MIEC

# MIEC New Law Alert

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## New laws affecting Hawaii clinicians

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***New Law Alert***
A publication of the
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*The Hawaii Legislature enacted a number of new laws affecting physicians, other health care professionals and patients: the board of nursing recognizes diversion programs offered by sponsors outside of the Hawaii Nurses Association; a task force will conduct a study to determine the feasibility of requiring every pharmacy to transmit and maintain prescriptions electronically; licensure requirements for the practice of respiratory care are established; liability protections for volunteer medical personnel are expanded; an immunization registry is created; a Child Protective Act is created; and the DEA allows electronic prescriptions for controlled substances. Laws are currently in effect unless otherwise noted.*

### Practice of nursing

Chapter 457, Hawaii Revised Statutes, SB 2163 Act 57

According to this Act, the Hawaii State Board of Nursing will adopt the provisions of the National Council of State Boards of Nursing (NCSBN) *Model Nursing Practice Act* and *Model Nursing Administrative Rules* relating to the scope and standards of nursing practice for registered nurses, licensed practical nurses, and advanced practice registered nurses.

The Board shall not be required to adopt rules or provisions that the Board finds are inappropriate or inapplicable; the Board shall state clearly in the record of the Board's proceedings its rationale for rejecting or modifying the NCSBN model rules.

The statute briefly describes the scope of nursing practice for RNs, LPNs, and APRNs and refers to specific sections in the NCSBN model rules for additional guidelines. The statute specifies that descriptions apply for each category of nursing "regardless of compensation or personal profit."

**Registered nurse**: The full scope of nursing that incorporates caring for all clients in all settings and is guided by the scope of practice authorized by this chapter, the rules of the Board, and nursing standards established or recognized by the Board.

**Licensed practical nurse:** The directed scope of nursing practice, that takes place under the direction of a registered nurse, advanced practice registered nurse (APRN), licensed physician, or other health care provider authorized by the State, and is guided by the scope of practice authorized by this chapter, the rules of the Board, and nursing standards established or recognized by the Board.

**Advanced practice registered nurse:** The scope of nursing in a category approved by the Board and includes the registered nurse scope of practice. The scope of an APRN includes, but is not limited to, advanced assessment and the diagnosis, prescription, selection, and administration of therapeutic measures including over-the-counter drugs, legend drugs, and controlled substances within the advanced practice registered nurse's role and specialty-appropriate education and certification.

The APRN's scope of practice supersedes the RN's scope of practice. APRNs shall practice within standards established or recognized by the Board and be guided by the scope of practice authorized by this chapter, the rules of the Board, and nursing standards established or recognized by the Board.

An APRN shall recognize the limits of his or her knowledge and experience and planning for the management of situations that exceed the scope of authorized practice, and consult with or refer clients to other health care providers, as appropriate.

**Delegation of tasks, functions and activities to unlicensed personnel:** A registered nurse may delegate nursing care tasks, functions, and activities to unlicensed assistive personnel in a manner that is appropriate to the level of knowledge and skill of the unlicensed assistive personnel; provided that the delegation of tasks complies with applicable federal and state laws and the functions of assessment, evaluation, and nursing judgment shall not be delegated.

The delegating nurse is responsible for individually assessing the patient and the situational circumstances and for ascertaining the competence of the delegate before delegating any task. The delegating nurse shall supervise, monitor, evaluate, and follow up on instructions to a delegate. The delegate shall assume liability for accepting the delegation and for the delegate's own actions in carrying out the delegated task.

A delegating nurse shall use the NCSBN delegation decision-making process as a model for decision-making. The delegating nurse shall consider and carefully analyze:

- Patient needs and circumstances;
- Qualifications of the proposed delegate;
- The nature of the delegating nurse's delegation authority;
- The delegating nurse's personal competence in the area of nursing relevant to the task to be delegated; and
- The protocols contained in NCSBN documents, including but not limited to: *Five Rights of Delegation, Delegation-Decision Making Tree*, and *The Continuum of Care Framework*.

