MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, January 21, 2014

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Guthrie, Martin, Lakey, Bock, and Schmidt

ABSENT/ EXCUSED: Chairman Heider, beginning of meeting

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Vice Chairman Nuxoll** called the meeting to order at 3:00. She then introduced the first agenda item, Overview of the Practice of Midwifery, and invited Kris Ellis to make her presentation.

PRESENTATION: **Overview of the Practice of Midwifery: Kris Ellis,** Idaho Midwifery Council, stated that the midwife law was passed in 2009 and is scheduled to sunset this year. She then presented points regarding the current status of midwifery in Idaho as follows.

Licensed Midwives in Idaho are Certified Professional Midwives (CPM’s) who are nationally credentialed midwives that provide primary maternity care. They are trained to provide health-promoting and preventative care that is evidence-based, incorporates best practices and avoids the overuse of drugs and interventions. CPM’s are the only maternity care providers specifically trained to attend out of hospital births and they meet the national standards of NARM, the North American Registry of Midwives.

The Certified Professional Midwife credential was established in 1994 and is accredited by the National Commission for Certifying Agencies. This is the same agency that accredits Certified Nurse Midwives. CPM's are trained in a variety of settings under the supervision of qualified instructors. The training may occur in a classroom, private practice or clinical setting but must include a minimum number of types of clinical experiences, including out of hospital births. Didactic knowledge and clinical skills are evaluated by qualified instructors. The education process generally takes three to five years to complete. All CPM's must meet the same requirements, and all must pass the national exam, which includes a hands-on skills assessment and an eight-hour written test

Certified Professional Midwives provide thorough care throughout the prenatal, delivery and postpartum stages of pregnancy for childbearing women who are healthy and experiencing a normal pregnancy. Care given includes monitoring the physical, psychological and social well being of the mother, as well as providing the mother with individualized education and counseling that emphasizes health promotion and the prevention of pregnancy problems, leading to healthy outcomes. The midwifery model of care views pregnancy and birth as a normal, healthy process and treats it as such, rather than as a disease, illness, or medical event. Midwives are experts in normal birth. However, they are also trained to recognize early warning signs of complications and refer to other health care specialists appropriately. Midwives provide hands on assistance during labor and delivery and postpartum support. Care also includes identifying when a mother is not a candidate for midwifery care, or is prevented from receiving midwifery care, and referring them to an obstetrician.

Midwife attended births have excellent outcomes and cost much less than hospital deliveries, which account for $86 billion a year in U.S. health care costs. Mothers who choose a midwife have fewer babies born prematurely, fewer babies with low-birth weight, and fewer babies exhibiting the effects of overused medical interventions such as inductions and c-sections that lead to costly stays in Neo-natal intensive care units.

Thirty states currently license or otherwise allow for midwives to practice. Alabama, Michigan and Massachusetts are considering licensure this year. Maryland is looking to license as a pilot project Delaware is considering amendments as only one person has licensed under their current law. Idaho is second in the country for births in a birth center per capita, and is tenth in the country for number of out of hospital births per capita Boise was recently ranked as a top city to have a baby, because of the NICU units at St. Luke's and St. Alphonsus, as well as the high number of midwives and birth coaches that give mothers options in delivery settings

Regarding licensure, before licensure there was not a standard for education or practice guidelines. Communication between medical professionals and midwives was poor in most of the State. Some midwives were not allowed in hospitals with the mothers they brought in. Some midwives were using medications allowed in our current law but that were not allowed at that time including life saving medications that allowed midwives to stop hemorrhaging. Midwives in Idaho were arrested for practicing medicine without a license in those rare instances when a mother was transported to a hospital. Now, after licensure, there is standardized education and protocol for midwives. Communication between midwives and other medical professionals is vastly improved in most areas of the State. Midwives are allowed to carry and administer life saving medications when necessary.

