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.
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.

[Signature]
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.

[Signature]
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 August, 2002.

[Signature]
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
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.illearning.com/catalog/9781449680168/](http://www.illearning.com/catalog/9781449680168/).

I'd be glad to help out with anything else you need, just send me an email or call me on my cell (316-323-4560) with any questions. Thank you!

 Regards,

Chris Cannon
Chair, Health and Human Services
FMS Program Director
Cowley College Allied Health Center
406 E. 8th Street
Olathe, KS 67106
620-229-5985
620-229-5989 Fax
www.cowley.edu/paramedic
www.facebook.com/cowleyems
July 27, 2015

Cowley College Press Releases

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 CPIMIH 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@cowler.edu.
Community Paramedic Course Application

Personal Information

First Name: ____________________________ (required)
Midio 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)

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

Required Documentation:

- One letter reference from your EMS service director
- One letter of reference from your medical director
- Completed immunization form
- Completed physical exam form
- 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:

-205-
C: 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
1403 E. 8th Street
Winfield, KS 67156
620.229.5935
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 e 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.

---207---
Education 207
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.

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<td>Demonstrates the ability to:</td>
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<td>The Community Paramedic will be able to define Community Paramedic.</td>
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<td>The Community Paramedic will be able to define his or her role within a distinct community.</td>
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<td>The Community Paramedic will demonstrate the ability to navigate and establish systems to better serve communities and clients.</td>
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<td>The Community Paramedic will be able to define his or her role as a direct service provider.</td>
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<td>The Community Paramedic will be able to define his or her role as a mentor and stakeholder empowerment advocate.</td>
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<td>The Community Paramedic will be able to discuss the history and future of their role.</td>
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<td>The Community Paramedic will be able to discuss rural and remote medical care dilemma in the United States.</td>
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<td>The Community Paramedic will be familiar with the 2004 Rural and Frontier EMS Agenda of the Future.</td>
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<td>The Community Paramedic will be familiar with the Community Healthcare and Emergency Cooperative (CHEC).</td>
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<td>The Community Paramedic will be familiar with the international Roundtable on Community Paramedics (IRCP).</td>
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<td>The Community Paramedic will be able to explain the “scope of practice” to stakeholders.</td>
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<td>The Community Paramedic will be able to define the current paramedic scope of practice and how it drives the Community Paramedic scope of practice.</td>
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<td>The Community Paramedic will assess and identify gaps between community needs and services</td>
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<td>The Community Paramedic will develop solutions to improve quality of life and health.</td>
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<td>The Community Paramedic will defend the importance of providing services only where and when there are no others to provide them.</td>
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<td>The Community Paramedic will predict how to establish and navigate systems to better serve citizens.</td>
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UNIT 2: Social Determinants of Health

Outcomes: The Community Paramedic will understand the social determinants of health.

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<td>The Community Paramedic will be able to define the social ecology model and the determinants of health.</td>
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<td>The Community Paramedic will be able to describe the correlation between health status indicators and individual characteristics.</td>
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<td>The Community Paramedic will describe age as an Individual health factor determinant.</td>
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<td>The Community Paramedic will describe gender as an Individual health factor determinant.</td>
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<td>The Community Paramedic will describe educational level as an Individual health factor determinant.</td>
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<td>The Community Paramedic will describe economic status as an Individual health factor determinant.</td>
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<td>The Community Paramedic will describe race as an Individual health factor determinant.</td>
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<td>The Community Paramedic will be able to identify social characteristics that are correlated with health status indicators.</td>
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<td>The Community Paramedic will describe race as a social health status indicator.</td>
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<td>The Community Paramedic will describe ethnicity as a social health status indicator.</td>
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<td>The Community Paramedic will describe relationship status as a social health indicator.</td>
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</table>
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 a 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 spiritually 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.

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**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.

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**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.

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- 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.

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<td>The Community Paramedic will be able to define and use a community needs assessment.</td>
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<td>The Community Paramedic will be able to develop potential patient profiles based upon EMS call volume.</td>
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<td>The Community Paramedic will extrapolate client profiles based on use of EMS, populations, morbidity, mortality, perception, and call acuity.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to discuss how mapping plays a role, as part of a community needs assessment.</td>
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<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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<td>The Community Paramedic will describe the process for taking referrals, receiving referrals, and evaluating receipt of assistance.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to create a resource map with types of services and types of clients specified on the map.</td>
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<td>The Community Paramedic will define and explain the web of resources.</td>
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<td>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.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to discuss the concept of negative consequences in working with clients.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to apply negative consequences to modify behavior while maintaining credibility with the client.</td>
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<td>The Community Paramedic will differentiate between threat of negative consequences and use of negative consequences.</td>
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<td>The Community Paramedic will be able to discuss the types of resources needed to apply negative consequences as a means of modifying unhealthy behavior.</td>
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<td>The Community Paramedic will be able to define outreach.</td>
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<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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<tr>
<th>The Community Paramedic will be able to identify, use, and discuss the purpose of community outreach with stakeholders.</th>
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<tr>
<td>The Community Paramedic will be able to use evaluation, deployment, follow-up, and interventions to translate a needs assessment into a community outreach strategy.</td>
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<td>The Community Paramedic will be able to use case findings, safely approaching a client, introductions, biopsychosocial assessment, and resource identification in individual outreach.</td>
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<td>The Community Paramedic will be able to discuss case findings from multiple sources of information for both housed and homeless clients.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to approach a client and introduce them in a manner that sets the tone for effective outreach.</td>
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<td>The Community Paramedic will be able to conduct a biopsychosocial assessment, a psycho-psychosocial assessment, and a bio-medical assessment.</td>
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<td>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.</td>
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<td>The Community Paramedic will be able to discuss the HOME (Homeless Outreach and Medical Emergency) Team Interventional Technique.</td>
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<td>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.</td>
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<td>The Community Paramedic will integrate system navigation and utilization of other sources of care into the web of resources to motivate clients to change.</td>
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<td>The Community Paramedic will be able to explain the different forms of client referrals (phone and written).</td>
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<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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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.

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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.

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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.
Hi Diane,

I’ve attached the syllabus for the Community Paramedic/MH 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
1400 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.


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.

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Education 223

OL/H
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.
<table>
<thead>
<tr>
<th>Course Grade</th>
<th>Letter Grade Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homework</td>
<td>86-93% = B</td>
</tr>
<tr>
<td>Fall Project</td>
<td>80-85% = C</td>
</tr>
<tr>
<td>Clinical Participation</td>
<td>70-79% = D</td>
</tr>
<tr>
<td>Capstone Project</td>
<td>Below 70% = F</td>
</tr>
<tr>
<td>Exams (2)</td>
<td></td>
</tr>
</tbody>
</table>

**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](http://www.cowley.edu/academics/tutoring/tutorschedule.html)

Online [http://www.cowley.edu/academics/tutoring/tutorschedule.html](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.

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

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Weights</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Lengths</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Vitals</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Head Circumference</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Hospice/End of life visits</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Communication with Primary Referring Provider</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Radiological diagnostic preparation instructions – CT</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Radiological diagnostic preparation instructions – MRI</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Radiological diagnostic preparation instructions – US</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Radiological diagnostic preparation instructions – Nuclear</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Results from diagnostic lab testing</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Identification of “red flags” and high risk results</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Identifying required further diagnostic testing needs</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Specimen collection techniques -- serum</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Specimen collection techniques -- urine</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Specimen collection techniques -- wound, throat, nasal or related culture</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Health promotion studies education (Cholesterol, HAIC, Colonoscopy, etc)</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Bedside diagnostics performance -- Fecal occult</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Bedside diagnostics performance -- FSBG</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Bedside chemistry strips</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Handheld point of care analyzers -- BGL</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Handheld point of care analyzers -- PT/INR</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

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

Education 227
OL/H
<table>
<thead>
<tr>
<th>Item</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handheld point of care analyzers – other blood tests</td>
<td>0</td>
</tr>
<tr>
<td>Digital Equipment (Sonogram)</td>
<td>0</td>
</tr>
<tr>
<td>Cameras</td>
<td>0</td>
</tr>
<tr>
<td>Computers/medical records</td>
<td>0</td>
</tr>
<tr>
<td>Telemedicine/Skype/Facetime</td>
<td>1</td>
</tr>
<tr>
<td>Otoscope</td>
<td>3</td>
</tr>
<tr>
<td>Bluetooth Stethoscope</td>
<td>2</td>
</tr>
<tr>
<td>Oxygen Delivery</td>
<td>1</td>
</tr>
<tr>
<td>CPAP</td>
<td>1</td>
</tr>
<tr>
<td>Bi-PAP</td>
<td>0</td>
</tr>
<tr>
<td>Walkers</td>
<td>1</td>
</tr>
<tr>
<td>Canes</td>
<td>1</td>
</tr>
<tr>
<td>Crutches</td>
<td>3</td>
</tr>
<tr>
<td>Commodes</td>
<td>1</td>
</tr>
<tr>
<td>Hospital beds</td>
<td>1</td>
</tr>
<tr>
<td>Hoyer lifts</td>
<td>1</td>
</tr>
<tr>
<td>Slide boards</td>
<td>1</td>
</tr>
<tr>
<td>Air lift cushions</td>
<td>1</td>
</tr>
<tr>
<td>Wheel chairs</td>
<td>1</td>
</tr>
<tr>
<td>Ports</td>
<td>3</td>
</tr>
<tr>
<td>Central lines</td>
<td>3</td>
</tr>
<tr>
<td>Ileostomy</td>
<td>2</td>
</tr>
<tr>
<td>Foley Catheters</td>
<td>2</td>
</tr>
</tbody>
</table>

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.
<table>
<thead>
<tr>
<th>Task</th>
<th>2</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight urinary catheters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colostomy care</td>
<td></td>
<td></td>
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<tr>
<td>Peg tubes</td>
<td></td>
<td></td>
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<tr>
<td>Wound management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify the signs of stress</td>
<td></td>
<td></td>
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<tr>
<td>Recognize defense mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determine Pre-existing conditions (psychological)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish goals of the intervention (psychological)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide psychological first aid</td>
<td></td>
<td></td>
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<tr>
<td>Pain and pain management</td>
<td></td>
<td></td>
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<tr>
<td>Hospice referral criteria</td>
<td></td>
<td></td>
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<tr>
<td>Understands palliative care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization schedule</td>
<td></td>
<td></td>
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<tr>
<td>TB medication administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home safety inspections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview to reporting communicable diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in community health activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak flow assessment for asthma</td>
<td></td>
<td></td>
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<tr>
<td>Assessment and management plan of a sub-acute patient with COPD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notice: Changes within the course syllabus such as, procedure, assignments and schedule may be made at the discretion of the instructor.
<table>
<thead>
<tr>
<th>Chest Physiotherapy</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Assessment and management plan of a sub-acute patient with diabetes</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with TBI</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with spinal cord injury</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with MS/MD</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with hypertension</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with a wound</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Demonstration of surgical asepsis</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with an infection</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute patient with regard to oral health</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Assessment and management plan of a sub-acute / semi-chronic psychiatric patient</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

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.

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(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
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.3owley.edu](http://www.3owley.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](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](http://www.cowley.edu/policy/policy403.html) (Institutional Policies: Student Affairs Council: Series 400.00: 403.00 Student Code Of Conduct)

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

Semester schedule:

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

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

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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
- 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/cowleveems
You are currently subscribed to kansas-ems as: jason.white3254@gmail.com. To unsubscribe send a blank email to leave-203154-193819.d7a2e7c0b373f14d8a64c247425307360list.da.ks.gov
Welcome to the Community Paramedic Program. We hope you take time to learn more about our 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: Cordial, unfettered access to underserved populations. In this case, we're expanding the role of EMT workers to provide health services where access to physicians, clinics, and hospitals is difficult or may not exist.

The Community Paramedic Program is organized. 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 build 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 help, please visit the program, please e-mail me.

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 who are poor.

Referrals 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 EMT 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 effort of those that have a stake in maintaining the health and well-being of its citizens.

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

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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 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. 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...
flu-like systems) at 10-40%.
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

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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.
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.6

---

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 thorough 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:

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 timeframe, in fact some may need to occur simultaneously.

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.

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.

Q 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
- Characteristics 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 Director
- Community Paramedic
- Program Coordinator
- Scheduler
- 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.
<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONNEL</td>
<td>Program Director, Community Paramedic(s), Quality Assurance Coordinator, Program Coordinator/Scheduler</td>
</tr>
<tr>
<td>CONSULTANT/CONTRACTUAL</td>
<td>Medical Oversight (licensed physician)</td>
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<td></td>
<td>Evaluation, Grant Writing</td>
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<tr>
<td>EQUIPMENT</td>
<td>Otoscope (with camera to send to physician)</td>
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<td></td>
<td>Stethoscope (digital to send read-out to physician)</td>
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<td></td>
<td>Temporal thermometer</td>
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<td></td>
<td>Pulse oximeter</td>
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<td></td>
<td>Digital camera (to send pictures to physician, e.g. wounds, cellulitis, home safety risks)</td>
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<td></td>
<td>Portable adult and baby scales</td>
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<td>LAB SUPPLIES</td>
<td>EKG/defibrillator</td>
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<td>Dressing changes</td>
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<tr>
<td>TRAVEL</td>
<td>Blood draw</td>
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<td>Non-emergency vehicle (fletching, lights, radio if new)</td>
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<tr>
<td>INSURANCE</td>
<td>Motor vehicle insurance/gas</td>
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<td></td>
<td>Additional malpractice Insurance (Check with insurance company)</td>
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<tr>
<td>UNIFORMS</td>
<td>Community Paramedic uniforms</td>
</tr>
<tr>
<td>TRAINING</td>
<td>Tuition, text books and supplies</td>
</tr>
</tbody>
</table>
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 stigmas 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 Paramedics 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.)
Community Paramedic™
Program Handbook

- 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.

3 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.

<table>
<thead>
<tr>
<th>Training: Three Levels</th>
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<tbody>
<tr>
<td>College Course</td>
</tr>
<tr>
<td>Lab Sessions</td>
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<tr>
<td>Clinical Rotations</td>
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</table>
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.

6. 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 be can 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 agreement 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 L).

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](http://www.IRCP.org)

- **Joint Committee on Rural Emergency Care:**
  National Association of State EMS Officials & National Organization of State Offices of Rural Health

- **Community Health Care Emergency Cooperative's Community Paramedic Curriculum:** [www.communityparamedic.org/Colleges.aspx](http://www.communityparamedic.org/Colleges.aspx)

- **WECAD Community Paramedic Program Development:**
  - Chris Montera, Chief, Western Eagle County Health Services District
    E-mail: cmontera@wecadems.com
    Website: [www.wecadems.com/cp.html](http://www.wecadems.com/cp.html)
  - Caring Anne Consulting, Anne Robinson, RN, President
    Public Health Nurse Consultant
    E-mail: car@caringanne.com
    Website: [www.caringanne.com](http://www.caringanne.com)
  - Silver Street Consulting, Jill Hunsaker Ryan, MPH, Principal
    Public Health Consultant
    E-mail: [www.silverstreetconsulting.net](http://www.silverstreetconsulting.net)
    Website: [silverstreetconsulting@gmail.com](mailto:silverstreetconsulting@gmail.com)
## Appendix B: Work Plan Template, Months 1-12

<table>
<thead>
<tr>
<th>Step (Vital Year)</th>
<th>Activity</th>
<th>Actor(s) Responsible</th>
<th>Activity Due Dates</th>
<th>Place X by Month(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to Plan</td>
<td>Background materials</td>
<td>Workplan</td>
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<tr>
<td>Determine Program Feasibility/Beg to Engage Key Partners</td>
<td>State EMS Office</td>
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<tr>
<td></td>
<td>Internal Leadership, Staff</td>
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<tr>
<td></td>
<td>Medical Community</td>
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<tr>
<td></td>
<td>College/University</td>
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<tr>
<td>Determine Medical Direction/Quality Assurance</td>
<td>Develop a plan</td>
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<tr>
<td>Assess Community Health Needs</td>
<td>Engage health department</td>
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<tr>
<td></td>
<td>Develop an assessment plan</td>
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<tr>
<td>Determine Program Scope</td>
<td>Services</td>
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<tr>
<td></td>
<td>Personnel Needs</td>
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<td></td>
<td>Budget</td>
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<tr>
<td></td>
<td>Needs for Fundraising</td>
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<tr>
<td>Engage Stakeholders</td>
<td>Identify</td>
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<td>Engage</td>
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<td></td>
<td>Form advisory committee</td>
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<tr>
<td>Develop Policies/Procedures</td>
<td>Identify needed policies/procedures</td>
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<td></td>
<td>Develop, incorporate into training</td>
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<tr>
<td>Plan for Training</td>
<td>Commitments for clinical rotations from providers</td>
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<tr>
<td></td>
<td>Plan training with college/university</td>
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<tr>
<td>Step</td>
<td>Activity</td>
<td>Activity Date</td>
<td>Plan (by Month)</td>
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<tr>
<td>Implement Training</td>
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<tr>
<td>Implement classroom training</td>
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<tr>
<td>Clinical rotations</td>
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<tr>
<td>Health Dept. trainings</td>
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<tr>
<td>Evaluate paramedics</td>
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<tr>
<td>Develop an Evaluation Plan</td>
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<tr>
<td>Client database tracking</td>
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<tr>
<td>Outcomes and how to measure</td>
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<tr>
<td>Case study procedures</td>
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<tr>
<td>Begin Operations</td>
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<tr>
<td>MOUs in place with providers</td>
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<tr>
<td>Scheduling procedures in place, providers trained</td>
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<tr>
<td>Begin accepting patients</td>
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<tr>
<td>Conduct chart reviews</td>
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<tr>
<td>Evaluate the Pilot Phase</td>
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<tr>
<td>Referral process</td>
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<tr>
<td>Response line</td>
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<td>Patient satisfaction</td>
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<tr>
<td>Quality assurance procedures</td>
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<tr>
<td>Patient database tracking</td>
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<tr>
<td>Make corrections to systems</td>
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</table>
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
the 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.

-270-
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 affected 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)**

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

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

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

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.
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.
WECAD Community Paramedic Fact Sheet
Continued

Health Care Statistics

Primary care shortage
- 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
- In 2010, 14.7% (342,122) of Colorado residents reportedly did not see a doctor in the previous 12 months, due to costs. 2
- During 2009/2010, 22% of Eagle County residents were reportedly uninsured, compared to Colorado at 15%. 3
- In 2005, 68% of Eagle County’s Latino households were reportedly uninsured. 4

Access to care statistics
- 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
- In 2005, 38% of Eagle County households reportedly had trouble accessing health care. 4
- In 2005, 43% of Eagle County residents reportedly were unable to access dental care. 4

Readmission rates
- 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
- In 2009, the cost to Medicare of unplanned re-hospitalizations was $22.9 billion nationally. 7

Cost of healthcare in ER
- ER costs per visit are generally 3 times higher than comparable care in an outpatient clinic. 6
- 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
- In Colorado in 2008, 80% of ER visits were not true emergencies. 6

Preventive services
- In 2005, 56% of Eagle County households were reportedly affected by chronic health issues. 4
- In 2009/2010 32% of Eagle County residents were reportedly overweight & 10.5% were obese. 9
- 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.cdpoe.state.co.us/pp/primarycare/shortage/pchpsa.pdf
3. Colorado Health Information Database (CoHID), Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Website: http://www.cdpoe.state.co.us/cohid/bfrss.html
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 CI 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.
# Release of Information Form

**Patient Information**

<table>
<thead>
<tr>
<th>Patient's Last Name</th>
<th>First</th>
<th>Middle</th>
<th>DOB</th>
</tr>
</thead>
</table>

**Information**

- Consult
- Discharge Summary
- Emergency Department Report
- EKG Tracings
- Graphic Record
- History and Physical
- Labs
- Physician Progress Notes
- MRI Report
- Operative Report
- X-Ray Report
- X-Ray MRI
- Immunization Record
- Other as specified below:

**Date of Order:**

**Purpose of Release:**

**This consent/authorization is to release health information from and to:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**This consent/authorization will remain in effect**

- From the date it is signed until: ______________
- Until the following event occurs: ______________

**Note:** If neither of the above options is selected, this consent/authorization will remain in effect for 100 days from the date it is signed.

1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted diseases, 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**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**If signed by Legal Representative, Legal Representative's authority to act on behalf of patient:**

| Relationship to patient: |

**For Office Use Only**

<table>
<thead>
<tr>
<th>Date Information Released</th>
<th>Medical Record Number</th>
</tr>
</thead>
</table>

---

-280-
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
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 ___
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 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 ___
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 aids 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
Social Support Evaluation

Last 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.
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 debridging. 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

Community Paramedic Patient Order Form

PATIENT INFORMATION
(Do submit patient face sheet for demographics)

Date of Order: Requested Date of Service: Primary Language:

Client Name: Last First Middle DOB: Gender:

[ ] M [ ] F

Physical Street Address

City/Town State Zip Code

Mailing Address (If different)

City/Town State Zip Code

Insurance (For research purposes only): [ ] No [ ] Yes If yes, company:

DIAGNOSIS

Diagnosis:

Reason for Visit:

LABORATORY SPECIMEN COLLECTION

[ ] Blood Draw

[ ] Stat Test (Corning Soon)

[ ] Stool Collection [ ] Urine Collection

Requested Labs/Blood Tubes:

CLINICAL CARE

Cardiovascular

[ ] Blood Pressure Check

[ ] EKG 12 Lead

[ ] Peripheral Intravenous Lines

Follow-up/Post Discharge

[ ] Diabetic Follow-up/Education

[ ] Neurological Assessment

[ ] Dressing Change/Wound Check/Type:

[ ] Discharge Follow-up/Diagnoses:

Respiratory

[ ] Asthma Meds/Education/Compliance

[ ] CPAP

[ ] MIU Use

[ ] Nebulizer Usage/Compliance

[ ] Peak Flow Meter Education/Usage

[ ] Oxygen Saturation Check

General

[ ] Assessment / H&P

[ ] Ear exams

[ ] Medication Evaluation or Medication Compliance

[ ] Post Injury/Infection Evaluation

[ ] Post Stroke Assessment/ Follow-up

[ ] Weight Check

Other Orders/Information:

PUBLIC HEALTH/SOCIAL SERVICES

[ ] Bright Beginnings

[ ] EHS Post Partum Visit

[ ] Fluoridation Clinic

[ ] Welfare Check

[ ] TB Meds DOT

ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)

Contact Number:

Referring Physician: __________________________ (Please Print)

Signature __________________________ Date ___

Fax report back to referring physician

Fax report to:
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, authoring 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.
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 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 (NCsBN, 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

Licensor
Licensor 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. Licensor regulations are generally established to ensure that an individual meets minimum standards to protect public health and safety.

Licensor 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. (Shoeder, 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. (Schmītt & 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 purpose 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. (Schmītt & 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)**
Healthcare 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. (Kiser 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


Fraher, Erin PhD, MPP, Director, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill.


Kizer, Kenneth W., Karen Shore, and Aimee Moulin UC Davis Institute for Population Health Improvement Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care.; July 2013.


Education 297
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 basic standards 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, 2016; 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, and 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.


Approved the ANA Board of Directors
February 28, 2014

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ADVANCED PRACTICE REGISTERED NURSES
HB 2280
AN ACT concerning the board of nursing; relating to the certified nurse-midwives; amending K.S.A. 2014 Supp. 65-1130 and repealing the existing section.

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

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

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

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

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

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

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

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

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

(f) An advanced practice registered nurse certified in the role of certified nurse-midwife while functioning as a certified nurse-midwife under sections 2 through 10, and amendments thereto, shall be subject to the provisions of sections 2 through 10, and amendments thereto, with
respect to prescribing drugs and shall not be subject to the provisions of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) has successfully completed a refresher course as defined in rules and regulations of the board if the individual has not been in active
midwifery practice for five years preceding the application.

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

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

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

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

(b) Any person who fails to secure the renewal of an authorization to
practice prior to the expiration of the authorization may secure a
reinstatement of such lapsed authorization by making application on a
form provided by the board. Such reinstatement shall be granted upon
receipt of proof that the applicant is competent and qualified to act as a
certified nurse-midwife, has satisfied all of the requirements and has paid
the board a reinstatement fee as established by the board by rules and
regulations in accordance with K.S.A. 65-1118, and amendments thereto.

New Sec. 6. (a) Each certified nurse-midwife shall be authorized to:
(1) Provide a full range of primary health care services for women
from adolescence to menopause and beyond. These services include
primary care, gynecologic and family planning services, pre-conception
care, care during pregnancy, childbirth and the postpartum period, care of
the normal newborn and treatment of male partners for sexually
transmitted infections;
(2) provide initial and ongoing comprehensive assessment, diagnosis
and treatment;
(3) conduct physical examinations;
(4) prescribe, distribute and administer medications, devices and
contraceptive methods, and controlled substances in schedules II-V of the
uniform controlled substances act;
(5) admit, manage and discharge patients;
(6) utilize and order diagnostic services, including a clinical
laboratory, sonography, radiology and electronic monitoring;
(7) interpret laboratory and diagnostic tests;
(8) order the use of medical devices; and
(9) provide health promotion, disease prevention and individualized
wellness education and counseling.

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

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

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

New Sec. 7. (a) The applicant for renewal of an authorization to
practice as a certified nurse-midwife shall:
(1) Have met the continuing education requirements for a certified
nurse-midwife as developed by the board or by a national organization
whose certifying standards are approved by the board as equal to or greater
than the corresponding standards established under this act;

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

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

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

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

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

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

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

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

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

(b) As part of the program of transition to full practice, a certified
nurse-midwife shall complete, within two years from the commencement
of the program by the certified nurse- midwife, a transition to full practice
period of 1,500 hours of licensed active practice either with a certified
nurse-midwife or with a physician. The certified nurse-midwife shall
administer medications as needed for safety and therapeutic purposes.

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

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

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

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

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

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

Sec. 12. This act shall take effect and be in force from and after its publication in the statute book.
HB 2205
AN ACT concerning advanced practice registered nurses; amending K.S.A. 2014 Supp. 65-1113 and 65-1130 and repealing the existing sections.

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

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

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

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

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

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

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

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

(c) Subject to the provisions of subsection (a), the rules and regulations adopted pursuant to this section shall:
Establish roles and identify titles and abbreviations of advanced practice registered nurses which are consistent with nursing practice specialties recognized by the nursing profession; and

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

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

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

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

(b) The joint committee shall be composed of six members. Three members shall be appointed by the board of nursing, and three members shall be appointed by the board of healing arts. All appointees of the board of nursing must hold a license as an advanced practice registered nurse and be actively engaged in advanced practice nursing. All appointees of the board of healing arts must hold a license to practice medicine and surgery
and be actively engaged in the practice of medicine and surgery. One
member appointed by the board of nursing must be a member of that
board, and one member appointed by the board of healing arts must be a
member of that board. In appointing their remaining representatives on the
joint committee, the boards shall consider any names submitted by the
respective professional associations.

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

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

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

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

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

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

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

(d) Practice of nursing. (1) The practice of professional nursing as
performed by a registered professional nurse for compensation or
gratuitously, except as permitted by K.S.A. 65-1124, and amendments
thereto, means the process in which substantial specialized knowledge
derived from the biological, physical, and behavioral sciences is applied
to: the care, diagnosis, treatment, counsel and health teaching of persons
who are experiencing changes in the normal health processes or who
require assistance in the maintenance of health or the prevention or
management of illness, injury or infirmity; administration, supervision or
teaching of the process as defined in this section; and the execution of the
medical regimen as prescribed by a person licensed to practice medicine
and surgery or a person licensed to practice dentistry. (2) The practice of
nursing as a licensed practical nurse means the performance for
compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
any amendments thereto, of tasks and responsibilities defined in part (1) of
this subsection (d)(1) which tasks and responsibilities are based on
acceptable educational preparation within the framework of supportive and
restorative care under the direction of a registered professional nurse, a
person licensed to practice medicine and surgery or a person licensed to
practice dentistry.

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

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

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

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

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

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

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

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

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

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

(d) An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Any written prescription order shall include the name, address and telephone number of the responsible physician pursuant to the rules and regulations adopted by the joint adopting authority. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced
practice registered nurse shall—(1) register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and customary practice of the responsible physician. An advanced practice registered nurse certified in the role of registered nurse anesthetist while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with respect to drugs and anesthetic agents and shall not be subject to the provisions of this subsection. For the purposes of this subsection, "responsible physician" means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced practice registered nurse when prescribing drugs.

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

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

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

Sec. 5. On July 1, 2016, K.S.A. 2014 Supp. 65-1113 and 65-1130 are hereby repealed.
Sec. 6. This act shall take effect and be in force from and after and its publication in the statute book.
SB 218
AN ACT concerning advanced practice registered nurses; amending K.S.A. 2014 Supp. 65-1113 and 65-1130 and repealing the existing sections.

