STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov
Louise R. Bailey, MEd, RN, Executive Officer

NURSING PRACTICE COMMITTEE MEETING

Hilton Los Angeles Airport
La Jolla Ballroom, 2nd Floor
5711 West Century Blvd.
Los Angeles, CA 90041

AGENDA

January 8, 2015

Thursday, January 8, 2015 – 2:00 pm – 3:30 pm

10.0 Call to Order

10.0.1 Review and Vote on whether to approve previous meeting's minutes:
- October 9, 2014

10.1 Review and Vote Whether to Recommend to Approve Advisory Statements for Registered Nursing and APRNs:

a) Military Spouses: Temporary RN Licenses
b) Telehealth: Patient Consent Required
c) Medical Assistants: Handing a Patient Properly Labeled and Prepackaged Prescriptions (Not including Controlled Substances)
d) Residential Care Facilities for the Elderly (RCFE)- Registered Nurses Providing Care and Training for Self-Administration of Medications
e) Emergency Epinephrine Auto-Injectors: Pupil Health
f) Workplace Violence Prevention Plan: Hospitals

10.2 Information: Health Workforce Pilot (HWPP) #173- Community Paramedicine Approval with Modifications

10.3 Review and Vote Whether to Recommend to Approve Goals and Objectives 2015-2016 to provide for continuing information on Nursing Practice in California

10.4 Public Comment for Items Not on the Agenda

10.5 Adjournment

NOTICE: All times are approximate. Meetings may be canceled without notice. For verification of meeting, call (916) 574-7600 or access the Board's Web Site www.rn.ca.gov under "Meetings." The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone (800) 326-2297). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum. The public will be provided an opportunity to comment on each agenda item at the time it is discussed; however, the committee may limit the time allowed to each speaker.

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BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE MINUTES

October 9, 2014

2:00 pm to 3:30 pm

Hilton Garden Inn San Francisco/Oakland Bay Bridge
1800 Powell Street
Emeryville, CA 94608
(510) 658-9300

MEMBERS PRESENT Trande Phillips, RN Chair
Michael Jackson, MSN, BSN, RN, CEN, MICN
Elizabeth A. Woods, RN, FNP, RN

STAFF PRESENT: Janette Wackerly, MBA, BSN, RN, SNEC, Staff Liaison

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Thursday, October 9, 2014
Meeting called to order at 2:30 PM by Trande Phillips
Members introductions: Trande Phillips Chair, Michael Jackson, Elizabeth Woods, and Cynthia Klein

10.0 Review and Vote on whether to approve previous meeting minutes August 7, 2014

MSC: Jackson/Woods move to approve meeting minutes of August 7, 2014

10.1 Information and Discussion: Review Nurse Practitioner National Certification.
Staff liaison requested by committee to return national certification documents, specified wanting detail from American Nurses Association-American Nurses Credentialing Center (AACN). The AACN Certification Corporation Adult-Gerontology Acute Care Nurse Practitioner Exam Handbook (attached). See packet documents for costs, initial and renewal, cost difference for member and non-member, renewal options, test plan adult-gerontology acute care nurse practitioner, and test plan for skills and procedures. All AACN Certification Corporation Adult-Gerontology Acute Care Nurse Practitioner Exam Handbook attached to Practice Committee packet.

10.2 Review and Vote on Whether to Approve: Update to Frequently Asked Question Regarding Nurse Practitioner Practice

MSC: Jackson/Wood move to approve Update to Frequently Asked Question Regarding Nurse Practitioner Practice.

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Suggestion that BRN website continue to have pertinent information on Hydrocodone moving from Schedule III to Schedule II and continue to assist NPs needing to obtain Schedule II privilege from DEA. On BRN website homepage go to schools> listing for> Schedule II courses. Liaison will follow-up with information on Pharmacy Board website. California Association of Nurse Practitioner stated they will send a letter regarding Schedule II.

10.3 Information and Discussion: California Association of Nurse Midwives:

a) Standardized Procedures related to ACNM Core Competencies for Basic Nurse-Midwifery Practice
b) Out of Hospital CNM Practice and physician supervision
c) Location of suturing and projection of public

Kim Q Dau CNM Chair of Health Policy Committee submitted a number of document they wish to discuss at Practice Committee meeting and the documents are attached.

1. Standardized Procedures related to CNM Core Competencies
    a) CA SPS and ACNM Core Competencies
    b) BRN Advisory- RN Scope and SPs
    c) BRN Advisory- SP and CNM Practice
2. Out of Hospital CNM Practice and physician supervision
    a) MBC Sunset Report 2012 re: LM Supervision
3. Location of suturing and protection of the public
    a) History of NMAC

Kim Q Dau, CNM submitted her talking points which are incorporated into the Practice Committee document as an attachment.

Nursing Practice Committee recommended Ms. Dau and interested CNMs work with key stakeholders to sponsor a change in the CNM laws. Ms. Dau may make contact with SEIU labor representative regarding support. Committee suggested Ms. Dau and CNMs work with Women and Children groups and national outreach by ACNM, apparently ACNM has educational materials available. Mentioned educate all women on choices regarding LMW/CNM. Discussion suggested now may be a very appropriate time for legislative change. Committee advised CNM organization to do research and Committee clarified that BRN is not the appropriate party to initiate legislation. Louse Bailey, Executive Office reinforced that the BRN cannot suspend existing laws or adopt a decision without a change in CNM laws.

10.4 Information: Drug Enforcement Administration Publishes Final Rule Rescheduling Hydrocodone Combination Products from Schedule III to Schedule II Controlled Substances.

The Drug Enforcement Administration will publish in the Federal Register the Final Rule moving Hydrocodone combination products (HCPs) from Schedule III to more restrictive Schedule II as recommended by the Assistant Secretary of Health of the U.S. Department of Health and Human

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Services (HHS). The Federal Register has made the Final Rule available for preview on its website http://go.usa/go.usa.gov/mc8d.

The BRN has been contacted by nurse practitioners who have Schedule III-V Controlled Substance DEA registration. If a NP wants to prescribe Schedule II, there is an additional requirement for education which must be met to obtain Schedule II registration form the DEA. Attached: DEA to Publish Final Rule Rescheduling Hydrocodone Combination Products. Attached is a CA.GOV Breeze licensing screen shot for nurse practitioner furnishing without Schedule II and second Breeze screen shot nurse practitioner furnishing with Specialty: Controlled Substance II.

The DEA applicant desk is looking at the Breeze nurse practitioner furnishing licensing screen to determine if BRN has entered Specialty Controlled Substance II that enables the DEA to issue the Schedule II DEA certificate.

10.5 Community Paramedicine- Office of Statewide Planning and Development Pilot Project 173

Emergency Medical Services Authority (EMSA) submitted a proposal for community paramedicine projects to the Office of Statewide Planning & Development (OSHPD). The proposal details plans to conduct 12 community paramedicine (CP) projects across California to test a new health care delivery model which will expand the paramedic scope of practice.

1. Transport patients with specified conditions not needing emergency care to non-ED locations (“alternate locations”)
2. After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transport the person to a hospital ED
3. Assist frequent 911 callers or frequent visitors to EDs to access primary care and other social services
4. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
5. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
6. Partner with community health workers and primary care providers in underserved areas to provide preventive care

Project Brief locations are as follows:

1. CP 001- Los Angeles County
2. CP 002- Glendale & Burbank
3. CP 003- Orange County
4. CP 004- Butte County
5. CP 005- Ventura County
6. CP 006- Santa Barbara & Ventura County
7. CP 007- Alameda County
8. CP 008- San Bernardino County
9. CP 009- Carlsbad

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10. CP010- San Diego
11. CP 011- Stanislaus County
12. CP 012- Solano County

Meeting adjourned at 3:30 p.m.

Submitted by:

Janette Wackerly, MBA, BSN, RN, SNEC
Supervising Nursing Education Consultant
NP Liaison

Accepted by:

Trande Phillips, RN, Chair, Direct Practice Member

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BOARD OF REGISTERED NURSING
Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: January 8, 2015

ACTION REQUESTED: **Vote on whether to approve nursing advisories:**

1. **Military Spouses: Temporary Licenses**
2. **Telehealth: Patient Consent Required**
3. **Medical Assistant: Handing to a patient properly labeled and prepackaged prescription, does not include controlled substances**
4. **Residential Care Facilities for the Elderly, RCFE, RN Functions**
5. **Workforce Violence Prevention Plans--Hospitals**
6. **Emergency Epinephrine Auto-Injectors**

REQUESTED BY: Trande Phillips, RN, Chairperson

BACKGROUND: Enacted Legislation in 2013-2014 Session which relates to registered nursing practice, nurse practitioner practice, and certified nurse mid-wives practice is placed on the BRN website to provide information. The information is referred to as advisory statements. The following advisories are requested to have Practice Committee approval and then forwarded to the Board for approval.

1. Military Spouses: Temporary RN Licenses: establishes temporary license provision to expire 12 months after issuance.
2. Telehealth- Prior to delivering health care services, provider must verbally inform the patient that telehealth may be used. Provider must obtain verbal consent from the patient and the healthcare provider is required to document the consent.
3. Medical Assistant: added to Medical Practice Act, Section 2069, “technical supportive services” performed by a medical assistant includes handing to a patient a properly labeled and prepackaged prescription, not including controlled substances, ordered by a MD, Podiatrist, PA, NP or CNM.
4. Residential Care for the Elderly, RCFE, Registered Nurse and other individuals may dial 911 to obtain emergency

services. The RCFE can now assist residents with prohibiting conditions by accessing home health and hospice services with RN care, and the RN can provide for RCFE employees with education for the Self-Administration of Medication, and training for RCFE direct care staff on postural support, restricted conditions or health services, and hospice care.

5. Emergency Epinephrine Auto-Injector: Pupil Health, school districts, county offices of education and charter schools to provide epinephrine auto-injectors to school nurse and trained personnel to use to provide emergency medical aid to persons suffering or reasonably believed, to be suffering from anaphylactic reaction.
6. Workforce Violence Prevention Plan requires general acute care hospitals and acute psychiatric hospitals to adopt a workforce violence prevention plan as a part of hospital's injury and illness prevention plan to protect health care workers and other facility personnel by January 1, 2017.

NEXT STEPS: Board of Registered Nursing

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: 916-574-7686
Email: janette.wackerly@dca.ca.gov

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Military Spouses: Temporary RN Licenses

Legislation enacted during the 2014 Session

AB 186 (Maienschein) Chapter 640 an act to add Section 115.6 to the Business and Professions Code, in addition to the expedited licensure, this provision does establish temporary license provision to expire 12 months after issuance.

This bill would, in addition to the expedited licensure provisions establish a temporary licensure process for specified licensed professions for an applicant who holds a current, active, and unrestricted license in another jurisdiction, as specified, and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. The added section to Business and Professions would require a temporary license issued pursuant to these provisions to expire 12 months after issuance, upon issuance of an expedited license, or upon denial of the application for expedited licensure by the board, whichever comes first.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated. Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders

Because the Section 115.6 Business and Professions Code would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

Assembly Bill No. 186

CHAPTER 640

An act to add Section 115.6 to the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

[Approved by Governor September 27, 2014. Filed with Secretary of State September 27, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 186, Maienschein. Professions and vocations: military spouses: temporary licenses.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated. Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would, in addition to the expedited licensure provisions described above, establish a temporary licensure process for specified licensed professions for an applicant who holds a current, active, and unrestricted license in another jurisdiction, as specified, and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. The bill would require a temporary license issued pursuant to these provisions to expire 12 months after issuance, upon issuance of an expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first.

This bill would also require an applicant seeking a temporary license as a civil engineer, geotechnical engineer, structural engineer, land surveyor, professional geologist, professional geophysicist, certified engineering geologist, or certified hydrogeologist to successfully pass the appropriate California-specific examination or examinations required for licensure in those respective professions by the Board for Professional Engineers, Land Surveyors, and Geologists.

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 115.6 is added to the Business and Professions Code, to read:

115.6. (a) A board within the department shall, after appropriate investigation, issue the following eligible temporary licenses to an applicant if he or she meets the requirements set forth in subdivision (c):

(1) Registered nurse license by the Board of Registered Nursing.

(2) Vocational nurse license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(3) Psychiatric technician license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(4) Speech-language pathologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(5) Audiologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(6) Veterinarian license issued by the Veterinary Medical Board.

(7) All licenses issued by the Board for Professional Engineers, Land Surveyors, and Geologists.

(8) All licenses issued by the Medical Board of California.

(b) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this section. This investigation may include a criminal background check.

(c) An applicant seeking a temporary license pursuant to this section shall meet the following requirements:

(1) The applicant shall supply evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) The applicant shall hold a current, active, and unrestricted license that confers upon him or her the authority to practice, in another state, district, or territory of the United States, the profession or vocation for which he or she seeks a temporary license from the board.

(3) The applicant shall submit an application to the board that shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

(4) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed. A violation of this paragraph may be grounds for the denial or revocation of a temporary license issued by the board.

(5) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(6) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

(d) A board may adopt regulations necessary to administer this section.

(e) A temporary license issued pursuant to this section may be immediately terminated upon a finding that the temporary licenseholder failed to meet any of the requirements described in subdivision (c) or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. Upon termination of the temporary license, the board shall issue a notice of termination that shall require the temporary licenseholder to immediately cease the practice of the licensed profession upon receipt.

(f) An applicant seeking a temporary license as a civil engineer, geotechnical engineer, structural engineer, land surveyor, professional geologist, professional geophysicist, certified engineering geologist, or certified hydrogeologist pursuant to this section shall successfully pass the appropriate California-specific examination or examinations required for licensure in those respective professions by the Board for Professional Engineers, Land Surveyors, and Geologists.

(g) A temporary license issued pursuant to this section shall expire 12 months after issuance, upon issuance of an expedited license pursuant to Section 115.5, or upon denial of the application for expedited licensure by the board, whichever occurs first.