There is a general consensus of the medical community that licensure of midwives has been a good thing. It has provided safety to midwives who are now allowed to practice without the fear of prosecution. It has improved public safety, it has improved coordinated care for those choosing a midwife, and there is the Board of Midwifery to address concerns and complaints from the public.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 1).

Ms. Ellis then turned the podium over to Barb Rawlings.

Barbara Rawlings, the chair of the Board of Midwifery, is a licensed midwife who has been practicing in Idaho for 38 years. In 2009 the Legislature passed H 185 which established the Board of Midwifery and has a provision that states, "The Board of Midwifery shall report on the status of the Board and the practice of licensed midwifery to the legislature in 2014." Now, five years later, she came to provide that report.

Ms. Rawlings reports that the Board is made up of five members appointed by the Governor. The members are:

- Barbara Rawlings, Chair, Licensed Midwife, Bonners Ferry
- Cathy Ward, Licensed Midwife, Kooskia
- Clarence William Blea M.D., Maternal/Fetal Medicine Specialist, Boise
- Kyndal May Verveckken, Public Member, Eagle
- Paula Wiens, Licensed Midwife, Boise

The Board is charged with public protection and they work toward that charge by ensuring that applicants meet all required qualifications prior to issuing a license, and by responding to all complaints filed regarding licensees.

The first midwife license was issued in May 2010 and in that year there were 29 licenses issued. In 2011 there were 32 licensees; in both 2012 and 2013, there were 35 licensees; and thus far in fiscal year (FY) 2014, there are 39 licensees, a 30 percent increase. The Board members believe the numbers will grow because Idaho's law is a good law. Students are staying in or coming to Idaho because they recognize that we have a strong law.

Ms. Rawlings shared information from data collected when midwives reapply for a license. The following statistics are from 2012 (January through December) and are from 25 licensed midwife practices:

- 551 births attended
- 182 of those were first babies.
- Average maternal age: 29.6
- Average birth weight: 8 pounds
- 46 women were transferred to hospitals during labor. The transfers were either in accordance with law or to maintain a standard of care.
- 28 had a cesarean section (c-section), a 5 percent c-section rate.
- 5 women transferred after the birth.
- 31 successful vaginal births after a previous c-section (VBAC), and 5 repeat c-sections from women who had attempted to have a VBAC.
- 7 newborn transfers
- 0 newborn or maternal deaths

To carry out the charge of public protection, they carry out investigations on all complaints received by the Board. Since the creation of the Board, they have received the following number of complaints, 28 total:

- FY 2010: 1
- FY 2011: 6
- FY 2012: 16
- FY 2013: 3
- FY 2014: 2 (just received)

Of those 28 complaints:

- 25 were against 9 licensed midwives.
- 15 of those 25 were against 2 midwives.
- 3 were for midwives not licensed in the State.

Resolution of the complaints is as follows:

- 19 of the 28 complaints resulted in disciplinary action including further education, updating documents, suspension (1) and revocation (2).
- 7 were closed without any disciplinary action as the investigation did not show any violations of the Board's rules or laws, or they did not fall under the Board's jurisdiction.
- 2 are newly under investigation.

Ms. Rawlings identified the origin of the complaints:

- 14 from medical personnel;
- 9 from clients;
- 2 from law enforcement; and
- 3 from information coming from the public regarding the unlicensed midwives.

Ms. Rawlings stated that some of these cases were very costly to investigate. Three went to hearing. As a result the Board's 2010 cash balance of $6,441 dropped to a negative cash balance of $79,908 at the end of FY 2013. She stated that it is not unusual for new licensing boards to have complaints and then have the number drop off, and that is what they are seeing. Most of these costs came from the cases involving the three midwives who went to hearings. None of those midwives are practicing. By December 31, 2013, the total had been reduced to $72,363 as a result of fewer complaints, fewer investigations, and more licensees. As they are a self-governing agency, they receive no general fund money and they operate on dedicated funds primarily from licensing and renewal fees. They also make every attempt to recoup costs of investigations.