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

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

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

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

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

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

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

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

(c) Subject to the provisions of subsection (a), the rules and regulations adopted pursuant to this section shall:
(1) Establish roles and identify titles and abbreviations of advanced practice registered nurses which are consistent with nursing practice specialties recognized by the nursing profession; and

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

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

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

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

(b) The joint committee shall be composed of six members. Three members shall be appointed by the board of nursing, and three members shall be appointed by the board of healing arts. All appointees of the board of nursing must hold a license as an advanced practice registered nurse and be actively engaged in advanced practice nursing. All appointees of the board of healing arts must hold a license to practice medicine and surgery
and be actively engaged in the practice of medicine and surgery. One
member appointed by the board of nursing must be a member of that
board, and one member appointed by the board of healing arts must be a
member of that board. In appointing their remaining representatives on the
joint committee, the boards shall consider any names submitted by the
respective professional associations.

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

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

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

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

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

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

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

(d) Practice of nursing. (1) The practice of professional nursing as
performed by a registered professional nurse for compensation or
gratuitously, except as permitted by K.S.A. 65-1124, and amendments
thereto, means the process in which substantial specialized knowledge
derived from the biological, physical, and behavioral sciences is applied
to: the care, diagnosis, treatment, counsel and health teaching of persons
who are experiencing changes in the normal health processes or who
require assistance in the maintenance of health or the prevention or
management of illness, injury or infirmity; administration, supervision or
teaching of the process as defined in this section; and the execution of the
medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry. (2) The practice of nursing as a licensed practical nurse means the performance for compensation or gratuitously, except as permitted by K.S.A. 65-1124, and any amendments thereto, of tasks and responsibilities defined in part (1) of this subsection (d)/(1) which tasks and responsibilities are based on acceptable educational preparation within the framework of supportive and restorative care under the direction of a registered professional nurse, a person licensed to practice medicine and surgery or a person licensed to practice dentistry.

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

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

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

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

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

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

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

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

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

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

(d) An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Any written prescription order shall include the name, address and telephone number of the responsible physician pursuant to the rules and regulations adopted by the joint adopting authority. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician.
practice registered nurse shall—(1) register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and customary practice of the responsible physician. An advanced practice registered nurse certified in the role of registered nurse anesthetist while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with respect to drugs and anesthetic agents and shall not be subject to the provisions of this subsection. For the purposes of this subsection, "responsible physician" means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced practice registered nurse when prescribing drugs.

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

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

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

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

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.
SB 69

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

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

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

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

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

(d) Practice of nursing. (1) The practice of professional nursing as performed by a registered professional nurse for compensation or gratuitously, except as permitted by K.S.A. 65-1124, and amendments thereto, means the process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, diagnosis, treatment, counsel and health teaching of persons who are experiencing changes in the normal health processes or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity; administration, supervision or teaching of the process as defined in this section; and the execution of the
medical regimen as prescribed by a person licensed to practice medicine and surgery—or, a person licensed to practice dentistry or by a person licensed to practice as an advanced practice registered nurse. (2) The practice of nursing as a licensed practical nurse means the performance for compensation or gratuitously, except as permitted by K.S.A. 65-1124, and any amendments thereto, of tasks and responsibilities defined in part (1) of this subsection (d)(1) which tasks and responsibilities are based on acceptable educational preparation within the framework of supportive and restorative care under the direction of a registered professional nurse, a person licensed to practice medicine and surgery—or, a person licensed to practice dentistry or by a person licensed to practice as an advanced practice registered nurse.

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

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

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

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

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

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

(d) The board shall adopt rules and regulations applicable to advanced practice registered nurses which:
(1) Establish roles and identify titles and abbreviations of advanced practice registered nurses which are consistent with advanced nursing practice specialties recognized by the nursing profession.

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

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

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

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

(d) (g) An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Advanced practice registered nurses are authorized to prescribe, procure and administer prescription drugs and controlled substances pursuant to applicable state and federal laws. Any written prescription order shall include the name, address and telephone number of the responsible physician. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced practice registered nurse shall: (1) Register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and customary practice of the responsible physician. An advanced practice registered nurse certified in the role of registered nurse anesthetist under K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with respect to drugs and anesthetic agents and shall not be subject to the
provisions of this subsection. For the purposes of this subsection, “responsible physician” means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced practice registered nurse when prescribing drugs.

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

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

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

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

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

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

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

(7) The board may adopt rules and regulations necessary to carry out the provisions of this subsection.
(8) An advanced practice registered nurse functioning in the role of registered nurse anesthetist shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, and shall not be subject to the provisions of this subsection.

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

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

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

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

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

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

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

(1) "Adult care home" means any nursing facility, nursing facility for mental health, intermediate care facility for people with intellectual disability, assisted living facility, residential health care facility, home plus, boarding care home and adult day care facility; all of which are
classifications of adult care homes and are required to be licensed by the
secretary for aging and disability services.

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

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

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

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

(6) "Residential health care facility" means any place or facility, or a
contiguous portion of a place or facility, caring for six or more individuals
not related within the third degree of relationship to the administrator,
operator or owner by blood or marriage and who, by choice or due to
functional impairments, may need personal care and may need supervised
nursing care to compensate for activities of daily living limitations and in
which the place or facility includes individual living units and provides or
coordinates personal care or supervised nursing care available on a 24-
hour, seven-days-a-week basis for the support of resident independence.
The provision of skilled nursing procedures to a resident in a residential
health care facility is not prohibited by this act. Generally, the skilled
services provided in a residential health care facility shall be provided on
an intermittent or limited term basis, or if limited in scope, a regular basis.

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

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

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

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

(11) "Skilled nursing care" means services performed by or under the
immediate supervision of a registered professional nurse and additional
licensed nursing personnel. Skilled nursing includes administration of
medications and treatments as prescribed by a licensed physician,
advanced practice registered nurse or dentist; and other nursing functions
which require substantial nursing judgment and skill based on the
knowledge and application of scientific principles.
"Supervised nursing care" means services provided by or under the guidance of a licensed nurse with initial direction for nursing procedures and periodic inspection of the actual act of accomplishing the procedures; administration of medications and treatments as prescribed by a licensed physician, advanced practice registered nurse or dentist and assistance of residents with the performance of activities of daily living.

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

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

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

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

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

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

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

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

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

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

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

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

(25) "Kitchen" means a food preparation area that includes a sink, refrigerator and a microwave oven or stove.
(26) The term "intermediate personal care home" for purposes of those individuals applying for or receiving veterans' benefits means residential health care facility.

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

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

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

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

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

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

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

(f) The licensing agency may by rule and regulation change the name of the different classes of homes when necessary to avoid confusion in terminology and the agency may further amend, substitute, change and in a
manner consistent with the definitions established in this section, further
define and identify the specific acts and services which shall fall within the
respective categories of facilities so long as the above categories for adult
care homes are used as guidelines to define and identify the specific acts.

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

(a) "Resident" means:

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

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

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

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

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

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

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

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

(1) Infliction of physical or mental injury;

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

(3) unreasonable use of a physical restraint, isolation or medication
that harms or is likely to harm a resident;
(4) unreasonable use of a physical or chemical restraint, medication
or isolation as punishment, for convenience, in conflict with a physician's
or advanced practice registered nurse's orders or as a substitute for
treatment, except where such conduct or physical restraint is in furtherance
of the health and safety of the resident or another resident;
(5) a threat or menacing conduct directed toward a resident that
results or might reasonably be expected to result in fear or emotional or
mental distress to a resident;
(6) fiduciary abuse; or
(7) omission or deprivation by a caretaker or another person of goods
or services which are necessary to avoid physical or mental harm or
illness.
(g) "Neglect" means the failure or omission by one's self, caretaker or
another person with a duty to provide goods or services which are
reasonably necessary to ensure safety and well-being and to avoid physical
or mental harm or illness.
(h) "Caretaker" means a person or institution who has assumed the
responsibility, whether legally or not, for the care of the resident
voluntarily, by contract or by order of a court of competent jurisdiction.
(i) "Exploitation" means misappropriation of resident property or
intentionally taking unfair advantage of an adult's physical or financial
resources for another individual's personal or financial advantage by the
use of undue influence, coercion, harassment, duress, deception, false
representation or false pretense by a caretaker or another person.
(j) "Medical care facility" means a facility licensed under K.S.A. 65-
425 et seq., and amendments thereto, but shall not include, for purposes of
this act, a state psychiatric hospital or state institution for people with
intellectual disability, including Larned state hospital, Osawatomie state
hospital and Rainbow mental health facility, Kansas neurological institute
and Parsons state hospital and training center.
(k) "Fiduciary abuse" means a situation in which any person who is
the caretaker of, or who stands in a position of trust to, a resident, takes,
secretes, or appropriates the resident's money or property, to any use or
purpose not in the due and lawful execution of such person's trust.
(l) "State psychiatric hospital" means Larned state hospital,
Osawatomie state hospital and Rainbow mental health facility.
(m) "State institution for people with intellectual disability" means
Kansas neurological institute and Parsons state hospital and training
center.
(n) "Report" means a description or accounting of an incident or
incidents of abuse, neglect or exploitation under this act and for the
purposes of this act shall not include any written assessment or findings.
(o) "Law enforcement" means the public office which is vested by law with the duty to maintain public order, make arrests for crimes and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.

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

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

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

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

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

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

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

(1) Infliction of physical or mental injury;
(2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;
(3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult;
(4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's or advanced practice registered nurse's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult;

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

(6) fiduciary abuse; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) (1) The home shall meet health standards and safety regulations of
the community and the provisions of chapter 20 of the national fire

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

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

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

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

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

(7) Sleeping rooms shall have space for personal items.

(8) Each client shall have a bed which is clean and in good condition.

(9) Lavatory and toilet facilities shall be accessible, available and in
working order.

(10) The kitchen shall be clean with appliances in good working
order.

(b) (1) A healthy and safe environment shall be maintained for clients.

(2) There shall be a telephone in the home.

(3) The provider may assist a client with the taking of medications when the medication is in a labeled bottle which clearly shows a physician's orders or an advanced practice registered nurse's orders and when the client requires assistance because of tremor, visual impairment, or similar reasons due to health conditions. The provider may assist or perform for the client such physical activities which do not require daily supervision such as assistance with eating, bathing and dressing, help with brace or walker and transferring from wheelchairs.

(4) There shall be no use of corporal punishment, restraints or punitive measures.

(5) The house shall be free from accumulated dirt, trash and vermin.

(6) Meals shall be planned and prepared for adequate nutrition, and for diets if directed by a physician.

(c) (1) The provider shall be at least 18 years of age and in good health at the time of initial application for registration. A written statement must be received from a physician, nurse practitioner, or physician assistant stating that the applicant and the members of the applicant's household are free of any infectious or communicable disease or health condition and are physically and mentally healthy. Such statements shall be renewed every two years.

(2) The provider shall not be totally dependent on the income from the clients for support of the provider or the provider's family.

(3) A criminal conviction shall not necessarily exclude registration as an adult family home; but an investigation thereof will be made as part of the determination of the suitability of the home.

(4) The provider shall be responsible for supervision at all times and shall be in charge of the home and provision of care, or shall have a responsible person on call. Any such substitute responsible person shall meet the same requirements as the provider.

(5) The provider is responsible for encouraging the client to seek and utilize available services when needed.

(6) The provider shall comply with the requirements of state and federal regulations concerning civil rights and section 504 of the federal rehabilitation act of 1973.

(7) The provider shall assure that clients have the privilege of privacy as well as the right to see relatives, friends and participate in regular community activities.

(8) The provider shall keep client information confidential. The use or disclosure of any information concerning a client for any purpose is
prohibited except on written consent of the client or upon order of the
court.
(9) The provider shall maintain contact with an assigned social
worker and shall allow the secretary and authorized representatives of the
secretary access to the home and grounds and to the records related to
clients in residence.
(10) The provider shall inform the social worker immediately of any
unscheduled client absence from the home.
(11) The provider is responsible for helping clients maintain their
clothing.
(12) The provider shall furnish or help clients arrange for
transportation.
(13) The provider shall help a client arrange for emergency and
regular medical care when necessary.
(14) The provider shall submit any information relating to the
operation of the adult family home which is required by the secretary.

Sec. 7. K.S.A. 40-4602 is hereby amended to read as follows: 40-
4602. As used in this act:
(a) "Emergency medical condition" means the sudden and, at the
time, unexpected onset of a health condition that requires immediate
medical attention, where failure to provide medical attention would result
in serious impairment to bodily functions or serious dysfunction of a
bodily organ or part, or would place the person's health in serious
jeopardy.
(b) "Emergency services" means ambulance services and health care
items and services furnished or required to evaluate and treat an
emergency medical condition, as directed or ordered by a physician or an
advanced practice registered nurse.
(c) "Health benefit plan" means any hospital or medical expense
policy, health, hospital or medical service corporation contract, a plan
provided by a municipal group-funded pool, a policy or agreement entered
into by a health insurer or a health maintenance organization contract
offered by an employer or any certificate issued under any such policies,
contracts or plans. "Health benefit plan" does not include policies or
certificates covering only accident, credit, dental, disability income, long-
term care, hospital indemnity, medicare supplement, specified disease,
vision care, coverage issued as a supplement to liability insurance,
insurance arising out of a workers compensation or similar law,
automobile medical-payment insurance, or insurance under which benefits
are payable with or without regard to fault and which is statutorily
required to be contained in any liability insurance policy or equivalent
self-insurance.
(d) "Health insurer" means any insurance company, nonprofit medical
and hospital service corporation, municipal group-funded pool, fraternal
benefit society, health maintenance organization, or any other entity which
offers a health benefit plan subject to the Kansas Statutes Annotated.
(e) "Insured" means a person who is covered by a health benefit plan.
(f) "Participating provider" means a provider who, under a contract
with the health insurer or with its contractor or subcontractor, has agreed
to provide one or more health care services to insureds with an expectation
of receiving payment, other than coinsurance, copayments or deductibles,
directly or indirectly from the health insurer.
(g) "Provider" means a physician, advanced practice registered nurse,
hospital or other person which is licensed, accredited or certified to
perform specified health care services.
(h) "Provider network" means those participating providers who have
entered into a contract or agreement with a health insurer to provide items
or health care services to individuals covered by a health benefit plan
offered by such health insurer.
(i) "Physician" means a person licensed by the state board of healing
arts to practice medicine and surgery.
Sec. 8. K.S.A. 59-2976 is hereby amended to read as follows: 59-
2976. (a) Medications and other treatments shall be prescribed, ordered
and administered only in conformity with accepted clinical practice.
Medication shall be administered only upon the written order of a
physician or an advanced practice registered nurse or upon a verbal order
noted in the patient's medical records and subsequently signed by the
physician or an advanced practice registered nurse. The attending
physician or an advanced practice registered nurse shall review regularly
the drug regimen of each patient under the physician's or an advanced
practice registered nurse's care and shall monitor any symptoms of
harmful side effects. Prescriptions for psychotropic medications shall be
written with a termination date not exceeding 30 days thereafter but may
be renewed.
(b) During the course of treatment the responsible physician, an
advanced practice registered nurse or psychologist or such person's
designee shall reasonably consult with the patient, the patient's legal
guardian, or a minor patient's parent and give consideration to the views
the patient, legal guardian or parent expresses concerning treatment and
any alternatives. No medication or other treatment may be administered to
any voluntary patient without the patient's consent, or the consent of such
patient's legal guardian or of such patient's parent if the patient is a minor.
(c) Consent for medical or surgical treatments not intended primarily
to treat a patient's mental disorder shall be obtained in accordance with
applicable law.
(d) Whenever any patient is receiving treatment pursuant to K.S.A.
59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments thereto, and the treatment facility is administering to the patient any medication or other treatment which alters the patient's mental state in such a way as to adversely affect the patient's judgment or hamper the patient in preparing for or participating in any hearing provided for by this act, then two days prior to and during any such hearing, the treatment facility may not administer such medication or other treatment unless such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others. Prior to the hearing, a report of all such medications or other treatment which have been administered to the patient, along with a copy of any written consent(s) which the patient may have signed, shall be submitted to the court. Counsel for the patient may preliminarily examine the attending physician regarding the administration of any medication to the patient within two days of the hearing with regard to the affect that medication may have had upon the patient's judgment or ability to prepare for or participate in the hearing. On the basis thereof, if the court determines that medication or other treatment has been administered which adversely affects the patient's judgment or ability to prepare for or participate in the hearing, the court may grant to the patient a reasonable continuance in order to allow for the patient to be better able to prepare for or participate in the hearing and the court shall order that such medication or other treatment be discontinued until the conclusion of the hearing, unless the court finds that such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others, in which case the court shall order that the hearing proceed.

(e) Whenever a patient receiving treatment pursuant to K.S.A. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments thereto, objects to taking any medication prescribed for psychiatric treatment, and after full explanation of the benefits and risks of such medication continues their objection, the medication may be administered over the patient's objection; except that the objection shall be recorded in the patient's medical record and at the same time written notice thereof shall be forwarded to the medical director of the treatment facility or the director's designee. Within five days after receiving such notice, excluding Saturdays, Sundays and legal holidays, the medical director or designee shall deliver to the patient and the patient's physician the medical director's or designee's written decision concerning the administration of that medication, and a copy of that decision shall be placed in the patient's medical record.

(f) In no case shall experimental medication be administered without the patient's consent, which consent shall be obtained in accordance with subsection (a)(6) of K.S.A. 59-2978(a)(6), and amendments thereto.

Sec. 9. K.S.A. 2014 Supp. 65-468 is hereby amended to read as
follows: 65-468. As used in K.S.A. 65-468 to 65-474, inclusive, and amendments thereto:

(a) "Health care provider" means any person licensed or otherwise authorized by law to provide health care services in this state or a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by law to form such corporation and who are health care providers as defined by this subsection, or an officer, employee or agent thereof, acting in the course and scope of employment or agency.

(b) "Member" means any hospital, emergency medical service, local health department, home health agency, adult care home, medical clinic, mental health center or clinic or nonemergency transportation system.

(c) "Mid-level practitioner" means a physician assistant or advanced practice registered nurse who has entered into a written protocol with a rural health network physician.

(d) "Advanced practice registered nurse" means an advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto.

(e) "Physician" means a person licensed to practice medicine and surgery.

(f) "Rural health network" means an alliance of members including at least one critical access hospital and at least one other hospital which has developed a comprehensive plan submitted to and approved by the secretary of health and environment regarding patient referral and transfer; the provision of emergency and nonemergency transportation among members; the development of a network-wide emergency services plan; and the development of a plan for sharing patient information and services between hospital members concerning medical staff credentialing, risk management, quality assurance and peer review.

(g) "Critical access hospital" means a member of a rural health network which makes available twenty-four hour emergency care services; provides not more than 25 acute care inpatient beds or in the case of a facility with an approved swing-bed agreement a combined total of extended care and acute care beds that does not exceed 25 beds; provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient; and provides nursing services under the direction of a licensed professional nurse and continuous licensed professional nursing services for not less than 24 hours of every day when any bed is occupied or the facility is open to provide services for patients unless an exemption is granted by the licensing agency pursuant to rules and regulations. The critical access hospital may provide any services otherwise required to be provided by a full-time, on-site dietician,
pharmacist, laboratory technician, medical technologist and radiological
technologist on a part-time, off-site basis under written agreements or
arrangements with one or more providers or suppliers recognized under
medicare. The critical access hospital may provide inpatient services by a
physician assistant, advanced practice registered nurse or a clinical nurse
specialist subject to the oversight of a physician who need not be present
in the facility or by an advanced practice registered nurse. In addition to
the facility's 25 acute beds or swing beds, or both, the critical access
hospital may have a psychiatric unit or a rehabilitation unit, or both. Each
unit shall not exceed 10 beds and neither unit will count toward the 25-bed
limit, nor will these units be subject to the average 96-hour length of stay
restriction.

(h) "Hospital" means a hospital other than a critical access
hospital which has entered into a written agreement with at least one
critical access hospital to form a rural health network and to provide
medical or administrative supporting services within the limit of the
hospital's capabilities.

Sec. 10. K.S.A. 2014 Supp. 65-507 is hereby amended to read as
follows: 65-507. (a) Each maternity center licensee shall keep a record
upon forms prescribed and provided by the secretary of health and
environment and the secretary for children and families which shall
include the name of every patient, together with the patient's place of
residence during the year preceding admission to the center and the name
and address of the attending physician or advanced practice registered
nurse in the classification of a nurse-midwife. Each child care facility
licensee shall keep a record upon forms prescribed and provided by the
secretary of health and environment which shall include the name and age
of each child received and cared for in the facility; the name of the
physician who attended any sick children in the facility, together with the
names and addresses of the parents or guardians of such children; and such
other information as the secretary of health and environment or secretary
for children and families may require. Each maternity center licensee and
each child care facility licensee shall apply to and shall receive without
charge from the secretary of health and environment and the secretary for
children and families forms for such records as may be required, which
forms shall contain a copy of this act.

(b) Information obtained under this section shall be confidential and
shall not be made public in a manner which would identify individuals.

Sec. 11. K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
read as follows: 65-1626. For the purposes of this act:

(a) "Administer" means the direct application of a drug, whether by
injection, inhalation, ingestion or any other means, to the body of a patient
or research subject by:

(1) A practitioner or pursuant to the lawful direction of a practitioner;
(2) the patient or research subject at the direction and in the presence of the practitioner; or
(3) a pharmacist as authorized in K.S.A. 65-1635a, and amendments thereto.

(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor or dispenser but shall not include a common carrier, public warehouseman or employee of the carrier or warehouseman when acting in the usual and lawful course of the carrier's or warehouseman's business.

(c) "Application service provider" means an entity that sells electronic prescription or pharmacy prescription applications as a hosted service where the entity controls access to the application and maintains the software and records on its server.

(d) "Authorized distributor of record" means a wholesale distributor with whom a manufacturer has established an ongoing relationship to distribute the manufacturer's prescription drug. An ongoing relationship is deemed to exist between such wholesale distributor and a manufacturer when the wholesale distributor, including any affiliated group of the wholesale distributor, as defined in section 1504 of the internal revenue code, complies with any one of the following: (1) The wholesale distributor has a written agreement currently in effect with the manufacturer evidencing such ongoing relationship; and (2) the wholesale distributor is listed on the manufacturer's current list of authorized distributors of record, which is updated by the manufacturer on no less than a monthly basis.

(e) "Board" means the state board of pharmacy created by K.S.A. 74-1603, and amendments thereto.

(f) "Brand exchange" means the dispensing of a different drug product of the same dosage form and strength and of the same generic name as the brand name drug product prescribed.

(g) "Brand name" means the registered trademark name given to a drug product by its manufacturer, labeler or distributor.

(h) "Chain pharmacy warehouse" means a permanent physical location for drugs or devices, or both, that acts as a central warehouse and performs intracompany sales or transfers of prescription drugs or devices to chain pharmacies that have the same ownership or control. Chain pharmacy warehouses must be registered as wholesale distributors.

(i) "Co-licensee" means a pharmaceutical manufacturer that has entered into an agreement with another pharmaceutical manufacturer to engage in a business activity or occupation related to the manufacture or distribution of a prescription drug and the national drug code on the drug
product label shall be used to determine the identity of the drug manufacturer.

(j) "DEA" means the U.S. department of justice, drug enforcement administration.

(k) "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another of any drug whether or not an agency relationship exists.

(l) "Direct supervision" means the process by which the responsible pharmacist shall observe and direct the activities of a pharmacy student or pharmacy technician to a sufficient degree to assure that all such activities are performed accurately, safely and without risk or harm to patients, and complete the final check before dispensing.

(m) "Dispense" means to deliver prescription medication to the ultimate user or research subject by or pursuant to the lawful order of a practitioner or pursuant to the prescription of a mid-level practitioner.

(n) "Dispenser" means a practitioner or pharmacist who dispenses prescription medication, or a physician assistant who has authority to dispense prescription-only drugs in accordance with subsection (b) of K.S.A. 65-28a08(b), and amendments thereto.

(o) "Distribute" means to deliver, other than by administering or dispensing, any drug.

(p) "Distributor" means a person who distributes a drug.

(q) "Drop shipment" means the sale, by a manufacturer, that manufacturer's co-licensee, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, of the manufacturer's prescription drug, to a wholesale distributor whereby the wholesale distributor takes title but not possession of such prescription drug and the wholesale distributor invoices the pharmacy, the chain pharmacy warehouse, or other designated person authorized by law to dispense or administer such prescription drug, and the pharmacy, the chain pharmacy warehouse, or other designated person authorized by law to dispense or administer such prescription drug receives delivery of the prescription drug directly from the manufacturer, that manufacturer's co-licensee, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, of such prescription drug. Drop shipment shall be part of the "normal distribution channel."

(r) "Drug" means: (1) Articles recognized in the official United States pharmacopoeia, or other such official compendiums of the United States, or official national formulary, or any supplement of any of them; (2) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; (3) articles, other than food, intended to affect the structure or any function of the body of man or other animals; and (4) articles intended for use as a component of any articles
specified in clause (1), (2) or (3) of this subsection; but does not include
device or their components, parts or accessories, except that the term
"drug" shall not include amygdalin (laetrile) or any livestock remedy, if
such livestock remedy had been registered in accordance with the
provisions of article 5 of chapter 47 of the Kansas Statutes Annotated,
prior to its repeal.

(s) "Durable medical equipment" means technologically sophisticated
medical devices that may be used in a residence, including the following:
(1) Oxygen and oxygen delivery system; (2) ventilators; (3) respiratory
disease management devices; (4) continuous positive airway pressure
(CPAP) devices; (5) electronic and computerized wheelchairs and seating
systems; (6) apnea monitors; (7) transcutaneous electrical nerve stimulator
(TENS) units; (8) low air loss cutaneous pressure management devices; (9)
sequential compression devices; (10) feeding pumps; (11) home
phototherapy devices; (12) infusion delivery devices; (13) distribution of
medical gases to end users for human consumption; (14) hospital beds;
(15) nebulizers; or (16) other similar equipment determined by the board
in rules and regulations adopted by the board.

(t) "Electronic prescription" means an electronically prepared
prescription that is authorized and transmitted from the prescriber to the
pharmacy by means of electronic transmission.

(u) "Electronic prescription application" means software that is used
to create electronic prescriptions and that is intended to be installed on the
prescriber's computers and servers where access and records are controlled
by the prescriber.

(v) "Electronic signature" means a confidential personalized digital
key, code, number or other method for secure electronic data transmissions
which identifies a particular person as the source of the message,
authenticates the signatory of the message and indicates the person's
approval of the information contained in the transmission.

(w) "Electronic transmission" means the transmission of an electronic
prescription, formatted as an electronic data file, from a prescriber's
electronic prescription application to a pharmacy's computer, where the
data file is imported into the pharmacy prescription application.

(x) "Electronically prepared prescription" means a prescription that is
generated using an electronic prescription application.

(y) "Exclusive distributor" means any entity that: (1) Contracts with a
manufacturer to provide or coordinate warehousing, wholesale distribution
or other services on behalf of a manufacturer and who takes title to that
manufacturer's prescription drug, but who does not have general
responsibility to direct the sale or disposition of the manufacturer's
prescription drug; (2) is registered as a wholesale distributor under the
pharmacy act of the state of Kansas; and (3) to be considered part of the
normal distribution channel, must be an authorized distributor of record.

(z) "Facsimile transmission" or "fax transmission" means the transmission of a digital image of a prescription from the prescriber or the prescriber's agent to the pharmacy. "Facsimile transmission" includes, but is not limited to, transmission of a written prescription between the prescriber's fax machine and the pharmacy's fax machine; transmission of an electronically prepared prescription from the prescriber's electronic prescription application to the pharmacy's fax machine, computer or printer; or transmission of an electronically prepared prescription from the prescriber's fax machine to the pharmacy's fax machine, computer or printer.

(aa) "Generic name" means the established chemical name or official name of a drug or drug product.

(bb) (1) "Institutional drug room" means any location where prescription-only drugs are stored and from which prescription-only drugs are administered or dispensed and which is maintained or operated for the purpose of providing the drug needs of:

(A) Inmates of a jail or correctional institution or facility;
(B) residents of a juvenile detention facility, as defined by the revised Kansas code for care of children and the revised Kansas juvenile justice code;
(C) students of a public or private university or college, a community college or any other institution of higher learning which is located in Kansas;
(D) employees of a business or other employer; or
(E) persons receiving inpatient hospice services.

(2) "Institutional drug room" does not include:

(A) Any registered pharmacy;
(B) any office of a practitioner; or
(C) a location where no prescription-only drugs are dispensed and no prescription-only drugs other than individual prescriptions are stored or administered.

