impose barriers to interdisciplinary communication or collaboration.

Accountability

Community paramedics should be accountable for self, to the community, and to a regulatory agency. Every effort should be made to ensure that the agency with oversight for CPs collaborates well with the agency or agencies that have oversight for other professionals with whom they will be cooperating and communicating as part of the healthcare team.

Evaluation

This emerging role of the community paramedic requires ongoing evaluation to determine effectiveness and inform healthcare providers and policy makers as to needed changes. Thus far, the focus in community paramedic demonstration projects has been on reduced costs through decreased emergency room visits, hospital admissions and readmissions. Evaluation should extend to include monitoring for improved patient outcomes and patient satisfaction and a decrease in adverse outcomes.

Sources

All URLs current as of 02/05/2012.

American Nurses Association (ANA, 2012). *Care coordination and registered nurses' essential role*. (ANA Position Statement: Approved 06, 2012.) Retrieved from <http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Care-Coordination-and-Registered-Nurses-Essential-Role.html>

American Nurses Association (ANA, 2010). *Nursing's Social Policy Statement: The essence of the profession*. Silver Spring, MD: Nursesbooks.org.

National Council of State Boards of Nursing (2009). *Changes in healthcare professions' scope of practice: Legislative considerations*. October. Retrieved from https://www.ncsbn.org/ScopeofPractice_09.pdf

North Central EMS Institute. (2014). *The Community Paramedic Program: A New Way of Thinking*. Retrieved from <http://communityparamedic.org/>

North Central EMS Institute. (2012). *Community paramedic lesson plan*. Retrieved from <http://aerospace.ceas.uc.edu/content/dam/aero/docs/fire/CP%20Lesson%20Plan.pdf>

Approved the ANA Board of Directors
February 28, 2014

Published March 2014.

American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910-3492
1-800-274-4ANA
www.Nursingworld.org

© 2014 American Nurses Association. All rights reserved. No part of this publication may be reproduced or utilized in any form or any means, electronic or mechanical, including photocopying and recording, or by any information storage and retrieval system, without permission in writing from ANA.

**ADVANCED PRACTICE
REGISTERED NURSES**

HB 2280

HOUSE BILL No. 2280

By Committee on Health and Human Services

2-10

1 AN ACT concerning the board of nursing; relating to the certified nurse-
2 midwives; amending K.S.A. 2014 Supp. 65-1130 and repealing the
3 existing section.
4

5 *Be it enacted by the Legislature of the State of Kansas:*

6 Section 1. K.S.A. 2014 Supp. 65-1130 is hereby amended to read as
7 follows: 65-1130. (a) No professional nurse shall announce or represent to
8 the public that such person is an advanced practice registered nurse unless
9 such professional nurse has complied with requirements established by the
10 board and holds a valid license as an advanced practice registered nurse in
11 accordance with the provisions of this section.

12 (b) The board shall establish standards and requirements for any
13 professional nurse who desires to obtain licensure as an advanced practice
14 registered nurse. Such standards and requirements shall include, but not be
15 limited to, standards and requirements relating to the education of
16 advanced practice registered nurses. The board may give such
17 examinations and secure such assistance as it deems necessary to
18 determine the qualifications of applicants.

19 (c) The board shall adopt rules and regulations applicable to advanced
20 practice registered nurses which:

21 (1) Establish roles and identify titles and abbreviations of advanced
22 practice registered nurses which are consistent with nursing practice
23 specialties recognized by the nursing profession.

24 (2) Establish education and qualifications necessary for licensure for
25 each role of advanced practice registered nurse established by the board at
26 a level adequate to assure the competent performance by advanced
27 practice registered nurses of functions and procedures which advanced
28 practice registered nurses are authorized to perform. Advanced practice
29 registered nursing is based on knowledge and skills acquired in basic
30 nursing education, licensure as a registered nurse and graduation from or
31 completion of a master's or higher degree in one of the advanced practice
32 registered nurse roles approved by the board of nursing.

33 (3) Define the role of advanced practice registered nurses and
34 establish limitations and restrictions on such role. The board shall adopt a
35 definition of the role under this subsection (c)(3) which is consistent with
36 the education and qualifications required to obtain a license as an

1 advanced practice registered nurse, which protects the public from persons
2 performing functions and procedures as advanced practice registered
3 nurses for which they lack adequate education and qualifications and
4 which authorizes advanced practice registered nurses to perform acts
5 generally recognized by the profession of nursing as capable of being
6 performed, in a manner consistent with the public health and safety, by
7 persons with postbasic education in nursing. In defining such role the
8 board shall consider: (A) The education required for a licensure as an
9 advanced practice registered nurse; (B) the type of nursing practice and
10 preparation in specialized advanced practice skills involved in each role of
11 advanced practice registered nurse established by the board; (C) the scope
12 and limitations of advanced practice nursing prescribed by national
13 advanced practice organizations; and (D) acts recognized by the nursing
14 profession as appropriate to be performed by persons with postbasic
15 education in nursing.

16 (d) An advanced practice registered nurse may prescribe drugs
17 pursuant to a written protocol as authorized by a responsible physician.
18 Each written protocol shall contain a precise and detailed medical plan of
19 care for each classification of disease or injury for which the advanced
20 practice registered nurse is authorized to prescribe and shall specify all
21 drugs which may be prescribed by the advanced practice registered nurse.
22 Any written prescription order shall include the name, address and
23 telephone number of the responsible physician. The advanced practice
24 registered nurse may not dispense drugs, but may request, receive and sign
25 for professional samples and may distribute professional samples to
26 patients pursuant to a written protocol as authorized by a responsible
27 physician. In order to prescribe controlled substances, the advanced
28 practice registered nurse shall: (1) Register with the federal drug
29 enforcement administration; and (2) notify the board of the name and
30 address of the responsible physician or physicians. In no case shall the
31 scope of authority of the advanced practice registered nurse exceed the
32 normal and customary practice of the responsible physician.

33 (e) An advanced practice registered nurse certified in the role of
34 registered nurse anesthetist while functioning as a registered nurse
35 anesthetist under K.S.A. 65-1151 ~~to through 65-1164, inclusive,~~ and
36 amendments thereto, shall be subject to the provisions of K.S.A. 65-1151
37 ~~to through 65-1164, inclusive,~~ and amendments thereto, with respect to
38 drugs and anesthetic agents and shall not be subject to the provisions of
39 ~~this subsection (d).~~

40 (f) *An advanced practice registered nurse certified in the role of*
41 *certified nurse-midwife while functioning as a certified nurse-midwife*
42 *under sections 2 through 10, and amendments thereto, shall be subject to*
43 *the provisions of sections 2 through 10, and amendments thereto, with*

1 *respect to prescribing drugs and shall not be subject to the provisions of*
2 *this section.*

3 (g) *As used in this section, "drug" means those articles and*
4 *substances defined as drugs in K.S.A. 65-1626 and 65-4101, and*
5 *amendments thereto.*

6 ~~(h) For the purposes of this subsection~~ *As used in the section,*
7 *"responsible physician" means a person licensed to practice medicine and*
8 *surgery in Kansas who has accepted responsibility for the protocol and the*
9 *actions of the advanced practice registered nurse when prescribing drugs.*

10 ~~(e) As used in this section, "drug" means those articles and substances~~
11 ~~defined as drugs in K.S.A. 65-1626 and 65-4101, and amendments thereto.~~

12 ~~(f)~~(i) A person registered to practice as an advanced registered nurse
13 practitioner in the state of Kansas immediately prior to the effective date of
14 this act shall be deemed to be licensed to practice as an advanced practice
15 registered nurse under this act and such person shall not be required to file
16 an original application for licensure under this act. Any application for
17 registration filed which has not been granted prior to the effective date of
18 this act shall be processed as an application for licensure under this act.

19 New Sec. 2. (a) As used in sections 2 through 10, and amendments
20 thereto:

21 (1) "Active midwifery practice" means clinical practice and
22 midwifery related administrative, educational and research activities.

23 (2) "Board" means the board of nursing.

24 (3) "Certified nurse-midwife" means an individual who meets the
25 following requirements:

26 (A) Is educated in the two disciplines of nursing and midwifery;

27 (B) is currently certified by a certifying board approved by the state
28 board of nursing; and

29 (C) is currently licensed under the Kansas nurse practice act.

30 (b) The board may adopt rules and regulations as necessary to
31 administer the provisions of sections 2 through 10, and amendments
32 thereto.

33 New Sec. 3. (a) In order to obtain authorization from the board to
34 practice as a certified nurse-midwife an individual shall meet the following
35 requirements:

36 (1) Be licensed to practice professional nursing under the Kansas
37 nurse practice act;

38 (2) has successfully completed a course of study in nurse-midwifery
39 in a school of nurse-midwifery approved by the board;

40 (3) has successfully completed a national certification approved by
41 the board; and

42 (4) has successfully completed a refresher course as defined in rules
43 and regulations of the board if the individual has not been in active

1 midwifery practice for five years preceding the application.

2 (b) Approval of schools of nurse-midwifery shall be based on
3 approval standards specified in K.S.A. 65-1133, and amendments thereto.

4 (c) For the purposes of determining whether an individual meets the
5 requirements of subsection (a)(2), the board, by rules and regulations, shall
6 establish criteria for determining whether a particular school of nurse-
7 midwifery maintains standards which are at least equal to schools of nurse-
8 midwifery which are approved by the board.

9 New Sec. 4. Upon application to the board by any licensed
10 professional nurse in this state and upon satisfaction of the standards and
11 requirements established under this act and K.S.A. 65-1130, and
12 amendments thereto, the board shall grant an authorization to the applicant
13 to perform the duties of a certified nurse-midwife and be licensed as an
14 advanced practice registered nurse. An application to the board for an
15 authorization, for an authorization with temporary authorization, for
16 biennial renewal of authorization, for reinstatement of authorization and
17 for reinstatement of authorization with temporary authorization shall be
18 upon such form and contain such information as the board may require and
19 shall be accompanied by a fee to assist in defraying the expenses in
20 connection with the administration of the provisions of this act. The fee
21 shall be fixed by rules and regulations adopted by the board in an amount
22 fixed by the board under K.S.A 65-1118, and amendments thereto. There
23 shall be no fee assessed for the initial, renewal or reinstatement of the
24 advanced practice registered nurse license as long as the certified nurse-
25 midwife maintains authorization. The executive administrator of the board
26 shall remit all moneys received to the state treasurer as provided by K.S.A.
27 74-1108, and amendments thereto.

28 New Sec. 5. (a) All authorizations to practice under this act, whether
29 initial or renewal, shall expire every two years. The biennial authorizations
30 to practice as a certified nurse-midwife shall expire at the same time as the
31 license to practice as a registered nurse. The board shall send a notice for
32 renewal of the authorization to practice to every certified nurse-midwife at
33 least 60 days prior to the expiration date of such person's authorization to
34 practice. To renew such authorization to practice the certified nurse-
35 midwife shall file with the board, before the date of expiration of such
36 authorization to practice, a renewal application together with the
37 prescribed biennial renewal fee. Upon satisfaction of the requirements of
38 section 7(a), and amendments thereto, the board shall grant the renewal of
39 an authorization to practice as a certified nurse-midwife to the applicant.

40 (b) Any person who fails to secure the renewal of an authorization to
41 practice prior to the expiration of the authorization may secure a
42 reinstatement of such lapsed authorization by making application on a
43 form provided by the board. Such reinstatement shall be granted upon

1 receipt of proof that the applicant is competent and qualified to act as a
2 certified nurse-midwife, has satisfied all of the requirements and has paid
3 the board a reinstatement fee as established by the board by rules and
4 regulations in accordance with K.S.A. 65-1118, and amendments thereto.

5 New Sec. 6. (a) Each certified nurse-midwife shall be authorized to:

6 (1) Provide a full range of primary health care services for women
7 from adolescence to menopause and beyond. These services include
8 primary care, gynecologic and family planning services, pre-conception
9 care, care during pregnancy, childbirth and the postpartum period, care of
10 the normal newborn and treatment of male partners for sexually
11 transmitted infections;

12 (2) provide initial and ongoing comprehensive assessment, diagnosis
13 and treatment;

14 (3) conduct physical examinations;

15 (4) prescribe, distribute and administer medications, devices and
16 contraceptive methods, and controlled substances in schedules II-V of the
17 uniform controlled substances act;

18 (5) admit, manage and discharge patients;

19 (6) utilize and order diagnostic services, including a clinical
20 laboratory, sonography, radiology and electronic monitoring;

21 (7) interpret laboratory and diagnostic tests;

22 (8) order the use of medical devices; and

23 (9) provide health promotion, disease prevention and individualized
24 wellness education and counseling.

25 (b) The surgical procedures performed by a certified nurse-midwife
26 shall be limited to the following: (1) Episiotomy; (2) repair of episiotomy
27 or laceration; and (3) circumcision. Any certified nurse-midwife who may
28 perform other surgical procedures if such certified nurse-midwife meets
29 the requirements of competencies of the American college of nurse-
30 midwife as approved by the board.

31 (c) Any certified nurse-midwife shall practice within a coordinated
32 system of health care system and have clinical relationships that provide
33 for consultation, collaborative management, co-management or referral, as
34 indicated by the health status of the patient.

35 (d) Any certified nurse-midwife shall have a written plan for
36 emergency referrals, with names and contact information of physicians,
37 hospitals and other medical personnel or facilities to be used in case of
38 emergency.

39 New Sec. 7. (a) The applicant for renewal of an authorization to
40 practice as a certified nurse-midwife shall:

41 (1) Have met the continuing education requirements for a certified
42 nurse-midwife as developed by the board or by a national organization
43 whose certifying standards are approved by the board as equal to or greater

1 than the corresponding standards established under this act;

2 (2) be currently licensed as a professional nurse; and

3 (3) have paid all applicable fees provided for in this act as fixed by
4 rules and regulations of the board.

5 (b) Continuing education credits approved by the board for purposes
6 of this section may be applied to satisfy the continuing education
7 requirements established by the board for licensed professional nurses
8 under K.S.A. 65-1117, and amendments thereto, if the board finds such
9 continuing education credits are equivalent to those required by the board
10 under K.S.A. 65-1117, and amendments thereto.

11 New Sec. 8. (a) Except as otherwise provided in sections 2 through
12 10, and amendments thereto, any licensed professional nurse or licensed
13 practical nurse who engages in nurse-midwifery without being authorized
14 by the board to practice as a certified nurse-midwife is guilty of a class A
15 misdemeanor.

16 (b) Any person, corporation, association or other entity, except as
17 otherwise provided in sections 2 through 10, and amendments thereto, who
18 engages in any of the following activities is guilty of a class B
19 misdemeanor except that upon conviction of a second or subsequent
20 violation of this subsection, the person is guilty of a class A misdemeanor:

21 (1) Employing or offering to employ any person as a certified nurse-
22 midwife with knowledge that such person is not authorized by the board to
23 practice as a certified nurse-midwife;

24 (2) fraudulently seeking, obtaining or furnishing documents
25 indicating that a person is authorized by the board to practice as a certified
26 nurse-midwife when such person is not so authorized, or aiding and
27 abetting such activities; or

28 (3) using in connection with one's name the title certified nurse-
29 midwife, the abbreviation NM or CNM, or any other designation tending
30 to imply that such person is authorized by the board to practice as a
31 certified nurse-midwife when such person is not authorized by the board to
32 practice as a certified nurse-midwife.

33 New Sec. 9. (a) The board, by rules and regulations, shall establish a
34 program of transition to full practice for all persons who, on and after the
35 effective date of this act, are granted initial licensure as an advanced
36 practice registered nurse in the classification of nurse- midwife, who have
37 less than 1,500 hours of licensed active practice as an advanced practice
38 registered nurse in their initial roles.

39 (b) As part of the program of transition to full practice, a certified
40 nurse-midwife shall complete, within two years from the commencement
41 of the program by the certified nurse- midwife, a transition to full practice
42 period of 1,500 hours of licensed active practice either with a certified
43 nurse-midwife or with a physician. The certified nurse-midwife shall

1 administer medications as needed for safety and therapeutic purposes.

2 (c) As part of the program of transition to full practice, the board shall
3 specify the manner and form in which the advanced practice registered
4 nurse in the classification of nurse-midwife participating in the program
5 may identify oneself professionally and to the public.

6 (d) The certified nurse-midwife shall be responsible for completing
7 the required documentation for the program of transition to full practice as
8 specified by the board. Upon the successful completion of the program of
9 transition to full practice, the board of nursing shall authorize the certified
10 nurse-midwife to engage in the practice of advanced practice registered
11 nursing without the limitations of this subsection and as otherwise
12 authorized by law.

13 (e) A person licensed to practice as a certified nurse-midwife in the
14 state immediately prior to the effective date of this act shall be deemed to
15 be licensed to practice as a certified nurse-midwife under this act and such
16 person shall not be required to file an original application for licensure
17 under this act. Any application for licensure filed which has not been
18 granted prior to the effective date of this act shall be processed as an
19 application for licensure under this act.

20 (f) All rules and regulations of the board in effect prior to the
21 effective date of this act which were adopted by the board and are
22 applicable to certified nurse-midwives shall continue to be effective until
23 revised, amended, revoked or nullified pursuant to law.

24 New Sec. 10. Sections 2 through 10, and amendments thereto, shall
25 be part of and supplemental to the Kansas nurse practice act.

26 Sec. 11. K.S.A. 2014 Supp. 65-1130 is hereby repealed.

27 Sec. 12. This act shall take effect and be in force from and after its
28 publication in the statute book.

HB 2205

HOUSE BILL No. 2205

By Committee on Health and Human Services

2-3

1 AN ACT concerning advanced practice registered nurses; amending
2 K.S.A. 2014 Supp. 65-1113 and 65-1130 and repealing the existing
3 sections.

4
5 *Be it enacted by the Legislature of the State of Kansas:*

6 New Section 1. (a) For the purposes of this act, the board of nursing
7 and the board of healing arts shall jointly adopt rules and regulations
8 relating to the role of advanced practice registered nurses including such
9 conditions, limitations and restrictions that the boards determine to be
10 necessary to protect the public health and safety, and to protect the public
11 from advanced practice registered nurses performing functions and
12 procedures for which they lack adequate education, training and
13 qualifications. Such rules and regulations shall include the authority to
14 prescribe medications, sign for and order tests and treatments, and perform
15 other delegated medical acts and functions, and shall specify those services
16 or clinical settings which shall require a collaborative practice agreement
17 or protocol with a physician. In such cases, the scope of authority of the
18 advanced practice registered nurse shall be within and consistent with the
19 normal and customary specialty, practice and competence of any
20 collaborating, delegating or supervising physician.

21 (b) In developing the rules and regulations defining the role of the
22 advanced practice registered nurse, the boards shall consider:

23 (1) The different practice and clinical settings in which advanced
24 practice registered nurses function, and the differing degrees of
25 collaboration, direction or supervision appropriate for such settings;

26 (2) the education required for licensure as an advanced practice
27 registered nurse;

28 (3) the type of nursing practice and preparation in specialized
29 advanced practice skills involved in each role of the advanced practice
30 registered nurse established by the board;

31 (4) the scope and limitations of advanced practice nursing prescribed
32 by national advanced practice organizations; and

33 (5) acts recognized by the nursing profession as appropriate to be
34 performed by persons with post basic education in nursing.

35 (c) Subject to the provisions of subsection (a), the rules and
36 regulations adopted pursuant to this section shall:

1 (1) Establish roles and identify titles and abbreviations of advanced
2 practice registered nurses which are consistent with nursing practice
3 specialties recognized by the nursing profession; and

4 (2) establish education and qualifications necessary for licensure for
5 each role of advanced practice registered nurse established by the board at
6 a level adequate to assure the competent performance by advanced
7 practice registered nurses of functions and procedures which advanced
8 practice registered nurses are authorized to perform. Advanced practice
9 registered nursing is based on knowledge and skills acquired in basic
10 nursing education, licensure as a registered nurse and graduation from or
11 completion of a master's or higher degree in one of the advanced practice
12 registered nurse roles approved by the board of nursing.

13 (d) The board of nursing and the state board of healing arts shall
14 constitute a joint adopting authority for the purpose of adopting rules and
15 regulations as provided in this section. On and before July 1, 2016, rules
16 and regulations adopted under this section shall be to implement the
17 provisions of K.S.A. 2014 Supp. 65-1130, as that section will be amended
18 on July 1, 2016, by section 4 of this act even though such section will not
19 be effective until July 1, 2016, and such rules and regulations shall become
20 effective on July 1, 2016. On and after July 1, 2016, rules and regulations
21 adopted by the joint adopting authority under this section shall apply as
22 provided in this section.

23 (e) The joint adopting authority shall provide, on or before January
24 15, 2016, a report to the senate committee on public health and welfare
25 and to the house committee on health and human services concerning the
26 progress made toward adopting rules and regulations under this section
27 which report shall include a copy of the rules and regulations which have
28 been developed.

29 New Sec. 2. (a) For the purposes of assisting the board of nursing and
30 board of healing arts to develop the rules and regulations required to be
31 adopted jointly under section 1, and amendments thereto, there is hereby
32 established a joint APRN advisory committee, which shall be attached to
33 the board of nursing. The committee shall be advisory to the boards of
34 nursing and healing arts on matters relating to APRN licensure, regulation
35 and practice and shall assist with the development of regulations which
36 define the role of advanced practice registered nurses and establish
37 limitations and restrictions on such role.

38 (b) The joint committee shall be composed of six members. Three
39 members shall be appointed by the board of nursing, and three members
40 shall be appointed by the board of healing arts. All appointees of the board
41 of nursing must hold a license as an advanced practice registered nurse and
42 be actively engaged in advanced practice nursing. All appointees of the
43 board of healing arts must hold a license to practice medicine and surgery

1 and be actively engaged in the practice of medicine and surgery. One
2 member appointed by the board of nursing must be a member of that
3 board, and one member appointed by the board of healing arts must be a
4 member of that board. In appointing their remaining representatives on the
5 joint committee, the boards shall consider any names submitted by the
6 respective professional associations.

7 (c) All members shall serve at the pleasure of the appointing board,
8 and any vacancies shall be filled by the respective appointing boards.
9 During odd-numbered years, the member of the joint committee who is a
10 member of the board of nursing shall serve as chairperson, and during
11 even-numbered years, the member of the joint committee who is a member
12 of the board of healing arts shall serve as chairperson. A quorum of the
13 joint committee shall be four, and all actions of the committee shall be
14 taken by a majority of those present when there is a quorum.

15 (d) The joint committee shall meet within the state on the call of the
16 chairperson or as requested by the two appointing boards.

17 (e) Members of the joint committee shall receive from their
18 appointing board amounts as provided in K.S.A. 75-3223(e), and
19 amendments thereto, when attending meetings of the committee. The
20 expenses of the committee shall be shared equally by the board of nursing
21 and the board of healing arts.

22 Sec. 3. On and after July 1, 2016, K.S.A. 2014 Supp. 65-1113 is
23 hereby amended to read as follows: 65-1113. When used in this act and the
24 act of which this section is amendatory:

25 (a) "Board" means the board of nursing.

26 (b) "Diagnosis" in the context of nursing practice means that
27 identification of and discrimination between physical and psychosocial
28 signs and symptoms essential to effective execution and management of
29 the nursing regimen and shall be construed as distinct from a medical
30 diagnosis.

31 (c) "Treatment" means the selection and performance of those
32 therapeutic measures essential to effective execution and management of
33 the nursing regimen, and any prescribed medical regimen.

34 (d) *Practice of nursing.* (1) The practice of professional nursing as
35 performed by a registered professional nurse for compensation or
36 gratuitously, except as permitted by K.S.A. 65-1124, and amendments
37 thereto, means the process in which substantial specialized knowledge
38 derived from the biological, physical, and behavioral sciences is applied
39 to: the care, diagnosis, treatment, counsel and health teaching of persons
40 who are experiencing changes in the normal health processes or who
41 require assistance in the maintenance of health or the prevention or
42 management of illness, injury or infirmity; administration, supervision or
43 teaching of the process as defined in this section; and the execution of the

1 medical regimen as prescribed by a person licensed to practice medicine
2 and surgery or a person licensed to practice dentistry. (2) The practice of
3 nursing as a licensed practical nurse means the performance for
4 compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
5 any amendments thereto, of tasks and responsibilities defined in ~~part (1) of~~
6 ~~this subsection (d)(1)~~ which tasks and responsibilities are based on
7 acceptable educational preparation within the framework of supportive and
8 restorative care under the direction of a registered professional nurse, a
9 person licensed to practice medicine and surgery or a person licensed to
10 practice dentistry.

11 (e) A "professional nurse" means a person who is licensed to practice
12 professional nursing as defined in ~~part (1) of~~ subsection (d)(1) of this
13 section.

14 (f) A "practical nurse" means a person who is licensed to practice
15 practical nursing as defined in ~~part (2) of~~ subsection (d)(2) of this section.

16 (g) "Advanced practice registered nurse" or "APRN" means a
17 professional nurse who holds a license from the board to function as a
18 professional nurse in an advanced role *by virtue of additional knowledge*
19 *and skills gained through a formal advanced practice education program*
20 *of nursing in a specialty area*, and this advanced role shall be defined by
21 rules and regulations *which are jointly* adopted by the board of nursing
22 *and the board of healing arts* in accordance with *section 1, and*
23 *amendments thereto*, and K.S.A. 65-1130, and amendments thereto.

24 (h) *"Joint adopting authority" means the state board of nursing and*
25 *the state board of healing arts as specified in section 1, and amendments*
26 *thereto.*

27 Sec. 4. On and after July 1, 2016, K.S.A. 2014 Supp. 65-1130 is
28 hereby amended to read as follows: 65-1130. (a) No professional nurse
29 shall announce or represent to the public that such person is an advanced
30 practice registered nurse unless such professional nurse has complied with
31 requirements established ~~by the board pursuant to law~~ and holds a valid
32 license as an advanced practice registered nurse in accordance with the
33 provisions of this section.

34 (b) ~~The board joint adopting authority~~ shall establish standards and
35 requirements for any professional nurse who desires to obtain licensure as
36 an advanced practice registered nurse. Such standards and requirements
37 shall include, but not be limited to, standards and requirements relating to
38 the education of advanced practice registered nurses. The board *of nursing*
39 may give such examinations and secure such assistance as it deems
40 necessary to determine the qualifications of applicants.

41 (c) ~~The board shall adopt rules and regulations applicable to advanced~~
42 ~~practice registered nurses which:~~

43 (1) ~~Establish roles and identify titles and abbreviations of advanced~~

1 practice registered nurses which are consistent with nursing practice
2 specialties recognized by the nursing profession.

3 (2) Establish education and qualifications necessary for licensure for
4 each role of advanced practice registered nurse established by the board at
5 a level adequate to assure the competent performance by advanced
6 practice registered nurses of functions and procedures which advanced
7 practice registered nurses are authorized to perform. Advanced practice
8 registered nursing is based on knowledge and skills acquired in basic
9 nursing education, licensure as a registered nurse and graduation from or
10 completion of a master's or higher degree in one of the advanced practice
11 registered nurse roles approved by the board of nursing.

12 (3) Define the role of advanced practice registered nurses and
13 establish limitations and restrictions on such role. The board shall adopt a
14 definition of the role under this subsection (c)(3) which is consistent with
15 the education and qualifications required to obtain a license as an
16 advanced practice registered nurse, which protects the public from persons
17 performing functions and procedures as advanced practice registered
18 nurses for which they lack adequate education and qualifications and
19 which authorizes advanced practice registered nurses to perform acts
20 generally recognized by the profession of nursing as capable of being
21 performed, in a manner consistent with the public health and safety, by
22 persons with postbasic education in nursing. In defining such role the
23 board shall consider: (A) The education required for a licensure as an
24 advanced practice registered nurse; (B) the type of nursing practice and
25 preparation in specialized advanced practice skills involved in each role of
26 advanced practice registered nurse established by the board; (C) the scope
27 and limitations of advanced practice nursing prescribed by national
28 advanced practice organizations; and (D) acts recognized by the nursing
29 profession as appropriate to be performed by persons with postbasic
30 education in nursing.

31 (d) An advanced practice registered nurse may prescribe drugs
32 pursuant to a written protocol as authorized by a responsible physician.
33 Each written protocol shall contain a precise and detailed medical plan of
34 care for each classification of disease or injury for which the advanced
35 practice registered nurse is authorized to prescribe and shall specify all
36 drugs which may be prescribed by the advanced practice registered nurse.
37 Any written prescription order shall include the name, address and
38 telephone number of the responsible physician pursuant to the rules and
39 regulations adopted by the joint adopting authority. The advanced practice
40 registered nurse may not dispense drugs, but may request, receive and sign
41 for professional samples and may distribute professional samples to
42 patients pursuant to a written protocol as authorized by a responsible
43 physician. In order to prescribe controlled substances, the advanced

1 practice registered nurse shall—~~(1) register with the federal drug~~
2 ~~enforcement administration; and (2) notify the board of the name and~~
3 ~~address of the responsible physician or physicians. In no case shall the~~
4 ~~scope of authority of the advanced practice registered nurse exceed the~~
5 ~~normal and customary practice of the responsible physician.~~ An advanced
6 practice registered nurse certified in the role of registered nurse anesthetist
7 while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to
8 65-1164, inclusive, and amendments thereto, shall be subject to the
9 provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments
10 thereto, with respect to drugs and anesthetic agents and shall not be subject
11 to the provisions of this subsection. ~~For the purposes of this subsection,~~
12 ~~"responsible physician" means a person licensed to practice medicine and~~
13 ~~surgery in Kansas who has accepted responsibility for the protocol and the~~
14 ~~actions of the advanced practice registered nurse when prescribing drugs.~~

15 ~~(e)(d)~~ As used in this section, "drug" means those articles and
16 substances defined as drugs in K.S.A. 65-1626 and 65-4101, and
17 amendments thereto.

18 ~~(f)(e)~~ A person ~~registered~~ *licensed* to practice as an advanced
19 registered nurse practitioner in the state of Kansas immediately prior to ~~the~~
20 ~~effective date of this act July 1, 2016,~~ shall be deemed to be licensed to
21 practice as an advanced practice registered nurse under this act and such
22 person shall not be required to file an original application for licensure
23 under this act. Any application for registration filed which has not been
24 granted prior to ~~the effective date of this act July 1, 2016,~~ shall be
25 processed as an application for licensure under this act.

26 *(f) All rules and regulations of the board in effect prior to July 1,*
27 *2016, which were adopted under this section and are applicable to*
28 *advanced practice registered nurses shall continue to be effective until*
29 *revised, amended, revoked or nullified pursuant to law.*

30 Sec. 5. On July 1, 2016, K.S.A. 2014 Supp. 65-1113 and 65-1130 are
31 hereby repealed.

32 Sec. 6. This act shall take effect and be in force from and after and its
33 publication in the statute book.

SB 218

SENATE BILL No. 218

By Committee on Ways and Means

2-12

1 AN ACT concerning advanced practice registered nurses; amending
2 K.S.A. 2014 Supp. 65-1113 and 65-1130 and repealing the existing
3 sections.
4

5 *Be it enacted by the Legislature of the State of Kansas:*

6 New Section 1. (a) For the purposes of this act, the board of nursing
7 and the board of healing arts shall jointly adopt rules and regulations
8 relating to the role of advanced practice registered nurses including such
9 conditions, limitations and restrictions that the boards determine to be
10 necessary to protect the public health and safety, and to protect the public
11 from advanced practice registered nurses performing functions and
12 procedures for which they lack adequate education, training and
13 qualifications. Such rules and regulations shall include the authority to
14 prescribe medications, sign for and order tests and treatments, and perform
15 other delegated medical acts and functions, and shall specify those services
16 or clinical settings which shall require a collaborative practice agreement
17 or protocol with a physician. In such cases, the scope of authority of the
18 advanced practice registered nurse shall be within and consistent with the
19 normal and customary specialty, practice and competence of any
20 collaborating, delegating or supervising physician.

21 (b) In developing the rules and regulations defining the role of the
22 advanced practice registered nurse, the boards shall consider:

23 (1) The different practice and clinical settings in which advanced
24 practice registered nurses function, and the differing degrees of
25 collaboration, direction or supervision appropriate for such settings;

26 (2) the education required for licensure as an advanced practice
27 registered nurse;

28 (3) the type of nursing practice and preparation in specialized
29 advanced practice skills involved in each role of the advanced practice
30 registered nurse established by the board;

31 (4) the scope and limitations of advanced practice nursing prescribed
32 by national advanced practice organizations; and

33 (5) acts recognized by the nursing profession as appropriate to be
34 performed by persons with post basic education in nursing.

35 (c) Subject to the provisions of subsection (a), the rules and
36 regulations adopted pursuant to this section shall:

1 (1) Establish roles and identify titles and abbreviations of advanced
2 practice registered nurses which are consistent with nursing practice
3 specialties recognized by the nursing profession; and

4 (2) establish education and qualifications necessary for licensure for
5 each role of advanced practice registered nurse established by the board at
6 a level adequate to assure the competent performance by advanced
7 practice registered nurses of functions and procedures which advanced
8 practice registered nurses are authorized to perform. Advanced practice
9 registered nursing is based on knowledge and skills acquired in basic
10 nursing education, licensure as a registered nurse and graduation from or
11 completion of a master's or higher degree in one of the advanced practice
12 registered nurse roles approved by the board of nursing.

13 (d) The board of nursing and the state board of healing arts shall
14 constitute a joint adopting authority for the purpose of adopting rules and
15 regulations as provided in this section. On and before July 1, 2016, rules
16 and regulations adopted under this section shall be to implement the
17 provisions of K.S.A. 2014 Supp. 65-1130, as that section will be amended
18 on July 1, 2016, by section 4 of this act even though such section will not
19 be effective until July 1, 2016, and such rules and regulations shall become
20 effective on July 1, 2016. On and after July 1, 2016, rules and regulations
21 adopted by the joint adopting authority under this section shall apply as
22 provided in this section.

23 (e) The joint adopting authority shall provide, on or before January
24 15, 2016, a report to the senate committee on public health and welfare
25 and to the house committee on health and human services concerning the
26 progress made toward adopting rules and regulations under this section,
27 which report shall include a copy of the rules and regulations which have
28 been developed.

29 New Sec. 2. (a) For the purposes of assisting the board of nursing and
30 board of healing arts to develop the rules and regulations required to be
31 adopted jointly under section 1, and amendments thereto, there is hereby
32 established a joint APRN advisory committee, which shall be attached to
33 the board of nursing. The committee shall be advisory to the boards of
34 nursing and healing arts on matters relating to APRN licensure, regulation
35 and practice and shall assist with the development of regulations which
36 define the role of advanced practice registered nurses and establish
37 limitations and restrictions on such role.

38 (b) The joint committee shall be composed of six members. Three
39 members shall be appointed by the board of nursing, and three members
40 shall be appointed by the board of healing arts. All appointees of the board
41 of nursing must hold a license as an advanced practice registered nurse and
42 be actively engaged in advanced practice nursing. All appointees of the
43 board of healing arts must hold a license to practice medicine and surgery

1 and be actively engaged in the practice of medicine and surgery. One
2 member appointed by the board of nursing must be a member of that
3 board, and one member appointed by the board of healing arts must be a
4 member of that board. In appointing their remaining representatives on the
5 joint committee, the boards shall consider any names submitted by the
6 respective professional associations.

7 (c) All members shall serve at the pleasure of the appointing board,
8 and any vacancies shall be filled by the respective appointing boards.
9 During odd-numbered years, the member of the joint committee who is a
10 member of the board of nursing shall serve as chairperson, and during
11 even-numbered years, the member of the joint committee who is a member
12 of the board of healing arts shall serve as chairperson. A quorum of the
13 joint committee shall be four, and all actions of the committee shall be
14 taken by a majority of those present when there is a quorum.

15 (d) The joint committee shall meet within the state on the call of the
16 chairperson or as requested by the two appointing boards.

17 (e) Members of the joint committee shall receive from their
18 appointing board amounts as provided in K.S.A. 75-3223(e), and
19 amendments thereto, when attending meetings of the committee. The
20 expenses of the committee shall be shared equally by the board of nursing
21 and the board of healing arts.

22 Sec. 3. On and after July 1, 2016, K.S.A. 2014 Supp. 65-1113 is
23 hereby amended to read as follows: 65-1113. When used in this act and the
24 act of which this section is amendatory:

25 (a) "Board" means the board of nursing.

26 (b) "Diagnosis" in the context of nursing practice means that
27 identification of and discrimination between physical and psychosocial
28 signs and symptoms essential to effective execution and management of
29 the nursing regimen and shall be construed as distinct from a medical
30 diagnosis.

31 (c) "Treatment" means the selection and performance of those
32 therapeutic measures essential to effective execution and management of
33 the nursing regimen, and any prescribed medical regimen.

34 (d) *Practice of nursing.* (1) The practice of professional nursing as
35 performed by a registered professional nurse for compensation or
36 gratuitously, except as permitted by K.S.A. 65-1124, and amendments
37 thereto, means the process in which substantial specialized knowledge
38 derived from the biological, physical, and behavioral sciences is applied
39 to: the care, diagnosis, treatment, counsel and health teaching of persons
40 who are experiencing changes in the normal health processes or who
41 require assistance in the maintenance of health or the prevention or
42 management of illness, injury or infirmity; administration, supervision or
43 teaching of the process as defined in this section; and the execution of the

1 medical regimen as prescribed by a person licensed to practice medicine
2 and surgery or a person licensed to practice dentistry. (2) The practice of
3 nursing as a licensed practical nurse means the performance for
4 compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
5 any amendments thereto, of tasks and responsibilities defined in ~~part (1) of~~
6 ~~this subsection (d)(1)~~ which tasks and responsibilities are based on
7 acceptable educational preparation within the framework of supportive and
8 restorative care under the direction of a registered professional nurse, a
9 person licensed to practice medicine and surgery or a person licensed to
10 practice dentistry.

11 (e) A "professional nurse" means a person who is licensed to practice
12 professional nursing as defined in ~~part (1) of~~ subsection (d)(1) of this
13 section.

14 (f) A "practical nurse" means a person who is licensed to practice
15 practical nursing as defined in ~~part (2) of~~ subsection (d)(2) of this section.

16 (g) "Advanced practice registered nurse" or "APRN" means a
17 professional nurse who holds a license from the board to function as a
18 professional nurse in an advanced role *by virtue of additional knowledge*
19 *and skills gained through a formal advanced practice education program*
20 *of nursing in a specialty area*, and this advanced role shall be defined by
21 rules and regulations *which are jointly* adopted by the board of nursing
22 *and the board of healing arts* in accordance with *section 1, and*
23 *amendments thereto*, and K.S.A. 65-1130, and amendments thereto.

24 (h) *"Joint adopting authority" means the state board of nursing and*
25 *the state board of healing arts as specified in section 1, and amendments*
26 *thereto.*

27 Sec. 4. On and after July 1, 2016, K.S.A. 2014 Supp. 65-1130 is
28 hereby amended to read as follows: 65-1130. (a) No professional nurse
29 shall announce or represent to the public that such person is an advanced
30 practice registered nurse unless such professional nurse has complied with
31 requirements established ~~by the board pursuant to law~~ and holds a valid
32 license as an advanced practice registered nurse in accordance with the
33 provisions of this section.

34 (b) ~~The board joint adopting authority~~ shall establish standards and
35 requirements for any professional nurse who desires to obtain licensure as
36 an advanced practice registered nurse. Such standards and requirements
37 shall include, but not be limited to, standards and requirements relating to
38 the education of advanced practice registered nurses. The board *of nursing*
39 may give such examinations and secure such assistance as it deems
40 necessary to determine the qualifications of applicants.

41 (c) ~~The board shall adopt rules and regulations applicable to advanced~~
42 ~~practice registered nurses which:~~

43 (1) ~~Establish roles and identify titles and abbreviations of advanced~~

1 practice registered nurses which are consistent with nursing practice
2 specialties recognized by the nursing profession.

3 (2) Establish education and qualifications necessary for licensure for
4 each role of advanced practice registered nurse established by the board at
5 a level adequate to assure the competent performance by advanced
6 practice registered nurses of functions and procedures which advanced
7 practice registered nurses are authorized to perform. Advanced practice
8 registered nursing is based on knowledge and skills acquired in basic
9 nursing education, licensure as a registered nurse and graduation from or
10 completion of a master's or higher degree in one of the advanced practice
11 registered nurse roles approved by the board of nursing.

12 (3) Define the role of advanced practice registered nurses and
13 establish limitations and restrictions on such role. The board shall adopt a
14 definition of the role under this subsection (c)(3) which is consistent with
15 the education and qualifications required to obtain a license as an
16 advanced practice registered nurse, which protects the public from persons
17 performing functions and procedures as advanced practice registered
18 nurses for which they lack adequate education and qualifications and
19 which authorizes advanced practice registered nurses to perform acts
20 generally recognized by the profession of nursing as capable of being
21 performed, in a manner consistent with the public health and safety, by
22 persons with postbasic education in nursing. In defining such role the
23 board shall consider: (A) The education required for a licensure as an
24 advanced practice registered nurse; (B) the type of nursing practice and
25 preparation in specialized advanced practice skills involved in each role of
26 advanced practice registered nurse established by the board; (C) the scope
27 and limitations of advanced practice nursing prescribed by national
28 advanced practice organizations; and (D) acts recognized by the nursing
29 profession as appropriate to be performed by persons with postbasic
30 education in nursing.

31 (d) An advanced practice registered nurse may prescribe drugs
32 pursuant to a written protocol as authorized by a responsible physician.
33 Each written protocol shall contain a precise and detailed medical plan of
34 care for each classification of disease or injury for which the advanced
35 practice registered nurse is authorized to prescribe and shall specify all
36 drugs which may be prescribed by the advanced practice registered nurse.
37 Any written prescription order shall include the name, address and
38 telephone number of the responsible physician *pursuant to the rules and*
39 *regulations adopted by the joint adopting authority.* The advanced practice
40 registered nurse may not dispense drugs, but may request, receive and sign
41 for professional samples and may distribute professional samples to
42 patients pursuant to a written protocol as authorized by a responsible
43 physician. In order to prescribe controlled substances, the advanced

1 practice registered nurse shall—(1) register with the federal drug
2 enforcement administration; and (2) notify the board of the name and
3 address of the responsible physician or physicians. In no case shall the
4 scope of authority of the advanced practice registered nurse exceed the
5 normal and customary practice of the responsible physician. An advanced
6 practice registered nurse certified in the role of registered nurse anesthetist
7 while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to
8 65-1164, inclusive, and amendments thereto, shall be subject to the
9 provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments
10 thereto, with respect to drugs and anesthetic agents and shall not be subject
11 to the provisions of this subsection. For the purposes of this subsection,
12 "responsible physician" means a person licensed to practice medicine and
13 surgery in Kansas who has accepted responsibility for the protocol and the
14 actions of the advanced practice registered nurse when prescribing drugs.

15 (e)(d) As used in this section, "drug" means those articles and
16 substances defined as drugs in K.S.A. 65-1626 and 65-4101, and
17 amendments thereto.

18 (f)(e) A person—registered licensed to practice as an advanced
19 registered nurse practitioner in the state of Kansas immediately prior to the
20 effective date of this act July 1, 2016, shall be deemed to be licensed to
21 practice as an advanced practice registered nurse under this act and such
22 person shall not be required to file an original application for licensure
23 under this act. Any application for registration filed which has not been
24 granted prior to the effective date of this act July 1, 2016, shall be
25 processed as an application for licensure under this act.