In order to carry out the charge of public protection the Board has submitted a proposed licensing fee increase for the Legislature's consideration.

In summary, **Ms. Rawlings** emphasized that the Board has worked effectively with all interested parties, including the Boards of Pharmacy and Medicine as well as the Idaho Midwifery Council and the Idaho Medical Association, and continue to do so. We were faced with difficult cases in our formative years; we have gained skills and knowledge along the way, remaining a cohesive, dedicated group. All involved feel that this licensing law has made a difference in public safety, improving midwifery practice by requiring standards and accountability. She expressed that it is an honor to serve the citizens of Idaho in this way.

DISCUSSION: **Senator Hieder** stated that this is an information hearing and the legislation is being started in the House.

Senator Martin referred to the $72,000 and asked how many members were in Ms. Rawlings' group so they could diminish that amount.

Ms. Rawlings responded that they currently have 39 licensed midwives, and that is continuing to grow. We have asked for a fee increase hoping to bring that down.

Senator Hagedorn congratulated Ms. Rawlings on their five-year anniversary. He understands what they have been through in the last five year, but asked what they wrestle with today. What is an impediment to growing your organization or providing a better service that we might see later and with which we may have to take action?

Ms. Rawlings stated that midwifery is growing. There are more women interested in births outside the hospital. In terms of midwifery their practice is pretty solid, and she does not see many things on the horizon. Licensing birth centers or having birth centers that are accredited so they could receive funding and be paid a facility fee, currently not happening, might be pending.

Senator Schmidt commented that while he wasn't here when the law was passed, he remembers that the discussion revolved around the unlicensed midwives, which aren't part of your organization. He reminded Ms Rawlings that she had said that in the complaint process there was reference to them, and that the Board just doesn't deal with that. He asked if there was some way to know if the function of unlicensed midwives has diminished or if there is a way to count that.

Ms. Rawlings replied that the Board tries to know who is out there. The complaints they had early on about unlicensed midwives included one who was working toward becoming licensed, and subsequently became licensed, and the other two practice in bordering states and live in Idaho. Those two have received information that they cannot advertise and practice as licensed midwifes in Idaho, and they have agreed to that. She then stated that it seems the number has decreased to zero, or people are keeping it hidden because they are not seeing or hearing about midwives who are not licensed. She went on to remind the Committee that when the Board was first here they were looking for a voluntary licensing bill which would allow unlicensed practice. They did not get the voluntary licensing, but did get a mandatory license. People are well-aware of that in Idaho.

Chairman Heider and Senator Lodge both thanked Ms. Rawlings and Ms. Ellis for their presentations.

DOCKET NO. 16-0309-1302

Medicaid Basic Plan Benefits - Aligned Rules with Federal Regulations for Tobacco Cessation Products for All Medicaid Eligible Participants (Pending Rule): Matt Wimmer, Bureau Chief for medical care, Division of Medicaid, Department of Health and Welfare, asked the Committee to adopt the rule in **Docket No. 16-0309-1302**. According to **Mr. Wimmer** , these rule changes will increase the ability to manage Medicaid providers who do not meet enrollment requirements and to comply with recent changes to federal regulations.

Mr. Wimmer identified several changes in this docket including requiring verification of information, and requiring some Medicaid providers to meet the same site visit requirements as Medicare providers. We have chosen to implement this requirement by using the existing Medicare infrastructure, an approach which minimizes the administrative burden for the provider. Other states have chosen to administer this requirement through their own Medicaid program and have incurred significant costs and administrative burden.

Another change requires that providers prescribing drugs or services covered by Medicaid be enrolled in the program. This prevents providers not meeting Medicaid credentialing requirements, such as those with a history of fraud, from continuing to order services for Medicaid participants.