(cc) "Intermediary" means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

(dd) "Intracompany transaction" means any transaction or transfer between any division, subsidiary, parent or affiliated or related company under common ownership or control of a corporate entity, or any transaction or transfer between co-licensees of a co-licensed product.

(ee) "Medical care facility" shall have the meaning provided in K.S.A. 65-425, and amendments thereto, except that the term shall also include facilities licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, except community mental health centers and
facilities for people with intellectual disability.

(ff) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a drug either directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the drug or labeling or relabeling of its container, except that this term shall not include the preparation or compounding of a drug by an individual for the individual's own use or the preparation, compounding, packaging or labeling of a drug by:

(1) A practitioner or a practitioner's authorized agent incident to such practitioner's administering or dispensing of a drug in the course of the practitioner's professional practice;
(2) a practitioner, by a practitioner's authorized agent or under a practitioner's supervision for the purpose of, or as an incident to, research, teaching or chemical analysis and not for sale; or
(3) a pharmacist or the pharmacist's authorized agent acting under the direct supervision of the pharmacist for the purpose of, or incident to, the dispensing of a drug by the pharmacist.

(gg) "Manufacturer" means a person licensed or approved by the FDA to engage in the manufacture of drugs and devices.

(hh) "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 pursuant to 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.

(ii) "Normal distribution channel" means a chain of custody for a prescription-only drug that goes from a manufacturer of the prescription-only drug, from that manufacturer to that manufacturer's co-licensed partner, from that manufacturer to that manufacturer's third-party logistics provider, or from that manufacturer to that manufacturer's exclusive distributor, directly or by drop shipment, to:

(1) A pharmacy to a patient or to other designated persons authorized by law to dispense or administer such drug to a patient;
(2) a wholesale distributor to a pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient;
(3) a wholesale distributor to a chain pharmacy warehouse to that chain pharmacy warehouse's intracompany pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug
(4) a chain pharmacy warehouse to the chain pharmacy warehouse's intracompany pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient.

(jj) "Person" means individual, corporation, government, governmental subdivision or agency, partnership, association or any other legal entity.

(kk) "Pharmacist" means any natural person licensed under this act to practice pharmacy.

(ll) "Pharmacist-in-charge" means the pharmacist who is responsible to the board for a registered establishment's compliance with the laws and regulations of this state pertaining to the practice of pharmacy, manufacturing of drugs and the distribution of drugs. The pharmacist-in-charge shall supervise such establishment on a full-time or a part-time basis and perform such other duties relating to supervision of a registered establishment as may be prescribed by the board by rules and regulations. Nothing in this definition shall relieve other pharmacists or persons from their responsibility to comply with state and federal laws and regulations.

(mm) "Pharmacist intern" means: (1) A student currently enrolled in an accredited pharmacy program; (2) a graduate of an accredited pharmacy program serving an internship; or (3) a graduate of a pharmacy program located outside of the United States which is not accredited and who has successfully passed equivalency examinations approved by the board.

(nn) "Pharmacy," "drugstore" or "apothecary" means premises, laboratory, area or other place: (1) Where drugs are offered for sale where the profession of pharmacy is practiced and where prescriptions are compounded and dispensed; or (2) which has displayed upon it or within it the words "pharmacist," "pharmaceutical chemist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "drug sundries" or any of these words or combinations of these words or words of similar import either in English or any sign containing any of these words; or (3) where the characteristic symbols of pharmacy or the characteristic prescription sign "Rx" may be exhibited. As used in this subsection, premises refers only to the portion of any building or structure leased, used or controlled by the licensee in the conduct of the business registered by the board at the address for which the registration was issued.

(oo) "Pharmacy prescription application" means software that is used to process prescription information, is installed on a pharmacy's computers or servers, and is controlled by the pharmacy.

(pp) "Pharmacy technician" means an individual who, under the direct supervision and control of a pharmacist, may perform packaging, manipulative, repetitive or other nondiscretionary tasks related to the processing of a prescription or medication order and who assists the
pharmacist in the performance of pharmacy related duties, but who does not perform duties restricted to a pharmacist.

(qq) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, a registered nurse anesthetist registered pursuant to K.S.A. 65-1154, and amendments thereto, or scientific investigator or other person authorized by law to use a prescription-only drug in teaching or chemical analysis or to conduct research with respect to a prescription-only drug.

(rr) "Preceptor" means a licensed pharmacist who possesses at least two years' experience as a pharmacist and who supervises students obtaining the pharmaceutical experience required by law as a condition to taking the examination for licensure as a pharmacist.

(ss) "Prescriber" means a practitioner or a mid-level practitioner.

(tt) "Prescription" or "prescription order" means: (1) An order to be filled by a pharmacist for prescription medication issued and signed by a prescriber in the authorized course of such prescriber's professional practice; or (2) an order transmitted to a pharmacist through word of mouth, note, telephone or other means of communication directed by such prescriber, regardless of whether the communication is oral, electronic, facsimile or in printed form.

(uu) "Prescription medication" means any drug, including label and container according to context, which is dispensed pursuant to a prescription order.

(vv) "Prescription-only drug" means any drug whether intended for use by man or animal, required by federal or state law, including 21 U.S.C. § 353, to be dispensed only pursuant to a written or oral prescription or order of a practitioner or is restricted to use by practitioners only.

(ww) "Probation" means the practice or operation under a temporary license, registration or permit or a conditional license, registration or permit of a business or profession for which a license, registration or permit is granted by the board under the provisions of the pharmacy act of the state of Kansas requiring certain actions to be accomplished or certain actions not to occur before a regular license, registration or permit is issued.

(xx) "Professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of pharmaceutical care to a degree which constitutes gross negligence, as determined by the board;

(2) repeated instances involving failure to adhere to the applicable standard of pharmaceutical care to a degree which constitutes ordinary
negligence, as determined by the board; or
(3) a pattern of pharmacy practice or other behavior which
demonstrates a manifest incapacity or incompetence to practice pharmacy.
(yy) "Readily retrievable" means that records kept by automatic data
processing applications or other electronic or mechanized record-keeping
systems can be separated out from all other records within a reasonable
time not to exceed 48 hours of a request from the board or other authorized
agent or that hard-copy records are kept on which certain items are
asterisked, redlined or in some other manner visually identifiable apart
from other items appearing on the records.
(zz) "Retail dealer" means a person selling at retail nonprescription
drugs which are prepackaged, fully prepared by the manufacturer or
distributor for use by the consumer and labeled in accordance with the
requirements of the state and federal food, drug and cosmetic acts. Such
nonprescription drugs shall not include: (1) A controlled substance; (2) a
prescription-only drug; or (3) a drug intended for human use by
hypodermic injection.
(aaa) "Secretary" means the executive secretary of the board.
(bbb) "Third party logistics provider" means an entity that: (1)
Provides or coordinates warehousing, distribution or other services on
behalf of a manufacturer, but does not take title to the prescription drug or
have general responsibility to direct the prescription drug's sale or
disposition; (2) is registered as a wholesale distributor under the pharmacy
act of the state of Kansas; and (3) to be considered part of the normal
distribution channel, must also be an authorized distributor of record.
(ccc) "Unprofessional conduct" means:
(1) Fraud in securing a registration or permit;
(2) intentional adulteration or mislabeling of any drug, medicine,
chemical or poison;
(3) causing any drug, medicine, chemical or poison to be adulterated
or mislabeled, knowing the same to be adulterated or mislabeled;
(4) intentionally falsifying or altering records or prescriptions;
(5) unlawful possession of drugs and unlawful diversion of drugs to
others;
(6) willful betrayal of confidential information under K.S.A. 65-1654,
and amendments thereto;
(7) conduct likely to deceive, defraud or harm the public;
(8) making a false or misleading statement regarding the licensee's
professional practice or the efficacy or value of a drug;
(9) commission of any act of sexual abuse, misconduct or exploitation
related to the licensee's professional practice; or
(10) performing unnecessary tests, examinations or services which
have no legitimate pharmaceutical purpose.
"Vaccination protocol" means a written protocol, agreed to by a pharmacist and a person licensed to practice medicine and surgery by the state board of healing arts, which establishes procedures and recordkeeping and reporting requirements for administering a vaccine by the pharmacist for a period of time specified therein, not to exceed two years.

"Valid prescription order" means a prescription that is issued for a legitimate medical purpose by an individual prescriber licensed by law to administer and prescribe drugs and acting in the usual course of such prescriber's professional practice. A prescription issued solely on the basis of an internet-based questionnaire or consultation without an appropriate prescriber-patient relationship is not a valid prescription order.

"Veterinary medical teaching hospital pharmacy" means any location where prescription-only drugs are stored as part of an accredited college of veterinary medicine and from which prescription-only drugs are distributed for use in treatment of or administration to a nonhuman.

"Wholesale distributor" means any person engaged in wholesale distribution of prescription drugs or devices in or into the state, including, but not limited to, manufacturers, repackers, own-label distributors, private-label distributors, jobbers, brokers, warehouses, including manufacturers' and distributors' warehouses, co-licensees, exclusive distributors, third party logistics providers, chain pharmacy warehouses that conduct wholesale distributions, and wholesale drug warehouses, independent wholesale drug traders and retail pharmacies that conduct wholesale distributions. Wholesale distributor shall not include persons engaged in the sale of durable medical equipment to consumers or patients.

"Wholesale distribution" means the distribution of prescription drugs or devices by wholesale distributors to persons other than consumers or patients, and includes the transfer of prescription drugs by a pharmacy to another pharmacy if the total number of units of transferred drugs during a twelve-month period does not exceed 5% of the total number of all units dispensed by the pharmacy during the immediately preceding twelve-month period. Wholesale distribution does not include:

1. The sale, purchase or trade of a prescription drug or device, an offer to sell, purchase or trade a prescription drug or device or the dispensing of a prescription drug or device pursuant to a prescription;
2. the sale, purchase or trade of a prescription drug or device or an offer to sell, purchase or trade a prescription drug or device for emergency medical reasons;
3. intracompany transactions, as defined in this section, unless in violation of own use provisions;
4. the sale, purchase or trade of a prescription drug or device or an
offer to sell, purchase or trade a prescription drug or device among
hospitals, chain pharmacy warehouses, pharmacies or other health care
entities that are under common control;
(5) the sale, purchase or trade of a prescription drug or device or the
offer to sell, purchase or trade a prescription drug or device by a charitable
organization described in 503(c)(3) of the internal revenue code of 1954 to
a nonprofit affiliate of the organization to the extent otherwise permitted
by law;
(6) the purchase or other acquisition by a hospital or other similar
health care entity that is a member of a group purchasing organization of a
prescription drug or device for its own use from the group purchasing
organization or from other hospitals or similar health care entities that are
members of these organizations;
(7) the transfer of prescription drugs or devices between pharmacies
pursuant to a centralized prescription processing agreement;
(8) the sale, purchase or trade of blood and blood components
intended for transfusion;
(9) the return of recalled, expired, damaged or otherwise non-salable
prescription drugs, when conducted by a hospital, health care entity,
pharmacy, chain pharmacy warehouse or charitable institution in
accordance with the board's rules and regulations;
(10) the sale, transfer, merger or consolidation of all or part of the
business of a retail pharmacy or pharmacies from or with another retail
pharmacy or pharmacies, whether accomplished as a purchase and sale of
stock or business assets, in accordance with the board's rules and
regulations;
(11) the distribution of drug samples by manufacturers' and
authorized distributors' representatives;
(12) the sale of minimal quantities of drugs by retail pharmacies to
licensed practitioners for office use; or
(13) the sale or transfer from a retail pharmacy or chain pharmacy
warehouse of expired, damaged, returned or recalled prescription drugs to
the original manufacturer, originating wholesale distributor or to a third
party returns processor in accordance with the board's rules and
regulations.
Sec. 12. K.S.A. 65-1660 is hereby amended to read as follows: 65-
1660. (a) Except as otherwise provided in this section, the provisions of
the pharmacy act of the state of Kansas shall not apply to dialytes,
devices or drugs which are designated by the board for the purposes of this
section relating to treatment of a person with chronic kidney failure
receiving dialysis and which are prescribed or ordered by a physician, an
advanced practice registered nurse or a mid-level practitioner for
administration or delivery to a person with chronic kidney failure if:
(1) The wholesale distributor is registered with the board and lawfully
holds the drug or device; and
(2) the wholesale distributor: (A) Delivers the drug or device to: (i) A
person with chronic kidney failure for self-administration at the person's
home or specified address; (ii) a physician for administration or delivery to
a person with chronic kidney failure; or (iii) a medicare approved renal
dialysis facility for administering or delivering to a person with chronic
kidney failure; and (B) has sufficient and qualified supervision to
adequately protect the public health.
(b) The wholesale distributor pursuant to subsection (a) shall be
supervised by a pharmacist consultant pursuant to rules and regulations
adopted by the board.
(c) The board shall adopt such rules or regulations as are necessary to
effectuate the provisions of this section.
(d) As used in this section, "physician" means a person licensed to
practice medicine and surgery; "mid-level practitioner" means mid-level
practitioner as such term is defined in subsection (ii) of K.S.A. 65-
1626, and amendments thereto; "advanced practice registered nurse"
means an advanced practice registered nurse who is licensed pursuant to
K.S.A. 65-1131, and amendments thereto, and who has authority to
prescribe drugs in accordance with K.S.A. 65-1130, and amendments
thereto.
(e) This section shall be part of and supplemental to the pharmacy act
of the state of Kansas.
Sec. 13. K.S.A. 2014 Supp. 65-1682 is hereby amended to read as
follows: 65-1682. As used in this act, unless the context otherwise
requires:
(a) "Board" means the state board of pharmacy.
(b) "Dispenser" means a practitioner or pharmacist who delivers a
scheduled substance or drug of concern to an ultimate user, but does not
include:
(1) A licensed hospital pharmacy that distributes such substances for
the purpose of inpatient hospital care;
(2) a medical care facility as defined in K.S.A. 65-425, and
amendments thereto, practitioner or other authorized person who
administers such a substance;
(3) a registered wholesale distributor of such substances;
(4) a veterinarian licensed by the Kansas board of veterinary
examiners who dispenses or prescribes a scheduled substance or drug of
concern; or
(5) a practitioner who has been exempted from the reporting
requirements of this act in rules and regulations promulgated by the board.
(c) "Drug of concern" means any drug that demonstrates a potential
for abuse and is designated as a drug of concern in rules and regulations promulgated by the board.

(d) "Patient" means the person who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed, or both.

(e) "Pharmacist" means an individual currently licensed by the board to practice the profession of pharmacy in this state.

(f) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, or other person authorized by law to prescribe or dispense scheduled substances and drugs of concern.

(g) "Scheduled substance" means controlled substances included in schedules II, III or IV of the schedules designated in K.S.A. 65-4107, 65-4109 and 65-4111, and amendments thereto, respectively, or the federal controlled substances act (21 U.S.C. § 812).

Sec. 14. K.S.A. 2014 Supp. 65-2837a is hereby amended to read as follows: 65-2837a. (a) It shall be unlawful for any person licensed to practice medicine and surgery to prescribe, order, dispense, administer, sell, supply or give or for any person licensed as an advanced practice registered nurse or for a mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto, to prescribe, administer, supply or give any amphetamine or sympathomimetic amine designated in schedule II, III or IV under the uniform controlled substances act, except as provided in this section. Failure to comply with this section by a licensee shall constitute unprofessional conduct under K.S.A. 65-2837, and amendments thereto.

(b) When any licensee prescribes, orders, dispenses, administers, sells, supplies or gives or when any advanced practice registered nurse or any mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto, prescribes, administers, sells, supplies or gives any amphetamine or sympathomimetic amine designated in schedule II, III or IV under the uniform controlled substances act, the patient's medical record shall adequately document the purpose for which the drug is being given. Such purpose shall be restricted to one or more of the following:

(1) The treatment of narcolepsy.
(2) The treatment of drug-induced brain dysfunction.
(3) The treatment of hyperkinesis.
(4) The differential diagnostic psychiatric evaluation of depression.
(5) The treatment of depression shown by adequate medical records and documentation to be unresponsive to other forms of treatment.
(6) The clinical investigation of the effects of such drugs or
compounds, in which case, before the investigation is begun, the licensee
shall, in addition to other requirements of applicable laws, apply for and
obtain approval of the investigation from the board of healing arts.

(7) The treatment of obesity with controlled substances, as may be
defined by rules and regulations adopted by the board of healing arts.

(8) The treatment of any other disorder or disease for which such
drugs or compounds have been found to be safe and effective by
competent scientific research which findings have been generally accepted
by the scientific community, in which case, the licensee before prescribing,
ordering, dispensing, administering, selling, supplying or giving the drug
or compound for a particular condition, or the licensee before authorizing
a mid-level practitioner to prescribe the drug or compound for a particular
condition, or the advanced practice registered nurse before prescribing,
ordering, administering or giving the drug for a particular condition, shall
obtain a determination from the board of healing arts that the drug or
compound can be used for that particular condition.

Sec. 15. K.S.A. 65-2892 is hereby amended to read as follows: 65-
2892. Any physician or advanced practice registered nurse, upon
consultation by any person under eighteen (18) years of age as a
patient, may, with the consent of such person who is hereby granted the
right of giving such consent, make a diagnostic examination for venereal
disease and prescribe for and treat such person for venereal disease
including prophylactic treatment for exposure to venereal disease
whenever such person is suspected of having a venereal disease or contact
with anyone having a venereal disease. All such examinations and
treatment may be performed without the consent of, or notification to, the
parent, parents, guardian or any other person having custody of such
person. Any physician or advanced practice registered nurse examining or
treating such person for venereal disease may, but shall not be obligated to,
in accord with his opinion of what will be most beneficial for such person,
inform the spouse, parent, custodian, guardian or fiance of such person as
to the treatment given or needed without the consent of such person. Such
informing shall not constitute libel or slander or a violation of the right of
privacy or privilege or otherwise subject the physician or advanced
practice registered nurse to any liability whatsoever. In any such case, the
physician or advanced practice registered nurse shall incur no civil or
criminal liability by reason of having made such diagnostic examination or
rendered such treatment, but such immunity shall not apply to any
negligent acts or omissions. The physician or advanced practice registered
nurse shall incur no civil or criminal liability by reason of any adverse
reaction to medication administered, provided reasonable care has been
taken to elicit from such person under eighteen (18) years of age any
history of sensitivity or previous adverse reaction to the medication.
Sec. 16. K.S.A. 2014 Supp. 65-2921 is hereby amended to read as follows: 65-2921. (a) Except as otherwise provided in subsection (d), a physical therapist may evaluate and initiate physical therapy treatment on a patient without referral from a licensed health care practitioner. If treating a patient without a referral from a licensed health care practitioner and the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable or functional improvement, or any combination thereof, after 10 patient visits or in a period of 15 business days from the initial treatment visits following the initial evaluation visit, the physical therapist shall obtain a referral from an appropriate licensed health care practitioner prior to continuing treatment.

(b) Physical therapists may provide, without a referral, services to: (1) Employees solely for the purpose of education and instruction related to workplace injury prevention; or (2) the public for the purpose of fitness, health promotion and education.

(c) Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan (IEP) or individualized family service plan (IFSP).

(d) Nothing in this section shall be construed to prevent a hospital or ambulatory surgical center from requiring a physician order or referral for physical therapy services for a patient currently being treated in such facility.

(e) When a patient self-refers to a physical therapist pursuant to this section, the physical therapist, prior to commencing treatment, shall provide written notice to the patient that a physical therapy diagnosis is not a medical diagnosis by a physician.

(f) Physical therapists shall perform wound debridement services only after approval by a person licensed to practice medicine and surgery or other licensed health care practitioner in appropriately related cases.

(g) As used in this section, "licensed health care practitioner" means a person licensed to practice medicine and surgery, a licensed podiatrist, a licensed physician assistant or a licensed advanced practice registered nurse working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed chiropractor, a licensed dentist or, a licensed optometrist or a licensed advanced practice registered nurse in appropriately related cases.

Sec. 17. K.S.A. 2013 Supp. 65-4101, as amended by section 50 of chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to read as follows: 65-4101. As used in this act: (a) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by:
(1) A practitioner or pursuant to the lawful direction of a practitioner; or
(2) the patient or research subject at the direction and in the presence of the practitioner.
(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor or dispenser. It does not include a common carrier, public warehouseman or employee of the carrier or warehouseman.
(c) "Application service provider" means an entity that sells electronic prescription or pharmacy prescription applications as a hosted service where the entity controls access to the application and maintains the software and records on its server.
(d) "Board" means the state board of pharmacy.
(e) "Bureau" means the bureau of narcotics and dangerous drugs, United States department of justice, or its successor agency.
(f) "Controlled substance" means any drug, substance or immediate precursor included in any of the schedules designated in K.S.A. 65-4105, 65-4107, 65-4111 and 65-4113, and amendments thereto.
(g) (1) "Controlled substance analog" means a substance that is intended for human consumption, and:
   (A) The chemical structure of which is substantially similar to the chemical structure of a controlled substance listed in or added to the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto;
   (B) which has a stimulant, depressant or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance included in the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto; or
   (C) with respect to a particular individual, which such individual represents or intends to have a stimulant, depressant or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance included in the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto.
(2) "Controlled substance analog" does not include:
   (A) A controlled substance;
   (B) a substance for which there is an approved new drug application; or
   (C) a substance with respect to which an exemption is in effect for investigational use by a particular person under section 505 of the federal food, drug and cosmetic act, 21 U.S.C. § 355, to the extent conduct with respect to the substance is permitted by the exemption.
(h) "Counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization bears the trademark, trade name or other identifying mark, imprint, number or device or any likeness thereof of a manufacturer, distributor or dispenser other than the person who in fact manufactured, distributed or dispensed the substance.

(i) "Cultivate" means the planting or promotion of growth of five or more plants which contain or can produce controlled substances.

(j) "DEA" means the U.S. department of justice, drug enforcement administration.

(k) "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship.

(l) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the packaging, labeling or compounding necessary to prepare the substance for that delivery, or pursuant to the prescription of a mid-level practitioner.

(m) "Dispenser" means a practitioner or pharmacist who dispenses, or a physician assistant who has authority to dispense prescription-only drugs in accordance with subsection (b) of K.S.A. 65-28a08(b), and amendments thereto.

(n) "Distribute" means to deliver other than by administering or dispensing a controlled substance.

(o) "Distributor" means a person who distributes.

(p) "Drug" means: (1) Substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States or official national formulary or any supplement to any of them; (2) substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; (3) substances (other than food) intended to affect the structure or any function of the body of man or animals; and (4) substances intended for use as a component of any article specified in clause (1), (2) or (3) of this subsection (p)(1), (2) or (3). It does not include devices or their components, parts or accessories.

(q) "Immediate precursor" means a substance which the board has found to be and by rule and regulation designates as being the principal compound commonly used or produced primarily for use and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail or limit manufacture.

(r) "Electronic prescription" means an electronically prepared prescription that is authorized and transmitted from the prescriber to the pharmacy by means of electronic transmission.
"Electronic prescription application" means software that is used to create electronic prescriptions and that is intended to be installed on the prescriber's computers and servers where access and records are controlled by the prescriber.

"Electronic signature" means a confidential personalized digital key, code, number or other method for secure electronic data transmissions which identifies a particular person as the source of the message, authenticates the signatory of the message and indicates the person's approval of the information contained in the transmission.

"Electronic transmission" means the transmission of an electronic prescription, formatted as an electronic data file, from a prescriber's electronic prescription application to a pharmacy's computer, where the data file is imported into the pharmacy prescription application.

"Electronically prepared prescription" means a prescription that is generated using an electronic prescription application.

"Facsimile transmission" or "fax transmission" means the transmission of a digital image of a prescription from the prescriber or the prescriber's agent to the pharmacy. "Facsimile transmission" includes, but is not limited to, transmission of a written prescription between the prescriber's fax machine and the pharmacy's fax machine; transmission of an electronically prepared prescription from the prescriber's electronic prescription application to the pharmacy's fax machine, computer or printer; or transmission of an electronically prepared prescription from the prescriber's fax machine to the pharmacy's fax machine, computer or printer.

"Intermediary" means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

"Isomer" means all enantiomers and diastereomers.

"Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a controlled substance either directly or indirectly or by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled substance by an individual for the individual's own lawful use or the preparation, compounding, packaging or labeling of a controlled substance:

1. By a practitioner or the practitioner's agent pursuant to a lawful order of a practitioner as an incident to the practitioner's administering or dispensing of a controlled substance in the course of the practitioner's 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
under K.S.A. 65-4102, and amendments thereto, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

(ff) "Opium poppy" means the plant of the species Papaver somniferum l. except its seeds.

(gg) "Person" means an individual, corporation, government, or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity.

(hh) "Pharmacist" means any natural person licensed under K.S.A. 65-1625 et seq., to practice pharmacy.

(ii) "Pharmacist intern" means: (1) A student currently enrolled in an accredited pharmacy program; (2) a graduate of an accredited pharmacy program serving such person's internship; or (3) a graduate of a pharmacy program located outside of the United States which is not accredited and who had successfully passed equivalency examinations approved by the board.

(jj) "Pharmacy prescription application" means software that is used to process prescription information, is installed on a pharmacy's computers and servers, and is controlled by the pharmacy.

(kk) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(II) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, or scientific investigator or other person authorized by law to use a controlled substance in teaching or chemical analysis or to conduct research with respect to a controlled substance.

(mm) "Prescriber" means a practitioner or a mid-level practitioner.

(nn) "Production" includes the manufacture, planting, cultivation, growing or harvesting of a controlled substance.

(oo) "Readily retrievable" means that records kept by automatic data processing applications or other electronic or mechanized recordkeeping systems can be separated out from all other records within a reasonable time not to exceed 48 hours of a request from the board or other authorized agent or that hard-copy records are kept on which certain items are asterisked, redlined or in some other manner visually identifiable apart from other items appearing on the records.

(pp) "Ultimate user" means a person who lawfully possesses a controlled substance for such person's own use or for the use of a member of such person's household or for administering to an animal owned by such person or by a member of such person's household.
Sec. 18. K.S.A. 2014 Supp. 65-4116 is hereby amended to read as follows: 65-4116. (a) Every person who manufactures, distributes or dispenses any controlled substance within this state or who proposes to engage in the manufacture, distribution or dispensing of any controlled substance within this state shall obtain annually a registration issued by the board in accordance with the uniform controlled substances act and with rules and regulations adopted by the board.

(b) Persons registered by the board under this act to manufacture, distribute, dispense or conduct research with controlled substances may possess, manufacture, distribute, dispense or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this act.

(c) The following persons need not register and may lawfully possess controlled substances under this act, as specified in this subsection:

(1) An agent or employee of any registered manufacturer, distributor or dispenser of any controlled substance if the agent or employee is acting in the usual course of such agent or employee's business or employment;

(2) a common carrier or warehouseman or an employee thereof whose possession of any controlled substance is in the usual course of business or employment;

(3) an ultimate user or a person in possession of any controlled substance pursuant to a lawful order of a practitioner or a mid-level practitioner or in lawful possession of a schedule V substance;

(4) persons licensed and registered by the board under the provisions of the acts contained in article 16 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, to manufacture, dispense or distribute drugs are considered to be in compliance with the registration provision of the uniform controlled substances act without additional proceedings before the board or the payment of additional fees, except that manufacturers and distributors shall complete and file the application form required under the uniform controlled substances act;

(5) any person licensed by the state board of healing arts under the Kansas healing arts act;

(6) any person licensed by the state board of veterinary examiners;

(7) any person licensed by the Kansas dental board;

(8) a mid-level practitioner; and

(9) any person who is a member of the Native American Church, with respect to use or possession of peyote, whose use or possession of peyote is in, or for use in, bona fide religious ceremonies of the Native American Church, but nothing in this paragraph shall authorize the use or possession of peyote in any place used for the confinement or housing of persons arrested, charged or convicted of criminal offenses or in the state security hospital; and
(10) any person licensed as an advanced practice registered nurse under K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto.

(d) (1) The board may waive by rules and regulations the requirement for registration of certain manufacturers, distributors or dispensers if the board finds it consistent with the public health and safety, except that licensure of any person by the state board of healing arts to practice any branch of the healing arts, Kansas dental board or, the state board of veterinary examiners or the board of nursing of advanced practice registered nurses shall constitute compliance with the registration requirements of the uniform controlled substances act by such person for such person's place of professional practice.

(2) Evidence of abuse as determined by the board relating to a person licensed by the state board of healing arts shall be submitted to the state board of healing arts and the attorney general within 60 days. The state board of healing arts shall, within 60 days, make findings of fact and take such action against such person as it deems necessary. All findings of fact and any action taken shall be reported by the state board of healing arts to the board of pharmacy and the attorney general.