26 (f) All rules and regulations of the board in effect prior to July 1,
27 2016, which were adopted under this section and are applicable to
28 advanced practice registered nurses shall continue to be effective until
29 revised, amended, revoked or nullified pursuant to law.

30 Sec. 5. On July 1, 2016, K.S.A. 2014 Supp. 65-1113 and 65-1130 are
31 hereby repealed.

32 Sec. 6. This act shall take effect and be in force from and after its
33 publication in the statute book.

SB 69

SENATE BILL No. 69

By Committee on Public Health and Welfare

1-22

1 AN ACT concerning advanced practice registered nurses; amending
2 K.S.A. 40-4602, 59-2976, 65-1660, 65-2892, 65-4134 and 65-5502 and
3 K.S.A. 2013 Supp. 65-1626, as amended by section 4 of chapter 131 of
4 the 2014 Session Laws of Kansas, 65-4101, as amended by section 50
5 of chapter 131 of the 2014 Session Laws of Kansas, 65-6112, as
6 amended by section 51 of chapter 131 of the 2014 Session Laws of
7 Kansas and 65-6124, as amended by section 52 of chapter 131 of the
8 2014 Session Laws of Kansas and K.S.A. 2014 Supp. 39-923, 39-1401,
9 39-1430, 39-1504, 65-468, 65-507, 65-1113, 65-1130, 65-1682, 65-
10 2837a, 65-2921, 65-4116, 65-4202, 65-5402, 65-5418, 65-6119, 65-
11 6120, 65-6121, 65-6123, 65-6144, 65-7003, 65-7302, 72-5213 and 75-
12 7429 and repealing the existing sections.

13

14 *Be it enacted by the Legislature of the State of Kansas:*

15 Section 1. K.S.A. 2014 Supp. 65-1113 is hereby amended to read as
16 follows: 65-1113. When used in this act and the act of which this section is
17 amendatory:

18 (a) "Board" means the board of nursing.

19 (b) "Diagnosis" in the context of nursing practice means that
20 identification of and discrimination between physical and psychosocial
21 signs and symptoms essential to effective execution and management of
22 the nursing regimen and shall be construed as distinct from a medical
23 diagnosis.

24 (c) "Treatment" means the selection and performance of those
25 therapeutic measures essential to effective execution and management of
26 the nursing regimen, and any prescribed medical regimen.

27 (d) *Practice of nursing.* (1) The practice of professional nursing as
28 performed by a registered professional nurse for compensation or
29 gratuitously, except as permitted by K.S.A. 65-1124, and amendments
30 thereto, means the process in which substantial specialized knowledge
31 derived from the biological, physical, and behavioral sciences is applied
32 to: the care, diagnosis, treatment, counsel and health teaching of persons
33 who are experiencing changes in the normal health processes or who
34 require assistance in the maintenance of health or the prevention or
35 management of illness, injury or infirmity; administration, supervision or
36 teaching of the process as defined in this section; and the execution of the

1 medical regimen as prescribed by a person licensed to practice medicine
2 and surgery ~~or, a person licensed to practice dentistry or by a person~~
3 *licensed to practice as an advanced practice registered nurse.* (2) The
4 practice of nursing as a licensed practical nurse means the performance for
5 compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
6 any amendments thereto, of tasks and responsibilities defined in ~~part (1) of~~
7 ~~this subsection (d)(1)~~ which tasks and responsibilities are based on
8 acceptable educational preparation within the framework of supportive and
9 restorative care under the direction of a registered professional nurse, a
10 person licensed to practice medicine and surgery ~~or, a person licensed to~~
11 *practice dentistry or by a person licensed to practice as an advanced*
12 *practice registered nurse.*

13 (e) A "professional nurse" means a person who is licensed to practice
14 professional nursing as defined in ~~part (1) of subsection (d) of this~~
15 ~~section(1).~~

16 (f) A "practical nurse" means a person who is licensed to practice
17 practical nursing as defined in ~~part (2) of subsection (d) of this section(2).~~

18 (g) "Advanced practice registered nurse" or "APRN" means a
19 professional nurse who holds a license from the board to function as a
20 professional nurse in an advanced role, and this advanced role shall be
21 defined by rules and regulations adopted by the board in accordance with
22 K.S.A. 65-1130, and amendments thereto.

23 Sec. 2. K.S.A. 2014 Supp. 65-1130 is hereby amended to read as
24 follows: 65-1130. (a) No professional nurse shall announce or represent to
25 the public that such person is an advanced practice registered nurse unless
26 such professional nurse has complied with requirements established by the
27 board and holds a valid license as an advanced practice registered nurse in
28 accordance with the provisions of this section.

29 (b) *On and after the effective date of this act, to be eligible for an*
30 *initial advanced practice registered nurse license, an applicant shall hold*
31 *and maintain a current advanced practice registered nurse certification*
32 *granted by a national certifying organization recognized by the board*
33 *whose certification standards are approved by the board as equal to or*
34 *greater than the corresponding standards established by the board.*

35 (c) The board shall establish standards and requirements for any
36 professional nurse who desires to obtain licensure as an advanced practice
37 registered nurse. Such standards and requirements shall include, but not be
38 limited to, standards and requirements relating to the education of
39 advanced practice registered nurses. The board may give such
40 examinations and secure such assistance as it deems necessary to
41 determine the qualifications of applicants.

42 (e) (d) The board shall adopt rules and regulations applicable to
43 advanced practice registered nurses which:

1 (1) Establish roles and identify titles and abbreviations of advanced
2 practice registered nurses which are consistent with *advanced* nursing
3 practice specialties recognized by the nursing profession.

4 (2) Establish education and qualifications necessary for licensure for
5 ~~each role of~~ advanced practice registered nurse *role* established by the
6 board at a level adequate to assure the competent performance by
7 advanced practice registered nurses of functions and procedures which
8 advanced practice registered nurses are authorized to perform. Advanced
9 practice registered nursing is based on knowledge and skills acquired in
10 basic nursing education, licensure as a registered nurse and graduation
11 from or completion of a master's or higher degree in one of the advanced
12 practice registered nurse roles approved by the board of nursing.

13 (3) Define the role of advanced practice registered nurses and
14 establish limitations and restrictions on such role. The board shall adopt a
15 definition of the role under this subsection (c)(3) which is consistent with
16 the education and qualifications required to obtain a license as an
17 advanced practice registered nurse, which protects the public from persons
18 performing functions and procedures as advanced practice registered
19 nurses for which they lack adequate education and qualifications and
20 which authorizes advanced practice registered nurses to perform acts
21 generally recognized by the profession of nursing as capable of being
22 performed, in a manner consistent with the public health and safety, by
23 persons with postbasic education in nursing. In defining such role the
24 board shall consider: (A) The education required for a licensure as an
25 advanced practice registered nurse; (B) the type of nursing practice and
26 preparation in specialized advanced practice skills involved in each role of
27 advanced practice registered nurse established by the board; (C) the scope
28 and limitations of advanced practice nursing prescribed by national
29 advanced practice organizations; ~~and~~ (D) acts recognized by the nursing
30 profession as appropriate to be performed by persons with postbasic
31 education in nursing; *and (E) the certification standards established by an*
32 *accredited national organization whose certification standards are*
33 *approved by the board as equal to or greater than the corresponding*
34 *standards established under this act for obtaining authorization to*
35 *practice as an advanced practice registered nurse in the specific role.*

36 (e) *"Treatment" means, when used in conjunction with the practice of*
37 *an advanced practice registered nurse, planning, diagnosing, ordering*
38 *and executing of a healthcare plan including, but not limited to,*
39 *pharmacologic and non-pharmacologic interventions. This term also*
40 *includes prescribing medical devices and equipment, nutrition, and*
41 *diagnostic and supportive services including, but not limited to, home*
42 *health care, hospice, physical and occupational therapy.*

43 (f) *The practice of nursing as an advanced practice registered nurse*

1 means the performance for compensation or gratuitously, except as
2 permitted by K.S.A. 65-1124, and amendments thereto, of the process in
3 which advanced knowledge derived from the biological, physical and
4 behavioral sciences is applied to direct and indirect care, including, but
5 not limited to, creating and executing a health care plan; nursing and
6 medical diagnosis, management, treatment and prescribing; administering
7 pharmacologic and non-pharmacologic interventions; counseling and
8 health teaching of persons who are experiencing changes in the normal
9 health processes or who require assistance in the maintenance of health;
10 or the prevention or management of illness, injury or infirmity;
11 administration, supervising or teaching within the advanced practice
12 registered nurse's role. Within the role of the advanced practice registered
13 nurse, an advanced practice registered nurse may serve as a primary care
14 provider and lead health care teams.

15 ~~(d) (g) An advanced practice registered nurse may prescribe drugs~~
16 ~~pursuant to a written protocol as authorized by a responsible physician.~~
17 ~~Each written protocol shall contain a precise and detailed medical plan of~~
18 ~~care for each classification of disease or injury for which the advanced~~
19 ~~practice registered nurse is authorized to prescribe and shall specify all~~
20 ~~drugs which may be prescribed by the advanced practice registered~~
21 ~~nurse.~~ *Advanced practice registered nurses are authorized to prescribe,*
22 *procure and administer prescription drugs and controlled substances*
23 *pursuant to applicable state and federal laws. Any written prescription*
24 *order shall include the name, address and telephone number of the*
25 ~~responsible physician~~ *advanced practice registered nurse.* The advanced
26 practice registered nurse may not dispense drugs, but may request, receive
27 and sign for professional samples and may distribute professional samples
28 to patients ~~pursuant to a written protocol as authorized by a responsible~~
29 ~~physician.~~ In order to prescribe controlled substances, the advanced
30 practice registered nurse shall: (1) Register with the federal drug
31 enforcement administration; and (2) notify the board of ~~the name and~~
32 ~~address of the responsible physician or physicians.~~ In no case shall the
33 scope of authority of the advanced practice registered nurse exceed the
34 normal and customary practice of the responsible physician *nursing of the*
35 *federal drug enforcement administration registration as prescribed by*
36 *rules and regulations of the board. An advanced practice registered nurse*
37 *shall comply with the federal drug enforcement administration*
38 *requirements related to controlled substances.* An advanced practice
39 registered nurse certified in the role of registered nurse anesthetist while
40 functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-
41 1164, inclusive, and amendments thereto, shall be subject to the provisions
42 of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with
43 respect to drugs and anesthetic agents and shall not be subject to the

1 provisions of this subsection. ~~For the purposes of this subsection,~~
2 ~~"responsible physician" means a person licensed to practice medicine and~~
3 ~~surgery in Kansas who has accepted responsibility for the protocol and the~~
4 ~~actions of the advanced practice registered nurse when prescribing drugs.~~

5 *(e) (h) An advanced practice registered nurse is accountable to*
6 *patients, the nursing profession and the board for complying with the*
7 *requirements of the nurse practice act, and any rules and regulations*
8 *adopted pursuant thereto, and is responsible for recognizing limits of*
9 *knowledge and experience, planning for the management of situations*
10 *beyond the advanced practice registered nurse's expertise and referring*
11 *patients to other health care professionals as appropriate.*

12 *(i) (1) The board, by rules and regulations, shall establish a program*
13 *of transition to full practice for all persons who on and after the effective*
14 *date of this act are granted initial licensure as an advanced practice*
15 *registered nurse or who have less than 2,000 hours of licensed active*
16 *practice as an advanced practice registered nurse in their initial roles.*

17 *(2) Advanced practice registered nurses who are subject to the*
18 *program of transition to full practice shall not prescribe medications*
19 *except as provided in this subsection.*

20 *(3) As part of the program of transition to full practice, an advanced*
21 *practice registered nurse shall complete, within two years from the*
22 *commencement of the program by the advanced practice registered nurse,*
23 *a transition to full practice period of 2,000 hours while maintaining a*
24 *collaborative relationship for practice and for prescribing medications*
25 *with either a licensed advanced practice registered nurse with full*
26 *prescriptive authority under subsection (g) or with a physician. The*
27 *advanced practice registered nurse shall engage in the practice of nursing*
28 *as an advanced practice registered nurse and may prescribe medications*
29 *as part of the collaborative relationship.*

30 *(4) As part of the program of transition to full practice, the board*
31 *shall specify the manner and form in which the advanced practice*
32 *registered nurse participating in the program may identify oneself*
33 *professionally and to the public.*

34 *(5) The advanced practice registered nurse shall be responsible for*
35 *completing the required documentation for the program of transition to*
36 *full practice as specified by the board.*

37 *(6) Upon the successful completion of the program of transition to*
38 *full practice, the board of nursing shall authorize the advanced practice*
39 *registered nurse to engage in the practice of advanced practice registered*
40 *nursing without the limitations of this subsection and as otherwise*
41 *authorized by law.*

42 *(7) The board may adopt rules and regulations necessary to carry out*
43 *the provisions of this subsection.*

1 (8) *An advanced practice registered nurse functioning in the role of*
2 *registered nurse anesthetist shall be subject to the provisions of K.S.A. 65-*
3 *1151 to 65-1164, inclusive, and amendments thereto, and shall not be*
4 *subject to the provisions of this subsection.*

5 (9) *As used in this subsection, "physician" means a person licensed to*
6 *practice medicine and surgery.*

7 (j) *When a provision of law or rule and regulation requires a*
8 *signature, certification, verification, affidavit or endorsement by a*
9 *physician, that requirement may be fulfilled by a licensed advanced*
10 *practice registered nurse working within the scope of practice of such*
11 *nurse's respective role.*

12 (k) *The confidential relations and communications between an*
13 *advance practice registered nurse and the advance practice registered*
14 *nurse's patient are placed on the same basis as provided by law as those*
15 *between a physician and a physician's patient in K.S.A. 60-427, and*
16 *amendments thereto.*

17 (l) *An advanced practice registered nurse shall maintain malpractice*
18 *insurance coverage in effect as a condition to rendering professional*
19 *service as an advanced practice registered nurse in this state and shall*
20 *provide proof of insurance at time of licensure and renewal of license. The*
21 *requirements of this subsection shall not apply to an advanced practice*
22 *registered nurse who practices solely in an employment which results in*
23 *the advanced practice registered nurse being covered under the federal*
24 *tort claim act or state tort claims act, or who practices solely as a*
25 *charitable health care provider under K.S.A. 75-6102, and amendments*
26 *thereto, or who is serving on active duty in the military service of the*
27 *United States.*

28 (m) *As used in this section, "drug" means those articles and*
29 *substances defined as drugs in K.S.A. 65-1626 and 65-4101, and*
30 *amendments thereto.*

31 ~~(f) A person registered to practice as an advanced registered nurse-~~
32 ~~practitioner in the state of Kansas immediately prior to the effective date of~~
33 ~~this act shall be deemed to be licensed to practice as an advanced practice~~
34 ~~registered nurse under this act and such person shall not be required to file~~
35 ~~an original application for licensure under this act. Any application for~~
36 ~~registration filed which has not been granted prior to the effective date of~~
37 ~~this act shall be processed as an application for licensure under this act.~~

38 Sec. 3. K.S.A. 2014 Supp. 39-923 is hereby amended to read as
39 follows: 39-923. (a) As used in this act:

40 (1) "Adult care home" means any nursing facility, nursing facility for
41 mental health, intermediate care facility for people with intellectual
42 disability, assisted living facility, residential health care facility, home plus,
43 boarding care home and adult day care facility; all of which are

1 classifications of adult care homes and are required to be licensed by the
2 secretary for aging and disability services.

3 (2) "Nursing facility" means any place or facility operating 24 hours a
4 day, seven days a week, caring for six or more individuals not related
5 within the third degree of relationship to the administrator or owner by
6 blood or marriage and who, due to functional impairments, need skilled
7 nursing care to compensate for activities of daily living limitations.

8 (3) "Nursing facility for mental health" means any place or facility
9 operating 24 hours a day, seven days a week, caring for six or more
10 individuals not related within the third degree of relationship to the
11 administrator or owner by blood or marriage and who, due to functional
12 impairments, need skilled nursing care and special mental health services
13 to compensate for activities of daily living limitations.

14 (4) "Intermediate care facility for people with intellectual disability"
15 means any place or facility operating 24 hours a day, seven days a week,
16 caring for four or more individuals not related within the third degree of
17 relationship to the administrator or owner by blood or marriage and who,
18 due to functional impairments caused by intellectual disability or related
19 conditions, need services to compensate for activities of daily living
20 limitations.

21 (5) "Assisted living facility" means any place or facility caring for six
22 or more individuals not related within the third degree of relationship to
23 the administrator, operator or owner by blood or marriage and who, by
24 choice or due to functional impairments, may need personal care and may
25 need supervised nursing care to compensate for activities of daily living
26 limitations and in which the place or facility includes apartments for
27 residents and provides or coordinates a range of services including
28 personal care or supervised nursing care available 24 hours a day, seven
29 days a week, for the support of resident independence. The provision of
30 skilled nursing procedures to a resident in an assisted living facility is not
31 prohibited by this act. Generally, the skilled services provided in an
32 assisted living facility shall be provided on an intermittent or limited term
33 basis, or if limited in scope, a regular basis.

34 (6) "Residential health care facility" means any place or facility, or a
35 contiguous portion of a place or facility, caring for six or more individuals
36 not related within the third degree of relationship to the administrator,
37 operator or owner by blood or marriage and who, by choice or due to
38 functional impairments, may need personal care and may need supervised
39 nursing care to compensate for activities of daily living limitations and in
40 which the place or facility includes individual living units and provides or
41 coordinates personal care or supervised nursing care available on a 24-
42 hour, seven-days-a-week basis for the support of resident independence.
43 The provision of skilled nursing procedures to a resident in a residential

1 health care facility is not prohibited by this act. Generally, the skilled
2 services provided in a residential health care facility shall be provided on
3 an intermittent or limited term basis, or if limited in scope, a regular basis.

4 (7) "Home plus" means any residence or facility caring for not more
5 than 12 individuals not related within the third degree of relationship to the
6 operator or owner by blood or marriage unless the resident in need of care
7 is approved for placement by the secretary for children and families, and
8 who, due to functional impairment, needs personal care and may need
9 supervised nursing care to compensate for activities of daily living
10 limitations. The level of care provided to residents shall be determined by
11 preparation of the staff and rules and regulations developed by the Kansas
12 department for aging and disability services. An adult care home may
13 convert a portion of one wing of the facility to a not less than five-bed and
14 not more than 12-bed home plus facility provided that the home plus
15 facility remains separate from the adult care home, and each facility must
16 remain contiguous. Any home plus that provides care for more than eight
17 individuals after the effective date of this act shall adjust staffing personnel
18 and resources as necessary to meet residents' needs in order to maintain the
19 current level of nursing care standards. Personnel of any home plus who
20 provide services for residents with dementia shall be required to take
21 annual dementia care training.

22 (8) "Boarding care home" means any place or facility operating 24
23 hours a day, seven days a week, caring for not more than 10 individuals
24 not related within the third degree of relationship to the operator or owner
25 by blood or marriage and who, due to functional impairment, need
26 supervision of activities of daily living but who are ambulatory and
27 essentially capable of managing their own care and affairs.

28 (9) "Adult day care" means any place or facility operating less than
29 24 hours a day caring for individuals not related within the third degree of
30 relationship to the operator or owner by blood or marriage and who, due to
31 functional impairment, need supervision of or assistance with activities of
32 daily living.

33 (10) "Place or facility" means a building or any one or more complete
34 floors of a building, or any one or more complete wings of a building, or
35 any one or more complete wings and one or more complete floors of a
36 building, and the term "place or facility" may include multiple buildings.

37 (11) "Skilled nursing care" means services performed by or under the
38 immediate supervision of a registered professional nurse and additional
39 licensed nursing personnel. Skilled nursing includes administration of
40 medications and treatments as prescribed by a licensed physician,
41 *advanced practice registered nurse* or dentist; and other nursing functions
42 which require substantial nursing judgment and skill based on the
43 knowledge and application of scientific principles.

1 (12) "Supervised nursing care" means services provided by or under
2 the guidance of a licensed nurse with initial direction for nursing
3 procedures and periodic inspection of the actual act of accomplishing the
4 procedures; administration of medications and treatments as prescribed by
5 a licensed physician, *advanced practice registered nurse* or dentist and
6 assistance of residents with the performance of activities of daily living.

7 (13) "Resident" means all individuals kept, cared for, treated, boarded
8 or otherwise accommodated in any adult care home.

9 (14) "Person" means any individual, firm, partnership, corporation,
10 company, association or joint-stock association, and the legal successor
11 thereof.

12 (15) "Operate an adult care home" means to own, lease, establish,
13 maintain, conduct the affairs of or manage an adult care home, except that
14 for the purposes of this definition the word "own" and the word "lease"
15 shall not include hospital districts, cities and counties which hold title to
16 an adult care home purchased or constructed through the sale of bonds.

17 (16) "Licensing agency" means the secretary for aging and disability
18 services.

19 (17) "Skilled nursing home" means a nursing facility.

20 (18) "Intermediate nursing care home" means a nursing facility.

21 (19) "Apartment" means a private unit which includes, but is not
22 limited to, a toilet room with bathing facilities, a kitchen, sleeping, living
23 and storage area and a lockable door.

24 (20) "Individual living unit" means a private unit which includes, but
25 is not limited to, a toilet room with bathing facilities, sleeping, living and
26 storage area and a lockable door.

27 (21) "Operator" means an individual registered pursuant to the
28 operator registration act, K.S.A. 2014 Supp. 39-973 et seq., and
29 amendments thereto, who may be appointed by a licensee to have the
30 authority and responsibility to oversee an assisted living facility or
31 residential health care facility with fewer than 61 residents, a home plus or
32 adult day care facility.

33 (22) "Activities of daily living" means those personal, functional
34 activities required by an individual for continued well-being, including,
35 but not limited to, eating, nutrition, dressing, personal hygiene, mobility
36 and toileting.

37 (23) "Personal care" means care provided by staff to assist an
38 individual with, or to perform activities of daily living.

39 (24) "Functional impairment" means an individual has experienced a
40 decline in physical, mental and psychosocial well-being and as a result, is
41 unable to compensate for the effects of the decline.

42 (25) "Kitchen" means a food preparation area that includes a sink,
43 refrigerator and a microwave oven or stove.

1 (26) The term "intermediate personal care home" for purposes of
2 those individuals applying for or receiving veterans' benefits means
3 residential health care facility.

4 (27) "Paid nutrition assistant" means an individual who is paid to feed
5 residents of an adult care home, or who is used under an arrangement with
6 another agency or organization, who is trained by a person meeting nurse
7 aide instructor qualifications as prescribed by 42 C.F.R. § 483.152, 42
8 C.F.R. § 483.160 and paragraph (h) of 42 C.F.R. § 483.35, and who
9 provides such assistance under the supervision of a registered professional
10 or licensed practical nurse.

11 (28) "Medicaid program" means the Kansas program of medical
12 assistance for which federal or state moneys, or any combination thereof,
13 are expended, or any successor federal or state, or both, health insurance
14 program or waiver granted thereunder.

15 (29) "Licensee" means any person or persons acting jointly or
16 severally who are licensed by the secretary for aging and disability
17 services pursuant to the adult care home licensure act, K.S.A. 39-923 et
18 seq., and amendments thereto.

19 (b) The term "adult care home" shall not include institutions operated
20 by federal or state governments, except institutions operated by the
21 director of the Kansas commission on veterans affairs office, hospitals or
22 institutions for the treatment and care of psychiatric patients, child care
23 facilities, maternity centers, hotels, offices of physicians or hospices which
24 are certified to participate in the medicare program under 42 code of
25 federal regulations, chapter IV, section 418.1 et seq., and amendments
26 thereto, and which provide services only to hospice patients.

27 (c) Nursing facilities in existence on the effective date of this act
28 changing licensure categories to become residential health care facilities
29 shall be required to provide private bathing facilities in a minimum of 20%
30 of the individual living units.

31 (d) Facilities licensed under the adult care home licensure act on the
32 day immediately preceding the effective date of this act shall continue to
33 be licensed facilities until the annual renewal date of such license and may
34 renew such license in the appropriate licensure category under the adult
35 care home licensure act subject to the payment of fees and other conditions
36 and limitations of such act.

37 (e) Nursing facilities with less than 60 beds converting a portion of
38 the facility to residential health care shall have the option of licensing for
39 residential health care for less than six individuals but not less than 10% of
40 the total bed count within a contiguous portion of the facility.

41 (f) The licensing agency may by rule and regulation change the name
42 of the different classes of homes when necessary to avoid confusion in
43 terminology and the agency may further amend, substitute, change and in a

1 manner consistent with the definitions established in this section, further
2 define and identify the specific acts and services which shall fall within the
3 respective categories of facilities so long as the above categories for adult
4 care homes are used as guidelines to define and identify the specific acts.

5 Sec. 4. K.S.A. 2014 Supp. 39-1401 is hereby amended to read as
6 follows: 39-1401. As used in this act:

7 (a) "Resident" means:

8 (1) Any resident, as defined by K.S.A. 39-923, and amendments
9 thereto; or

10 (2) any individual kept, cared for, treated, boarded or otherwise
11 accommodated in a medical care facility; or

12 (3) any individual, kept, cared for, treated, boarded or otherwise
13 accommodated in a state psychiatric hospital or state institution for people
14 with intellectual disability.

15 (b) "Adult care home" has the meaning ascribed thereto in K.S.A. 39-
16 923, and amendments thereto.

17 (c) "In need of protective services" means that a resident is unable to
18 perform or obtain services which are necessary to maintain physical or
19 mental health, or both.

20 (d) "Services which are necessary to maintain physical and mental
21 health" include, but are not limited to, the provision of medical care for
22 physical and mental health needs, the relocation of a resident to a facility
23 or institution able to offer such care, assistance in personal hygiene, food,
24 clothing, adequately heated and ventilated shelter, protection from health
25 and safety hazards, protection from maltreatment the result of which
26 includes, but is not limited to, malnutrition, deprivation of necessities or
27 physical punishment and transportation necessary to secure any of the
28 above stated needs, except that this term shall not include taking such
29 person into custody without consent, except as provided in this act.

30 (e) "Protective services" means services provided by the state or other
31 governmental agency or any private organizations or individuals which are
32 necessary to prevent abuse, neglect or exploitation. Such protective
33 services shall include, but not be limited to, evaluation of the need for
34 services, assistance in obtaining appropriate social services and assistance
35 in securing medical and legal services.

36 (f) "Abuse" means any act or failure to act performed intentionally or
37 recklessly that causes or is likely to cause harm to a resident, including:

38 (1) Infliction of physical or mental injury;

39 (2) any sexual act with a resident when the resident does not consent
40 or when the other person knows or should know that the resident is
41 incapable of resisting or declining consent to the sexual act due to mental
42 deficiency or disease or due to fear of retribution or hardship;

43 (3) unreasonable use of a physical restraint, isolation or medication

1 that harms or is likely to harm a resident;

2 (4) unreasonable use of a physical or chemical restraint, medication
3 or isolation as punishment, for convenience, in conflict with a physician's
4 *or advanced practice registered nurse's* orders or as a substitute for
5 treatment, except where such conduct or physical restraint is in furtherance
6 of the health and safety of the resident or another resident;

7 (5) a threat or menacing conduct directed toward a resident that
8 results or might reasonably be expected to result in fear or emotional or
9 mental distress to a resident;

10 (6) fiduciary abuse; or

11 (7) omission or deprivation by a caretaker or another person of goods
12 or services which are necessary to avoid physical or mental harm or
13 illness.

14 (g) "Neglect" means the failure or omission by one's self, caretaker or
15 another person with a duty to provide goods or services which are
16 reasonably necessary to ensure safety and well-being and to avoid physical
17 or mental harm or illness.

18 (h) "Caretaker" means a person or institution who has assumed the
19 responsibility, whether legally or not, for the care of the resident
20 voluntarily, by contract or by order of a court of competent jurisdiction.

21 (i) "Exploitation" means misappropriation of resident property or
22 intentionally taking unfair advantage of an adult's physical or financial
23 resources for another individual's personal or financial advantage by the
24 use of undue influence, coercion, harassment, duress, deception, false
25 representation or false pretense by a caretaker or another person.

26 (j) "Medical care facility" means a facility licensed under K.S.A. 65-
27 425 et seq., and amendments thereto, but shall not include, for purposes of
28 this act, a state psychiatric hospital or state institution for people with
29 intellectual disability, including Larned state hospital, Osawatomie state
30 hospital and Rainbow mental health facility, Kansas neurological institute
31 and Parsons state hospital and training center.

32 (k) "Fiduciary abuse" means a situation in which any person who is
33 the caretaker of, or who stands in a position of trust to, a resident, takes,
34 secretes, or appropriates the resident's money or property, to any use or
35 purpose not in the due and lawful execution of such person's trust.

36 (l) "State psychiatric hospital" means Larned state hospital,
37 Osawatomie state hospital and Rainbow mental health facility.

38 (m) "State institution for people with intellectual disability" means
39 Kansas neurological institute and Parsons state hospital and training
40 center.

41 (n) "Report" means a description or accounting of an incident or
42 incidents of abuse, neglect or exploitation under this act and for the
43 purposes of this act shall not include any written assessment or findings.

1 (o) "Law enforcement" means the public office which is vested by
2 law with the duty to maintain public order, make arrests for crimes and
3 investigate criminal acts, whether that duty extends to all crimes or is
4 limited to specific crimes.

5 (p) "Legal representative" means an agent designated in a durable
6 power of attorney, power of attorney or durable power of attorney for
7 health care decisions or a court appointed guardian, conservator or trustee.

8 (q) "Financial institution" means any bank, trust company, escrow
9 company, finance company, saving institution or credit union, chartered
10 and supervised under state or federal law.

11 (r) "Governmental assistance provider" means an agency, or
12 employee of such agency, which is funded solely or in part to provide
13 assistance within the Kansas senior care act, K.S.A. 75-5926 et seq., and
14 amendments thereto, including medicaid and medicare.

15 No person shall be considered to be abused, neglected or exploited or
16 in need of protective services for the sole reason that such person relies
17 upon spiritual means through prayer alone for treatment in accordance
18 with the tenets and practices of a recognized church or religious
19 denomination in lieu of medical treatment.

20 Sec. 5. K.S.A. 2014 Supp. 39-1430 is hereby amended to read as
21 follows: 39-1430. As used in this act:

22 (a) "Adult" means an individual 18 years of age or older alleged to be
23 unable to protect their own interest and who is harmed or threatened with
24 harm, whether financial, mental or physical in nature, through action or
25 inaction by either another individual or through their own action or
26 inaction when: (1) Such person is residing in such person's own home, the
27 home of a family member or the home of a friend; (2) such person resides
28 in an adult family home as defined in K.S.A. 39-1501, and amendments
29 thereto; or (3) such person is receiving services through a provider of
30 community services and affiliates thereof operated or funded by the
31 Kansas department for children and families or the Kansas department for
32 aging and disability services or a residential facility licensed pursuant to
33 K.S.A. 75-3307b, and amendments thereto. Such term shall not include
34 persons to whom K.S.A. 39-1401 et seq., and amendments thereto, apply.

35 (b) "Abuse" means any act or failure to act performed intentionally or
36 recklessly that causes or is likely to cause harm to an adult, including:

37 (1) Infliction of physical or mental injury;

38 (2) any sexual act with an adult when the adult does not consent or
39 when the other person knows or should know that the adult is incapable of
40 resisting or declining consent to the sexual act due to mental deficiency or
41 disease or due to fear of retribution or hardship;

42 (3) unreasonable use of a physical restraint, isolation or medication
43 that harms or is likely to harm an adult;

1 (4) unreasonable use of a physical or chemical restraint, medication
2 or isolation as punishment, for convenience, in conflict with a physician's
3 *or advanced practice registered nurse's* orders or as a substitute for
4 treatment, except where such conduct or physical restraint is in furtherance
5 of the health and safety of the adult;

6 (5) a threat or menacing conduct directed toward an adult that results
7 or might reasonably be expected to result in fear or emotional or mental
8 distress to an adult;

9 (6) fiduciary abuse; or

10 (7) omission or deprivation by a caretaker or another person of goods
11 or services which are necessary to avoid physical or mental harm or
12 illness.

13 (c) "Neglect" means the failure or omission by one's self, caretaker or
14 another person with a duty to supply or provide goods or services which
15 are reasonably necessary to ensure safety and well-being and to avoid
16 physical or mental harm or illness.

17 (d) "Exploitation" means misappropriation of an adult's property or
18 intentionally taking unfair advantage of an adult's physical or financial
19 resources for another individual's personal or financial advantage by the
20 use of undue influence, coercion, harassment, duress, deception, false
21 representation or false pretense by a caretaker or another person.

22 (e) "Fiduciary abuse" means a situation in which any person who is
23 the caretaker of, or who stands in a position of trust to, an adult, takes,
24 secretes, or appropriates their money or property, to any use or purpose not
25 in the due and lawful execution of such person's trust or benefit.

26 (f) "In need of protective services" means that an adult is unable to
27 provide for or obtain services which are necessary to maintain physical or
28 mental health or both.

29 (g) "Services which are necessary to maintain physical or mental
30 health or both" include, but are not limited to, the provision of medical
31 care for physical and mental health needs, the relocation of an adult to a
32 facility or institution able to offer such care, assistance in personal
33 hygiene, food, clothing, adequately heated and ventilated shelter,
34 protection from health and safety hazards, protection from maltreatment
35 the result of which includes, but is not limited to, malnutrition, deprivation
36 of necessities or physical punishment and transportation necessary to
37 secure any of the above stated needs, except that this term shall not include
38 taking such person into custody without consent except as provided in this
39 act.

40 (h) "Protective services" means services provided by the state or other
41 governmental agency or by private organizations or individuals which are
42 necessary to prevent abuse, neglect or exploitation. Such protective
43 services shall include, but shall not be limited to, evaluation of the need for

1 services, assistance in obtaining appropriate social services, and assistance
2 in securing medical and legal services.

3 (i) "Caretaker" means a person who has assumed the responsibility,
4 whether legally or not, for an adult's care or financial management or both.

5 (j) "Secretary" means the secretary for the Kansas department for
6 children and families.

7 (k) "Report" means a description or accounting of an incident or
8 incidents of abuse, neglect or exploitation under this act and for the
9 purposes of this act shall not include any written assessment or findings.

10 (l) "Law enforcement" means the public office which is vested by law
11 with the duty to maintain public order, make arrests for crimes, investigate
12 criminal acts and file criminal charges, whether that duty extends to all
13 crimes or is limited to specific crimes.

14 (m) "Involved adult" means the adult who is the subject of a report of
15 abuse, neglect or exploitation under this act.

16 (n) "Legal representative," "financial institution" and "governmental
17 assistance provider" shall have the meanings ascribed thereto in K.S.A.
18 39-1401, and amendments thereto.

19 No person shall be considered to be abused, neglected or exploited or
20 in need of protective services for the sole reason that such person relies
21 upon spiritual means through prayer alone for treatment in accordance
22 with the tenets and practices of a recognized church or religious
23 denomination in lieu of medical treatment.

24 Sec. 6. K.S.A. 2014 Supp. 39-1504 is hereby amended to read as
25 follows: 39-1504. The secretary shall administer the adult family home
26 registration program in accordance with the following requirements:

27 (a) (1) The home shall meet health standards and safety regulations of
28 the community and the provisions of chapter 20 of the national fire
29 protection association, life safety code, pamphlet no. 101, 1981 edition.

30 (2) The home shall have a written plan to get persons out of the home
31 rapidly in case of fire, tornado or other emergency.

32 (3) No more than two clients shall be in residence at any one time.

33 (4) The home shall have adequate living and sleeping space for
34 clients.

35 (5) Each room shall have an operable outside window.

36 (6) Electric fans shall be made available to reduce the temperature if
37 there is no air conditioning. Rooms shall be heated, lighted, ventilated and
38 available.

39 (7) Sleeping rooms shall have space for personal items.

40 (8) Each client shall have a bed which is clean and in good condition.

41 (9) Lavatory and toilet facilities shall be accessible, available and in
42 working order.

43 (10) The kitchen shall be clean with appliances in good working

1 order.

2 (b) (1) A healthy and safe environment shall be maintained for
3 clients.

4 (2) There shall be a telephone in the home.

5 (3) The provider may assist a client with the taking of medications
6 when the medication is in a labeled bottle which clearly shows a
7 physician's orders *or an advanced practice registered nurse's orders* and
8 when the client requires assistance because of tremor, visual impairment,
9 or similar reasons due to health conditions. The provider may assist or
10 perform for the client such physical activities which do not require daily
11 supervision such as assistance with eating, bathing and dressing, help with
12 brace or walker and transferring from wheelchairs.

13 (4) There shall be no use of corporal punishment, restraints or
14 punitive measures.

15 (5) The house shall be free from accumulated dirt, trash and vermin.

16 (6) Meals shall be planned and prepared for adequate nutrition, and
17 for diets if directed by a physician.

18 (c) (1) The provider shall be at least 18 years of age and in good
19 health at the time of initial application for registration. A written statement
20 must be received from a physician, nurse practitioner, or physician
21 assistant stating that the applicant and the members of the applicant's
22 household are free of any infectious or communicable disease or health
23 condition and are physically and mentally healthy. Such statements shall
24 be renewed every two years.

25 (2) The provider shall not be totally dependent on the income from
26 the clients for support of the provider or the provider's family.

27 (3) A criminal conviction shall not necessarily exclude registration as
28 an adult family home; but an investigation thereof will be made as part of
29 the determination of the suitability of the home.

30 (4) The provider shall be responsible for supervision at all times and
31 shall be in charge of the home and provision of care, or shall have a
32 responsible person on call. Any such substitute responsible person shall
33 meet the same requirements as the provider.

34 (5) The provider is responsible for encouraging the client to seek and
35 utilize available services when needed.

36 (6) The provider shall comply with the requirements of state and
37 federal regulations concerning civil rights and section 504 of the federal
38 rehabilitation act of 1973.

39 (7) The provider shall assure that clients have the privilege of privacy
40 as well as the right to see relatives, friends and participate in regular
41 community activities.

42 (8) The provider shall keep client information confidential. The use or
43 disclosure of any information concerning a client for any purpose is

1 prohibited except on written consent of the client or upon order of the
2 court.

3 (9) The provider shall maintain contact with an assigned social
4 worker and shall allow the secretary and authorized representatives of the
5 secretary access to the home and grounds and to the records related to
6 clients in residence.

7 (10) The provider shall inform the social worker immediately of any
8 unscheduled client absence from the home.

9 (11) The provider is responsible for helping clients maintain their
10 clothing.

11 (12) The provider shall furnish or help clients arrange for
12 transportation.

13 (13) The provider shall help a client arrange for emergency and
14 regular medical care when necessary.

15 (14) The provider shall submit any information relating to the
16 operation of the adult family home which is required by the secretary.

17 Sec. 7. K.S.A. 40-4602 is hereby amended to read as follows: 40-
18 4602. As used in this act:

19 (a) "Emergency medical condition" means the sudden and, at the
20 time, unexpected onset of a health condition that requires immediate
21 medical attention, where failure to provide medical attention would result
22 in serious impairment to bodily functions or serious dysfunction of a
23 bodily organ or part, or would place the person's health in serious
24 jeopardy.

25 (b) "Emergency services" means ambulance services and health care
26 items and services furnished or required to evaluate and treat an
27 emergency medical condition, as directed or ordered by a physician *or an*
28 *advanced practice registered nurse*.

29 (c) "Health benefit plan" means any hospital or medical expense
30 policy, health, hospital or medical service corporation contract, a plan
31 provided by a municipal group-funded pool, a policy or agreement entered
32 into by a health insurer or a health maintenance organization contract
33 offered by an employer or any certificate issued under any such policies,
34 contracts or plans. "Health benefit plan" does not include policies or
35 certificates covering only accident, credit, dental, disability income, long-
36 term care, hospital indemnity, medicare supplement, specified disease,
37 vision care, coverage issued as a supplement to liability insurance,
38 insurance arising out of a workers compensation or similar law,
39 automobile medical-payment insurance, or insurance under which benefits
40 are payable with or without regard to fault and which is statutorily
41 required to be contained in any liability insurance policy or equivalent
42 self-insurance.

43 (d) "Health insurer" means any insurance company, nonprofit medical

1 and hospital service corporation, municipal group-funded pool, fraternal
2 benefit society, health maintenance organization, or any other entity which
3 offers a health benefit plan subject to the Kansas Statutes Annotated.

4 (e) "Insured" means a person who is covered by a health benefit plan.

5 (f) "Participating provider" means a provider who, under a contract
6 with the health insurer or with its contractor or subcontractor, has agreed
7 to provide one or more health care services to insureds with an expectation
8 of receiving payment, other than coinsurance, copayments or deductibles,
9 directly or indirectly from the health insurer.

10 (g) "Provider" means a physician, *advanced practice registered nurse*,
11 hospital or other person which is licensed, accredited or certified to
12 perform specified health care services.

13 (h) "Provider network" means those participating providers who have
14 entered into a contract or agreement with a health insurer to provide items
15 or health care services to individuals covered by a health benefit plan
16 offered by such health insurer.

17 (i) "Physician" means a person licensed by the state board of healing
18 arts to practice medicine and surgery.

19 Sec. 8. K.S.A. 59-2976 is hereby amended to read as follows: 59-
20 2976. (a) Medications and other treatments shall be prescribed, ordered
21 and administered only in conformity with accepted clinical practice.
22 Medication shall be administered only upon the written order of a
23 physician *or an advanced practice registered nurse* or upon a verbal order
24 noted in the patient's medical records and subsequently signed by the
25 physician *or an advanced practice registered nurse*. The attending
26 physician *or an advanced practice registered nurse* shall review regularly
27 the drug regimen of each patient under the physician's *or an advanced*
28 *practice registered nurse's* care and shall monitor any symptoms of
29 harmful side effects. Prescriptions for psychotropic medications shall be
30 written with a termination date not exceeding 30 days thereafter but may
31 be renewed.

32 (b) During the course of treatment the responsible physician, *an*
33 *advanced practice registered nurse* or psychologist or such person's
34 designee shall reasonably consult with the patient, the patient's legal
35 guardian, or a minor patient's parent and give consideration to the views
36 the patient, legal guardian or parent expresses concerning treatment and
37 any alternatives. No medication or other treatment may be administered to
38 any voluntary patient without the patient's consent, or the consent of such
39 patient's legal guardian or of such patient's parent if the patient is a minor.

40 (c) Consent for medical or surgical treatments not intended primarily
41 to treat a patient's mental disorder shall be obtained in accordance with
42 applicable law.

43 (d) Whenever any patient is receiving treatment pursuant to K.S.A.

1 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and
2 amendments thereto, and the treatment facility is administering to the
3 patient any medication or other treatment which alters the patient's mental
4 state in such a way as to adversely affect the patient's judgment or hamper
5 the patient in preparing for or participating in any hearing provided for by
6 this act, then two days prior to and during any such hearing, the treatment
7 facility may not administer such medication or other treatment unless such
8 medication or other treatment is necessary to sustain the patient's life or to
9 protect the patient or others. Prior to the hearing, a report of all such
10 medications or other treatment which have been administered to the
11 patient, along with a copy of any written consent(s) which the patient may
12 have signed, shall be submitted to the court. Counsel for the patient may
13 preliminarily examine the attending physician regarding the administration
14 of any medication to the patient within two days of the hearing with regard
15 to the affect that medication may have had upon the patient's judgment or
16 ability to prepare for or participate in the hearing. On the basis thereof, if
17 the court determines that medication or other treatment has been
18 administered which adversely affects the patient's judgment or ability to
19 prepare for or participate in the hearing, the court may grant to the patient
20 a reasonable continuance in order to allow for the patient to be better able
21 to prepare for or participate in the hearing and the court shall order that
22 such medication or other treatment be discontinued until the conclusion of
23 the hearing, unless the court finds that such medication or other treatment
24 is necessary to sustain the patient's life or to protect the patient or others,
25 in which case the court shall order that the hearing proceed.