Other changes in the docket clarify procedures for managing, denying and terminating providers who do not meet Medicaid enrollment requirements, and it clarifies these rules to conform with or refer to relevant federal requirements.

The Department asks that the Committee adopt the rule in this docket.

Supporting documents related to and giving more detailed information regarding this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 2).

Vice Chairman Nuxoll read from page 263, "The Department will not reimburse providers when participants do not attend scheduled appointments. Providers may not bill participants for missed appointments." She asked if the participant does not show up does the provider have to stand the cost of them not showing up.

Mr. Wimmer answered that her interpretation was correct.

Vice Chairman Nuxoll than asked if that was a federal requirement.

Mr. Wimmer replied that it is a federal requirement.

Senator Hagedorn referred to page 264 and the references to 42 CFR and asked who, from Mr. Wimmer's department, is monitoring this CFR to see what changes listed in the Federal Registry might be happening that will affect both the citizens and the providers. Senator Hagedorn has great concerns that the CFR is being changed daily, and when we reference the CFR, and not the specifics in the CFR, misunderstandings can occur. He stated that when we approve a rule the CFR is just a reference, but when the CFR changes it is still approved. He asked if Mr. Wimmer has a process for monitoring the changes in the CFR so they don't negatively impact what rules the Legislature puts in place.

Mr. Wimmer stated that the policy staff of the Division of Medicaid closely monitor those changes to the CFR in order to keep them aligned with those changes to federal regulations.

Senator Hagedorn stated his concern regarding the CFR references being used in the rules without stating the specifics of those references. He commented that those referenced items may change to something this Committee would choose not to approve. He asked how the Legislature would know and understand the impact of that change.

Mr. Wimmer replied that they monitor those changes and try to stay ahead of the change. He believes the Administrative Procedures section also has processes for making changes to rules to keep them aligned with changes to federal regulations.

Vice Chairman Nuxoll referring to page 266, section 205, number 3, Provider Agreement, "Provider agreements may be terminated with our without cause ..." and then says "Termination for cause may be appealed as a contested case in accordance with IDAPA Rules Governing Contested Case ..." She continued her reference: "The Department may at its discretion take any of the following actions for cause based on the provider's conduct or the conduct of its employers or agents." She asked if Mr. Wimmer was saying they are changing the sentence including "... with or without cause ..." or if that is still standing due to the following additions?

Mr. Wimmer stated that we are saying that we may still terminate with or without cause. This might happen without cause in the case of transitioning a program to managed care.

Vice Chairman Nuxoll asked if there could be another reason for a without-cause termination.

Mr. Wimmer stated there could be.

Vice Chairman Nuxoll asked for testimony. There being none she presented the docket before the committee.

MOTION: **Chairman Heider** moved, seconded by **Senator Martin,** to adopt **Docket No. 16-0309-1302** to be sent forward with a do pass.

Senator Hagedorn stated that he will be voting no, saying that he has great concerns about referencing our rules to fluctuating federal rules where this Legislature has no control over those fluctuating rules. He would prefer to see, if a provider fails to comply with requirements of the rule, those applicable requirements specified in our regulations. He continued that if there are changes in the CFR then we can come back in a year and make those changes. He further stated that giving our oversight authority to those that watch the federal registry for changes that affect our businesses or citizens is not something he can support.

Senator Lakey said he has struggled with the same issue. Although we may not have a lot of control as these are federal requirements, if we simply reference the CFR without being limited to a specific version or date, we are not really reviewing any rules in the future as they change in the CFR and are ceding our authority.

Vice Chairman Nuxoll also had comments. She stated that she also has a problem with the issue presented by Senators Hagedorn and Lakey, but that she is still concerned about the items she mentioned as they are not fair to the providers. She said she will be voting no also.

The **motion** carried five to four by roll call vote with votes as follows: Aye**--Senators Heider, Martin, Bock, Schmidt, and Lodge**; Nay–**Senators Nuxoll, Hagedorn, Lakey, and Guthrie**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 2).