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Telehealth: Patient Consent Required

Legislation enacted in the 2014 Session

AB 809 (Logue) Chapter 404 an act to amend Section 2290.5 of the Business and Professions Code, Medical Practice Act relating to telehealth and taking effect immediately, September 18, 2014

The amendment to Section 2290.5 of the Business and Professions Code, Medical Practice Act requires the health care provider initiating the use of telehealth to obtain verbal or written consent from the patient for the use of telehealth, as specified. The health care provider is required to document the consent.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

Assembly Bill No. 809

CHAPTER 404

An act to amend Section 2290.5 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 809, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would require the health care provider initiating the use of telehealth to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved

areas of California, the increasing strain on existing providers that occurred with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

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Nurse Practitioner and Nurse-Midwives

Medical Assistants: Handing to a patient properly labeled and prepackaged prescriptions, and does not include controlled substances

Legislation enacted in the 2014 session

AB 1841 (Mullin) Chapter 333 an act to amend Section 2069 of the Business and Professions Code, relating to medicine: Medical Practice Act

Section 2069 Business and Professions Code, Medical Practice Act, specifies that the "technical supportive services" a medical assistant may perform in those California State Board of Pharmacy licensed facilities, now includes handing to a patient a properly labeled and prepackaged prescription drug, other than a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife, as specified.

Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California. The act authorizes a medical assistant to administer medication only by intradermal, subcutaneous, or intramuscular injections and to perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law defines the term "technical supportive services" to mean simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law, the Pharmacy Law, prohibits a prescriber, as defined, from dispensing drugs to patients in his or her office unless specified conditions are satisfied, and authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor who functions pursuant to a specified protocol or procedure to hand to a patient of his or her supervising physician a properly labeled and prepackaged prescription drug.

Assembly Bill No. 1841

CHAPTER 333

An act to amend Section 2069 of the Business and Professions Code, relating to medicine.

[Approved by Governor September 15, 2014. Filed with Secretary of State September 15, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1841, Mullin. Medical assistants.

Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California. The act authorizes a medical assistant to administer medication only by intradermal, subcutaneous, or intramuscular injections and to perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law defines the term "technical supportive services" to mean simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law, the Pharmacy Law, prohibits a prescriber, as defined, from dispensing drugs to patients in his or her office unless specified conditions are satisfied, and authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor who functions pursuant to a specified protocol or procedure to hand to a patient of his or her supervising physician a properly labeled and prepackaged prescription drug. Existing law authorizes specified facilities licensed by the California State Board of Pharmacy to purchase drugs at wholesale for administration or dispensing, under the direction of a physician and surgeon, to patients registered for care at those facilities.

This bill would specify that the "technical supportive services" a medical assistant may perform in those California State Board of Pharmacy licensed facilities also includes handing to a patient a properly labeled and prepackaged prescription drug, other than a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:

(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

(1) “Medical assistant” means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) “Specific authorization” means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on

a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

(4) (A) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a).

(B) Notwithstanding any other law, in a facility licensed by the California State Board of Pharmacy under Section 4180 or 4190, other than a facility operated by the state, "technical supportive services" also includes handing to a patient a prepackaged prescription drug, excluding a controlled substance, that is labeled in compliance with Section 4170 and all other applicable state and federal laws and ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife in accordance with subdivision (a). In every instance, prior to handing the medication to a patient pursuant to this subparagraph, the properly labeled and prepackaged prescription drug shall have the patient's name affixed to the package and a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife shall verify that it is the correct medication and dosage for that specific patient and shall provide the appropriate patient consultation regarding use of the drug.

(c) Nothing in this section shall be construed as authorizing any of the following:

(1) The licensure of medical assistants.

(2) The administration of local anesthetic agents by a medical assistant.

(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).

(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined

in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

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Residential Care Facilities for the Elderly, RCFE, Registered Nurses

Legislative enacted 2014 Session

Senate Bill 911 (Block) Chapter 705 effective September 28, 20214 an act to amend, repeal, and add Sections 156.616, 1569.62, and 1569.69 of, and to add Sections 1569.37, 1569.39 and 1569.696 to Health and Safety Code, relating to residential care facilities for the elderly.

The Health and Safety Code will prohibit a license, or officers or employee of the licensee, from discrimination or retaliating against any person receiving services of the licensee's residential care facility, the basis, for the reasons that, the person, employee, or any other person dialed or called 911.

For a complete review of Health and Safety Code Sections described as amended, repealed and added to Residential Care Facilities for the Elderly interested parties will need to access all the code sections. Health and Safety Code contains numerous provisions specifically for the operation of RCFE facilities by the Department of Social Services.

Existing law, the California Residential Care Facilities for the Elderly Act, provides for the licensure and regulation of residential care facilities for the elderly by the State Department of Social Services. A person who violates the act is guilty of a misdemeanor and subject to civil penalty and suspension or revocation of license.

Please note that the following sections, 1569.39, 1569.69 and 1569.696 shall become operative January 1, 2016.

Sec. 2. Section 1569.39 is added to the Health and Safety Code, to read:
1569.39 (a) A residential care facility for the elderly that accept or retains residents with prohibited health conditions, as defined by the department, in Section 87615 of Title 22 of the California Code of Regulations, shall assist residents with accessing home health or hospice services, as indicated in the resident's current appraisal, to ensure that residents receive medical care as prescribed by the resident's physician and contained in the resident's service plan.
(b) A residential care facility for the elderly that accepts or retains residents with restricted health conditions, as defined by the department, shall ensure that residents receive medical care as prescribed by the resident's physician and contained in the resident's service plan by appropriately skilled professional acting within their scope of practice. An appropriately skilled professional may not be required when the resident is providing self-care, as defined by the department, and there is documentation in the resident's service plan that the resident is capable of providing self-care.
(c) An "appropriately skilled professional" means, for purposes of this section, an individual who has training and is licensed to perform the necessary medical procedures prescribed by a physician. This includes, but is not limited to, a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, or respiratory therapist. These professionals may include, but are not limited to, those persons employed by a home health agency, the resident, or a facility, and who are currently licensed in this state.
(d) Failure to meet or arrange to meet the needs of those residents who require health-related services as specified in the resident's written record of care, defined pursuant to Section 1569.80, or failure to notify the physician of a resident's illness or injury that poses a danger of death or serious bodily harm is a licensing violation and subject to civil penalty pursuant to Section 1569.49.
(e) This section shall become operative on January 1, 2016.

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Sec.7. Section 1569.69 of the Health and Safety Code is amended to read:
1569.69 (a) Each residential care facility for the elderly licensed under this chapter shall ensure that each employee of the facility who assists residents with the self-administration of medications meets the following training requirements:
(1) In facilities licensed to provide care for 16 or more persons, the employee shall complete 16 hours of initial training. This training shall consist of eight hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and eight hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.
(2) In facilities licensed to provide care for 15 or fewer persons, the employee shall complete six hours of initial training. This training shall consist of two hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and four hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.
(3) An employee shall be required to complete the training requirements for hands-on shadowing training described in this subdivision prior to assisting any resident in the self-administration of medications. The training and instruction described in this subdivision shall be completed, in their entirety, within the first two weeks of employment.
(4) The training shall cover all of the following areas:
(A) The role, responsibilities, and limitations of staff who assist residents with the self-administration of medication, including tasks limited to licensed medical professionals.
(B) An explanation of the terminology specific to medication assistance.
(C) An explanation of the different types of medication orders: prescription, over-the-counter, controlled, and other medications.
(D) An explanation of the basic rules and precautions of medication assistance.
(E) Information on medication forms and routes for medications taken by residents.
(F) A description of procedures for providing assistance with the self-administration of medications in and out of the facility, and information on the medication documentation system used in the facility.
(G) An explanation of guidelines for the proper storage, security, and documentation of centrally stored medications.
(H) A description of the processes used for medication ordering, refills, and the receipt of medications from the pharmacy.
(I) An explanation of medication side effects, adverse reactions, and errors.
(5) To complete the training requirements set forth in this subdivision, each employee shall pass an examination that tests the employee's comprehensions of, and competency in, the subjects listed in paragraph (4).
(6) Residential care facilities for the elderly shall encourage pharmacists and licensed medical professionals to use plain English when preparing labels on medications supplied to residents. As used in this section, "plain English" means that no abbreviations, symbols, or Latin medical terms shall be used in the instructions for the self-administration of medication.
(7) The training requirements of this section are not limited to replace or supplant those required of all staff members who assist residents with personal activities of daily livings as set forth in Section 1569.625.
(8) The training requirements of this section shall be repeated if either of the following occurs:
(A) An employee returns to work for the same licensee after a break of service of more than 180 consecutive calendar days.
(B) An employee goes to work for another licensee in a facility in which he or she assists residents with the self-administration of medication.
(b) Each employee who received training and passed the examination required in paragraph (5) of subdivision (a), and who continues to assist with the self-administration of medicines, shall also complete four hours of in-service training on medication-related issues in each succeeding 12-month period.
(c) The requirements set forth in subdivisions (a) and (b) do not apply to persons who are licensed medical professionals.
(d) Each residential care facility for the elderly that provides employee training under this section shall use the training material and the accompanying examination that are developed by, or in consultation with, a licensed nurse, pharmacist, or physician. The licensed residential care facility for the elderly shall maintain the following documentation for each medical consultant used to develop the training:
(1) The name, address, and telephone number of the consultant.
(2) The date when consultation was provided.

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(3) The consultant's organization affiliation, if any, and any educational and professional qualifications specific to medication management.
(4) The training topics for which consultation was provided.
(e) Each person who provides employee training under this section shall meet the following education and experience requirements:
(1) A minimum of five hours of initial, or certified continuing, education or three semester units, or the equivalent, from an accredited educational institution, on topics relevant to medication management.
(2) The person shall meet any of the following practical experience or licensure requirements:
(A) Two years of full-time experience, within the last four years, as a consultant with expertise in medication management is areas covered by the training described in subdivision (a).
(B) Two years of full-time experience, or the equivalent, within the last four years, as an administrator for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.
(C) Two years of full-time experience, or the equivalent, within the last four years, as a direct care provider assisting with the self-administration of medications for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.
(D) Possession of a license as a medical professional.
(3) The licensed residential care facility for the elderly shall maintain the following documentation on each person who provides employee training under this section:
(A) The person's name, address, and telephone number.
(B) Information on the topics or subject matter covered in the training.
(C) The time, dates, and hours of training provided.
(f) Other training or instruction, as required in paragraphs (1) and (2) of subdivision (a), may be provided offsite, and may use various methods of instruction, including, but not limited to, all of the following:
(1) Lectures by presenters who are knowledgeable about medication management.
(2) Video recorded instruction, interactive material, online training, and books.
(3) Other written or visual materials approved by organizations or individuals with expertise in medication management.
(g) Residential care facilities for the elderly licensed to provide care for 16 or more persons shall maintain documentation that demonstrates that a consultant pharmacist or nurse has reviewed the facility's medication management program and procedures at least twice a year.
(h) Nothing in this section authorizes unlicensed personnel to directly administer medications.
(i) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 8
Section 1569.69 is added to the Health and Safety Code, to read:
1569.69.
(a) Each residential care facility for the elderly licensed under this chapter shall ensure that each employee of the facility who assists residents with the self-administration of medications meets all of the following training requirements:
(1) In facilities licensed to provide care for 16 or more persons, the employee shall complete 24 hours of initial training. This training shall consist of 16 hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and 8 hours of other training or instruction, as described in subdivision (f), which shall be completed within the first four weeks of employment.
(2) In facilities licensed to provide care for 15 or fewer persons, the employee shall complete 10 hours of initial training. This training shall consist of 6 hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and 4 hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.

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(3) An employee shall be required to complete the training requirements for hands-on shadowing training described in this subdivision prior to assisting any resident in the self-administration of medications. The training and instruction described in this subdivision shall be completed, in their entirety, within the first two weeks of employment.
(4) The training shall cover all of the following areas:
(A) The role, responsibilities, and limitations of staff who assist residents with the self-administration of medication, including tasks limited to licensed medical professionals.
(B) An explanation of the terminology specific to medication assistance.
(C) An explanation of the different types of medication orders: prescription, over-the-counter, controlled, and other medications.
(D) An explanation of the basic rules and precautions of medication assistance.
(E) Information on medication forms and routes for medication taken by residents.
(F) A description of procedures for providing assistance with the self-administration of medications in and out of the facility, and information on the medication documentation system used in the facility.
(G) An explanation of guidelines for the proper storage, security, and documentation of centrally stored medications.
(H) A description of the processes used for medication ordering, refills, and the receipt of medications from the pharmacy.
(I) An explanation of medication side effects, adverse reactions, errors, the adverse effects of psychotropic drugs for use in controlling the behavior of persons with dementia, and the increased risk of death when elderly residents with dementia are given antipsychotic medications.
(5) To complete the training requirements set forth in this subdivision, each employee shall pass an examination that tests the employee's comprehension of, and competency in, the subjects listed in paragraph (4).
(6) Residential care facilities for the elderly shall encourage pharmacists and licensed medical professionals to use plain English when preparing labels on medications supplied to residents. As used in this section, "plain English" means that no abbreviations, symbols, or Latin medical terms shall be used in the instructions for the self-administration of medication.
(7) The training requirements of this section are not intended to replace or supplant those required of all staff members who assist residents with personal activities of daily living as set forth in Sections 1569.625 and 1569.696.
(8) The training requirements of this section shall be repeated if either of the following occur:
(A) An employee returns to work for the same licensee after a break of service of more than 180 consecutive calendar days.
(B) An employee goes to work for another licensee in a facility in which he or she assists residents with the self-administration of medication.
(b) Each employee who received training and passed the examination required in paragraph (5) of subdivision (a), and who continues to assist with the self-administration of medicines, shall also complete eight hours of in-service training on medication-related issues in each succeeding 12-month period.
(c) The requirements set forth in subdivisions (a) and (b) do not apply to persons who are licensed medical professionals.
(d) Each residential care facility for the elderly that provides employee training under this section shall use the training material and the accompanying examination that are developed by, or in consultation with, a licensed nurse, pharmacist, or physician. The licensed residential care facility for the elderly shall maintain the following documentation for each medical consultant used to develop the training:
(1) The name, address, and telephone number of the consultant.
(2) The date when consultation was provided.
(3) The consultant's organization affiliation, if any, and any educational and professional qualifications specific to medication management.
(4) The training topics for which consultation was provided.
(e) Each person who provides employee training under this section shall meet the following education and experience requirements:
(1) A minimum of five hours of initial, or certified continuing, education or three semester units, or the equivalent, from an accredited educational institution, on topics relevant to medication management.
(2) The person shall meet any of the following practical experience or licensure requirements:
(A) Two years of full-time experience, within the last four years, as a consultant with expertise in medication management in areas covered by the training described in subdivision (a).