26 (e) Whenever a patient receiving treatment pursuant to K.S.A. 59-
27 2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments
28 thereto, objects to taking any medication prescribed for psychiatric
29 treatment, and after full explanation of the benefits and risks of such
30 medication continues their objection, the medication may be administered
31 over the patient's objection; except that the objection shall be recorded in
32 the patient's medical record and at the same time written notice thereof
33 shall be forwarded to the medical director of the treatment facility or the
34 director's designee. Within five days after receiving such notice, excluding
35 Saturdays, Sundays and legal holidays, the medical director or designee
36 shall deliver to the patient and the patient's physician the medical director's
37 or designee's written decision concerning the administration of that
38 medication, and a copy of that decision shall be placed in the patient's
39 medical record.

40 (f) In no case shall experimental medication be administered without
41 the patient's consent, which consent shall be obtained in accordance with
42 ~~subsection (a)(6) of~~ K.S.A. 59-2978(a)(6), and amendments thereto.

43 Sec. 9. K.S.A. 2014 Supp. 65-468 is hereby amended to read as

1 follows: 65-468. As used in K.S.A. 65-468 to 65-474, inclusive, and
2 amendments thereto:

3 (a) "Health care provider" means any person licensed or otherwise
4 authorized by law to provide health care services in this state or a
5 professional corporation organized pursuant to the professional
6 corporation law of Kansas by persons who are authorized by law to form
7 such corporation and who are health care providers as defined by this
8 subsection, or an officer, employee or agent thereof, acting in the course
9 and scope of employment or agency.

10 (b) "Member" means any hospital, emergency medical service, local
11 health department, home health agency, adult care home, medical clinic,
12 mental health center or clinic or nonemergency transportation system.

13 (c) "Mid-level practitioner" means a physician assistant or advanced
14 practice registered nurse who has entered into a written protocol with a
15 rural health network physician.

16 (d) *"Advanced practice registered nurse" means an advanced*
17 *practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
18 *amendments thereto, and who has authority to prescribe drugs in*
19 *accordance with K.S.A. 65-1130, and amendments thereto.*

20 (e) "Physician" means a person licensed to practice medicine and
21 surgery.

22 (f) "Rural health network" means an alliance of members
23 including at least one critical access hospital and at least one other hospital
24 which has developed a comprehensive plan submitted to and approved by
25 the secretary of health and environment regarding patient referral and
26 transfer; the provision of emergency and nonemergency transportation
27 among members; the development of a network-wide emergency services
28 plan; and the development of a plan for sharing patient information and
29 services between hospital members concerning medical staff credentialing,
30 risk management, quality assurance and peer review.

31 (g) "Critical access hospital" means a member of a rural health
32 network which makes available twenty-four hour emergency care services;
33 provides not more than 25 acute care inpatient beds or in the case of a
34 facility with an approved swing-bed agreement a combined total of
35 extended care and acute care beds that does not exceed 25 beds; provides
36 acute inpatient care for a period that does not exceed, on an annual average
37 basis, 96 hours per patient; and provides nursing services under the
38 direction of a licensed professional nurse and continuous licensed
39 professional nursing services for not less than 24 hours of every day when
40 any bed is occupied or the facility is open to provide services for patients
41 unless an exemption is granted by the licensing agency pursuant to rules
42 and regulations. The critical access hospital may provide any services
43 otherwise required to be provided by a full-time, on-site dietician,

1 pharmacist, laboratory technician, medical technologist and radiological
2 technologist on a part-time, off-site basis under written agreements or
3 arrangements with one or more providers or suppliers recognized under
4 medicare. The critical access hospital may provide inpatient services by a
5 physician assistant, ~~advanced practice registered nurse or a clinical nurse~~
6 ~~specialist~~ subject to the oversight of a physician who need not be present
7 in the facility *or by an advanced practice registered nurse*. In addition to
8 the facility's 25 acute beds or swing beds, or both, the critical access
9 hospital may have a psychiatric unit or a rehabilitation unit, or both. Each
10 unit shall not exceed 10 beds and neither unit will count toward the 25-bed
11 limit, nor will these units be subject to the average 96-hour length of stay
12 restriction.

13 ~~(g)~~ (h) "Hospital" means a hospital other than a critical access
14 hospital which has entered into a written agreement with at least one
15 critical access hospital to form a rural health network and to provide
16 medical or administrative supporting services within the limit of the
17 hospital's capabilities.

18 Sec. 10. K.S.A. 2014 Supp. 65-507 is hereby amended to read as
19 follows: 65-507. (a) Each maternity center licensee shall keep a record
20 upon forms prescribed and provided by the secretary of health and
21 environment and the secretary for children and families which shall
22 include the name of every patient, together with the patient's place of
23 residence during the year preceding admission to the center and the name
24 and address of the attending physician *or advanced practice registered*
25 *nurse in the classification of a nurse-midwife*. Each child care facility
26 licensee shall keep a record upon forms prescribed and provided by the
27 secretary of health and environment which shall include the name and age
28 of each child received and cared for in the facility; the name of the
29 physician who attended any sick children in the facility, together with the
30 names and addresses of the parents or guardians of such children; and such
31 other information as the secretary of health and environment or secretary
32 for children and families may require. Each maternity center licensee and
33 each child care facility licensee shall apply to and shall receive without
34 charge from the secretary of health and environment and the secretary for
35 children and families forms for such records as may be required, which
36 forms shall contain a copy of this act.

37 (b) Information obtained under this section shall be confidential and
38 shall not be made public in a manner which would identify individuals.

39 Sec. 11. K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
40 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
41 read as follows: 65-1626. For the purposes of this act:

42 (a) "Administer" means the direct application of a drug, whether by
43 injection, inhalation, ingestion or any other means, to the body of a patient

1 or research subject by:

2 (1) A practitioner or pursuant to the lawful direction of a practitioner;

3 (2) the patient or research subject at the direction and in the presence
4 of the practitioner; or

5 (3) a pharmacist as authorized in K.S.A. 65-1635a, and amendments
6 thereto.

7 (b) "Agent" means an authorized person who acts on behalf of or at
8 the direction of a manufacturer, distributor or dispenser but shall not
9 include a common carrier, public warehouseman or employee of the
10 carrier or warehouseman when acting in the usual and lawful course of the
11 carrier's or warehouseman's business.

12 (c) "Application service provider" means an entity that sells
13 electronic prescription or pharmacy prescription applications as a hosted
14 service where the entity controls access to the application and maintains
15 the software and records on its server.

16 (d) "Authorized distributor of record" means a wholesale distributor
17 with whom a manufacturer has established an ongoing relationship to
18 distribute the manufacturer's prescription drug. An ongoing relationship is
19 deemed to exist between such wholesale distributor and a manufacturer
20 when the wholesale distributor, including any affiliated group of the
21 wholesale distributor, as defined in section 1504 of the internal revenue
22 code, complies with any one of the following: (1) The wholesale
23 distributor has a written agreement currently in effect with the
24 manufacturer evidencing such ongoing relationship; and (2) the wholesale
25 distributor is listed on the manufacturer's current list of authorized
26 distributors of record, which is updated by the manufacturer on no less
27 than a monthly basis.

28 (e) "Board" means the state board of pharmacy created by K.S.A. 74-
29 1603, and amendments thereto.

30 (f) "Brand exchange" means the dispensing of a different drug
31 product of the same dosage form and strength and of the same generic
32 name as the brand name drug product prescribed.

33 (g) "Brand name" means the registered trademark name given to a
34 drug product by its manufacturer, labeler or distributor.

35 (h) "Chain pharmacy warehouse" means a permanent physical
36 location for drugs or devices, or both, that acts as a central warehouse and
37 performs intracompany sales or transfers of prescription drugs or devices
38 to chain pharmacies that have the same ownership or control. Chain
39 pharmacy warehouses must be registered as wholesale distributors.

40 (i) "Co-licensee" means a pharmaceutical manufacturer that has
41 entered into an agreement with another pharmaceutical manufacturer to
42 engage in a business activity or occupation related to the manufacture or
43 distribution of a prescription drug and the national drug code on the drug

1 product label shall be used to determine the identity of the drug
2 manufacturer.

3 (j) "DEA" means the U.S. department of justice, drug enforcement
4 administration.

5 (k) "Deliver" or "delivery" means the actual, constructive or
6 attempted transfer from one person to another of any drug whether or not
7 an agency relationship exists.

8 (l) "Direct supervision" means the process by which the responsible
9 pharmacist shall observe and direct the activities of a pharmacy student or
10 pharmacy technician to a sufficient degree to assure that all such activities
11 are performed accurately, safely and without risk or harm to patients, and
12 complete the final check before dispensing.

13 (m) "Dispense" means to deliver prescription medication to the
14 ultimate user or research subject by or pursuant to the lawful order of a
15 practitioner or pursuant to the prescription of a mid-level practitioner.

16 (n) "Dispenser" means a practitioner or pharmacist who dispenses
17 prescription medication, or a physician assistant who has authority to
18 dispense prescription-only drugs in accordance with ~~subsection (b) of~~
19 K.S.A. 65-28a08(b), and amendments thereto.

20 (o) "Distribute" means to deliver, other than by administering or
21 dispensing, any drug.

22 (p) "Distributor" means a person who distributes a drug.

23 (q) "Drop shipment" means the sale, by a manufacturer, that
24 manufacturer's co-licensee, that manufacturer's third party logistics
25 provider, or that manufacturer's exclusive distributor, of the manufacturer's
26 prescription drug, to a wholesale distributor whereby the wholesale
27 distributor takes title but not possession of such prescription drug and the
28 wholesale distributor invoices the pharmacy, the chain pharmacy
29 warehouse, or other designated person authorized by law to dispense or
30 administer such prescription drug, and the pharmacy, the chain pharmacy
31 warehouse, or other designated person authorized by law to dispense or
32 administer such prescription drug receives delivery of the prescription
33 drug directly from the manufacturer, that manufacturer's co-licensee, that
34 manufacturer's third party logistics provider, or that manufacturer's
35 exclusive distributor, of such prescription drug. Drop shipment shall be
36 part of the "normal distribution channel."

37 (r) "Drug" means: (1) Articles recognized in the official United States
38 pharmacopoeia, or other such official compendiums of the United States,
39 or official national formulary, or any supplement of any of them; (2)
40 articles intended for use in the diagnosis, cure, mitigation, treatment or
41 prevention of disease in man or other animals; (3) articles, other than food,
42 intended to affect the structure or any function of the body of man or other
43 animals; and (4) articles intended for use as a component of any articles

1 specified in clause (1), (2) or (3) of this subsection; but does not include
2 devices or their components, parts or accessories, except that the term
3 "drug" shall not include amygdalin (laetrile) or any livestock remedy, if
4 such livestock remedy had been registered in accordance with the
5 provisions of article 5 of chapter 47 of the Kansas Statutes Annotated,
6 prior to its repeal.

7 (s) "Durable medical equipment" means technologically sophisticated
8 medical devices that may be used in a residence, including the following:
9 (1) Oxygen and oxygen delivery system; (2) ventilators; (3) respiratory
10 disease management devices; (4) continuous positive airway pressure
11 (CPAP) devices; (5) electronic and computerized wheelchairs and seating
12 systems; (6) apnea monitors; (7) transcutaneous electrical nerve stimulator
13 (TENS) units; (8) low air loss cutaneous pressure management devices; (9)
14 sequential compression devices; (10) feeding pumps; (11) home
15 phototherapy devices; (12) infusion delivery devices; (13) distribution of
16 medical gases to end users for human consumption; (14) hospital beds;
17 (15) nebulizers; or (16) other similar equipment determined by the board
18 in rules and regulations adopted by the board.

19 (t) "Electronic prescription" means an electronically prepared
20 prescription that is authorized and transmitted from the prescriber to the
21 pharmacy by means of electronic transmission.

22 (u) "Electronic prescription application" means software that is used
23 to create electronic prescriptions and that is intended to be installed on the
24 prescriber's computers and servers where access and records are controlled
25 by the prescriber.

26 (v) "Electronic signature" means a confidential personalized digital
27 key, code, number or other method for secure electronic data transmissions
28 which identifies a particular person as the source of the message,
29 authenticates the signatory of the message and indicates the person's
30 approval of the information contained in the transmission.

31 (w) "Electronic transmission" means the transmission of an electronic
32 prescription, formatted as an electronic data file, from a prescriber's
33 electronic prescription application to a pharmacy's computer, where the
34 data file is imported into the pharmacy prescription application.

35 (x) "Electronically prepared prescription" means a prescription that is
36 generated using an electronic prescription application.

37 (y) "Exclusive distributor" means any entity that: (1) Contracts with a
38 manufacturer to provide or coordinate warehousing, wholesale distribution
39 or other services on behalf of a manufacturer and who takes title to that
40 manufacturer's prescription drug, but who does not have general
41 responsibility to direct the sale or disposition of the manufacturer's
42 prescription drug; (2) is registered as a wholesale distributor under the
43 pharmacy act of the state of Kansas; and (3) to be considered part of the

1 normal distribution channel, must be an authorized distributor of record.

2 (z) "Facsimile transmission" or "fax transmission" means the
3 transmission of a digital image of a prescription from the prescriber or the
4 prescriber's agent to the pharmacy. "Facsimile transmission" includes, but
5 is not limited to, transmission of a written prescription between the
6 prescriber's fax machine and the pharmacy's fax machine; transmission of
7 an electronically prepared prescription from the prescriber's electronic
8 prescription application to the pharmacy's fax machine, computer or
9 printer; or transmission of an electronically prepared prescription from the
10 prescriber's fax machine to the pharmacy's fax machine, computer or
11 printer.

12 (aa) "Generic name" means the established chemical name or official
13 name of a drug or drug product.

14 (bb) (1) "Institutional drug room" means any location where
15 prescription-only drugs are stored and from which prescription-only drugs
16 are administered or dispensed and which is maintained or operated for the
17 purpose of providing the drug needs of:

18 (A) Inmates of a jail or correctional institution or facility;

19 (B) residents of a juvenile detention facility, as defined by the revised
20 Kansas code for care of children and the revised Kansas juvenile justice
21 code;

22 (C) students of a public or private university or college, a community
23 college or any other institution of higher learning which is located in
24 Kansas;

25 (D) employees of a business or other employer; or

26 (E) persons receiving inpatient hospice services.

27 (2) "Institutional drug room" does not include:

28 (A) Any registered pharmacy;

29 (B) any office of a practitioner; or

30 (C) a location where no prescription-only drugs are dispensed and no
31 prescription-only drugs other than individual prescriptions are stored or
32 administered.

33 (cc) "Intermediary" means any technology system that receives and
34 transmits an electronic prescription between the prescriber and the
35 pharmacy.

36 (dd) "Intracompany transaction" means any transaction or transfer
37 between any division, subsidiary, parent or affiliated or related company
38 under common ownership or control of a corporate entity, or any
39 transaction or transfer between co-licensees of a co-licensed product.

40 (ee) "Medical care facility" shall have the meaning provided in
41 K.S.A. 65-425, and amendments thereto, except that the term shall also
42 include facilities licensed under the provisions of K.S.A. 75-3307b, and
43 amendments thereto, except community mental health centers and

1 facilities for people with intellectual disability.

2 (ff) "Manufacture" means the production, preparation, propagation,
3 compounding, conversion or processing of a drug either directly or
4 indirectly by extraction from substances of natural origin, independently
5 by means of chemical synthesis or by a combination of extraction and
6 chemical synthesis and includes any packaging or repackaging of the drug
7 or labeling or relabeling of its container, except that this term shall not
8 include the preparation or compounding of a drug by an individual for the
9 individual's own use or the preparation, compounding, packaging or
10 labeling of a drug by:

11 (1) A practitioner or a practitioner's authorized agent incident to such
12 practitioner's administering or dispensing of a drug in the course of the
13 practitioner's professional practice;

14 (2) a practitioner, by a practitioner's authorized agent or under a
15 practitioner's supervision for the purpose of, or as an incident to, research,
16 teaching or chemical analysis and not for sale; or

17 (3) a pharmacist or the pharmacist's authorized agent acting under the
18 direct supervision of the pharmacist for the purpose of, or incident to, the
19 dispensing of a drug by the pharmacist.

20 (gg) "Manufacturer" means a person licensed or approved by the FDA
21 to engage in the manufacture of drugs and devices.

22 (hh) "Mid-level practitioner" means ~~an advanced practice registered~~
23 ~~nurse issued a license pursuant to K.S.A. 65-1131, and amendments~~
24 ~~thereto, who has authority to prescribe drugs pursuant to a written protocol~~
25 ~~with a responsible physician under K.S.A. 65-1130, and amendments~~
26 ~~thereto, or a physician assistant licensed pursuant to the physician assistant~~
27 ~~licensure act who has authority to prescribe drugs pursuant to a written~~
28 ~~protocol with a supervising physician under K.S.A. 65-28a08, and~~
29 ~~amendments thereto.~~

30 (ii) "Normal distribution channel" means a chain of custody for a
31 prescription-only drug that goes from a manufacturer of the prescription-
32 only drug, from that manufacturer to that manufacturer's co-licensed
33 partner, from that manufacturer to that manufacturer's third-party logistics
34 provider, or from that manufacturer to that manufacturer's exclusive
35 distributor, directly or by drop shipment, to:

36 (1) A pharmacy to a patient or to other designated persons authorized
37 by law to dispense or administer such drug to a patient;

38 (2) a wholesale distributor to a pharmacy to a patient or other
39 designated persons authorized by law to dispense or administer such drug
40 to a patient;

41 (3) a wholesale distributor to a chain pharmacy warehouse to that
42 chain pharmacy warehouse's intracompany pharmacy to a patient or other
43 designated persons authorized by law to dispense or administer such drug

1 to a patient; or

2 (4) a chain pharmacy warehouse to the chain pharmacy warehouse's
3 intracompany pharmacy to a patient or other designated persons authorized
4 by law to dispense or administer such drug to a patient.

5 (jj) "Person" means individual, corporation, government,
6 governmental subdivision or agency, partnership, association or any other
7 legal entity.

8 (kk) "Pharmacist" means any natural person licensed under this act to
9 practice pharmacy.

10 (ll) "Pharmacist-in-charge" means the pharmacist who is responsible
11 to the board for a registered establishment's compliance with the laws and
12 regulations of this state pertaining to the practice of pharmacy,
13 manufacturing of drugs and the distribution of drugs. The pharmacist-in-
14 charge shall supervise such establishment on a full-time or a part-time
15 basis and perform such other duties relating to supervision of a registered
16 establishment as may be prescribed by the board by rules and regulations.
17 Nothing in this definition shall relieve other pharmacists or persons from
18 their responsibility to comply with state and federal laws and regulations.

19 (mm) "Pharmacist intern" means: (1) A student currently enrolled in
20 an accredited pharmacy program; (2) a graduate of an accredited pharmacy
21 program serving an internship; or (3) a graduate of a pharmacy program
22 located outside of the United States which is not accredited and who has
23 successfully passed equivalency examinations approved by the board.

24 (nn) "Pharmacy," "drugstore" or "apothecary" means premises,
25 laboratory, area or other place: (1) Where drugs are offered for sale where
26 the profession of pharmacy is practiced and where prescriptions are
27 compounded and dispensed; or (2) which has displayed upon it or within it
28 the words "pharmacist," "pharmaceutical chemist," "pharmacy,"
29 "apothecary," "drugstore," "druggist," "drugs," "drug sundries" or any of
30 these words or combinations of these words or words of similar import
31 either in English or any sign containing any of these words; or (3) where
32 the characteristic symbols of pharmacy or the characteristic prescription
33 sign "Rx" may be exhibited. As used in this subsection, premises refers
34 only to the portion of any building or structure leased, used or controlled
35 by the licensee in the conduct of the business registered by the board at the
36 address for which the registration was issued.

37 (oo) "Pharmacy prescription application" means software that is used
38 to process prescription information, is installed on a pharmacy's computers
39 or servers, and is controlled by the pharmacy.

40 (pp) "Pharmacy technician" means an individual who, under the
41 direct supervision and control of a pharmacist, may perform packaging,
42 manipulative, repetitive or other nondiscretionary tasks related to the
43 processing of a prescription or medication order and who assists the

1 pharmacist in the performance of pharmacy related duties, but who does
2 not perform duties restricted to a pharmacist.

3 (qq) "Practitioner" means a person licensed to practice medicine and
4 surgery, dentist, podiatrist, veterinarian, optometrist, *advanced practice*
5 *registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
6 *amendments thereto, and who has authority to prescribe drugs in*
7 *accordance with K.S.A. 65-1130, and amendments thereto, a registered*
8 *nurse anesthetist registered pursuant to K.S.A. 65-1154, and amendments*
9 *thereto, or scientific investigator or other person authorized by law to use a*
10 *prescription-only drug in teaching or chemical analysis or to conduct*
11 *research with respect to a prescription-only drug.*

12 (rr) "Preceptor" means a licensed pharmacist who possesses at least
13 two years' experience as a pharmacist and who supervises students
14 obtaining the pharmaceutical experience required by law as a condition to
15 taking the examination for licensure as a pharmacist.

16 (ss) "Prescriber" means a practitioner or a mid-level practitioner.

17 (tt) "Prescription" or "prescription order" means: (1) An order to be
18 filled by a pharmacist for prescription medication issued and signed by a
19 prescriber in the authorized course of such prescriber's professional
20 practice; or (2) an order transmitted to a pharmacist through word of
21 mouth, note, telephone or other means of communication directed by such
22 prescriber, regardless of whether the communication is oral, electronic,
23 facsimile or in printed form.

24 (uu) "Prescription medication" means any drug, including label and
25 container according to context, which is dispensed pursuant to a
26 prescription order.

27 (vv) "Prescription-only drug" means any drug whether intended for
28 use by man or animal, required by federal or state law, including 21 U.S.C.
29 § 353, to be dispensed only pursuant to a written or oral prescription or
30 order of a practitioner or is restricted to use by practitioners only.

31 (ww) "Probation" means the practice or operation under a temporary
32 license, registration or permit or a conditional license, registration or
33 permit of a business or profession for which a license, registration or
34 permit is granted by the board under the provisions of the pharmacy act of
35 the state of Kansas requiring certain actions to be accomplished or certain
36 actions not to occur before a regular license, registration or permit is
37 issued.

38 (xx) "Professional incompetency" means:

39 (1) One or more instances involving failure to adhere to the
40 applicable standard of pharmaceutical care to a degree which constitutes
41 gross negligence, as determined by the board;

42 (2) repeated instances involving failure to adhere to the applicable
43 standard of pharmaceutical care to a degree which constitutes ordinary

1 negligence, as determined by the board; or

2 (3) a pattern of pharmacy practice or other behavior which
3 demonstrates a manifest incapacity or incompetence to practice pharmacy.

4 (yy) "Readily retrievable" means that records kept by automatic data
5 processing applications or other electronic or mechanized record-keeping
6 systems can be separated out from all other records within a reasonable
7 time not to exceed 48 hours of a request from the board or other authorized
8 agent or that hard-copy records are kept on which certain items are
9 asterisked, redlined or in some other manner visually identifiable apart
10 from other items appearing on the records.

11 (zz) "Retail dealer" means a person selling at retail nonprescription
12 drugs which are prepackaged, fully prepared by the manufacturer or
13 distributor for use by the consumer and labeled in accordance with the
14 requirements of the state and federal food, drug and cosmetic acts. Such
15 nonprescription drugs shall not include: (1) A controlled substance; (2) a
16 prescription-only drug; or (3) a drug intended for human use by
17 hypodermic injection.

18 (aaa) "Secretary" means the executive secretary of the board.

19 (bbb) "Third party logistics provider" means an entity that: (1)
20 Provides or coordinates warehousing, distribution or other services on
21 behalf of a manufacturer, but does not take title to the prescription drug or
22 have general responsibility to direct the prescription drug's sale or
23 disposition; (2) is registered as a wholesale distributor under the pharmacy
24 act of the state of Kansas; and (3) to be considered part of the normal
25 distribution channel, must also be an authorized distributor of record.

26 (ccc) "Unprofessional conduct" means:

27 (1) Fraud in securing a registration or permit;

28 (2) intentional adulteration or mislabeling of any drug, medicine,
29 chemical or poison;

30 (3) causing any drug, medicine, chemical or poison to be adulterated
31 or mislabeled, knowing the same to be adulterated or mislabeled;

32 (4) intentionally falsifying or altering records or prescriptions;

33 (5) unlawful possession of drugs and unlawful diversion of drugs to
34 others;

35 (6) willful betrayal of confidential information under K.S.A. 65-1654,
36 and amendments thereto;

37 (7) conduct likely to deceive, defraud or harm the public;

38 (8) making a false or misleading statement regarding the licensee's
39 professional practice or the efficacy or value of a drug;

40 (9) commission of any act of sexual abuse, misconduct or exploitation
41 related to the licensee's professional practice; or

42 (10) performing unnecessary tests, examinations or services which
43 have no legitimate pharmaceutical purpose.

1 (ddd) "Vaccination protocol" means a written protocol, agreed to by a
2 pharmacist and a person licensed to practice medicine and surgery by the
3 state board of healing arts, which establishes procedures and
4 recordkeeping and reporting requirements for administering a vaccine by
5 the pharmacist for a period of time specified therein, not to exceed two
6 years.

7 (eee) "Valid prescription order" means a prescription that is issued for
8 a legitimate medical purpose by an individual prescriber licensed by law to
9 administer and prescribe drugs and acting in the usual course of such
10 prescriber's professional practice. A prescription issued solely on the basis
11 of an internet-based questionnaire or consultation without an appropriate
12 prescriber-patient relationship is not a valid prescription order.

13 (fff) "Veterinary medical teaching hospital pharmacy" means any
14 location where prescription-only drugs are stored as part of an accredited
15 college of veterinary medicine and from which prescription-only drugs are
16 distributed for use in treatment of or administration to a nonhuman.

17 (ggg) "Wholesale distributor" means any person engaged in
18 wholesale distribution of prescription drugs or devices in or into the state,
19 including, but not limited to, manufacturers, repackagers, own-label
20 distributors, private-label distributors, jobbers, brokers, warehouses,
21 including manufacturers' and distributors' warehouses, co-licensees,
22 exclusive distributors, third party logistics providers, chain pharmacy
23 warehouses that conduct wholesale distributions, and wholesale drug
24 warehouses, independent wholesale drug traders and retail pharmacies that
25 conduct wholesale distributions. Wholesale distributor shall not include
26 persons engaged in the sale of durable medical equipment to consumers or
27 patients.

28 (hhh) "Wholesale distribution" means the distribution of prescription
29 drugs or devices by wholesale distributors to persons other than consumers
30 or patients, and includes the transfer of prescription drugs by a pharmacy
31 to another pharmacy if the total number of units of transferred drugs
32 during a twelve-month period does not exceed 5% of the total number of
33 all units dispensed by the pharmacy during the immediately preceding
34 twelve-month period. Wholesale distribution does not include:

35 (1) The sale, purchase or trade of a prescription drug or device, an
36 offer to sell, purchase or trade a prescription drug or device or the
37 dispensing of a prescription drug or device pursuant to a prescription;

38 (2) the sale, purchase or trade of a prescription drug or device or an
39 offer to sell, purchase or trade a prescription drug or device for emergency
40 medical reasons;

41 (3) intracompany transactions, as defined in this section, unless in
42 violation of own use provisions;

43 (4) the sale, purchase or trade of a prescription drug or device or an

1 offer to sell, purchase or trade a prescription drug or device among
2 hospitals, chain pharmacy warehouses, pharmacies or other health care
3 entities that are under common control;

4 (5) the sale, purchase or trade of a prescription drug or device or the
5 offer to sell, purchase or trade a prescription drug or device by a charitable
6 organization described in 503(c)(3) of the internal revenue code of 1954 to
7 a nonprofit affiliate of the organization to the extent otherwise permitted
8 by law;

9 (6) the purchase or other acquisition by a hospital or other similar
10 health care entity that is a member of a group purchasing organization of a
11 prescription drug or device for its own use from the group purchasing
12 organization or from other hospitals or similar health care entities that are
13 members of these organizations;

14 (7) the transfer of prescription drugs or devices between pharmacies
15 pursuant to a centralized prescription processing agreement;

16 (8) the sale, purchase or trade of blood and blood components
17 intended for transfusion;

18 (9) the return of recalled, expired, damaged or otherwise non-salable
19 prescription drugs, when conducted by a hospital, health care entity,
20 pharmacy, chain pharmacy warehouse or charitable institution in
21 accordance with the board's rules and regulations;

22 (10) the sale, transfer, merger or consolidation of all or part of the
23 business of a retail pharmacy or pharmacies from or with another retail
24 pharmacy or pharmacies, whether accomplished as a purchase and sale of
25 stock or business assets, in accordance with the board's rules and
26 regulations;

27 (11) the distribution of drug samples by manufacturers' and
28 authorized distributors' representatives;

29 (12) the sale of minimal quantities of drugs by retail pharmacies to
30 licensed practitioners for office use; or

31 (13) the sale or transfer from a retail pharmacy or chain pharmacy
32 warehouse of expired, damaged, returned or recalled prescription drugs to
33 the original manufacturer, originating wholesale distributor or to a third
34 party returns processor in accordance with the board's rules and
35 regulations.

36 Sec. 12. K.S.A. 65-1660 is hereby amended to read as follows: 65-
37 1660. (a) Except as otherwise provided in this section, the provisions of
38 the pharmacy act of the state of Kansas shall not apply to dialysates,
39 devices or drugs which are designated by the board for the purposes of this
40 section relating to treatment of a person with chronic kidney failure
41 receiving dialysis and which are prescribed or ordered by a physician, *an*
42 *advanced practice registered nurse* or a mid-level practitioner for
43 administration or delivery to a person with chronic kidney failure if:

1 (1) The wholesale distributor is registered with the board and lawfully
2 holds the drug or device; and

3 (2) the wholesale distributor: (A) Delivers the drug or device to: (i) A
4 person with chronic kidney failure for self-administration at the person's
5 home or specified address; (ii) a physician for administration or delivery to
6 a person with chronic kidney failure; or (iii) a medicare approved renal
7 dialysis facility for administering or delivering to a person with chronic
8 kidney failure; and (B) has sufficient and qualified supervision to
9 adequately protect the public health.

10 (b) The wholesale distributor pursuant to subsection (a) shall be
11 supervised by a pharmacist consultant pursuant to rules and regulations
12 adopted by the board.

13 (c) The board shall adopt such rules or regulations as are necessary to
14 effectuate the provisions of this section.

15 (d) As used in this section, "physician" means a person licensed to
16 practice medicine and surgery; "mid-level practitioner" means mid-level
17 practitioner as such term is defined ~~in subsection (ii) of~~ by K.S.A. 65-
18 1626, and amendments thereto; *"advanced practice registered nurse"*
19 *means an advanced practice registered nurse who is licensed pursuant to*
20 *K.S.A. 65-1131, and amendments thereto, and who has authority to*
21 *prescribe drugs in accordance with K.S.A. 65-1130, and amendments*
22 *thereto.*

23 (e) This section shall be part of and supplemental to the pharmacy act
24 of the state of Kansas.

25 Sec. 13. K.S.A. 2014 Supp. 65-1682 is hereby amended to read as
26 follows: 65-1682. As used in this act, unless the context otherwise
27 requires:

28 (a) "Board" means the state board of pharmacy.

29 (b) "Dispenser" means a practitioner or pharmacist who delivers a
30 scheduled substance or drug of concern to an ultimate user, but does not
31 include:

32 (1) A licensed hospital pharmacy that distributes such substances for
33 the purpose of inpatient hospital care;

34 (2) a medical care facility as defined in K.S.A. 65-425, and
35 amendments thereto, practitioner or other authorized person who
36 administers such a substance;

37 (3) a registered wholesale distributor of such substances;

38 (4) a veterinarian licensed by the Kansas board of veterinary
39 examiners who dispenses or prescribes a scheduled substance or drug of
40 concern; or

41 (5) a practitioner who has been exempted from the reporting
42 requirements of this act in rules and regulations promulgated by the board.

43 (c) "Drug of concern" means any drug that demonstrates a potential

1 for abuse and is designated as a drug of concern in rules and regulations
2 promulgated by the board.

3 (d) "Patient" means the person who is the ultimate user of a drug for
4 whom a prescription is issued or for whom a drug is dispensed, or both.

5 (e) "Pharmacist" means an individual currently licensed by the board
6 to practice the profession of pharmacy in this state.

7 (f) "Practitioner" means a person licensed to practice medicine and
8 surgery, dentist, podiatrist, optometrist, *advanced practice registered nurse*
9 *who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and*
10 *who has authority to prescribe drugs in accordance with K.S.A. 65-1130,*
11 *and amendments thereto,* or other person authorized by law to prescribe or
12 dispense scheduled substances and drugs of concern.

13 (g) "Scheduled substance" means controlled substances included in
14 schedules II, III or IV of the schedules designated in K.S.A. 65-4107, 65-
15 4109 and 65-4111, and amendments thereto, respectively, or the federal
16 controlled substances act (21 U.S.C. § 812).

17 Sec. 14. K.S.A. 2014 Supp. 65-2837a is hereby amended to read as
18 follows: 65-2837a. (a) It shall be unlawful for any person licensed to
19 practice medicine and surgery to prescribe, order, dispense, administer,
20 sell, supply or give *or for any person licensed as an advanced practice*
21 *registered nurse* or for a mid-level practitioner as defined ~~in subsection (ii)~~
22 ~~of~~ by K.S.A. 65-1626, and amendments thereto, to prescribe, administer,
23 supply or give any amphetamine or sympathomimetic amine designated in
24 schedule II, III or IV under the uniform controlled substances act, except
25 as provided in this section. Failure to comply with this section by a
26 licensee shall constitute unprofessional conduct under K.S.A. 65-2837,
27 and amendments thereto.

28 (b) When any licensee prescribes, orders, dispenses, administers,
29 sells, supplies or gives or when *any advanced practice registered nurse or*
30 *any mid-level practitioner as defined in subsection (ii) of* by K.S.A. 65-
31 1626, and amendments thereto, prescribes, administers, sells, supplies or
32 gives any amphetamine or sympathomimetic amine designated in schedule
33 II, III or IV under the uniform controlled substances act, the patient's
34 medical record shall adequately document the purpose for which the drug
35 is being given. Such purpose shall be restricted to one or more of the
36 following:

- 37 (1) The treatment of narcolepsy.
38 (2) The treatment of drug-induced brain dysfunction.
39 (3) The treatment of hyperkinesis.
40 (4) The differential diagnostic psychiatric evaluation of depression.
41 (5) The treatment of depression shown by adequate medical records
42 and documentation to be unresponsive to other forms of treatment.
43 (6) The clinical investigation of the effects of such drugs or

1 compounds, in which case, before the investigation is begun, the licensee
2 shall, in addition to other requirements of applicable laws, apply for and
3 obtain approval of the investigation from the board of healing arts.

4 (7) The treatment of obesity with controlled substances, as may be
5 defined by rules and regulations adopted by the board of healing arts.

6 (8) The treatment of any other disorder or disease for which such
7 drugs or compounds have been found to be safe and effective by
8 competent scientific research which findings have been generally accepted
9 by the scientific community, in which case, the licensee before prescribing,
10 ordering, dispensing, administering, selling, supplying or giving the drug
11 or compound for a particular condition, or the licensee before authorizing
12 a mid-level practitioner to prescribe the drug or compound for a particular
13 condition, *or the advanced practice registered nurse before prescribing,*
14 *ordering, administering or giving the drug for a particular condition,* shall
15 obtain a determination from the board of healing arts that the drug or
16 compound can be used for that particular condition.

17 Sec. 15. K.S.A. 65-2892 is hereby amended to read as follows: 65-
18 2892. Any physician *or advanced practice registered nurse*, upon
19 consultation by any person under ~~eighteen~~ *(18)* 18 years of age as a
20 patient, may, with the consent of such person who is hereby granted the
21 right of giving such consent, make a diagnostic examination for venereal
22 disease and prescribe for and treat such person for venereal disease
23 including prophylactic treatment for exposure to venereal disease
24 whenever such person is suspected of having a venereal disease or contact
25 with anyone having a venereal disease. All such examinations and
26 treatment may be performed without the consent of, or notification to, the
27 parent, parents, guardian or any other person having custody of such
28 person. Any physician *or advanced practice registered nurse* examining or
29 treating such person for venereal disease may, but shall not be obligated to,
30 in accord with his opinion of what will be most beneficial for such person,
31 inform the spouse, parent, custodian, guardian or fiancé of such person as
32 to the treatment given or needed without the consent of such person. Such
33 informing shall not constitute libel or slander or a violation of the right of
34 privacy or privilege or otherwise subject the physician *or advanced*
35 *practice registered nurse* to any liability whatsoever. In any such case, the
36 physician *or advanced practice registered nurse* shall incur no civil or
37 criminal liability by reason of having made such diagnostic examination or
38 rendered such treatment, but such immunity shall not apply to any
39 negligent acts or omissions. The physician *or advanced practice registered*
40 *nurse* shall incur no civil or criminal liability by reason of any adverse
41 reaction to medication administered, provided reasonable care has been
42 taken to elicit from such person under ~~eighteen~~ *(18)* 18 years of age any
43 history of sensitivity or previous adverse reaction to the medication.

1 Sec. 16. K.S.A. 2014 Supp. 65-2921 is hereby amended to read as
2 follows: 65-2921. (a) Except as otherwise provided in subsection (d), a
3 physical therapist may evaluate and initiate physical therapy treatment on
4 a patient without referral from a licensed health care practitioner. If
5 treating a patient without a referral from a licensed health care practitioner
6 and the patient is not progressing toward documented treatment goals as
7 demonstrated by objective, measurable or functional improvement, or any
8 combination thereof, after 10 patient visits or in a period of 15 business
9 days from the initial treatment visits following the initial evaluation visit,
10 the physical therapist shall obtain a referral from an appropriate licensed
11 health care practitioner prior to continuing treatment.

12 (b) Physical therapists may provide, without a referral, services to: (1)
13 Employees solely for the purpose of education and instruction related to
14 workplace injury prevention; or (2) the public for the purpose of fitness,
15 health promotion and education.

16 (c) Physical therapists may provide services without a referral to
17 special education students who need physical therapy services to fulfill the
18 provisions of their individualized education plan (IEP) or individualized
19 family service plan (IFSP).

20 (d) Nothing in this section shall be construed to prevent a hospital or
21 ambulatory surgical center from requiring a physician order or referral for
22 physical therapy services for a patient currently being treated in such
23 facility.

24 (e) When a patient self-refers to a physical therapist pursuant to this
25 section, the physical therapist, prior to commencing treatment, shall
26 provide written notice to the patient that a physical therapy diagnosis is not
27 a medical diagnosis by a physician.

28 (f) Physical therapists shall perform wound debridement services only
29 after approval by a person licensed to practice medicine and surgery or
30 other licensed health care practitioner in appropriately related cases.

31 (g) As used in this section, "licensed health care practitioner" means a
32 person licensed to practice medicine and surgery, a licensed podiatrist, a
33 licensed physician assistant ~~or a licensed advanced practice registered~~
34 ~~nurse~~ working pursuant to the order or direction of a person licensed to
35 practice medicine and surgery, a licensed chiropractor, a licensed dentist
36 ~~or, a licensed optometrist or a licensed advanced practice registered nurse~~
37 in appropriately related cases.

38 Sec. 17. K.S.A. 2013 Supp. 65-4101, as amended by section 50 of
39 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
40 read as follows: 65-4101. As used in this act: (a) "Administer" means the
41 direct application of a controlled substance, whether by injection,
42 inhalation, ingestion or any other means, to the body of a patient or
43 research subject by:

1 (1) A practitioner or pursuant to the lawful direction of a practitioner;
2 or

3 (2) the patient or research subject at the direction and in the presence
4 of the practitioner.

5 (b) "Agent" means an authorized person who acts on behalf of or at
6 the direction of a manufacturer, distributor or dispenser. It does not include
7 a common carrier, public warehouseman or employee of the carrier or
8 warehouseman.

9 (c) "Application service provider" means an entity that sells
10 electronic prescription or pharmacy prescription applications as a hosted
11 service where the entity controls access to the application and maintains
12 the software and records on its server.

13 (d) "Board" means the state board of pharmacy.

14 (e) "Bureau" means the bureau of narcotics and dangerous drugs,
15 United States department of justice, or its successor agency.

16 (f) "Controlled substance" means any drug, substance or immediate
17 precursor included in any of the schedules designated in K.S.A. 65-4105,
18 65-4107, 65-4109, 65-4111 and 65-4113, and amendments thereto.

19 (g) (1) "Controlled substance analog" means a substance that is
20 intended for human consumption, and:

21 (A) The chemical structure of which is substantially similar to the
22 chemical structure of a controlled substance listed in or added to the
23 schedules designated in K.S.A. 65-4105 or 65-4107, and amendments
24 thereto;

25 (B) which has a stimulant, depressant or hallucinogenic effect on the
26 central nervous system substantially similar to the stimulant, depressant or
27 hallucinogenic effect on the central nervous system of a controlled
28 substance included in the schedules designated in K.S.A. 65-4105 or 65-
29 4107, and amendments thereto; or

30 (C) with respect to a particular individual, which such individual
31 represents or intends to have a stimulant, depressant or hallucinogenic
32 effect on the central nervous system substantially similar to the stimulant,
33 depressant or hallucinogenic effect on the central nervous system of a
34 controlled substance included in the schedules designated in K.S.A. 65-
35 4105 or 65-4107, and amendments thereto.

36 (2) "Controlled substance analog" does not include:

37 (A) A controlled substance;

38 (B) a substance for which there is an approved new drug application;
39 or

40 (C) a substance with respect to which an exemption is in effect for
41 investigational use by a particular person under section 505 of the federal
42 food, drug and cosmetic act, 21 U.S.C. § 355, to the extent conduct with
43 respect to the substance is permitted by the exemption.

1 (h) "Counterfeit substance" means a controlled substance which, or
2 the container or labeling of which, without authorization bears the
3 trademark, trade name or other identifying mark, imprint, number or
4 device or any likeness thereof of a manufacturer, distributor or dispenser
5 other than the person who in fact manufactured, distributed or dispensed
6 the substance.

7 (i) "Cultivate" means the planting or promotion of growth of five or
8 more plants which contain or can produce controlled substances.

9 (j) "DEA" means the U.S. department of justice, drug enforcement
10 administration.

11 (k) "Deliver" or "delivery" means the actual, constructive or
12 attempted transfer from one person to another of a controlled substance,
13 whether or not there is an agency relationship.

14 (l) "Dispense" means to deliver a controlled substance to an ultimate
15 user or research subject by or pursuant to the lawful order of a practitioner,
16 including the packaging, labeling or compounding necessary to prepare the
17 substance for that delivery, or pursuant to the prescription of a mid-level
18 practitioner.

19 (m) "Dispenser" means a practitioner or pharmacist who dispenses, or
20 a physician assistant who has authority to dispense prescription-only drugs
21 in accordance with ~~subsection (b)~~ of K.S.A. 65-28a08(b), and amendments
22 thereto.

23 (n) "Distribute" means to deliver other than by administering or
24 dispensing a controlled substance.

25 (o) "Distributor" means a person who distributes.