(3) Evidence of abuse as determined by the board relating to a person licensed by the state board of veterinary examiners shall be submitted to the state board of veterinary examiners and the attorney general within 60 days. The state board of veterinary examiners shall, within 60 days, make findings of fact and take such action against such person as it deems necessary. All findings of fact and any action taken shall be reported by the state board of veterinary examiners to the board of pharmacy and the attorney general.

(4) Evidence of abuse as determined by the board relating to a dentist licensed by the Kansas dental board shall be submitted to the Kansas dental board and the attorney general within 60 days. The Kansas dental board shall, within 60 days, make findings of fact and take such action against such dentist as it deems necessary. All findings of fact and any action taken shall be reported by the Kansas dental board to the board of pharmacy and the attorney general.

(5) Evidence of abuse as determined by the board relating to an advanced practice registered nurse licensed by the board of nursing shall be submitted to the board of nursing and the attorney general within 60 days. The board of nursing shall, within 60 days, make findings of fact and take such action against such advanced practice registered nurse as it deems necessary. All findings of fact and any action taken shall be reported by the board of nursing to the board of pharmacy and the attorney general.
(e) A separate annual registration is required at each place of business or professional practice where the applicant manufactures, distributes or dispenses controlled substances.

(f) The board may inspect the establishment of a registrant or applicant for registration in accordance with the board's rules and regulations.

(g) (1) The registration of any person or location shall terminate when such person or authorized representative of a location dies, ceases legal existence, discontinues business or professional practice or changes the location as shown on the certificate of registration. Any registrant who ceases legal existence, discontinues business or professional practice, or changes location as shown on the certificate of registration, shall notify the board promptly of such fact and forthwith deliver the certificate of registration directly to the secretary or executive secretary of the board. In the event of a change in name or mailing address the person or authorized representative of the location shall notify the board promptly in advance of the effective date of this change by filing the change of name or mailing address with the board. This change shall be noted on the original application on file with the board.

(2) No registration or any authority conferred thereby shall be assigned or otherwise transferred except upon such conditions as the board may specifically designate and then only pursuant to the written consent of the board.

Sec. 19. K.S.A. 65-4134 is hereby amended to read as follows: 65-4134. A practitioner engaged in medical practice or research, a practitioner who is an advanced practice registered nurse acting in the usual course of such practitioner's practice or a mid-level practitioner acting in the usual course of such mid-level practitioner's practice is not required or compelled to furnish the name or identity of a patient or research subject to the board, nor may such practitioner or mid-level practitioner be compelled in any state or local civil, criminal, administrative, legislative or other proceedings to furnish the name or identity of an individual that the practitioner or mid-level practitioner is obligated to keep confidential.

Sec. 20. K.S.A. 2014 Supp. 65-4202 is hereby amended to read as follows: 65-4202. As used in this act: (a) "Board" means the state board of nursing.

(b) The "practice of mental health technology" means the performance, under the direction of a physician licensed to practice medicine and surgery or registered professional nurse, of services in caring for and treatment of the mentally ill, emotionally disturbed, or people with intellectual disability for compensation or personal profit, which services:

(1) Involve responsible nursing and therapeutic procedures for
patients with mental illness or intellectual disability requiring interpersonal and technical skills in the observations and recognition of symptoms and reactions of such patients, the accurate recording of such symptoms and reactions and the carrying out of treatments and medications as prescribed by a licensed physician, a licensed advanced practice registered nurse or a mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto; and

(2) require an application of techniques and procedures that involve understanding of cause and effect and the safeguarding of life and health of the patient and others; and

(3) require the performance of duties that are necessary to facilitate rehabilitation of the patient or are necessary in the physical, therapeutic and psychiatric care of the patient and require close work with persons licensed to practice medicine and surgery, psychiatrists, psychologists, rehabilitation therapists, social workers, registered nurses, and other professional personnel.

(c) A "licensed mental health technician" means a person who lawfully practices mental health technology as defined in this act.

(d) An "approved course in mental health technology" means a program of training and study including a basic curriculum which shall be prescribed and approved by the board in accordance with the standards prescribed herein, the successful completion of which shall be required before licensure as a mental health technician, except as hereinafter provided.

Sec. 21. K.S.A. 2014 Supp. 65-5402 is hereby amended to read as follows: 65-5402. As used in K.S.A. 65-5401 to 65-5417, inclusive, and K.S.A. 65-5418 to 65-5420, inclusive, and amendments thereto:

(a) "Board" means the state board of healing arts.

(b) "Practice of occupational therapy" means the therapeutic use of purposeful and meaningful occupations (goal-directed activities) to evaluate and treat, pursuant to the referral, supervision, order or direction of a physician, a licensed podiatrist, a licensed dentist, a licensed physician assistant, or a licensed advanced practice registered nurse working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed advanced practice registered nurse, a licensed chiropractor, or a licensed optometrist, individuals who have a disease or disorder, impairment, activity limitation or participation restriction that interferes with their ability to function independently in daily life roles and to promote health and wellness. Occupational therapy intervention may include:

(1) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological cognitive processes;
(2) adaptation of tasks, process, or the environment or the teaching of compensatory techniques in order to enhance performance;
(3) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and
(4) health promotion strategies and practices that enhance performance abilities.
(c) "Occupational therapy services" include, but are not limited to:
(1) Evaluating, developing, improving, sustaining, or restoring skills in activities of daily living (ADL), work or productive activities, including instrumental activities of daily living (IADL) and play and leisure activities;
(2) evaluating, developing, remediating, or restoring sensorimotor, cognitive or psychosocial components of performance;
(3) designing, fabricating, applying, or training in the use of assistive technology or orthotic devices and training in the use of prosthetic devices;
(4) adapting environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles;
(5) applying physical agent modalities as an adjunct to or in preparation for engagement in occupations;
(6) evaluating and providing intervention in collaboration with the client, family, caregiver or others;
(7) educating the client, family, caregiver or others in carrying out appropriate nonskilled interventions; and
(8) consulting with groups, programs, organizations or communities to provide population-based services.
(d) "Occupational therapist" means a person licensed to practice occupational therapy as defined in this act.
(e) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist.
(f) "Person" means any individual, partnership, unincorporated organization or corporation.
(g) "Physician" means a person licensed to practice medicine and surgery.
(h) "Occupational therapy aide," "occupational therapy tech" or "occupational therapy paraprofessional" means a person who provides supportive services to occupational therapists and occupational therapy assistants in accordance with K.S.A. 65-5419, and amendments thereto.
Sec. 22. K.S.A. 2014 Supp. 65-5418 is hereby amended to read as follows: 65-5418. (a) Nothing in the occupational therapy practice act is intended to limit, preclude or otherwise interfere with the practices of other health care providers formally trained and licensed, registered,
credentialed or certified by appropriate agencies of the state of Kansas.

(b) The practice of occupational therapy shall not be construed to include the following:

(1) Persons rendering assistance in the case of an emergency;
(2) members of any church practicing their religious tenets;
(3) persons whose services are performed pursuant to the delegation of and under the supervision of an occupational therapist who is licensed under this act;
(4) any person employed as an occupational therapist or occupational therapy assistant by the government of the United States or any agency thereof, if such person practices occupational therapy solely under the direction or control of the organization by which such person is employed;
(5) licensees under the healing arts act when licensed and practicing in accordance with the provisions of law or persons performing services pursuant to a delegation authorized under subsection (g) of K.S.A. 65-2872(g), and amendments thereto;
(6) dentists practicing their professions, when licensed and practicing in accordance with the provisions of law;
(7) nurses practicing their professions, when licensed and practicing pursuant to the delegation of a licensed nurse under subsection (m) of K.S.A. 65-1124(m), and amendments thereto;
(8) health care providers who have been formally trained and are practicing in accordance with the training or have received specific training in one or more functions included in the occupational therapy practice act pursuant to established educational protocols, or both;
(9) any person pursuing a supervised course of study leading to a degree or certificate in occupational therapy at an accredited or approved educational program, if the person is designated by the title which clearly indicates such person's status as a student or trainee;
(10) any person fulfilling the supervised fieldwork experience requirements as part of the experience necessary to meet the requirement of the occupational therapy practice act;
(11) self-care by a patient or gratuitous care by a friend or family member who does not represent or hold oneself out to the public to be an occupational therapist or an occupational therapy assistant;
(12) optometrists practicing their profession when licensed and practicing in accordance with the provisions of article 15 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto;
(13) podiatrists practicing their profession when licensed and practicing in accordance with the provisions of article 15 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto;
(14) physical therapists practicing their profession when licensed and
practicing in accordance with K.S.A. 65-2901 et seq., and amendments thereto;

(15) physician assistants practicing their profession when licensed and practicing in accordance with the physician assistant licensure act;

(16) athletic trainers practicing their profession when licensed and practicing in accordance with the athletic trainers licensure act;

(17) manufacturers of prosthetic devices;

(18) any person performing occupational therapy services, if these services are performed for no more than 45 days in a calendar year in association with an occupational therapist licensed under the occupational therapy practice act so long as: (A) The person is registered or licensed under the laws of another state which has licensure requirements at least as stringent as the licensure requirements of this act; or (B) the person meets the requirements for certification as an occupational therapist registered (OTR) or a certified occupational therapy assistant (COTA) established by the national board for certification in occupational therapy (NBCOT).

(c) Any patient monitoring, assessment or other procedures designed to evaluate the effectiveness of prescribed occupational therapy must be performed by or pursuant to the delegation of a licensed occupational therapist or other health care provider.

(d) Education related therapy services provided by an occupational therapist to school systems or consultation regarding prevention, ergonomics and wellness within the occupational therapy scope of practice shall not require a referral, supervision, order or direction of a physician, an advanced practice registered nurse, a licensed podiatrist, a licensed dentist or a licensed optometrist. However, when in the course of providing such services an occupational therapist reasonably believes that an individual may have an underlying injury, illness, disease, disorder or impairment, the occupational therapist shall refer the individual to a physician, an advanced practice registered nurse, a licensed podiatrist, a licensed dentist or a licensed optometrist, as appropriate.

(e) Nothing in the occupational therapy practice act shall be construed to permit the practice of medicine and surgery. No statute granting authority to licensees of the state board of healing arts shall be construed to confer authority upon occupational therapists to engage in any activity not conferred by the occupational therapy practice act.

(f) This section shall be part of and supplemental to the occupational therapy practice act.

Sec. 23. K.S.A. 65-5502 is hereby amended to read as follows: 65-5502. As used in K.S.A. 65-5501 to 65-5517, inclusive and amendments thereto:

(a) "Board" means the state board of healing arts.

(b) "Respiratory therapy" is a health care profession whose therapists
practice under the supervision of a qualified medical director and with the
prescription of a licensed physician or an advanced practice registered
nurse providing therapy, management, rehabilitation, respiratory
assessment and care of patients with deficiencies and abnormalities which
affect the pulmonary system and associated other systems functions. The
duties which may be performed by a respiratory therapist include:
(1) Direct and indirect respiratory therapy services that are safe,
aesthetic, preventative and restorative to the patient.
(2) Direct and indirect respiratory therapy services, including but not
limited to, the administration of pharmacological and diagnostic and
therapeutic agents related to respiratory therapy procedures to implement a
treatment, disease prevention or pulmonary rehabilitative regimen
prescribed by a physician or an advanced practice registered nurse.
(3) Administration of medical gases, exclusive of general anesthesia,
aerosols, humidification and environmental control systems.
(4) Transcription and implementation of written or verbal orders of a
physician or an advanced practice registered nurse pertaining to the
practice of respiratory therapy.
(5) Implementation of respiratory therapy protocols as defined by the
medical staff of an institution or a qualified medical director or other
written protocol, changes in treatment pursuant to the written or verbal
orders of a physician or an advanced practice registered nurse or the
initiation of emergency procedures as authorized by written protocols.
(c) "Respiratory therapist" means a person who is licensed to practice
respiratory therapy as defined in this act.
(d) "Person" means any individual, partnership, unincorporated
organization or corporation.
(e) "Physician" means a person who is licensed by the board to
practice medicine and surgery.
(f) "Qualified medical director" means the medical director of any
inpatient or outpatient respiratory therapy service, department or home
care agency. The medical director shall be a physician who has interest and
knowledge in the diagnosis and treatment of respiratory problems. This
physician shall be responsible for the quality, safety and appropriateness of
the respiratory services provided and require that respiratory therapy be
ordered by a physician or an advanced practice registered nurse who has
medical responsibility for the patient. The medical director shall be readily
accessible to the respiratory therapy practitioner.
(g) "Advanced practice registered nurse" means an advanced
practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
amendments thereto, and who has authority to prescribe drugs in
accordance with K.S.A. 65-1130, and amendments thereto.
Sec. 24. K.S.A. 2013 Supp. 65-6112, as amended by section 51 of
chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to read as follows: 65-6112. As used in this act:

(a) "Administrator" means the executive director of the emergency medical services board.

(b) "Advanced emergency medical technician" means a person who holds an advanced emergency medical technician certificate issued pursuant to this act.

(c) "Advanced practice registered nurse" means an advanced practice registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

(d) "Ambulance" means any privately or publicly owned motor vehicle, airplane or helicopter designed, constructed, prepared, staffed and equipped for use in transporting and providing emergency care for individuals who are ill or injured.

(e) "Ambulance service" means any organization operated for the purpose of transporting sick or injured persons to or from a place where medical care is furnished, whether or not such persons may be in need of emergency or medical care in transit.

(f) "Attendant" means a first responder, an emergency medical responder, emergency medical technician, emergency medical technician-intermediate, emergency medical technician-defibrillator, emergency medical technician-intermediate/defibrillator, advanced emergency medical technician, mobile intensive care technician or paramedic certified pursuant to this act.

(g) "Board" means the emergency medical services board established pursuant to K.S.A. 65-6102, and amendments thereto.

(h) "Emergency medical service" means the effective and coordinated delivery of such care as may be required by an emergency which includes the care and transportation of individuals by ambulance services and the performance of authorized emergency care by a physician, advanced practice registered nurse, professional nurse, a licensed physician assistant or attendant.

(i) "Emergency medical technician" means a person who holds an emergency medical technician certificate issued pursuant to this act.

(j) "Emergency medical technician-defibrillator" means a person who holds an emergency medical technician-defibrillator certificate issued pursuant to this act.

(k) "Emergency medical technician-intermediate" means a person who holds an emergency medical technician-intermediate certificate issued pursuant to this act.

(l) "Emergency medical technician-intermediate/defibrillator" means a person who holds both an emergency medical technician-intermediate and emergency medical technician-defibrillator certificate issued pursuant to this act.
(m) "Emergency medical responder" means a person who holds an emergency medical responder certificate issued pursuant to this act.
(n) "First responder" means a person who holds a first responder certificate issued pursuant to this act.
(o) "Hospital" means a hospital as defined by K.S.A. 65-425, and amendments thereto.
(p) "Instructor-coordinator" means a person who is certified under this act to teach initial certification and continuing education classes.
(q) "Medical director" means a physician.
(r) "Medical protocols" mean written guidelines which authorize attendants to perform certain medical procedures prior to contacting a physician, physician assistant authorized by a physician, advanced practice registered nurse, or professional nurse authorized by a physician. The medical protocols shall be approved by a county medical society or the medical staff of a hospital to which the ambulance service primarily transports patients, or if neither of the above are able or available to approve the medical protocols, then the medical protocols shall be submitted to the medical advisory council for approval.
(s) "Mobile intensive care technician" means a person who holds a mobile intensive care technician certificate issued pursuant to this act.
(t) "Municipality" means any city, county, township, fire district or ambulance service district.
(u) "Nonemergency transportation" means the care and transport of a sick or injured person under a foreseen combination of circumstances calling for continuing care of such person. As used in this subsection, transportation includes performance of the authorized level of services of the attendant whether within or outside the vehicle as part of such transportation services.
(v) "Operator" means a person or municipality who has a permit to operate an ambulance service in the state of Kansas.
(w) "Paramedic" means a person who holds a paramedic certificate issued pursuant to this act.
(x) "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.
(y) "Physician" means a person licensed by the state board of healing arts to practice medicine and surgery.
(z) "Physician assistant" means a person who is licensed under the physician assistant licensure act and who is acting under the direction of a supervising physician.
(aa) "Professional nurse" means a licensed professional nurse as defined by K.S.A. 65-1113, and amendments thereto.
(bb) "Provider of training" means a corporation, partnership, accredited postsecondary education institution, ambulance service, fire
department, hospital or municipality that conducts training programs that
include, but are not limited to, initial courses of instruction and continuing
education for attendants, instructor-coordinators or training officers.

(cc) "Supervising physician" means supervising physician as such
term is defined under K.S.A. 65-28a02, and amendments thereto.

(dd) "Training officer" means a person who is certified pursuant to
this act to teach, coordinate or both, initial courses of instruction for first
responders or emergency medical responders and continuing education as
prescribed by the board.

Sec. 25. K.S.A. 2014 Supp. 65-6119 is hereby amended to read as
follows: 65-6119. (a) Notwithstanding any other provision of law, mobile
intensive care technicians may:

1. Perform all the authorized activities identified in K.S.A. 65-6120,
   65-6121, 65-6123, 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, 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 (a)(2);
3. Perform, during an emergency, those activities specified in
   subsection (a)(2) before contacting a person identified in subsection (a)(2)
   when specifically authorized to perform such activities by medical
   protocols; and
4. Perform, during nonemergency transportation, those activities
   specified in this section when specifically authorized to perform such
   activities by medical protocols.

(b) An individual who holds a valid certificate as a mobile intensive
care technician once meeting the continuing education requirements
prescribed by the rules and regulations of the board, upon application for
renewal, shall be deemed to hold a certificate as a paramedic under this
act, and such individual shall not be required to file an original application
as a paramedic for certification under this act.

(c) "Renewal" as used in subsection (b), refers to the first opportunity
that a mobile intensive care technician has to apply for renewal of a
certificate following the effective date of this act.

(d) Upon transition notwithstanding any other provision of law, a
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 (4) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.

Sec. 26. K.S.A. 2014 Supp. 65-6120 is hereby amended to read as follows: 65-6120. (a) Notwithstanding any other provision of law to the contrary, an emergency medical technician-intermediate may: (1) Perform any of the activities identified by K.S.A. 65-6121, and amendments thereto; (2) when approved by medical protocols or where voice contact by radio or telephone is monitored by a physician, physician assistant where authorized by a physician, advanced practice registered nurse where authorized by a physician or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such person, may perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions, endotracheal intubation and administration of nebulized albuterol; (3) perform, during an emergency, those activities specified in subsection (a)(2) before contacting the persons identified in subsection (a)(2) when specifically authorized to perform such activities by medical protocols; or (4) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.

(b) An individual who holds a valid certificate as an emergency medical technician-intermediate once successfully completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an advanced emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an advanced emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of the successful completion of a transition course and such individual shall not be required to file an
original application for certification as an advanced emergency medical
technician under this act.
  (c) "Renewal" as used in subsection (b), refers to the first or second
opportunity after December 31, 2011, that an emergency medical
technician-intermediate has to apply for renewal of a certificate.
  (d) Emergency medical technician-intermediates who fail to meet the
transition requirements as specified may complete either the board
prescribed emergency medical technician transition course or emergency
medical responder transition course, provide validation of cognitive and
psychomotor competency and all continuing education hour requirements
inclusive of the successful completion of a transition course as determined
by rules and regulations of the board. Upon completion, such emergency
medical technician-intermediate may apply to transition to become an
emergency medical technician or an emergency medical responder,
depending on the transition course that was successfully completed.
Alternatively, upon application for renewal of an emergency medical
technician-intermediate certificate, the applicant shall be renewed as an
emergency medical technician or an emergency medical responder,
depending on the transition course that was successfully completed. Such
individual shall not be required to file an original application for
certification as an emergency medical technician or emergency medical
responder.
  (e) Failure to successfully complete either an advanced emergency
medical technician transition course, an emergency medical technician
transition course or emergency medical responder transition course will
result in loss of certification.
  (f) Upon transition, notwithstanding any other provision of law to the
contrary, an advanced emergency medical technician may:
    (1) Perform any of the activities identified by K.S.A. 65-6121, and
amendments thereto; and
    (2) perform any of the following interventions, by use of the devices,
medications and equipment, or any combination thereof, as specifically
identified in rules and regulations, after successfully completing an
approved course of instruction, local specialized device training and
competency validation and when authorized by medical protocols, or upon
order when direct communication is maintained by radio, telephone or
video conference with a physician, physician assistant where authorized by
a physician, an advanced practice registered nurse where authorized by a
physician, or licensed professional nurse where authorized by a physician
upon order of such a person: (A) Continuous positive airway pressure
devices; (B) advanced airway management; (C) referral of patient of
alternate medical care site based on assessment; (D) transportation of a
patient with a capped arterial line; (E) veni-puncture for obtaining blood
sample; (F) initiation and maintenance of intravenous infusion or saline lock; (G) initiation of intraosseous infusion; (H) nebulized therapy; (I) manual defibrillation and cardioversion; (J) cardiac monitoring; (K) electrocardiogram interpretation; (L) administration of generic or trade name medications by one or more of the following methods: (i) Aerosolization; (ii) nebulization; (iii) intravenous; (iv) intranasal; (v) rectal; (vi) subcutaneous; (vii) intraosseous; (viii) intramuscular; or (ix) sublingual.

(g) An individual who holds a valid certificate as both an emergency medical technician-intermediate and as an emergency medical technician-defibrillator once successfully completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to an advanced emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an advanced emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of successful completion of a transition course, and such individual shall not be required to file an original application for certification as an advanced emergency medical technician under this act.

(h) "Renewal" as used in subsection (g), refers to the first or second opportunity after December 31, 2011, that an emergency medical technician-intermediate and emergency medical technician-defibrillator has to apply for renewal of a certificate.

(i) An individual who holds both an emergency medical technician-intermediate certificate and an emergency medical technician-defibrillator certificate, who fails to meet the transition requirements as specified may complete either the board prescribed emergency medical technician transition course or emergency medical responder transition course, and provide validation of cognitive and psychomotor competency and all continuing education hour requirements inclusive of successful completion of a transition course as determined by rules and regulations of the board. Upon completion, such individual may apply to transition to become an emergency medical technician or emergency medical responder, depending on the transition course that was successfully completed. Alternatively, upon application for renewal of an emergency medical technician-intermediate certificate and an emergency medical technician-defibrillator certificate, the applicant shall be renewed as an emergency medical technician or an emergency medical responder, depending on the transition course that was successfully completed. Such individual shall not be required to file an original application for certification as an emergency medical technician or emergency medical responder.

(j) Failure to successfully complete either the advanced emergency
medical technician transition requirements, an emergency medical technician transition course or the emergency medical responder transition course will result in loss of certification.

Sec. 27. K.S.A. 2014 Supp. 65-6121 is hereby amended to read as follows: 65-6121. (a) Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following activities:

1. Patient assessment and vital signs;
2. Airway maintenance including the use of:
   a. Oropharyngeal and nasopharyngeal airways;
   b. Esophageal obturator airways with or without gastric suction device;
   c. Multi-lumen airway; and
   d. Oxygen demand valves.
3. Oxygen therapy;
4. Oropharyngeal suctioning;
5. Cardiopulmonary resuscitation procedures;
6. Control accessible bleeding;
7. Apply pneumatic anti-shock garment;
8. Manage outpatient medical emergencies;
9. Extricate patients and utilize lifting and moving techniques;
10. Manage musculoskeletal and soft tissue injuries including dressing and bandaging wounds or the splinting of fractures, dislocations, sprains or strains;
11. Use of backboards to immobilize the spine;
12. Administer activated charcoal and glucose;
13. Monitor intravenous line delivering intravenous fluids during interfacility transport with the following restrictions:
   a. The physician approves the transfer by an emergency medical technician;
   b. No medications or nutrients have been added to the intravenous fluids; and
   c. The emergency medical technician may monitor, maintain and shut off the flow of intravenous fluid;
14. Use automated external defibrillators;
15. Administer epinephrine auto-injectors provided that:
   a. The emergency medical technician successfully completes a course of instruction approved by the board in the administration of epinephrine;
   b. The emergency medical technician serves with an ambulance service or a first response organization that provides emergency medical services; and
   c. The emergency medical technician is acting pursuant to medical
(16) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols; or

(17) when authorized by medical protocol, assist the patient in the administration of the following medications which have been prescribed for that patient: Auto-injection epinephrine, sublingual nitroglycerin and inhalers for asthma and emphysema.

(b) An individual who holds a valid certificate as an emergency medical technician at the current basic level once successfully completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of successful completion of a transition course, and such individual shall not be required to file an original application for certification as an emergency medical technician.

(c) "Renewal" as used in subsection (b), refers to the first opportunity after December 31, 2011, that an emergency medical technician has to apply for renewal of a certificate following the effective date of this act.

(d) Emergency medical technicians who fail to meet the transition requirements as specified may successfully complete the board prescribed emergency medical responder transition course, provide validation of cognitive and psychomotor competency and all continuing education hour requirements inclusive of the successful completion of a transition course as determined by rules and regulations of the board. Alternatively, upon application for renewal of an emergency medical technician certificate, the applicant shall be deemed to hold a certificate as an emergency medical responder under this act, and such individual shall not be required to file an original application for certification as an emergency medical responder.

(e) Failure to successfully complete either an emergency medical technician transition course or emergency medical responder transition course will result in loss of certification.

(f) Upon transition, notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any activities identified in K.S.A. 65-6144, and amendments thereto, and any of the following interventions, by use of the devices, medications and equipment, or any combination thereof, after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols, or upon order when
direct communication is maintained by radio, telephone or video
conference is monitored by a physician, physician assistant when
authorized by a physician, an advanced practice registered nurse—when
authorized by a physician—or a licensed professional nurse when authorized
by a physician, upon order of such person:

(1) Airway maintenance including use of:
   (A) Single lumen airways as approved by the board;
   (B) multilumen airways;
   (C) ventilator devices;
   (D) forceps removal of airway obstruction;
   (E) CO2 monitoring;
   (F) airway suctioning;

(2) apply pneumatic anti-shock garment;

(3) assist with childbirth;

(4) monitoring urinary catheter;

(5) capillary blood sampling;

(6) cardiac monitoring;

(7) administration of patient assisted medications as approved by the
    board;

(8) administration of medications as approved by the board by
    appropriate routes; and

(9) monitor, maintain or discontinue flow of IV line if a physician
    approves transfer by an emergency medical technician.

Sec. 28. K.S.A. 2014 Supp. 65-6123 is hereby amended to read as
follows: 65-6123. (a) Notwithstanding any other provision of law to the
contrary, an emergency medical technician-defibrillator may:

(1) Perform any of the activities identified in K.S.A. 65-6121, and
    amendments thereto;

(2) when approved by medical protocols or where voice contact by
    radio or telephone is monitored by a physician, physician assistant where
    authorized by a physician, advanced practice registered nurse—where—
    authorized by a physician, or licensed professional nurse where authorized
    by a physician, and direct communication is maintained, upon order of
    such person, may perform electrocardiographic monitoring and
    defibrillation;

(3) perform, during an emergency, those activities specified in
    subsection (b) before contacting the persons identified in subsection (b)
    when specifically authorized to perform such activities by medical
    protocols; or

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

(b) An individual who holds a valid certificate as an emergency
medical technician-defibrillator once successfully completing an emergency medical technician-intermediate, initial course of instruction and the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an advanced emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an advanced emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of successful completion of a transition course, and such individual shall not be required to file an original application for certification as an advanced emergency medical technician.

(c) "Renewal" as used in subsection (b), refers to the second opportunity after December 31, 2011, that an attendant has to apply for renewal of a certificate.

(d) Emergency medical technician-defibrillator attendants who fail to meet the transition requirements as specified may complete either the board prescribed emergency medical technician transition course or emergency medical responder transition course, provide validation of cognitive and psychomotor competency provided such individual has completed all continuing education hour requirements inclusive of the successful completion of a transition course as determined by rules and regulations of the board. Upon completion, such emergency medical technician-defibrillator may apply to transition to become an emergency medical technician or an emergency medical responder, depending on the transition course that was successfully completed. Alternatively, upon application for renewal of an emergency medical technician-defibrillator certificate, the applicant shall be renewed as an emergency medical technician or an emergency medical responder, depending on the transition course that was successfully completed. Such individual shall not be required to file an original application for certification as an emergency medical technician or emergency medical responder.

(e) Failure to complete either the advanced emergency medical technician transition requirements, an emergency medical technician transition course or an emergency medical responder transition course will result in loss of certification.

Sec. 29. K.S.A. 2013 Supp. 65-6124, as amended by section 52 of chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to read as follows: 65-6124. (a) No physician, physician assistant, advanced practice registered nurse or licensed professional nurse, who gives emergency instructions to an attendant as defined by K.S.A. 65-6112, and amendments thereto, during an emergency, shall be liable for any civil damages as a result of issuing the instructions, except such damages which
may result from gross negligence in giving such instructions.