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(B) Two years of full-time experience, or the equivalent, within the last four years, as an administrator for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.
(C) Two years of full-time experience, or the equivalent, within the last four years, as a direct care provider assisting with the self-administration of medications for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.
(D) Possession of a license as a medical professional.
(3) The licensed residential care facility for the elderly shall maintain the following documentation on each person who provides employee training under this section:
(A) The person's name, address, and telephone number.
(B) Information on the topics or subject matter covered in the training.
(C) The times, dates, and hours of training provided.
(f) Other training or instruction, as required in paragraphs (1) and (2) of subdivision (a), may be provided offsite, and may use various methods of instruction, including, but not limited to, all of the following:
(1) Lectures by presenters who are knowledgeable about medication management.
(2) Video recorded instruction, interactive material, online training, and books.
(3) Other written or visual materials approved by organizations or individuals with expertise in medication management.
(g) Residential care facilities for the elderly licensed to provide care for 16 or more persons shall maintain documentation that demonstrates that a consultant pharmacist or nurse has reviewed the facility's medication management program and procedures at least twice a year.
(h) Nothing in this section authorizes unlicensed personnel to directly administer medications.
(i) This section shall become operative on January 1, 2016.

SEC. 9.
Section 1569.696 is added to the Health and Safety Code, to read:
1569.696.
(a) All residential care facilities for the elderly shall provide training to direct care staff on postural supports, restricted conditions or health services, and hospice care as a component of the training requirements specified in Section 1569.625. The training shall include all of the following:
(1) Four hours of training on the care, supervision, and special needs of those residents, prior to providing direct care to residents. The facility may utilize various methods of instruction, including, but not limited to, preceptorship, mentoring, and other forms of observation and demonstration. The orientation time shall be exclusive of any administrative instruction.
(2) Four hours of training thereafter of in-service training per year on the subject of serving those residents.
(b) This training shall be developed in consultation with individuals or organizations with specific expertise in the care of those residents described in subdivision (a). In formulating and providing this training, reference may be made to written materials and literature. This training requirement may be provided at the facility or offsite and may include a combination of observation and practical application.
(c) This section shall become operative on January 1, 2016.

Senate Bill No. 911

CHAPTER 705

An act to amend, repeal, and add Sections 1569.616, 1569.62, and 1569.69 of, and to add Sections 1569.371, 1569.39, and 1569.696 to, the Health and Safety Code, relating to residential care facilities for the elderly.

[Approved by Governor September 28, 2014. Filed with Secretary of State September 28, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 911, Block. Residential care facilities for the elderly.

(1) Existing law, the California Residential Care Facilities for the Elderly Act, provides for the licensure and regulation of residential care facilities for the elderly by the State Department of Social Services. A person who violates the act is guilty of a misdemeanor and subject to civil penalty and suspension or revocation of his or her license.

Existing law requires an administrator of a residential care facility for the elderly to successfully complete a department-approved certification program prior to employment that requires, among other things, a minimum of 40 hours of classroom instruction on a uniform core of knowledge, which includes resident admission, retention, and assessment procedures, and passage of a written test administered by the department.

This bill would change the minimum hours of classroom instruction to 80 hours, including 60 hours of in-person instruction, and would add additional topics to the uniform core of knowledge, including the adverse effects of psychotropic drugs for use in controlling the behavior of persons with dementia. The bill would also require the department to take specific actions with regard to the test, including ensuring that it consists of at least 100 questions.

This bill would prohibit a licensee, or officer or employee of the licensee, from discriminating or retaliating against any person receiving the services of the licensee's residential care facility for the elderly, or against any employee of the licensee's facility, on the basis, or for the reason that, the person, employee, or any other person dialed or called 911.

This bill would require a residential care facility for the elderly that accepts or retains residents with prohibited health conditions, as defined by the department, to assist residents with accessing home health or hospice services by appropriately skilled professionals, acting within their scope of practice, to ensure that residents receive medical care as prescribed by the resident's physician and contained in the resident's service plan. The bill would define an "appropriately skilled professional" as an individual who has training and is licensed to perform the necessary medical procedures prescribed by a physician, which includes, but is not limited to, a registered nurse, licensed

vocational nurse, physical therapist, occupational therapist, or respiratory therapist. The bill would provide that an appropriately skilled professional is not required if a resident is providing self-care, as defined by the department, and there is documentation in the resident's service plan that the resident is capable of providing self-care.

(2) Existing law requires the Director of Social Services to ensure that licensees, administrators, and staffs of residential care facilities for the elderly have appropriate training to provide the care and services for which a license or certificate is issued. Existing law requires the department to develop a uniform core of knowledge for the continuing education of administrators of residential care facilities for the elderly.

This bill would also require the department to develop a uniform core of knowledge jointly with the California Department of Aging for the initial certification of administrators, and add additional topics to the uniform core of knowledge, including, but not limited to, applicable laws and regulations and residents' rights.

(3) Existing law requires that employees who assist residents with the self-administration of medications at a licensed residential care facility for the elderly, which provides care for 16 or more persons, complete 16 hours of initial training, consisting of 8 hours of hands-on shadowing training and 8 hours of other training or instruction, to be completed within the first 2 weeks of employment. If that facility provides care for 15 or fewer persons, existing law requires employees to complete 6 hours of initial training, consisting of 2 hours of hands-on shadowing training and 4 hours of other training or instruction, to be completed within the first 2 weeks of employment.

This bill would require employees at a licensed residential care facility for the elderly that provides care for 16 or more persons, to complete 24 hours of initial training, consisting of 16 hours of hands-on shadowing training and 8 hours of other training or instruction, to be completed within the first 4 weeks of employment. For facilities providing care for 15 or fewer persons, the bill would increase those training requirements to 10 hours of initial training, consisting of 6 hours of hands-on shadowing training, and 4 hours of other training, to be completed within the first 2 weeks of employment.

This bill would require all residential care facilities for the elderly to provide training to direct care staff on postural supports, restricted conditions or health services, and hospice care that includes 4 hours of training on the care, supervision, and special needs of those residents, prior to providing direct care to residents. The bill also would require 4 hours of training thereafter of in-service training per year on the subject of serving those residents.

(4) Because a violation of any of the above provisions would be a misdemeanor, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

(5) This bill would make its provisions operative on January 1, 2016.

(6) This bill would become operative only if AB 1570 is enacted and takes effect on or before January 1, 2015.

The people of the State of California do enact as follows:

SECTION 1. Section 1569.371 is added to the Health and Safety Code, to read:

1569.371. (a) No licensee, or officer or employee of the licensee, shall discriminate or retaliate in any manner against any person receiving the services of the licensee's residential care facility for the elderly, or against any employee of the licensee's facility, on the basis, or for the reason that, the person, employee, or any other person dialed or called 911.

(b) A violation of this section is subject to civil penalty pursuant to Section 1569.49.

(c) This section shall become operative on January 1, 2016.

SEC. 2. Section 1569.39 is added to the Health and Safety Code, to read:

1569.39. (a) A residential care facility for the elderly that accepts or retains residents with prohibited health conditions, as defined by the department, in Section 87615 of Title 22 of the California Code of Regulations, shall assist residents with accessing home health or hospice services, as indicated in the resident's current appraisal, to ensure that residents receive medical care as prescribed by the resident's physician and contained in the resident's service plan.

(b) A residential care facility for the elderly that accepts or retains residents with restricted health conditions, as defined by the department, shall ensure that residents receive medical care as prescribed by the resident's physician and contained in the resident's service plan by appropriately skilled professionals acting within their scope of practice. An appropriately skilled professional may not be required when the resident is providing self-care, as defined by the department, and there is documentation in the resident's service plan that the resident is capable of providing self-care.

(c) An "appropriately skilled professional" means, for purposes of this section, an individual who has training and is licensed to perform the necessary medical procedures prescribed by a physician. This includes, but is not limited to, a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, or respiratory therapist. These professionals may include, but are not limited to, those persons employed by a home health agency, the resident, or a facility, and who are currently licensed in this state.

(d) Failure to meet or arrange to meet the needs of those residents who require health-related services as specified in the resident's written record of care, defined pursuant to Section 1569.80, or failure to notify the physician of a resident's illness or injury that poses a danger of death or serious bodily

harm is a licensing violation and subject to civil penalty pursuant to Section 1569.49.

(e) This section shall become operative on January 1, 2016.

SEC. 3. Section 1569.616 of the Health and Safety Code is amended to read:

1569.616. (a) (1) An administrator of a residential care facility for the elderly shall be required to successfully complete a department-approved certification program prior to employment.

(2) In those cases where the individual is both the licensee and the administrator of a facility, or a licensed nursing home administrator, the individual shall comply with the requirements of this section unless he or she qualifies for one of the exemptions provided for in subdivision (b).

(3) Failure to comply with this section shall constitute cause for revocation of the license of the facility where an individual is functioning as the administrator.

(4) The licensee shall notify the department within 30 days of any change in administrators.

(b) Individuals seeking exemptions under paragraph (2) of subdivision (a) shall meet the following criteria and fulfill the required portions of the certification program, as the case may be:

(1) An individual designated as the administrator of a residential care facility for the elderly who holds a valid license as a nursing home administrator issued in accordance with Chapter 2.35 (commencing with Section 1416) of Division 2 shall be required to complete the areas in the uniform core of knowledge required by this section that pertain to the law, regulations, policies, and procedural standards that impact the operations of residential care facilities for the elderly, the use, misuse, and interaction of medication commonly used by the elderly in a residential setting, and resident admission, retention, and assessment procedures, equal to 12 hours of classroom instruction. An individual meeting the requirements of this paragraph shall not be required to take a written test.

(2) In those cases where the individual was both the licensee and administrator on or before July 1, 1991, the individual shall be required to complete all the areas specified for the certification program, but shall not be required to take the written test required by this section. Those individuals exempted from the written test shall be issued a conditional certification that is valid only for the administrator of the facility for which the exemption was granted.

(A) As a condition to becoming an administrator of another facility, the individual shall be required to pass the written test provided for in this section.

(B) As a condition to applying for a new facility license, the individual shall be required to pass the written test provided for in Section 1569.23.

(c) (1) The administrator certification program shall require a minimum of 40 hours of classroom instruction that provides training on a uniform core of knowledge in each of the following areas:

(A) Laws, regulations, and policies and procedural standards that impact the operations of residential care facilities for the elderly.

(B) Business operations.

(C) Management and supervision of staff.

(D) Psychosocial needs of the elderly.

(E) Community and support services.

(F) Physical needs for elderly persons.

(G) Use, misuse, and interaction of medication commonly used by the elderly.

(H) Resident admission, retention, and assessment procedures.

(I) Training focused specifically on serving clients with dementia. This training shall be for at least four hours.

(J) Cultural competency and sensitivity in issues relating to the underserved aging lesbian, gay, bisexual, and transgender community.

(2) Individuals applying for certification under this section shall successfully complete an approved certification program, pass a written test administered by the department within 60 days of completing the program, and submit the documentation required by subdivision (d) to the department within 30 days of being notified of having passed the test. The department may extend these time deadlines for good cause. The department shall notify the applicant of his or her test results within 30 days of administering the test.

(d) The department shall not begin the process of issuing a certificate until receipt of all of the following:

(1) A certificate of completion of the administrator training required pursuant to this chapter.

(2) The fee required for issuance of the certificate. A fee of one hundred dollars ($100) shall be charged by the department to cover the costs of processing the application for certification.

(3) Documentation of passing the written test or of qualifying for an exemption pursuant to subdivision (b).

(4) Submission of fingerprints. The department and the Department of Justice shall expedite the criminal record clearance for holders of certificates of completion. The department may waive the submission for those persons who have a current criminal record clearance on file.

(e) It shall be unlawful for a person not certified under this section to hold himself or herself out as a certified administrator of a residential care facility for the elderly. Any person willfully making a false representation as being a certified administrator is guilty of a misdemeanor.

(f) (1) Certificates issued under this section shall be renewed every two years and renewal shall be conditional upon the certificate holder submitting documentation of completion of 40 hours of continuing education related to the core of knowledge specified in paragraph (1) of subdivision (c). No more than one-half of the required 40 hours of continuing education necessary to renew the certificate may be satisfied through online courses. All other continuing education hours shall be completed in a classroom setting. For purposes of this section, individuals who hold a valid license

as a nursing home administrator issued in accordance with Chapter 2.35 (commencing with Section 1416) of Division 2 of the Health and Safety Code and meet the requirements of paragraph (1) of subdivision (b) shall only be required to complete 20 hours of continuing education.

(2) Every certified administrator of a residential care facility for the elderly is required to renew his or her certificate and shall complete the continuing education requirements of this subdivision whether he or she is certified according to subdivision (a) or (b). At least 8 hours of the 40-hour continuing education requirement for a certified administrator of a residential care facility for the elderly shall include instruction on serving clients with dementia, including, but not limited to, instruction related to direct care, physical environment, and admissions procedures and assessment.

(3) Certificates issued under this section shall expire every two years, on the anniversary date of the initial issuance of the certificate, except that any administrator receiving his or her initial certification on or after January 1, 1999, shall make an irrevocable election to have his or her recertification date for any subsequent recertification either on the date two years from the date of issuance of the certificate or on the individual's birthday during the second calendar year following certification. The department shall send a renewal notice to the certificate holder 90 days prior to the expiration date of the certificate. If the certificate is not renewed prior to its expiration date, reinstatement shall only be permitted after the certificate holder has paid a delinquency fee equal to three times the renewal fee and has provided evidence of completion of the continuing education required.