26 (p) "Drug" means: (1) Substances recognized as drugs in the official
27 United States pharmacopoeia, official homeopathic pharmacopoeia of the
28 United States or official national formulary or any supplement to any of
29 them; (2) substances intended for use in the diagnosis, cure, mitigation,
30 treatment or prevention of disease in man or animals; (3) substances (other
31 than food) intended to affect the structure or any function of the body of
32 man or animals; and (4) substances intended for use as a component of any
33 article specified in ~~clause (1), (2) or (3) of this subsection~~ (p)(1), (2) or (3).
34 It does not include devices or their components, parts or accessories.

35 (q) "Immediate precursor" means a substance which the board has
36 found to be and by rule and regulation designates as being the principal
37 compound commonly used or produced primarily for use and which is an
38 immediate chemical intermediary used or likely to be used in the
39 manufacture of a controlled substance, the control of which is necessary to
40 prevent, curtail or limit manufacture.

41 (r) "Electronic prescription" means an electronically prepared
42 prescription that is authorized and transmitted from the prescriber to the
43 pharmacy by means of electronic transmission.

1 (s) "Electronic prescription application" means software that is used
2 to create electronic prescriptions and that is intended to be installed on the
3 prescriber's computers and servers where access and records are controlled
4 by the prescriber.

5 (t) "Electronic signature" means a confidential personalized digital
6 key, code, number or other method for secure electronic data transmissions
7 which identifies a particular person as the source of the message,
8 authenticates the signatory of the message and indicates the person's
9 approval of the information contained in the transmission.

10 (u) "Electronic transmission" means the transmission of an electronic
11 prescription, formatted as an electronic data file, from a prescriber's
12 electronic prescription application to a pharmacy's computer, where the
13 data file is imported into the pharmacy prescription application.

14 (v) "Electronically prepared prescription" means a prescription that is
15 generated using an electronic prescription application.

16 (w) "Facsimile transmission" or "fax transmission" means the
17 transmission of a digital image of a prescription from the prescriber or the
18 prescriber's agent to the pharmacy. "Facsimile transmission" includes, but
19 is not limited to, transmission of a written prescription between the
20 prescriber's fax machine and the pharmacy's fax machine; transmission of
21 an electronically prepared prescription from the prescriber's electronic
22 prescription application to the pharmacy's fax machine, computer or
23 printer; or transmission of an electronically prepared prescription from the
24 prescriber's fax machine to the pharmacy's fax machine, computer or
25 printer.

26 (x) "Intermediary" means any technology system that receives and
27 transmits an electronic prescription between the prescriber and the
28 pharmacy.

29 (y) "Isomer" means all enantiomers and diastereomers.

30 (z) "Manufacture" means the production, preparation, propagation,
31 compounding, conversion or processing of a controlled substance either
32 directly or indirectly or by extraction from substances of natural origin or
33 independently by means of chemical synthesis or by a combination of
34 extraction and chemical synthesis and includes any packaging or
35 repackaging of the substance or labeling or relabeling of its container,
36 except that this term does not include the preparation or compounding of a
37 controlled substance by an individual for the individual's own lawful use
38 or the preparation, compounding, packaging or labeling of a controlled
39 substance:

40 (1) By a practitioner or the practitioner's agent pursuant to a lawful
41 order of a practitioner as an incident to the practitioner's administering or
42 dispensing of a controlled substance in the course of the practitioner's
43 professional practice; or

(2) by a practitioner or by the practitioner's authorized agent under such practitioner's supervision for the purpose of or as an incident to research, teaching or chemical analysis or by a pharmacist or medical care facility as an incident to dispensing of a controlled substance.

(aa) "Marijuana" means all parts of all varieties of the plant *Cannabis* whether growing or not, the seeds thereof, the resin extracted from any part of the plant and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, except the resin extracted therefrom, fiber, oil, or cake or the sterilized seed of the plant which is incapable of germination.

(bb) "Medical care facility" shall have the meaning ascribed to that term in K.S.A. 65-425, and amendments thereto.

(cc) "Mid-level practitioner" means ~~an advanced practice registered nurse issued a license pursuant to K.S.A. 65-1131, and amendments thereto, who has authority to prescribe drugs pursuant to a written protocol with a responsible physician under K.S.A. 65-1130, and amendments thereto, or a physician assistant licensed under the physician assistant licensure act who has authority to prescribe drugs pursuant to a written protocol with a supervising physician under K.S.A. 65-28a08, and amendments thereto.~~

(dd) "Narcotic drug" means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) Opium and opiate and any salt, compound, derivative or preparation of opium or opiate;

(2) any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of the substances referred to in ~~clause~~ *paragraph* (1) but not including the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, compound, derivative or preparation of coca leaves, and any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine.

(ee) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled

1 under K.S.A. 65-4102, and amendments thereto, the dextrorotatory isomer
2 of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does
3 include its racemic and levorotatory forms.

4 (ff) "Opium poppy" means the plant of the species *Papaver*
5 *somniferum* L. except its seeds.

6 (gg) "Person" means an individual, corporation, government, or
7 governmental subdivision or agency, business trust, estate, trust,
8 partnership or association or any other legal entity.

9 (hh) "Pharmacist" means any natural person licensed under K.S.A.
10 65-1625 et seq., to practice pharmacy.

11 (ii) "Pharmacist intern" means: (1) A student currently enrolled in an
12 accredited pharmacy program; (2) a graduate of an accredited pharmacy
13 program serving such person's internship; or (3) a graduate of a pharmacy
14 program located outside of the United States which is not accredited and
15 who had successfully passed equivalency examinations approved by the
16 board.

17 (jj) "Pharmacy prescription application" means software that is used
18 to process prescription information, is installed on a pharmacy's computers
19 and servers, and is controlled by the pharmacy.

20 (kk) "Poppy straw" means all parts, except the seeds, of the opium
21 poppy, after mowing.

22 (ll) "Practitioner" means a person licensed to practice medicine and
23 surgery, dentist, podiatrist, veterinarian, optometrist, *advanced practice*
24 *registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
25 *amendments thereto, and who has authority to prescribe drugs in*
26 *accordance with K.S.A. 65-1130, and amendments thereto*, or scientific
27 investigator or other person authorized by law to use a controlled
28 substance in teaching or chemical analysis or to conduct research with
29 respect to a controlled substance.

30 (mm) "Prescriber" means a practitioner or a mid-level practitioner.

31 (nn) "Production" includes the manufacture, planting, cultivation,
32 growing or harvesting of a controlled substance.

33 (oo) "Readily retrievable" means that records kept by automatic data
34 processing applications or other electronic or mechanized recordkeeping
35 systems can be separated out from all other records within a reasonable
36 time not to exceed 48 hours of a request from the board or other authorized
37 agent or that hard-copy records are kept on which certain items are
38 asterisked, redlined or in some other manner visually identifiable apart
39 from other items appearing on the records.

40 (pp) "Ultimate user" means a person who lawfully possesses a
41 controlled substance for such person's own use or for the use of a member
42 of such person's household or for administering to an animal owned by
43 such person or by a member of such person's household.

1 Sec. 18. K.S.A. 2014 Supp. 65-4116 is hereby amended to read as
2 follows: 65-4116. (a) Every person who manufactures, distributes or
3 dispenses any controlled substance within this state or who proposes to
4 engage in the manufacture, distribution or dispensing of any controlled
5 substance within this state shall obtain annually a registration issued by the
6 board in accordance with the uniform controlled substances act and with
7 rules and regulations adopted by the board.

8 (b) Persons registered by the board under this act to manufacture,
9 distribute, dispense or conduct research with controlled substances may
10 possess, manufacture, distribute, dispense or conduct research with those
11 substances to the extent authorized by their registration and in conformity
12 with the other provisions of this act.

13 (c) The following persons need not register and may lawfully possess
14 controlled substances under this act, as specified in this subsection:

15 (1) An agent or employee of any registered manufacturer, distributor
16 or dispenser of any controlled substance if the agent or employee is acting
17 in the usual course of such agent or employee's business or employment;

18 (2) a common carrier or warehouseman or an employee thereof
19 whose possession of any controlled substance is in the usual course of
20 business or employment;

21 (3) an ultimate user or a person in possession of any controlled
22 substance pursuant to a lawful order of a practitioner or a mid-level
23 practitioner or in lawful possession of a schedule V substance;

24 (4) persons licensed and registered by the board under the provisions
25 of the acts contained in article 16 of chapter 65 of the Kansas Statutes
26 Annotated, and amendments thereto, to manufacture, dispense or distribute
27 drugs are considered to be in compliance with the registration provision of
28 the uniform controlled substances act without additional proceedings
29 before the board or the payment of additional fees, except that
30 manufacturers and distributors shall complete and file the application form
31 required under the uniform controlled substances act;

32 (5) any person licensed by the state board of healing arts under the
33 Kansas healing arts act;

34 (6) any person licensed by the state board of veterinary examiners;

35 (7) any person licensed by the Kansas dental board;

36 (8) a mid-level practitioner; ~~and~~

37 (9) any person who is a member of the Native American Church, with
38 respect to use or possession of peyote, whose use or possession of peyote
39 is in, or for use in, bona fide religious ceremonies of the Native American
40 Church, but nothing in this paragraph shall authorize the use or possession
41 of peyote in any place used for the confinement or housing of persons
42 arrested, charged or convicted of criminal offenses or in the state security
43 hospital; *and*

1 (10) *any person licensed as an advanced practice registered nurse*
2 *under K.S.A. 65-1131, and amendments thereto, and who has authority to*
3 *prescribe drugs in accordance with K.S.A. 65-1130, and amendments*
4 *thereto.*

5 (d) (1) The board may waive by rules and regulations the requirement
6 for registration of certain manufacturers, distributors or dispensers if the
7 board finds it consistent with the public health and safety, except that
8 licensure of any person by the state board of healing arts to practice any
9 branch of the healing arts, Kansas dental board~~or~~, the state board of
10 veterinary examiners *or the board of nursing of advanced practice*
11 *registered nurses* shall constitute compliance with the registration
12 requirements of the uniform controlled substances act by such person for
13 such person's place of professional practice.

14 (2) Evidence of abuse as determined by the board relating to a person
15 licensed by the state board of healing arts shall be submitted to the state
16 board of healing arts and the attorney general within 60 days. The state
17 board of healing arts shall, within 60 days, make findings of fact and take
18 such action against such person as it deems necessary. All findings of fact
19 and any action taken shall be reported by the state board of healing arts to
20 the board of pharmacy and the attorney general.

21 (3) Evidence of abuse as determined by the board relating to a person
22 licensed by the state board of veterinary examiners shall be submitted to
23 the state board of veterinary examiners and the attorney general within 60
24 days. The state board of veterinary examiners shall, within 60 days, make
25 findings of fact and take such action against such person as it deems
26 necessary. All findings of fact and any action taken shall be reported by the
27 state board of veterinary examiners to the board of pharmacy and the
28 attorney general.

29 (4) Evidence of abuse as determined by the board relating to a dentist
30 licensed by the Kansas dental board shall be submitted to the Kansas
31 dental board and the attorney general within 60 days. The Kansas dental
32 board shall, within 60 days, make findings of fact and take such action
33 against such dentist as it deems necessary. All findings of fact and any
34 action taken shall be reported by the Kansas dental board to the board of
35 pharmacy and the attorney general.

36 (5) *Evidence of abuse as determined by the board relating to an*
37 *advanced practice registered nurse licensed by the board of nursing shall*
38 *be submitted to the board of nursing and the attorney general within 60*
39 *days. The board of nursing shall, within 60 days, make findings of fact and*
40 *take such action against such advanced practice registered nurse as it*
41 *deems necessary. All findings of fact and any action taken shall be*
42 *reported by the board of nursing to the board of pharmacy and the*
43 *attorney general.*

1 (e) A separate annual registration is required at each place of business
2 or professional practice where the applicant manufactures, distributes or
3 dispenses controlled substances.

4 (f) The board may inspect the establishment of a registrant or
5 applicant for registration in accordance with the board's rules and
6 regulations.

7 (g) (1) The registration of any person or location shall terminate when
8 such person or authorized representative of a location dies, ceases legal
9 existence, discontinues business or professional practice or changes the
10 location as shown on the certificate of registration. Any registrant who
11 ceases legal existence, discontinues business or professional practice, or
12 changes location as shown on the certificate of registration, shall notify the
13 board promptly of such fact and forthwith deliver the certificate of
14 registration directly to the secretary or executive secretary of the board. In
15 the event of a change in name or mailing address the person or authorized
16 representative of the location shall notify the board promptly in advance of
17 the effective date of this change by filing the change of name or mailing
18 address with the board. This change shall be noted on the original
19 application on file with the board.

20 (2) No registration or any authority conferred thereby shall be
21 assigned or otherwise transferred except upon such conditions as the board
22 may specifically designate and then only pursuant to the written consent of
23 the board.

24 Sec. 19. K.S.A. 65-4134 is hereby amended to read as follows: 65-
25 4134. A practitioner engaged in medical practice or research, *a*
26 *practitioner who is an advanced practice registered nurse acting in the*
27 *usual course of such practitioner's practice* or a mid-level practitioner
28 acting in the usual course of such mid-level practitioner's practice is not
29 required or compelled to furnish the name or identity of a patient or
30 research subject to the board, nor may such practitioner or mid-level
31 practitioner be compelled in any state or local civil, criminal,
32 administrative, legislative or other proceedings to furnish the name or
33 identity of an individual that the practitioner or mid-level practitioner is
34 obligated to keep confidential.

35 Sec. 20. K.S.A. 2014 Supp. 65-4202 is hereby amended to read as
36 follows: 65-4202. As used in this act: (a) "Board" means the state board of
37 nursing.

38 (b) The "practice of mental health technology" means the
39 performance, under the direction of a physician licensed to practice
40 medicine and surgery or registered professional nurse, of services in caring
41 for and treatment of the mentally ill, emotionally disturbed, or people with
42 intellectual disability for compensation or personal profit, which services:

43 (1) Involve responsible nursing and therapeutic procedures for

1 patients with mental illness or intellectual disability requiring interpersonal
2 and technical skills in the observations and recognition of symptoms and
3 reactions of such patients, the accurate recording of such symptoms and
4 reactions and the carrying out of treatments and medications as prescribed
5 by a licensed physician, *a licensed advanced practice registered nurse* or a
6 mid-level practitioner as defined in subsection (ii) of ~~by~~ K.S.A. 65-1626,
7 and amendments thereto; and

8 (2) require an application of techniques and procedures that involve
9 understanding of cause and effect and the safeguarding of life and health
10 of the patient and others; and

11 (3) require the performance of duties that are necessary to facilitate
12 rehabilitation of the patient or are necessary in the physical, therapeutic
13 and psychiatric care of the patient and require close work with persons
14 licensed to practice medicine and surgery, psychiatrists, psychologists,
15 rehabilitation therapists, social workers, registered nurses, and other
16 professional personnel.

17 (c) A "licensed mental health technician" means a person who
18 lawfully practices mental health technology as defined in this act.

19 (d) An "approved course in mental health technology" means a
20 program of training and study including a basic curriculum which shall be
21 prescribed and approved by the board in accordance with the standards
22 prescribed herein, the successful completion of which shall be required
23 before licensure as a mental health technician, except as hereinafter
24 provided.

25 Sec. 21. K.S.A. 2014 Supp. 65-5402 is hereby amended to read as
26 follows: 65-5402. As used in K.S.A. 65-5401 to 65-5417, inclusive, and
27 K.S.A. 65-5418 to 65-5420, inclusive, and amendments thereto:

28 (a) "Board" means the state board of healing arts.

29 (b) "Practice of occupational therapy" means the therapeutic use of
30 purposeful and meaningful occupations (goal-directed activities) to
31 evaluate and treat, pursuant to the referral, supervision, order or direction
32 of a physician, a licensed podiatrist, a licensed dentist, a licensed physician
33 assistant, ~~or a licensed advanced practice registered nurse~~ working
34 pursuant to the order or direction of a person licensed to practice medicine
35 and surgery, *a licensed advanced practice registered nurse*, a licensed
36 chiropractor, or a licensed optometrist, individuals who have a disease or
37 disorder, impairment, activity limitation or participation restriction that
38 interferes with their ability to function independently in daily life roles and
39 to promote health and wellness. Occupational therapy intervention may
40 include:

41 (1) Remediation or restoration of performance abilities that are
42 limited due to impairment in biological, physiological, psychological or
43 neurological cognitive processes;

1 (2) adaptation of tasks, process, or the environment or the teaching of
2 compensatory techniques in order to enhance performance;

3 (3) disability prevention methods and techniques that facilitate the
4 development or safe application of performance skills; and

5 (4) health promotion strategies and practices that enhance
6 performance abilities.

7 (c) "Occupational therapy services" include, but are not limited to:

8 (1) Evaluating, developing, improving, sustaining, or restoring skills
9 in activities of daily living (ADL), work or productive activities, including
10 instrumental activities of daily living (IADL) and play and leisure
11 activities;

12 (2) evaluating, developing, remediating, or restoring sensorimotor,
13 cognitive or psychosocial components of performance;

14 (3) designing, fabricating, applying, or training in the use of assistive
15 technology or orthotic devices and training in the use of prosthetic devices;

16 (4) adapting environments and processes, including the application of
17 ergonomic principles, to enhance performance and safety in daily life
18 roles;

19 (5) applying physical agent modalities as an adjunct to or in
20 preparation for engagement in occupations;

21 (6) evaluating and providing intervention in collaboration with the
22 client, family, caregiver or others;

23 (7) educating the client, family, caregiver or others in carrying out
24 appropriate nonskilled interventions; and

25 (8) consulting with groups, programs, organizations or communities
26 to provide population-based services.

27 (d) "Occupational therapist" means a person licensed to practice
28 occupational therapy as defined in this act.

29 (e) "Occupational therapy assistant" means a person licensed to assist
30 in the practice of occupational therapy under the supervision of an
31 occupational therapist.

32 (f) "Person" means any individual, partnership, unincorporated
33 organization or corporation.

34 (g) "Physician" means a person licensed to practice medicine and
35 surgery.

36 (h) "Occupational therapy aide," "occupational therapy tech" or
37 "occupational therapy paraprofessional" means a person who provides
38 supportive services to occupational therapists and occupational therapy
39 assistants in accordance with K.S.A. 65-5419, and amendments thereto.

40 Sec. 22. K.S.A. 2014 Supp. 65-5418 is hereby amended to read as
41 follows: 65-5418. (a) Nothing in the occupational therapy practice act is
42 intended to limit, preclude or otherwise interfere with the practices of
43 other health care providers formally trained and licensed, registered,

1 credentialed or certified by appropriate agencies of the state of Kansas.

2 (b) The practice of occupational therapy shall not be construed to
3 include the following:

4 (1) Persons rendering assistance in the case of an emergency;

5 (2) members of any church practicing their religious tenets;

6 (3) persons whose services are performed pursuant to the delegation
7 of and under the supervision of an occupational therapist who is licensed
8 under this act;

9 (4) any person employed as an occupational therapist or occupational
10 therapy assistant by the government of the United States or any agency
11 thereof, if such person practices occupational therapy solely under the
12 direction or control of the organization by which such person is employed;

13 (5) licensees under the healing arts act when licensed and practicing
14 in accordance with the provisions of law or persons performing services
15 pursuant to a delegation authorized under ~~subsection (g) of~~ K.S.A. 65-
16 2872(g), and amendments thereto;

17 (6) dentists practicing their professions, when licensed and practicing
18 in accordance with the provisions of law;

19 (7) nurses practicing their professions, when licensed and practicing
20 in accordance with the provisions of law or persons performing services
21 pursuant to the delegation of a licensed nurse under ~~subsection (m) of~~
22 K.S.A. 65-1124(m), and amendments thereto;

23 (8) health care providers who have been formally trained and are
24 practicing in accordance with the training or have received specific
25 training in one or more functions included in the occupational therapy
26 practice act pursuant to established educational protocols, or both;

27 (9) any person pursuing a supervised course of study leading to a
28 degree or certificate in occupational therapy at an accredited or approved
29 educational program, if the person is designated by the title which clearly
30 indicates such person's status as a student or trainee;

31 (10) any person fulfilling the supervised fieldwork experience
32 requirements as part of the experience necessary to meet the requirement
33 of the occupational therapy practice act;

34 (11) self-care by a patient or gratuitous care by a friend or family
35 member who does not represent or hold oneself out to the public to be an
36 occupational therapist or an occupational therapy assistant;

37 (12) optometrists practicing their profession when licensed and
38 practicing in accordance with the provisions of article 15 of chapter 65 of
39 the Kansas Statutes Annotated, and amendments thereto;

40 (13) podiatrists practicing their profession when licensed and
41 practicing in accordance with the provisions of article 15 of chapter 65 of
42 the Kansas Statutes Annotated, and amendments thereto;

43 (14) physical therapists practicing their profession when licensed and

1 practicing in accordance with K.S.A. 65-2901 et seq., and amendments
2 thereto;

3 (15) physician assistants practicing their profession when licensed
4 and practicing in accordance with the physician assistant licensure act;

5 (16) athletic trainers practicing their profession when licensed and
6 practicing in accordance with the athletic trainers licensure act;

7 (17) manufacturers of prosthetic devices;

8 (18) any person performing occupational therapy services, if these
9 services are performed for no more than 45 days in a calendar year in
10 association with an occupational therapist licensed under the occupational
11 therapy practice act so long as: (A) The person is registered or licensed
12 under the laws of another state which has licensure requirements at least as
13 stringent as the licensure requirements of this act; or (B) the person meets
14 the requirements for certification as an occupational therapist registered
15 (OTR) or a certified occupational therapy assistant (COTA) established by
16 the national board for certification in occupational therapy (NBCOT).

17 (c) Any patient monitoring, assessment or other procedures designed
18 to evaluate the effectiveness of prescribed occupational therapy must be
19 performed by or pursuant to the delegation of a licensed occupational
20 therapist or other health care provider.

21 (d) Education related therapy services provided by an occupational
22 therapist to school systems or consultation regarding prevention,
23 ergonomics and wellness within the occupational therapy scope of practice
24 shall not require a referral, supervision, order or direction of a physician,
25 *an advanced practice registered nurse*, a licensed podiatrist, a licensed
26 dentist or a licensed optometrist. However, when in the course of
27 providing such services an occupational therapist reasonably believes that
28 an individual may have an underlying injury, illness, disease, disorder or
29 impairment, the occupational therapist shall refer the individual to a
30 physician, *an advanced practice registered nurse*, a licensed podiatrist, a
31 licensed dentist or a licensed optometrist, as appropriate.

32 (e) Nothing in the occupational therapy practice act shall be construed
33 to permit the practice of medicine and surgery. No statute granting
34 authority to licensees of the state board of healing arts shall be construed
35 to confer authority upon occupational therapists to engage in any activity
36 not conferred by the occupational therapy practice act.

37 (f) This section shall be part of and supplemental to the occupational
38 therapy practice act.

39 Sec. 23. K.S.A. 65-5502 is hereby amended to read as follows: 65-
40 5502. As used in K.S.A. 65-5501 to 65-5517, inclusive and amendments
41 thereto:

42 (a) "Board" means the state board of healing arts.

43 (b) "Respiratory therapy" is a health care profession whose therapists

1 practice under the supervision of a qualified medical director and with the
2 prescription of a licensed physician *or an advanced practice registered*
3 *nurse* providing therapy, management, rehabilitation, respiratory
4 assessment and care of patients with deficiencies and abnormalities which
5 affect the pulmonary system and associated other systems functions. The
6 duties which may be performed by a respiratory therapist include:

7 (1) Direct and indirect respiratory therapy services that are safe,
8 aseptic, preventative and restorative to the patient.

9 (2) Direct and indirect respiratory therapy services, including but not
10 limited to, the administration of pharmacological and diagnostic and
11 therapeutic agents related to respiratory therapy procedures to implement a
12 treatment, disease prevention or pulmonary rehabilitative regimen
13 prescribed by a physician *or an advanced practice registered nurse*.

14 (3) Administration of medical gases, exclusive of general anesthesia,
15 aerosols, humidification and environmental control systems.

16 (4) Transcription and implementation of written or verbal orders of a
17 physician *or an advanced practice registered nurse* pertaining to the
18 practice of respiratory therapy.

19 (5) Implementation of respiratory therapy protocols as defined by the
20 medical staff of an institution or a qualified medical director or other
21 written protocol, changes in treatment pursuant to the written or verbal
22 orders of a physician *or an advanced practice registered nurse* or the
23 initiation of emergency procedures as authorized by written protocols.

24 (c) "Respiratory therapist" means a person who is licensed to practice
25 respiratory therapy as defined in this act.

26 (d) "Person" means any individual, partnership, unincorporated
27 organization or corporation.

28 (e) "Physician" means a person who is licensed by the board to
29 practice medicine and surgery.

30 (f) "Qualified medical director" means the medical director of any
31 inpatient or outpatient respiratory therapy service, department or home
32 care agency. The medical director shall be a physician who has interest and
33 knowledge in the diagnosis and treatment of respiratory problems. This
34 physician shall be responsible for the quality, safety and appropriateness of
35 the respiratory services provided and require that respiratory therapy be
36 ordered by a physician *or an advanced practice registered nurse* who has
37 medical responsibility for the patient. The medical director shall be readily
38 accessible to the respiratory therapy practitioner.

39 (g) "Advanced practice registered nurse" means an advanced
40 practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
41 amendments thereto, and who has authority to prescribe drugs in
42 accordance with K.S.A. 65-1130, and amendments thereto.

43 Sec. 24. K.S.A. 2013 Supp. 65-6112, as amended by section 51 of

1 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
2 read as follows: 65-6112. As used in this act:

3 (a) "Administrator" means the executive director of the emergency
4 medical services board.

5 (b) "Advanced emergency medical technician" means a person who
6 holds an advanced emergency medical technician certificate issued
7 pursuant to this act.

8 (c) "Advanced practice registered nurse" means an advanced practice
9 registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

10 (d) "Ambulance" means any privately or publicly owned motor
11 vehicle, airplane or helicopter designed, constructed, prepared, staffed and
12 equipped for use in transporting and providing emergency care for
13 individuals who are ill or injured.

14 (e) "Ambulance service" means any organization operated for the
15 purpose of transporting sick or injured persons to or from a place where
16 medical care is furnished, whether or not such persons may be in need of
17 emergency or medical care in transit.

18 (f) "Attendant" means a first responder, an emergency medical
19 responder, emergency medical technician, emergency medical technician-
20 intermediate, emergency medical technician-defibrillator, emergency
21 medical technician-intermediate/defibrillator, advanced emergency
22 medical technician, mobile intensive care technician or paramedic certified
23 pursuant to this act.

24 (g) "Board" means the emergency medical services board established
25 pursuant to K.S.A. 65-6102, and amendments thereto.

26 (h) "Emergency medical service" means the effective and coordinated
27 delivery of such care as may be required by an emergency which includes
28 the care and transportation of individuals by ambulance services and the
29 performance of authorized emergency care by a physician, advanced
30 practice registered nurse, professional nurse, a licensed physician assistant
31 or attendant.

32 (i) "Emergency medical technician" means a person who holds an
33 emergency medical technician certificate issued pursuant to this act.

34 (j) "Emergency medical technician-defibrillator" means a person who
35 holds an emergency medical technician-defibrillator certificate issued
36 pursuant to this act.

37 (k) "Emergency medical technician-intermediate" means a person
38 who holds an emergency medical technician-intermediate certificate issued
39 pursuant to this act.

40 (l) "Emergency medical technician-intermediate/defibrillator" means
41 a person who holds both an emergency medical technician-intermediate
42 and emergency medical technician-defibrillator certificate issued pursuant
43 to this act.

1 (m) "Emergency medical responder" means a person who holds an
2 emergency medical responder certificate issued pursuant to this act.

3 (n) "First responder" means a person who holds a first responder
4 certificate issued pursuant to this act.

5 (o) "Hospital" means a hospital as defined by K.S.A. 65-425, and
6 amendments thereto.

7 (p) "Instructor-coordinator" means a person who is certified under
8 this act to teach initial certification and continuing education classes.

9 (q) "Medical director" means a physician.

10 (r) "Medical protocols" mean written guidelines which authorize
11 attendants to perform certain medical procedures prior to contacting a
12 physician, physician assistant authorized by a physician, advanced practice
13 registered nurse ~~authorized by a physician~~ or professional nurse authorized
14 by a physician. The medical protocols shall be approved by a county
15 medical society or the medical staff of a hospital to which the ambulance
16 service primarily transports patients, or if neither of the above are able or
17 available to approve the medical protocols, then the medical protocols
18 shall be submitted to the medical advisory council for approval.

19 (s) "Mobile intensive care technician" means a person who holds a
20 mobile intensive care technician certificate issued pursuant to this act.

21 (t) "Municipality" means any city, county, township, fire district or
22 ambulance service district.

23 (u) "Nonemergency transportation" means the care and transport of a
24 sick or injured person under a foreseen combination of circumstances
25 calling for continuing care of such person. As used in this subsection,
26 transportation includes performance of the authorized level of services of
27 the attendant whether within or outside the vehicle as part of such
28 transportation services.

29 (v) "Operator" means a person or municipality who has a permit to
30 operate an ambulance service in the state of Kansas.

31 (w) "Paramedic" means a person who holds a paramedic certificate
32 issued pursuant to this act.

33 (x) "Person" means an individual, a partnership, an association, a
34 joint-stock company or a corporation.

35 (y) "Physician" means a person licensed by the state board of healing
36 arts to practice medicine and surgery.

37 (z) "Physician assistant" means a person who is licensed under the
38 physician assistant licensure act and who is acting under the direction of a
39 supervising physician.

40 (aa) "Professional nurse" means a licensed professional nurse as
41 defined by K.S.A. 65-1113, and amendments thereto.

42 (bb) "Provider of training" means a corporation, partnership,
43 accredited postsecondary education institution, ambulance service, fire

1 department, hospital or municipality that conducts training programs that
2 include, but are not limited to, initial courses of instruction and continuing
3 education for attendants, instructor-coordinators or training officers.

4 (cc) "Supervising physician" means supervising physician as such
5 term is defined under K.S.A. 65-28a02, and amendments thereto.

6 (dd) "Training officer" means a person who is certified pursuant to
7 this act to teach, coordinate or both, initial courses of instruction for first
8 responders or emergency medical responders and continuing education as
9 prescribed by the board.

10 Sec. 25. K.S.A. 2014 Supp. 65-6119 is hereby amended to read as
11 follows: 65-6119. (a) Notwithstanding any other provision of law, mobile
12 intensive care technicians may:

13 (1) Perform all the authorized activities identified in K.S.A. 65-6120,
14 65-6121, 65-6123, 65-6144, and amendments thereto;

15 (2) when voice contact or a telemetered electrocardiogram is
16 monitored by a physician, physician assistant where authorized by a
17 physician, an advanced practice registered nurse ~~where authorized by a~~
18 ~~physician~~ or licensed professional nurse where authorized by a physician
19 and direct communication is maintained, and upon order of such person
20 may administer such medications or procedures as may be deemed
21 necessary by a person identified in subsection (a)(2);

22 (3) perform, during an emergency, those activities specified in
23 subsection (a)(2) before contacting a person identified in subsection (a)(2)
24 when specifically authorized to perform such activities by medical
25 protocols; and

26 (4) perform, during nonemergency transportation, those activities
27 specified in this section when specifically authorized to perform such
28 activities by medical protocols.

29 (b) An individual who holds a valid certificate as a mobile intensive
30 care technician once meeting the continuing education requirements
31 prescribed by the rules and regulations of the board, upon application for
32 renewal, shall be deemed to hold a certificate as a paramedic under this
33 act, and such individual shall not be required to file an original application
34 as a paramedic for certification under this act.

35 (c) "Renewal" as used in subsection (b), refers to the first opportunity
36 that a mobile intensive care technician has to apply for renewal of a
37 certificate following the effective date of this act.

38 (d) Upon transition notwithstanding any other provision of law, a
39 paramedic may:

40 (1) Perform all the authorized activities identified in K.S.A. 65-6120,
41 65-6121, 65-6144, and amendments thereto;

42 (2) when voice contact or a telemetered electrocardiogram is
43 monitored by a physician, physician assistant where authorized by a

1 physician or an advanced practice registered nurse ~~where authorized by a~~
2 ~~physician~~ or licensed professional nurse where authorized by a physician
3 and direct communication is maintained, and upon order of such person,
4 may administer such medications or procedures as may be deemed
5 necessary by a person identified in subsection (d)(2);

6 (3) perform, during an emergency, those activities specified in
7 subsection (d)(2) before contacting a person identified in subsection (d)(2)
8 when specifically authorized to perform such activities by medical
9 protocols; and

10 (4) perform, during nonemergency transportation, those activities
11 specified in this section when specifically authorized to perform such
12 activities by medical protocols.

13 Sec. 26. K.S.A. 2014 Supp. 65-6120 is hereby amended to read as
14 follows: 65-6120. (a) Notwithstanding any other provision of law to the
15 contrary, an emergency medical technician-intermediate may:

16 (1) Perform any of the activities identified by K.S.A. 65-6121, and
17 amendments thereto;

18 (2) when approved by medical protocols or where voice contact by
19 radio or telephone is monitored by a physician, physician assistant where
20 authorized by a physician, advanced practice registered nurse ~~where~~
21 ~~authorized by a physician~~ or licensed professional nurse where authorized
22 by a physician, and direct communication is maintained, upon order of
23 such person, may perform veni-puncture for the purpose of blood sampling
24 collection and initiation and maintenance of intravenous infusion of saline
25 solutions, dextrose and water solutions or ringers lactate IV solutions,
26 endotracheal intubation and administration of nebulized albuterol;

27 (3) perform, during an emergency, those activities specified in
28 subsection (a)(2) before contacting the persons identified in subsection (a)
29 (2) when specifically authorized to perform such activities by medical
30 protocols; or

31 (4) perform, during nonemergency transportation, those activities
32 specified in this section when specifically authorized to perform such
33 activities by medical protocols.

34 (b) An individual who holds a valid certificate as an emergency
35 medical technician-intermediate once successfully completing the board
36 prescribed transition course, and validation of cognitive and psychomotor
37 competency as determined by rules and regulations of the board, may
38 apply to transition to become an advanced emergency medical technician.
39 Alternatively, upon application for renewal, such individual shall be
40 deemed to hold a certificate as an advanced emergency medical technician
41 under this act, provided such individual has completed all continuing
42 education hour requirements inclusive of the successful completion of a
43 transition course and such individual shall not be required to file an

1 original application for certification as an advanced emergency medical
2 technician under this act.

3 (c) "Renewal" as used in subsection (b), refers to the first or second
4 opportunity after December 31, 2011, that an emergency medical
5 technician-intermediate has to apply for renewal of a certificate.

6 (d) Emergency medical technician-intermediates who fail to meet the
7 transition requirements as specified may complete either the board
8 prescribed emergency medical technician transition course or emergency
9 medical responder transition course, provide validation of cognitive and
10 psychomotor competency and all continuing education hour requirements
11 inclusive of the successful completion of a transition course as determined
12 by rules and regulations of the board. Upon completion, such emergency
13 medical technician-intermediate may apply to transition to become an
14 emergency medical technician or an emergency medical responder,
15 depending on the transition course that was successfully completed.
16 Alternatively, upon application for renewal of an emergency medical
17 technician-intermediate certificate, the applicant shall be renewed as an
18 emergency medical technician or an emergency medical responder,
19 depending on the transition course that was successfully completed. Such
20 individual shall not be required to file an original application for
21 certification as an emergency medical technician or emergency medical
22 responder.

23 (e) Failure to successfully complete either an advanced emergency
24 medical technician transition course, an emergency medical technician
25 transition course or emergency medical responder transition course will
26 result in loss of certification.

27 (f) Upon transition, notwithstanding any other provision of law to the
28 contrary, an advanced emergency medical technician may:

29 (1) Perform any of the activities identified by K.S.A. 65-6121, and
30 amendments thereto; and

31 (2) perform any of the following interventions, by use of the devices,
32 medications and equipment, or any combination thereof, as specifically
33 identified in rules and regulations, after successfully completing an
34 approved course of instruction, local specialized device training and
35 competency validation and when authorized by medical protocols, or upon
36 order when direct communication is maintained by radio, telephone or
37 video conference with a physician, physician assistant where authorized by
38 a physician, an advanced practice registered nurse ~~where authorized by a~~
39 ~~physician~~, or licensed professional nurse where authorized by a physician
40 upon order of such a person: (A) Continuous positive airway pressure
41 devices; (B) advanced airway management; (C) referral of patient of
42 alternate medical care site based on assessment; (D) transportation of a
43 patient with a capped arterial line; (E) venipuncture for obtaining blood

1 sample; (F) initiation and maintenance of intravenous infusion or saline
2 lock; (G) initiation of intraosseous infusion; (H) nebulized therapy; (I)
3 manual defibrillation and cardioversion; (J) cardiac monitoring; (K)
4 electrocardiogram interpretation; (L) administration of generic or trade
5 name medications by one or more of the following methods: (i)
6 Aerosolization; (ii) nebulization; (iii) intravenous; (iv) intranasal; (v)
7 rectal; (vi) subcutaneous; (vii) intraosseous; (viii) intramuscular; or (ix)
8 sublingual.

9 (g) An individual who holds a valid certificate as both an emergency
10 medical technician-intermediate and as an emergency medical technician-
11 defibrillator once successfully completing the board prescribed transition
12 course, and validation of cognitive and psychomotor competency as
13 determined by rules and regulations of the board, may apply to transition
14 to an advanced emergency medical technician. Alternatively, upon
15 application for renewal, such individual shall be deemed to hold a
16 certificate as an advanced emergency medical technician under this act,
17 provided such individual has completed all continuing education hour
18 requirements inclusive of successful completion of a transition course, and
19 such individual shall not be required to file an original application for
20 certification as an advanced emergency medical technician under this act.

21 (h) "Renewal" as used in subsection (g), refers to the first or second
22 opportunity after December 31, 2011, that an emergency medical
23 technician-intermediate and emergency medical technician-defibrillator
24 has to apply for renewal of a certificate.

25 (i) An individual who holds both an emergency medical technician-
26 intermediate certificate and an emergency medical technician-defibrillator
27 certificate, who fails to meet the transition requirements as specified may
28 complete either the board prescribed emergency medical technician
29 transition course or emergency medical responder transition course, and
30 provide validation of cognitive and psychomotor competency and all
31 continuing education hour requirements inclusive of successful completion
32 of a transition course as determined by rules and regulations of the board.
33 Upon completion, such individual may apply to transition to become an
34 emergency medical technician or emergency medical responder, depending
35 on the transition course that was successfully completed. Alternatively,
36 upon application for renewal of an emergency medical technician-
37 intermediate certificate and an emergency medical technician-defibrillator
38 certificate, the applicant shall be renewed as an emergency medical
39 technician or an emergency medical responder, depending on the transition
40 course that was successfully completed. Such individual shall not be
41 required to file an original application for certification as an emergency
42 medical technician or emergency medical responder.

43 (j) Failure to successfully complete either the advanced emergency

1 medical technician transition requirements, an emergency medical
2 technician transition course or the emergency medical responder transition
3 course will result in loss of certification.

4 Sec. 27. K.S.A. 2014 Supp. 65-6121 is hereby amended to read as
5 follows: 65-6121. (a) Notwithstanding any other provision of law to the
6 contrary, an emergency medical technician may perform any of the
7 following activities:

- 8 (1) Patient assessment and vital signs;
- 9 (2) airway maintenance including the use of:
 - 10 (A) Oropharyngeal and nasopharyngeal airways;
 - 11 (B) esophageal obturator airways with or without gastric suction
12 device;
 - 13 (C) multi-lumen airway; and
 - 14 (D) oxygen demand valves.
- 15 (3) Oxygen therapy;
- 16 (4) oropharyngeal suctioning;
- 17 (5) cardiopulmonary resuscitation procedures;
- 18 (6) control accessible bleeding;
- 19 (7) apply pneumatic anti-shock garment;
- 20 (8) manage outpatient medical emergencies;
- 21 (9) extricate patients and utilize lifting and moving techniques;
- 22 (10) manage musculoskeletal and soft tissue injuries including
23 dressing and bandaging wounds or the splinting of fractures, dislocations,
24 sprains or strains;
- 25 (11) use of backboards to immobilize the spine;
- 26 (12) administer activated charcoal and glucose;
- 27 (13) monitor intravenous line delivering intravenous fluids during
28 interfacility transport with the following restrictions:
 - 29 (A) The physician approves the transfer by an emergency medical
30 technician;
 - 31 (B) no medications or nutrients have been added to the intravenous
32 fluids; and
 - 33 (C) the emergency medical technician may monitor, maintain and
34 shut off the flow of intravenous fluid;
- 35 (14) use automated external defibrillators;
- 36 (15) administer epinephrine auto-injectors provided that:
 - 37 (A) The emergency medical technician successfully completes a
38 course of instruction approved by the board in the administration of
39 epinephrine;
 - 40 (B) the emergency medical technician serves with an ambulance
41 service or a first response organization that provides emergency medical
42 services; and
 - 43 (C) the emergency medical technician is acting pursuant to medical

1 protocols;

2 (16) perform, during nonemergency transportation, those activities
3 specified in this section when specifically authorized to perform such
4 activities by medical protocols; or

5 (17) when authorized by medical protocol, assist the patient in the
6 administration of the following medications which have been prescribed
7 for that patient: Auto-injection epinephrine, sublingual nitroglycerin and
8 inhalers for asthma and emphysema.

9 (b) An individual who holds a valid certificate as an emergency
10 medical technician at the current basic level once successfully completing
11 the board prescribed transition course, and validation of cognitive and
12 psychomotor competency as determined by rules and regulations of the
13 board, may apply to transition to become an emergency medical
14 technician. Alternatively, upon application for renewal, such individual
15 shall be deemed to hold a certificate as an emergency medical technician
16 under this act, provided such individual has completed all continuing
17 education hour requirements inclusive of successful completion of a
18 transition course, and such individual shall not be required to file an
19 original application for certification as an emergency medical technician.

20 (c) "Renewal" as used in subsection (b), refers to the first opportunity
21 after December 31, 2011, that an emergency medical technician has to
22 apply for renewal of a certificate following the effective date of this act.

23 (d) Emergency medical technicians who fail to meet the transition
24 requirements as specified may successfully complete the board prescribed
25 emergency medical responder transition course, provide validation of
26 cognitive and psychomotor competency and all continuing education hour
27 requirements inclusive of the successful completion of a transition course
28 as determined by rules and regulations of the board. Alternatively, upon
29 application for renewal of an emergency medical technician certificate, the
30 applicant shall be deemed to hold a certificate as an emergency medical
31 responder under this act, and such individual shall not be required to file
32 an original application for certification as an emergency medical
33 responder.

34 (e) Failure to successfully complete either an emergency medical
35 technician transition course or emergency medical responder transition
36 course will result in loss of certification.