DOCKET NO. 16-0309-1303

Medicaid Basic Plan Benefits - Aligned Rules with Federal Regulations for Tobacco Cessation Products for All Medicaid Eligible Participants (Pending): Matt Wimmer, Bureau Chief for Medical Care at the Division of Medicaid, stated he is here to ask the committee to adopt the pending rule in **Docket No. 16-0309-1303** as final. These changes are being completed to comply with changes to federal laws and regulations that include tobacco cessation products and drugs as part of the mandatory set of benefits for state medicaid programs.

Mr. Wimmer explained that the history related to Idaho Medicaid and its coverage of tobacco cessation products dates back to 2006 with the Preventive Health Assistance voucher program, and in 2013 the Legislature approved direct pharmacy coverage for pregnant women and children under 21. He stated that this rule change will complete transitioning that coverage from the voucher system to direct pharmacy coverage for all participants. No fiscal impact is expected because it is a shift in the form of coverage rather than a change. **Mr. Wimmer** also stated that Medicaid's pharmacy program prior authorization and preferred drug requirements will ensure that use of these products appropriately supports the participants who want to quit using tobacco.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 3).

Mr. Wimmer asked the Committee to adopt the rule in this docket.

Senator Schmidt pointed out that there is also a reference to weight management in this rule change, so it's not just tobacco.

Senator Guthrie asked where e-cigarettes fall into tobacco cessation.

Mr. Wimmer said that would be a matter of interpretation.

Senator Guthrie asked whose interpretation.

Mr. Wimmer stated that the federal legislation refers to tobacco cessation products and that is the language we use.

Senator Guthrie referred to the language Senator Schmidt alluded to regarding weight management, and asked Mr. Wimmer to address the issue of relieving the participant of an actual goal for weight management while allowing the participant to simply enroll in the program.

Mr. Wimmer explained that this item is to update the references to reflect that this is solely around weight management.

Senator Lakey commented that at least they are enrolling in a program. Anyone can set a goal, but either one doesn't require completion.

MOTION: **Senator Schmidt** moved, seconded by **Senator Lodge,** to adopt **Docket No. 16-0309-1303**. The motion carried by **voice vote.**

DOCKET NO. 16-0504-1301 **Rules relating to Idaho Council on Domestic Violence and Victim Assistance Grant Funding (Pending): Anne Chatfield,** Grants/Contracts Officer, Idaho Council on Domestic Violence and Victim Assistance, said she is presenting this docket on the revision of the domestic violence program and personnel standards, and the sexual assault program and personnel standards being combined into one document entitled "Service Standards for ICDVVA-Funded Programs."

Ms. Chatfield reported that the Council manages federal funds from the Department of Justice, Victims of Crime Act, Department of Health and Human Services, Family Violence Prevention and Services Grant, and a Domestic Violence Project Account. The funds are granted through a competitive process yearly to programs serving victims of crime throughout the State.

She went on to say the revision of the standards will support program and system innovation through the development and delivery of effective services that integrate provider expertise, that is trauma informed, and that is based on current evidence per funding requirements. The emphasis of the standards revision is the safety and well-being of victims impacted by violence and the ensurance that programs serving victims are high quality, viable and sustainable.

Ms. Chatfield indicated that types of programs providing services to crime victims vary widely across Idaho, as do the diverse approaches used by the programs and the populations that are funded and served.

In regard to the development of the new standards, **Ms. Chatfield** said the council focused on ensure that they adhered to all statutory obligations, and they integrated the values and ethics of victim-centered programming. Victims deserve high-quality services, and future funding requires the Council to show they are making progress in addressing crime and providing services to victims.

Ms. Chatfield presented a history of the committee established to revise the standards. They began working on the revision in March 2012, with the first draft distributed to crime victim service providers and appropriate entities for review and input in July 2013. Multiple opportunities for input were provided through quarterly meetings, website updates, and personal communication. Careful consideration was given to input provided to the committee; many of the suggestions were incorporated into the revised standards resulting in consensus agreement and support.