(4) To renew a certificate, the certificate holder shall, on or before the certificate expiration date, request renewal by submitting to the department documentation of completion of the required continuing education courses and pay the renewal fee of one hundred dollars ($100), irrespective of receipt of the department's notification of the renewal. A renewal request postmarked on or before the expiration of the certificate is proof of compliance with this paragraph.

(5) A suspended or revoked certificate is subject to expiration as provided for in this section. If reinstatement of the certificate is approved by the department, the certificate holder, as a condition precedent to reinstatement, shall pay a fee in an amount equal to the renewal fee, plus the delinquency fee, if any, accrued at the time of its revocation or suspension.

(6) A certificate that is not renewed within four years after its expiration shall not be renewed, restored, reissued, or reinstated except upon completion of a certification program, passing any test that may be required of an applicant for a new certificate at that time, and paying the appropriate fees provided for in this section.

(7) A fee of twenty-five dollars ($25) shall be charged for the reissuance of a lost certificate.

(8) A certificate holder shall inform the department of his or her employment status within 30 days of any change.

(g) The department may revoke a certificate issued under this section for any of the following:

(1) Procuring a certificate by fraud or misrepresentation.

(2) Knowingly making or giving any false statement or information in conjunction with the application for issuance of a certificate.

(3) Criminal conviction, unless an exemption is granted pursuant to Section 1569.17.

(h) The certificate shall be considered forfeited under either of the following conditions:

(1) The administrator has had a license revoked, suspended, or denied as authorized under Section 1569.50.

(2) The administrator has been denied employment, residence, or presence in a facility based on action resulting from an administrative hearing pursuant to Section 1569.58.

(i) (1) The department shall establish, by regulation, the program content, the testing instrument, the process for approving certification programs, and criteria to be used in authorizing individuals, organizations, or educational institutions to conduct certification programs and continuing education courses. These regulations shall be developed in consultation with provider and consumer organizations, and shall be made available at least six months prior to the deadline required for certification. The department may deny vendor approval to any agency or person that has not provided satisfactory evidence of their ability to meet the requirements of vendorization set out in the regulations adopted pursuant to subdivision (j).

(2) (A) A vendor of online programs for continuing education shall ensure that each online course contains all of the following:

(i) An interactive portion where the participant receives feedback, through online communication, based on input from the participant.

(ii) Required use of a personal identification number or personal identification information to confirm the identity of the participant.

(iii) A final screen displaying a printable statement, to be signed by the participant, certifying that the identified participant completed the course. The vendor shall obtain a copy of the final screen statement with the original signature of the participant prior to the issuance of a certificate of completion. The signed statement of completion shall be maintained by the vendor for a period of three years and be available to the department upon demand. Any person who certifies as true any material matter pursuant to this section that he or she knows to be false is guilty of a misdemeanor.

(B) Nothing in this subdivision shall prohibit the department from approving online programs for continuing education that do not meet the requirements of subparagraph (A) if the vendor demonstrates to the department's satisfaction that, through advanced technology, the course and the course delivery meet the requirements of this section.

(3) The department may authorize vendors to conduct the administrator certification training program pursuant to provisions set forth in this section. The department shall conduct the written test pursuant to regulations adopted by the department.

(4) The department shall prepare and maintain an updated list of approved training vendors.

(5) The department may inspect training programs, continuing education courses, and online courses, at no charge to the department, in order to determine if content and teaching methods comply with paragraphs (1) and (2), if applicable, and with regulations. If the department determines that a vendor is not complying with the intent of this section, the department shall take appropriate action to bring the program into compliance, which may include removing the vendor from the approved list.

(6) The department shall establish reasonable procedures and timeframes, not to exceed 30 days, for the approval of vendor training programs.

(7) The department may charge a reasonable fee, not to exceed one hundred fifty dollars ($150) every two years, to certification program vendors for review and approval of the initial 40-hour training program pursuant to subdivision (c). The department may also charge the vendor a fee, not to exceed one hundred dollars ($100) every two years, for the review and approval of the continuing education courses needed for recertification pursuant to this subdivision.

(j) This section shall be operative upon regulations being adopted by the department to implement the administrator certification program as provided for in this section.

(k) The department shall establish a registry for holders of certificates that shall include, at a minimum, information on employment status and criminal record clearance.

(*l*) Notwithstanding any law to the contrary, vendors approved by the department who exclusively provide either initial or continuing education courses for certification of administrators of a residential care facility for the elderly, as defined in subdivision (k) of Section 1569.2, a group home facility, as defined by regulations of the department, or an adult residential care facility, as defined by regulations of the department, shall be regulated solely by the department pursuant to this chapter. No other state or local governmental entity shall be responsible for regulating the activity of those vendors.

(m) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 4. Section 1569.616 is added to the Health and Safety Code, to read:

1569.616. (a) (1) An administrator of a residential care facility for the elderly shall be required to successfully complete a department-approved certification program prior to employment.

(2) In those cases where the individual is both the licensee and the administrator of a facility, or a licensed nursing home administrator, the individual shall comply with the requirements of this section unless he or she qualifies for one of the exemptions provided for in subdivision (b).

(3) Failure to comply with this section shall constitute cause for revocation of the license of the facility where an individual is functioning as the administrator.

(4) The licensee shall notify the department within 30 days of any change in administrators.

(b) Individuals seeking exemptions under paragraph (2) of subdivision (a) shall meet the following criteria and fulfill the required portions of the certification program, as the case may be:

(1) An individual designated as the administrator of a residential care facility for the elderly who holds a valid license as a nursing home administrator issued in accordance with Chapter 2.35 (commencing with Section 1416) of Division 2 shall be required to complete the areas in the uniform core of knowledge required by this section that pertain to the law, regulations, policies, and procedural standards that impact the operations of residential care facilities for the elderly, the use, misuse, and interaction of medication commonly used by the elderly in a residential setting, and resident admission, retention, and assessment procedures, equal to 12 hours of classroom instruction. An individual meeting the requirements of this paragraph shall not be required to take a written test.

(2) In those cases where the individual was both the licensee and administrator on or before July 1, 1991, the individual shall be required to complete all the areas specified for the certification program, but shall not be required to take the written test required by this section. Those individuals exempted from the written test shall be issued a conditional certification that is valid only for the administrator of the facility for which the exemption was granted.

(A) As a condition to becoming an administrator of another facility, the individual shall be required to pass the written test provided for in this section.

(B) As a condition to applying for a new facility license, the individual shall be required to pass the written test provided for in Section 1569.23.

(c) (1) The administrator certification program shall require a minimum of 80 hours of coursework, which shall include at least 60 hours of in-person instruction that provides training on a uniform core of knowledge in each of the following areas:

(A) Laws, regulations, and policies and procedural standards that impact the operations of residential care facilities for the elderly.

(B) Business operations.

(C) Management and supervision of staff.

(D) Psychosocial needs of the elderly.

(E) Community and support services.

(F) Physical needs for elderly persons.

(G) Medication management, including the use, misuse, and interaction of medication commonly used by the elderly, including antipsychotics and the adverse effects of psychotropic drugs for use in controlling the behavior of persons with dementia.

(H) Resident admission, retention, and assessment procedures.

(I) Managing Alzheimer's disease and related dementias, including nonpharmacologic, person-centered approaches to dementia care.

(J) Cultural competency and sensitivity in issues relating to the underserved aging lesbian, gay, bisexual, and transgender community.

(K) Residents' rights and the importance of initial and ongoing training for all staff to ensure that residents' rights are fully respected and implemented.

(L) Managing the physical environment, including, but not limited to, maintenance and housekeeping.

(M) Postural supports, restricted health conditions, and hospice care.

(2) Individuals applying for certification under this section shall successfully complete an approved certification program, pass a written test administered by the department within 60 days of completing the program, and submit the documentation required by subdivision (d) to the department within 30 days of being notified of having passed the test. The department may extend these time deadlines for good cause. The department shall notify the applicant of his or her test results within 30 days of administering the test.

(3) The department shall ensure the test consists of at least 100 questions and allows an applicant to have access to the California Residential Care Facilities for the Elderly Act and related regulations during the test. The department, no later than July 1 of every other year, shall review and revise the test in order to ensure the rigor and quality of the test. Each year, the department shall ensure, by January 1, that the test is not in conflict with prevailing law. The department may convene a stakeholder group to assist in developing and reviewing test questions.

(d) The department shall not begin the process of issuing a certificate until receipt of all of the following:

(1) A certificate of completion of the administrator training required pursuant to this chapter.

(2) The fee required for issuance of the certificate. A fee of one hundred dollars ($100) shall be charged by the department to cover the costs of processing the application for certification.

(3) Documentation of passing the written test or of qualifying for an exemption pursuant to subdivision (b).

(4) Submission of fingerprints. The department and the Department of Justice shall expedite the criminal record clearance for holders of certificates of completion. The department may waive the submission for those persons who have a current criminal record clearance on file.

(e) It shall be unlawful for a person not certified under this section to hold himself or herself out as a certified administrator of a residential care facility for the elderly. Any person willfully making a false representation as being a certified administrator is guilty of a misdemeanor.

(f) (1) Certificates issued under this section shall be renewed every two years and renewal shall be conditional upon the certificate holder submitting documentation of completion of 40 hours of continuing education related to the uniform core of knowledge specified in paragraph (1) of subdivision (c). No more than one-half of the required 40 hours of continuing education necessary to renew the certificate may be satisfied through online courses.

All other continuing education hours shall be completed in a classroom setting. For purposes of this section, individuals who hold a valid license as a nursing home administrator issued in accordance with Chapter 2.35 (commencing with Section 1416) of Division 2 and meet the requirements of paragraph (1) of subdivision (b) shall only be required to complete 20 hours of continuing education.

(2) Every certified administrator of a residential care facility for the elderly is required to renew his or her certificate and shall complete the continuing education requirements of this subdivision whether he or she is certified according to subdivision (a) or (b). At least eight hours of the 40-hour continuing education requirement for a certified administrator of a residential care facility for the elderly shall include instruction on serving clients with dementia, including, but not limited to, instruction related to direct care, physical environment, and admissions procedures and assessment.

(3) Certificates issued under this section shall expire every two years, on the anniversary date of the initial issuance of the certificate, except that any administrator receiving his or her initial certification on or after January 1, 1999, shall make an irrevocable election to have his or her recertification date for any subsequent recertification either on the date two years from the date of issuance of the certificate or on the individual's birthday during the second calendar year following certification. The department shall send a renewal notice to the certificate holder 90 days prior to the expiration date of the certificate. If the certificate is not renewed prior to its expiration date, reinstatement shall only be permitted after the certificate holder has paid a delinquency fee equal to three times the renewal fee and has provided evidence of completion of the continuing education required.

(4) To renew a certificate, the certificate holder shall, on or before the certificate expiration date, request renewal by submitting to the department documentation of completion of the required continuing education courses and pay the renewal fee of one hundred dollars ($100), irrespective of receipt of the department's notification of the renewal. A renewal request postmarked on or before the expiration of the certificate is proof of compliance with this paragraph.

(5) A suspended or revoked certificate is subject to expiration as provided for in this section. If reinstatement of the certificate is approved by the department, the certificate holder, as a condition precedent to reinstatement, shall pay a fee in an amount equal to the renewal fee, plus the delinquency fee, if any, accrued at the time of its revocation or suspension.

(6) A certificate that is not renewed within four years after its expiration shall not be renewed, restored, reissued, or reinstated except upon completion of a certification program, passing any test that may be required of an applicant for a new certificate at that time, and paying the appropriate fees provided for in this section.

(7) A fee of twenty-five dollars ($25) shall be charged for the reissuance of a lost certificate.

(8) A certificate holder shall inform the department of his or her employment status within 30 days of any change.

(g) The department may revoke a certificate issued under this section for any of the following:

(1) Procuring a certificate by fraud or misrepresentation.

(2) Knowingly making or giving any false statement or information in conjunction with the application for issuance of a certificate.

(3) Criminal conviction, unless an exemption is granted pursuant to Section 1569.17.

(h) The certificate shall be considered forfeited under either of the following conditions:

(1) The administrator has had a license revoked, suspended, or denied as authorized under Section 1569.50.

(2) The administrator has been denied employment, residence, or presence in a facility based on action resulting from an administrative hearing pursuant to Section 1569.58.

(i) (1) The department shall establish, by regulation, the program content, the testing instrument, the process for approving certification programs, and criteria to be used in authorizing individuals, organizations, or educational institutions to conduct certification programs and continuing education courses. These regulations shall be developed in consultation with provider and consumer organizations, and shall be made available at least six months prior to the deadline required for certification. The department may deny vendor approval to any agency or person that has not provided satisfactory evidence of their ability to meet the requirements of vendorization set out in the regulations adopted pursuant to subdivision (j).

(2) (A) A vendor of online programs for continuing education shall ensure that each online course contains all of the following:

(i) An interactive portion where the participant receives feedback, through online communication, based on input from the participant.

(ii) Required use of a personal identification number or personal identification information to confirm the identity of the participant.

(iii) A final screen displaying a printable statement, to be signed by the participant, certifying that the identified participant completed the course. The vendor shall obtain a copy of the final screen statement with the original signature of the participant prior to the issuance of a certificate of completion. The signed statement of completion shall be maintained by the vendor for a period of three years and be available to the department upon demand. Any person who certifies as true any material matter pursuant to this section that he or she knows to be false is guilty of a misdemeanor.

(B) Nothing in this subdivision shall prohibit the department from approving online programs for continuing education that do not meet the requirements of subparagraph (A) if the vendor demonstrates to the department's satisfaction that, through advanced technology, the course and the course delivery meet the requirements of this section.

(3) The department may authorize vendors to conduct the administrator certification training program pursuant to provisions set forth in this section.

The department shall conduct the written test pursuant to regulations adopted by the department.

(4) The department shall prepare and maintain an updated list of approved training vendors.