37 (f) Upon transition, notwithstanding any other provision of law to the
38 contrary, an emergency medical technician may perform any activities
39 identified in K.S.A. 65-6144, and amendments thereto, and any of the
40 following interventions, by use of the devices, medications and equipment,
41 or any combination thereof, after successfully completing an approved
42 course of instruction, local specialized device training and competency
43 validation and when authorized by medical protocols, or upon order when

1 direct communication is maintained by radio, telephone or video
2 conference is monitored by a physician, physician assistant when
3 authorized by a physician, an advanced practice registered nurse ~~when~~
4 ~~authorized by a physician~~ or a licensed professional nurse when authorized
5 by a physician, upon order of such person:

- 6 (1) Airway maintenance including use of:
 - 7 (A) Single lumen airways as approved by the board;
 - 8 (B) multilumen airways;
 - 9 (C) ventilator devices;
 - 10 (D) forceps removal of airway obstruction;
 - 11 (E) CO2 monitoring;
 - 12 (F) airway suctioning;
- 13 (2) apply pneumatic anti-shock garment;
- 14 (3) assist with childbirth;
- 15 (4) monitoring urinary catheter;
- 16 (5) capillary blood sampling;
- 17 (6) cardiac monitoring;
- 18 (7) administration of patient assisted medications as approved by the
19 board;
- 20 (8) administration of medications as approved by the board by
21 appropriate routes; and
- 22 (9) monitor, maintain or discontinue flow of IV line if a physician
23 approves transfer by an emergency medical technician.

24 Sec. 28. K.S.A. 2014 Supp. 65-6123 is hereby amended to read as
25 follows: 65-6123. (a) Notwithstanding any other provision of law to the
26 contrary, an emergency medical technician-defibrillator may:

- 27 (1) Perform any of the activities identified in K.S.A. 65-6121, and
28 amendments thereto;
- 29 (2) when approved by medical protocols or where voice contact by
30 radio or telephone is monitored by a physician, physician assistant where
31 authorized by a physician, advanced practice registered nurse ~~where~~
32 ~~authorized by a physician~~, or licensed professional nurse where authorized
33 by a physician, and direct communication is maintained, upon order of
34 such person, may perform electrocardiographic monitoring and
35 defibrillation;
- 36 (3) perform, during an emergency, those activities specified in
37 subsection (b) before contacting the persons identified in subsection (b)
38 when specifically authorized to perform such activities by medical
39 protocols; or
- 40 (4) perform, during nonemergency transportation, those activities
41 specified in this section when specifically authorized to perform such
42 activities by medical protocols.
- 43 (b) An individual who holds a valid certificate as an emergency

1 medical technician-defibrillator once successfully completing an
2 emergency medical technician-intermediate, initial course of instruction
3 and the board prescribed transition course, and validation of cognitive and
4 psychomotor competency as determined by rules and regulations of the
5 board, may apply to transition to become an advanced emergency medical
6 technician. Alternatively, upon application for renewal, such individual
7 shall be deemed to hold a certificate as an advanced emergency medical
8 technician under this act, provided such individual has completed all
9 continuing education hour requirements inclusive of successful completion
10 of a transition course, and such individual shall not be required to file an
11 original application for certification as an advanced emergency medical
12 technician.

13 (c) "Renewal" as used in subsection (b), refers to the second
14 opportunity after December 31, 2011, that an attendant has to apply for
15 renewal of a certificate.

16 (d) Emergency medical technician-defibrillator attendants who fail to
17 meet the transition requirements as specified may complete either the
18 board prescribed emergency medical technician transition course or
19 emergency medical responder transition course, provide validation of
20 cognitive and psychomotor competency provided such individual has
21 completed all continuing education hour requirements inclusive of the
22 successful completion of a transition course as determined by rules and
23 regulations of the board. Upon completion, such emergency medical
24 technician-defibrillator may apply to transition to become an emergency
25 medical technician or an emergency medical responder, depending on the
26 transition course that was successfully completed. Alternatively, upon
27 application for renewal of an emergency medical technician-defibrillator
28 certificate, the applicant shall be renewed as an emergency medical
29 technician or an emergency medical responder, depending on the transition
30 course that was successfully completed. Such individual shall not be
31 required to file an original application for certification as an emergency
32 medical technician or emergency medical responder.

33 (e) Failure to complete either the advanced emergency medical
34 technician transition requirements, an emergency medical technician
35 transition course or an emergency medical responder transition course will
36 result in loss of certification.

37 Sec. 29. K.S.A. 2013 Supp. 65-6124, as amended by section 52 of
38 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
39 read as follows: 65-6124. (a) No physician, physician assistant, advanced
40 practice registered nurse or licensed professional nurse, who gives
41 emergency instructions to an attendant as defined by K.S.A. 65-6112, and
42 amendments thereto, during an emergency, shall be liable for any civil
43 damages as a result of issuing the instructions, except such damages which

1 may result from gross negligence in giving such instructions.

2 (b) No attendant as defined by K.S.A. 65-6112, and amendments
3 thereto, who renders emergency care during an emergency pursuant to
4 instructions given by a physician, *an advanced practice registered nurse*,
5 the supervising physician for a physician assistant, ~~advanced practice~~
6 ~~registered nurse~~ or licensed professional nurse shall be liable for civil
7 damages as a result of implementing such instructions, except such
8 damages which may result from gross negligence or by willful or wanton
9 acts or omissions on the part of such attendant as defined by K.S.A. 65-
10 6112, and amendments thereto.

11 (c) No person certified as an instructor-coordinator and no training
12 officer shall be liable for any civil damages which may result from such
13 instructor-coordinator's or training officer's course of instruction, except
14 such damages which may result from gross negligence or by willful or
15 wanton acts or omissions on the part of the instructor-coordinator or
16 training officer.

17 (d) No medical adviser who reviews, approves and monitors the
18 activities of attendants shall be liable for any civil damages as a result of
19 such review, approval or monitoring, except such damages which may
20 result from gross negligence in such review, approval or monitoring.

21 Sec. 30. K.S.A. 2014 Supp. 65-6144 is hereby amended to read as
22 follows: 65-6144. (a) A first responder may perform any of the following
23 activities:

24 (1) Initial scene management including, but not limited to, gaining
25 access to the individual in need of emergency care, extricating, lifting and
26 moving the individual;

27 (2) cardiopulmonary resuscitation and airway management;

28 (3) control of bleeding;

29 (4) extremity splinting excluding traction splinting;

30 (5) stabilization of the condition of the individual in need of
31 emergency care;

32 (6) oxygen therapy;

33 (7) use of oropharyngeal airways;

34 (8) use of bag valve masks;

35 (9) use automated external defibrillators; and

36 (10) other techniques of preliminary care a first responder is trained
37 to provide as approved by the board.

38 (b) An individual who holds a valid certificate as a first responder,
39 once completing the board prescribed transition course, and validation of
40 cognitive and psychomotor competency as determined by rules and
41 regulations of the board, may apply to transition to become an emergency
42 medical responder. Alternatively, upon application for renewal of such
43 certificate, such individual shall be deemed to hold a certificate as an

1 emergency medical responder under this act, provided such individual has
2 completed all continuing education hour requirements inclusive of a
3 transition course and such individual shall not be required to file an
4 original application for certification as an emergency medical responder.

5 (c) "Renewal" as used in subsection (b), refers to the first opportunity
6 after December 31, 2011, that an attendant has to apply for renewal of a
7 certificate.

8 (d) First responder attendants who fail to meet the transition
9 requirements as specified will forfeit their certification.

10 (e) Upon transition, notwithstanding any other provision of law to the
11 contrary, an emergency medical responder may perform any of the
12 following interventions, by use of the devices, medications and equipment,
13 or any combination thereof, after successfully completing an approved
14 course of instruction, local specialized device training and competency
15 validation and when authorized by medical protocols, or upon order when
16 direct communication is maintained by radio, telephone or video
17 conference is monitored by a physician, physician assistant when
18 authorized by a physician, an advanced practice registered nurse ~~when~~
19 ~~authorized by a physician~~ or a licensed professional nurse when authorized
20 by a physician, upon order of such person: (1) Emergency vehicle
21 operations; (2) initial scene management; (3) patient assessment and
22 stabilization; (4) cardiopulmonary resuscitation and airway management;
23 (5) control of bleeding; (6) extremity splinting; (7) spinal immobilization;
24 (8) oxygen therapy; (9) use of bag-valve-mask; (10) use of automated
25 external defibrillator; (11) nebulizer therapy; (12) intramuscular injections
26 with auto-injector; (13) administration of oral glucose; (14) administration
27 of aspirin; (15) recognize and comply with advanced directives; (16)
28 insertion and maintenance of oral and nasal pharyngeal airways; (17) use
29 of blood glucose monitoring; and (18) other techniques and devices of
30 preliminary care an emergency medical responder is trained to provide as
31 approved by the board.

32 Sec. 31. K.S.A. 2014 Supp. 65-7003 is hereby amended to read as
33 follows: 65-7003. As used in K.S.A. 65-7001 through 65-7015, and
34 amendments thereto:

35 (a) "Act" means the Kansas chemical control act;

36 (b) "administer" means the application of a regulated chemical
37 whether by injection, inhalation, ingestion or any other means, directly
38 into the body of a patient or research subject, such administration to be
39 conducted by: (1) A practitioner, or in the practitioner's presence, by such
40 practitioner's authorized agent; or

41 (2) the patient or research subject at the direction and in the presence
42 of the practitioner;

43 (c) "agent or representative" means a person who is authorized to

1 receive, possess, manufacture or distribute or in any other manner control
2 or has access to a regulated chemical on behalf of another person;

3 (d) "bureau" means the Kansas bureau of investigation;

4 (e) "department" means the Kansas department of health and
5 environment;

6 (f) "director" means the director of the Kansas bureau of
7 investigation;

8 (g) "dispense" means to deliver a regulated chemical to an ultimate
9 user, patient or research subject by, or pursuant to the lawful order of, a
10 practitioner, including the prescribing, administering, packaging, labeling
11 or compounding necessary to prepare the regulated chemical for that
12 delivery;

13 (h) "distribute" means to deliver other than by administering or
14 dispensing a regulated chemical;

15 (i) "manufacture" means to produce, prepare, propagate, compound,
16 convert or process a regulated chemical directly or indirectly, by extraction
17 from substances of natural origin, chemical synthesis or a combination of
18 extraction and chemical synthesis, and includes packaging or repackaging
19 of the substance or labeling or relabeling of its container. The term
20 excludes the preparation, compounding, packaging, repackaging, labeling
21 or relabeling of a regulated chemical:

22 (1) By a practitioner as an incident to the practitioner's administering
23 or dispensing of a regulated chemical in the course of the practitioner's
24 professional practice; or

25 (2) by a practitioner, or by the practitioner's authorized agent under
26 the practitioner's supervision, for the purpose of, or as an incident to
27 research, teaching or chemical analysis and not for sale;

28 (j) "person" means individual, corporation, business trust, estate,
29 trust, partnership, association, joint venture, government, governmental
30 subdivision or agency, or any other legal or commercial entity;

31 (k) "practitioner" means a person licensed to practice medicine and
32 surgery, pharmacist, dentist, podiatrist, veterinarian, optometrist, *advanced*
33 *practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
34 *amendments thereto, and who has authority to prescribe drugs in*
35 *accordance with K.S.A. 65-1130, and amendments thereto, or scientific*
36 *investigator or other person authorized by law to use a controlled*
37 *substance in teaching or chemical analysis or to conduct research with*
38 *respect to a controlled substance;*

39 (l) "regulated chemical" means a chemical that is used directly or
40 indirectly to manufacture a controlled substance or other regulated
41 chemical, or is used as a controlled substance analog, in violation of the
42 state controlled substances act or this act. The fact that a chemical may be
43 used for a purpose other than the manufacturing of a controlled substance

1 or regulated chemical does not exempt it from the provisions of this act.

2 Regulated chemical includes:

- 3 (1) Acetic anhydride (CAS No. 108-24-7);
- 4 (2) benzaldehyde (CAS No. 100-52-7);
- 5 (3) benzyl chloride (CAS No. 100-44-7);
- 6 (4) benzyl cyanide (CAS No. 140-29-4);
- 7 (5) diethylamine and its salts (CAS No. 109-89-7);
- 8 (6) ephedrine, its salts, optical isomers and salts of optical isomers
- 9 (CAS No. 299-42-3), except products containing ephedra or ma huang,
- 10 which do not contain any chemically synthesized ephedrine alkaloids, and
- 11 are lawfully marketed as dietary supplements under federal law;
- 12 (7) hydriodic acid (CAS No. 10034-85-2);
- 13 (8) iodine (CAS No. 7553-56-2);
- 14 (9) lithium (CAS No. 7439-93-2);
- 15 (10) methylamine and its salts (CAS No. 74-89-5);
- 16 (11) nitroethane (CAS No. 79-24-3);
- 17 (12) chloroephedrine, its salts, optical isomers, and salts of optical
- 18 isomers (CAS No. 30572-91-9);
- 19 (13) phenylacetic acid, its esters and salts (CAS No. 103-82-2);
- 20 (14) phenylpropanolamine, its salts, optical isomers, and salts of
- 21 optical isomers (CAS No. 14838-15-4);
- 22 (15) piperidine and its salts (CAS No. 110-89-4);
- 23 (16) pseudoephedrine, its salts, optical isomers, and salts of optical
- 24 isomers (CAS No. 90-82-4);
- 25 (17) red phosphorous (CAS No. 7723-14-0);
- 26 (18) sodium (CAS No. 7440-23-5); and
- 27 (19) thionylchloride (CAS No. 7719-09-7);
- 28 (20) gamma butyrolactone (GBL), including butyrolactone;
- 29 butyrolactone gamma; 4-butyrolactone; 2(3H)-furanone dihydro; dihydro-
- 30 2(3H)-furanone; tetrahydro-2-furanone; 1,2-butanolide; 1,4-butanolide; 4-
- 31 butanolide; gamma-hydroxybutyric acid lactone; 3-hydroxybutyric acid
- 32 lactone and 4-hydroxybutanoic acid lactone; CAS No. 96-48-0; and
- 33 (21) 1,4 butanediol, including butanediol; butane-1,4-diol; 1,4-
- 34 butylene glycol; butylene glycol; 1,4-dihydroxybutane; 1,4-tetramethylene
- 35 glycol; tetramethylene glycol; tetramethylene 1,4-diol; CAS No. 110-63-4;
- 36 (m) "regulated chemical distributor" means any person subject to the
- 37 provisions of the Kansas chemical control act who manufactures or
- 38 distributes a regulated chemical;
- 39 (n) "regulated chemical retailer" means any person who sells
- 40 regulated chemicals directly to the public;
- 41 (o) "regulated chemical transaction" means the manufacture of a
- 42 regulated chemical or the distribution, sale, exchange or other transfer of a
- 43 regulated chemical within or into the state or from this state into another

1 state; and

2 (p) "secretary" means the secretary of health and environment.

3 Sec. 32. K.S.A. 2014 Supp. 65-7302 is hereby amended to read as
4 follows: 65-7302. As used in this act:

5 (a) "Board" means the state board of healing arts.

6 (b) "Ionizing radiation" means x-rays, gamma rays, alpha and beta
7 particles, high speed electrons, protons, neutrons and other nuclear
8 particles capable of producing ions directly or indirectly in its passage
9 through matter.

10 (c) "License" means a certificate issued by the board authorizing the
11 licensee to perform radiologic technology procedures on humans for
12 diagnostic or therapeutic purposes.

13 (d) "Licensed practitioner" means a person licensed to practice
14 medicine and surgery, dentistry, podiatry—~~or~~, chiropractic *or advanced*
15 *practice registered nursing* in this state.

16 (e) "Licensure" and "licensing" mean a method of regulation by
17 which the state grants permission to persons who meet predetermined
18 qualifications to engage in a health related occupation or profession.

19 (f) "Nuclear medicine technologist" means a person who uses radio
20 pharmaceutical agents on humans for diagnostic or therapeutic purposes.

21 (g) "Nuclear medicine technology" means the use of radio nuclides on
22 human beings for diagnostic or therapeutic purposes.

23 (h) "Radiation therapist" means a person who applies radiation to
24 humans for therapeutic purposes.

25 (i) "Radiation therapy" means the use of any radiation procedure or
26 article intended for the cure, mitigation or prevention of disease in
27 humans.

28 (j) "Radiographer" means a person who applies radiation to humans
29 for diagnostic purposes.

30 (k) "Radiography" means the use of ionizing radiation on human
31 beings for diagnostic purposes.

32 (l) "Radiologic technologist" means any person who is a
33 radiographer, radiation therapist or nuclear medicine technologist.

34 (m) "Radiologic technology" means the use of radioactive substance
35 or equipment emitting or detecting ionizing radiation on humans for
36 diagnostic or therapeutic purposes upon prescription of a licensed
37 practitioner. The term includes the practice of radiography, nuclear
38 medicine technology and radiation therapy, but does not include
39 echocardiography, diagnostic sonography and magnetic resonance
40 imaging.

41 (n) This section shall take effect on and after July 1, 2005.

42 Sec. 33. K.S.A. 2014 Supp. 72-5213 is hereby amended to read as
43 follows: 72-5213. (a) Every board of education shall require all employees

1 of the school district, who come in regular contact with the pupils of the
2 school district, to submit a certification of health on a form prescribed by
3 the secretary of health and environment and signed by a person licensed to
4 practice medicine and surgery under the laws of any state, or by a person
5 who is licensed as a physician assistant under the laws of this state when
6 such person is working at the direction of or in collaboration with a person
7 licensed to practice medicine and surgery, or by a person holding a license
8 to practice as an advanced practice registered nurse under the laws of this
9 state ~~when such person is working at the direction of or in collaboration~~
10 ~~with a person licensed to practice medicine and surgery.~~ The certification
11 shall include a statement that there is no evidence of a physical condition
12 that would conflict with the health, safety, or welfare of the pupils; and
13 that freedom from tuberculosis has been established by chest x-ray or
14 negative tuberculin skin test. If at any time there is reasonable cause to
15 believe that any such employee of the school district is suffering from an
16 illness detrimental to the health of the pupils, the school board may require
17 a new certification of health.

18 (b) Upon presentation of a signed statement by the employee of a
19 school district, to whom the provisions of subsection (a) apply, that the
20 employee is an adherent of a religious denomination whose religious
21 teachings are opposed to physical examinations, the employee shall be
22 permitted to submit, as an alternative to the certification of health required
23 under subsection (a), certification signed by a person licensed to practice
24 medicine and surgery under the laws of any state, or by a person who is
25 licensed as a physician assistant under the laws of this state when such
26 person is working at the direction of or in collaboration with a person
27 licensed to practice medicine and surgery, or by a person holding a license
28 to practice as an advanced practice registered nurse under the laws of this
29 state ~~when such person is working at the direction of or in collaboration~~
30 ~~with a person licensed to practice medicine and surgery~~ that freedom of
31 the employee from tuberculosis has been established.

32 (c) Every board of education may require persons, other than
33 employees of the school district, to submit to the same certification of
34 health requirements as are imposed upon employees of the school district
35 under the provisions of subsection (a) if such persons perform or provide
36 services to or for a school district which require such persons to come in
37 regular contact with the pupils of the school district. No such person shall
38 be required to submit a certification of health if the person presents a
39 signed statement that the person is an adherent of a religious denomination
40 whose religious teachings are opposed to physical examinations. Such
41 persons shall be permitted to submit, as an alternative to a certification of
42 health, certification signed by a person licensed to practice medicine and
43 surgery under the laws of any state, or by a person who is licensed as a

1 physician assistant under the laws of this state when such person is
2 working at the direction of or in collaboration with a person licensed to
3 practice medicine and surgery, or by a person holding a license to practice
4 as an advanced practice registered nurse under the laws of this state ~~when~~
5 ~~such person is working at the direction of or in collaboration with a person~~
6 ~~licensed to practice medicine and surgery~~ that freedom of such persons
7 from tuberculosis has been established.

8 (d) The expense of obtaining certifications of health and certifications
9 of freedom from tuberculosis may be borne by the board of education.

10 Sec. 34. K.S.A. 2014 Supp. 75-7429 is hereby amended to read as
11 follows: 75-7429. (a) As used in this section, "medical home" means a
12 health care delivery model in which a patient establishes an ongoing
13 relationship with a physician or other personal care provider in a
14 physician-directed team, *or with an advanced practice registered nurse* to
15 provide comprehensive, accessible and continuous evidence-based primary
16 and preventive care, and to coordinate the patient's health care needs
17 across the health care system in order to improve quality and health
18 outcomes in a cost effective manner.

19 (b) The department of health and environment shall incorporate the
20 use of the medical home delivery system within:

21 (1) The Kansas program of medical assistance established in
22 accordance with title XIX of the federal social security act, 42 U.S.C. §
23 1396 et seq., and amendments thereto;

24 (2) the health benefits program for children established under K.S.A.
25 38-2001 et seq., and amendments thereto, and developed and submitted in
26 accordance with federal guidelines established under title XXI of the
27 federal social security act, section 4901 of public law 105-33, 42 U.S.C. §
28 1397aa et seq., and amendments thereto; and

29 (3) the state mediKan program.

30 (c) The Kansas state employees health care commission established
31 under K.S.A. 75-6502, and amendments thereto, shall incorporate the use
32 of a medical home delivery system within the state health care benefits
33 program as provided in K.S.A. 75-6501 through 75-6523, and amendments
34 thereto. Except that compliance with a medical home delivery system shall
35 not be required of program participants receiving treatment in accordance
36 with a religious method of healing pursuant to the provisions of K.S.A.
37 2014 Supp. 75-6501, and amendments thereto.

38 Sec. 35. K.S.A. 40-4602, 59-2976, 65-1660, 65-2892, 65-4134 and
39 65-5502 and K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
40 chapter 131 of the 2014 Session Laws of Kansas, 65-4101, as amended by
41 section 50 of chapter 131 of the 2014 Session Laws of Kansas, 65-6112, as
42 amended by section 51 of chapter 131 of the 2014 Session Laws of Kansas
43 and 65-6124, as amended by section 52 of chapter 131 of the 2014 Session

1 Laws of Kansas and K.S.A. 2014 Supp. 39-923, 39-1401, 39-1430, 39-
2 1504, 65-468, 65-507, 65-1113, 65-1130, 65-1682, 65-2837a, 65-2921, 65-
3 4116, 65-4202, 65-5402, 65-5418, 65-6119, 65-6120, 65-6121, 65-6123,
4 65-6144, 65-7003, 65-7302, 72-5213 and 75-7429 are hereby repealed.

5 Sec. 36. This act shall take effect and be in force from and after July
6 1, 2016, and its publication in the statute book.

HB 2122

HOUSE BILL No. 2122

By Committee on Health and Human Services

1-23

1 AN ACT concerning advanced practice registered nurses; amending
2 K.S.A. 40-4602, 59-2976, 65-1660, 65-2892, 65-4134 and 65-5502 and
3 K.S.A. 2013 Supp. 65-1626, as amended by section 4 of chapter 131 of
4 the 2014 Session Laws of Kansas, 65-4101, as amended by section 50
5 of chapter 131 of the 2014 Session Laws of Kansas, 65-6112, as
6 amended by section 51 of chapter 131 of the 2014 Session Laws of
7 Kansas and 65-6124, as amended by section 52 of chapter 131 of the
8 2014 Session Laws of Kansas and K.S.A. 2014 Supp. 39-923, 39-1401,
9 39-1430, 39-1504, 65-468, 65-507, 65-1113, 65-1130, 65-1682, 65-
10 2837a, 65-2921, 65-4116, 65-4202, 65-5402, 65-5418, 65-6119, 65-
11 6120, 65-6121, 65-6123, 65-6144, 65-7003, 65-7302, 72-5213 and 75-
12 7429 and repealing the existing sections.

13

14 *Be it enacted by the Legislature of the State of Kansas:*

15 Section 1. K.S.A. 2014 Supp. 65-1113 is hereby amended to read as
16 follows: 65-1113. When used in this act and the act of which this section is
17 amendatory:

18 (a) "Board" means the board of nursing.

19 (b) "Diagnosis" in the context of nursing practice means that
20 identification of and discrimination between physical and psychosocial
21 signs and symptoms essential to effective execution and management of
22 the nursing regimen and shall be construed as distinct from a medical
23 diagnosis.

24 (c) "Treatment" means the selection and performance of those
25 therapeutic measures essential to effective execution and management of
26 the nursing regimen, and any prescribed medical regimen.

27 (d) *Practice of nursing.* (1) The practice of professional nursing as
28 performed by a registered professional nurse for compensation or
29 gratuitously, except as permitted by K.S.A. 65-1124, and amendments
30 thereto, means the process in which substantial specialized knowledge
31 derived from the biological, physical, and behavioral sciences is applied
32 to: the care, diagnosis, treatment, counsel and health teaching of persons
33 who are experiencing changes in the normal health processes or who
34 require assistance in the maintenance of health or the prevention or
35 management of illness, injury or infirmity; administration, supervision or
36 teaching of the process as defined in this section; and the execution of the

1 medical regimen as prescribed by a person licensed to practice medicine
2 and surgery ~~or, a person licensed to practice dentistry or by a person~~
3 *licensed to practice as an advanced practice registered nurse.* (2) The
4 practice of nursing as a licensed practical nurse means the performance for
5 compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
6 any amendments thereto, of tasks and responsibilities defined in ~~part (1) of~~
7 ~~this subsection (d)(1)~~ which tasks and responsibilities are based on
8 acceptable educational preparation within the framework of supportive and
9 restorative care under the direction of a registered professional nurse, a
10 person licensed to practice medicine and surgery ~~or, a person licensed to~~
11 *practice dentistry or by a person licensed to practice as an advanced*
12 *practice registered nurse.*

13 (e) A "professional nurse" means a person who is licensed to practice
14 professional nursing as defined in ~~part (1) of subsection (d) of this~~
15 ~~section(1).~~

16 (f) A "practical nurse" means a person who is licensed to practice
17 practical nursing as defined in ~~part (2) of subsection (d) of this section(2).~~

18 (g) "Advanced practice registered nurse" or "APRN" means a
19 professional nurse who holds a license from the board to function as a
20 professional nurse in an advanced role, and this advanced role shall be
21 defined by rules and regulations adopted by the board in accordance with
22 K.S.A. 65-1130, and amendments thereto.

23 Sec. 2. K.S.A. 2014 Supp. 65-1130 is hereby amended to read as
24 follows: 65-1130. (a) No professional nurse shall announce or represent to
25 the public that such person is an advanced practice registered nurse unless
26 such professional nurse has complied with requirements established by the
27 board and holds a valid license as an advanced practice registered nurse in
28 accordance with the provisions of this section.

29 (b) *On and after the effective date of this act, to be eligible for an*
30 *initial advanced practice registered nurse license, an applicant shall hold*
31 *and maintain a current advanced practice registered nurse certification*
32 *granted by a national certifying organization recognized by the board*
33 *whose certification standards are approved by the board as equal to or*
34 *greater than the corresponding standards established by the board.*

35 (c) The board shall establish standards and requirements for any
36 professional nurse who desires to obtain licensure as an advanced practice
37 registered nurse. Such standards and requirements shall include, but not be
38 limited to, standards and requirements relating to the education of
39 advanced practice registered nurses. The board may give such
40 examinations and secure such assistance as it deems necessary to
41 determine the qualifications of applicants.

42 (e) (d) The board shall adopt rules and regulations applicable to
43 advanced practice registered nurses which:

1 (1) Establish roles and identify titles and abbreviations of advanced
2 practice registered nurses which are consistent with *advanced* nursing
3 practice specialties recognized by the nursing profession.

4 (2) Establish education and qualifications necessary for licensure for
5 each ~~role of~~ advanced practice registered nurse *role* established by the
6 board at a level adequate to assure the competent performance by
7 advanced practice registered nurses of functions and procedures which
8 advanced practice registered nurses are authorized to perform. Advanced
9 practice registered nursing is based on knowledge and skills acquired in
10 basic nursing education, licensure as a registered nurse and graduation
11 from or completion of a master's or higher degree in one of the advanced
12 practice registered nurse roles approved by the board of nursing.

13 (3) Define the role of advanced practice registered nurses and
14 establish limitations and restrictions on such role. The board shall adopt a
15 definition of the role under this subsection (c)(3) which is consistent with
16 the education and qualifications required to obtain a license as an
17 advanced practice registered nurse, which protects the public from persons
18 performing functions and procedures as advanced practice registered
19 nurses for which they lack adequate education and qualifications and
20 which authorizes advanced practice registered nurses to perform acts
21 generally recognized by the profession of nursing as capable of being
22 performed, in a manner consistent with the public health and safety, by
23 persons with postbasic education in nursing. In defining such role the
24 board shall consider: (A) The education required for a licensure as an
25 advanced practice registered nurse; (B) the type of nursing practice and
26 preparation in specialized advanced practice skills involved in each role of
27 advanced practice registered nurse established by the board; (C) the scope
28 and limitations of advanced practice nursing prescribed by national
29 advanced practice organizations; ~~and~~ (D) acts recognized by the nursing
30 profession as appropriate to be performed by persons with postbasic
31 education in nursing; *and (E) the certification standards established by an*
32 *accredited national organization whose certification standards are*
33 *approved by the board as equal to or greater than the corresponding*
34 *standards established under this act for obtaining authorization to*
35 *practice as an advanced practice registered nurse in the specific role.*

36 (e) *"Treatment" means, when used in conjunction with the practice of*
37 *an advanced practice registered nurse, planning, diagnosing, ordering*
38 *and executing of a healthcare plan including, but not limited to,*
39 *pharmacologic and non-pharmacologic interventions. This term also*
40 *includes prescribing medical devices and equipment, nutrition, and*
41 *diagnostic and supportive services including, but not limited to, home*
42 *health care, hospice, physical and occupational therapy.*

43 (f) *The practice of nursing as an advanced practice registered nurse*

1 means the performance for compensation or gratuitously, except as
2 permitted by K.S.A. 65-1124, and amendments thereto, of the process in
3 which advanced knowledge derived from the biological, physical and
4 behavioral sciences is applied to direct and indirect care, including, but
5 not limited to, creating and executing a health care plan; nursing and
6 medical diagnosis, management, treatment and prescribing; administering
7 pharmacologic and non-pharmacologic interventions; counseling and
8 health teaching of persons who are experiencing changes in the normal
9 health processes or who require assistance in the maintenance of health;
10 or the prevention or management of illness, injury or infirmity;
11 administration, supervising or teaching within the advanced practice
12 registered nurse's role. Within the role of the advanced practice registered
13 nurse, an advanced practice registered nurse may serve as a primary care
14 provider and lead health care teams.

15 ~~(d) (g) An advanced practice registered nurse may prescribe drugs~~
16 ~~pursuant to a written protocol as authorized by a responsible physician.~~
17 ~~Each written protocol shall contain a precise and detailed medical plan of~~
18 ~~care for each classification of disease or injury for which the advanced~~
19 ~~practice registered nurse is authorized to prescribe and shall specify all~~
20 ~~drugs which may be prescribed by the advanced practice registered~~
21 ~~nurse.~~ *Advanced practice registered nurses are authorized to prescribe,*
22 *procure and administer prescription drugs and controlled substances*
23 *pursuant to applicable state and federal laws. Any written prescription*
24 *order shall include the name, address and telephone number of the*
25 ~~responsible physician~~ *advanced practice registered nurse.* The advanced
26 practice registered nurse may not dispense drugs, but may request, receive
27 and sign for professional samples and may distribute professional samples
28 to patients ~~pursuant to a written protocol as authorized by a responsible~~
29 ~~physician.~~ In order to prescribe controlled substances, the advanced
30 practice registered nurse shall: (1) Register with the federal drug
31 enforcement administration; and (2) notify the board of ~~the name and~~
32 ~~address of the responsible physician or physicians.~~ In no case shall the
33 scope of authority of the advanced practice registered nurse exceed the
34 normal and customary practice of the responsible physician *nursing of the*
35 *federal drug enforcement administration registration as prescribed by*
36 *rules and regulations of the board. An advanced practice registered nurse*
37 *shall comply with the federal drug enforcement administration*
38 *requirements related to controlled substances.* An advanced practice
39 registered nurse certified in the role of registered nurse anesthetist while
40 functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-
41 1164, inclusive, and amendments thereto, shall be subject to the provisions
42 of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with
43 respect to drugs and anesthetic agents and shall not be subject to the

1 provisions of this subsection. ~~For the purposes of this subsection,~~
2 ~~"responsible physician" means a person licensed to practice medicine and~~
3 ~~surgery in Kansas who has accepted responsibility for the protocol and the~~
4 ~~actions of the advanced practice registered nurse when prescribing drugs.~~

5 *(e) (h) An advanced practice registered nurse is accountable to*
6 *patients, the nursing profession and the board for complying with the*
7 *requirements of the nurse practice act, and any rules and regulations*
8 *adopted pursuant thereto, and is responsible for recognizing limits of*
9 *knowledge and experience, planning for the management of situations*
10 *beyond the advanced practice registered nurse's expertise and referring*
11 *patients to other health care professionals as appropriate.*

12 *(i) (1) The board, by rules and regulations, shall establish a program*
13 *of transition to full practice for all persons who on and after the effective*
14 *date of this act are granted initial licensure as an advanced practice*
15 *registered nurse or who have less than 2,000 hours of licensed active*
16 *practice as an advanced practice registered nurse in their initial roles.*

17 *(2) Advanced practice registered nurses who are subject to the*
18 *program of transition to full practice shall not prescribe medications*
19 *except as provided in this subsection.*

20 *(3) As part of the program of transition to full practice, an advanced*
21 *practice registered nurse shall complete, within two years from the*
22 *commencement of the program by the advanced practice registered nurse,*
23 *a transition to full practice period of 2,000 hours while maintaining a*
24 *collaborative relationship for practice and for prescribing medications*
25 *with either a licensed advanced practice registered nurse with full*
26 *prescriptive authority under subsection (g) or with a physician. The*
27 *advanced practice registered nurse shall engage in the practice of nursing*
28 *as an advanced practice registered nurse and may prescribe medications*
29 *as part of the collaborative relationship.*

30 *(4) As part of the program of transition to full practice, the board*
31 *shall specify the manner and form in which the advanced practice*
32 *registered nurse participating in the program may identify oneself*
33 *professionally and to the public.*

34 *(5) The advanced practice registered nurse shall be responsible for*
35 *completing the required documentation for the program of transition to*
36 *full practice as specified by the board.*

37 *(6) Upon the successful completion of the program of transition to*
38 *full practice, the board of nursing shall authorize the advanced practice*
39 *registered nurse to engage in the practice of advanced practice registered*
40 *nursing without the limitations of this subsection and as otherwise*
41 *authorized by law.*

42 *(7) The board may adopt rules and regulations necessary to carry out*
43 *the provisions of this subsection.*

1 (8) *An advanced practice registered nurse functioning in the role of*
2 *registered nurse anesthetist shall be subject to the provisions of K.S.A. 65-*
3 *1151 to 65-1164, inclusive, and amendments thereto, and shall not be*
4 *subject to the provisions of this subsection.*

5 (9) *As used in this subsection, "physician" means a person licensed to*
6 *practice medicine and surgery.*

7 (j) *When a provision of law or rule and regulation requires a*
8 *signature, certification, verification, affidavit or endorsement by a*
9 *physician, that requirement may be fulfilled by a licensed advanced*
10 *practice registered nurse working within the scope of practice of such*
11 *nurse's respective role.*

12 (k) *The confidential relations and communications between an*
13 *advance practice registered nurse and the advance practice registered*
14 *nurse's patient are placed on the same basis as provided by law as those*
15 *between a physician and a physician's patient in K.S.A. 60-427, and*
16 *amendments thereto.*

17 (l) *An advanced practice registered nurse shall maintain malpractice*
18 *insurance coverage in effect as a condition to rendering professional*
19 *service as an advanced practice registered nurse in this state and shall*
20 *provide proof of insurance at time of licensure and renewal of license. The*
21 *requirements of this subsection shall not apply to an advanced practice*
22 *registered nurse who practices solely in an employment which results in*
23 *the advanced practice registered nurse being covered under the federal*
24 *tort claim act or state tort claims act, or who practices solely as a*
25 *charitable health care provider under K.S.A. 75-6102, and amendments*
26 *thereto, or who is serving on active duty in the military service of the*
27 *United States.*

28 (m) *As used in this section, "drug" means those articles and*
29 *substances defined as drugs in K.S.A. 65-1626 and 65-4101, and*
30 *amendments thereto.*

31 ~~(f) A person registered to practice as an advanced registered nurse~~
32 ~~practitioner in the state of Kansas immediately prior to the effective date of~~
33 ~~this act shall be deemed to be licensed to practice as an advanced practice~~
34 ~~registered nurse under this act and such person shall not be required to file~~
35 ~~an original application for licensure under this act. Any application for~~
36 ~~registration filed which has not been granted prior to the effective date of~~
37 ~~this act shall be processed as an application for licensure under this act.~~

38 Sec. 3. K.S.A. 2014 Supp. 39-923 is hereby amended to read as
39 follows: 39-923. (a) As used in this act:

40 (1) "Adult care home" means any nursing facility, nursing facility for
41 mental health, intermediate care facility for people with intellectual
42 disability, assisted living facility, residential health care facility, home plus,
43 boarding care home and adult day care facility; all of which are

1 classifications of adult care homes and are required to be licensed by the
2 secretary for aging and disability services.

3 (2) "Nursing facility" means any place or facility operating 24 hours a
4 day, seven days a week, caring for six or more individuals not related
5 within the third degree of relationship to the administrator or owner by
6 blood or marriage and who, due to functional impairments, need skilled
7 nursing care to compensate for activities of daily living limitations.

8 (3) "Nursing facility for mental health" means any place or facility
9 operating 24 hours a day, seven days a week, caring for six or more
10 individuals not related within the third degree of relationship to the
11 administrator or owner by blood or marriage and who, due to functional
12 impairments, need skilled nursing care and special mental health services
13 to compensate for activities of daily living limitations.

14 (4) "Intermediate care facility for people with intellectual disability"
15 means any place or facility operating 24 hours a day, seven days a week,
16 caring for four or more individuals not related within the third degree of
17 relationship to the administrator or owner by blood or marriage and who,
18 due to functional impairments caused by intellectual disability or related
19 conditions, need services to compensate for activities of daily living
20 limitations.

21 (5) "Assisted living facility" means any place or facility caring for six
22 or more individuals not related within the third degree of relationship to
23 the administrator, operator or owner by blood or marriage and who, by
24 choice or due to functional impairments, may need personal care and may
25 need supervised nursing care to compensate for activities of daily living
26 limitations and in which the place or facility includes apartments for
27 residents and provides or coordinates a range of services including
28 personal care or supervised nursing care available 24 hours a day, seven
29 days a week, for the support of resident independence. The provision of
30 skilled nursing procedures to a resident in an assisted living facility is not
31 prohibited by this act. Generally, the skilled services provided in an
32 assisted living facility shall be provided on an intermittent or limited term
33 basis, or if limited in scope, a regular basis.

34 (6) "Residential health care facility" means any place or facility, or a
35 contiguous portion of a place or facility, caring for six or more individuals
36 not related within the third degree of relationship to the administrator,
37 operator or owner by blood or marriage and who, by choice or due to
38 functional impairments, may need personal care and may need supervised
39 nursing care to compensate for activities of daily living limitations and in
40 which the place or facility includes individual living units and provides or
41 coordinates personal care or supervised nursing care available on a 24-
42 hour, seven-days-a-week basis for the support of resident independence.
43 The provision of skilled nursing procedures to a resident in a residential

1 health care facility is not prohibited by this act. Generally, the skilled
2 services provided in a residential health care facility shall be provided on
3 an intermittent or limited term basis, or if limited in scope, a regular basis.

4 (7) "Home plus" means any residence or facility caring for not more
5 than 12 individuals not related within the third degree of relationship to the
6 operator or owner by blood or marriage unless the resident in need of care
7 is approved for placement by the secretary for children and families, and
8 who, due to functional impairment, needs personal care and may need
9 supervised nursing care to compensate for activities of daily living
10 limitations. The level of care provided to residents shall be determined by
11 preparation of the staff and rules and regulations developed by the Kansas
12 department for aging and disability services. An adult care home may
13 convert a portion of one wing of the facility to a not less than five-bed and
14 not more than 12-bed home plus facility provided that the home plus
15 facility remains separate from the adult care home, and each facility must
16 remain contiguous. Any home plus that provides care for more than eight
17 individuals after the effective date of this act shall adjust staffing personnel
18 and resources as necessary to meet residents' needs in order to maintain the
19 current level of nursing care standards. Personnel of any home plus who
20 provide services for residents with dementia shall be required to take
21 annual dementia care training.

22 (8) "Boarding care home" means any place or facility operating 24
23 hours a day, seven days a week, caring for not more than 10 individuals
24 not related within the third degree of relationship to the operator or owner
25 by blood or marriage and who, due to functional impairment, need
26 supervision of activities of daily living but who are ambulatory and
27 essentially capable of managing their own care and affairs.

28 (9) "Adult day care" means any place or facility operating less than
29 24 hours a day caring for individuals not related within the third degree of
30 relationship to the operator or owner by blood or marriage and who, due to
31 functional impairment, need supervision of or assistance with activities of
32 daily living.

33 (10) "Place or facility" means a building or any one or more complete
34 floors of a building, or any one or more complete wings of a building, or
35 any one or more complete wings and one or more complete floors of a
36 building, and the term "place or facility" may include multiple buildings.

37 (11) "Skilled nursing care" means services performed by or under the
38 immediate supervision of a registered professional nurse and additional
39 licensed nursing personnel. Skilled nursing includes administration of
40 medications and treatments as prescribed by a licensed physician,
41 *advanced practice registered nurse* or dentist; and other nursing functions
42 which require substantial nursing judgment and skill based on the
43 knowledge and application of scientific principles.

1 (12) "Supervised nursing care" means services provided by or under
2 the guidance of a licensed nurse with initial direction for nursing
3 procedures and periodic inspection of the actual act of accomplishing the
4 procedures; administration of medications and treatments as prescribed by
5 a licensed physician, *advanced practice registered nurse* or dentist and
6 assistance of residents with the performance of activities of daily living.

7 (13) "Resident" means all individuals kept, cared for, treated, boarded
8 or otherwise accommodated in any adult care home.

9 (14) "Person" means any individual, firm, partnership, corporation,
10 company, association or joint-stock association, and the legal successor
11 thereof.

12 (15) "Operate an adult care home" means to own, lease, establish,
13 maintain, conduct the affairs of or manage an adult care home, except that
14 for the purposes of this definition the word "own" and the word "lease"
15 shall not include hospital districts, cities and counties which hold title to
16 an adult care home purchased or constructed through the sale of bonds.

17 (16) "Licensing agency" means the secretary for aging and disability
18 services.

19 (17) "Skilled nursing home" means a nursing facility.

20 (18) "Intermediate nursing care home" means a nursing facility.

21 (19) "Apartment" means a private unit which includes, but is not
22 limited to, a toilet room with bathing facilities, a kitchen, sleeping, living
23 and storage area and a lockable door.

24 (20) "Individual living unit" means a private unit which includes, but
25 is not limited to, a toilet room with bathing facilities, sleeping, living and
26 storage area and a lockable door.

27 (21) "Operator" means an individual registered pursuant to the
28 operator registration act, K.S.A. 2014 Supp. 39-973 et seq., and
29 amendments thereto, who may be appointed by a licensee to have the
30 authority and responsibility to oversee an assisted living facility or
31 residential health care facility with fewer than 61 residents, a home plus or
32 adult day care facility.

33 (22) "Activities of daily living" means those personal, functional
34 activities required by an individual for continued well-being, including,
35 but not limited to, eating, nutrition, dressing, personal hygiene, mobility
36 and toileting.

37 (23) "Personal care" means care provided by staff to assist an
38 individual with, or to perform activities of daily living.

39 (24) "Functional impairment" means an individual has experienced a
40 decline in physical, mental and psychosocial well-being and as a result, is
41 unable to compensate for the effects of the decline.

42 (25) "Kitchen" means a food preparation area that includes a sink,
43 refrigerator and a microwave oven or stove.