(b) No attendant as defined by K.S.A. 65-6112, and amendments thereto, who renders emergency care during an emergency pursuant to instructions given by a physician, an advanced practice registered nurse, the supervising physician for a physician assistant, advanced practice registered nurse or licensed professional nurse shall be liable for civil damages as a result of implementing such instructions, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of such attendant as defined by K.S.A. 65-6112, and amendments thereto.

(c) No person certified as an instructor-coordinator and no training officer shall be liable for any civil damages which may result from such instructor-coordinator's or training officer's course of instruction, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of the instructor-coordinator or training officer.

(d) No medical adviser who reviews, approves and monitors the activities of attendants shall be liable for any civil damages as a result of such review, approval or monitoring, except such damages which may result from gross negligence in such review, approval or monitoring.

Sec. 30. K.S.A. 2014 Supp. 65-6144 is hereby amended to read as follows: 65-6144. (a) A first responder may perform any of the following activities:

(1) Initial scene management including, but not limited to, gaining access to the individual in need of emergency care, extricating, lifting and moving the individual;

(2) cardiopulmonary resuscitation and airway management;

(3) control of bleeding;

(4) extremity splinting excluding traction splinting;

(5) stabilization of the condition of the individual in need of emergency care;

(6) oxygen therapy;

(7) use of oropharyngeal airways;

(8) use of bag valve masks;

(9) use automated external defibrillators; and

(10) other techniques of preliminary care a first responder is trained to provide as approved by the board.

(b) An individual who holds a valid certificate as a first responder, once completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an emergency medical responder. Alternatively, upon application for renewal of such certificate, such individual shall be deemed to hold a certificate as an
emergency medical responder under this act, provided such individual has
completed all continuing education hour requirements inclusive of a
transition course and such individual shall not be required to file an
original application for certification as an emergency medical responder.

(c) "Renewal" as used in subsection (b), refers to the first opportunity
after December 31, 2011, that an attendant has to apply for renewal of a
certificate.

(d) First responder attendants who fail to meet the transition
requirements as specified will forfeit their certification.

(e) Upon transition, notwithstanding any other provision of law to the
 contrary, an emergency medical responder may perform any of the
following interventions, by use of the devices, medications and equipment,
or any combination thereof, after successfully completing an approved
course of instruction, local specialized device training and competency
validation and when authorized by medical protocols, or upon order when
direct communication is maintained by radio, telephone or video
conference is monitored by a physician, physician assistant when
authorized by a physician, an advanced practice registered nurse when
authorized by a physician, or a licensed professional nurse when authorized
by a physician, upon order of such person: (1) Emergency vehicle
operations; (2) initial scene management; (3) patient assessment and
stabilization; (4) cardiopulmonary resuscitation and airway management;
(5) control of bleeding; (6) extremity splinting; (7) spinal immobilization;
(8) oxygen therapy; (9) use of bag-valve-mask; (10) use of automated
external defibrillator; (11) nebulizer therapy; (12) intramuscular injections
with auto-injector; (13) administration of oral glucose; (14) administration
of aspirin; (15) recognize and comply with advanced directives; (16)
insertion and maintenance of oral and nasal pharyngeal airways; (17) use
of blood glucose monitoring; and (18) other techniques and devices of
preliminary care an emergency medical responder is trained to provide as
approved by the board.

Sec. 31. K.S.A. 2014 Supp. 65-7003 is hereby amended to read as
follows: 65-7003. As used in K.S.A. 65-7001 through 65-7015, and
amendments thereto:

(a) "Act" means the Kansas chemical control act;
(b) "administer" means the application of a regulated chemical
whether by injection, inhalation, ingestion or any other means, directly
into the body of a patient or research subject, such administration to be
conducted by: (1) A practitioner, or in the practitioner's presence, by such
practitioner's authorized agent; or
(2) the patient or research subject at the direction and in the presence
of the practitioner;
(c) "agent or representative" means a person who is authorized to
receive, possess, manufacture or distribute or in any other manner control
or has access to a regulated chemical on behalf of another person;
(d) "bureau" means the Kansas bureau of investigation;
(e) "department" means the Kansas department of health and
environment;
(f) "director" means the director of the Kansas bureau of
investigation;
(g) "dispense" means to deliver a regulated chemical to an ultimate
user, patient or research subject by, or pursuant to the lawful order of, a
practitioner, including the prescribing, administering, packaging, labeling
or compounding necessary to prepare the regulated chemical for that
delivery;
(h) "distribute" means to deliver other than by administering or
dispensing a regulated chemical;
(i) "manufacture" means to produce, prepare, propagate, compound,
convert or process a regulated chemical directly or indirectly, by extraction
from substances of natural origin, chemical synthesis or a combination of
extraction and chemical synthesis, and includes packaging or repackaging
of the substance or labeling or relabeling of its container. The term
excludes the preparation, compounding, packaging, repackaging, labeling
or relabeling of a regulated chemical:
(1) By a practitioner as an incident to the practitioner's administering
or dispensing of a regulated chemical in the course of the practitioner's
professional practice; or
(2) by a practitioner, or by the practitioner's authorized agent under
the practitioner's supervision, for the purpose of, or as an incident to
research, teaching or chemical analysis and not for sale;
(j) "person" means individual, corporation, business trust, estate,
trust, partnership, association, joint venture, government, governmental
subdivision or agency, or any other legal or commercial entity;
(k) "practitioner" means a person licensed to practice medicine and
surgery, pharmacist, dentist, podiatrist, veterinarian, optometrist, advanced
practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
amendments thereto, and who has authority to prescribe drugs in
accordance with K.S.A. 65-1130, and amendments thereto, or scientific
investigator or other person authorized by law to use a controlled
substance in teaching or chemical analysis or to conduct research with
respect to a controlled substance;
(l) "regulated chemical" means a chemical that is used directly or
indirectly to manufacture a controlled substance or other regulated
chemical, or is used as a controlled substance analog, in violation of the
state controlled substances act or this act. The fact that a chemical may be
used for a purpose other than the manufacturing of a controlled substance
or regulated chemical does not exempt it from the provisions of this act. Regulated chemical includes:

(1) Acetic anhydride (CAS No. 108-24-7);
(2) benzaldehyde (CAS No. 100-52-7);
(3) benzyl chloride (CAS No. 100-44-7);
(4) benzyl cyanide (CAS No. 140-29-4);
(5) diethylamine and its salts (CAS No. 109-89-7);
(6) ephedrine, its salts, optical isomers and salts of optical isomers (CAS No. 299-42-3), except products containing ephedra or ma huang, which do not contain any chemically synthesized ephedrine alkaloids, and are lawfully marketed as dietary supplements under federal law;
(7) hydriodic acid (CAS No. 10034-85-2);
(8) iodine (CAS No. 7553-56-2);
(9) lithium (CAS No. 7439-93-2);
(10) methyamine and its salts (CAS No. 74-89-5);
(11) nitroethane (CAS No. 79-24-3);
(12) chloroephedrine, its salts, optical isomers, and salts of optical isomers (CAS No. 30572-91-9);
(13) phenylacetic acid, its esters and salts (CAS No. 103-82-2);
(14) phenylpropanolamine, its salts, optical isomers, and salts of optical isomers (CAS No. 14838-15-4);
(15) piperidine and its salts (CAS No. 110-89-4);
(16) pseudoephedrine, its salts, optical isomers, and salts of optical isomers (CAS No. 90-82-4);
(17) red phosphorous (CAS No. 7723-14-0);
(18) sodium (CAS No. 7440-23-5); and
(19) thionylchloride (CAS No. 7719-09-7);
(20) gamma butyrolactone (GBL), including butyrolactone; butyrolactone gamma; 4-butyrolactone; 2(3H)-furanone dihydro; dihydro-2(3H)-furanone; tetrahydro-2-furanone; 1,2-butanolide; 1,4-butanolide; 4-butanolide; gamma-hydroxybutyric acid lactone; 3-hydroxybutyric acid lactone and 4-hydroxybutanoic acid lactone; CAS No. 96-48-0; and
(21) 1,4 butanediol, including butanediol; butane-1,4-diol; 1,4-butylen glycol; butylene glycol; 1,4-dihydroxybutane; 1,4-tetramethylene glycol; tetramethylene glycol; tetramethylene 1,4-diol; CAS No. 110-63-4;
(m) "regulated chemical distributor" means any person subject to the provisions of the Kansas chemical control act who manufactures or distributes a regulated chemical;
(n) "regulated chemical retailer" means any person who sells regulated chemicals directly to the public;
(o) "regulated chemical transaction" means the manufacture of a regulated chemical or the distribution, sale, exchange or other transfer of a regulated chemical within or into the state or from this state into another
state; and
(p) "secretary" means the secretary of health and environment.
Sec. 32. K.S.A. 2014 Supp. 65-7302 is hereby amended to read as follows: 65-7302. As used in this act:
(a) "Board" means the state board of healing arts.
(b) "Ionizing radiation" means x-rays, gamma rays, alpha and beta particles, high speed electrons, protons, neutrons and other nuclear particles capable of producing ions directly or indirectly in its passage through matter.
(c) "License" means a certificate issued by the board authorizing the licensee to perform radiologic technology procedures on humans for diagnostic or therapeutic purposes.
(d) "Licensed practitioner" means a person licensed to practice medicine and surgery, dentistry, podiatry or, chiropractic or advanced practice registered nursing in this state.
(e) "Licensure" and "licensing" mean a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health related occupation or profession.
(f) "Nuclear medicine technologist" means a person who uses radio pharmaceutical agents on humans for diagnostic or therapeutic purposes.
(g) "Nuclear medicine technology" means the use of radio nuclides on human beings for diagnostic or therapeutic purposes.
(h) "Radiation therapist" means a person who applies radiation to humans for therapeutic purposes.
(i) "Radiation therapy" means the use of any radiation procedure or article intended for the cure, mitigation or prevention of disease in humans.
(j) "Radiographer" means a person who applies radiation to humans for diagnostic purposes.
(k) "Radiography" means the use of ionizing radiation on human beings for diagnostic purposes.
(l) "Radiologic technologist" means any person who is a radiographer, radiation therapist or nuclear medicine technologist.
(m) "Radiologic technology" means the use of radioactive substance or equipment emitting or detecting ionizing radiation on humans for diagnostic or therapeutic purposes upon prescription of a licensed practitioner. The term includes the practice of radiography, nuclear medicine technology and radiation therapy, but does not include echocardiography, diagnostic sonography and magnetic resonance imaging.
(n) This section shall take effect on and after July 1, 2005.
Sec. 33. K.S.A. 2014 Supp. 72-5213 is hereby amended to read as follows: 72-5213. (a) Every board of education shall require all employees
of the school district, who come in regular contact with the pupils of the
school district, to submit a certification of health on a form prescribed by
the secretary of health and environment and signed by a person licensed to
practice medicine and surgery under the laws of any state, or by a person
who is licensed as a physician assistant under the laws of this state when
such person is working at the direction of or in collaboration with a person
licensed to practice medicine and surgery, or by a person holding a license
to practice as an advanced practice registered nurse under the laws of this
state when such person is working at the direction of or in collaboration
with a person licensed to practice medicine and surgery. The certification
shall include a statement that there is no evidence of a physical condition
that would conflict with the health, safety, or welfare of the pupils; and
that freedom from tuberculosis has been established by chest x-ray or
negative tuberculin skin test. If at any time there is reasonable cause to
believe that any such employee of the school district is suffering from an
illness detrimental to the health of the pupils, the school board may require
a new certification of health.

(b) Upon presentation of a signed statement by the employee of a
school district, to whom the provisions of subsection (a) apply, that the
employee is an adherent of a religious denomination whose religious
teachings are opposed to physical examinations, the employee shall be
permitted to submit, as an alternative to the certification of health required
under subsection (a), certification signed by a person licensed to practice
medicine and surgery under the laws of any state, or by a person who is
licensed as a physician assistant under the laws of this state when such
person is working at the direction of or in collaboration with a person
licensed to practice medicine and surgery, or by a person holding a license
to practice as an advanced practice registered nurse under the laws of this
state when such person is working at the direction of or in collaboration
with a person licensed to practice medicine and surgery that freedom of
the employee from tuberculosis has been established.

(c) Every board of education may require persons, other than
employees of the school district, to submit to the same certification of
health requirements as are imposed upon employees of the school district
under the provisions of subsection (a) if such persons perform or provide
services to or for a school district which require such persons to come in
regular contact with the pupils of the school district. No such person shall
be required to submit a certification of health if the person presents a
signed statement that the person is an adherent of a religious denomination
whose religious teachings are opposed to physical examinations. Such
persons shall be permitted to submit, as an alternative to a certification of
health, certification signed by a person licensed to practice medicine and
surgery under the laws of any state, or by a person who is licensed as a
physician assistant under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery, or by a person holding a license to practice as an advanced practice registered nurse under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery that freedom of such persons from tuberculosis has been established.

(d) The expense of obtaining certifications of health and certifications of freedom from tuberculosis may be borne by the board of education.

Sec. 34. K.S.A. 2014 Supp. 75-7429 is hereby amended to read as follows: 75-7429. (a) As used in this section, "medical home" means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, or with an advanced practice registered nurse to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.

(b) The department of health and environment shall incorporate the use of the medical home delivery system within:

(1) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto;

(2) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C. § 1397aa et seq., and amendments thereto; and

(3) the state mediKan program.

(c) The Kansas state employees health care commission established under K.S.A. 75-6502, and amendments thereto, shall incorporate the use of a medical home delivery system within the state health care benefits program as provided in K.S.A. 75-6501 through 75-6523, and amendments thereto. Except that compliance with a medical home delivery system shall not be required of program participants receiving treatment in accordance with a religious method of healing pursuant to the provisions of K.S.A. 2014 Supp. 75-6501, and amendments thereto.


Sec. 36. This act shall take effect and be in force from and after July 1, 2016, and its publication in the statute book.
HB 2122
HOUSE BILL No. 2122

By Committee on Health and Human Services


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

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

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

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

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

(d) Practice of nursing. (1) The practice of professional nursing as performed by a registered professional nurse for compensation or gratuitously, except as permitted by K.S.A. 65-1124, and amendments thereto, means the process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, diagnosis, treatment, counsel and health teaching of persons who are experiencing changes in the normal health processes or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity; administration, supervision or teaching of the process as defined in this section; and the execution of the
medical regimen as prescribed by a person licensed to practice medicine
and surgery—or, a person licensed to practice dentistry or by a person
licensed to practice as an advanced practice registered nurse. (2) The
practice of nursing as a licensed practical nurse means the performance for
compensation or gratuitously, except as permitted by K.S.A. 65-1124, and
any amendments thereto, of tasks and responsibilities defined in part (1) of
this subsection (d)(1) which tasks and responsibilities are based on
acceptable educational preparation within the framework of supportive and
restorative care under the direction of a registered professional nurse, a
person licensed to practice medicine and surgery—or, a person licensed to
practice dentistry or by a person licensed to practice as an advanced
practice registered nurse.

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

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

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

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

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

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

(d) The board shall adopt rules and regulations applicable to
advanced practice registered nurses which:
(1) Establish roles and identify titles and abbreviations of advanced practice registered nurses which are consistent with advanced nursing practice specialties recognized by the nursing profession.

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

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

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

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

(d) (g) An advanced practice registered nurse may prescribe drugs pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced practice registered nurse is authorized to prescribe and shall specify all drugs which may be prescribed by the advanced practice registered nurse. Advanced practice registered nurses are authorized to prescribe, procure and administer prescription drugs and controlled substances pursuant to applicable state and federal laws. Any written prescription order shall include the name, address and telephone number of the responsible physician. The advanced practice registered nurse may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients pursuant to a written protocol as authorized by a responsible physician. In order to prescribe controlled substances, the advanced practice registered nurse shall: (1) Register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians. In no case shall the scope of authority of the advanced practice registered nurse exceed the normal and customary practice of the responsible physician. An advanced practice registered nurse certified in the role of registered nurse anesthetist while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with respect to drugs and anesthetic agents and shall not be subject to the
provisions of this subsection. For the purposes of this subsection, "responsible physician" means a person licensed to practice medicine and surgery in Kansas who has accepted responsibility for the protocol and the actions of the advanced practice registered nurse when prescribing drugs.

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

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

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

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

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

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

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

(7) The board may adopt rules and regulations necessary to carry out the provisions of this subsection.
(8) An advanced practice registered nurse functioning in the role of registered nurse anesthetist shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, and shall not be subject to the provisions of this subsection.

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

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

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

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

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

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

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

(1) "Adult care home" means any nursing facility, nursing facility for mental health, intermediate care facility for people with intellectual disability, assisted living facility, residential health care facility, home plus, boarding care home and adult day care facility; all of which are
classifications of adult care homes and are required to be licensed by the
secretary for aging and disability services.
(2) "Nursing facility" means any place or facility operating 24 hours a
day, seven days a week, caring for six or more individuals not related
within the third degree of relationship to the administrator or owner by
blood or marriage and who, due to functional impairments, need skilled
nursing care to compensate for activities of daily living limitations.
(3) "Nursing facility for mental health" means any place or facility
operating 24 hours a day, seven days a week, caring for six or more
individuals not related within the third degree of relationship to the
administrator or owner by blood or marriage and who, due to functional
impairments, need skilled nursing care and special mental health services
to compensate for activities of daily living limitations.
(4) "Intermediate care facility for people with intellectual disability"
means any place or facility operating 24 hours a day, seven days a week,
caring for four or more individuals not related within the third degree of
relationship to the administrator or owner by blood or marriage and who,
due to functional impairments caused by intellectual disability or related
conditions, need services to compensate for activities of daily living
limitations.
(5) "Assisted living facility" means any place or facility caring for six
or more individuals not related within the third degree of relationship to
the administrator, operator or owner by blood or marriage and who, by
choice or due to functional impairments, may need personal care and may
need supervised nursing care to compensate for activities of daily living
limitations and in which the place or facility includes apartments for
residents and provides or coordinates a range of services including
personal care or supervised nursing care available 24 hours a day, seven
days a week, for the support of resident independence. The provision of
skilled nursing procedures to a resident in an assisted living facility is not
prohibited by this act. Generally, the skilled services provided in an
assisted living facility shall be provided on an intermittent or limited term
basis, or if limited in scope, a regular basis.
(6) "Residential health care facility" means any place or facility, or a
contiguous portion of a place or facility, caring for six or more individuals
not related within the third degree of relationship to the administrator,
operator or owner by blood or marriage and who, by choice or due to
functional impairments, may need personal care and may need supervised
nursing care to compensate for activities of daily living limitations and in
which the place or facility includes individual living units and provides or
coordinates personal care or supervised nursing care available on a 24-
hour, seven-days-a-week basis for the support of resident independence.
The provision of skilled nursing procedures to a resident in a residential
health care facility is not prohibited by this act. Generally, the skilled
services provided in a residential health care facility shall be provided on
an intermittent or limited term basis, or if limited in scope, a regular basis.

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

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

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

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

(11) "Skilled nursing care" means services performed by or under the
immediate supervision of a registered professional nurse and additional
licensed nursing personnel. Skilled nursing includes administration of
medications and treatments as prescribed by a licensed physician,
advanced practice registered nurse or dentist; and other nursing functions
which require substantial nursing judgment and skill based on the
knowledge and application of scientific principles.
(12) "Supervised nursing care" means services provided by or under the guidance of a licensed nurse with initial direction for nursing procedures and periodic inspection of the actual act of accomplishing the procedures; administration of medications and treatments as prescribed by a licensed physician, advanced practice registered nurse or dentist and assistance of residents with the performance of activities of daily living.

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

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

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

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

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

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

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

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

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

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

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

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

(25) "Kitchen" means a food preparation area that includes a sink, refrigerator and a microwave oven or stove.
The term "intermediate personal care home" for purposes of those individuals applying for or receiving veterans' benefits means residential health care facility.

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

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

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

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

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

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

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

The licensing agency may by rule and regulation change the name of the different classes of homes when necessary to avoid confusion in terminology and the agency may further amend, substitute, change and in a
manner consistent with the definitions established in this section, further
define and identify the specific acts and services which shall fall within the
descriptive categories of facilities so long as the above categories for adult
care homes are used as guidelines to define and identify the specific acts.
Sec. 4. K.S.A. 2014 Supp. 39-1401 is hereby amended to read as
follows: 39-1401. As used in this act:
(a) "Resident" means:
   (1) Any resident, as defined by K.S.A. 39-923, and amendments
       thereto; or
   (2) any individual kept, cared for, treated, boarded or otherwise
       accommodated in a medical care facility; or
   (3) any individual, kept, cared for, treated, boarded or otherwise
       accommodated in a state psychiatric hospital or state institution for people
       with intellectual disability.
(b) "Adult care home" has the meaning ascribed thereto in K.S.A. 39-
    923, and amendments thereto.
(c) "In need of protective services" means that a resident is unable to
    perform or obtain services which are necessary to maintain physical or
    mental health, or both.
(d) "Services which are necessary to maintain physical and mental
    health" include, but are not limited to, the provision of medical care for
    physical and mental health needs, the relocation of a resident to a facility
    or institution able to offer such care, assistance in personal hygiene, food,
    clothing, adequately heated and ventilated shelter, protection from health
    and safety hazards, protection from maltreatment the result of which
    includes, but is not limited to, malnutrition, deprivation of necessities or
    physical punishment and transportation necessary to secure any of the
    above stated needs, except that this term shall not include taking such
    person into custody without consent, except as provided in this act.
(e) "Protective services" means services provided by the state or other
    governmental agency or any private organizations or individuals which are
    necessary to prevent abuse, neglect or exploitation. Such protective
    services shall include, but not be limited to, evaluation of the need for
    services, assistance in obtaining appropriate social services and assistance
    in securing medical and legal services.
(f) "Abuse" means any act or failure to act performed intentionally or
    recklessly that causes or is likely to cause harm to a resident, including:
       (1) Infliction of physical or mental injury;
       (2) any sexual act with a resident when the resident does not consent
           or when the other person knows or should know that the resident is
           incapable of resisting or declining consent to the sexual act due to mental
           deficiency or disease or due to fear of retribution or hardship;
       (3) unreasonable use of a physical restraint, isolation or medication
that harms or is likely to harm a resident;

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

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

(6) fiduciary abuse; or

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

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

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

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

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

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

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

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

(n) "Report" means a description or accounting of an incident or incidents of abuse, neglect or exploitation under this act and for the purposes of this act shall not include any written assessment or findings.
"Law enforcement" means the public office which is vested by law with the duty to maintain public order, make arrests for crimes and investigate criminal acts, whether that duty extends to all crimes or is limited to specific crimes.

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

"Financial institution" means any bank, trust company, escrow company, finance company, saving institution or credit union, chartered and supervised under state or federal law.

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

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

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

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

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

(1) Infliction of physical or mental injury;
(2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable of resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship;
(3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to harm an adult;
(4) unreasonable use of a physical or chemical restraint, medication or isolation as punishment, for convenience, in conflict with a physician's or advanced practice registered nurse's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult;

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

(6) fiduciary abuse; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Sleeping rooms shall have space for personal items.

(8) Each client shall have a bed which is clean and in good condition.

(9) Lavatory and toilet facilities shall be accessible, available and in working order.

(10) The kitchen shall be clean with appliances in good working
(b) (1) A healthy and safe environment shall be maintained for clients.
(2) There shall be a telephone in the home.
(3) The provider may assist a client with the taking of medications when the medication is in a labeled bottle which clearly shows a physician's orders or an advanced practice registered nurse's orders and when the client requires assistance because of tremor, visual impairment, or similar reasons due to health conditions. The provider may assist or perform for the client such physical activities which do not require daily supervision such as assistance with eating, bathing and dressing, help with brace or walker and transferring from wheelchairs.
(4) There shall be no use of corporal punishment, restraints or punitive measures.
(5) The house shall be free from accumulated dirt, trash and vermin.
(6) Meals shall be planned and prepared for adequate nutrition, and for diets if directed by a physician.

(c) (1) The provider shall be at least 18 years of age and in good health at the time of initial application for registration. A written statement must be received from a physician, nurse practitioner, or physician assistant stating that the applicant and the members of the applicant's household are free of any infectious or communicable disease or health condition and are physically and mentally healthy. Such statements shall be renewed every two years.
(2) The provider shall not be totally dependent on the income from the clients for support of the provider or the provider's family.
(3) A criminal conviction shall not necessarily exclude registration as an adult family home; but an investigation thereof will be made as part of the determination of the suitability of the home.
(4) The provider shall be responsible for supervision at all times and shall be in charge of the home and provision of care, or shall have a responsible person on call. Any such substitute responsible person shall meet the same requirements as the provider.
(5) The provider is responsible for encouraging the client to seek and utilize available services when needed.
(6) The provider shall comply with the requirements of state and federal regulations concerning civil rights and section 504 of the federal rehabilitation act of 1973.
(7) The provider shall assure that clients have the privilege of privacy as well as the right to see relatives, friends and participate in regular community activities.
(8) The provider shall keep client information confidential. The use or disclosure of any information concerning a client for any purpose is
prohibited except on written consent of the client or upon order of the court.

(9) The provider shall maintain contact with an assigned social worker and shall allow the secretary and authorized representatives of the secretary access to the home and grounds and to the records related to clients in residence.

(10) The provider shall inform the social worker immediately of any unscheduled client absence from the home.

(11) The provider is responsible for helping clients maintain their clothing.

(12) The provider shall furnish or help clients arrange for transportation.

(13) The provider shall help a client arrange for emergency and regular medical care when necessary.

(14) The provider shall submit any information relating to the operation of the adult family home which is required by the secretary.

Sec. 7. K.S.A. 40-4602 is hereby amended to read as follows: 40-4602. As used in this act:

(a) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(b) "Emergency services" means ambulance services and health care items and services furnished or required to evaluate and treat an emergency medical condition, as directed or ordered by a physician or an advanced practice registered nurse.

(c) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, a plan provided by a municipal group-funded pool, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(d) "Health insurer" means any insurance company, nonprofit medical
and hospital service corporation, municipal group-funded pool, fraternal
benefit society, health maintenance organization, or any other entity which
offers a health benefit plan subject to the Kansas Statutes Annotated.

(e) "Insured" means a person who is covered by a health benefit plan.

(f) "Participating provider" means a provider who, under a contract
with the health insurer or with its contractor or subcontractor, has agreed
to provide one or more health care services to insureds with an expectation
of receiving payment, other than coinsurance, copayments or deductibles,
directly or indirectly from the health insurer.

(g) "Provider" means a physician, advanced practice registered nurse,
hospital or other person which is licensed, accredited or certified to
perform specified health care services.

(h) "Provider network" means those participating providers who have
entered into a contract or agreement with a health insurer to provide items
or health care services to individuals covered by a health benefit plan
offered by such health insurer.

(i) "Physician" means a person licensed by the state board of healing
arts to practice medicine and surgery.

Sec. 8. K.S.A. 59-2976 is hereby amended to read as follows: 59-
2976. (a) Medications and other treatments shall be prescribed, ordered
and administered only in conformity with accepted clinical practice.
Medication shall be administered only upon the written order of a
physician or an advanced practice registered nurse or upon a verbal order
noted in the patient's medical records and subsequently signed by the
physician or an advanced practice registered nurse. The attending
physician or an advanced practice registered nurse shall review regularly
the drug regimen of each patient under the physician's or an advanced
practice registered nurse's care and shall monitor any symptoms of
harmful side effects. Prescriptions for psychotropic medications shall be
written with a termination date not exceeding 30 days thereafter but may
be renewed.

(b) During the course of treatment the responsible physician, an
advanced practice registered nurse or psychologist or such person's
designee shall reasonably consult with the patient, the patient's legal
guardian, or a minor patient's parent and give consideration to the views
the patient, legal guardian or parent expresses concerning treatment and
any alternatives. No medication or other treatment may be administered to
any voluntary patient without the patient's consent, or the consent of such
patient's legal guardian or of such patient's parent if the patient is a minor.

(c) Consent for medical or surgical treatments not intended primarily
to treat a patient's mental disorder shall be obtained in accordance with
applicable law.