(5) The department may inspect training programs, continuing education courses, and online courses, at no charge to the department, in order to determine if content and teaching methods comply with paragraphs (1) and (2), if applicable, and with regulations. If the department determines that a vendor is not complying with the intent of this section, the department shall take appropriate action to bring the program into compliance, which may include removing the vendor from the approved list.

(6) The department shall establish reasonable procedures and timeframes, not to exceed 30 days, for the approval of vendor training programs.

(7) The department may charge a reasonable fee, not to exceed one hundred fifty dollars ($150) every two years, to certification program vendors for review and approval of the initial 80-hour training program pursuant to subdivision (c). The department may also charge the vendor a fee, not to exceed one hundred dollars ($100) every two years, for the review and approval of the continuing education courses needed for recertification pursuant to this subdivision.

(j) This section shall be operative upon regulations being adopted by the department to implement the administrator certification program as provided for in this section.

(k) The department shall establish a registry for holders of certificates that shall include, at a minimum, information on employment status and criminal record clearance.

(*l*) Notwithstanding any law to the contrary, vendors approved by the department who exclusively provide either initial or continuing education courses for certification of administrators of a residential care facility for the elderly, as defined in subdivision (k) of Section 1569.2, a group home facility, as defined by regulations of the department, or an adult residential care facility, as defined by regulations of the department, shall be regulated solely by the department pursuant to this chapter. No other state or local governmental entity shall be responsible for regulating the activity of those vendors.

(m) This section shall become operative on January 1, 2016.

SEC. 5. Section 1569.62 of the Health and Safety Code is amended to read:

1569.62. (a) The director shall ensure that licensees, administrators, and staffs of residential care facilities for the elderly have appropriate training to provide the care and services for which a license or certificate is issued.

(b) The department shall develop jointly with the California Department of Aging, with input from provider organizations, requirements for a uniform core of knowledge within the required 20 hours of continuing education for administrators, and their designated substitutes, and for recertification of administrators of residential care facilities for the elderly. This knowledge base shall include, as a minimum, basic understanding of the psychosocial

and physical care needs of elderly persons and administration. The department shall develop jointly with the California Department of Aging, with input from provider organizations, a uniform resident assessment tool to be used by all residential care facilities for the elderly. The assessment tool shall, in lay terms, help to identify resident needs for service and assistance with activities of daily living.

The departments shall develop a mandatory training program on the utilization of the assessment tool to be given to administrators and their designated substitutes.

(c) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 6. Section 1569.62 is added to the Health and Safety Code, to read:

1569.62. (a) The director shall ensure that licensees, administrators, and staff of residential care facilities for the elderly have appropriate training to provide the care and services for which a license or certificate is issued.

(b) The department shall develop jointly with the California Department of Aging requirements for a uniform core of knowledge for the required initial certification and continuing education for administrators, and their designated substitutes, and for recertification of administrators of residential care facilities for the elderly. This knowledge base shall include, as a minimum, basic understanding of the psychosocial and physical care needs of elderly persons, applicable laws and regulations, residents' rights, and administration. This training shall be developed in consultation with individuals or organizations with specific expertise in residential care facilities for the elderly or assisted living services, or by an outside source with expertise in residential care facilities for the elderly or assisted living services.

(1) The initial certification training for administrators shall consist of at least 80 hours.

(2) The continuing education requirement for administrators is at least 40 hours of training during each two-year certification period, as specified in paragraph (1) of subdivision (f) of Section 1569.616.

(c) (1) The department shall develop a uniform resident assessment tool to be used by all residential care facilities for the elderly. The assessment tool shall, in lay terms, help to identify resident needs for service and assistance with activities of daily living.

(2) The departments shall develop a mandatory training program on the utilization of the assessment tool to be given to administrators and their designated substitutes.

(d) This section shall become operative on January 1, 2016.

SEC. 7. Section 1569.69 of the Health and Safety Code is amended to read:

1569.69. (a) Each residential care facility for the elderly licensed under this chapter shall ensure that each employee of the facility who assists residents with the self-administration of medications meets the following training requirements:

(1) In facilities licensed to provide care for 16 or more persons, the employee shall complete 16 hours of initial training. This training shall consist of eight hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and eight hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.

(2) In facilities licensed to provide care for 15 or fewer persons, the employee shall complete six hours of initial training. This training shall consist of two hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and four hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.

(3) An employee shall be required to complete the training requirements for hands-on shadowing training described in this subdivision prior to assisting any resident in the self-administration of medications. The training and instruction described in this subdivision shall be completed, in their entirety, within the first two weeks of employment.

(4) The training shall cover all of the following areas:

(A) The role, responsibilities, and limitations of staff who assist residents with the self-administration of medication, including tasks limited to licensed medical professionals.

(B) An explanation of the terminology specific to medication assistance.

(C) An explanation of the different types of medication orders: prescription, over-the-counter, controlled, and other medications.

(D) An explanation of the basic rules and precautions of medication assistance.

(E) Information on medication forms and routes for medication taken by residents.

(F) A description of procedures for providing assistance with the self-administration of medications in and out of the facility, and information on the medication documentation system used in the facility.

(G) An explanation of guidelines for the proper storage, security, and documentation of centrally stored medications.

(H) A description of the processes used for medication ordering, refills, and the receipt of medications from the pharmacy.

(I) An explanation of medication side effects, adverse reactions, and errors.

(5) To complete the training requirements set forth in this subdivision, each employee shall pass an examination that tests the employee's comprehension of, and competency in, the subjects listed in paragraph (4).

(6) Residential care facilities for the elderly shall encourage pharmacists and licensed medical professionals to use plain English when preparing labels on medications supplied to residents. As used in this section, "plain English" means that no abbreviations, symbols, or Latin medical terms shall be used in the instructions for the self-administration of medication.

(7) The training requirements of this section are not intended to replace or supplant those required of all staff members who assist residents with personal activities of daily living as set forth in Section 1569.625.

(8) The training requirements of this section shall be repeated if either of the following occurs:

(A) An employee returns to work for the same licensee after a break of service of more than 180 consecutive calendar days.

(B) An employee goes to work for another licensee in a facility in which he or she assists residents with the self-administration of medication.

(b) Each employee who received training and passed the examination required in paragraph (5) of subdivision (a), and who continues to assist with the self-administration of medicines, shall also complete four hours of in-service training on medication-related issues in each succeeding 12-month period.

(c) The requirements set forth in subdivisions (a) and (b) do not apply to persons who are licensed medical professionals.

(d) Each residential care facility for the elderly that provides employee training under this section shall use the training material and the accompanying examination that are developed by, or in consultation with, a licensed nurse, pharmacist, or physician. The licensed residential care facility for the elderly shall maintain the following documentation for each medical consultant used to develop the training:

(1) The name, address, and telephone number of the consultant.

(2) The date when consultation was provided.

(3) The consultant's organization affiliation, if any, and any educational and professional qualifications specific to medication management.

(4) The training topics for which consultation was provided.

(e) Each person who provides employee training under this section shall meet the following education and experience requirements:

(1) A minimum of five hours of initial, or certified continuing, education or three semester units, or the equivalent, from an accredited educational institution, on topics relevant to medication management.

(2) The person shall meet any of the following practical experience or licensure requirements:

(A) Two years of full-time experience, within the last four years, as a consultant with expertise in medication management in areas covered by the training described in subdivision (a).

(B) Two years of full-time experience, or the equivalent, within the last four years, as an administrator for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.

(C) Two years of full-time experience, or the equivalent, within the last four years, as a direct care provider assisting with the self-administration of medications for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.

(D) Possession of a license as a medical professional.

(3) The licensed residential care facility for the elderly shall maintain the following documentation on each person who provides employee training under this section:

(A) The person's name, address, and telephone number.

(B) Information on the topics or subject matter covered in the training.

(C) The time, dates, and hours of training provided.

(f) Other training or instruction, as required in paragraphs (1) and (2) of subdivision (a), may be provided offsite, and may use various methods of instruction, including, but not limited to, all of the following:

(1) Lectures by presenters who are knowledgeable about medication management.

(2) Video recorded instruction, interactive material, online training, and books.

(3) Other written or visual materials approved by organizations or individuals with expertise in medication management.

(g) Residential care facilities for the elderly licensed to provide care for 16 or more persons shall maintain documentation that demonstrates that a consultant pharmacist or nurse has reviewed the facility's medication management program and procedures at least twice a year.

(h) Nothing in this section authorizes unlicensed personnel to directly administer medications.

(i) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 8. Section 1569.69 is added to the Health and Safety Code, to read:

1569.69. (a) Each residential care facility for the elderly licensed under this chapter shall ensure that each employee of the facility who assists residents with the self-administration of medications meets all of the following training requirements:

(1) In facilities licensed to provide care for 16 or more persons, the employee shall complete 24 hours of initial training. This training shall consist of 16 hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and 8 hours of other training or instruction, as described in subdivision (f), which shall be completed within the first four weeks of employment.

(2) In facilities licensed to provide care for 15 or fewer persons, the employee shall complete 10 hours of initial training. This training shall consist of 6 hours of hands-on shadowing training, which shall be completed prior to assisting with the self-administration of medications, and 4 hours of other training or instruction, as described in subdivision (f), which shall be completed within the first two weeks of employment.

(3) An employee shall be required to complete the training requirements for hands-on shadowing training described in this subdivision prior to assisting any resident in the self-administration of medications. The training and instruction described in this subdivision shall be completed, in their entirety, within the first two weeks of employment.

(4) The training shall cover all of the following areas:

(A) The role, responsibilities, and limitations of staff who assist residents with the self-administration of medication, including tasks limited to licensed medical professionals.

(B) An explanation of the terminology specific to medication assistance.

(C) An explanation of the different types of medication orders: prescription, over-the-counter, controlled, and other medications.

(D) An explanation of the basic rules and precautions of medication assistance.

(E) Information on medication forms and routes for medication taken by residents.

(F) A description of procedures for providing assistance with the self-administration of medications in and out of the facility, and information on the medication documentation system used in the facility.

(G) An explanation of guidelines for the proper storage, security, and documentation of centrally stored medications.

(H) A description of the processes used for medication ordering, refills, and the receipt of medications from the pharmacy.

(I) An explanation of medication side effects, adverse reactions, errors, the adverse effects of psychotropic drugs for use in controlling the behavior of persons with dementia, and the increased risk of death when elderly residents with dementia are given antipsychotic medications.

(5) To complete the training requirements set forth in this subdivision, each employee shall pass an examination that tests the employee's comprehension of, and competency in, the subjects listed in paragraph (4).

(6) Residential care facilities for the elderly shall encourage pharmacists and licensed medical professionals to use plain English when preparing labels on medications supplied to residents. As used in this section, "plain English" means that no abbreviations, symbols, or Latin medical terms shall be used in the instructions for the self-administration of medication.

(7) The training requirements of this section are not intended to replace or supplant those required of all staff members who assist residents with personal activities of daily living as set forth in Sections 1569.625 and 1569.696.

(8) The training requirements of this section shall be repeated if either of the following occur:

(A) An employee returns to work for the same licensee after a break of service of more than 180 consecutive calendar days.

(B) An employee goes to work for another licensee in a facility in which he or she assists residents with the self-administration of medication.

(b) Each employee who received training and passed the examination required in paragraph (5) of subdivision (a), and who continues to assist with the self-administration of medicines, shall also complete eight hours of in-service training on medication-related issues in each succeeding 12-month period.

(c) The requirements set forth in subdivisions (a) and (b) do not apply to persons who are licensed medical professionals.

(d) Each residential care facility for the elderly that provides employee training under this section shall use the training material and the accompanying examination that are developed by, or in consultation with, a licensed nurse, pharmacist, or physician. The licensed residential care facility for the elderly shall maintain the following documentation for each medical consultant used to develop the training:

(1) The name, address, and telephone number of the consultant.

(2) The date when consultation was provided.

(3) The consultant's organization affiliation, if any, and any educational and professional qualifications specific to medication management.

(4) The training topics for which consultation was provided.

(e) Each person who provides employee training under this section shall meet the following education and experience requirements:

(1) A minimum of five hours of initial, or certified continuing, education or three semester units, or the equivalent, from an accredited educational institution, on topics relevant to medication management.

(2) The person shall meet any of the following practical experience or licensure requirements:

(A) Two years of full-time experience, within the last four years, as a consultant with expertise in medication management in areas covered by the training described in subdivision (a).

(B) Two years of full-time experience, or the equivalent, within the last four years, as an administrator for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.

(C) Two years of full-time experience, or the equivalent, within the last four years, as a direct care provider assisting with the self-administration of medications for a residential care facility for the elderly, during which time the individual has acted in substantial compliance with applicable regulations.

(D) Possession of a license as a medical professional.

(3) The licensed residential care facility for the elderly shall maintain the following documentation on each person who provides employee training under this section:

(A) The person's name, address, and telephone number.

(B) Information on the topics or subject matter covered in the training.

(C) The times, dates, and hours of training provided.

(f) Other training or instruction, as required in paragraphs (1) and (2) of subdivision (a), may be provided offsite, and may use various methods of instruction, including, but not limited to, all of the following:

(1) Lectures by presenters who are knowledgeable about medication management.

(2) Video recorded instruction, interactive material, online training, and books.

(3) Other written or visual materials approved by organizations or individuals with expertise in medication management.

(g) Residential care facilities for the elderly licensed to provide care for 16 or more persons shall maintain documentation that demonstrates that a consultant pharmacist or nurse has reviewed the facility's medication management program and procedures at least twice a year.

(h) Nothing in this section authorizes unlicensed personnel to directly administer medications.

(i) This section shall become operative on January 1, 2016.

SEC. 9. Section 1569.696 is added to the Health and Safety Code, to read:

1569.696. (a) All residential care facilities for the elderly shall provide training to direct care staff on postural supports, restricted conditions or health services, and hospice care as a component of the training requirements specified in Section 1569.625. The training shall include all of the following:

(1) Four hours of training on the care, supervision, and special needs of those residents, prior to providing direct care to residents. The facility may utilize various methods of instruction, including, but not limited to, preceptorship, mentoring, and other forms of observation and demonstration. The orientation time shall be exclusive of any administrative instruction.