1 (26) The term "intermediate personal care home" for purposes of
2 those individuals applying for or receiving veterans' benefits means
3 residential health care facility.

4 (27) "Paid nutrition assistant" means an individual who is paid to feed
5 residents of an adult care home, or who is used under an arrangement with
6 another agency or organization, who is trained by a person meeting nurse
7 aide instructor qualifications as prescribed by 42 C.F.R. § 483.152, 42
8 C.F.R. § 483.160 and paragraph (h) of 42 C.F.R. § 483.35, and who
9 provides such assistance under the supervision of a registered professional
10 or licensed practical nurse.

11 (28) "Medicaid program" means the Kansas program of medical
12 assistance for which federal or state moneys, or any combination thereof,
13 are expended, or any successor federal or state, or both, health insurance
14 program or waiver granted thereunder.

15 (29) "Licensee" means any person or persons acting jointly or
16 severally who are licensed by the secretary for aging and disability
17 services pursuant to the adult care home licensure act, K.S.A. 39-923 et
18 seq., and amendments thereto.

19 (b) The term "adult care home" shall not include institutions operated
20 by federal or state governments, except institutions operated by the
21 director of the Kansas commission on veterans affairs office, hospitals or
22 institutions for the treatment and care of psychiatric patients, child care
23 facilities, maternity centers, hotels, offices of physicians or hospices which
24 are certified to participate in the medicare program under 42 code of
25 federal regulations, chapter IV, section 418.1 et seq., and amendments
26 thereto, and which provide services only to hospice patients.

27 (c) Nursing facilities in existence on the effective date of this act
28 changing licensure categories to become residential health care facilities
29 shall be required to provide private bathing facilities in a minimum of 20%
30 of the individual living units.

31 (d) Facilities licensed under the adult care home licensure act on the
32 day immediately preceding the effective date of this act shall continue to
33 be licensed facilities until the annual renewal date of such license and may
34 renew such license in the appropriate licensure category under the adult
35 care home licensure act subject to the payment of fees and other conditions
36 and limitations of such act.

37 (e) Nursing facilities with less than 60 beds converting a portion of
38 the facility to residential health care shall have the option of licensing for
39 residential health care for less than six individuals but not less than 10% of
40 the total bed count within a contiguous portion of the facility.

41 (f) The licensing agency may by rule and regulation change the name
42 of the different classes of homes when necessary to avoid confusion in
43 terminology and the agency may further amend, substitute, change and in a

1 manner consistent with the definitions established in this section, further
2 define and identify the specific acts and services which shall fall within the
3 respective categories of facilities so long as the above categories for adult
4 care homes are used as guidelines to define and identify the specific acts.

5 Sec. 4. K.S.A. 2014 Supp. 39-1401 is hereby amended to read as
6 follows: 39-1401. As used in this act:

7 (a) "Resident" means:

8 (1) Any resident, as defined by K.S.A. 39-923, and amendments
9 thereto; or

10 (2) any individual kept, cared for, treated, boarded or otherwise
11 accommodated in a medical care facility; or

12 (3) any individual, kept, cared for, treated, boarded or otherwise
13 accommodated in a state psychiatric hospital or state institution for people
14 with intellectual disability.

15 (b) "Adult care home" has the meaning ascribed thereto in K.S.A. 39-
16 923, and amendments thereto.

17 (c) "In need of protective services" means that a resident is unable to
18 perform or obtain services which are necessary to maintain physical or
19 mental health, or both.

20 (d) "Services which are necessary to maintain physical and mental
21 health" include, but are not limited to, the provision of medical care for
22 physical and mental health needs, the relocation of a resident to a facility
23 or institution able to offer such care, assistance in personal hygiene, food,
24 clothing, adequately heated and ventilated shelter, protection from health
25 and safety hazards, protection from maltreatment the result of which
26 includes, but is not limited to, malnutrition, deprivation of necessities or
27 physical punishment and transportation necessary to secure any of the
28 above stated needs, except that this term shall not include taking such
29 person into custody without consent, except as provided in this act.

30 (e) "Protective services" means services provided by the state or other
31 governmental agency or any private organizations or individuals which are
32 necessary to prevent abuse, neglect or exploitation. Such protective
33 services shall include, but not be limited to, evaluation of the need for
34 services, assistance in obtaining appropriate social services and assistance
35 in securing medical and legal services.

36 (f) "Abuse" means any act or failure to act performed intentionally or
37 recklessly that causes or is likely to cause harm to a resident, including:

38 (1) Infliction of physical or mental injury;

39 (2) any sexual act with a resident when the resident does not consent
40 or when the other person knows or should know that the resident is
41 incapable of resisting or declining consent to the sexual act due to mental
42 deficiency or disease or due to fear of retribution or hardship;

43 (3) unreasonable use of a physical restraint, isolation or medication

1 that harms or is likely to harm a resident;

2 (4) unreasonable use of a physical or chemical restraint, medication
3 or isolation as punishment, for convenience, in conflict with a physician's
4 *or advanced practice registered nurse's* orders or as a substitute for
5 treatment, except where such conduct or physical restraint is in furtherance
6 of the health and safety of the resident or another resident;

7 (5) a threat or menacing conduct directed toward a resident that
8 results or might reasonably be expected to result in fear or emotional or
9 mental distress to a resident;

10 (6) fiduciary abuse; or

11 (7) omission or deprivation by a caretaker or another person of goods
12 or services which are necessary to avoid physical or mental harm or
13 illness.

14 (g) "Neglect" means the failure or omission by one's self, caretaker or
15 another person with a duty to provide goods or services which are
16 reasonably necessary to ensure safety and well-being and to avoid physical
17 or mental harm or illness.

18 (h) "Caretaker" means a person or institution who has assumed the
19 responsibility, whether legally or not, for the care of the resident
20 voluntarily, by contract or by order of a court of competent jurisdiction.

21 (i) "Exploitation" means misappropriation of resident property or
22 intentionally taking unfair advantage of an adult's physical or financial
23 resources for another individual's personal or financial advantage by the
24 use of undue influence, coercion, harassment, duress, deception, false
25 representation or false pretense by a caretaker or another person.

26 (j) "Medical care facility" means a facility licensed under K.S.A. 65-
27 425 et seq., and amendments thereto, but shall not include, for purposes of
28 this act, a state psychiatric hospital or state institution for people with
29 intellectual disability, including Larned state hospital, Osawatimie state
30 hospital and Rainbow mental health facility, Kansas neurological institute
31 and Parsons state hospital and training center.

32 (k) "Fiduciary abuse" means a situation in which any person who is
33 the caretaker of, or who stands in a position of trust to, a resident, takes,
34 secretes, or appropriates the resident's money or property, to any use or
35 purpose not in the due and lawful execution of such person's trust.

36 (l) "State psychiatric hospital" means Larned state hospital,
37 Osawatimie state hospital and Rainbow mental health facility.

38 (m) "State institution for people with intellectual disability" means
39 Kansas neurological institute and Parsons state hospital and training
40 center.

41 (n) "Report" means a description or accounting of an incident or
42 incidents of abuse, neglect or exploitation under this act and for the
43 purposes of this act shall not include any written assessment or findings.

1 (o) "Law enforcement" means the public office which is vested by
2 law with the duty to maintain public order, make arrests for crimes and
3 investigate criminal acts, whether that duty extends to all crimes or is
4 limited to specific crimes.

5 (p) "Legal representative" means an agent designated in a durable
6 power of attorney, power of attorney or durable power of attorney for
7 health care decisions or a court appointed guardian, conservator or trustee.

8 (q) "Financial institution" means any bank, trust company, escrow
9 company, finance company, saving institution or credit union, chartered
10 and supervised under state or federal law.

11 (r) "Governmental assistance provider" means an agency, or
12 employee of such agency, which is funded solely or in part to provide
13 assistance within the Kansas senior care act, K.S.A. 75-5926 et seq., and
14 amendments thereto, including medicaid and medicare.

15 No person shall be considered to be abused, neglected or exploited or
16 in need of protective services for the sole reason that such person relies
17 upon spiritual means through prayer alone for treatment in accordance
18 with the tenets and practices of a recognized church or religious
19 denomination in lieu of medical treatment.

20 Sec. 5. K.S.A. 2014 Supp. 39-1430 is hereby amended to read as
21 follows: 39-1430. As used in this act:

22 (a) "Adult" means an individual 18 years of age or older alleged to be
23 unable to protect their own interest and who is harmed or threatened with
24 harm, whether financial, mental or physical in nature, through action or
25 inaction by either another individual or through their own action or
26 inaction when: (1) Such person is residing in such person's own home, the
27 home of a family member or the home of a friend; (2) such person resides
28 in an adult family home as defined in K.S.A. 39-1501, and amendments
29 thereto; or (3) such person is receiving services through a provider of
30 community services and affiliates thereof operated or funded by the
31 Kansas department for children and families or the Kansas department for
32 aging and disability services or a residential facility licensed pursuant to
33 K.S.A. 75-3307b, and amendments thereto. Such term shall not include
34 persons to whom K.S.A. 39-1401 et seq., and amendments thereto, apply.

35 (b) "Abuse" means any act or failure to act performed intentionally or
36 recklessly that causes or is likely to cause harm to an adult, including:

37 (1) Infliction of physical or mental injury;

38 (2) any sexual act with an adult when the adult does not consent or
39 when the other person knows or should know that the adult is incapable of
40 resisting or declining consent to the sexual act due to mental deficiency or
41 disease or due to fear of retribution or hardship;

42 (3) unreasonable use of a physical restraint, isolation or medication
43 that harms or is likely to harm an adult;

1 (4) unreasonable use of a physical or chemical restraint, medication
2 or isolation as punishment, for convenience, in conflict with a physician's
3 *or advanced practice registered nurse's* orders or as a substitute for
4 treatment, except where such conduct or physical restraint is in furtherance
5 of the health and safety of the adult;

6 (5) a threat or menacing conduct directed toward an adult that results
7 or might reasonably be expected to result in fear or emotional or mental
8 distress to an adult;

9 (6) fiduciary abuse; or

10 (7) omission or deprivation by a caretaker or another person of goods
11 or services which are necessary to avoid physical or mental harm or
12 illness.

13 (c) "Neglect" means the failure or omission by one's self, caretaker or
14 another person with a duty to supply or provide goods or services which
15 are reasonably necessary to ensure safety and well-being and to avoid
16 physical or mental harm or illness.

17 (d) "Exploitation" means misappropriation of an adult's property or
18 intentionally taking unfair advantage of an adult's physical or financial
19 resources for another individual's personal or financial advantage by the
20 use of undue influence, coercion, harassment, duress, deception, false
21 representation or false pretense by a caretaker or another person.

22 (e) "Fiduciary abuse" means a situation in which any person who is
23 the caretaker of, or who stands in a position of trust to, an adult, takes,
24 secretes, or appropriates their money or property, to any use or purpose not
25 in the due and lawful execution of such person's trust or benefit.

26 (f) "In need of protective services" means that an adult is unable to
27 provide for or obtain services which are necessary to maintain physical or
28 mental health or both.

29 (g) "Services which are necessary to maintain physical or mental
30 health or both" include, but are not limited to, the provision of medical
31 care for physical and mental health needs, the relocation of an adult to a
32 facility or institution able to offer such care, assistance in personal
33 hygiene, food, clothing, adequately heated and ventilated shelter,
34 protection from health and safety hazards, protection from maltreatment
35 the result of which includes, but is not limited to, malnutrition, deprivation
36 of necessities or physical punishment and transportation necessary to
37 secure any of the above stated needs, except that this term shall not include
38 taking such person into custody without consent except as provided in this
39 act.

40 (h) "Protective services" means services provided by the state or other
41 governmental agency or by private organizations or individuals which are
42 necessary to prevent abuse, neglect or exploitation. Such protective
43 services shall include, but shall not be limited to, evaluation of the need for

1 services, assistance in obtaining appropriate social services, and assistance
2 in securing medical and legal services.

3 (i) "Caretaker" means a person who has assumed the responsibility,
4 whether legally or not, for an adult's care or financial management or both.

5 (j) "Secretary" means the secretary for the Kansas department for
6 children and families.

7 (k) "Report" means a description or accounting of an incident or
8 incidents of abuse, neglect or exploitation under this act and for the
9 purposes of this act shall not include any written assessment or findings.

10 (l) "Law enforcement" means the public office which is vested by law
11 with the duty to maintain public order, make arrests for crimes, investigate
12 criminal acts and file criminal charges, whether that duty extends to all
13 crimes or is limited to specific crimes.

14 (m) "Involved adult" means the adult who is the subject of a report of
15 abuse, neglect or exploitation under this act.

16 (n) "Legal representative," "financial institution" and "governmental
17 assistance provider" shall have the meanings ascribed thereto in K.S.A.
18 39-1401, and amendments thereto.

19 No person shall be considered to be abused, neglected or exploited or
20 in need of protective services for the sole reason that such person relies
21 upon spiritual means through prayer alone for treatment in accordance
22 with the tenets and practices of a recognized church or religious
23 denomination in lieu of medical treatment.

24 Sec. 6. K.S.A. 2014 Supp. 39-1504 is hereby amended to read as
25 follows: 39-1504. The secretary shall administer the adult family home
26 registration program in accordance with the following requirements:

27 (a) (1) The home shall meet health standards and safety regulations of
28 the community and the provisions of chapter 20 of the national fire
29 protection association, life safety code, pamphlet no. 101, 1981 edition.

30 (2) The home shall have a written plan to get persons out of the home
31 rapidly in case of fire, tornado or other emergency.

32 (3) No more than two clients shall be in residence at any one time.

33 (4) The home shall have adequate living and sleeping space for
34 clients.

35 (5) Each room shall have an operable outside window.

36 (6) Electric fans shall be made available to reduce the temperature if
37 there is no air conditioning. Rooms shall be heated, lighted, ventilated and
38 available.

39 (7) Sleeping rooms shall have space for personal items.

40 (8) Each client shall have a bed which is clean and in good condition.

41 (9) Lavatory and toilet facilities shall be accessible, available and in
42 working order.

43 (10) The kitchen shall be clean with appliances in good working

1 order.

2 (b) (1) A healthy and safe environment shall be maintained for
3 clients.

4 (2) There shall be a telephone in the home.

5 (3) The provider may assist a client with the taking of medications
6 when the medication is in a labeled bottle which clearly shows a
7 physician's orders *or an advanced practice registered nurse's orders* and
8 when the client requires assistance because of tremor, visual impairment,
9 or similar reasons due to health conditions. The provider may assist or
10 perform for the client such physical activities which do not require daily
11 supervision such as assistance with eating, bathing and dressing, help with
12 brace or walker and transferring from wheelchairs.

13 (4) There shall be no use of corporal punishment, restraints or
14 punitive measures.

15 (5) The house shall be free from accumulated dirt, trash and vermin.

16 (6) Meals shall be planned and prepared for adequate nutrition, and
17 for diets if directed by a physician.

18 (c) (1) The provider shall be at least 18 years of age and in good
19 health at the time of initial application for registration. A written statement
20 must be received from a physician, nurse practitioner, or physician
21 assistant stating that the applicant and the members of the applicant's
22 household are free of any infectious or communicable disease or health
23 condition and are physically and mentally healthy. Such statements shall
24 be renewed every two years.

25 (2) The provider shall not be totally dependent on the income from
26 the clients for support of the provider or the provider's family.

27 (3) A criminal conviction shall not necessarily exclude registration as
28 an adult family home; but an investigation thereof will be made as part of
29 the determination of the suitability of the home.

30 (4) The provider shall be responsible for supervision at all times and
31 shall be in charge of the home and provision of care, or shall have a
32 responsible person on call. Any such substitute responsible person shall
33 meet the same requirements as the provider.

34 (5) The provider is responsible for encouraging the client to seek and
35 utilize available services when needed.

36 (6) The provider shall comply with the requirements of state and
37 federal regulations concerning civil rights and section 504 of the federal
38 rehabilitation act of 1973.

39 (7) The provider shall assure that clients have the privilege of privacy
40 as well as the right to see relatives, friends and participate in regular
41 community activities.

42 (8) The provider shall keep client information confidential. The use or
43 disclosure of any information concerning a client for any purpose is

1 prohibited except on written consent of the client or upon order of the
2 court.

3 (9) The provider shall maintain contact with an assigned social
4 worker and shall allow the secretary and authorized representatives of the
5 secretary access to the home and grounds and to the records related to
6 clients in residence.

7 (10) The provider shall inform the social worker immediately of any
8 unscheduled client absence from the home.

9 (11) The provider is responsible for helping clients maintain their
10 clothing.

11 (12) The provider shall furnish or help clients arrange for
12 transportation.

13 (13) The provider shall help a client arrange for emergency and
14 regular medical care when necessary.

15 (14) The provider shall submit any information relating to the
16 operation of the adult family home which is required by the secretary.

17 Sec. 7. K.S.A. 40-4602 is hereby amended to read as follows: 40-
18 4602. As used in this act:

19 (a) "Emergency medical condition" means the sudden and, at the
20 time, unexpected onset of a health condition that requires immediate
21 medical attention, where failure to provide medical attention would result
22 in serious impairment to bodily functions or serious dysfunction of a
23 bodily organ or part, or would place the person's health in serious
24 jeopardy.

25 (b) "Emergency services" means ambulance services and health care
26 items and services furnished or required to evaluate and treat an
27 emergency medical condition, as directed or ordered by a physician *or an*
28 *advanced practice registered nurse*.

29 (c) "Health benefit plan" means any hospital or medical expense
30 policy, health, hospital or medical service corporation contract, a plan
31 provided by a municipal group-funded pool, a policy or agreement entered
32 into by a health insurer or a health maintenance organization contract
33 offered by an employer or any certificate issued under any such policies,
34 contracts or plans. "Health benefit plan" does not include policies or
35 certificates covering only accident, credit, dental, disability income, long-
36 term care, hospital indemnity, medicare supplement, specified disease,
37 vision care, coverage issued as a supplement to liability insurance,
38 insurance arising out of a workers compensation or similar law,
39 automobile medical-payment insurance, or insurance under which benefits
40 are payable with or without regard to fault and which is statutorily
41 required to be contained in any liability insurance policy or equivalent
42 self-insurance.

43 (d) "Health insurer" means any insurance company, nonprofit medical

1 and hospital service corporation, municipal group-funded pool, fraternal
2 benefit society, health maintenance organization, or any other entity which
3 offers a health benefit plan subject to the Kansas Statutes Annotated.

4 (e) "Insured" means a person who is covered by a health benefit plan.

5 (f) "Participating provider" means a provider who, under a contract
6 with the health insurer or with its contractor or subcontractor, has agreed
7 to provide one or more health care services to insureds with an expectation
8 of receiving payment, other than coinsurance, copayments or deductibles,
9 directly or indirectly from the health insurer.

10 (g) "Provider" means a physician, *advanced practice registered nurse*,
11 hospital or other person which is licensed, accredited or certified to
12 perform specified health care services.

13 (h) "Provider network" means those participating providers who have
14 entered into a contract or agreement with a health insurer to provide items
15 or health care services to individuals covered by a health benefit plan
16 offered by such health insurer.

17 (i) "Physician" means a person licensed by the state board of healing
18 arts to practice medicine and surgery.

19 Sec. 8. K.S.A. 59-2976 is hereby amended to read as follows: 59-
20 2976. (a) Medications and other treatments shall be prescribed, ordered
21 and administered only in conformity with accepted clinical practice.
22 Medication shall be administered only upon the written order of a
23 physician *or an advanced practice registered nurse* or upon a verbal order
24 noted in the patient's medical records and subsequently signed by the
25 physician *or an advanced practice registered nurse*. The attending
26 physician *or an advanced practice registered nurse* shall review regularly
27 the drug regimen of each patient under the physician's *or an advanced*
28 *practice registered nurse's* care and shall monitor any symptoms of
29 harmful side effects. Prescriptions for psychotropic medications shall be
30 written with a termination date not exceeding 30 days thereafter but may
31 be renewed.

32 (b) During the course of treatment the responsible physician, *an*
33 *advanced practice registered nurse* or psychologist or such person's
34 designee shall reasonably consult with the patient, the patient's legal
35 guardian, or a minor patient's parent and give consideration to the views
36 the patient, legal guardian or parent expresses concerning treatment and
37 any alternatives. No medication or other treatment may be administered to
38 any voluntary patient without the patient's consent, or the consent of such
39 patient's legal guardian or of such patient's parent if the patient is a minor.

40 (c) Consent for medical or surgical treatments not intended primarily
41 to treat a patient's mental disorder shall be obtained in accordance with
42 applicable law.

43 (d) Whenever any patient is receiving treatment pursuant to K.S.A.

1 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and
2 amendments thereto, and the treatment facility is administering to the
3 patient any medication or other treatment which alters the patient's mental
4 state in such a way as to adversely affect the patient's judgment or hamper
5 the patient in preparing for or participating in any hearing provided for by
6 this act, then two days prior to and during any such hearing, the treatment
7 facility may not administer such medication or other treatment unless such
8 medication or other treatment is necessary to sustain the patient's life or to
9 protect the patient or others. Prior to the hearing, a report of all such
10 medications or other treatment which have been administered to the
11 patient, along with a copy of any written consent(s) which the patient may
12 have signed, shall be submitted to the court. Counsel for the patient may
13 preliminarily examine the attending physician regarding the administration
14 of any medication to the patient within two days of the hearing with regard
15 to the affect that medication may have had upon the patient's judgment or
16 ability to prepare for or participate in the hearing. On the basis thereof, if
17 the court determines that medication or other treatment has been
18 administered which adversely affects the patient's judgment or ability to
19 prepare for or participate in the hearing, the court may grant to the patient
20 a reasonable continuance in order to allow for the patient to be better able
21 to prepare for or participate in the hearing and the court shall order that
22 such medication or other treatment be discontinued until the conclusion of
23 the hearing, unless the court finds that such medication or other treatment
24 is necessary to sustain the patient's life or to protect the patient or others,
25 in which case the court shall order that the hearing proceed.

26 (e) Whenever a patient receiving treatment pursuant to K.S.A. 59-
27 2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments
28 thereto, objects to taking any medication prescribed for psychiatric
29 treatment, and after full explanation of the benefits and risks of such
30 medication continues their objection, the medication may be administered
31 over the patient's objection; except that the objection shall be recorded in
32 the patient's medical record and at the same time written notice thereof
33 shall be forwarded to the medical director of the treatment facility or the
34 director's designee. Within five days after receiving such notice, excluding
35 Saturdays, Sundays and legal holidays, the medical director or designee
36 shall deliver to the patient and the patient's physician the medical director's
37 or designee's written decision concerning the administration of that
38 medication, and a copy of that decision shall be placed in the patient's
39 medical record.

40 (f) In no case shall experimental medication be administered without
41 the patient's consent, which consent shall be obtained in accordance with
42 ~~subsection (a)(6) of~~ K.S.A. 59-2978(a)(6), and amendments thereto.

43 Sec. 9. K.S.A. 2014 Supp. 65-468 is hereby amended to read as

1 follows: 65-468. As used in K.S.A. 65-468 to 65-474, inclusive, and
2 amendments thereto:

3 (a) "Health care provider" means any person licensed or otherwise
4 authorized by law to provide health care services in this state or a
5 professional corporation organized pursuant to the professional
6 corporation law of Kansas by persons who are authorized by law to form
7 such corporation and who are health care providers as defined by this
8 subsection, or an officer, employee or agent thereof, acting in the course
9 and scope of employment or agency.

10 (b) "Member" means any hospital, emergency medical service, local
11 health department, home health agency, adult care home, medical clinic,
12 mental health center or clinic or nonemergency transportation system.

13 (c) "Mid-level practitioner" means a physician assistant or advanced
14 practice registered nurse who has entered into a written protocol with a
15 rural health network physician.

16 (d) *"Advanced practice registered nurse" means an advanced*
17 *practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
18 *amendments thereto, and who has authority to prescribe drugs in*
19 *accordance with K.S.A. 65-1130, and amendments thereto.*

20 (e) "Physician" means a person licensed to practice medicine and
21 surgery.

22 (f) "Rural health network" means an alliance of members
23 including at least one critical access hospital and at least one other hospital
24 which has developed a comprehensive plan submitted to and approved by
25 the secretary of health and environment regarding patient referral and
26 transfer; the provision of emergency and nonemergency transportation
27 among members; the development of a network-wide emergency services
28 plan; and the development of a plan for sharing patient information and
29 services between hospital members concerning medical staff credentialing,
30 risk management, quality assurance and peer review.

31 (g) "Critical access hospital" means a member of a rural health
32 network which makes available twenty-four hour emergency care services;
33 provides not more than 25 acute care inpatient beds or in the case of a
34 facility with an approved swing-bed agreement a combined total of
35 extended care and acute care beds that does not exceed 25 beds; provides
36 acute inpatient care for a period that does not exceed, on an annual average
37 basis, 96 hours per patient; and provides nursing services under the
38 direction of a licensed professional nurse and continuous licensed
39 professional nursing services for not less than 24 hours of every day when
40 any bed is occupied or the facility is open to provide services for patients
41 unless an exemption is granted by the licensing agency pursuant to rules
42 and regulations. The critical access hospital may provide any services
43 otherwise required to be provided by a full-time, on-site dietician,

1 pharmacist, laboratory technician, medical technologist and radiological
2 technologist on a part-time, off-site basis under written agreements or
3 arrangements with one or more providers or suppliers recognized under
4 medicare. The critical access hospital may provide inpatient services by a
5 physician assistant, ~~advanced practice registered nurse or a clinical nurse~~
6 ~~specialist~~ subject to the oversight of a physician who need not be present
7 in the facility *or by an advanced practice registered nurse*. In addition to
8 the facility's 25 acute beds or swing beds, or both, the critical access
9 hospital may have a psychiatric unit or a rehabilitation unit, or both. Each
10 unit shall not exceed 10 beds and neither unit will count toward the 25-bed
11 limit, nor will these units be subject to the average 96-hour length of stay
12 restriction.

13 ~~(g)~~ (h) "Hospital" means a hospital other than a critical access
14 hospital which has entered into a written agreement with at least one
15 critical access hospital to form a rural health network and to provide
16 medical or administrative supporting services within the limit of the
17 hospital's capabilities.

18 Sec. 10. K.S.A. 2014 Supp. 65-507 is hereby amended to read as
19 follows: 65-507. (a) Each maternity center licensee shall keep a record
20 upon forms prescribed and provided by the secretary of health and
21 environment and the secretary for children and families which shall
22 include the name of every patient, together with the patient's place of
23 residence during the year preceding admission to the center and the name
24 and address of the attending physician *or advanced practice registered*
25 *nurse in the classification of a nurse-midwife*. Each child care facility
26 licensee shall keep a record upon forms prescribed and provided by the
27 secretary of health and environment which shall include the name and age
28 of each child received and cared for in the facility; the name of the
29 physician who attended any sick children in the facility, together with the
30 names and addresses of the parents or guardians of such children; and such
31 other information as the secretary of health and environment or secretary
32 for children and families may require. Each maternity center licensee and
33 each child care facility licensee shall apply to and shall receive without
34 charge from the secretary of health and environment and the secretary for
35 children and families forms for such records as may be required, which
36 forms shall contain a copy of this act.

37 (b) Information obtained under this section shall be confidential and
38 shall not be made public in a manner which would identify individuals.

39 Sec. 11. K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
40 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
41 read as follows: 65-1626. For the purposes of this act:

42 (a) "Administer" means the direct application of a drug, whether by
43 injection, inhalation, ingestion or any other means, to the body of a patient

1 or research subject by:

2 (1) A practitioner or pursuant to the lawful direction of a practitioner;

3 (2) the patient or research subject at the direction and in the presence
4 of the practitioner; or

5 (3) a pharmacist as authorized in K.S.A. 65-1635a, and amendments
6 thereto.

7 (b) "Agent" means an authorized person who acts on behalf of or at
8 the direction of a manufacturer, distributor or dispenser but shall not
9 include a common carrier, public warehouseman or employee of the
10 carrier or warehouseman when acting in the usual and lawful course of the
11 carrier's or warehouseman's business.

12 (c) "Application service provider" means an entity that sells
13 electronic prescription or pharmacy prescription applications as a hosted
14 service where the entity controls access to the application and maintains
15 the software and records on its server.

16 (d) "Authorized distributor of record" means a wholesale distributor
17 with whom a manufacturer has established an ongoing relationship to
18 distribute the manufacturer's prescription drug. An ongoing relationship is
19 deemed to exist between such wholesale distributor and a manufacturer
20 when the wholesale distributor, including any affiliated group of the
21 wholesale distributor, as defined in section 1504 of the internal revenue
22 code, complies with any one of the following: (1) The wholesale
23 distributor has a written agreement currently in effect with the
24 manufacturer evidencing such ongoing relationship; and (2) the wholesale
25 distributor is listed on the manufacturer's current list of authorized
26 distributors of record, which is updated by the manufacturer on no less
27 than a monthly basis.

28 (e) "Board" means the state board of pharmacy created by K.S.A. 74-
29 1603, and amendments thereto.

30 (f) "Brand exchange" means the dispensing of a different drug
31 product of the same dosage form and strength and of the same generic
32 name as the brand name drug product prescribed.

33 (g) "Brand name" means the registered trademark name given to a
34 drug product by its manufacturer, labeler or distributor.

35 (h) "Chain pharmacy warehouse" means a permanent physical
36 location for drugs or devices, or both, that acts as a central warehouse and
37 performs intracompany sales or transfers of prescription drugs or devices
38 to chain pharmacies that have the same ownership or control. Chain
39 pharmacy warehouses must be registered as wholesale distributors.

40 (i) "Co-licensee" means a pharmaceutical manufacturer that has
41 entered into an agreement with another pharmaceutical manufacturer to
42 engage in a business activity or occupation related to the manufacture or
43 distribution of a prescription drug and the national drug code on the drug

1 product label shall be used to determine the identity of the drug
2 manufacturer.

3 (j) "DEA" means the U.S. department of justice, drug enforcement
4 administration.

5 (k) "Deliver" or "delivery" means the actual, constructive or
6 attempted transfer from one person to another of any drug whether or not
7 an agency relationship exists.

8 (l) "Direct supervision" means the process by which the responsible
9 pharmacist shall observe and direct the activities of a pharmacy student or
10 pharmacy technician to a sufficient degree to assure that all such activities
11 are performed accurately, safely and without risk or harm to patients, and
12 complete the final check before dispensing.

13 (m) "Dispense" means to deliver prescription medication to the
14 ultimate user or research subject by or pursuant to the lawful order of a
15 practitioner or pursuant to the prescription of a mid-level practitioner.

16 (n) "Dispenser" means a practitioner or pharmacist who dispenses
17 prescription medication, or a physician assistant who has authority to
18 dispense prescription-only drugs in accordance with ~~subsection (b) of~~
19 K.S.A. 65-28a08(b), and amendments thereto.

20 (o) "Distribute" means to deliver, other than by administering or
21 dispensing, any drug.

22 (p) "Distributor" means a person who distributes a drug.

23 (q) "Drop shipment" means the sale, by a manufacturer, that
24 manufacturer's co-licensee, that manufacturer's third party logistics
25 provider, or that manufacturer's exclusive distributor, of the manufacturer's
26 prescription drug, to a wholesale distributor whereby the wholesale
27 distributor takes title but not possession of such prescription drug and the
28 wholesale distributor invoices the pharmacy, the chain pharmacy
29 warehouse, or other designated person authorized by law to dispense or
30 administer such prescription drug, and the pharmacy, the chain pharmacy
31 warehouse, or other designated person authorized by law to dispense or
32 administer such prescription drug receives delivery of the prescription
33 drug directly from the manufacturer, that manufacturer's co-licensee, that
34 manufacturer's third party logistics provider, or that manufacturer's
35 exclusive distributor, of such prescription drug. Drop shipment shall be
36 part of the "normal distribution channel."

37 (r) "Drug" means: (1) Articles recognized in the official United States
38 pharmacopoeia, or other such official compendiums of the United States,
39 or official national formulary, or any supplement of any of them; (2)
40 articles intended for use in the diagnosis, cure, mitigation, treatment or
41 prevention of disease in man or other animals; (3) articles, other than food,
42 intended to affect the structure or any function of the body of man or other
43 animals; and (4) articles intended for use as a component of any articles

1 specified in clause (1), (2) or (3) of this subsection; but does not include
2 devices or their components, parts or accessories, except that the term
3 "drug" shall not include amygdalin (laetrile) or any livestock remedy, if
4 such livestock remedy had been registered in accordance with the
5 provisions of article 5 of chapter 47 of the Kansas Statutes Annotated,
6 prior to its repeal.

7 (s) "Durable medical equipment" means technologically sophisticated
8 medical devices that may be used in a residence, including the following:
9 (1) Oxygen and oxygen delivery system; (2) ventilators; (3) respiratory
10 disease management devices; (4) continuous positive airway pressure
11 (CPAP) devices; (5) electronic and computerized wheelchairs and seating
12 systems; (6) apnea monitors; (7) transcutaneous electrical nerve stimulator
13 (TENS) units; (8) low air loss cutaneous pressure management devices; (9)
14 sequential compression devices; (10) feeding pumps; (11) home
15 phototherapy devices; (12) infusion delivery devices; (13) distribution of
16 medical gases to end users for human consumption; (14) hospital beds;
17 (15) nebulizers; or (16) other similar equipment determined by the board
18 in rules and regulations adopted by the board.

19 (t) "Electronic prescription" means an electronically prepared
20 prescription that is authorized and transmitted from the prescriber to the
21 pharmacy by means of electronic transmission.

22 (u) "Electronic prescription application" means software that is used
23 to create electronic prescriptions and that is intended to be installed on the
24 prescriber's computers and servers where access and records are controlled
25 by the prescriber.

26 (v) "Electronic signature" means a confidential personalized digital
27 key, code, number or other method for secure electronic data transmissions
28 which identifies a particular person as the source of the message,
29 authenticates the signatory of the message and indicates the person's
30 approval of the information contained in the transmission.

31 (w) "Electronic transmission" means the transmission of an electronic
32 prescription, formatted as an electronic data file, from a prescriber's
33 electronic prescription application to a pharmacy's computer, where the
34 data file is imported into the pharmacy prescription application.

35 (x) "Electronically prepared prescription" means a prescription that is
36 generated using an electronic prescription application.

37 (y) "Exclusive distributor" means any entity that: (1) Contracts with a
38 manufacturer to provide or coordinate warehousing, wholesale distribution
39 or other services on behalf of a manufacturer and who takes title to that
40 manufacturer's prescription drug, but who does not have general
41 responsibility to direct the sale or disposition of the manufacturer's
42 prescription drug; (2) is registered as a wholesale distributor under the
43 pharmacy act of the state of Kansas; and (3) to be considered part of the

1 normal distribution channel, must be an authorized distributor of record.

2 (z) "Facsimile transmission" or "fax transmission" means the
3 transmission of a digital image of a prescription from the prescriber or the
4 prescriber's agent to the pharmacy. "Facsimile transmission" includes, but
5 is not limited to, transmission of a written prescription between the
6 prescriber's fax machine and the pharmacy's fax machine; transmission of
7 an electronically prepared prescription from the prescriber's electronic
8 prescription application to the pharmacy's fax machine, computer or
9 printer; or transmission of an electronically prepared prescription from the
10 prescriber's fax machine to the pharmacy's fax machine, computer or
11 printer.

12 (aa) "Generic name" means the established chemical name or official
13 name of a drug or drug product.

14 (bb) (1) "Institutional drug room" means any location where
15 prescription-only drugs are stored and from which prescription-only drugs
16 are administered or dispensed and which is maintained or operated for the
17 purpose of providing the drug needs of:

18 (A) Inmates of a jail or correctional institution or facility;

19 (B) residents of a juvenile detention facility, as defined by the revised
20 Kansas code for care of children and the revised Kansas juvenile justice
21 code;

22 (C) students of a public or private university or college, a community
23 college or any other institution of higher learning which is located in
24 Kansas;

25 (D) employees of a business or other employer; or

26 (E) persons receiving inpatient hospice services.

27 (2) "Institutional drug room" does not include:

28 (A) Any registered pharmacy;

29 (B) any office of a practitioner; or

30 (C) a location where no prescription-only drugs are dispensed and no
31 prescription-only drugs other than individual prescriptions are stored or
32 administered.

33 (cc) "Intermediary" means any technology system that receives and
34 transmits an electronic prescription between the prescriber and the
35 pharmacy.

36 (dd) "Intracompany transaction" means any transaction or transfer
37 between any division, subsidiary, parent or affiliated or related company
38 under common ownership or control of a corporate entity, or any
39 transaction or transfer between co-licensees of a co-licensed product.

40 (ee) "Medical care facility" shall have the meaning provided in
41 K.S.A. 65-425, and amendments thereto, except that the term shall also
42 include facilities licensed under the provisions of K.S.A. 75-3307b, and
43 amendments thereto, except community mental health centers and

1 facilities for people with intellectual disability.

2 (ff) "Manufacture" means the production, preparation, propagation,
3 compounding, conversion or processing of a drug either directly or
4 indirectly by extraction from substances of natural origin, independently
5 by means of chemical synthesis or by a combination of extraction and
6 chemical synthesis and includes any packaging or repackaging of the drug
7 or labeling or relabeling of its container, except that this term shall not
8 include the preparation or compounding of a drug by an individual for the
9 individual's own use or the preparation, compounding, packaging or
10 labeling of a drug by:

11 (1) A practitioner or a practitioner's authorized agent incident to such
12 practitioner's administering or dispensing of a drug in the course of the
13 practitioner's professional practice;

14 (2) a practitioner, by a practitioner's authorized agent or under a
15 practitioner's supervision for the purpose of, or as an incident to, research,
16 teaching or chemical analysis and not for sale; or

17 (3) a pharmacist or the pharmacist's authorized agent acting under the
18 direct supervision of the pharmacist for the purpose of, or incident to, the
19 dispensing of a drug by the pharmacist.

20 (gg) "Manufacturer" means a person licensed or approved by the FDA
21 to engage in the manufacture of drugs and devices.

22 (hh) "Mid-level practitioner" means ~~an advanced practice registered~~
23 ~~nurse issued a license pursuant to K.S.A. 65-1131, and amendments~~
24 ~~thereto, who has authority to prescribe drugs pursuant to a written protocol~~
25 ~~with a responsible physician under K.S.A. 65-1130, and amendments~~
26 ~~thereto, or a physician assistant licensed pursuant to the physician assistant~~
27 ~~licensure act who has authority to prescribe drugs pursuant to a written~~
28 ~~protocol with a supervising physician under K.S.A. 65-28a08, and~~
29 ~~amendments thereto.~~

30 (ii) "Normal distribution channel" means a chain of custody for a
31 prescription-only drug that goes from a manufacturer of the prescription-
32 only drug, from that manufacturer to that manufacturer's co-licensed
33 partner, from that manufacturer to that manufacturer's third-party logistics
34 provider, or from that manufacturer to that manufacturer's exclusive
35 distributor, directly or by drop shipment, to:

36 (1) A pharmacy to a patient or to other designated persons authorized
37 by law to dispense or administer such drug to a patient;

38 (2) a wholesale distributor to a pharmacy to a patient or other
39 designated persons authorized by law to dispense or administer such drug
40 to a patient;

41 (3) a wholesale distributor to a chain pharmacy warehouse to that
42 chain pharmacy warehouse's intracompany pharmacy to a patient or other
43 designated persons authorized by law to dispense or administer such drug

1 to a patient; or

2 (4) a chain pharmacy warehouse to the chain pharmacy warehouse's
3 intracompany pharmacy to a patient or other designated persons authorized
4 by law to dispense or administer such drug to a patient.

5 (jj) "Person" means individual, corporation, government,
6 governmental subdivision or agency, partnership, association or any other
7 legal entity.

8 (kk) "Pharmacist" means any natural person licensed under this act to
9 practice pharmacy.

10 (ll) "Pharmacist-in-charge" means the pharmacist who is responsible
11 to the board for a registered establishment's compliance with the laws and
12 regulations of this state pertaining to the practice of pharmacy,
13 manufacturing of drugs and the distribution of drugs. The pharmacist-in-
14 charge shall supervise such establishment on a full-time or a part-time
15 basis and perform such other duties relating to supervision of a registered
16 establishment as may be prescribed by the board by rules and regulations.
17 Nothing in this definition shall relieve other pharmacists or persons from
18 their responsibility to comply with state and federal laws and regulations.

19 (mm) "Pharmacist intern" means: (1) A student currently enrolled in
20 an accredited pharmacy program; (2) a graduate of an accredited pharmacy
21 program serving an internship; or (3) a graduate of a pharmacy program
22 located outside of the United States which is not accredited and who has
23 successfully passed equivalency examinations approved by the board.

24 (nn) "Pharmacy," "drugstore" or "apothecary" means premises,
25 laboratory, area or other place: (1) Where drugs are offered for sale where
26 the profession of pharmacy is practiced and where prescriptions are
27 compounded and dispensed; or (2) which has displayed upon it or within it
28 the words "pharmacist," "pharmaceutical chemist," "pharmacy,"
29 "apothecary," "drugstore," "druggist," "drugs," "drug sundries" or any of
30 these words or combinations of these words or words of similar import
31 either in English or any sign containing any of these words; or (3) where
32 the characteristic symbols of pharmacy or the characteristic prescription
33 sign "Rx" may be exhibited. As used in this subsection, premises refers
34 only to the portion of any building or structure leased, used or controlled
35 by the licensee in the conduct of the business registered by the board at the
36 address for which the registration was issued.

37 (oo) "Pharmacy prescription application" means software that is used
38 to process prescription information, is installed on a pharmacy's computers
39 or servers, and is controlled by the pharmacy.

40 (pp) "Pharmacy technician" means an individual who, under the
41 direct supervision and control of a pharmacist, may perform packaging,
42 manipulative, repetitive or other nondiscretionary tasks related to the
43 processing of a prescription or medication order and who assists the

1 pharmacist in the performance of pharmacy related duties, but who does
2 not perform duties restricted to a pharmacist.

3 (qq) "Practitioner" means a person licensed to practice medicine and
4 surgery, dentist, podiatrist, veterinarian, optometrist, *advanced practice*
5 *registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
6 *amendments thereto, and who has authority to prescribe drugs in*
7 *accordance with K.S.A. 65-1130, and amendments thereto, a registered*
8 *nurse anesthetist registered pursuant to K.S.A. 65-1154, and amendments*
9 *thereto, or scientific investigator or other person authorized by law to use a*
10 *prescription-only drug in teaching or chemical analysis or to conduct*
11 *research with respect to a prescription-only drug.*

12 (rr) "Preceptor" means a licensed pharmacist who possesses at least
13 two years' experience as a pharmacist and who supervises students
14 obtaining the pharmaceutical experience required by law as a condition to
15 taking the examination for licensure as a pharmacist.

16 (ss) "Prescriber" means a practitioner or a mid-level practitioner.

17 (tt) "Prescription" or "prescription order" means: (1) An order to be
18 filled by a pharmacist for prescription medication issued and signed by a
19 prescriber in the authorized course of such prescriber's professional
20 practice; or (2) an order transmitted to a pharmacist through word of
21 mouth, note, telephone or other means of communication directed by such
22 prescriber, regardless of whether the communication is oral, electronic,
23 facsimile or in printed form.

24 (uu) "Prescription medication" means any drug, including label and
25 container according to context, which is dispensed pursuant to a
26 prescription order.

27 (vv) "Prescription-only drug" means any drug whether intended for
28 use by man or animal, required by federal or state law, including 21 U.S.C.
29 § 353, to be dispensed only pursuant to a written or oral prescription or
30 order of a practitioner or is restricted to use by practitioners only.