(d) Whenever any patient is receiving treatment pursuant to K.S.A.
59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments thereto, and the treatment facility is administering to the patient any medication or other treatment which alters the patient's mental state in such a way as to adversely affect the patient's judgment or hamper the patient in preparing for or participating in any hearing provided for by this act, then two days prior to and during any such hearing, the treatment facility may not administer such medication or other treatment unless such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others. Prior to the hearing, a report of all such medications or other treatment which have been administered to the patient, along with a copy of any written consent(s) which the patient may have signed, shall be submitted to the court. Counsel for the patient may preliminarily examine the attending physician regarding the administration of any medication to the patient within two days of the hearing with regard to the affect that medication may have had upon the patient's judgment or ability to prepare for or participate in the hearing. On the basis thereof, if the court determines that medication or other treatment has been administered which adversely affects the patient's judgment or ability to prepare for or participate in the hearing, the court may grant to the patient a reasonable continuance in order to allow for the patient to be better able to prepare for or participate in the hearing and the court shall order that such medication or other treatment be discontinued until the conclusion of the hearing, unless the court finds that such medication or other treatment is necessary to sustain the patient's life or to protect the patient or others, in which case the court shall order that the hearing proceed.

(e) Whenever a patient receiving treatment pursuant to K.S.A. 59-2954, 59-2958, 59-2959, 59-2964, 59-2966 or 59-2967, and amendments thereto, objects to taking any medication prescribed for psychiatric treatment, and after full explanation of the benefits and risks of such medication continues their objection, the medication may be administered over the patient's objection; except that the objection shall be recorded in the patient's medical record and at the same time written notice thereof shall be forwarded to the medical director of the treatment facility or the director's designee. Within five days after receiving such notice, excluding Saturdays, Sundays and legal holidays, the medical director or designee shall deliver to the patient and the patient's physician the medical director's or designee's written decision concerning the administration of that medication, and a copy of that decision shall be placed in the patient's medical record.

(f) In no case shall experimental medication be administered without the patient's consent, which consent shall be obtained in accordance with subsection (a)(6) of K.S.A. 59-2978(a)(6), and amendments thereto.

Sec. 9. K.S.A. 2014 Supp. 65-468 is hereby amended to read as
follows: 65-468. As used in K.S.A. 65-468 to 65-474, inclusive, and amendments thereto:

(a) "Health care provider" means any person licensed or otherwise authorized by law to provide health care services in this state or a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by law to form such corporation and who are health care providers as defined by this subsection, or an officer, employee or agent thereof, acting in the course and scope of employment or agency.

(b) "Member" means any hospital, emergency medical service, local health department, home health agency, adult care home, medical clinic, mental health center or clinic or nonemergency transportation system.

(c) "Mid-level practitioner" means a physician assistant or advanced practice registered nurse who has entered into a written protocol with a rural health network physician.

(d) "Advanced practice registered nurse" means an advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto.

(e) "Physician" means a person licensed to practice medicine and surgery.

(f) "Rural health network" means an alliance of members including at least one critical access hospital and at least one other hospital which has developed a comprehensive plan submitted to and approved by the secretary of health and environment regarding patient referral and transfer; the provision of emergency and nonemergency transportation among members; the development of a network-wide emergency services plan; and the development of a plan for sharing patient information and services between hospital members concerning medical staff credentialing, risk management, quality assurance and peer review.

(g) "Critical access hospital" means a member of a rural health network which makes available twenty-four hour emergency care services; provides not more than 25 acute care inpatient beds or in the case of a facility with an approved swing-bed agreement a combined total of extended care and acute care beds that does not exceed 25 beds; provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient; and provides nursing services under the direction of a licensed professional nurse and continuous licensed professional nursing services for not less than 24 hours of every day when any bed is occupied or the facility is open to provide services for patients unless an exemption is granted by the licensing agency pursuant to rules and regulations. The critical access hospital may provide any services otherwise required to be provided by a full-time, on-site dietitian,
pharmacist, laboratory technician, medical technologist and radiological
technologist on a part-time, off-site basis under written agreements or
arrangements with one or more providers or suppliers recognized under
medicare. The critical access hospital may provide inpatient services by a
physician assistant, advanced practice registered nurse or a clinical nurse
specialist subject to the oversight of a physician who need not be present
in the facility or by an advanced practice registered nurse. In addition to
the facility's 25 acute beds or swing beds, or both, the critical access
hospital may have a psychiatric unit or a rehabilitation unit, or both. Each
unit shall not exceed 10 beds and neither unit will count toward the 25-bed
limit, nor will these units be subject to the average 96-hour length of stay
restriction.

(h) "Hospital" means a hospital other than a critical access
hospital which has entered into a written agreement with at least one
critical access hospital to form a rural health network and to provide
medical or administrative supporting services within the limit of the
hospital's capabilities.

Sec. 10. K.S.A. 2014 Supp. 65-507 is hereby amended to read as
follows: 65-507. (a) Each maternity center licensee shall keep a record
upon forms prescribed and provided by the secretary of health and
environment and the secretary for children and families which shall
include the name of every patient, together with the patient's place of
residence during the year preceding admission to the center and the name
and address of the attending physician or advanced practice registered
nurse in the classification of a nurse-midwife. Each child care facility
licensee shall keep a record upon forms prescribed and provided by the
secretary of health and environment which shall include the name and age
of each child received and cared for in the facility; the name of the
physician who attended any sick children in the facility, together with the
names and addresses of the parents or guardians of such children; and such
other information as the secretary of health and environment or secretary
for children and families may require. Each maternity center licensee and
each child care facility licensee shall apply to and shall receive without
charge from the secretary of health and environment and the secretary for
children and families forms for such records as may be required, which
forms shall contain a copy of this act.

(b) Information obtained under this section shall be confidential and
shall not be made public in a manner which would identify individuals.

Sec. 11. K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
read as follows: 65-1626. For the purposes of this act:

(a) "Administer" means the direct application of a drug, whether by
injection, inhalation, ingestion or any other means, to the body of a patient
or research subject by:

(1) A practitioner or pursuant to the lawful direction of a practitioner;
(2) the patient or research subject at the direction and in the presence
of the practitioner; or
(3) a pharmacist as authorized in K.S.A. 65-1635a, and amendments
thereto.

(b) "Agent" means an authorized person who acts on behalf of or at
the direction of a manufacturer, distributor or dispenser but shall not
include a common carrier, public warehouseman or employee of the
carrier or warehouseman when acting in the usual and lawful course of the
carrier's or warehouseman's business.

(c) "Application service provider" means an entity that sells
electronic prescription or pharmacy prescription applications as a hosted
service where the entity controls access to the application and maintains
the software and records on its server.

(d) "Authorized distributor of record" means a wholesale distributor
with whom a manufacturer has established an ongoing relationship to
distribute the manufacturer's prescription drug. An ongoing relationship is
deemed to exist between such wholesale distributor and a manufacturer
when the wholesale distributor, including any affiliated group of the
wholesale distributor, as defined in section 1504 of the internal revenue
code, complies with any one of the following: (1) The wholesale
distributor has a written agreement currently in effect with the
manufacturer evidencing such ongoing relationship; and (2) the wholesale
distributor is listed on the manufacturer's current list of authorized
distributors of record, which is updated by the manufacturer on no less
than a monthly basis.

(e) "Board" means the state board of pharmacy created by K.S.A. 74-
1603, and amendments thereto.

(f) "Brand exchange" means the dispensing of a different drug
product of the same dosage form and strength and of the same generic
name as the brand name drug product prescribed.

(g) "Brand name" means the registered trademark name given to a
drug product by its manufacturer, labeler or distributor.

(h) "Chain pharmacy warehouse" means a permanent physical
location for drugs or devices, or both, that acts as a central warehouse and
performs intracompany sales or transfers of prescription drugs or devices
to chain pharmacies that have the same ownership or control. Chain
pharmacy warehouses must be registered as wholesale distributors.

(i) "Co-licensee" means a pharmaceutical manufacturer that has
entered into an agreement with another pharmaceutical manufacturer to
engage in a business activity or occupation related to the manufacture or
distribution of a prescription drug and the national drug code on the drug
product label shall be used to determine the identity of the drug manufacturer.

(j) "DEA" means the U.S. department of justice, drug enforcement administration.

(k) "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another of any drug whether or not an agency relationship exists.

(l) "Direct supervision" means the process by which the responsible pharmacist shall observe and direct the activities of a pharmacy student or pharmacy technician to a sufficient degree to assure that all such activities are performed accurately, safely and without risk or harm to patients, and complete the final check before dispensing.

(m) "Dispense" means to deliver prescription medication to the ultimate user or research subject by or pursuant to the lawful order of a practitioner or pursuant to the prescription of a mid-level practitioner.

(n) "Dispenser" means a practitioner or pharmacist who dispenses prescription medication, or a physician assistant who has authority to dispense prescription-only drugs in accordance with subsection (b) of K.S.A. 65-28a08(b), and amendments thereto.

(o) "Distribute" means to deliver, other than by administering or dispensing, any drug.

(p) "Distributor" means a person who distributes a drug.

(q) "Drop shipment" means the sale, by a manufacturer, that manufacturer's co-licensee, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, of the manufacturer's prescription drug, to a wholesale distributor whereby the wholesale distributor takes title but not possession of such prescription drug and the wholesale distributor invoices the pharmacy, the chain pharmacy warehouse, or other designated person authorized by law to dispense or administer such prescription drug, and the pharmacy, the chain pharmacy warehouse, or other designated person authorized by law to dispense or administer such prescription drug receives delivery of the prescription drug directly from the manufacturer, that manufacturer's co-licensee, that manufacturer's third party logistics provider, or that manufacturer's exclusive distributor, of such prescription drug. Drop shipment shall be part of the "normal distribution channel."

(r) "Drug" means: (1) Articles recognized in the official United States pharmacopoeia, or other such official compendiums of the United States, or official national formulary, or any supplement of any of them; (2) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals; (3) articles, other than food, intended to affect the structure or any function of the body of man or other animals; and (4) articles intended for use as a component of any articles
specified in clause (1), (2) or (3) of this subsection; but does not include
devices or their components, parts or accessories, except that the term
"drug" shall not include amygdalin (laetrile) or any livestock remedy, if
such livestock remedy had been registered in accordance with the
provisions of article 5 of chapter 47 of the Kansas Statutes Annotated,
prior to its repeal.

(s) "Durable medical equipment" means technologically sophisticated
medical devices that may be used in a residence, including the following:
(1) Oxygen and oxygen delivery system; (2) ventilators; (3) respiratory
disease management devices; (4) continuous positive airway pressure
(CPAP) devices; (5) electronic and computerized wheelchairs and seating
systems; (6) apnea monitors; (7) transcutaneous electrical nerve stimulator
(TENS) units; (8) low air loss cutaneous pressure management devices; (9)
sequential compression devices; (10) feeding pumps; (11) home
phototherapy devices; (12) infusion delivery devices; (13) distribution of
medical gases to end users for human consumption; (14) hospital beds;
(15) nebulizers; or (16) other similar equipment determined by the board
in rules and regulations adopted by the board.

(t) "Electronic prescription" means an electronically prepared
prescription that is authorized and transmitted from the prescriber to the
pharmacy by means of electronic transmission.

(u) "Electronic prescription application" means software that is used
to create electronic prescriptions and that is intended to be installed on the
prescriber's computers and servers where access and records are controlled
by the prescriber.

(v) "Electronic signature" means a confidential personalized digital
key, code, number or other method for secure electronic data transmissions
which identifies a particular person as the source of the message,
authenticates the signatory of the message and indicates the person's
approval of the information contained in the transmission.

(w) "Electronic transmission" means the transmission of an electronic
prescription, formatted as an electronic data file, from a prescriber's
electronic prescription application to a pharmacy's computer, where the
data file is imported into the pharmacy prescription application.

(x) "Electronically prepared prescription" means a prescription that is
generated using an electronic prescription application.

(y) "Exclusive distributor" means any entity that: (1) Contracts with a
manufacturer to provide or coordinate warehousing, wholesale distribution
or other services on behalf of a manufacturer and who takes title to that
manufacturer's prescription drug, but who does not have general
responsibility to direct the sale or disposition of the manufacturer's
prescription drug; (2) is registered as a wholesale distributor under the
pharmacy act of the state of Kansas; and (3) to be considered part of the
normal distribution channel, must be an authorized distributor of record.

(z) "Facsimile transmission" or "fax transmission" means the transmission of a digital image of a prescription from the prescriber or the prescriber's agent to the pharmacy. "Facsimile transmission" includes, but is not limited to, transmission of a written prescription between the prescriber's fax machine and the pharmacy's fax machine; transmission of an electronically prepared prescription from the prescriber's electronic prescription application to the pharmacy's fax machine, computer or printer; or transmission of an electronically prepared prescription from the prescriber's fax machine to the pharmacy's fax machine, computer or printer.

(aa) "Generic name" means the established chemical name or official name of a drug or drug product.

(bb) (1) "Institutional drug room" means any location where prescription-only drugs are stored and from which prescription-only drugs are administered or dispensed and which is maintained or operated for the purpose of providing the drug needs of:

(A) Inmates of a jail or correctional institution or facility;
(B) residents of a juvenile detention facility, as defined by the revised Kansas code for care of children and the revised Kansas juvenile justice code;
(C) students of a public or private university or college, a community college or any other institution of higher learning which is located in Kansas;
(D) employees of a business or other employer; or
(E) persons receiving inpatient hospice services.

(2) "Institutional drug room" does not include:

(A) Any registered pharmacy;
(B) any office of a practitioner; or
(C) a location where no prescription-only drugs are dispensed and no prescription-only drugs other than individual prescriptions are stored or administered.

(cc) "Intermediary" means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

(dd) "Intracompany transaction" means any transaction or transfer between any division, subsidiary, parent or affiliated or related company under common ownership or control of a corporate entity, or any transaction or transfer between co-licensees of a co-licensed product.

(ee) "Medical care facility" shall have the meaning provided in K.S.A. 65-425, and amendments thereto, except that the term shall also include facilities licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, except community mental health centers and
facilities for people with intellectual disability.

(ff) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a drug either directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the drug or labeling or relabeling of its container, except that this term shall not include the preparation or compounding of a drug by an individual for the individual's own use or the preparation, compounding, packaging or labeling of a drug by:

1. A practitioner or a practitioner's authorized agent incident to such practitioner's administering or dispensing of a drug in the course of the practitioner's professional practice;
2. A practitioner, by a practitioner's authorized agent or under a practitioner's supervision for the purpose of, or as an incident to, research, teaching or chemical analysis and not for sale; or
3. A pharmacist or the pharmacist's authorized agent acting under the direct supervision of the pharmacist for the purpose of, or incident to, the dispensing of a drug by the pharmacist.

(gg) "Manufacturer" means a person licensed or approved by the FDA to engage in the manufacture of drugs and devices.

(hh) "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 pursuant to 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.

(ii) "Normal distribution channel" means a chain of custody for a prescription-only drug that goes from a manufacturer of the prescription-only drug, from that manufacturer to that manufacturer's co-licensed partner, from that manufacturer to that manufacturer's third-party logistics provider, or from that manufacturer to that manufacturer's exclusive distributor, directly or by drop shipment, to:

1. A pharmacy to a patient or to other designated persons authorized by law to dispense or administer such drug to a patient;
2. A wholesale distributor to a pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug to a patient;
3. A wholesale distributor to a chain pharmacy warehouse to that chain pharmacy warehouse's intracompany pharmacy to a patient or other designated persons authorized by law to dispense or administer such drug
to a patient; or

(4) a chain pharmacy warehouse to the chain pharmacy warehouse's
intra-company pharmacy to a patient or other designated persons authorized
by law to dispense or administer such drug to a patient.

(jj) "Person" means individual, corporation, government,
governmental subdivision or agency, partnership, association or any other
legal entity.

(kk) "Pharmacist" means any natural person licensed under this act to
practice pharmacy.

(ll) "Pharmacist-in-charge" means the pharmacist who is responsible
to the board for a registered establishment's compliance with the laws and
regulations of this state pertaining to the practice of pharmacy,
manufacturing of drugs and the distribution of drugs. The pharmacist-in-
charge shall supervise such establishment on a full-time or a part-time
basis and perform such other duties relating to supervision of a registered
establishment as may be prescribed by the board by rules and regulations.
Nothing in this definition shall relieve other pharmacists or persons from
their responsibility to comply with state and federal laws and regulations.

(mm) "Pharmacist intern" means: (1) A student currently enrolled in
an accredited pharmacy program; (2) a graduate of an accredited pharmacy
program serving an internship; or (3) a graduate of a pharmacy program
located outside of the United States which is not accredited and who has
successfully passed equivalency examinations approved by the board.

(nn) "Pharmacy," "drugstore" or "apothecary" means premises,
laboratory, area or other place: (1) Where drugs are offered for sale where
the profession of pharmacy is practiced and where prescriptions are
compounded and dispensed; or (2) which has displayed upon it or within it
the words "pharmacist," "pharmaceutical chemist," "pharmacy,
apothecary," "drugstore," "druggist," "drugs," "drug sundries" or any of
these words or combinations of these words or words of similar import
either in English or any sign containing any of these words; or (3) where
the characteristic symbols of pharmacy or the characteristic prescription
sign "Rx" may be exhibited. As used in this subsection, premises refers
only to the portion of any building or structure leased, used or controlled
by the licensee in the conduct of the business registered by the board at the
address for which the registration was issued.

(oo) "Pharmacy prescription application" means software that is used
to process prescription information, is installed on a pharmacy's computers
or servers, and is controlled by the pharmacy.

(pp) "Pharmacy technician" means an individual who, under the
direct supervision and control of a pharmacist, may perform packaging,
manipulative, repetitive or other nondiscretionary tasks related to the
processing of a prescription or medication order and who assists the
pharmacist in the performance of pharmacy related duties, but who does not perform duties restricted to a pharmacist.

(qq) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, a registered nurse anesthetist registered pursuant to K.S.A. 65-1154, and amendments thereto, or scientific investigator or other person authorized by law to use a prescription-only drug in teaching or chemical analysis or to conduct research with respect to a prescription-only drug.

(rr) "Preceptor" means a licensed pharmacist who possesses at least two years' experience as a pharmacist and who supervises students obtaining the pharmaceutical experience required by law as a condition to taking the examination for licensure as a pharmacist.

(ss) "Prescriber" means a practitioner or a mid-level practitioner.

(tt) "Prescription" or "prescription order" means: (1) An order to be filled by a pharmacist for prescription medication issued and signed by a prescriber in the authorized course of such prescriber's professional practice; or (2) an order transmitted to a pharmacist through word of mouth, note, telephone or other means of communication directed by such prescriber, regardless of whether the communication is oral, electronic, facsimile or in printed form.

(uu) "Prescription medication" means any drug, including label and container according to context, which is dispensed pursuant to a prescription order.

(vv) "Prescription-only drug" means any drug whether intended for use by man or animal, required by federal or state law, including 21 U.S.C. § 353, to be dispensed only pursuant to a written or oral prescription or order of a practitioner or is restricted to use by practitioners only.

(ww) "Probation" means the practice or operation under a temporary license, registration or permit or a conditional license, registration or permit of a business or profession for which a license, registration or permit is granted by the board under the provisions of the pharmacy act of the state of Kansas requiring certain actions to be accomplished or certain actions not to occur before a regular license, registration or permit is issued.

(xx) "Professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of pharmaceutical care to a degree which constitutes gross negligence, as determined by the board;

(2) repeated instances involving failure to adhere to the applicable standard of pharmaceutical care to a degree which constitutes ordinary
negligence, as determined by the board; or

(3) a pattern of pharmacy practice or other behavior which demonstrates a manifest incapacity or incompetence to practice pharmacy.

(yy) "Readily retrievable" means that records kept by automatic data processing applications or other electronic or mechanized record-keeping systems can be separated out from all other records within a reasonable time not to exceed 48 hours of a request from the board or other authorized agent or that hard-copy records are kept on which certain items are asterisked, redlined or in some other manner visually identifiable apart from other items appearing on the records.

(zz) "Retail dealer" means a person selling at retail nonprescription drugs which are prepackaged, fully prepared by the manufacturer or distributor for use by the consumer and labeled in accordance with the requirements of the state and federal food, drug and cosmetic acts. Such nonprescription drugs shall not include: (1) A controlled substance; (2) a prescription-only drug; or (3) a drug intended for human use by hypodermic injection.

(aaa) "Secretary" means the executive secretary of the board.

(bbb) "Third party logistics provider" means an entity that: (1) Provides or coordinates warehousing, distribution or other services on behalf of a manufacturer, but does not take title to the prescription drug or have general responsibility to direct the prescription drug's sale or disposition; (2) is registered as a wholesale distributor under the pharmacy act of the state of Kansas; and (3) to be considered part of the normal distribution channel, must also be an authorized distributor of record.

(ccc) "Unprofessional conduct" means:

(1) Fraud in securing a registration or permit;
(2) intentional adulteration or mislabeling of any drug, medicine, chemical or poison;
(3) causing any drug, medicine, chemical or poison to be adulterated or mislabeled, knowing the same to be adulterated or mislabeled;
(4) intentionally falsifying or altering records or prescriptions;
(5) unlawful possession of drugs and unlawful diversion of drugs to others;
(6) willful betrayal of confidential information under K.S.A. 65-1654, and amendments thereto;
(7) conduct likely to deceive, defraud or harm the public;
(8) making a false or misleading statement regarding the licensee's professional practice or the efficacy or value of a drug;
(9) commission of any act of sexual abuse, misconduct or exploitation related to the licensee's professional practice; or
(10) performing unnecessary tests, examinations or services which have no legitimate pharmaceutical purpose.
"Vaccination protocol" means a written protocol, agreed to by a pharmacist and a person licensed to practice medicine and surgery by the state board of healing arts, which establishes procedures and recordkeeping and reporting requirements for administering a vaccine by the pharmacist for a period of time specified therein, not to exceed two years.

"Valid prescription order" means a prescription that is issued for a legitimate medical purpose by an individual prescriber licensed by law to administer and prescribe drugs and acting in the usual course of such prescriber's professional practice. A prescription issued solely on the basis of an internet-based questionnaire or consultation without an appropriate prescriber-patient relationship is not a valid prescription order.

"Veterinary medical teaching hospital pharmacy" means any location where prescription-only drugs are stored as part of an accredited college of veterinary medicine and from which prescription-only drugs are distributed for use in treatment of or administration to a nonhuman.

"Wholesale distributor" means any person engaged in wholesale distribution of prescription drugs or devices in or into the state, including, but not limited to, manufacturers, repackagers, own-label distributors, private-label distributors, jobbers, brokers, warehouses, including manufacturers' and distributors' warehouses, co-licensees, exclusive distributors, third party logistics providers, chain pharmacy warehouses that conduct wholesale distributions, and wholesale drug warehouses, independent wholesale drug traders and retail pharmacies that conduct wholesale distributions. Wholesale distributor shall not include persons engaged in the sale of durable medical equipment to consumers or patients.

"Wholesale distribution" means the distribution of prescription drugs or devices by wholesale distributors to persons other than consumers or patients, and includes the transfer of prescription drugs by a pharmacy to another pharmacy if the total number of units of transferred drugs during a twelve-month period does not exceed 5% of the total number of all units dispensed by the pharmacy during the immediately preceding twelve-month period. Wholesale distribution does not include:

1. The sale, purchase or trade of a prescription drug or device, an offer to sell, purchase or trade a prescription drug or device or the dispensing of a prescription drug or device pursuant to a prescription;
2. the sale, purchase or trade of a prescription drug or device or an offer to sell, purchase or trade a prescription drug or device for emergency medical reasons;
3. intracompany transactions, as defined in this section, unless in violation of own use provisions;
4. the sale, purchase or trade of a prescription drug or device or an
offer to sell, purchase or trade a prescription drug or device among
hospitals, chain pharmacy warehouses, pharmacies or other health care
entities that are under common control;
(5) the sale, purchase or trade of a prescription drug or device or the
offer to sell, purchase or trade a prescription drug or device by a charitable
organization described in 503(c)(3) of the internal revenue code of 1954 to
a nonprofit affiliate of the organization to the extent otherwise permitted
by law;
(6) the purchase or other acquisition by a hospital or other similar
health care entity that is a member of a group purchasing organization of a
prescription drug or device for its own use from the group purchasing
organization or from other hospitals or similar health care entities that are
members of these organizations;
(7) the transfer of prescription drugs or devices between pharmacies
pursuant to a centralized prescription processing agreement;
(8) the sale, purchase or trade of blood and blood components
intended for transfusion;
(9) the return of recalled, expired, damaged or otherwise non-salable
prescription drugs, when conducted by a hospital, health care entity,
pharmacy, chain pharmacy warehouse or charitable institution in
accordance with the board's rules and regulations;
(10) the sale, transfer, merger or consolidation of all or part of the
business of a retail pharmacy or pharmacies from or with another retail
pharmacy or pharmacies, whether accomplished as a purchase and sale of
stock or business assets, in accordance with the board's rules and
regulations;
(11) the distribution of drug samples by manufacturers' and
authorized distributors' representatives;
(12) the sale of minimal quantities of drugs by retail pharmacies to
licensed practitioners for office use; or
(13) the sale or transfer from a retail pharmacy or chain pharmacy
warehouse of expired, damaged, returned or recalled prescription drugs to
the original manufacturer, originating wholesale distributor or to a third
party returns processor in accordance with the board's rules and
regulations.
Sec. 12. K.S.A. 65-1660 is hereby amended to read as follows: 65-
1660. (a) Except as otherwise provided in this section, the provisions of
the pharmacy act of the state of Kansas shall not apply to dialysates,
devices or drugs which are designated by the board for the purposes of this
section relating to treatment of a person with chronic kidney failure
receiving dialysis and which are prescribed or ordered by a physician, an
advanced practice registered nurse or a mid-level practitioner for
administration or delivery to a person with chronic kidney failure if:
(1) The wholesale distributor is registered with the board and lawfully holds the drug or device; and
(2) the wholesale distributor: (A) Delivers the drug or device to: (i) A person with chronic kidney failure for self-administration at the person's home or specified address; (ii) a physician for administration or delivery to a person with chronic kidney failure; or (iii) a medicare approved renal dialysis facility for administering or delivering to a person with chronic kidney failure; and (B) has sufficient and qualified supervision to adequately protect the public health.
(b) The wholesale distributor pursuant to subsection (a) shall be supervised by a pharmacist consultant pursuant to rules and regulations adopted by the board.
(c) The board shall adopt such rules or regulations as are necessary to effectuate the provisions of this section.
(d) As used in this section, "physician" means a person licensed to practice medicine and surgery; "mid-level practitioner" means mid-level practitioner as such term is defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto; "advanced practice registered nurse" means an advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto.
(e) This section shall be part of and supplemental to the pharmacy act of the state of Kansas.
Sec. 13. K.S.A. 2014 Supp. 65-1682 is hereby amended to read as follows: 65-1682. As used in this act, unless the context otherwise requires:
(a) "Board" means the state board of pharmacy.
(b) "Dispenser" means a practitioner or pharmacist who delivers a scheduled substance or drug of concern to an ultimate user, but does not include:
(1) A licensed hospital pharmacy that distributes such substances for the purpose of inpatient hospital care;
(2) a medical care facility as defined in K.S.A. 65-425, and amendments thereto, practitioner or other authorized person who administers such a substance;
(3) a registered wholesale distributor of such substances;
(4) a veterinarian licensed by the Kansas board of veterinary examiners who dispenses or prescribes a scheduled substance or drug of concern; or
(5) a practitioner who has been exempted from the reporting requirements of this act in rules and regulations promulgated by the board.
(c) "Drug of concern" means any drug that demonstrates a potential
for abuse and is designated as a drug of concern in rules and regulations promulgated by the board.

(d) "Patient" means the person who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed, or both.

(e) "Pharmacist" means an individual currently licensed by the board to practice the profession of pharmacy in this state.

(f) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, or other person authorized by law to prescribe or dispense scheduled substances and drugs of concern.

(g) "Scheduled substance" means controlled substances included in schedules II, III or IV of the schedules designated in K.S.A. 65-4107, 65-4109 and 65-4111, and amendments thereto, respectively, or the federal controlled substances act (21 U.S.C. § 812).

Sec. 14. K.S.A. 2014 Supp. 65-2837a is hereby amended to read as follows: 65-2837a. (a) It shall be unlawful for any person licensed to practice medicine and surgery to prescribe, order, dispense, administer, sell, supply or give or for any person licensed as an advanced practice registered nurse or for a mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto, to prescribe, administer, supply or give any amphetamine or sympathomimetic amine designated in schedule II, III or IV under the uniform controlled substances act, except as provided in this section. Failure to comply with this section by a licensee shall constitute unprofessional conduct under K.S.A. 65-2837, and amendments thereto.

(b) When any licensee prescribes, orders, dispenses, administers, sells, supplies or gives or when any advanced practice registered nurse or any mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626, and amendments thereto, prescribes, administers, sells, supplies or gives any amphetamine or sympathomimetic amine designated in schedule II, III or IV under the uniform controlled substances act, the patient's medical record shall adequately document the purpose for which the drug is being given. Such purpose shall be restricted to one or more of the following:

(1) The treatment of narcolepsy.
(2) The treatment of drug-induced brain dysfunction.
(3) The treatment of hyperkinesis.
(4) The differential diagnostic psychiatric evaluation of depression.
(5) The treatment of depression shown by adequate medical records and documentation to be unresponsive to other forms of treatment.
(6) The clinical investigation of the effects of such drugs or
compounds, in which case, before the investigation is begun, the licensee shall, in addition to other requirements of applicable laws, apply for and obtain approval of the investigation from the board of healing arts.