(2) Four hours of training thereafter of in-service training per year on the subject of serving those residents.

(b) This training shall be developed in consultation with individuals or organizations with specific expertise in the care of those residents described in subdivision (a). In formulating and providing this training, reference may be made to written materials and literature. This training requirement may be provided at the facility or offsite and may include a combination of observation and practical application.

(c) This section shall become operative on January 1, 2016.

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 11. This act shall become operative only if Assembly Bill 1570 is enacted and takes effect on or before January 1, 2015.

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Emergency Epinephrine Auto-Injectors: Pupil Health

Legislation enacted during the 2014 Session

SB 1266 (Huff), Chapter 321 an act to amend Section 4119.2 of the Business and Professions Code, and amend Section 49414 of the Education Code, relating to pupil health.

The amendments to 1449.2 Business and Professions Code and Section 4119.2 of the Education Code, require school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses and trained personnel who have volunteered, as specified, and would authorize school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. The enacted law will require school districts, county offices of education, and charter schools to distribute a notice requesting volunteers at least once a year. The enacted law requires a qualified supervisor of health or administrator at a school district, county office of education, or charter school to obtain the prescription for epinephrine auto-injectors from an authorizing physician and surgeon, as defined, and would authorize the prescription to be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers. The enacted law requires epinephrine auto-injectors to be stocked and restocked by the qualified supervisor of health or administrator in accordance with specified provisions. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This law change provides that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

The people of the State of California do enact as follows:

SECTION 1.
Section 4119.2 of the Business and Professions Code is amended to read:
4119.2.
(a) Notwithstanding any other law, a pharmacy may furnish epinephrine auto-injectors to a school district, county office of education, or charter school pursuant to Section 49414 of the Education Code if all of the following are met:

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(1) The epinephrine auto-injectors are furnished exclusively for use at a school district site, county office of education, or charter school.
(2) A physician and surgeon provides a written order that specifies the quantity of epinephrine auto-injectors to be furnished.
(b) Records regarding the acquisition and disposition of epinephrine auto-injectors furnished pursuant to subdivision (a) shall be maintained by the school district, county office of education, or charter school for a period of three years from the date the records were created. The school district, county office of education, or charter school shall be responsible for monitoring the supply of epinephrine auto-injectors and ensuring the destruction of expired epinephrine auto-injectors.

SEC. 2.
Section 49414 of the Education Code is amended to read:
49414.
(a) School districts, county offices of education, and charter schools shall provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered pursuant to subdivision (d), and school nurses or trained personnel may use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.
(b) For purposes of this section, the following terms have the following meanings:
(1) “Anaphylaxis” means a potentially life-threatening hypersensitivity to a substance.
(A) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.
(B) Causes of anaphylaxis may include, but are not limited to, an insect sting, food allergy, drug reaction, and exercise.
(2) “Authorizing physician and surgeon” may include, but is not limited to, a physician and surgeon employed by, or contracting with, a local educational agency, a medical director of the local health department, or a local emergency medical services director.
(3) “Epinephrine auto-injector” means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering a potentially fatal reaction to anaphylaxis.
(4) “Qualified supervisor of health” may include, but is not limited to, a school nurse.
(5) “Volunteer” or “trained personnel” means an employee who has volunteered to administer epinephrine auto-injectors to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, has been designated by a school, and has received training pursuant to subdivision (d).
(c) Each private elementary and secondary school in the state may voluntarily determine whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. In making this determination, a school shall evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to epinephrine auto-injectors and trained personnel. A private elementary or secondary school choosing to exercise the authority provided under this subdivision shall not receive state funds specifically for purposes of this subdivision.
(d) Each public and private elementary and secondary school in the state may designate one or more volunteers to receive initial and annual refresher training, based on the standards developed pursuant to subdivision (e), regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by an authorizing physician and surgeon.
(e) (1) Every five years, or sooner as deemed necessary by the Superintendent, the Superintendent shall review minimum standards of training for the administration of epinephrine auto-injectors that satisfy the requirements of paragraph (2). For purposes of this subdivision, the Superintendent shall consult with organizations and providers with expertise in administering epinephrine auto-injectors and administering medication in a school environment, including, but not limited to, the State Department of Public Health, the Emergency Medical Services Authority, the American Academy of Allergy, Asthma and Immunology, the California School Nurses Organization, the California Medical Association, the American Academy of Pediatrics, Food Allergy Research and Education, the California Society of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, the Stanford Allergy Center, and others.
(2) Training established pursuant to this subdivision shall include all of the following:

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(A) Techniques for recognizing symptoms of anaphylaxis.
(B) Standards and procedures for the storage, restocking, and emergency use of epinephrine auto-injectors.
(C) Emergency followup procedures, including calling the emergency 911 telephone number and contacting, if possible, the pupil's parent and physician.
(D) Recommendations on the necessity of instruction and certification in cardiopulmonary resuscitation.
(E) Instruction on how to determine whether to use an adult epinephrine auto-injector or a junior epinephrine auto-injector, which shall include consideration of a pupil's grade level or age as a guideline of equivalency for the appropriate pupil weight determination.
(F) Written materials covering the information required under this subdivision.
(3) Training established pursuant to this subdivision shall be consistent with the most recent Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs published by the federal Centers for Disease Control and Prevention and the most recent guidelines for medication administration issued by the department.
(4) A school shall retain for reference the written materials prepared under subparagraph (F) of paragraph (2).
(f) A school district, county office of education, or charter school shall distribute a notice at least once per school year to all staff that contains the following information:
(1) A description of the volunteer request stating that the request is for volunteers to be trained to administer an epinephrine auto-injector to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, as specified in subdivision (b).
(2) A description of the training that the volunteer will receive pursuant to subdivision (d).
(g) (1) A qualified supervisor of health at a school district, county office of education, or charter school shall obtain from an authorizing physician and surgeon a prescription for each school for epinephrine auto-injectors that, at a minimum, includes, for elementary schools, one regular epinephrine auto-injector and one junior epinephrine auto-injector, and for junior high schools, middle schools, and high schools, if there are no pupils who require a junior epinephrine auto-injector, one regular epinephrine auto-injector. A qualified supervisor of health at a school district, county office of education, or charter school shall be responsible for stocking the epinephrine auto-injector and restocking it if it is used.
(2) If a school district, county office of education, or charter school does not have a qualified supervisor of health, an administrator at the school district, county office of education, or charter school shall carry out the duties specified in paragraph (1).
(3) A prescription pursuant to this subdivision may be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.
(h) A school nurse or, if the school does not have a school nurse or the school nurse is not onsite or available, a volunteer may administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at school or a school activity when a physician is not immediately available. If the epinephrine auto-injector is used it shall be restocked as soon as reasonably possible, but no later than two weeks after it is used. Epinephrine auto-injectors shall be restocked before their expiration date.
(i) A volunteer shall initiate emergency medical services or other appropriate medical followup in accordance with the training materials retained pursuant to paragraph (4) of subdivision (e).
(j) A school district, county office of education, or charter school shall ensure that each employee who volunteers under this section will be provided defense and indemnification by the school district, county office of education, or charter school for any and all civil liability, in accordance with, but not limited to, that provided in Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. This information shall be reduced to writing, provided to the volunteer, and retained in the volunteer's personnel file.
(k) A state agency, the department, or a public school may accept gifts, grants, and donations from any source for the support of the public school carrying out the provisions of this section, including, but not limited to, the acceptance of epinephrine auto-injectors from a manufacturer or wholesaler.

SEC. 3.
If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

California LEGISLATIVE INFORMATION

SB-1266 Pupil health: epinephrine auto-injectors. (2013-2014)

Senate Bill No. 1266

CHAPTER 321

An act to amend Section 4119.2 of the Business and Professions Code, and to amend Section 49414 of the Education Code, relating to pupil health.

[Approved by Governor September 15, 2014. Filed with Secretary of State September 15, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1266, Huff. Pupil health: epinephrine auto-injectors.

(1) Existing law authorizes a school district or county office of education to provide emergency epinephrine auto-injectors to trained personnel, and authorizes trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering from an anaphylactic reaction. Existing law authorizes each public and private elementary and secondary school in the state to designate one or more school personnel on a voluntary basis to receive initial and annual refresher training regarding the storage and emergency use of an epinephrine auto-injector, as specified. Existing law authorizes a school nurse, or a person who has received the training described above if the school does not have a school nurse, to, among other things, obtain a prescription for epinephrine auto-injectors.

This bill would instead require school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses and trained personnel who have volunteered, as specified, and would authorize school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. The bill would require school districts, county offices of education, and charter schools to distribute a notice requesting volunteers at least once a year. The bill would require a qualified supervisor of health or administrator at a school district, county office of education, or charter school to obtain the prescription for epinephrine auto-injectors from an authorizing physician and surgeon, as defined, and would authorize the prescription to be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers. The bill would require epinephrine auto-injectors to be stocked and restocked by the qualified supervisor of health or administrator in accordance with specified provisions. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program.

(2) Existing law requires the Superintendent of Public Instruction to establish minimum standards of training for the administration of epinephrine auto-injectors, as specified, and requires a school district or county office of education to create a plan relating to its use.

This bill would delete the requirement for creating a plan, would revise the training requirements, and would require the Superintendent to review the minimum standards of training at least every 5 years. The bill would require a school district, county office of education, or charter school to ensure that each employee who volunteers is provided defense and indemnification by the school district, county office of education, or charter school for any and all civil liability, as specified. The bill would authorize a state agency, the State Department of Education, or a public school to accept gifts, grants, and donations from any source for the support of the public school carrying out these provisions. By requiring local educational agencies to perform additional duties related to epinephrine auto-injectors, the bill would impose a state-mandated local program.

(3) Existing law authorizes a pharmacy to furnish epinephrine auto-injectors to a school district or county office of education if certain requirements are met.

This bill would also authorize a pharmacy to furnish epinephrine auto-injectors to charter schools pursuant to those provisions.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4119.2 of the Business and Professions Code is amended to read:

4119.2. (a) Notwithstanding any other law, a pharmacy may furnish epinephrine auto-injectors to a school district, county office of education, or charter school pursuant to Section 49414 of the Education Code if all of the following are met:

(1) The epinephrine auto-injectors are furnished exclusively for use at a school district site, county office of education, or charter school.

(2) A physician and surgeon provides a written order that specifies the quantity of epinephrine auto-injectors to be furnished.

(b) Records regarding the acquisition and disposition of epinephrine auto-injectors furnished pursuant to subdivision (a) shall be maintained by the school district, county office of education, or charter school for a period of three years from the date the records were created. The school district, county office of education, or charter school shall be responsible for monitoring the supply of epinephrine auto-injectors and ensuring the destruction of expired epinephrine auto-injectors.

SEC. 2. Section 49414 of the Education Code is amended to read:

49414. (a) School districts, county offices of education, and charter schools shall provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered pursuant to subdivision (d), and school nurses or trained personnel may use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.

(A) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.

(B) Causes of anaphylaxis may include, but are not limited to, an insect sting, food allergy, drug reaction, and exercise.

(2) "Authorizing physician and surgeon" may include, but is not limited to, a physician and surgeon employed by, or contracting with, a local educational agency, a medical director of the local health department, or a local emergency medical services director.

(3) "Epinephrine auto-injector" means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering a potentially fatal reaction to anaphylaxis.

(4) "Qualified supervisor of health" may include, but is not limited to, a school nurse.

(5) "Volunteer" or "trained personnel" means an employee who has volunteered to administer epinephrine auto-injectors to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, has been designated by a school, and has received training pursuant to subdivision (d).

(c) Each private elementary and secondary school in the state may voluntarily determine whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. In making this determination, a school shall evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to epinephrine auto-injectors and trained personnel. A private elementary or secondary school choosing to exercise the authority provided under this subdivision shall not receive state funds specifically for purposes of this subdivision.

(d) Each public and private elementary and secondary school in the state may designate one or more volunteers to receive initial and annual refresher training, based on the standards developed pursuant to subdivision (e), regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by an authorizing physician and surgeon.

(e) (1) Every five years, or sooner as deemed necessary by the Superintendent, the Superintendent shall review minimum standards of training for the administration of epinephrine auto-injectors that satisfy the requirements of paragraph (2). For purposes of this subdivision, the Superintendent shall consult with organizations and providers with expertise in administering epinephrine auto-injectors and administering medication in a school environment, including, but not limited to, the State Department of Public Health, the Emergency Medical Services Authority, the American Academy of Allergy, Asthma and Immunology, the California School Nurses Organization, the California Medical Association, the American Academy of Pediatrics, Food Allergy Research and Education, the California Society of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, the Stanford Allergy Center, and others.

(2) Training established pursuant to this subdivision shall include all of the following:

(A) Techniques for recognizing symptoms of anaphylaxis.

(B) Standards and procedures for the storage, restocking, and emergency use of epinephrine auto-injectors.

(C) Emergency followup procedures, including calling the emergency 911 telephone number and contacting, if possible, the pupil's parent and physician.

(D) Recommendations on the necessity of instruction and certification in cardiopulmonary resuscitation.

(E) Instruction on how to determine whether to use an adult epinephrine auto-injector or a junior epinephrine auto-injector, which shall include consideration of a pupil's grade level or age as a guideline of equivalency for the appropriate pupil weight determination.

(F) Written materials covering the information required under this subdivision.

(3) Training established pursuant to this subdivision shall be consistent with the most recent Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs published by the federal Centers for Disease Control and Prevention and the most recent guidelines for medication administration issued by the department.

(4) A school shall retain for reference the written materials prepared under subparagraph (F) of paragraph (2).

(f) A school district, county office of education, or charter school shall distribute a notice at least once per school year to all staff that contains the following information:

(1) A description of the volunteer request stating that the request is for volunteers to be trained to administer an epinephrine auto-injector to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, as specified in subdivision (b).

(2) A description of the training that the volunteer will receive pursuant to subdivision (d).