31 (ww) "Probation" means the practice or operation under a temporary
32 license, registration or permit or a conditional license, registration or
33 permit of a business or profession for which a license, registration or
34 permit is granted by the board under the provisions of the pharmacy act of
35 the state of Kansas requiring certain actions to be accomplished or certain
36 actions not to occur before a regular license, registration or permit is
37 issued.

38 (xx) "Professional incompetency" means:

39 (1) One or more instances involving failure to adhere to the
40 applicable standard of pharmaceutical care to a degree which constitutes
41 gross negligence, as determined by the board;

42 (2) repeated instances involving failure to adhere to the applicable
43 standard of pharmaceutical care to a degree which constitutes ordinary

1 negligence, as determined by the board; or

2 (3) a pattern of pharmacy practice or other behavior which
3 demonstrates a manifest incapacity or incompetence to practice pharmacy.

4 (yy) "Readily retrievable" means that records kept by automatic data
5 processing applications or other electronic or mechanized record-keeping
6 systems can be separated out from all other records within a reasonable
7 time not to exceed 48 hours of a request from the board or other authorized
8 agent or that hard-copy records are kept on which certain items are
9 asterisked, redlined or in some other manner visually identifiable apart
10 from other items appearing on the records.

11 (zz) "Retail dealer" means a person selling at retail nonprescription
12 drugs which are prepackaged, fully prepared by the manufacturer or
13 distributor for use by the consumer and labeled in accordance with the
14 requirements of the state and federal food, drug and cosmetic acts. Such
15 nonprescription drugs shall not include: (1) A controlled substance; (2) a
16 prescription-only drug; or (3) a drug intended for human use by
17 hypodermic injection.

18 (aaa) "Secretary" means the executive secretary of the board.

19 (bbb) "Third party logistics provider" means an entity that: (1)
20 Provides or coordinates warehousing, distribution or other services on
21 behalf of a manufacturer, but does not take title to the prescription drug or
22 have general responsibility to direct the prescription drug's sale or
23 disposition; (2) is registered as a wholesale distributor under the pharmacy
24 act of the state of Kansas; and (3) to be considered part of the normal
25 distribution channel, must also be an authorized distributor of record.

26 (ccc) "Unprofessional conduct" means:

27 (1) Fraud in securing a registration or permit;

28 (2) intentional adulteration or mislabeling of any drug, medicine,
29 chemical or poison;

30 (3) causing any drug, medicine, chemical or poison to be adulterated
31 or mislabeled, knowing the same to be adulterated or mislabeled;

32 (4) intentionally falsifying or altering records or prescriptions;

33 (5) unlawful possession of drugs and unlawful diversion of drugs to
34 others;

35 (6) willful betrayal of confidential information under K.S.A. 65-1654,
36 and amendments thereto;

37 (7) conduct likely to deceive, defraud or harm the public;

38 (8) making a false or misleading statement regarding the licensee's
39 professional practice or the efficacy or value of a drug;

40 (9) commission of any act of sexual abuse, misconduct or exploitation
41 related to the licensee's professional practice; or

42 (10) performing unnecessary tests, examinations or services which
43 have no legitimate pharmaceutical purpose.

1 (ddd) "Vaccination protocol" means a written protocol, agreed to by a
2 pharmacist and a person licensed to practice medicine and surgery by the
3 state board of healing arts, which establishes procedures and
4 recordkeeping and reporting requirements for administering a vaccine by
5 the pharmacist for a period of time specified therein, not to exceed two
6 years.

7 (eee) "Valid prescription order" means a prescription that is issued for
8 a legitimate medical purpose by an individual prescriber licensed by law to
9 administer and prescribe drugs and acting in the usual course of such
10 prescriber's professional practice. A prescription issued solely on the basis
11 of an internet-based questionnaire or consultation without an appropriate
12 prescriber-patient relationship is not a valid prescription order.

13 (fff) "Veterinary medical teaching hospital pharmacy" means any
14 location where prescription-only drugs are stored as part of an accredited
15 college of veterinary medicine and from which prescription-only drugs are
16 distributed for use in treatment of or administration to a nonhuman.

17 (ggg) "Wholesale distributor" means any person engaged in
18 wholesale distribution of prescription drugs or devices in or into the state,
19 including, but not limited to, manufacturers, repackagers, own-label
20 distributors, private-label distributors, jobbers, brokers, warehouses,
21 including manufacturers' and distributors' warehouses, co-licensees,
22 exclusive distributors, third party logistics providers, chain pharmacy
23 warehouses that conduct wholesale distributions, and wholesale drug
24 warehouses, independent wholesale drug traders and retail pharmacies that
25 conduct wholesale distributions. Wholesale distributor shall not include
26 persons engaged in the sale of durable medical equipment to consumers or
27 patients.

28 (hhh) "Wholesale distribution" means the distribution of prescription
29 drugs or devices by wholesale distributors to persons other than consumers
30 or patients, and includes the transfer of prescription drugs by a pharmacy
31 to another pharmacy if the total number of units of transferred drugs
32 during a twelve-month period does not exceed 5% of the total number of
33 all units dispensed by the pharmacy during the immediately preceding
34 twelve-month period. Wholesale distribution does not include:

35 (1) The sale, purchase or trade of a prescription drug or device, an
36 offer to sell, purchase or trade a prescription drug or device or the
37 dispensing of a prescription drug or device pursuant to a prescription;

38 (2) the sale, purchase or trade of a prescription drug or device or an
39 offer to sell, purchase or trade a prescription drug or device for emergency
40 medical reasons;

41 (3) intracompany transactions, as defined in this section, unless in
42 violation of own use provisions;

43 (4) the sale, purchase or trade of a prescription drug or device or an

1 offer to sell, purchase or trade a prescription drug or device among
2 hospitals, chain pharmacy warehouses, pharmacies or other health care
3 entities that are under common control;

4 (5) the sale, purchase or trade of a prescription drug or device or the
5 offer to sell, purchase or trade a prescription drug or device by a charitable
6 organization described in 503(c)(3) of the internal revenue code of 1954 to
7 a nonprofit affiliate of the organization to the extent otherwise permitted
8 by law;

9 (6) the purchase or other acquisition by a hospital or other similar
10 health care entity that is a member of a group purchasing organization of a
11 prescription drug or device for its own use from the group purchasing
12 organization or from other hospitals or similar health care entities that are
13 members of these organizations;

14 (7) the transfer of prescription drugs or devices between pharmacies
15 pursuant to a centralized prescription processing agreement;

16 (8) the sale, purchase or trade of blood and blood components
17 intended for transfusion;

18 (9) the return of recalled, expired, damaged or otherwise non-salable
19 prescription drugs, when conducted by a hospital, health care entity,
20 pharmacy, chain pharmacy warehouse or charitable institution in
21 accordance with the board's rules and regulations;

22 (10) the sale, transfer, merger or consolidation of all or part of the
23 business of a retail pharmacy or pharmacies from or with another retail
24 pharmacy or pharmacies, whether accomplished as a purchase and sale of
25 stock or business assets, in accordance with the board's rules and
26 regulations;

27 (11) the distribution of drug samples by manufacturers' and
28 authorized distributors' representatives;

29 (12) the sale of minimal quantities of drugs by retail pharmacies to
30 licensed practitioners for office use; or

31 (13) the sale or transfer from a retail pharmacy or chain pharmacy
32 warehouse of expired, damaged, returned or recalled prescription drugs to
33 the original manufacturer, originating wholesale distributor or to a third
34 party returns processor in accordance with the board's rules and
35 regulations.

36 Sec. 12. K.S.A. 65-1660 is hereby amended to read as follows: 65-
37 1660. (a) Except as otherwise provided in this section, the provisions of
38 the pharmacy act of the state of Kansas shall not apply to dialysates,
39 devices or drugs which are designated by the board for the purposes of this
40 section relating to treatment of a person with chronic kidney failure
41 receiving dialysis and which are prescribed or ordered by a physician, *an*
42 *advanced practice registered nurse* or a mid-level practitioner for
43 administration or delivery to a person with chronic kidney failure if:

1 (1) The wholesale distributor is registered with the board and lawfully
2 holds the drug or device; and

3 (2) the wholesale distributor: (A) Delivers the drug or device to: (i) A
4 person with chronic kidney failure for self-administration at the person's
5 home or specified address; (ii) a physician for administration or delivery to
6 a person with chronic kidney failure; or (iii) a medicare approved renal
7 dialysis facility for administering or delivering to a person with chronic
8 kidney failure; and (B) has sufficient and qualified supervision to
9 adequately protect the public health.

10 (b) The wholesale distributor pursuant to subsection (a) shall be
11 supervised by a pharmacist consultant pursuant to rules and regulations
12 adopted by the board.

13 (c) The board shall adopt such rules or regulations as are necessary to
14 effectuate the provisions of this section.

15 (d) As used in this section, "physician" means a person licensed to
16 practice medicine and surgery; "mid-level practitioner" means mid-level
17 practitioner as such term is defined ~~in subsection (ii) of~~ by K.S.A. 65-
18 1626, and amendments thereto; *"advanced practice registered nurse"*
19 *means an advanced practice registered nurse who is licensed pursuant to*
20 *K.S.A. 65-1131, and amendments thereto, and who has authority to*
21 *prescribe drugs in accordance with K.S.A. 65-1130, and amendments*
22 *thereto.*

23 (e) This section shall be part of and supplemental to the pharmacy act
24 of the state of Kansas.

25 Sec. 13. K.S.A. 2014 Supp. 65-1682 is hereby amended to read as
26 follows: 65-1682. As used in this act, unless the context otherwise
27 requires:

28 (a) "Board" means the state board of pharmacy.

29 (b) "Dispenser" means a practitioner or pharmacist who delivers a
30 scheduled substance or drug of concern to an ultimate user, but does not
31 include:

32 (1) A licensed hospital pharmacy that distributes such substances for
33 the purpose of inpatient hospital care;

34 (2) a medical care facility as defined in K.S.A. 65-425, and
35 amendments thereto, practitioner or other authorized person who
36 administers such a substance;

37 (3) a registered wholesale distributor of such substances;

38 (4) a veterinarian licensed by the Kansas board of veterinary
39 examiners who dispenses or prescribes a scheduled substance or drug of
40 concern; or

41 (5) a practitioner who has been exempted from the reporting
42 requirements of this act in rules and regulations promulgated by the board.

43 (c) "Drug of concern" means any drug that demonstrates a potential

1 for abuse and is designated as a drug of concern in rules and regulations
2 promulgated by the board.

3 (d) "Patient" means the person who is the ultimate user of a drug for
4 whom a prescription is issued or for whom a drug is dispensed, or both.

5 (e) "Pharmacist" means an individual currently licensed by the board
6 to practice the profession of pharmacy in this state.

7 (f) "Practitioner" means a person licensed to practice medicine and
8 surgery, dentist, podiatrist, optometrist, *advanced practice registered nurse*
9 *who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and*
10 *who has authority to prescribe drugs in accordance with K.S.A. 65-1130,*
11 *and amendments thereto,* or other person authorized by law to prescribe or
12 dispense scheduled substances and drugs of concern.

13 (g) "Scheduled substance" means controlled substances included in
14 schedules II, III or IV of the schedules designated in K.S.A. 65-4107, 65-
15 4109 and 65-4111, and amendments thereto, respectively, or the federal
16 controlled substances act (21 U.S.C. § 812).

17 Sec. 14. K.S.A. 2014 Supp. 65-2837a is hereby amended to read as
18 follows: 65-2837a. (a) It shall be unlawful for any person licensed to
19 practice medicine and surgery to prescribe, order, dispense, administer,
20 sell, supply or give *or for any person licensed as an advanced practice*
21 *registered nurse* or for a mid-level practitioner as defined ~~in subsection (ii)~~
22 ~~of~~ by K.S.A. 65-1626, and amendments thereto, to prescribe, administer,
23 supply or give any amphetamine or sympathomimetic amine designated in
24 schedule II, III or IV under the uniform controlled substances act, except
25 as provided in this section. Failure to comply with this section by a
26 licensee shall constitute unprofessional conduct under K.S.A. 65-2837,
27 and amendments thereto.

28 (b) When any licensee prescribes, orders, dispenses, administers,
29 sells, supplies or gives or when *any advanced practice registered nurse or*
30 *any mid-level practitioner as defined in subsection (ii) of* by K.S.A. 65-
31 1626, and amendments thereto, prescribes, administers, sells, supplies or
32 gives any amphetamine or sympathomimetic amine designated in schedule
33 II, III or IV under the uniform controlled substances act, the patient's
34 medical record shall adequately document the purpose for which the drug
35 is being given. Such purpose shall be restricted to one or more of the
36 following:

- 37 (1) The treatment of narcolepsy.
- 38 (2) The treatment of drug-induced brain dysfunction.
- 39 (3) The treatment of hyperkinesis.
- 40 (4) The differential diagnostic psychiatric evaluation of depression.
- 41 (5) The treatment of depression shown by adequate medical records
42 and documentation to be unresponsive to other forms of treatment.
- 43 (6) The clinical investigation of the effects of such drugs or

1 compounds, in which case, before the investigation is begun, the licensee
2 shall, in addition to other requirements of applicable laws, apply for and
3 obtain approval of the investigation from the board of healing arts.

4 (7) The treatment of obesity with controlled substances, as may be
5 defined by rules and regulations adopted by the board of healing arts.

6 (8) The treatment of any other disorder or disease for which such
7 drugs or compounds have been found to be safe and effective by
8 competent scientific research which findings have been generally accepted
9 by the scientific community, in which case, the licensee before prescribing,
10 ordering, dispensing, administering, selling, supplying or giving the drug
11 or compound for a particular condition, or the licensee before authorizing
12 a mid-level practitioner to prescribe the drug or compound for a particular
13 condition, *or the advanced practice registered nurse before prescribing,*
14 *ordering, administering or giving the drug for a particular condition,* shall
15 obtain a determination from the board of healing arts that the drug or
16 compound can be used for that particular condition.

17 Sec. 15. K.S.A. 65-2892 is hereby amended to read as follows: 65-
18 2892. Any physician *or advanced practice registered nurse*, upon
19 consultation by any person under ~~eighteen~~ *(18)* 18 years of age as a
20 patient, may, with the consent of such person who is hereby granted the
21 right of giving such consent, make a diagnostic examination for venereal
22 disease and prescribe for and treat such person for venereal disease
23 including prophylactic treatment for exposure to venereal disease
24 whenever such person is suspected of having a venereal disease or contact
25 with anyone having a venereal disease. All such examinations and
26 treatment may be performed without the consent of, or notification to, the
27 parent, parents, guardian or any other person having custody of such
28 person. Any physician *or advanced practice registered nurse* examining or
29 treating such person for venereal disease may, but shall not be obligated to,
30 in accord with his opinion of what will be most beneficial for such person,
31 inform the spouse, parent, custodian, guardian or fiancé of such person as
32 to the treatment given or needed without the consent of such person. Such
33 informing shall not constitute libel or slander or a violation of the right of
34 privacy or privilege or otherwise subject the physician *or advanced*
35 *practice registered nurse* to any liability whatsoever. In any such case, the
36 physician *or advanced practice registered nurse* shall incur no civil or
37 criminal liability by reason of having made such diagnostic examination or
38 rendered such treatment, but such immunity shall not apply to any
39 negligent acts or omissions. The physician *or advanced practice registered*
40 *nurse* shall incur no civil or criminal liability by reason of any adverse
41 reaction to medication administered, provided reasonable care has been
42 taken to elicit from such person under ~~eighteen~~ *(18)* 18 years of age any
43 history of sensitivity or previous adverse reaction to the medication.

1 Sec. 16. K.S.A. 2014 Supp. 65-2921 is hereby amended to read as
2 follows: 65-2921. (a) Except as otherwise provided in subsection (d), a
3 physical therapist may evaluate and initiate physical therapy treatment on
4 a patient without referral from a licensed health care practitioner. If
5 treating a patient without a referral from a licensed health care practitioner
6 and the patient is not progressing toward documented treatment goals as
7 demonstrated by objective, measurable or functional improvement, or any
8 combination thereof, after 10 patient visits or in a period of 15 business
9 days from the initial treatment visits following the initial evaluation visit,
10 the physical therapist shall obtain a referral from an appropriate licensed
11 health care practitioner prior to continuing treatment.

12 (b) Physical therapists may provide, without a referral, services to: (1)
13 Employees solely for the purpose of education and instruction related to
14 workplace injury prevention; or (2) the public for the purpose of fitness,
15 health promotion and education.

16 (c) Physical therapists may provide services without a referral to
17 special education students who need physical therapy services to fulfill the
18 provisions of their individualized education plan (IEP) or individualized
19 family service plan (IFSP).

20 (d) Nothing in this section shall be construed to prevent a hospital or
21 ambulatory surgical center from requiring a physician order or referral for
22 physical therapy services for a patient currently being treated in such
23 facility.

24 (e) When a patient self-refers to a physical therapist pursuant to this
25 section, the physical therapist, prior to commencing treatment, shall
26 provide written notice to the patient that a physical therapy diagnosis is not
27 a medical diagnosis by a physician.

28 (f) Physical therapists shall perform wound debridement services only
29 after approval by a person licensed to practice medicine and surgery or
30 other licensed health care practitioner in appropriately related cases.

31 (g) As used in this section, "licensed health care practitioner" means a
32 person licensed to practice medicine and surgery, a licensed podiatrist, a
33 licensed physician assistant ~~or a licensed advanced practice registered~~
34 ~~nurse~~ working pursuant to the order or direction of a person licensed to
35 practice medicine and surgery, a licensed chiropractor, a licensed dentist
36 ~~or, a licensed optometrist or a licensed advanced practice registered nurse~~
37 in appropriately related cases.

38 Sec. 17. K.S.A. 2013 Supp. 65-4101, as amended by section 50 of
39 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
40 read as follows: 65-4101. As used in this act: (a) "Administer" means the
41 direct application of a controlled substance, whether by injection,
42 inhalation, ingestion or any other means, to the body of a patient or
43 research subject by:

1 (1) A practitioner or pursuant to the lawful direction of a practitioner;
2 or

3 (2) the patient or research subject at the direction and in the presence
4 of the practitioner.

5 (b) "Agent" means an authorized person who acts on behalf of or at
6 the direction of a manufacturer, distributor or dispenser. It does not include
7 a common carrier, public warehouseman or employee of the carrier or
8 warehouseman.

9 (c) "Application service provider" means an entity that sells
10 electronic prescription or pharmacy prescription applications as a hosted
11 service where the entity controls access to the application and maintains
12 the software and records on its server.

13 (d) "Board" means the state board of pharmacy.

14 (e) "Bureau" means the bureau of narcotics and dangerous drugs,
15 United States department of justice, or its successor agency.

16 (f) "Controlled substance" means any drug, substance or immediate
17 precursor included in any of the schedules designated in K.S.A. 65-4105,
18 65-4107, 65-4109, 65-4111 and 65-4113, and amendments thereto.

19 (g) (1) "Controlled substance analog" means a substance that is
20 intended for human consumption, and:

21 (A) The chemical structure of which is substantially similar to the
22 chemical structure of a controlled substance listed in or added to the
23 schedules designated in K.S.A. 65-4105 or 65-4107, and amendments
24 thereto;

25 (B) which has a stimulant, depressant or hallucinogenic effect on the
26 central nervous system substantially similar to the stimulant, depressant or
27 hallucinogenic effect on the central nervous system of a controlled
28 substance included in the schedules designated in K.S.A. 65-4105 or 65-
29 4107, and amendments thereto; or

30 (C) with respect to a particular individual, which such individual
31 represents or intends to have a stimulant, depressant or hallucinogenic
32 effect on the central nervous system substantially similar to the stimulant,
33 depressant or hallucinogenic effect on the central nervous system of a
34 controlled substance included in the schedules designated in K.S.A. 65-
35 4105 or 65-4107, and amendments thereto.

36 (2) "Controlled substance analog" does not include:

37 (A) A controlled substance;

38 (B) a substance for which there is an approved new drug application;
39 or

40 (C) a substance with respect to which an exemption is in effect for
41 investigational use by a particular person under section 505 of the federal
42 food, drug and cosmetic act, 21 U.S.C. § 355, to the extent conduct with
43 respect to the substance is permitted by the exemption.

1 (h) "Counterfeit substance" means a controlled substance which, or
2 the container or labeling of which, without authorization bears the
3 trademark, trade name or other identifying mark, imprint, number or
4 device or any likeness thereof of a manufacturer, distributor or dispenser
5 other than the person who in fact manufactured, distributed or dispensed
6 the substance.

7 (i) "Cultivate" means the planting or promotion of growth of five or
8 more plants which contain or can produce controlled substances.

9 (j) "DEA" means the U.S. department of justice, drug enforcement
10 administration.

11 (k) "Deliver" or "delivery" means the actual, constructive or
12 attempted transfer from one person to another of a controlled substance,
13 whether or not there is an agency relationship.

14 (l) "Dispense" means to deliver a controlled substance to an ultimate
15 user or research subject by or pursuant to the lawful order of a practitioner,
16 including the packaging, labeling or compounding necessary to prepare the
17 substance for that delivery, or pursuant to the prescription of a mid-level
18 practitioner.

19 (m) "Dispenser" means a practitioner or pharmacist who dispenses, or
20 a physician assistant who has authority to dispense prescription-only drugs
21 in accordance with ~~subsection (b)~~ of K.S.A. 65-28a08(b), and amendments
22 thereto.

23 (n) "Distribute" means to deliver other than by administering or
24 dispensing a controlled substance.

25 (o) "Distributor" means a person who distributes.

26 (p) "Drug" means: (1) Substances recognized as drugs in the official
27 United States pharmacopoeia, official homeopathic pharmacopoeia of the
28 United States or official national formulary or any supplement to any of
29 them; (2) substances intended for use in the diagnosis, cure, mitigation,
30 treatment or prevention of disease in man or animals; (3) substances (other
31 than food) intended to affect the structure or any function of the body of
32 man or animals; and (4) substances intended for use as a component of any
33 article specified in ~~clause (1), (2) or (3) of this subsection~~ (p)(1), (2) or (3).
34 It does not include devices or their components, parts or accessories.

35 (q) "Immediate precursor" means a substance which the board has
36 found to be and by rule and regulation designates as being the principal
37 compound commonly used or produced primarily for use and which is an
38 immediate chemical intermediary used or likely to be used in the
39 manufacture of a controlled substance, the control of which is necessary to
40 prevent, curtail or limit manufacture.

41 (r) "Electronic prescription" means an electronically prepared
42 prescription that is authorized and transmitted from the prescriber to the
43 pharmacy by means of electronic transmission.

1 (s) "Electronic prescription application" means software that is used
2 to create electronic prescriptions and that is intended to be installed on the
3 prescriber's computers and servers where access and records are controlled
4 by the prescriber.

5 (t) "Electronic signature" means a confidential personalized digital
6 key, code, number or other method for secure electronic data transmissions
7 which identifies a particular person as the source of the message,
8 authenticates the signatory of the message and indicates the person's
9 approval of the information contained in the transmission.

10 (u) "Electronic transmission" means the transmission of an electronic
11 prescription, formatted as an electronic data file, from a prescriber's
12 electronic prescription application to a pharmacy's computer, where the
13 data file is imported into the pharmacy prescription application.

14 (v) "Electronically prepared prescription" means a prescription that is
15 generated using an electronic prescription application.

16 (w) "Facsimile transmission" or "fax transmission" means the
17 transmission of a digital image of a prescription from the prescriber or the
18 prescriber's agent to the pharmacy. "Facsimile transmission" includes, but
19 is not limited to, transmission of a written prescription between the
20 prescriber's fax machine and the pharmacy's fax machine; transmission of
21 an electronically prepared prescription from the prescriber's electronic
22 prescription application to the pharmacy's fax machine, computer or
23 printer; or transmission of an electronically prepared prescription from the
24 prescriber's fax machine to the pharmacy's fax machine, computer or
25 printer.

26 (x) "Intermediary" means any technology system that receives and
27 transmits an electronic prescription between the prescriber and the
28 pharmacy.

29 (y) "Isomer" means all enantiomers and diastereomers.

30 (z) "Manufacture" means the production, preparation, propagation,
31 compounding, conversion or processing of a controlled substance either
32 directly or indirectly or by extraction from substances of natural origin or
33 independently by means of chemical synthesis or by a combination of
34 extraction and chemical synthesis and includes any packaging or
35 repackaging of the substance or labeling or relabeling of its container,
36 except that this term does not include the preparation or compounding of a
37 controlled substance by an individual for the individual's own lawful use
38 or the preparation, compounding, packaging or labeling of a controlled
39 substance:

40 (1) By a practitioner or the practitioner's agent pursuant to a lawful
41 order of a practitioner as an incident to the practitioner's administering or
42 dispensing of a controlled substance in the course of the practitioner's
43 professional practice; or

(2) by a practitioner or by the practitioner's authorized agent under such practitioner's supervision for the purpose of or as an incident to research, teaching or chemical analysis or by a pharmacist or medical care facility as an incident to dispensing of a controlled substance.

(aa) "Marijuana" means all parts of all varieties of the plant *Cannabis* whether growing or not, the seeds thereof, the resin extracted from any part of the plant and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, except the resin extracted therefrom, fiber, oil, or cake or the sterilized seed of the plant which is incapable of germination.

(bb) "Medical care facility" shall have the meaning ascribed to that term in K.S.A. 65-425, and amendments thereto.

(cc) "Mid-level practitioner" means ~~an advanced practice registered nurse issued a license pursuant to K.S.A. 65-1131, and amendments thereto, who has authority to prescribe drugs pursuant to a written protocol with a responsible physician under K.S.A. 65-1130, and amendments thereto, or a physician assistant licensed under the physician assistant licensure act who has authority to prescribe drugs pursuant to a written protocol with a supervising physician under K.S.A. 65-28a08, and amendments thereto.~~

(dd) "Narcotic drug" means any of the following whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis:

(1) Opium and opiate and any salt, compound, derivative or preparation of opium or opiate;

(2) any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of the substances referred to in ~~clause~~ *paragraph* (1) but not including the isoquinoline alkaloids of opium;

(3) opium poppy and poppy straw;

(4) coca leaves and any salt, compound, derivative or preparation of coca leaves, and any salt, compound, isomer, derivative or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine.

(ee) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled

1 under K.S.A. 65-4102, and amendments thereto, the dextrorotatory isomer
2 of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does
3 include its racemic and levorotatory forms.

4 (ff) "Opium poppy" means the plant of the species *Papaver*
5 *somniferum* L. except its seeds.

6 (gg) "Person" means an individual, corporation, government, or
7 governmental subdivision or agency, business trust, estate, trust,
8 partnership or association or any other legal entity.

9 (hh) "Pharmacist" means any natural person licensed under K.S.A.
10 65-1625 et seq., to practice pharmacy.

11 (ii) "Pharmacist intern" means: (1) A student currently enrolled in an
12 accredited pharmacy program; (2) a graduate of an accredited pharmacy
13 program serving such person's internship; or (3) a graduate of a pharmacy
14 program located outside of the United States which is not accredited and
15 who had successfully passed equivalency examinations approved by the
16 board.

17 (jj) "Pharmacy prescription application" means software that is used
18 to process prescription information, is installed on a pharmacy's computers
19 and servers, and is controlled by the pharmacy.

20 (kk) "Poppy straw" means all parts, except the seeds, of the opium
21 poppy, after mowing.

22 (ll) "Practitioner" means a person licensed to practice medicine and
23 surgery, dentist, podiatrist, veterinarian, optometrist, *advanced practice*
24 *registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
25 *amendments thereto, and who has authority to prescribe drugs in*
26 *accordance with K.S.A. 65-1130, and amendments thereto,* or scientific
27 investigator or other person authorized by law to use a controlled
28 substance in teaching or chemical analysis or to conduct research with
29 respect to a controlled substance.

30 (mm) "Prescriber" means a practitioner or a mid-level practitioner.

31 (nn) "Production" includes the manufacture, planting, cultivation,
32 growing or harvesting of a controlled substance.

33 (oo) "Readily retrievable" means that records kept by automatic data
34 processing applications or other electronic or mechanized recordkeeping
35 systems can be separated out from all other records within a reasonable
36 time not to exceed 48 hours of a request from the board or other authorized
37 agent or that hard-copy records are kept on which certain items are
38 asterisked, redlined or in some other manner visually identifiable apart
39 from other items appearing on the records.

40 (pp) "Ultimate user" means a person who lawfully possesses a
41 controlled substance for such person's own use or for the use of a member
42 of such person's household or for administering to an animal owned by
43 such person or by a member of such person's household.

1 Sec. 18. K.S.A. 2014 Supp. 65-4116 is hereby amended to read as
2 follows: 65-4116. (a) Every person who manufactures, distributes or
3 dispenses any controlled substance within this state or who proposes to
4 engage in the manufacture, distribution or dispensing of any controlled
5 substance within this state shall obtain annually a registration issued by the
6 board in accordance with the uniform controlled substances act and with
7 rules and regulations adopted by the board.

8 (b) Persons registered by the board under this act to manufacture,
9 distribute, dispense or conduct research with controlled substances may
10 possess, manufacture, distribute, dispense or conduct research with those
11 substances to the extent authorized by their registration and in conformity
12 with the other provisions of this act.

13 (c) The following persons need not register and may lawfully possess
14 controlled substances under this act, as specified in this subsection:

15 (1) An agent or employee of any registered manufacturer, distributor
16 or dispenser of any controlled substance if the agent or employee is acting
17 in the usual course of such agent or employee's business or employment;

18 (2) a common carrier or warehouseman or an employee thereof
19 whose possession of any controlled substance is in the usual course of
20 business or employment;

21 (3) an ultimate user or a person in possession of any controlled
22 substance pursuant to a lawful order of a practitioner or a mid-level
23 practitioner or in lawful possession of a schedule V substance;

24 (4) persons licensed and registered by the board under the provisions
25 of the acts contained in article 16 of chapter 65 of the Kansas Statutes
26 Annotated, and amendments thereto, to manufacture, dispense or distribute
27 drugs are considered to be in compliance with the registration provision of
28 the uniform controlled substances act without additional proceedings
29 before the board or the payment of additional fees, except that
30 manufacturers and distributors shall complete and file the application form
31 required under the uniform controlled substances act;

32 (5) any person licensed by the state board of healing arts under the
33 Kansas healing arts act;

34 (6) any person licensed by the state board of veterinary examiners;

35 (7) any person licensed by the Kansas dental board;

36 (8) a mid-level practitioner; ~~and~~

37 (9) any person who is a member of the Native American Church, with
38 respect to use or possession of peyote, whose use or possession of peyote
39 is in, or for use in, bona fide religious ceremonies of the Native American
40 Church, but nothing in this paragraph shall authorize the use or possession
41 of peyote in any place used for the confinement or housing of persons
42 arrested, charged or convicted of criminal offenses or in the state security
43 hospital; *and*

1 (10) *any person licensed as an advanced practice registered nurse*
2 *under K.S.A. 65-1131, and amendments thereto, and who has authority to*
3 *prescribe drugs in accordance with K.S.A. 65-1130, and amendments*
4 *thereto.*

5 (d) (1) The board may waive by rules and regulations the requirement
6 for registration of certain manufacturers, distributors or dispensers if the
7 board finds it consistent with the public health and safety, except that
8 licensure of any person by the state board of healing arts to practice any
9 branch of the healing arts, Kansas dental board ~~or~~, the state board of
10 veterinary examiners *or the board of nursing of advanced practice*
11 *registered nurses* shall constitute compliance with the registration
12 requirements of the uniform controlled substances act by such person for
13 such person's place of professional practice.

14 (2) Evidence of abuse as determined by the board relating to a person
15 licensed by the state board of healing arts shall be submitted to the state
16 board of healing arts and the attorney general within 60 days. The state
17 board of healing arts shall, within 60 days, make findings of fact and take
18 such action against such person as it deems necessary. All findings of fact
19 and any action taken shall be reported by the state board of healing arts to
20 the board of pharmacy and the attorney general.

21 (3) Evidence of abuse as determined by the board relating to a person
22 licensed by the state board of veterinary examiners shall be submitted to
23 the state board of veterinary examiners and the attorney general within 60
24 days. The state board of veterinary examiners shall, within 60 days, make
25 findings of fact and take such action against such person as it deems
26 necessary. All findings of fact and any action taken shall be reported by the
27 state board of veterinary examiners to the board of pharmacy and the
28 attorney general.

29 (4) Evidence of abuse as determined by the board relating to a dentist
30 licensed by the Kansas dental board shall be submitted to the Kansas
31 dental board and the attorney general within 60 days. The Kansas dental
32 board shall, within 60 days, make findings of fact and take such action
33 against such dentist as it deems necessary. All findings of fact and any
34 action taken shall be reported by the Kansas dental board to the board of
35 pharmacy and the attorney general.

36 (5) *Evidence of abuse as determined by the board relating to an*
37 *advanced practice registered nurse licensed by the board of nursing shall*
38 *be submitted to the board of nursing and the attorney general within 60*
39 *days. The board of nursing shall, within 60 days, make findings of fact and*
40 *take such action against such advanced practice registered nurse as it*
41 *deems necessary. All findings of fact and any action taken shall be*
42 *reported by the board of nursing to the board of pharmacy and the*
43 *attorney general.*

1 (e) A separate annual registration is required at each place of business
2 or professional practice where the applicant manufactures, distributes or
3 dispenses controlled substances.

4 (f) The board may inspect the establishment of a registrant or
5 applicant for registration in accordance with the board's rules and
6 regulations.

7 (g) (1) The registration of any person or location shall terminate when
8 such person or authorized representative of a location dies, ceases legal
9 existence, discontinues business or professional practice or changes the
10 location as shown on the certificate of registration. Any registrant who
11 ceases legal existence, discontinues business or professional practice, or
12 changes location as shown on the certificate of registration, shall notify the
13 board promptly of such fact and forthwith deliver the certificate of
14 registration directly to the secretary or executive secretary of the board. In
15 the event of a change in name or mailing address the person or authorized
16 representative of the location shall notify the board promptly in advance of
17 the effective date of this change by filing the change of name or mailing
18 address with the board. This change shall be noted on the original
19 application on file with the board.

20 (2) No registration or any authority conferred thereby shall be
21 assigned or otherwise transferred except upon such conditions as the board
22 may specifically designate and then only pursuant to the written consent of
23 the board.

24 Sec. 19. K.S.A. 65-4134 is hereby amended to read as follows: 65-
25 4134. A practitioner engaged in medical practice or research, *a*
26 *practitioner who is an advanced practice registered nurse acting in the*
27 *usual course of such practitioner's practice* or a mid-level practitioner
28 acting in the usual course of such mid-level practitioner's practice is not
29 required or compelled to furnish the name or identity of a patient or
30 research subject to the board, nor may such practitioner or mid-level
31 practitioner be compelled in any state or local civil, criminal,
32 administrative, legislative or other proceedings to furnish the name or
33 identity of an individual that the practitioner or mid-level practitioner is
34 obligated to keep confidential.

35 Sec. 20. K.S.A. 2014 Supp. 65-4202 is hereby amended to read as
36 follows: 65-4202. As used in this act: (a) "Board" means the state board of
37 nursing.

38 (b) The "practice of mental health technology" means the
39 performance, under the direction of a physician licensed to practice
40 medicine and surgery or registered professional nurse, of services in caring
41 for and treatment of the mentally ill, emotionally disturbed, or people with
42 intellectual disability for compensation or personal profit, which services:

43 (1) Involve responsible nursing and therapeutic procedures for

1 patients with mental illness or intellectual disability requiring interpersonal
2 and technical skills in the observations and recognition of symptoms and
3 reactions of such patients, the accurate recording of such symptoms and
4 reactions and the carrying out of treatments and medications as prescribed
5 by a licensed physician, *a licensed advanced practice registered nurse* or a
6 mid-level practitioner as defined in subsection (ii) of by K.S.A. 65-1626,
7 and amendments thereto; and

8 (2) require an application of techniques and procedures that involve
9 understanding of cause and effect and the safeguarding of life and health
10 of the patient and others; and

11 (3) require the performance of duties that are necessary to facilitate
12 rehabilitation of the patient or are necessary in the physical, therapeutic
13 and psychiatric care of the patient and require close work with persons
14 licensed to practice medicine and surgery, psychiatrists, psychologists,
15 rehabilitation therapists, social workers, registered nurses, and other
16 professional personnel.

17 (c) A "licensed mental health technician" means a person who
18 lawfully practices mental health technology as defined in this act.

19 (d) An "approved course in mental health technology" means a
20 program of training and study including a basic curriculum which shall be
21 prescribed and approved by the board in accordance with the standards
22 prescribed herein, the successful completion of which shall be required
23 before licensure as a mental health technician, except as hereinafter
24 provided.

25 Sec. 21. K.S.A. 2014 Supp. 65-5402 is hereby amended to read as
26 follows: 65-5402. As used in K.S.A. 65-5401 to 65-5417, inclusive, and
27 K.S.A. 65-5418 to 65-5420, inclusive, and amendments thereto:

28 (a) "Board" means the state board of healing arts.

29 (b) "Practice of occupational therapy" means the therapeutic use of
30 purposeful and meaningful occupations (goal-directed activities) to
31 evaluate and treat, pursuant to the referral, supervision, order or direction
32 of a physician, a licensed podiatrist, a licensed dentist, a licensed physician
33 assistant, ~~or a licensed advanced practice registered nurse~~ working
34 pursuant to the order or direction of a person licensed to practice medicine
35 and surgery, *a licensed advanced practice registered nurse*, a licensed
36 chiropractor, or a licensed optometrist, individuals who have a disease or
37 disorder, impairment, activity limitation or participation restriction that
38 interferes with their ability to function independently in daily life roles and
39 to promote health and wellness. Occupational therapy intervention may
40 include:

41 (1) Remediation or restoration of performance abilities that are
42 limited due to impairment in biological, physiological, psychological or
43 neurological cognitive processes;

1 (2) adaptation of tasks, process, or the environment or the teaching of
2 compensatory techniques in order to enhance performance;

3 (3) disability prevention methods and techniques that facilitate the
4 development or safe application of performance skills; and

5 (4) health promotion strategies and practices that enhance
6 performance abilities.

7 (c) "Occupational therapy services" include, but are not limited to:

8 (1) Evaluating, developing, improving, sustaining, or restoring skills
9 in activities of daily living (ADL), work or productive activities, including
10 instrumental activities of daily living (IADL) and play and leisure
11 activities;

12 (2) evaluating, developing, remediating, or restoring sensorimotor,
13 cognitive or psychosocial components of performance;

14 (3) designing, fabricating, applying, or training in the use of assistive
15 technology or orthotic devices and training in the use of prosthetic devices;

16 (4) adapting environments and processes, including the application of
17 ergonomic principles, to enhance performance and safety in daily life
18 roles;

19 (5) applying physical agent modalities as an adjunct to or in
20 preparation for engagement in occupations;

21 (6) evaluating and providing intervention in collaboration with the
22 client, family, caregiver or others;

23 (7) educating the client, family, caregiver or others in carrying out
24 appropriate nonskilled interventions; and

25 (8) consulting with groups, programs, organizations or communities
26 to provide population-based services.

27 (d) "Occupational therapist" means a person licensed to practice
28 occupational therapy as defined in this act.

29 (e) "Occupational therapy assistant" means a person licensed to assist
30 in the practice of occupational therapy under the supervision of an
31 occupational therapist.

32 (f) "Person" means any individual, partnership, unincorporated
33 organization or corporation.

34 (g) "Physician" means a person licensed to practice medicine and
35 surgery.

36 (h) "Occupational therapy aide," "occupational therapy tech" or
37 "occupational therapy paraprofessional" means a person who provides
38 supportive services to occupational therapists and occupational therapy
39 assistants in accordance with K.S.A. 65-5419, and amendments thereto.

40 Sec. 22. K.S.A. 2014 Supp. 65-5418 is hereby amended to read as
41 follows: 65-5418. (a) Nothing in the occupational therapy practice act is
42 intended to limit, preclude or otherwise interfere with the practices of
43 other health care providers formally trained and licensed, registered,

1 credentialed or certified by appropriate agencies of the state of Kansas.

2 (b) The practice of occupational therapy shall not be construed to
3 include the following:

4 (1) Persons rendering assistance in the case of an emergency;

5 (2) members of any church practicing their religious tenets;

6 (3) persons whose services are performed pursuant to the delegation
7 of and under the supervision of an occupational therapist who is licensed
8 under this act;

9 (4) any person employed as an occupational therapist or occupational
10 therapy assistant by the government of the United States or any agency
11 thereof, if such person practices occupational therapy solely under the
12 direction or control of the organization by which such person is employed;

13 (5) licensees under the healing arts act when licensed and practicing
14 in accordance with the provisions of law or persons performing services
15 pursuant to a delegation authorized under ~~subsection (g) of~~ K.S.A. 65-
16 2872(g), and amendments thereto;

17 (6) dentists practicing their professions, when licensed and practicing
18 in accordance with the provisions of law;

19 (7) nurses practicing their professions, when licensed and practicing
20 in accordance with the provisions of law or persons performing services
21 pursuant to the delegation of a licensed nurse under ~~subsection (m) of~~
22 K.S.A. 65-1124(m), and amendments thereto;

23 (8) health care providers who have been formally trained and are
24 practicing in accordance with the training or have received specific
25 training in one or more functions included in the occupational therapy
26 practice act pursuant to established educational protocols, or both;

27 (9) any person pursuing a supervised course of study leading to a
28 degree or certificate in occupational therapy at an accredited or approved
29 educational program, if the person is designated by the title which clearly
30 indicates such person's status as a student or trainee;

31 (10) any person fulfilling the supervised fieldwork experience
32 requirements as part of the experience necessary to meet the requirement
33 of the occupational therapy practice act;

34 (11) self-care by a patient or gratuitous care by a friend or family
35 member who does not represent or hold oneself out to the public to be an
36 occupational therapist or an occupational therapy assistant;

37 (12) optometrists practicing their profession when licensed and
38 practicing in accordance with the provisions of article 15 of chapter 65 of
39 the Kansas Statutes Annotated, and amendments thereto;

40 (13) podiatrists practicing their profession when licensed and
41 practicing in accordance with the provisions of article 15 of chapter 65 of
42 the Kansas Statutes Annotated, and amendments thereto;

43 (14) physical therapists practicing their profession when licensed and

1 practicing in accordance with K.S.A. 65-2901 et seq., and amendments
2 thereto;

3 (15) physician assistants practicing their profession when licensed
4 and practicing in accordance with the physician assistant licensure act;

5 (16) athletic trainers practicing their profession when licensed and
6 practicing in accordance with the athletic trainers licensure act;

7 (17) manufacturers of prosthetic devices;

8 (18) any person performing occupational therapy services, if these
9 services are performed for no more than 45 days in a calendar year in
10 association with an occupational therapist licensed under the occupational
11 therapy practice act so long as: (A) The person is registered or licensed
12 under the laws of another state which has licensure requirements at least as
13 stringent as the licensure requirements of this act; or (B) the person meets
14 the requirements for certification as an occupational therapist registered
15 (OTR) or a certified occupational therapy assistant (COTA) established by
16 the national board for certification in occupational therapy (NBCOT).

17 (c) Any patient monitoring, assessment or other procedures designed
18 to evaluate the effectiveness of prescribed occupational therapy must be
19 performed by or pursuant to the delegation of a licensed occupational
20 therapist or other health care provider.