According to **Ms. Chatfield** the existing domestic violence standards document, developed in 1998, has a total of nine pages, and the sexual assault standards document has a total of eight pages. The newly revised standards document has a total of 41 pages and is a more comprehensive and detailed manual expanding the elements of the existing standards. It will allow victim service programs throughout the State to reference a more specific document to meet service requirements and the needs of victims while staying in compliance with state and federal rules. She requested the approval of **Docket No. 16-0504-1301**.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 4).

Senator Lakey stated for disclosure that he had served as a volunteer on the board for the Idaho Coalition Against Domestic Violence. This is a volunteer position and there would be no financial impact for him.

MOTION: **Senator Schmidt** moved, seconded by Chairman Heider, to adopt **Docket 16-5040-1301**. The motion carried unanimously by **voice vote.**

DOCKET NO. 23-0101-1301

Rules regarding Delegation Ability of Nurses (Pending): Sandra Evans, Executive Director, Idaho Board of Nursing, defined nurse delegation as the process of transferring the authority to perform a selected nursing task to a competent individual in a selected setting. She explained that when delegating a nursing task, administrative rules of the Board of Nursing require the nurse to perform a number of procedural steps to assure the delegation is safe and appropriate. This process is best supported in structured settings and in settings where the nurse retains responsibility and accountability for the client. In situations where the delegation process is not supported, the nurse must be able to engage in other relationships in order to be of benefit to the client.

Ms. Evans stated that the changes proposed will accomplish the following:

- They add to functions that may be performed by licensed registered and licensed practical nurses to specifically include engaging in appropriate interfaces with health care providers and other workers in settings where there is not a structured nursing organization and in settings where health care plays a secondary role.
- They delete a list of specific procedures that should not be delegated by a licensed nurse to unlicensed persons.

She further explained that adoption of these rules will:

- Allow nurses to engage in relationships where the structure or setting is not conducive to the delegation process but where the recipient of health care will benefit from the knowledge and expertise of the nurse through an alternative interface.
- Allow nurses to appropriately delegate functions without limiting their authority to determine which tasks can be safely delegated in any individual circumstance and setting.

Regarding the public response, **Ms. Evans** stated that the intent to promulgate rules and negotiated rule-making was published on July 3, 2013, and written and oral comments were received at a public meeting on July 18 and during the prescribed comment period. The comments were generally in support of the change noting how the rules will:

- Allow nurses to make informed decisions on the appropriate delegation of tasks in a broad range of settings.
- Allow nurses to make appropriate decisions based on their assessment of each client, care provider and setting.
- Empower nurses to train individuals other than nurses to provide care when transferring that responsibility is in the best interest of the client and public safety.
- Remove unnecessary barriers that limit what can be delegated.
- Allow nurses to determine what is safe and appropriate in each individual circumstance.

All concerns and suggestions were considered by the Board and responses were posted on the Board's website. Responses have been distributed to the Committee for your information.

Ms. Evans stated that in response to concerns, the Board rules will continue to clearly articulate responsibility of the delegating nurse. Nurses will be supported in their ability to be of benefit to the public in settings outside of traditional health care settings. She also stated that there is no fiscal impact from these rules.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 5).

DISCUSSION: **Senator Martin** asked what is the need of this proposed change; is it to help the nurse assist the person for whom he or she is providing, or is it to help the facility owners to not hire additional nurses to take care of the work they would normally do?

Ms. Evans explained that the purpose of the rule change was to provide clarity to the functions in which nurses engage, and the autonomy they retain in that. The actual process of delegating is maintained in the rule–that doesn't change. Adding the other interfaces as a clear function of nurses allows them to engage in settings outside of health care– to teach, to consult, to guide, to direct. They feel that the unlicensed person who has received sufficient training can safely perform the functions. The idea that in an employment setting the change in the rule would allow an employer to discontinue the hiring of nurses, or reduce the number of nurses that are hired, would be inconsistent with the rule because of the delegation process and the specific knowledge necessary to perform many of the functions in those settings.