(g) (1) A qualified supervisor of health at a school district, county office of education, or charter school shall obtain from an authorizing physician and surgeon a prescription for each school for epinephrine auto-injectors that, at a minimum, includes, for elementary schools, one regular epinephrine auto-injector and one junior epinephrine auto-injector, and for junior high schools, middle schools, and high schools, if there are no pupils who require a junior epinephrine auto-injector, one regular epinephrine auto-injector. A qualified supervisor of health at a school district, county office of education, or charter school shall be responsible for stocking the epinephrine auto-injector and restocking it if it is used.

(2) If a school district, county office of education, or charter school does not have a qualified supervisor of health, an administrator at the school district, county office of education, or charter school shall carry out the duties specified in paragraph (1).

(3) A prescription pursuant to this subdivision may be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.

(h) A school nurse or, if the school does not have a school nurse or the school nurse is not onsite or available, a volunteer may administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at school or a school activity when a physician is not immediately available. If the epinephrine auto-injector is used it shall be restocked as soon as reasonably possible, but no later than two weeks after it is used. Epinephrine auto-injectors shall be restocked before their expiration date.

(i) A volunteer shall initiate emergency medical services or other appropriate medical followup in accordance with the training materials retained pursuant to paragraph (4) of subdivision (e).

(j) A school district, county office of education, or charter school shall ensure that each employee who volunteers under this section will be provided defense and indemnification by the school district, county office of education, or charter school for any and all civil liability, in accordance with, but not limited to, that provided in Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. This information shall be reduced to writing, provided to the volunteer, and retained in the volunteer's personnel file.

(k) A state agency, the department, or a public school may accept gifts, grants, and donations from any source for the support of the public school carrying out the provisions of this section, including, but not limited to, the acceptance of epinephrine auto-injectors from a manufacturer or wholesaler.

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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Workplace Violence Prevention Plans-- Hospitals

Legislation enacted during the 2014 Session

SB 1299 (Padilla) Chapter 842 an act to add Section 6401.8 to the Labor Code, relating to occupational safety and health

The enacted law requires the Occupational Safety and Health Standards Board, no later than July 1, 2016, to adopt standards developed by the Division of Occupational Safety and Health that require specified types of hospitals, including a general acute care hospital or an acute psychiatric hospital, to adopt a workplace violence prevention plan as a part of the hospital's injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior. The bill would require the standards to include prescribed requirements for a plan. The bill would require the division, by January 1, 2017, and annually thereafter, to post a report on its Internet Web site containing specified information regarding violent incidents at hospitals. The bill would exempt certain state-operated hospitals from these provisions.

The California Occupational Safety and Health Act of 1973 imposes safety responsibilities on employers and employees, including the requirement that an employer establish, implement, and maintain an effective injury prevention program, and makes specified violations of these provisions a crime.

The people of the State of California do enact as follows:

SECTION 1.
Section 6401.8 is added to the Labor Code, to read:
6401.8.
(a) The standards board, no later than July 1, 2016, shall adopt standards developed by the division that require a hospital licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code, except as exempted by subdivision (d), to adopt a workplace violence prevention plan as a part of its injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior.
(b) The standards adopted pursuant to subdivision (a) shall include all of the following:
(1) A requirement that the workplace violence prevention plan be in effect at all times in all patient care units, including inpatient and outpatient settings and clinics on the hospital's license.
(2) A definition of workplace violence that includes, but is not limited to, both of the following:
(A) The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
(B) An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.
(3) A requirement that a workplace violence prevention plan include, but not be limited to, all of the following:

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(A) Personnel education and training policies that require all health care workers who provide direct care to patients to, at least annually, receive education and training that is designed to provide an opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan. The education and training shall cover topics that include, but are not limited to, the following topics:
(i) How to recognize potential for violence, and when and how to seek assistance to prevent or respond to violence.
(ii) How to report violent incidents to law enforcement.
(iii) Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs.
(B) A system for responding to, and investigating violent incidents and situations involving violence or the risk of violence.
(C) A system to, at least annually, assess and improve upon factors that may contribute to, or help prevent workplace violence, including, but not limited to, the following factors:
(i) Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence.
(ii) Sufficiency of security systems, including alarms, emergency response, and security personnel availability.
(iii) Job design, equipment, and facilities.
(iv) Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas.
(4) A requirement that all workplace violence prevention plans be developed in conjunction with affected employees, including their recognized collective bargaining agents, if any.
(5) A requirement that all temporary personnel be oriented to the workplace violence prevention plan.
(6) Provisions prohibiting hospitals from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.
(7) A requirement that hospitals document, and retain for a period of five years, a written record of any violent incident against a hospital employee, regardless of whether the employee sustains an injury, and regardless of whether the report is made by the employee who is the subject of the violent incident or any other employee.
(8) A requirement that a hospital report violent incidents to the division. If the incident results in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel, the hospital shall report the incident to the division within 24 hours. All other incidents of violence shall be reported to the division within 72 hours.
(c) By January 1, 2017, and annually thereafter, the division, in a manner that protects patient and employee confidentiality, shall post a report on its Internet Web site containing information regarding violent incidents at hospitals, that includes, but is not limited to, the total number of reports, and which specific hospitals filed reports, pursuant to paragraph (8) of subdivision (b), the outcome of any related inspection or investigation, the citations levied against a hospital based on a violent incident, and recommendations of the division on the prevention of violent incidents at hospitals.
(d) This section shall not apply to a hospital operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Corrections and Rehabilitation.
(e) This section does not limit the authority of the standards board to adopt standards to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require other employers, including, but not limited to, employers exempted from this section by subdivision (d), to adopt plans to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require an employer subject to this section, or any other employer, to adopt a workplace violence prevention plan that includes elements or requirements additional to, or broader in scope than, those described in this section.

SEC. 2.
No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Senate Bill No. 1299

CHAPTER 842

An act to add Section 6401.8 to the Labor Code, relating to occupational safety and health.

[Approved by Governor September 29, 2014. Filed with Secretary of State September 29, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1299, Padilla. Workplace violence prevention plans: hospitals.

Existing law regulates the operation of health facilities, including hospitals.

The California Occupational Safety and Health Act of 1973 imposes safety responsibilities on employers and employees, including the requirement that an employer establish, implement, and maintain an effective injury prevention program, and makes specified violations of these provisions a crime.

This bill would require the Occupational Safety and Health Standards Board, no later than July 1, 2016, to adopt standards developed by the Division of Occupational Safety and Health that require specified types of hospitals, including a general acute care hospital or an acute psychiatric hospital, to adopt a workplace violence prevention plan as a part of the hospital's injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior. The bill would require the standards to include prescribed requirements for a plan. The bill would require the division, by January 1, 2017, and annually thereafter, to post a report on its Internet Web site containing specified information regarding violent incidents at hospitals. The bill would exempt certain state-operated hospitals from these provisions.

Because this bill would expand the scope of a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 6401.8 is added to the Labor Code, to read:

6401.8. (a) The standards board, no later than July 1, 2016, shall adopt standards developed by the division that require a hospital licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code,

except as exempted by subdivision (d), to adopt a workplace violence prevention plan as a part of its injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior.

(b) The standards adopted pursuant to subdivision (a) shall include all of the following:

(1) A requirement that the workplace violence prevention plan be in effect at all times in all patient care units, including inpatient and outpatient settings and clinics on the hospital's license.

(2) A definition of workplace violence that includes, but is not limited to, both of the following:

(A) The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

(B) An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

(3) A requirement that a workplace violence prevention plan include, but not be limited to, all of the following:

(A) Personnel education and training policies that require all health care workers who provide direct care to patients to, at least annually, receive education and training that is designed to provide an opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan. The education and training shall cover topics that include, but are not limited to, the following topics:

(i) How to recognize potential for violence, and when and how to seek assistance to prevent or respond to violence.

(ii) How to report violent incidents to law enforcement.

(iii) Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs.

(B) A system for responding to, and investigating violent incidents and situations involving violence or the risk of violence.

(C) A system to, at least annually, assess and improve upon factors that may contribute to, or help prevent workplace violence, including, but not limited to, the following factors:

(i) Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence.

(ii) Sufficiency of security systems, including alarms, emergency response, and security personnel availability.

(iii) Job design, equipment, and facilities.

(iv) Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas.

(4) A requirement that all workplace violence prevention plans be developed in conjunction with affected employees, including their recognized collective bargaining agents, if any.

(5) A requirement that all temporary personnel be oriented to the workplace violence prevention plan.

(6) Provisions prohibiting hospitals from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.

(7) A requirement that hospitals document, and retain for a period of five years, a written record of any violent incident against a hospital employee, regardless of whether the employee sustains an injury, and regardless of whether the report is made by the employee who is the subject of the violent incident or any other employee.

(8) A requirement that a hospital report violent incidents to the division. If the incident results in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel, the hospital shall report the incident to the division within 24 hours. All other incidents of violence shall be reported to the division within 72 hours.

(c) By January 1, 2017, and annually thereafter, the division, in a manner that protects patient and employee confidentiality, shall post a report on its Internet Web site containing information regarding violent incidents at hospitals, that includes, but is not limited to, the total number of reports, and which specific hospitals filed reports, pursuant to paragraph (8) of subdivision (b), the outcome of any related inspection or investigation, the citations levied against a hospital based on a violent incident, and recommendations of the division on the prevention of violent incidents at hospitals.

(d) This section shall not apply to a hospital operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Corrections and Rehabilitation.

(e) This section does not limit the authority of the standards board to adopt standards to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require other employers, including, but not limited to, employers exempted from this section by subdivision (d), to adopt plans to protect employees from workplace violence. Nothing in this section shall be interpreted to preclude the standards board from adopting standards that require an employer subject to this section, or any other employer, to adopt a workplace violence prevention plan that includes elements or requirements additional to, or broader in scope than, those described in this section.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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BOARD OF REGISTERED NURSING
Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: January 8, 2015

ACTION REQUESTED: Information and discussion: Health Workforce Pilot Project (HWPP) #173 Community Paramedicine Approval with Modifications

REQUESTED BY: Trande Phillips, RN, Chairperson

BACKGROUND: A November 14, 2014 letter to Dr. Becker MD, MPH, Director, Emergency Medical Services Authority was notified by OSHPD Director Robert P. David that the Health Workforce Pilot Project (HWPP) # 173 could go forward with staff recommendations for modifications:

- Transport patients with specified conditions to alternate locations other than acute care emergency departments
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments
- Provide short-term home follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to and hospital
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions (see attached letter).

The modifications specified in the OSHPD staff recommendations are in a letter dated October 13, 2014, attached. The modified recommendation includes Patient Safety, Representation, Consent Forms, Training, Pilot Project Evaluation, Data Collection and Analysis, and other listed considerations by HWPP Program Monitoring in the letter of November 14, 2014.

The Health Workforce Pilot Project (HWPP) Program #173 Community Paramedicine Advisory Committee met on December 8, 2014 and will meet again on January 22, 2015 in Sacramento, California. Meeting minutes for December 8, 2014 were not published to attach for Practice Committee January 8, 2015.

Please contact Kristen Widdifield, Program Administrator at (916) 326-3718 or by email at Kristen.Widdifield@oshpd.ca.gov if you have questions.

NEXT STEPS: **Board**

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:
Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: 916-574-7686
Email: janette.wackerly@dca.ca.gov

OSHPD Office of Statewide Health Planning and Development

Director's Office
400 R Street, Suite 310
Sacramento, California 95811-6213
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www.oshpd.ca.gov

November 14, 2014

Howard Backer, MD, MPH
Director
Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

RE: Health Workforce Pilot Project (HWPP) #173 – Community Paramedicine Approval with Modifications

Dear Dr. Backer:

I am pleased to announce the approval of the Emergency Medical Services Authority (EMSA) application, HWPP #173 Community Paramedicine with modifications. This project will test, demonstrate, and evaluate the practice of Community Paramedicine in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department;
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments;
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital; and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The Emergency Medical Services Authority, as the project sponsor, is approved to proceed with all of the concepts and pilot sites proposed in its application for HWPP #173 provided that all of the modifications specified in the OSHPD staff recommendation memorandum dated October 13, 2014 (attached for reference) are implemented. Those recommendations are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current

regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.

- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.
- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
    - When was the patient discharged?
    - Where was the patient discharged (i.e. home or hospitalized)?
    - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

Additionally, all of the following five provisions must be met:

- In addition to the requirements specified in the OSHPD staff recommendation memorandum dated October 13, 2014, the sponsor shall ensure that all project sites modify the Informed Consent form to read as follows:

  "Patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. An exception to this requirement will be allowed for study sites where the main objective is to evaluate alternative destinations for

patients with mental health issues that potentially prevent them from having adequate capacity to consent, and where paramedics participating in the Behavioral Health Pilot Project have completed a specified Psychiatric Emergency Response Team Training Course in Behavioral Health issues in addition to the completion of the Community Paramedicine Core Training. In these cases, efforts should still be made to obtain informed patient consent for the study, but inability for psychiatric reasons will not prevent the patient from participating. Patients in these mental health projects with other reasons for incapacity, such as unresponsiveness, and patients in all other projects cannot be included in the pilot projects unless consent is lawfully given."

- The sponsor shall work with the project sites to develop further consistency with the medical criteria, protocols and training for similar concepts that are being tested.
- The sponsor shall ensure that all alternate destination concepts (CP 001, CP 003, CP 009 and CP 012) send additional personnel to both the statewide and local training.
- The sponsor shall require all sites to pursue local Institutional Review Board (IRB) approval.
- OSHPD will ensure that data safety monitoring is included in the responsibility of the HWPP #173 Advisory Committee, through site visits and data submission reports.

As was stated in the staff recommendation, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Program Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and make available its findings to the general public.

We appreciate your willingness to modify aspects of your project as a result of the review and comment phase of the application process. This approval is granted pursuant to Health and Safety Code Section 128125 of the governing administration of the HWPP Program.

This approval is effective immediately and will expire on November 14, 2015. You will be asked to submit reports and data that describe the progress in meeting objectives. If an extension of time is needed, you will be required to provide this Office with information to justify the request by September 15, 2015.