(7) The treatment of obesity with controlled substances, as may be defined by rules and regulations adopted by the board of healing arts.

(8) The treatment of any other disorder or disease for which such drugs or compounds have been found to be safe and effective by competent scientific research which findings have been generally accepted by the scientific community, in which case, the licensee before prescribing, ordering, dispensing, administering, selling, supplying or giving the drug or compound for a particular condition, or the licensee before authorizing a mid-level practitioner to prescribe the drug or compound for a particular condition, or the advanced practice registered nurse before prescribing, ordering, administering or giving the drug for a particular condition, shall obtain a determination from the board of healing arts that the drug or compound can be used for that particular condition.

Sec. 15. K.S.A. 65-2892 is hereby amended to read as follows: 65-2892. Any physician or advanced practice registered nurse, upon consultation by any person under eighteen (18) years of age as a patient, may, with the consent of such person who is hereby granted the right of giving such consent, make a diagnostic examination for venereal disease and prescribe for and treat such person for venereal disease including prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease. All such examinations and treatment may be performed without the consent of, or notification to, the parent, parents, guardian or any other person having custody of such person. Any physician or advanced practice registered nurse examining or treating such person for venereal disease may, but shall not be obligated to, in accord with his opinion of what will be most beneficial for such person, inform the spouse, parent, custodian, guardian or fiance of such person as to the treatment given or needed without the consent of such person. Such informing shall not constitute libel or slander or a violation of the right of privacy or privilege or otherwise subject the physician or advanced practice registered nurse to any liability whatsoever. In any such case, the physician or advanced practice registered nurse shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions. The physician or advanced practice registered nurse shall incur no civil or criminal liability by reason of any adverse reaction to medication administered, provided reasonable care has been taken to elicit from such person under eighteen (18) years of age any history of sensitivity or previous adverse reaction to the medication.
Sec. 16. K.S.A. 2014 Supp. 65-2921 is hereby amended to read as follows: 65-2921. (a) Except as otherwise provided in subsection (d), a physical therapist may evaluate and initiate physical therapy treatment on a patient without referral from a licensed health care practitioner. If treating a patient without a referral from a licensed health care practitioner and the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable or functional improvement, or any combination thereof, after 10 patient visits or in a period of 15 business days from the initial treatment visits following the initial evaluation visit, the physical therapist shall obtain a referral from an appropriate licensed health care practitioner prior to continuing treatment.

(b) Physical therapists may provide, without a referral, services to: (1) Employees solely for the purpose of education and instruction related to workplace injury prevention; or (2) the public for the purpose of fitness, health promotion and education.

(c) Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan (IEP) or individualized family service plan (IFSP).

(d) Nothing in this section shall be construed to prevent a hospital or ambulatory surgical center from requiring a physician order or referral for physical therapy services for a patient currently being treated in such facility.

(e) When a patient self-refers to a physical therapist pursuant to this section, the physical therapist, prior to commencing treatment, shall provide written notice to the patient that a physical therapy diagnosis is not a medical diagnosis by a physician.

(f) Physical therapists shall perform wound debridement services only after approval by a person licensed to practice medicine and surgery or other licensed health care practitioner in appropriately related cases.

(g) As used in this section, "licensed health care practitioner" means a person licensed to practice medicine and surgery, a licensed podiatrist, a licensed physician assistant or a licensed advanced practice registered nurse working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed chiropractor, a licensed dentist or a licensed optometrist or a licensed advanced practice registered nurse in appropriately related cases.

Sec. 17. K.S.A. 2013 Supp. 65-4101, as amended by section 50 of chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to read as follows: 65-4101. As used in this act: (a) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by:
(1) A practitioner or pursuant to the lawful direction of a practitioner; or
(2) the patient or research subject at the direction and in the presence of the practitioner.

(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor or dispenser. It does not include a common carrier, public warehouseman or employee of the carrier or warehouseman.

c) "Application service provider" means an entity that sells electronic prescription or pharmacy prescription applications as a hosted service where the entity controls access to the application and maintains the software and records on its server.

d) "Board" means the state board of pharmacy.

e) "Bureau" means the bureau of narcotics and dangerous drugs, United States department of justice, or its successor agency.

(f) "Controlled substance" means any drug, substance or immediate precursor included in any of the schedules designated in K.S.A. 65-4105, 65-4107, 65-4111 and 65-4113, and amendments thereto.

(g) (1) "Controlled substance analog" means a substance that is intended for human consumption, and:
(A) The chemical structure of which is substantially similar to the chemical structure of a controlled substance listed in or added to the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto;
(B) which has a stimulant, depressant or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance included in the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto; or
(C) with respect to a particular individual, which such individual represents or intends to have a stimulant, depressant or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant or hallucinogenic effect on the central nervous system of a controlled substance included in the schedules designated in K.S.A. 65-4105 or 65-4107, and amendments thereto.

(2) "Controlled substance analog" does not include:
(A) A controlled substance;
(B) a substance for which there is an approved new drug application; or
(C) a substance with respect to which an exemption is in effect for investigational use by a particular person under section 505 of the federal food, drug and cosmetic act, 21 U.S.C. § 355, to the extent conduct with respect to the substance is permitted by the exemption.
(h) "Counterfeit substance" means a controlled substance which, or the container or labeling of which, without authorization bears the trademark, trade name or other identifying mark, imprint, number or device or any likeness thereof of a manufacturer, distributor or dispenser other than the person who in fact manufactured, distributed or dispensed the substance.

(i) "Cultivate" means the planting or promotion of growth of five or more plants which contain or can produce controlled substances.

(j) "DEA" means the U.S. department of justice, drug enforcement administration.

(k) "Deliver" or "delivery" means the actual, constructive or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship.

(l) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the packaging, labeling or compounding necessary to prepare the substance for that delivery, or pursuant to the prescription of a mid-level practitioner.

(m) "Dispenser" means a practitioner or pharmacist who dispenses, or a physician assistant who has authority to dispense prescription-only drugs in accordance with subsection (b) of K.S.A. 65-28a08(b), and amendments thereto.

(n) "Distribute" means to deliver other than by administering or dispensing a controlled substance.

(o) "Distributor" means a person who distributes.

(p) "Drug" means: (1) Substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States or official national formulary or any supplement to any of them; (2) substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; (3) substances (other than food) intended to affect the structure or any function of the body of man or animals; and (4) substances intended for use as a component of any article specified in clause (1), (2) or (3) of this subsection (p)(1), (2) or (3). It does not include devices or their components, parts or accessories.

(q) "Immediate precursor" means a substance which the board has found to be and by rule and regulation designates as being the principal compound commonly used or produced primarily for use and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance, the control of which is necessary to prevent, curtail or limit manufacture.

(r) "Electronic prescription" means an electronically prepared prescription that is authorized and transmitted from the prescriber to the pharmacy by means of electronic transmission.
(s) "Electronic prescription application" means software that is used to create electronic prescriptions and that is intended to be installed on the prescriber's computers and servers where access and records are controlled by the prescriber.

(t) "Electronic signature" means a confidential personalized digital key, code, number or other method for secure electronic data transmissions which identifies a particular person as the source of the message, authenticates the signatory of the message and indicates the person's approval of the information contained in the transmission.

(u) "Electronic transmission" means the transmission of an electronic prescription, formatted as an electronic data file, from a prescriber's electronic prescription application to a pharmacy's computer, where the data file is imported into the pharmacy prescription application.

(v) "Electronically prepared prescription" means a prescription that is generated using an electronic prescription application.

(w) "Facsimile transmission" or "fax transmission" means the transmission of a digital image of a prescription from the prescriber or the prescriber's agent to the pharmacy. "Facsimile transmission" includes, but is not limited to, transmission of a written prescription between the prescriber's fax machine and the pharmacy's fax machine; transmission of an electronically prepared prescription from the prescriber's electronic prescription application to the pharmacy's fax machine, computer or printer; or transmission of an electronically prepared prescription from the prescriber's fax machine to the pharmacy's fax machine, computer or printer.

(x) "Intermediary" means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

(y) "Isomer" means all enantiomers and diastereomers.

(z) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a controlled substance either directly or indirectly or by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled substance by an individual for the individual's own lawful use or the preparation, compounding, packaging or labeling of a controlled substance:

(1) By a practitioner or the practitioner's agent pursuant to a lawful order of a practitioner as an incident to the practitioner's administering or dispensing of a controlled substance in the course of the practitioner's 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
under K.S.A. 65-4102, and amendments thereto, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

(ff) "Opium poppy" means the plant of the species Papaver somniferum l. except its seeds.

(gg) "Person" means an individual, corporation, government, or governmental subdivision or agency, business trust, estate, trust, partnership or association or any other legal entity.

(hh) "Pharmacist" means any natural person licensed under K.S.A. 65-1625 et seq., to practice pharmacy.

(ii) "Pharmacist intern" means: (1) A student currently enrolled in an accredited pharmacy program; (2) a graduate of an accredited pharmacy program serving such person's internship; or (3) a graduate of a pharmacy program located outside of the United States which is not accredited and who had successfully passed equivalency examinations approved by the board.

(jj) "Pharmacy prescription application" means software that is used to process prescription information, is installed on a pharmacy's computers and servers, and is controlled by the pharmacy.

(kk) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(ll) "Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, optometrist, advanced practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto, or scientific investigator or other person authorized by law to use a controlled substance in teaching or chemical analysis or to conduct research with respect to a controlled substance.

(mm) "Prescriber" means a practitioner or a mid-level practitioner.

(nn) "Production" includes the manufacture, planting, cultivation, growing or harvesting of a controlled substance.

(oo) "Readily retrievable" means that records kept by automatic data processing applications or other electronic or mechanized recordkeeping systems can be separated out from all other records within a reasonable time not to exceed 48 hours of a request from the board or other authorized agent or that hard-copy records are kept on which certain items are asterisked, redlined or in some other manner visually identifiable apart from other items appearing on the records.

(pp) "Ultimate user" means a person who lawfully possesses a controlled substance for such person's own use or for the use of a member of such person's household or for administering to an animal owned by such person or by a member of such person's household.
Sec. 18. K.S.A. 2014 Supp. 65-4116 is hereby amended to read as follows: 65-4116. (a) Every person who manufactures, distributes or dispenses any controlled substance within this state or who proposes to engage in the manufacture, distribution or dispensing of any controlled substance within this state shall obtain annually a registration issued by the board in accordance with the uniform controlled substances act and with rules and regulations adopted by the board.

(b) Persons registered by the board under this act to manufacture, distribute, dispense or conduct research with controlled substances may possess, manufacture, distribute, dispense or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this act.

(c) The following persons need not register and may lawfully possess controlled substances under this act, as specified in this subsection:

(1) An agent or employee of any registered manufacturer, distributor or dispenser of any controlled substance if the agent or employee is acting in the usual course of such agent or employee's business or employment;

(2) a common carrier or warehouseman or an employee thereof whose possession of any controlled substance is in the usual course of business or employment;

(3) an ultimate user or a person in possession of any controlled substance pursuant to a lawful order of a practitioner or a mid-level practitioner or in lawful possession of a schedule V substance;

(4) persons licensed and registered by the board under the provisions of the acts contained in article 16 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, to manufacture, dispense or distribute drugs are considered to be in compliance with the registration provision of the uniform controlled substances act without additional proceedings before the board or the payment of additional fees, except that manufacturers and distributors shall complete and file the application form required under the uniform controlled substances act;

(5) any person licensed by the state board of healing arts under the Kansas healing arts act;

(6) any person licensed by the state board of veterinary examiners;

(7) any person licensed by the Kansas dental board;

(8) a mid-level practitioner; and

(9) any person who is a member of the Native American Church, with respect to use or possession of peyote, whose use or possession of peyote is in, or for use in, bona fide religious ceremonies of the Native American Church, but nothing in this paragraph shall authorize the use or possession of peyote in any place used for the confinement or housing of persons arrested, charged or convicted of criminal offenses or in the state security hospital; and
(10) any person licensed as an advanced practice registered nurse under K.S.A. 65-1131, and amendments thereto, and who has authority to prescribe drugs in accordance with K.S.A. 65-1130, and amendments thereto.

(d) (1) The board may waive by rules and regulations the requirement for registration of certain manufacturers, distributors or dispensers if the board finds it consistent with the public health and safety, except that licensure of any person by the state board of healing arts to practice any branch of the healing arts, Kansas dental board—or, the state board of veterinary examiners or the board of nursing of advanced practice registered nurses shall constitute compliance with the registration requirements of the uniform controlled substances act by such person for such person's place of professional practice.

(2) Evidence of abuse as determined by the board relating to a person licensed by the state board of healing arts shall be submitted to the state board of healing arts and the attorney general within 60 days. The state board of healing arts shall, within 60 days, make findings of fact and take such action against such person as it deems necessary. All findings of fact and any action taken shall be reported by the state board of healing arts to the board of pharmacy and the attorney general.

(3) Evidence of abuse as determined by the board relating to a person licensed by the state board of veterinary examiners shall be submitted to the state board of veterinary examiners and the attorney general within 60 days. The state board of veterinary examiners shall, within 60 days, make findings of fact and take such action against such person as it deems necessary. All findings of fact and any action taken shall be reported by the state board of veterinary examiners to the board of pharmacy and the attorney general.

(4) Evidence of abuse as determined by the board relating to a dentist licensed by the Kansas dental board shall be submitted to the Kansas dental board and the attorney general within 60 days. The Kansas dental board shall, within 60 days, make findings of fact and take such action against such dentist as it deems necessary. All findings of fact and any action taken shall be reported by the Kansas dental board to the board of pharmacy and the attorney general.

(5) Evidence of abuse as determined by the board relating to an advanced practice registered nurse licensed by the board of nursing shall be submitted to the board of nursing and the attorney general within 60 days. The board of nursing shall, within 60 days, make findings of fact and take such action against such advanced practice registered nurse as it deems necessary. All findings of fact and any action taken shall be reported by the board of nursing to the board of pharmacy and the attorney general.
(e) A separate annual registration is required at each place of business or professional practice where the applicant manufactures, distributes or dispenses controlled substances.

(f) The board may inspect the establishment of a registrant or applicant for registration in accordance with the board's rules and regulations.

(g) (1) The registration of any person or location shall terminate when such person or authorized representative of a location dies, ceases legal existence, discontinues business or professional practice or changes the location as shown on the certificate of registration. Any registrant who ceases legal existence, discontinues business or professional practice, or changes location as shown on the certificate of registration, shall notify the board promptly of such fact and forthwith deliver the certificate of registration directly to the secretary or executive secretary of the board. In the event of a change in name or mailing address the person or authorized representative of the location shall notify the board promptly in advance of the effective date of this change by filing the change of name or mailing address with the board. This change shall be noted on the original application on file with the board.

(2) No registration or any authority conferred thereby shall be assigned or otherwise transferred except upon such conditions as the board may specifically designate and then only pursuant to the written consent of the board.

Sec. 19. K.S.A. 65-4134 is hereby amended to read as follows: 65-4134. A practitioner engaged in medical practice or research, a practitioner who is an advanced practice registered nurse acting in the usual course of such practitioner's practice or a mid-level practitioner acting in the usual course of such mid-level practitioner's practice is not required or compelled to furnish the name or identity of a patient or research subject to the board, nor may such practitioner or mid-level practitioner be compelled in any state or local civil, criminal, administrative, legislative or other proceedings to furnish the name or identity of an individual that the practitioner or mid-level practitioner is obligated to keep confidential.

Sec. 20. K.S.A. 2014 Supp. 65-4202 is hereby amended to read as follows: 65-4202. As used in this act: (a) "Board" means the state board of nursing.

(b) The "practice of mental health technology" means the performance, under the direction of a physician licensed to practice medicine and surgery or registered professional nurse, of services in caring for and treatment of the mentally ill, emotionally disturbed, or people with intellectual disability for compensation or personal profit, which services:

(1) Involve responsible nursing and therapeutic procedures for
patients with mental illness or intellectual disability requiring interpersonal
and technical skills in the observations and recognition of symptoms and
reactions of such patients, the accurate recording of such symptoms and
reactions and the carrying out of treatments and medications as prescribed
by a licensed physician, a licensed advanced practice registered nurse or a
mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626,
and amendments thereto; and
(2) require an application of techniques and procedures that involve
understanding of cause and effect and the safeguarding of life and health
of the patient and others; and
(3) require the performance of duties that are necessary to facilitate
rehabilitation of the patient or are necessary in the physical, therapeutic
and psychiatric care of the patient and require close work with persons
licensed to practice medicine and surgery, psychiatrists, psychologists,
rehabilitation therapists, social workers, registered nurses, and other
professional personnel.

(c) A "licensed mental health technician" means a person who
lawfully practices mental health technology as defined in this act.
(d) An "approved course in mental health technology" means a
program of training and study including a basic curriculum which shall be
prescribed and approved by the board in accordance with the standards
prescribed herein, the successful completion of which shall be required
before licensure as a mental health technician, except as hereinafter
provided.

Sec. 21. K.S.A. 2014 Supp. 65-5402 is hereby amended to read as
follows: 65-5402. As used in K.S.A. 65-5401 to 65-5417, inclusive, and
K.S.A. 65-5418 to 65-5420, inclusive, and amendments thereto:

(a) "Board" means the state board of healing arts.
(b) "Practice of occupational therapy" means the therapeutic use of
purposeful and meaningful occupations (goal-directed activities) to
evaluate and treat, pursuant to the referral, supervision, order or direction
of a physician, a licensed podiatrist, a licensed dentist, a licensed physician
assistant, or a licensed advanced practice registered nurse working
pursuant to the order or direction of a person licensed to practice medicine
and surgery, a licensed advanced practice registered nurse, a licensed
chiropractor, or a licensed optometrist, individuals who have a disease or
disorder, impairment, activity limitation or participation restriction that
interferes with their ability to function independently in daily life roles and
to promote health and wellness. Occupational therapy intervention may
include:

(1) Remediation or restoration of performance abilities that are
limited due to impairment in biological, physiological, psychological or
neurological cognitive processes;
adaptation of tasks, process, or the environment or the teaching of compensatory techniques in order to enhance performance;

(3) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and

(4) health promotion strategies and practices that enhance performance abilities.

c) "Occupational therapy services" include, but are not limited to:

(1) Evaluating, developing, improving, sustaining, or restoring skills in activities of daily living (ADL), work or productive activities, including instrumental activities of daily living (IADL) and play and leisure activities;

(2) evaluating, developing, remediating, or restoring sensorimotor, cognitive or psychosocial components of performance;

(3) designing, fabricating, applying, or training in the use of assistive technology or orthotic devices and training in the use of prosthetic devices;

(4) adapting environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles;

(5) applying physical agent modalities as an adjunct to or in preparation for engagement in occupations;

(6) evaluating and providing intervention in collaboration with the client, family, caregiver or others;

(7) educating the client, family, caregiver or others in carrying out appropriate nonskilled interventions; and

(8) consulting with groups, programs, organizations or communities to provide population-based services.

d) "Occupational therapist" means a person licensed to practice occupational therapy as defined in this act.

e) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist.

(f) "Person" means any individual, partnership, unincorporated organization or corporation.

g) "Physician" means a person licensed to practice medicine and surgery.

(h) "Occupational therapy aide," "occupational therapy tech" or "occupational therapy paraprofessional" means a person who provides supportive services to occupational therapists and occupational therapy assistants in accordance with K.S.A. 65-5419, and amendments thereto.
credentialed or certified by appropriate agencies of the state of Kansas.

(b) The practice of occupational therapy shall not be construed to include the following:

(1) Persons rendering assistance in the case of an emergency;
(2) members of any church practicing their religious tenets;
(3) persons whose services are performed pursuant to the delegation of and under the supervision of an occupational therapist who is licensed under this act;
(4) any person employed as an occupational therapist or occupational therapy assistant by the government of the United States or any agency thereof, if such person practices occupational therapy solely under the direction or control of the organization by which such person is employed;
(5) licensees under the healing arts act when licensed and practicing in accordance with the provisions of law or persons performing services pursuant to a delegation authorized under subsection (g) of K.S.A. 65-2872(g), and amendments thereto;
(6) dentists practicing their professions, when licensed and practicing in accordance with the provisions of law;
(7) nurses practicing their professions, when licensed and practicing pursuant to the delegation of a licensed nurse under subsection (m) of K.S.A. 65-1124(m), and amendments thereto;
(8) health care providers who have been formally trained and are practicing in accordance with the training or have received specific training in one or more functions included in the occupational therapy practice act pursuant to established educational protocols, or both;
(9) any person pursuing a supervised course of study leading to a degree or certificate in occupational therapy at an accredited or approved educational program, if the person is designated by the title which clearly indicates such person's status as a student or trainee;
(10) any person fulfilling the supervised fieldwork experience requirements as part of the experience necessary to meet the requirement of the occupational therapy practice act;
(11) self-care by a patient or gratuitous care by a friend or family member who does not represent or hold oneself out to the public to be an occupational therapist or an occupational therapy assistant;
(12) optometrists practicing their profession when licensed and practicing in accordance with the provisions of article 15 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto;
(13) podiatrists practicing their profession when licensed and practicing in accordance with the provisions of article 15 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto;
(14) physical therapists practicing their profession when licensed and
practicing in accordance with K.S.A. 65-2901 et seq., and amendments thereto;

(15) physician assistants practicing their profession when licensed and practicing in accordance with the physician assistant licensure act;

(16) athletic trainers practicing their profession when licensed and practicing in accordance with the athletic trainers licensure act;

(17) manufacturers of prosthetic devices;

(18) any person performing occupational therapy services, if these services are performed for no more than 45 days in a calendar year in association with an occupational therapist licensed under the occupational therapy practice act so long as: (A) The person is registered or licensed under the laws of another state which has licensure requirements at least as stringent as the licensure requirements of this act; or (B) the person meets the requirements for certification as an occupational therapist registered (OTR) or a certified occupational therapy assistant (COTA) established by the national board for certification in occupational therapy (NBCOT).

(c) Any patient monitoring, assessment or other procedures designed to evaluate the effectiveness of prescribed occupational therapy must be performed by or pursuant to the delegation of a licensed occupational therapist or other health care provider.

(d) Education related therapy services provided by an occupational therapist to school systems or consultation regarding prevention, ergonomics and wellness within the occupational therapy scope of practice shall not require a referral, supervision, order or direction of a physician, an advanced practice registered nurse, a licensed podiatrist, a licensed dentist or a licensed optometrist. However, when in the course of providing such services an occupational therapist reasonably believes that an individual may have an underlying injury, illness, disease, disorder or impairment, the occupational therapist shall refer the individual to a physician, an advanced practice registered nurse, a licensed podiatrist, a licensed dentist or a licensed optometrist, as appropriate.

(e) Nothing in the occupational therapy practice act shall be construed to permit the practice of medicine and surgery. No statute granting authority to licensees of the state board of healing arts shall be construed to confer authority upon occupational therapists to engage in any activity not conferred by the occupational therapy practice act.

(f) This section shall be part of and supplemental to the occupational therapy practice act.

Sec. 23. K.S.A. 65-5502 is hereby amended to read as follows: 65-5502. As used in K.S.A. 65-5501 to 65-5517, inclusive and amendments thereto:

(a) "Board" means the state board of healing arts.

(b) "Respiratory therapy" is a health care profession whose therapists
practice under the supervision of a qualified medical director and with the
prescription of a licensed physician or an advanced practice registered
nurse providing therapy, management, rehabilitation, respiratory
assessment and care of patients with deficiencies and abnormalities which
affect the pulmonary system and associated other systems functions. The
duties which may be performed by a respiratory therapist include:

(1) Direct and indirect respiratory therapy services that are safe,
aesthetic, preventive and restorative to the patient.

(2) Direct and indirect respiratory therapy services, including but not
limited to, the administration of pharmacological and diagnostic and
therapeutic agents related to respiratory therapy procedures to implement a
treatment, disease prevention or pulmonary rehabilitative regimen
prescribed by a physician or an advanced practice registered nurse.

(3) Administration of medical gases, exclusive of general anesthesia,
aerosols, humidification and environmental control systems.

(4) Transcription and implementation of written or verbal orders of a
physician or an advanced practice registered nurse pertaining to the
practice of respiratory therapy.

(5) Implementation of respiratory therapy protocols as defined by the
medical staff of an institution or a qualified medical director or other
written protocol, changes in treatment pursuant to the written or verbal
orders of a physician or an advanced practice registered nurse or the
initiation of emergency procedures as authorized by written protocols.

(c) "Respiratory therapist" means a person who is licensed to practice
respiratory therapy as defined in this act.

(d) "Person" means any individual, partnership, unincorporated
organization or corporation.

(e) "Physician" means a person who is licensed by the board to
practice medicine and surgery.

(f) "Qualified medical director" means the medical director of any
inpatient or outpatient respiratory therapy service, department or home
care agency. The medical director shall be a physician who has interest and
knowledge in the diagnosis and treatment of respiratory problems. This
physician shall be responsible for the quality, safety and appropriateness of
the respiratory services provided and require that respiratory therapy be
ordered by a physician or an advanced practice registered nurse who has
medical responsibility for the patient. The medical director shall be readily
accessible to the respiratory therapy practitioner.

(g) "Advanced practice registered nurse" means an advanced
practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
amendments thereto, and who has authority to prescribe drugs in
accordance with K.S.A. 65-1130, and amendments thereto.
chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to read as follows: 65-6112. As used in this act:

(a) "Administrator" means the executive director of the emergency medical services board.

(b) "Advanced emergency medical technician" means a person who holds an advanced emergency medical technician certificate issued pursuant to this act.

(c) "Advanced practice registered nurse" means an advanced practice registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

(d) "Ambulance" means any privately or publicly owned motor vehicle, airplane or helicopter designed, constructed, prepared, staffed and equipped for use in transporting and providing emergency care for individuals who are ill or injured.

(e) "Ambulance service" means any organization operated for the purpose of transporting sick or injured persons to or from a place where medical care is furnished, whether or not such persons may be in need of emergency or medical care in transit.

(f) "Attendant" means a first responder, an emergency medical responder, emergency medical technician, emergency medical technician-intermediate, emergency medical technician-defibrillator, emergency medical technician-intermediate/defibrillator, advanced emergency medical technician, mobile intensive care technician or paramedic certified pursuant to this act.

(g) "Board" means the emergency medical services board established pursuant to K.S.A. 65-6102, and amendments thereto.

(h) "Emergency medical service" means the effective and coordinated delivery of such care as may be required by an emergency which includes the care and transportation of individuals by ambulance services and the performance of authorized emergency care by a physician, advanced practice registered nurse, professional nurse, a licensed physician assistant or attendant.

(i) "Emergency medical technician" means a person who holds an emergency medical technician certificate issued pursuant to this act.

(j) "Emergency medical technician-defibrillator" means a person who holds an emergency medical technician-defibrillator certificate issued pursuant to this act.

(k) "Emergency medical technician-intermediate" means a person who holds an emergency medical technician-intermediate certificate issued pursuant to this act.

(l) "Emergency medical technician-intermediate/defibrillator" means a person who holds both an emergency medical technician-intermediate and emergency medical technician-defibrillator certificate issued pursuant to this act.
(m) "Emergency medical responder" means a person who holds an emergency medical responder certificate issued pursuant to this act.
(n) "First responder" means a person who holds a first responder certificate issued pursuant to this act.
(o) "Hospital" means a hospital as defined by K.S.A. 65-425, and amendments thereto.
(p) "Instructor-coordinator" means a person who is certified under this act to teach initial certification and continuing education classes.
(q) "Medical director" means a physician.
(r) "Medical protocols" mean written guidelines which authorize attendants to perform certain medical procedures prior to contacting a physician, physician assistant authorized by a physician, advanced practice registered nurse authorized by a physician or professional nurse authorized by a physician. The medical protocols shall be approved by a county medical society or the medical staff of a hospital to which the ambulance service primarily transports patients, or if neither of the above are able or available to approve the medical protocols, then the medical protocols shall be submitted to the medical advisory council for approval.
(s) "Mobile intensive care technician" means a person who holds a mobile intensive care technician certificate issued pursuant to this act.
(t) "Municipality" means any city, county, township, fire district or ambulance service district.
(u) "Nonemergency transportation" means the care and transport of a sick or injured person under a foreseen combination of circumstances calling for continuing care of such person. As used in this subsection, transportation includes performance of the authorized level of services of the attendant whether within or outside the vehicle as part of such transportation services.
(v) "Operator" means a person or municipality who has a permit to operate an ambulance service in the state of Kansas.
(w) "Paramedic" means a person who holds a paramedic certificate issued pursuant to this act.
(x) "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.
(y) "Physician" means a person licensed by the state board of healing arts to practice medicine and surgery.
(z) "Physician assistant" means a person who is licensed under the physician assistant licensure act and who is acting under the direction of a supervising physician.
(aa) "Professional nurse" means a licensed professional nurse as defined by K.S.A. 65-1113, and amendments thereto.
(bb) "Provider of training" means a corporation, partnership, accredited postsecondary education institution, ambulance service, fire
department, hospital or municipality that conducts training programs that
include, but are not limited to, initial courses of instruction and continuing
education for attendants, instructor-coordinators or training officers.