21 (d) Education related therapy services provided by an occupational
22 therapist to school systems or consultation regarding prevention,
23 ergonomics and wellness within the occupational therapy scope of practice
24 shall not require a referral, supervision, order or direction of a physician,
25 *an advanced practice registered nurse*, a licensed podiatrist, a licensed
26 dentist or a licensed optometrist. However, when in the course of
27 providing such services an occupational therapist reasonably believes that
28 an individual may have an underlying injury, illness, disease, disorder or
29 impairment, the occupational therapist shall refer the individual to a
30 physician, *an advanced practice registered nurse*, a licensed podiatrist, a
31 licensed dentist or a licensed optometrist, as appropriate.

32 (e) Nothing in the occupational therapy practice act shall be construed
33 to permit the practice of medicine and surgery. No statute granting
34 authority to licensees of the state board of healing arts shall be construed
35 to confer authority upon occupational therapists to engage in any activity
36 not conferred by the occupational therapy practice act.

37 (f) This section shall be part of and supplemental to the occupational
38 therapy practice act.

39 Sec. 23. K.S.A. 65-5502 is hereby amended to read as follows: 65-
40 5502. As used in K.S.A. 65-5501 to 65-5517, inclusive and amendments
41 thereto:

42 (a) "Board" means the state board of healing arts.

43 (b) "Respiratory therapy" is a health care profession whose therapists

1 practice under the supervision of a qualified medical director and with the
2 prescription of a licensed physician *or an advanced practice registered*
3 *nurse* providing therapy, management, rehabilitation, respiratory
4 assessment and care of patients with deficiencies and abnormalities which
5 affect the pulmonary system and associated other systems functions. The
6 duties which may be performed by a respiratory therapist include:

7 (1) Direct and indirect respiratory therapy services that are safe,
8 aseptic, preventative and restorative to the patient.

9 (2) Direct and indirect respiratory therapy services, including but not
10 limited to, the administration of pharmacological and diagnostic and
11 therapeutic agents related to respiratory therapy procedures to implement a
12 treatment, disease prevention or pulmonary rehabilitative regimen
13 prescribed by a physician *or an advanced practice registered nurse*.

14 (3) Administration of medical gases, exclusive of general anesthesia,
15 aerosols, humidification and environmental control systems.

16 (4) Transcription and implementation of written or verbal orders of a
17 physician *or an advanced practice registered nurse* pertaining to the
18 practice of respiratory therapy.

19 (5) Implementation of respiratory therapy protocols as defined by the
20 medical staff of an institution or a qualified medical director or other
21 written protocol, changes in treatment pursuant to the written or verbal
22 orders of a physician *or an advanced practice registered nurse* or the
23 initiation of emergency procedures as authorized by written protocols.

24 (c) "Respiratory therapist" means a person who is licensed to practice
25 respiratory therapy as defined in this act.

26 (d) "Person" means any individual, partnership, unincorporated
27 organization or corporation.

28 (e) "Physician" means a person who is licensed by the board to
29 practice medicine and surgery.

30 (f) "Qualified medical director" means the medical director of any
31 inpatient or outpatient respiratory therapy service, department or home
32 care agency. The medical director shall be a physician who has interest and
33 knowledge in the diagnosis and treatment of respiratory problems. This
34 physician shall be responsible for the quality, safety and appropriateness of
35 the respiratory services provided and require that respiratory therapy be
36 ordered by a physician *or an advanced practice registered nurse* who has
37 medical responsibility for the patient. The medical director shall be readily
38 accessible to the respiratory therapy practitioner.

39 (g) "Advanced practice registered nurse" means an advanced
40 practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
41 amendments thereto, and who has authority to prescribe drugs in
42 accordance with K.S.A. 65-1130, and amendments thereto.

43 Sec. 24. K.S.A. 2013 Supp. 65-6112, as amended by section 51 of

1 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
2 read as follows: 65-6112. As used in this act:

3 (a) "Administrator" means the executive director of the emergency
4 medical services board.

5 (b) "Advanced emergency medical technician" means a person who
6 holds an advanced emergency medical technician certificate issued
7 pursuant to this act.

8 (c) "Advanced practice registered nurse" means an advanced practice
9 registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

10 (d) "Ambulance" means any privately or publicly owned motor
11 vehicle, airplane or helicopter designed, constructed, prepared, staffed and
12 equipped for use in transporting and providing emergency care for
13 individuals who are ill or injured.

14 (e) "Ambulance service" means any organization operated for the
15 purpose of transporting sick or injured persons to or from a place where
16 medical care is furnished, whether or not such persons may be in need of
17 emergency or medical care in transit.

18 (f) "Attendant" means a first responder, an emergency medical
19 responder, emergency medical technician, emergency medical technician-
20 intermediate, emergency medical technician-defibrillator, emergency
21 medical technician-intermediate/defibrillator, advanced emergency
22 medical technician, mobile intensive care technician or paramedic certified
23 pursuant to this act.

24 (g) "Board" means the emergency medical services board established
25 pursuant to K.S.A. 65-6102, and amendments thereto.

26 (h) "Emergency medical service" means the effective and coordinated
27 delivery of such care as may be required by an emergency which includes
28 the care and transportation of individuals by ambulance services and the
29 performance of authorized emergency care by a physician, advanced
30 practice registered nurse, professional nurse, a licensed physician assistant
31 or attendant.

32 (i) "Emergency medical technician" means a person who holds an
33 emergency medical technician certificate issued pursuant to this act.

34 (j) "Emergency medical technician-defibrillator" means a person who
35 holds an emergency medical technician-defibrillator certificate issued
36 pursuant to this act.

37 (k) "Emergency medical technician-intermediate" means a person
38 who holds an emergency medical technician-intermediate certificate issued
39 pursuant to this act.

40 (l) "Emergency medical technician-intermediate/defibrillator" means
41 a person who holds both an emergency medical technician-intermediate
42 and emergency medical technician-defibrillator certificate issued pursuant
43 to this act.

1 (m) "Emergency medical responder" means a person who holds an
2 emergency medical responder certificate issued pursuant to this act.

3 (n) "First responder" means a person who holds a first responder
4 certificate issued pursuant to this act.

5 (o) "Hospital" means a hospital as defined by K.S.A. 65-425, and
6 amendments thereto.

7 (p) "Instructor-coordinator" means a person who is certified under
8 this act to teach initial certification and continuing education classes.

9 (q) "Medical director" means a physician.

10 (r) "Medical protocols" mean written guidelines which authorize
11 attendants to perform certain medical procedures prior to contacting a
12 physician, physician assistant authorized by a physician, advanced practice
13 registered nurse ~~authorized by a physician~~ or professional nurse authorized
14 by a physician. The medical protocols shall be approved by a county
15 medical society or the medical staff of a hospital to which the ambulance
16 service primarily transports patients, or if neither of the above are able or
17 available to approve the medical protocols, then the medical protocols
18 shall be submitted to the medical advisory council for approval.

19 (s) "Mobile intensive care technician" means a person who holds a
20 mobile intensive care technician certificate issued pursuant to this act.

21 (t) "Municipality" means any city, county, township, fire district or
22 ambulance service district.

23 (u) "Nonemergency transportation" means the care and transport of a
24 sick or injured person under a foreseen combination of circumstances
25 calling for continuing care of such person. As used in this subsection,
26 transportation includes performance of the authorized level of services of
27 the attendant whether within or outside the vehicle as part of such
28 transportation services.

29 (v) "Operator" means a person or municipality who has a permit to
30 operate an ambulance service in the state of Kansas.

31 (w) "Paramedic" means a person who holds a paramedic certificate
32 issued pursuant to this act.

33 (x) "Person" means an individual, a partnership, an association, a
34 joint-stock company or a corporation.

35 (y) "Physician" means a person licensed by the state board of healing
36 arts to practice medicine and surgery.

37 (z) "Physician assistant" means a person who is licensed under the
38 physician assistant licensure act and who is acting under the direction of a
39 supervising physician.

40 (aa) "Professional nurse" means a licensed professional nurse as
41 defined by K.S.A. 65-1113, and amendments thereto.

42 (bb) "Provider of training" means a corporation, partnership,
43 accredited postsecondary education institution, ambulance service, fire

1 department, hospital or municipality that conducts training programs that
2 include, but are not limited to, initial courses of instruction and continuing
3 education for attendants, instructor-coordinators or training officers.

4 (cc) "Supervising physician" means supervising physician as such
5 term is defined under K.S.A. 65-28a02, and amendments thereto.

6 (dd) "Training officer" means a person who is certified pursuant to
7 this act to teach, coordinate or both, initial courses of instruction for first
8 responders or emergency medical responders and continuing education as
9 prescribed by the board.

10 Sec. 25. K.S.A. 2014 Supp. 65-6119 is hereby amended to read as
11 follows: 65-6119. (a) Notwithstanding any other provision of law, mobile
12 intensive care technicians may:

13 (1) Perform all the authorized activities identified in K.S.A. 65-6120,
14 65-6121, 65-6123, 65-6144, and amendments thereto;

15 (2) when voice contact or a telemetered electrocardiogram is
16 monitored by a physician, physician assistant where authorized by a
17 physician, an advanced practice registered nurse ~~where authorized by a~~
18 ~~physician~~ or licensed professional nurse where authorized by a physician
19 and direct communication is maintained, and upon order of such person
20 may administer such medications or procedures as may be deemed
21 necessary by a person identified in subsection (a)(2);

22 (3) perform, during an emergency, those activities specified in
23 subsection (a)(2) before contacting a person identified in subsection (a)(2)
24 when specifically authorized to perform such activities by medical
25 protocols; and

26 (4) perform, during nonemergency transportation, those activities
27 specified in this section when specifically authorized to perform such
28 activities by medical protocols.

29 (b) An individual who holds a valid certificate as a mobile intensive
30 care technician once meeting the continuing education requirements
31 prescribed by the rules and regulations of the board, upon application for
32 renewal, shall be deemed to hold a certificate as a paramedic under this
33 act, and such individual shall not be required to file an original application
34 as a paramedic for certification under this act.

35 (c) "Renewal" as used in subsection (b), refers to the first opportunity
36 that a mobile intensive care technician has to apply for renewal of a
37 certificate following the effective date of this act.

38 (d) Upon transition notwithstanding any other provision of law, a
39 paramedic may:

40 (1) Perform all the authorized activities identified in K.S.A. 65-6120,
41 65-6121, 65-6144, and amendments thereto;

42 (2) when voice contact or a telemetered electrocardiogram is
43 monitored by a physician, physician assistant where authorized by a

1 physician or an advanced practice registered nurse ~~where authorized by a~~
2 ~~physician~~ or licensed professional nurse where authorized by a physician
3 and direct communication is maintained, and upon order of such person,
4 may administer such medications or procedures as may be deemed
5 necessary by a person identified in subsection (d)(2);

6 (3) perform, during an emergency, those activities specified in
7 subsection (d)(2) before contacting a person identified in subsection (d)(2)
8 when specifically authorized to perform such activities by medical
9 protocols; and

10 (4) perform, during nonemergency transportation, those activities
11 specified in this section when specifically authorized to perform such
12 activities by medical protocols.

13 Sec. 26. K.S.A. 2014 Supp. 65-6120 is hereby amended to read as
14 follows: 65-6120. (a) Notwithstanding any other provision of law to the
15 contrary, an emergency medical technician-intermediate may:

16 (1) Perform any of the activities identified by K.S.A. 65-6121, and
17 amendments thereto;

18 (2) when approved by medical protocols or where voice contact by
19 radio or telephone is monitored by a physician, physician assistant where
20 authorized by a physician, advanced practice registered nurse ~~where~~
21 ~~authorized by a physician~~ or licensed professional nurse where authorized
22 by a physician, and direct communication is maintained, upon order of
23 such person, may perform veni-puncture for the purpose of blood sampling
24 collection and initiation and maintenance of intravenous infusion of saline
25 solutions, dextrose and water solutions or ringers lactate IV solutions,
26 endotracheal intubation and administration of nebulized albuterol;

27 (3) perform, during an emergency, those activities specified in
28 subsection (a)(2) before contacting the persons identified in subsection (a)
29 (2) when specifically authorized to perform such activities by medical
30 protocols; or

31 (4) perform, during nonemergency transportation, those activities
32 specified in this section when specifically authorized to perform such
33 activities by medical protocols.

34 (b) An individual who holds a valid certificate as an emergency
35 medical technician-intermediate once successfully completing the board
36 prescribed transition course, and validation of cognitive and psychomotor
37 competency as determined by rules and regulations of the board, may
38 apply to transition to become an advanced emergency medical technician.
39 Alternatively, upon application for renewal, such individual shall be
40 deemed to hold a certificate as an advanced emergency medical technician
41 under this act, provided such individual has completed all continuing
42 education hour requirements inclusive of the successful completion of a
43 transition course and such individual shall not be required to file an

1 original application for certification as an advanced emergency medical
2 technician under this act.

3 (c) "Renewal" as used in subsection (b), refers to the first or second
4 opportunity after December 31, 2011, that an emergency medical
5 technician-intermediate has to apply for renewal of a certificate.

6 (d) Emergency medical technician-intermediates who fail to meet the
7 transition requirements as specified may complete either the board
8 prescribed emergency medical technician transition course or emergency
9 medical responder transition course, provide validation of cognitive and
10 psychomotor competency and all continuing education hour requirements
11 inclusive of the successful completion of a transition course as determined
12 by rules and regulations of the board. Upon completion, such emergency
13 medical technician-intermediate may apply to transition to become an
14 emergency medical technician or an emergency medical responder,
15 depending on the transition course that was successfully completed.
16 Alternatively, upon application for renewal of an emergency medical
17 technician-intermediate certificate, the applicant shall be renewed as an
18 emergency medical technician or an emergency medical responder,
19 depending on the transition course that was successfully completed. Such
20 individual shall not be required to file an original application for
21 certification as an emergency medical technician or emergency medical
22 responder.

23 (e) Failure to successfully complete either an advanced emergency
24 medical technician transition course, an emergency medical technician
25 transition course or emergency medical responder transition course will
26 result in loss of certification.

27 (f) Upon transition, notwithstanding any other provision of law to the
28 contrary, an advanced emergency medical technician may:

29 (1) Perform any of the activities identified by K.S.A. 65-6121, and
30 amendments thereto; and

31 (2) perform any of the following interventions, by use of the devices,
32 medications and equipment, or any combination thereof, as specifically
33 identified in rules and regulations, after successfully completing an
34 approved course of instruction, local specialized device training and
35 competency validation and when authorized by medical protocols, or upon
36 order when direct communication is maintained by radio, telephone or
37 video conference with a physician, physician assistant where authorized by
38 a physician, an advanced practice registered nurse ~~where authorized by a~~
39 ~~physician~~, or licensed professional nurse where authorized by a physician
40 upon order of such a person: (A) Continuous positive airway pressure
41 devices; (B) advanced airway management; (C) referral of patient of
42 alternate medical care site based on assessment; (D) transportation of a
43 patient with a capped arterial line; (E) venipuncture for obtaining blood

1 sample; (F) initiation and maintenance of intravenous infusion or saline
2 lock; (G) initiation of intraosseous infusion; (H) nebulized therapy; (I)
3 manual defibrillation and cardioversion; (J) cardiac monitoring; (K)
4 electrocardiogram interpretation; (L) administration of generic or trade
5 name medications by one or more of the following methods: (i)
6 Aerosolization; (ii) nebulization; (iii) intravenous; (iv) intranasal; (v)
7 rectal; (vi) subcutaneous; (vii) intraosseous; (viii) intramuscular; or (ix)
8 sublingual.

9 (g) An individual who holds a valid certificate as both an emergency
10 medical technician-intermediate and as an emergency medical technician-
11 defibrillator once successfully completing the board prescribed transition
12 course, and validation of cognitive and psychomotor competency as
13 determined by rules and regulations of the board, may apply to transition
14 to an advanced emergency medical technician. Alternatively, upon
15 application for renewal, such individual shall be deemed to hold a
16 certificate as an advanced emergency medical technician under this act,
17 provided such individual has completed all continuing education hour
18 requirements inclusive of successful completion of a transition course, and
19 such individual shall not be required to file an original application for
20 certification as an advanced emergency medical technician under this act.

21 (h) "Renewal" as used in subsection (g), refers to the first or second
22 opportunity after December 31, 2011, that an emergency medical
23 technician-intermediate and emergency medical technician-defibrillator
24 has to apply for renewal of a certificate.

25 (i) An individual who holds both an emergency medical technician-
26 intermediate certificate and an emergency medical technician-defibrillator
27 certificate, who fails to meet the transition requirements as specified may
28 complete either the board prescribed emergency medical technician
29 transition course or emergency medical responder transition course, and
30 provide validation of cognitive and psychomotor competency and all
31 continuing education hour requirements inclusive of successful completion
32 of a transition course as determined by rules and regulations of the board.
33 Upon completion, such individual may apply to transition to become an
34 emergency medical technician or emergency medical responder, depending
35 on the transition course that was successfully completed. Alternatively,
36 upon application for renewal of an emergency medical technician-
37 intermediate certificate and an emergency medical technician-defibrillator
38 certificate, the applicant shall be renewed as an emergency medical
39 technician or an emergency medical responder, depending on the transition
40 course that was successfully completed. Such individual shall not be
41 required to file an original application for certification as an emergency
42 medical technician or emergency medical responder.

43 (j) Failure to successfully complete either the advanced emergency

1 medical technician transition requirements, an emergency medical
2 technician transition course or the emergency medical responder transition
3 course will result in loss of certification.

4 Sec. 27. K.S.A. 2014 Supp. 65-6121 is hereby amended to read as
5 follows: 65-6121. (a) Notwithstanding any other provision of law to the
6 contrary, an emergency medical technician may perform any of the
7 following activities:

- 8 (1) Patient assessment and vital signs;
- 9 (2) airway maintenance including the use of:
 - 10 (A) Oropharyngeal and nasopharyngeal airways;
 - 11 (B) esophageal obturator airways with or without gastric suction
12 device;
 - 13 (C) multi-lumen airway; and
 - 14 (D) oxygen demand valves.
- 15 (3) Oxygen therapy;
- 16 (4) oropharyngeal suctioning;
- 17 (5) cardiopulmonary resuscitation procedures;
- 18 (6) control accessible bleeding;
- 19 (7) apply pneumatic anti-shock garment;
- 20 (8) manage outpatient medical emergencies;
- 21 (9) extricate patients and utilize lifting and moving techniques;
- 22 (10) manage musculoskeletal and soft tissue injuries including
23 dressing and bandaging wounds or the splinting of fractures, dislocations,
24 sprains or strains;
- 25 (11) use of backboards to immobilize the spine;
- 26 (12) administer activated charcoal and glucose;
- 27 (13) monitor intravenous line delivering intravenous fluids during
28 interfacility transport with the following restrictions:
 - 29 (A) The physician approves the transfer by an emergency medical
30 technician;
 - 31 (B) no medications or nutrients have been added to the intravenous
32 fluids; and
 - 33 (C) the emergency medical technician may monitor, maintain and
34 shut off the flow of intravenous fluid;
- 35 (14) use automated external defibrillators;
- 36 (15) administer epinephrine auto-injectors provided that:
 - 37 (A) The emergency medical technician successfully completes a
38 course of instruction approved by the board in the administration of
39 epinephrine;
 - 40 (B) the emergency medical technician serves with an ambulance
41 service or a first response organization that provides emergency medical
42 services; and
 - 43 (C) the emergency medical technician is acting pursuant to medical

1 protocols;

2 (16) perform, during nonemergency transportation, those activities
3 specified in this section when specifically authorized to perform such
4 activities by medical protocols; or

5 (17) when authorized by medical protocol, assist the patient in the
6 administration of the following medications which have been prescribed
7 for that patient: Auto-injection epinephrine, sublingual nitroglycerin and
8 inhalers for asthma and emphysema.

9 (b) An individual who holds a valid certificate as an emergency
10 medical technician at the current basic level once successfully completing
11 the board prescribed transition course, and validation of cognitive and
12 psychomotor competency as determined by rules and regulations of the
13 board, may apply to transition to become an emergency medical
14 technician. Alternatively, upon application for renewal, such individual
15 shall be deemed to hold a certificate as an emergency medical technician
16 under this act, provided such individual has completed all continuing
17 education hour requirements inclusive of successful completion of a
18 transition course, and such individual shall not be required to file an
19 original application for certification as an emergency medical technician.

20 (c) "Renewal" as used in subsection (b), refers to the first opportunity
21 after December 31, 2011, that an emergency medical technician has to
22 apply for renewal of a certificate following the effective date of this act.

23 (d) Emergency medical technicians who fail to meet the transition
24 requirements as specified may successfully complete the board prescribed
25 emergency medical responder transition course, provide validation of
26 cognitive and psychomotor competency and all continuing education hour
27 requirements inclusive of the successful completion of a transition course
28 as determined by rules and regulations of the board. Alternatively, upon
29 application for renewal of an emergency medical technician certificate, the
30 applicant shall be deemed to hold a certificate as an emergency medical
31 responder under this act, and such individual shall not be required to file
32 an original application for certification as an emergency medical
33 responder.

34 (e) Failure to successfully complete either an emergency medical
35 technician transition course or emergency medical responder transition
36 course will result in loss of certification.

37 (f) Upon transition, notwithstanding any other provision of law to the
38 contrary, an emergency medical technician may perform any activities
39 identified in K.S.A. 65-6144, and amendments thereto, and any of the
40 following interventions, by use of the devices, medications and equipment,
41 or any combination thereof, after successfully completing an approved
42 course of instruction, local specialized device training and competency
43 validation and when authorized by medical protocols, or upon order when

1 direct communication is maintained by radio, telephone or video
2 conference is monitored by a physician, physician assistant when
3 authorized by a physician, an advanced practice registered nurse ~~when~~
4 ~~authorized by a physician~~ or a licensed professional nurse when authorized
5 by a physician, upon order of such person:

- 6 (1) Airway maintenance including use of:
 - 7 (A) Single lumen airways as approved by the board;
 - 8 (B) multilumen airways;
 - 9 (C) ventilator devices;
 - 10 (D) forceps removal of airway obstruction;
 - 11 (E) CO2 monitoring;
 - 12 (F) airway suctioning;
- 13 (2) apply pneumatic anti-shock garment;
- 14 (3) assist with childbirth;
- 15 (4) monitoring urinary catheter;
- 16 (5) capillary blood sampling;
- 17 (6) cardiac monitoring;
- 18 (7) administration of patient assisted medications as approved by the
19 board;
- 20 (8) administration of medications as approved by the board by
21 appropriate routes; and
- 22 (9) monitor, maintain or discontinue flow of IV line if a physician
23 approves transfer by an emergency medical technician.

24 Sec. 28. K.S.A. 2014 Supp. 65-6123 is hereby amended to read as
25 follows: 65-6123. (a) Notwithstanding any other provision of law to the
26 contrary, an emergency medical technician-defibrillator may:

- 27 (1) Perform any of the activities identified in K.S.A. 65-6121, and
28 amendments thereto;
- 29 (2) when approved by medical protocols or where voice contact by
30 radio or telephone is monitored by a physician, physician assistant where
31 authorized by a physician, advanced practice registered nurse ~~where~~
32 ~~authorized by a physician~~, or licensed professional nurse where authorized
33 by a physician, and direct communication is maintained, upon order of
34 such person, may perform electrocardiographic monitoring and
35 defibrillation;
- 36 (3) perform, during an emergency, those activities specified in
37 subsection (b) before contacting the persons identified in subsection (b)
38 when specifically authorized to perform such activities by medical
39 protocols; or
- 40 (4) perform, during nonemergency transportation, those activities
41 specified in this section when specifically authorized to perform such
42 activities by medical protocols.
- 43 (b) An individual who holds a valid certificate as an emergency

1 medical technician-defibrillator once successfully completing an
2 emergency medical technician-intermediate, initial course of instruction
3 and the board prescribed transition course, and validation of cognitive and
4 psychomotor competency as determined by rules and regulations of the
5 board, may apply to transition to become an advanced emergency medical
6 technician. Alternatively, upon application for renewal, such individual
7 shall be deemed to hold a certificate as an advanced emergency medical
8 technician under this act, provided such individual has completed all
9 continuing education hour requirements inclusive of successful completion
10 of a transition course, and such individual shall not be required to file an
11 original application for certification as an advanced emergency medical
12 technician.

13 (c) "Renewal" as used in subsection (b), refers to the second
14 opportunity after December 31, 2011, that an attendant has to apply for
15 renewal of a certificate.

16 (d) Emergency medical technician-defibrillator attendants who fail to
17 meet the transition requirements as specified may complete either the
18 board prescribed emergency medical technician transition course or
19 emergency medical responder transition course, provide validation of
20 cognitive and psychomotor competency provided such individual has
21 completed all continuing education hour requirements inclusive of the
22 successful completion of a transition course as determined by rules and
23 regulations of the board. Upon completion, such emergency medical
24 technician-defibrillator may apply to transition to become an emergency
25 medical technician or an emergency medical responder, depending on the
26 transition course that was successfully completed. Alternatively, upon
27 application for renewal of an emergency medical technician-defibrillator
28 certificate, the applicant shall be renewed as an emergency medical
29 technician or an emergency medical responder, depending on the transition
30 course that was successfully completed. Such individual shall not be
31 required to file an original application for certification as an emergency
32 medical technician or emergency medical responder.

33 (e) Failure to complete either the advanced emergency medical
34 technician transition requirements, an emergency medical technician
35 transition course or an emergency medical responder transition course will
36 result in loss of certification.

37 Sec. 29. K.S.A. 2013 Supp. 65-6124, as amended by section 52 of
38 chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
39 read as follows: 65-6124. (a) No physician, physician assistant, advanced
40 practice registered nurse or licensed professional nurse, who gives
41 emergency instructions to an attendant as defined by K.S.A. 65-6112, and
42 amendments thereto, during an emergency, shall be liable for any civil
43 damages as a result of issuing the instructions, except such damages which

1 may result from gross negligence in giving such instructions.

2 (b) No attendant as defined by K.S.A. 65-6112, and amendments
3 thereto, who renders emergency care during an emergency pursuant to
4 instructions given by a physician, *an advanced practice registered nurse*,
5 the supervising physician for a physician assistant, ~~advanced practice~~
6 ~~registered nurse~~ or licensed professional nurse shall be liable for civil
7 damages as a result of implementing such instructions, except such
8 damages which may result from gross negligence or by willful or wanton
9 acts or omissions on the part of such attendant as defined by K.S.A. 65-
10 6112, and amendments thereto.

11 (c) No person certified as an instructor-coordinator and no training
12 officer shall be liable for any civil damages which may result from such
13 instructor-coordinator's or training officer's course of instruction, except
14 such damages which may result from gross negligence or by willful or
15 wanton acts or omissions on the part of the instructor-coordinator or
16 training officer.

17 (d) No medical adviser who reviews, approves and monitors the
18 activities of attendants shall be liable for any civil damages as a result of
19 such review, approval or monitoring, except such damages which may
20 result from gross negligence in such review, approval or monitoring.

21 Sec. 30. K.S.A. 2014 Supp. 65-6144 is hereby amended to read as
22 follows: 65-6144. (a) A first responder may perform any of the following
23 activities:

24 (1) Initial scene management including, but not limited to, gaining
25 access to the individual in need of emergency care, extricating, lifting and
26 moving the individual;

27 (2) cardiopulmonary resuscitation and airway management;

28 (3) control of bleeding;

29 (4) extremity splinting excluding traction splinting;

30 (5) stabilization of the condition of the individual in need of
31 emergency care;

32 (6) oxygen therapy;

33 (7) use of oropharyngeal airways;

34 (8) use of bag valve masks;

35 (9) use automated external defibrillators; and

36 (10) other techniques of preliminary care a first responder is trained
37 to provide as approved by the board.

38 (b) An individual who holds a valid certificate as a first responder,
39 once completing the board prescribed transition course, and validation of
40 cognitive and psychomotor competency as determined by rules and
41 regulations of the board, may apply to transition to become an emergency
42 medical responder. Alternatively, upon application for renewal of such
43 certificate, such individual shall be deemed to hold a certificate as an

1 emergency medical responder under this act, provided such individual has
2 completed all continuing education hour requirements inclusive of a
3 transition course and such individual shall not be required to file an
4 original application for certification as an emergency medical responder.

5 (c) "Renewal" as used in subsection (b), refers to the first opportunity
6 after December 31, 2011, that an attendant has to apply for renewal of a
7 certificate.

8 (d) First responder attendants who fail to meet the transition
9 requirements as specified will forfeit their certification.

10 (e) Upon transition, notwithstanding any other provision of law to the
11 contrary, an emergency medical responder may perform any of the
12 following interventions, by use of the devices, medications and equipment,
13 or any combination thereof, after successfully completing an approved
14 course of instruction, local specialized device training and competency
15 validation and when authorized by medical protocols, or upon order when
16 direct communication is maintained by radio, telephone or video
17 conference is monitored by a physician, physician assistant when
18 authorized by a physician, an advanced practice registered nurse ~~when~~
19 ~~authorized by a physician~~ or a licensed professional nurse when authorized
20 by a physician, upon order of such person: (1) Emergency vehicle
21 operations; (2) initial scene management; (3) patient assessment and
22 stabilization; (4) cardiopulmonary resuscitation and airway management;
23 (5) control of bleeding; (6) extremity splinting; (7) spinal immobilization;
24 (8) oxygen therapy; (9) use of bag-valve-mask; (10) use of automated
25 external defibrillator; (11) nebulizer therapy; (12) intramuscular injections
26 with auto-injector; (13) administration of oral glucose; (14) administration
27 of aspirin; (15) recognize and comply with advanced directives; (16)
28 insertion and maintenance of oral and nasal pharyngeal airways; (17) use
29 of blood glucose monitoring; and (18) other techniques and devices of
30 preliminary care an emergency medical responder is trained to provide as
31 approved by the board.

32 Sec. 31. K.S.A. 2014 Supp. 65-7003 is hereby amended to read as
33 follows: 65-7003. As used in K.S.A. 65-7001 through 65-7015, and
34 amendments thereto:

35 (a) "Act" means the Kansas chemical control act;

36 (b) "administer" means the application of a regulated chemical
37 whether by injection, inhalation, ingestion or any other means, directly
38 into the body of a patient or research subject, such administration to be
39 conducted by: (1) A practitioner, or in the practitioner's presence, by such
40 practitioner's authorized agent; or

41 (2) the patient or research subject at the direction and in the presence
42 of the practitioner;

43 (c) "agent or representative" means a person who is authorized to

1 receive, possess, manufacture or distribute or in any other manner control
2 or has access to a regulated chemical on behalf of another person;

3 (d) "bureau" means the Kansas bureau of investigation;

4 (e) "department" means the Kansas department of health and
5 environment;

6 (f) "director" means the director of the Kansas bureau of
7 investigation;

8 (g) "dispense" means to deliver a regulated chemical to an ultimate
9 user, patient or research subject by, or pursuant to the lawful order of, a
10 practitioner, including the prescribing, administering, packaging, labeling
11 or compounding necessary to prepare the regulated chemical for that
12 delivery;

13 (h) "distribute" means to deliver other than by administering or
14 dispensing a regulated chemical;

15 (i) "manufacture" means to produce, prepare, propagate, compound,
16 convert or process a regulated chemical directly or indirectly, by extraction
17 from substances of natural origin, chemical synthesis or a combination of
18 extraction and chemical synthesis, and includes packaging or repackaging
19 of the substance or labeling or relabeling of its container. The term
20 excludes the preparation, compounding, packaging, repackaging, labeling
21 or relabeling of a regulated chemical:

22 (1) By a practitioner as an incident to the practitioner's administering
23 or dispensing of a regulated chemical in the course of the practitioner's
24 professional practice; or

25 (2) by a practitioner, or by the practitioner's authorized agent under
26 the practitioner's supervision, for the purpose of, or as an incident to
27 research, teaching or chemical analysis and not for sale;

28 (j) "person" means individual, corporation, business trust, estate,
29 trust, partnership, association, joint venture, government, governmental
30 subdivision or agency, or any other legal or commercial entity;

31 (k) "practitioner" means a person licensed to practice medicine and
32 surgery, pharmacist, dentist, podiatrist, veterinarian, optometrist, *advanced*
33 *practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and*
34 *amendments thereto, and who has authority to prescribe drugs in*
35 *accordance with K.S.A. 65-1130, and amendments thereto, or scientific*
36 *investigator or other person authorized by law to use a controlled*
37 *substance in teaching or chemical analysis or to conduct research with*
38 *respect to a controlled substance;*

39 (l) "regulated chemical" means a chemical that is used directly or
40 indirectly to manufacture a controlled substance or other regulated
41 chemical, or is used as a controlled substance analog, in violation of the
42 state controlled substances act or this act. The fact that a chemical may be
43 used for a purpose other than the manufacturing of a controlled substance

1 or regulated chemical does not exempt it from the provisions of this act.

2 Regulated chemical includes:

- 3 (1) Acetic anhydride (CAS No. 108-24-7);
- 4 (2) benzaldehyde (CAS No. 100-52-7);
- 5 (3) benzyl chloride (CAS No. 100-44-7);
- 6 (4) benzyl cyanide (CAS No. 140-29-4);
- 7 (5) diethylamine and its salts (CAS No. 109-89-7);
- 8 (6) ephedrine, its salts, optical isomers and salts of optical isomers
- 9 (CAS No. 299-42-3), except products containing ephedra or ma huang,
- 10 which do not contain any chemically synthesized ephedrine alkaloids, and
- 11 are lawfully marketed as dietary supplements under federal law;
- 12 (7) hydriodic acid (CAS No. 10034-85-2);
- 13 (8) iodine (CAS No. 7553-56-2);
- 14 (9) lithium (CAS No. 7439-93-2);
- 15 (10) methylamine and its salts (CAS No. 74-89-5);
- 16 (11) nitroethane (CAS No. 79-24-3);
- 17 (12) chloroephedrine, its salts, optical isomers, and salts of optical
- 18 isomers (CAS No. 30572-91-9);
- 19 (13) phenylacetic acid, its esters and salts (CAS No. 103-82-2);
- 20 (14) phenylpropanolamine, its salts, optical isomers, and salts of
- 21 optical isomers (CAS No. 14838-15-4);
- 22 (15) piperidine and its salts (CAS No. 110-89-4);
- 23 (16) pseudoephedrine, its salts, optical isomers, and salts of optical
- 24 isomers (CAS No. 90-82-4);
- 25 (17) red phosphorous (CAS No. 7723-14-0);
- 26 (18) sodium (CAS No. 7440-23-5); and
- 27 (19) thionylchloride (CAS No. 7719-09-7);
- 28 (20) gamma butyrolactone (GBL), including butyrolactone;
- 29 butyrolactone gamma; 4-butyrolactone; 2(3H)-furanone dihydro; dihydro-
- 30 2(3H)-furanone; tetrahydro-2-furanone; 1,2-butanolide; 1,4-butanolide; 4-
- 31 butanolide; gamma-hydroxybutyric acid lactone; 3-hydroxybutyric acid
- 32 lactone and 4-hydroxybutanoic acid lactone; CAS No. 96-48-0; and
- 33 (21) 1,4 butanediol, including butanediol; butane-1,4-diol; 1,4-
- 34 butylene glycol; butylene glycol; 1,4-dihydroxybutane; 1,4-tetramethylene
- 35 glycol; tetramethylene glycol; tetramethylene 1,4-diol; CAS No. 110-63-4;
- 36 (m) "regulated chemical distributor" means any person subject to the
- 37 provisions of the Kansas chemical control act who manufactures or
- 38 distributes a regulated chemical;
- 39 (n) "regulated chemical retailer" means any person who sells
- 40 regulated chemicals directly to the public;
- 41 (o) "regulated chemical transaction" means the manufacture of a
- 42 regulated chemical or the distribution, sale, exchange or other transfer of a
- 43 regulated chemical within or into the state or from this state into another

1 state; and

2 (p) "secretary" means the secretary of health and environment.

3 Sec. 32. K.S.A. 2014 Supp. 65-7302 is hereby amended to read as
4 follows: 65-7302. As used in this act:

5 (a) "Board" means the state board of healing arts.

6 (b) "Ionizing radiation" means x-rays, gamma rays, alpha and beta
7 particles, high speed electrons, protons, neutrons and other nuclear
8 particles capable of producing ions directly or indirectly in its passage
9 through matter.

10 (c) "License" means a certificate issued by the board authorizing the
11 licensee to perform radiologic technology procedures on humans for
12 diagnostic or therapeutic purposes.

13 (d) "Licensed practitioner" means a person licensed to practice
14 medicine and surgery, dentistry, podiatry~~or~~, chiropractic *or advanced*
15 *practice registered nursing* in this state.

16 (e) "Licensure" and "licensing" mean a method of regulation by
17 which the state grants permission to persons who meet predetermined
18 qualifications to engage in a health related occupation or profession.

19 (f) "Nuclear medicine technologist" means a person who uses radio
20 pharmaceutical agents on humans for diagnostic or therapeutic purposes.

21 (g) "Nuclear medicine technology" means the use of radio nuclides on
22 human beings for diagnostic or therapeutic purposes.

23 (h) "Radiation therapist" means a person who applies radiation to
24 humans for therapeutic purposes.

25 (i) "Radiation therapy" means the use of any radiation procedure or
26 article intended for the cure, mitigation or prevention of disease in
27 humans.

28 (j) "Radiographer" means a person who applies radiation to humans
29 for diagnostic purposes.

30 (k) "Radiography" means the use of ionizing radiation on human
31 beings for diagnostic purposes.

32 (l) "Radiologic technologist" means any person who is a
33 radiographer, radiation therapist or nuclear medicine technologist.

34 (m) "Radiologic technology" means the use of radioactive substance
35 or equipment emitting or detecting ionizing radiation on humans for
36 diagnostic or therapeutic purposes upon prescription of a licensed
37 practitioner. The term includes the practice of radiography, nuclear
38 medicine technology and radiation therapy, but does not include
39 echocardiography, diagnostic sonography and magnetic resonance
40 imaging.

41 (n) This section shall take effect on and after July 1, 2005.

42 Sec. 33. K.S.A. 2014 Supp. 72-5213 is hereby amended to read as
43 follows: 72-5213. (a) Every board of education shall require all employees

1 of the school district, who come in regular contact with the pupils of the
2 school district, to submit a certification of health on a form prescribed by
3 the secretary of health and environment and signed by a person licensed to
4 practice medicine and surgery under the laws of any state, or by a person
5 who is licensed as a physician assistant under the laws of this state when
6 such person is working at the direction of or in collaboration with a person
7 licensed to practice medicine and surgery, or by a person holding a license
8 to practice as an advanced practice registered nurse under the laws of this
9 state ~~when such person is working at the direction of or in collaboration~~
10 ~~with a person licensed to practice medicine and surgery.~~ The certification
11 shall include a statement that there is no evidence of a physical condition
12 that would conflict with the health, safety, or welfare of the pupils; and
13 that freedom from tuberculosis has been established by chest x-ray or
14 negative tuberculin skin test. If at any time there is reasonable cause to
15 believe that any such employee of the school district is suffering from an
16 illness detrimental to the health of the pupils, the school board may require
17 a new certification of health.

18 (b) Upon presentation of a signed statement by the employee of a
19 school district, to whom the provisions of subsection (a) apply, that the
20 employee is an adherent of a religious denomination whose religious
21 teachings are opposed to physical examinations, the employee shall be
22 permitted to submit, as an alternative to the certification of health required
23 under subsection (a), certification signed by a person licensed to practice
24 medicine and surgery under the laws of any state, or by a person who is
25 licensed as a physician assistant under the laws of this state when such
26 person is working at the direction of or in collaboration with a person
27 licensed to practice medicine and surgery, or by a person holding a license
28 to practice as an advanced practice registered nurse under the laws of this
29 state ~~when such person is working at the direction of or in collaboration~~
30 ~~with a person licensed to practice medicine and surgery~~ that freedom of
31 the employee from tuberculosis has been established.

32 (c) Every board of education may require persons, other than
33 employees of the school district, to submit to the same certification of
34 health requirements as are imposed upon employees of the school district
35 under the provisions of subsection (a) if such persons perform or provide
36 services to or for a school district which require such persons to come in
37 regular contact with the pupils of the school district. No such person shall
38 be required to submit a certification of health if the person presents a
39 signed statement that the person is an adherent of a religious denomination
40 whose religious teachings are opposed to physical examinations. Such
41 persons shall be permitted to submit, as an alternative to a certification of
42 health, certification signed by a person licensed to practice medicine and
43 surgery under the laws of any state, or by a person who is licensed as a

1 physician assistant under the laws of this state when such person is
2 working at the direction of or in collaboration with a person licensed to
3 practice medicine and surgery, or by a person holding a license to practice
4 as an advanced practice registered nurse under the laws of this state ~~when~~
5 ~~such person is working at the direction of or in collaboration with a person~~
6 ~~licensed to practice medicine and surgery~~ that freedom of such persons
7 from tuberculosis has been established.

8 (d) The expense of obtaining certifications of health and certifications
9 of freedom from tuberculosis may be borne by the board of education.

10 Sec. 34. K.S.A. 2014 Supp. 75-7429 is hereby amended to read as
11 follows: 75-7429. (a) As used in this section, "medical home" means a
12 health care delivery model in which a patient establishes an ongoing
13 relationship with a physician or other personal care provider in a
14 physician-directed team, *or with an advanced practice registered nurse* to
15 provide comprehensive, accessible and continuous evidence-based primary
16 and preventive care, and to coordinate the patient's health care needs
17 across the health care system in order to improve quality and health
18 outcomes in a cost effective manner.

19 (b) The department of health and environment shall incorporate the
20 use of the medical home delivery system within:

21 (1) The Kansas program of medical assistance established in
22 accordance with title XIX of the federal social security act, 42 U.S.C. §
23 1396 et seq., and amendments thereto;

24 (2) the health benefits program for children established under K.S.A.
25 38-2001 et seq., and amendments thereto, and developed and submitted in
26 accordance with federal guidelines established under title XXI of the
27 federal social security act, section 4901 of public law 105-33, 42 U.S.C. §
28 1397aa et seq., and amendments thereto; and

29 (3) the state mediKan program.

30 (c) The Kansas state employees health care commission established
31 under K.S.A. 75-6502, and amendments thereto, shall incorporate the use
32 of a medical home delivery system within the state health care benefits
33 program as provided in K.S.A. 75-6501 through 75-6523, and amendments
34 thereto. Except that compliance with a medical home delivery system shall
35 not be required of program participants receiving treatment in accordance
36 with a religious method of healing pursuant to the provisions of K.S.A.
37 2014 Supp. 75-6501, and amendments thereto.

38 Sec. 35. K.S.A. 40-4602, 59-2976, 65-1660, 65-2892, 65-4134 and
39 65-5502 and K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
40 chapter 131 of the 2014 Session Laws of Kansas, 65-4101, as amended by
41 section 50 of chapter 131 of the 2014 Session Laws of Kansas, 65-6112, as
42 amended by section 51 of chapter 131 of the 2014 Session Laws of Kansas
43 and 65-6124, as amended by section 52 of chapter 131 of the 2014 Session

1 Laws of Kansas and K.S.A. 2014 Supp. 39-923, 39-1401, 39-1430, 39-
2 1504, 65-468, 65-507, 65-1113, 65-1130, 65-1682, 65-2837a, 65-2921, 65-
3 4116, 65-4202, 65-5402, 65-5418, 65-6119, 65-6120, 65-6121, 65-6123,
4 65-6144, 65-7003, 65-7302, 72-5213 and 75-7429 are hereby repealed.
5 Sec. 36. This act shall take effect and be in force from and after July
6 1, 2016, and its publication in the statute book.