Senator Schmidt expressed concern about the number of comments from others referencing injecting insulin, and he has talked to teachers who sometimes feel they are placed in a nursing role. It sounds like the way these rules have changed, if there was a school nurse who wasn't on site and who was aware that a students was a Type I diabetic, then the nurse could decide that it was okay for the teacher to provide insulin. He asked if this was an example of a situation with which the comments are concerned.

Ms. Evans responded that his was an excellent example because that was a lot of the testimony they received. The Board of Nursing is aware that the administration of insulin and some other medications can be safely performed by individuals who are appropriately educated to recognize the procedure itself and the danger involved. The rule continues to make it the nurse's decision in assessing the patient, the knowledge and/or willingness to provide the care by another individual and the safety in doing that, rather than another individual such as a principal or superintendent. Many school districts in Idaho do not have a school nurse. Some districts have one nurse for multiple buildings so the nurse is not available to students needing medications. The change will remove the arbitrary listing of things that cannot be delegated. She thinks a lot of care providers as well as employers relied on this list for the decision whether or not something could be safely assumed by someone else without the assessment necessary to determine, in a specific situation, whether or not that would be appropriate. It does address the issue stated in your original question. The new rules would allow the nurse to engage in other interfaces that would make it safe in settings where the nurse is not present at all or not present all the time.

Chairman Heider brought up the use of epinephrine in schools by school nurses, teachers, principals, etc. who may not be licensed or not be nurses but provide an epinephrine dose to a child who gets a bee sting or has an allergic reaction in the cafeteria. He asked if this rule prohibits them from giving that shot.

Ms. Evans stated that this rule would allow the nurse to engage in the interface that would be appropriate and to provide for the education and preparation of those individuals who might need to perform those functions. It would not place the nurse in a delegating situation. The continual assessment, assumption of authority, and responsibility continues to be on the part of the nurse. The nurse would be responsible for the appropriate training, for delivering the appropriate guidance, but not to have to intervene in all those situations. She further stated that in a rural state with limited resources and care providers, the role of the nurse is critical but needs to be flexible in these situations where the nurse is not present all of the time.

Chairman Heider asked if this rule means that the delivery of an epinephrine shot by a teacher, a principal, or a school nurse is acceptable in those situations where the appropriate training has preceded the application.

Ms. Evans answered that the administration of these critical drugs when they are necessary needs to happen, whether a nurse is present or not. Whoever is administering needs to be appropriately educated with the right direction from a logical person and that likely would be a nurse.

Senator Schmidt stated that he has heard from teachers that they did not want to be placed in the situation where they would be required to give an injection. They felt like the nursing standards protected them from that requirement. He asked if, by removing this limitation, teachers can be required in their contracts or in their relationships with their supervisors to do this activity because they are no longer prohibited.

Ms. Evans replied that her belief is that the Board of Nursing's list of things that cannot be delegated never protected anybody. It limited the ability of the nurse to engage in some teaching activities because something showed up on a list when the nurse thought it would be safe. Whether a teacher can be forced to administer epinephrine is outside of the jurisdiction of the Board of Nursing. If that's the case, then she thinks there needs to be a dialogue with the Department of Education on the policies that are in place in the schools to prevent those kinds of things from happening.

Senator Schmidt asked if the teachers or the Department of Education were involved in this rule making.

Ms. Evans stated that prior to the negotiated rule making the Board did engage with the drug-free workplace person in the Department of Education. She and her colleagues gave their support that this made better sense for the schools, but they also continued their dialogue with the Department of Education assuring that there were guidelines in place for the schools that would be appropriate for the role of the nurse as well as the functions that would be assumed by school personnel in protecting students.