OSHPD will monitor HWPP #173 through written reports and site visit evaluations. In addition, we expect the Advisory Committee to assist the Office with the monitoring and development of guidelines to strengthen protocols, if possible, pursuant to their findings.

Ms. Kristen M. Widdifield will serve as the Program Administrator and you may contact her with any questions at (916) 326-3718 or Kristen.Widdifield@oshpd.ca.gov.

Very truly yours,

ROBERT P. DAVID
Director

cc: Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division

Memorandum

State of California

OSHPD

"Access to Safe, Quality Healthcare Environments that Meet California's Diverse and Dynamic Needs"

To: Robert P. David
Director

Date: October 13, 2014

Via: Stephanie Clendenin
Chief Deputy Director

From: Lupe Alonzo-Diaz
Deputy Director
Healthcare Workforce Development Division

Subject: Recommendation Regarding Health Workforce Pilot Project (HWPP) #173
Community Paramedicine Proposal

On December 28, 2013, the California Emergency Medical Services Authority (EMSA) submitted an application for the HWPP Program's consideration for status as a pilot project. EMSA proposes a pilot project regarding the practice of Community Paramedicine (CP) in the following areas:

- Transport patients with specified conditions to alternate locations other than an acute care emergency department,
- Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments,
- Provide short-term home follow-up care for persons recently discharged from a hospital and at increased risk of a return visit to the emergency department or readmission to the hospital, and
- Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

The HWPP Program has completed a review process for application HWPP #173 in accordance with California Health and Safety Code Section 128175. This included:

- A review of the application to ensure that it met statutory and regulatory criteria,
- Seeking input from relevant healing arts licensing boards and professional organizations,
- Posting the application for public comment before and during the public meeting and public hearing,
- Holding a public meeting on April 9, 2014 to permit the HWPP #173 sponsor to present and receive public input on the application, and
- Holding a public hearing on July 30, 2014 by a disinterested state government official as is required for projects sponsored by a state agency.

I recommend approval of the HWPP #173 application for pilot project status with the following modifications and provisions. This recommendation is based on the HWPP

Program's review and consideration of the information presented via the review process.

The required modifications and provisions are as follows:

Patient Safety

- The sponsor shall work with the HWPP Program and HWPP #173 project evaluator to determine the scope and timeline for data submission and reports during the initial six months of the Phase III: Intervention Period.
- The sponsor shall require all sites to include in their patient eligibility protocols and consent forms that patients who cannot consent due to inebriation, mental incapacity, legal incapacity, or no responsiveness will be treated in accordance with current regulations and local protocols governing EMT-Paramedics. These patients would not be included in the pilot project unless consent is lawfully given.
- The sponsor shall provide triage protocols for each site to the HWPP Program and HWPP Program Advisory Committee for review and feedback, and strengthen those protocols if requested by the HWPP Program.

Representation

- The sponsor shall include a paramedic and a member of the general public who is not a licensed healthcare provider on each site's Community Paramedic Steering Committee.

Consent Forms

- The sponsor shall require all sites to incorporate the following heading on all consent forms "Informed Consent" as identified in the program regulations.
- The sponsor shall require all sites to develop an Informed Consent form specific to languages of the population proposed to be served.

Training

- The sponsor shall ensure that core standards for training address multiple disciplinary team coordination.
- The sponsor shall require additional training for project participants, where warranted (i.e., if after the review and expansion of additional data collection elements, the HWPP Program deems additional training necessary to ensure patient safety).

Pilot Project Evaluation

- The sponsor shall conduct an overall evaluation of the pilot project and an evaluation at the site level.

Data Collection and Analysis

- The sponsor shall work with the HWPP Program to more explicitly define "patient safety" as it relates to the submission of data during the Phase III: Intervention Period.

- The sponsor shall work with the HWPP Program in collaboration with the HWPP Advisory Committee to identify and expand the data elements collected during the Phase III: Intervention Period to include patient outcomes. The expansion of patient outcomes will be specific to each site and may include items such as:
    - When was the patient discharged?
    - Where was the patient discharged (i.e. home or hospitalized)?
    - Did the patient need additional treatment?
- The sponsor shall collaborate with the HWPP Program in determining the frequency of data submission to HWPP.

HWPP Program Monitoring
If the project is approved, the HWPP Program will:

- Monitor the approved project through reporting and site visit evaluations as well as collaborate with the HWPP Program Advisory Committee,
- Request the sponsor's oversight advisory committee assist the HWPP Program with monitoring and development of guidelines to tighten protocols pursuant to any findings, and
- Request the sponsor to submit a copy of each site's Institutional Review Board (IRB) approved report for each site seeking IRB approval. The IRB approval should be obtained prior to the implementation of the employment/utilization phase.

Any findings related to an endangerment to participating patients will be addressed as follows:

- Sponsor shall provide immediate notification to the HWPP Program regarding any and all patient safety concerns and adverse consequences, and
- Sponsor shall advise the HWPP Program of any resolution or proposed resolution to the safety concerns and adverse consequences.

Notwithstanding any proposed resolutions to safety concerns and adverse consequences, the HWPP Program will:

- Consider any proposed solution brought by the sponsor, the site's Community Paramedicine Steering Committee, and the HWPP Advisory Committee,
- Consider the degree of endangerment by reviewing all data collected, reports written and any other relevant information which may provide insight into the activity,
- Review program regulations and project protocols to determine if the project was operating in compliance with the stated guidelines,
- Consider suspending project activities at the specified site and the trainee(s) involved,
- Consider the termination of that portion of the pilot project if it deems there has been no satisfactory resolution,

- Consider the termination of the pilot project if there were system-wide concerns relating to any endangerment activity without resolution, and
- Make available its findings to the general public.

OSHPD Office of Statewide Health Planning and Development

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Health Workforce Pilot Projects (HWPP) Program #173 Community Paramedicine Advisory Committee
Roles and Responsibilities

Pursuant to Health and Safety Code 128125-128195, the Office of Statewide Health Planning and Development Department (OSHPD) is authorized to administer the Health Workforce Pilot Projects (HWPP) Program. HWPP tests, demonstrates and evaluates new and expanded skills sets and alternative methods of delivering health care.

OSHPD has reviewed and approved HWPP #173. This project is sponsored by the Emergency Medical Services Authority and will test a Community Paramedicine model including the following concepts at 12 project sites located throughout California:

- Alternate destinations
- Post discharge follow-up
- Direct observed treatment for tuberculosis
- Hospice patient support
- 911 frequent users

The HWPP #173 Community Paramedicine Advisory Committee shall provide oversight and make recommendations to OSHPD on various aspects of the project. Major roles and responsibilities will include the following:

- Participation and attendance in Advisory Committee meetings
- Advisement on the efficacies of training, competencies and the collection of data
- Review and advisement of project protocols related to triage and the ongoing assurance of patient safety
- Participation and attendance in site visits
- Advisement on the evaluation of project reports as needed
- Advisement on project issues, should they arise
- Serve as a voting member

The HWPP #173 Community Paramedicine Advisory Committee is encouraged to share feedback from stakeholders at Advisory Committee meetings and disseminate project activities to interested constituents. The commitment for HWPP #173 Community Paramedicine Advisory Committee members will minimally be until November 2015. Eligible travel expenses will be reimbursed by OSHPD in accordance with State guidelines.

Please contact Kristen Widdifield, Program Administrator at (916) 326-3718 or by email at Kristen.Widdifield@oshpd.ca.gov you have questions.

BOARD OF REGISTERED NURSING
Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.3
DATE: January 8, 2015

ACTION REQUESTED: **Report on Goals and Objectives 2013-2014**
Vote on Whether to Recommend to approve 2015-2016 Goals and Objectives

REQUESTED BY: Trande Phillips, RN, Chairperson

BACKGROUND: Practice Committee agenda's and SNEC liaison staff work contribute to the report on 2013-2014 Practice Committee Goals and Objectives

RESOURCES:

NEXT STEPS: Board

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:
Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: 916-574-7686
Email: janette.wackerly@dca.ca.gov

BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE

2013/2014 GOALS AND OBJECTIVES

GOAL 1 **In support of the consumers' right to quality care, identify, and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

Objective 1.1 Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

GOAL 2 **Promote patient safety as an essential and vital component of quality nursing care.**

Objective 2.1 Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example, just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

Objective 2.2 Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, and magnet hospitals.

GOAL 3 **Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.**

Objective 3.1 Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

The nursing education consultants, weekly, Monday through Friday, answer telephone and web-mail questions in response to public and private organizations, and state agencies involved with health care to clarify registered nursing practice and advanced nursing practice including nurse practitioner, certified nurse-midwives, certified nurse anesthetists, and clinical nurse specialists. Over the 2014 year call volume and webmail on average has increased with each assigned NEC responding to approximately 20+ calls/web-mails per day. The complexity of the calls/web-mail in many instances requires the NEC to research and explore the topic in order to respond with factual information.

GOAL 4 **Identify and implement strategies to impact identified trends and issues.**

Objective 4.1 Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.

Community Paramedicine: Office of Statewide Health Planning and Development Pilot Project 173 was submitted by the Emergency Medical Services Authority. The proposal details plans to conduct 12 community paramedicine projects across California to test a new health care delivery model which will expand the paramedic scope of practice. Selected paramedics will receive additional training to provide services beyond their customary roles in emergency response and transport. Staff will continue to participate and monitor development and outcomes of this pilot project, brining information to the Practice Committee

California Department of Public Health, Licensing and Certification Dr. Steven Otto, Chief Medial Consultant, re-convened a workgroup to finalize new changes to the sedation practice directions where Federal regulations (CMS) requires administration (and monitoring) by a privileged anesthesia provider. Practice Committee staff liaison continues lines of communication with CDPH-L&C.

Objective 4.2 Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

NECs collaborate on education/licensing and legislation pertaining to nursing practice daily through telephone and at the Joint NEC meetings held the first day the Board is in session.

Objective 4.3 Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

The 2014 BRN advisories are described in the Practice Committee Agenda's and the advisories are related to enacted legislation during the 2014 session.

- Military Spouses: Temporary Licenses
- Telehealth: Patient Consent Required
- Medical Assistants: NP and CNM may supervise MA when delegated in Standardized Procedure by the Physician
- Medical Assistants: Handing a Patient Properly Labeled and Prepackaged Prescription and does not include Controlled Substances.
- Residential Care for the Elderly (RCFE)-Registered Nurses Providing Care and Training for Self-Administration of Medications
- Emergency Epinephrine Auto-Injector: Pupil Health
- Frequently Asked Questions Regarding Nurse Practitioner Practice

- Workplace Violence Prevention
- Communicable Diseases: Immunization Exemptions
- Business and Profession Code Section 2725.4 Abortion by aspiration techniques; Requirements

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GOAL 5 **Goal 5 Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advance practice nursing and to promote maximum utilization of advanced practice nursing.**

Objective 5.1 Support and promote full utilization of advanced practice nurses.

The BreEZE System supports one or more area(s) of nurse practitioner specialization. Interested parties and employers may now verify on the nurse practitioner licensing screen the area(s) of specialization. The previous BRN computer system could not support one or more area(s) of specialization.

Objective 5.2 Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention, and managing patients through the continuum of care.

Objective 5.3 Actively participate with organizations and agencies focusing on advanced practice nursing.

Nurse Practitioner Laws and Regulations-Title 16 of the California Code of Regulations Article 8, Sections 1480-1484, Nursing Education Consultants Workgroup suggestions for updating and revisions that includes the evaluation of the NCSBN APRN Consensus Model with comparison to existing California regulatory language.

Participation by the following groups and individuals in support of regulation updating to current national model regulations.
*California Action Coalition is part of the national Future of Nursing -------
Campaign for Action by Robert Wood Johnson Foundation
California Association of Clinical Nurse Specialist.
AARP Blanca Castro-Paszinski, Advocacy Manager
Karen Ann Wolf PhD, ANP, Professor Samuel Merritt University
Judith Martin-Holland PhD, RN, CNS, FNP, FAAN
Karen Karp, CRNA, MS, California Association of Nurse Anesthetists, Inc.
Wendy Owens, California Nurse Midwives Association
Trisha Hunter, American Nurses Association California
California Association of Nurse Practitioners

Participation by California Nurses Association (CNA):
CNA does not endorse or support the NCSBN's Consensus Model and maintains strong concerns with any effort to conform California statute or regulations to the model.

The APRN-NEC work group process has been to focus on uniformity of titles, roles, licensure and certification, graduate degrees/post graduate certificates, national certification, and accreditation of schools.

The APRN-NEC work group has provided the Practice Committee with information regarding National Organization of Nurse Practitioner Faculties (NONPF) and their work identifying the nurse practitioner core competencies that are integrated and build upon existing Master's and DNP core competencies. The APRN-NEC workgroup has provided information about nurse practitioner practice based on education at the graduate level with additional preparation advance pathophysiology, advanced physical assessment, advanced pharmacology, with additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care. The APRN-NEC work group identified where NPs work and requirements for reimbursement determined by Centers for Medicare and Medicaid in California.

Objective 5.3 Actively Participate with organizations and agencies focusing on advanced practice nursing

The California Association of Nurse-Midwives, Health Policy Chair, submitted a number of documents for discussion: 1. Standardized Procedures Related to ACNM Core Competencies, 2.Out of hospital CNM practice and physician supervision, 3. Location of suturing and protection of the public

Objective 5.4 In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.

BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE

2015/2016 GOALS AND OBJECTIVES

GOAL 1 **In support of the consumers' right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

Objective 1.1 Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

GOAL 2 **Promote patient safety as an essential and vital component of quality nursing care.**

Objective 2.1 Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example, just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

Objective 2.2 Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, and magnet hospitals.

GOAL 3 **Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.**

Objective 3.1 Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

GOAL 4 **Identify and implement strategies to impact identified trends and issues.**

Objective 4.1 Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.

Objective 4.2 Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

Objective 4.3 Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

GOAL 5	**Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.**
Objective 5.1	Support and promote full utilization of advanced practice nurses.
Objective 5.2	Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention, and managing patients through the continuum of care.
Objective 5.3	Actively participate with organizations and agencies focusing on advanced practice nursing.
Objective 5.4	In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.