(cc) "Supervising physician" means supervising physician as such
term is defined under K.S.A. 65-28a02, and amendments thereto.

(dd) "Training officer" means a person who is certified pursuant to
this act to teach, coordinate or both, initial courses of instruction for first
responders or emergency medical responders and continuing education as
prescribed by the board.

Sec. 25. K.S.A. 2014 Supp. 65-6119 is hereby amended to read as
follows: 65-6119. (a) Notwithstanding any other provision of law, mobile
intensive care technicians may:

(1) Perform all the authorized activities identified in K.S.A. 65-6120,
65-6121, 65-6123, 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, 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 (a)(2);

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

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

(b) An individual who holds a valid certificate as a mobile intensive
care technician once meeting the continuing education requirements
prescribed by the rules and regulations of the board, upon application for
renewal, shall be deemed to hold a certificate as a paramedic under this
act, and such individual shall not be required to file an original application
as a paramedic for certification under this act.

(c) "Renewal" as used in subsection (b), refers to the first opportunity
that a mobile intensive care technician has to apply for renewal of a
certificate following the effective date of this act.

(d) Upon transition notwithstanding any other provision of law, a
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

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

Sec. 26. K.S.A. 2014 Supp. 65-6120 is hereby amended to read as follows: 65-6120. (a) Notwithstanding any other provision of law to the contrary, an emergency medical technician-intermediate may:

(1) Perform any of the activities identified by K.S.A. 65-6121, and amendments thereto;

(2) when approved by medical protocols or where voice contact by radio or telephone is monitored by a physician, physician assistant where authorized by a physician, advanced practice registered nurse where authorized by a physician or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such person, may perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions, endotracheal intubation and administration of nebulized albuterol;

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

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

(b) An individual who holds a valid certificate as an emergency medical technician-intermediate once successfully completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an advanced emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an advanced emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of the successful completion of a transition course and such individual shall not be required to file an
original application for certification as an advanced emergency medical
technician under this act.

(c) "Renewal" as used in subsection (b), refers to the first or second
opportunity after December 31, 2011, that an emergency medical
technician-intermediate has to apply for renewal of a certificate.

(d) Emergency medical technician-intermediates who fail to meet the
transition requirements as specified may complete either the board
prescribed emergency medical technician transition course or emergency
medical responder transition course, provide validation of cognitive and
psychomotor competency and all continuing education hour requirements
inclusive of the successful completion of a transition course as determined
by rules and regulations of the board. Upon completion, such emergency
medical technician-intermediate may apply to transition to become an
emergency medical technician or an emergency medical responder,
depending on the transition course that was successfully completed.
Alternatively, upon application for renewal of an emergency medical
technician-intermediate certificate, the applicant shall be renewed as an
emergency medical technician or an emergency medical responder,
depending on the transition course that was successfully completed. Such
individual shall not be required to file an original application for
certification as an emergency medical technician or emergency medical
responder.

(e) Failure to successfully complete either an advanced emergency
medical technician transition course, an emergency medical technician
transition course or emergency medical responder transition course will
result in loss of certification.

(f) Upon transition, notwithstanding any other provision of law to the
contrary, an advanced emergency medical technician may:

(1) Perform any of the activities identified by K.S.A. 65-6121, and
amendments thereto; and

(2) perform any of the following interventions, by use of the devices,
medications and equipment, or any combination thereof, as specifically
identified in rules and regulations, after successfully completing an
approved course of instruction, local specialized device training and
competency validation and when authorized by medical protocols, or upon
order when direct communication is maintained by radio, telephone or
video conference with a physician, physician assistant where authorized by
a physician, an advanced practice registered nurse where authorized by a
physician, or licensed professional nurse where authorized by a physician
upon order of such a person: (A) Continuous positive airway pressure
devices; (B) advanced airway management; (C) referral of patient of
alternate medical care site based on assessment; (D) transportation of a
patient with a capped arterial line; (E) veni-puncture for obtaining blood
sample; (F) initiation and maintenance of intravenous infusion or saline
lock; (G) initiation of intraosseous infusion; (H) nebulized therapy; (I)
manual defibrillation and cardioversion; (J) cardiac monitoring; (K)
electrocardiogram interpretation; (L) administration of generic or trade
name medications by one or more of the following methods: (i)
Aerosolization; (ii) nebulization; (iii) intravenous; (iv) intranasal; (v)
rectal; (vi) subcutaneous; (vii) intraosseous; (viii) intramuscular; or (ix)
sublingual.

(g) An individual who holds a valid certificate as both an emergency
medical technician-intermediate and as an emergency medical technician-
defibrillator once successfully completing the board prescribed transition
course, and validation of cognitive and psychomotor competency as
determined by rules and regulations of the board, may apply to transition
to an advanced emergency medical technician. Alternatively, upon
application for renewal, such individual shall be deemed to hold a
certificate as an advanced emergency medical technician under this act,
provided such individual has completed all continuing education hour
requirements inclusive of successful completion of a transition course, and
such individual shall not be required to file an original application for
certification as an advanced emergency medical technician under this act.

(h) "Renewal" as used in subsection (g), refers to the first or second
opportunity after December 31, 2011, that an emergency medical
technician-intermediate and emergency medical technician-defibrillator
has to apply for renewal of a certificate.

(i) An individual who holds both an emergency medical technician-
intermediate certificate and an emergency medical technician-defibrillator
certificate, who fails to meet the transition requirements as specified may
complete either the board prescribed emergency medical technician
transition course or emergency medical responder transition course, and
provide validation of cognitive and psychomotor competency and all
continuing education hour requirements inclusive of successful completion
of a transition course as determined by rules and regulations of the board.
Upon completion, such individual may apply to transition to become an
emergency medical technician or emergency medical responder, depending
on the transition course that was successfully completed. Alternatively,
on application for renewal of an emergency medical technician-
intermediate certificate and an emergency medical technician-defibrillator
certificate, the applicant shall be renewed as an emergency medical
technician or an emergency medical responder, depending on the transition
course that was successfully completed. Such individual shall not be
required to file an original application for certification as an emergency
medical technician or emergency medical responder.

(j) Failure to successfully complete either the advanced emergency
medical technician transition requirements, an emergency medical technician transition course or the emergency medical responder transition course will result in loss of certification.

Sec. 27. K.S.A. 2014 Supp. 65-6121 is hereby amended to read as follows: 65-6121. (a) Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following activities:

1. Patient assessment and vital signs;
2. Airway maintenance including the use of:
   (A) Oropharyngeal and nasopharyngeal airways;
   (B) Esophageal obturator airways with or without gastric suction device;
   (C) Multi-lumen airway; and
   (D) Oxygen demand valves.
3. Oxygen therapy;
4. Oropharyngeal suctioning;
5. Cardiopulmonary resuscitation procedures;
6. Control accessible bleeding;
7. Apply pneumatic anti-shock garment;
8. Manage outpatient medical emergencies;
9. Extricate patients and utilize lifting and moving techniques;
10. Manage musculoskeletal and soft tissue injuries including dressing and bandaging wounds or the splinting of fractures, dislocations, sprains or strains;
11. Use of backboards to immobilize the spine;
12. Administer activated charcoal and glucose;
13. Monitor intravenous line delivering intravenous fluids during interfacility transport with the following restrictions:
   (A) The physician approves the transfer by an emergency medical technician;
   (B) No medications or nutrients have been added to the intravenous fluids; and
   (C) The emergency medical technician may monitor, maintain and shut off the flow of intravenous fluid;
14. Use automated external defibrillators;
15. Administer epinephrine auto-injectors provided that:
   (A) The emergency medical technician successfully completes a course of instruction approved by the board in the administration of epinephrine;
   (B) The emergency medical technician serves with an ambulance service or a first response organization that provides emergency medical services; and
   (C) The emergency medical technician is acting pursuant to medical
protocols;

(16) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols; or
(17) when authorized by medical protocol, assist the patient in the administration of the following medications which have been prescribed for that patient: Auto-injection epinephrine, sublingual nitroglycerin and inhalers for asthma and emphysema.

(b) An individual who holds a valid certificate as an emergency medical technician at the current basic level once successfully completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an emergency medical technician. Alternatively, upon application for renewal, such individual shall be deemed to hold a certificate as an emergency medical technician under this act, provided such individual has completed all continuing education hour requirements inclusive of successful completion of a transition course, and such individual shall not be required to file an original application for certification as an emergency medical technician.

(c) "Renewal" as used in subsection (b), refers to the first opportunity after December 31, 2011, that an emergency medical technician has to apply for renewal of a certificate following the effective date of this act.

(d) Emergency medical technicians who fail to meet the transition requirements as specified may successfully complete the board prescribed emergency medical responder transition course, provide validation of cognitive and psychomotor competency and all continuing education hour requirements inclusive of the successful completion of a transition course as determined by rules and regulations of the board. Alternatively, upon application for renewal of an emergency medical technician certificate, the applicant shall be deemed to hold a certificate as an emergency medical responder under this act, and such individual shall not be required to file an original application for certification as an emergency medical responder.

(e) Failure to successfully complete either an emergency medical technician transition course or emergency medical responder transition course will result in loss of certification.

(f) Upon transition, notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any activities identified in K.S.A. 65-6144, and amendments thereto, and any of the following interventions, by use of the devices, medications and equipment, or any combination thereof, after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols, or upon order when
direct communication is maintained by radio, telephone or video
conference is monitored by a physician, physician assistant when
authorized by a physician, an advanced practice registered nurse—when
authorized by a physician or a licensed professional nurse when authorized
by a physician, upon order of such person:

1. Airway maintenance including use of:
   A. Single lumen airways as approved by the board;
   B. Multilumen airways;
   C. Ventilator devices;
   D. Forceps removal of airway obstruction;
   E. CO2 monitoring;
   F. Airway suctioning;

2. Apply pneumatic anti-shock garment;

3. Assist with childbirth;

4. Monitoring urinary catheter;

5. Capillary blood sampling;

6. Cardiac monitoring;

7. Administration of patient assisted medications as approved by the
   board;

8. Administration of medications as approved by the board by
   appropriate routes; and

9. Monitor, maintain or discontinue flow of IV line if a physician
   approves transfer by an emergency medical technician.

Sec. 28. K.S.A. 2014 Supp. 65-6123 is hereby amended to read as
follows: 65-6123. (a) Notwithstanding any other provision of law to the
contrary, an emergency medical technician-defibrillator may:

1. Perform any of the activities identified in K.S.A. 65-6121, and
   amendments thereto;

2. When approved by medical protocols or where voice contact by
   radio or telephone is monitored by a physician, physician assistant where
   authorized by a physician, advanced practice registered nurse—when
   authorized by a physician, or licensed professional nurse where authorized
   by a physician, and direct communication is maintained, upon order of
   such person, may perform electrocardiographic monitoring and
   defibrillation;

3. Perform, during an emergency, those activities specified in
   subsection (b) before contacting the persons identified in subsection (b)
   when specifically authorized to perform such activities by medical
   protocols; or

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

(b) An individual who holds a valid certificate as an emergency
medical technician-defibrillator once successfully completing an
emergency medical technician-intermediate, initial course of instruction
and the board prescribed transition course, and validation of cognitive and
psychomotor competency as determined by rules and regulations of the
board, may apply to transition to become an advanced emergency medical
technician. Alternatively, upon application for renewal, such individual
shall be deemed to hold a certificate as an advanced emergency medical
technician under this act, provided such individual has completed all
continuing education hour requirements inclusive of successful completion
of a transition course, and such individual shall not be required to file an
original application for certification as an advanced emergency medical
technician.

(c) "Renewal" as used in subsection (b), refers to the second
opportunity after December 31, 2011, that an attendant has to apply for
renewal of a certificate.

(d) Emergency medical technician-defibrillator attendants who fail to
meet the transition requirements as specified may complete either the
board prescribed emergency medical technician transition course or
emergency medical responder transition course, provide validation of
cognitive and psychomotor competency provided such individual has
completed all continuing education hour requirements inclusive of the
successful completion of a transition course as determined by rules and
regulations of the board. Upon completion, such emergency medical
technician-defibrillator may apply to transition to become an emergency
medical technician or an emergency medical responder, depending on the
transition course that was successfully completed. Alternatively, upon
application for renewal of an emergency medical technician-defibrillator
certificate, the applicant shall be renewed as an emergency medical
technician or an emergency medical responder, depending on the transition
course that was successfully completed. Such individual shall not be
required to file an original application for certification as an emergency
medical technician or emergency medical responder.

(e) Failure to complete either the advanced emergency medical
technician transition requirements, an emergency medical technician
transition course or an emergency medical responder transition course will
result in loss of certification.

Sec. 29. K.S.A. 2013 Supp. 65-6124, as amended by section 52 of
chapter 131 of the 2014 Session Laws of Kansas, is hereby amended to
read as follows: 65-6124. (a) No physician, physician assistant, advanced
practice registered nurse or licensed professional nurse, who gives
emergency instructions to an attendant as defined by K.S.A. 65-6112, and
amendments thereto, during an emergency, shall be liable for any civil
damages as a result of issuing the instructions, except such damages which
may result from gross negligence in giving such instructions.
(b) No attendant as defined by K.S.A. 65-6112, and amendments thereto, who renders emergency care during an emergency pursuant to instructions given by a physician, an advanced practice registered nurse, the supervising physician for a physician assistant, advanced practice registered nurse or licensed professional nurse shall be liable for civil damages as a result of implementing such instructions, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of such attendant as defined by K.S.A. 65-6112, and amendments thereto.
(c) No person certified as an instructor-coordinator and no training officer shall be liable for any civil damages which may result from such instructor-coordinator's or training officer's course of instruction, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of the instructor-coordinator or training officer.
(d) No medical adviser who reviews, approves and monitors the activities of attendants shall be liable for any civil damages as a result of such review, approval or monitoring, except such damages which may result from gross negligence in such review, approval or monitoring.

Sec. 30. K.S.A. 2014 Supp. 65-6144 is hereby amended to read as follows: 65-6144. (a) A first responder may perform any of the following activities:
(1) Initial scene management including, but not limited to, gaining access to the individual in need of emergency care, extricating, lifting and moving the individual;
(2) cardiopulmonary resuscitation and airway management;
(3) control of bleeding;
(4) extremity splinting excluding traction splinting;
(5) stabilization of the condition of the individual in need of emergency care;
(6) oxygen therapy;
(7) use of oropharyngeal airways;
(8) use of bag valve masks;
(9) use automated external defibrillators; and
(10) other techniques of preliminary care a first responder is trained to provide as approved by the board.
(b) An individual who holds a valid certificate as a first responder, once completing the board prescribed transition course, and validation of cognitive and psychomotor competency as determined by rules and regulations of the board, may apply to transition to become an emergency medical responder. Alternatively, upon application for renewal of such certificate, such individual shall be deemed to hold a certificate as an
emergency medical responder under this act, provided such individual has
completed all continuing education hour requirements inclusive of a
transition course and such individual shall not be required to file an
original application for certification as an emergency medical responder.
(c) "Renewal" as used in subsection (b), refers to the first opportunity
after December 31, 2011, that an attendant has to apply for renewal of a
certificate.
(d) First responder attendants who fail to meet the transition
requirements as specified will forfeit their certification.
(e) Upon transition, notwithstanding any other provision of law to the
 contrary, an emergency medical responder may perform any of the
following interventions, by use of the devices, medications and equipment,
or any combination thereof, after successfully completing an approved
course of instruction, local specialized device training and competency
validation and when authorized by medical protocols, or upon order when
direct communication is maintained by radio, telephone or video
conference is monitored by a physician, physician assistant when
authorized by a physician, an advanced practice registered nurse—where
authorized by a physician or a licensed professional nurse when authorized
by a physician, upon order of such person: (1) Emergency vehicle
operations; (2) initial scene management; (3) patient assessment and
stabilization; (4) cardiopulmonary resuscitation and airway management;
(5) control of bleeding; (6) extremity splinting; (7) spinal immobilization;
(8) oxygen therapy; (9) use of bag-valve-mask; (10) use of automated
external defibrillator; (11) nebulizer therapy; (12) intramuscular injections
with auto-injector; (13) administration of oral glucose; (14) administration
of aspirin; (15) recognize and comply with advanced directives; (16)
insertion and maintenance of oral and nasal pharyngeal airways; (17) use
of blood glucose monitoring; and (18) other techniques and devices of
preliminary care an emergency medical responder is trained to provide as
approved by the board.
Sec. 31. K.S.A. 2014 Supp. 65-7003 is hereby amended to read as
follows: 65-7003. As used in K.S.A. 65-7001 through 65-7015, and
amendments thereto:
(a) "Act" means the Kansas chemical control act;
(b) "administer" means the application of a regulated chemical
whether by injection, inhalation, ingestion or any other means, directly
into the body of a patient or research subject, such administration to be
conducted by: (1) A practitioner, or in the practitioner's presence, by such
practitioner's authorized agent; or
(2) the patient or research subject at the direction and in the presence
of the practitioner;
(c) "agent or representative" means a person who is authorized to
receive, possess, manufacture or distribute or in any other manner control
or has access to a regulated chemical on behalf of another person;
(d) "bureau" means the Kansas bureau of investigation;
(e) "department" means the Kansas department of health and
environment;
(f) "director" means the director of the Kansas bureau of
investigation;
(g) "dispense" means to deliver a regulated chemical to an ultimate
user, patient or research subject by, or pursuant to the lawful order of, a
practitioner, including the prescribing, administering, packaging, labeling
or compounding necessary to prepare the regulated chemical for that
delivery;
(h) "distribute" means to deliver other than by administering or
dispensing a regulated chemical;
(i) "manufacture" means to produce, prepare, propagate, compound,
convert or process a regulated chemical directly or indirectly, by extraction
from substances of natural origin, chemical synthesis or a combination of
extraction and chemical synthesis, and includes packaging or repackaging
of the substance or labeling or relabeling of its container. The term
excludes the preparation, compounding, packaging, repackaging, labeling
or relabeling of a regulated chemical:
(1) By a practitioner as an incident to the practitioner's administering
or dispensing of a regulated chemical in the course of the practitioner's
professional practice; or
(2) by a practitioner, or by the practitioner's authorized agent under
the practitioner's supervision, for the purpose of, or as an incident to
research, teaching or chemical analysis and not for sale;
(j) "person" means individual, corporation, business trust, estate,
trust, partnership, association, joint venture, government, governmental
subsection or agency, or any other legal or commercial entity;
(k) "practitioner" means a person licensed to practice medicine and
surgery, pharmacist, dentist, podiatrist, veterinarian, optometrist, advanced
practice registered nurse who is licensed pursuant to K.S.A. 65-1131, and
amendments thereto, and who has authority to prescribe drugs in
accordance with K.S.A. 65-1130, and amendments thereto, or scientific
investigator or other person authorized by law to use a controlled
substance in teaching or chemical analysis or to conduct research with
respect to a controlled substance;
(l) "regulated chemical" means a chemical that is used directly or
indirectly to manufacture a controlled substance or other regulated
chemical, or is used as a controlled substance analog, in violation of the
state controlled substances act or this act. The fact that a chemical may be
used for a purpose other than the manufacturing of a controlled substance.
or regulated chemical does not exempt it from the provisions of this act.

Regulated chemical includes:

1. Acetic anhydride (CAS No. 108-24-7);
2. Benzaldehyde (CAS No. 100-52-7);
3. Benzyl chloride (CAS No. 100-44-7);
4. Benzyl cyanide (CAS No. 140-29-4);
5. Diethylamine and its salts (CAS No. 109-89-7);
6. Ephedrine, its salts, optical isomers and salts of optical isomers (CAS No. 299-42-3), except products containing ephedra or ma huang, which do not contain any chemically synthesized ephedrine alkaloids, and are lawfully marketed as dietary supplements under federal law;
7. Hydriodic acid (CAS No. 10034-85-2);
8. Iodine (CAS No. 7553-56-2);
9. Lithium (CAS No. 7439-93-2);
10. Methylamine and its salts (CAS No. 74-89-5);
11. Nitroethane (CAS No. 79-24-3);
12. Chloroephedrine, its salts, optical isomers, and salts of optical isomers (CAS No. 30572-91-9);
13. Phenylacetic acid, its esters and salts (CAS No. 103-82-2);
14. Phenylpropanolamine, its salts, optical isomers, and salts of optical isomers (CAS No. 14838-15-4);
15. Piperidine and its salts (CAS No. 110-89-4);
16. Pseudoephedrine, its salts, optical isomers, and salts of optical isomers (CAS No. 90-82-4);
17. Red phosphorous (CAS No. 7723-14-0);
18. Sodium (CAS No. 7440-23-5); and
19. Thionylchloride (CAS No. 7719-09-7);
20. Gamma butyrolactone (GBL), including butyrolactone; butyrolactone gamma; 4-butyrolactone; 2(3H)-furanone dihydro; dihydro-2(3H)-furanone; tetrahydro-2-furanone; 1,2-butanolide; 1,4-butanolide; 4-butanolide; gamma-hydroxybutyric acid lactone; 3-hydroxybutyric acid lactone and 4-hydroxybutanoic acid lactone; CAS No. 96-48-0; and
21. 1,4 butanediol, including butanediol; butane-1,4-diol; 1,4-butylene glycol; butylene glycol; 1,4-dihydroxybutane; 1,4-tetramethylene glycol; tetramethylene glycol; tetramethylene 1,4-diol; CAS No. 110-63-4;

(m) "regulated chemical distributor" means any person subject to the provisions of the Kansas chemical control act who manufactures or distributes a regulated chemical;
(n) "regulated chemical retailer" means any person who sells regulated chemicals directly to the public;
(o) "regulated chemical transaction" means the manufacture of a regulated chemical or the distribution, sale, exchange or other transfer of a regulated chemical within or into the state or from this state into another
Sec. 32. K.S.A. 2014 Supp. 65-7302 is hereby amended to read as follows: 65-7302. As used in this act:
(a) "Board" means the state board of healing arts.
(b) "Ionizing radiation" means x-rays, gamma rays, alpha and beta particles, high speed electrons, protons, neutrons and other nuclear particles capable of producing ions directly or indirectly in its passage through matter.
(c) "License" means a certificate issued by the board authorizing the licensee to perform radiologic technology procedures on humans for diagnostic or therapeutic purposes.
(d) "Licensed practitioner" means a person licensed to practice medicine and surgery, dentistry, podiatry, chiropractic or advanced practice registered nursing in this state.
(e) "Licensure" and "licensing" mean a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in a health related occupation or profession.
(f) "Nuclear medicine technologist" means a person who uses radiopharmaceutical agents on humans for diagnostic or therapeutic purposes.
(g) "Nuclear medicine technology" means the use of radio nuclides on human beings for diagnostic or therapeutic purposes.
(h) "Radiation therapist" means a person who applies radiation to humans for therapeutic purposes.
(i) "Radiation therapy" means the use of any radiation procedure or article intended for the cure, mitigation or prevention of disease in humans.
(j) "Radiographer" means a person who applies radiation to humans for diagnostic purposes.
(k) "Radiography" means the use of ionizing radiation on human beings for diagnostic purposes.
(l) "Radiologic technologist" means any person who is a radiographer, radiation therapist or nuclear medicine technologist.
(m) "Radiologic technology" means the use of radioactive substance or equipment emitting or detecting ionizing radiation on humans for diagnostic or therapeutic purposes upon prescription of a licensed practitioner. The term includes the practice of radiography, nuclear medicine technology and radiation therapy, but does not include echocardiography, diagnostic sonography and magnetic resonance imaging.
(n) This section shall take effect on and after July 1, 2005.
Sec. 33. K.S.A. 2014 Supp. 72-5213 is hereby amended to read as follows: 72-5213. (a) Every board of education shall require all employees
of the school district, who come in regular contact with the pupils of the school district, to submit a certification of health on a form prescribed by the secretary of health and environment and signed by a person licensed to practice medicine and surgery under the laws of any state, or by a person who is licensed as a physician assistant under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery, or by a person holding a license to practice as an advanced practice registered nurse under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery. The certification shall include a statement that there is no evidence of a physical condition that would conflict with the health, safety, or welfare of the pupils; and that freedom from tuberculosis has been established by chest x-ray or negative tuberculin skin test. If at any time there is reasonable cause to believe that any such employee of the school district is suffering from an illness detrimental to the health of the pupils, the school board may require a new certification of health.

(b) Upon presentation of a signed statement by the employee of a school district, to whom the provisions of subsection (a) apply, that the employee is an adherent of a religious denomination whose religious teachings are opposed to physical examinations, the employee shall be permitted to submit, as an alternative to the certification of health required under subsection (a), certification signed by a person licensed to practice medicine and surgery under the laws of any state, or by a person who is licensed as a physician assistant under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery, or by a person holding a license to practice as an advanced practice registered nurse under the laws of this state when such person is working at the direction of or in collaboration with a person licensed to practice medicine and surgery that freedom of the employee from tuberculosis has been established.

(c) Every board of education may require persons, other than employees of the school district, to submit to the same certification of health requirements as are imposed upon employees of the school district under the provisions of subsection (a) if such persons perform or provide services to or for a school district which require such persons to come in regular contact with the pupils of the school district. No such person shall be required to submit a certification of health if the person presents a signed statement that the person is an adherent of a religious denomination whose religious teachings are opposed to physical examinations. Such persons shall be permitted to submit, as an alternative to a certification of health, certification signed by a person licensed to practice medicine and surgery under the laws of any state, or by a person who is licensed as a
physician assistant under the laws of this state when such person is
working at the direction of or in collaboration with a person licensed to
practice medicine and surgery, or by a person holding a license to practice
as an advanced practice registered nurse under the laws of this state when
such person is working at the direction of or in collaboration with a person
licensed to practice medicine and surgery that freedom of such persons
from tuberculosis has been established.

(d) The expense of obtaining certifications of health and certifications
of freedom from tuberculosis may be borne by the board of education.

Sec. 34. K.S.A. 2014 Supp. 75-7429 is hereby amended to read as
follows: 75-7429. (a) As used in this section, "medical home" means a
health care delivery model in which a patient establishes an ongoing
relationship with a physician or other personal care provider in a
physician-directed team, or with an advanced practice registered nurse to
provide comprehensive, accessible and continuous evidence-based primary
and preventive care, and to coordinate the patient's health care needs
across the health care system in order to improve quality and health
outcomes in a cost effective manner.

(b) The department of health and environment shall incorporate the
use of the medical home delivery system within:

(1) The Kansas program of medical assistance established in
accordance with title XIX of the federal social security act, 42 U.S.C. §
1396 et seq., and amendments thereto;

(2) the health benefits program for children established under K.S.A.
38-2001 et seq., and amendments thereto, and developed and submitted in
accordance with federal guidelines established under title XXI of the
federal social security act, section 4901 of public law 105-33, 42 U.S.C. §
1397aa et seq., and amendments thereto; and

(3) the state mediKan program.

(c) The Kansas state employees health care commission established
under K.S.A. 75-6502, and amendments thereto, shall incorporate the use
of a medical home delivery system within the state health care benefits
program as provided in K.S.A. 75-6501 through 75-6523, and amendments
thereto. Except that compliance with a medical home delivery system shall
not be required of program participants receiving treatment in accordance
with a religious method of healing pursuant to the provisions of K.S.A.
2014 Supp. 75-6501, and amendments thereto.

Sec. 35. K.S.A. 40-4602, 59-2976, 65-1660, 65-2892, 65-4134 and
65-5502 and K.S.A. 2013 Supp. 65-1626, as amended by section 4 of
chapter 131 of the 2014 Session Laws of Kansas, 65-4101, as amended by
section 50 of chapter 131 of the 2014 Session Laws of Kansas, 65-6112, as
amended by section 51 of chapter 131 of the 2014 Session Laws of Kansas
and 65-6124, as amended by section 52 of chapter 131 of the 2014 Session
65-6144, 65-7003, 65-7302, 72-5213 and 75-7429 are hereby repealed.
Sec. 36. This act shall take effect and be in force from and after July 1, 2016, and its publication in the statute book.