Vice Chairman Nuxoll asked if Tony Smith was going to testify on this docket.

Tony Smith requested to defer his time to Larry Benton and let him speak on behalf of the American Diabetes Association.

TESTIMONY: **Larry Benton** expressed concern with the schools since the schools do not have many people authorized to do injections of insulin to kids with Type I diabetes. Currently there are many diabetic students in school. This law would be very helpful to diabetic students. As pointed out by Ms. Evans, there are not very many school nurses out there. Those practicing are centralized and there are a lot of schools without nurses. He stated that while the figure may be inaccurate, he has heard that about 18 percent of schools actually have a nurse available. He addressed the concern of requiring the school personnel to participate saying that his understanding is that it is voluntary. You can't make someone give an injection; the rule doesn't say you shall, it says you may. This goes beyond a good health proposal to a life or death proposal for the students who have Type I diabetes. If I had a diabetic child I would want that child to have access to an injection when he needed it. I encourage you on behalf of the ADA to pass this bill. As far as

the school is concerned and the kids that are diabetics, this is a real plus bill. The injection of insulin is not something that is going to have a serious contraindication, and it is something that is a life saving maneuver that could bring them back from a less than desirable situation. I encourage the Committee to look at it from that standpoint and pass this rule.

MOTION: **Senator Martin** moved, seconded by **Senator Guthrie,** to adopt **Docket No. 23-0101-1301.** The motion carried unanimously by **voice vote.**

Vice Chairman Nuxoll commented that she thinks it is a common sense rule, one that takes away the pharisaical outline of law where you can only follow exactly the letter of the law. I like it and I vote for it.

DOCKET NO. 23-0101-1302 **Rules of the Idaho Board of Nursing, Sandra Evans,** Executive Director, Idaho Board of Nursing, stated that this is both a temporary and a pending rule. A change in model rules of the Nurse Licensure Compact (Compact), of which Idaho is a member, necessitates a similar change in Board of Nursing rule IDAPA 23.01.01.077. Data collected by Compact members indicate that 30 days is insufficient to process and issue a nursing license. Administrators determined that a 90 day period provides an acceptable time frame to process and issue a license. The change in this docket increases from 30 to 90 days that a nurse moving to Idaho may practice on his/her existing license in another Compact state while the Idaho license is processed.

Ms. Evans reported that there were no comments received during the comment period that began on October 2, 2013, and that there is no fiscal impact with this rule.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 6).

MOTION: **Senator Guthrie** moved, seconded by **Senator Bock** that we accept **Docket No. 23-0101-1302.** The motion carried by **voice vote.**

DOCKET NO. 16-0501-1301 **Rule relating to HIPAA Privacy Rule (Pending): Heidi Graham,** Civil Rights Manager/Privacy, Division of Operational Services, Human Resources, Department of Health and Welfare, presented this docket. The U. S. Department of Health and Human Services modified the HIPPA Privacy Rule. This docket brings the Idaho Department of Health and Welfare's Use and Disclosure rules into compliance with those modifications and allows–not mandates–that the Department disclose a decedent's health information to family members and others who were involved in their care. The rule change gives the Department more latitude to release decedent records, but the effect will be minimal.

Ms. Graham reported that there is no anticipated fiscal impact to the state general fund, and we know of no outstanding issues with this rule. She asked that the Committee adopt this docket as a final rule.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 7).

MOTION: **Senator Bock** moved, seconded by **Senator Heider,** to adopt **Docket No. 16-0501-1301.** The motion carried unanimously by **voice vote.**

PASSED THE GAVEL: Vice Chairman Nuxoll passed the gavel back to Chairman Heider.

ADJOURNED: **Chairman Heider** thanked everyone and adjourned the meeting at 4:18 p.m.

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Senator Heider
Chair

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Linda Hamlet
Secretary

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Carol Cornwall
Assistant Secretary