**APRN prescriptive authority:** An APRN with prescriptive authority shall not be authorized to request, receive, or sign for professional controlled substance samples.

APRNs with prescriptive authority who prescribe *non-controlled/legend drugs* or who are applying for prescriptive authority to prescribe non-controlled/legend drugs are no longer required to have a collegial agreement with a physician, effective immediately. In the past, an APRN with prescriptive authority was required to have a collegial working relationship with a physician and file a collegial relationship agreement with the Department of Commerce and Consumer Affairs; an APRN could not prescribe drugs or pharmaceuticals excluded in the collegial relationship agreement.

According to information posted on the Board of Nursing web site, the Board is in the process of adopting extensive amendments to Hawaii Administrative Rules, Chapter 89, which include amendments to APRN scope of practice and further clarifies the requirements for APRNs who wish to prescribe *controlled substances,* which will include in part a collaborative agreement. The rules will be posted on the board of nursing web site once adopted.

Fore more information:

State Board of Nursing web site:
http://hawaii.gov/dcca/pvl/boards/nursing/

Direct link to the model Nursing Practice Act
http://hawaii.gov/dcca/pvl/news-releases/nursing_announcements/Model_Nursing_Practice_Act_Dec09.pdf

## Nurse diversion program sponsors expanded

§§334D-1, and 334D-3, Hawaii Revised Statutes (HRS)

The diversion program established by chapter 334D, Hawaii Revised Statutes, requires a third-party sponsor to objectively evaluate, counsel, monitor progress, and provide ongoing support for rehabilitative services. Under previous law, that third-party sponsor was the Hawaii Nurses Association (HNA) and only nurses who had been reported by HNA were able to participate. The new law allows the board of nursing to recognize diversion programs that are offered by other sponsors in addition to the HNA.

According to the new law, nurses who participate in the diversion program shall provide evidence verified by licensed professional health care providers of successful completion of all terms and conditions of the program and of sufficient rehabilitation to safely practice nursing. A nurse who fails the requirements of the diversion program may be subject to disciplinary action.

## Electronic prescription feasibility study

(Chapter yet to be determined by the legislature) SB 2811 Act 125

This Act directs the chair of the Board of Pharmacy to establish a task force to conduct a study to determine the feasibility of requiring every pharmacy and remote dispensing pharmacy to have the capacity to transmit and maintain prescriptions and prescription information electronically. The study will also determine the feasibility of lowering the age at which vaccinations may be administered by pharmacists. The task force is directed to submit a report of its findings and recommendations, including any implementing legislation, to the legislature.

## Licensure requirements for the practice of respiratory care established

(Chapter yet to be determined by the legislature)
The HRS is amended by adding a new chapter, "Respiratory Therapists" SB 2600 Act 178
Effective Date (of portions cited): July 1, 2011

This Act establishes licensure requirements for the practice of respiratory care. The practice of respiratory care is defined as providing assessment, therapy, management, rehabilitation, support services for diagnostic evaluation, education, and care for patients with deficiencies and abnormalities that affect the pulmonary system, including:

1. Respiratory care services, including the administration of pharmacological, diagnostic, and therapeutic care related to respiratory care procedures necessary for treatment, disease prevention, rehabilitative, or diagnostic regimens prescribed by a physician;

2. Observation and monitoring of signs, symptoms, reactions, and physical responses to respiratory care treatment and diagnostic testing;

3. Diagnostic or therapeutic use of:

   a. Medical gases, excluding general anesthesia;

   b. Aerosols, humidification, environmental control systems, or invasive and non-invasive modalities;

   c. Pharmacological care related to respiratory care procedures;

   d. Mechanical or physiological ventilatory support, including maintenance of natural airways and insertion and maintenance of artificial airways;

   e. Cardiopulmonary resuscitation; and

   f. Respiratory protocol and evaluation or diagnostic and testing techniques for implementation of respiratory care protocols; and

4. The transcription and implementation of the written, verbal, and tele-communicated orders of a physician pertaining to the practice of respiratory care

No person (except as noted in the exemptions below) shall engage in the practice of respiratory therapy or refer to themselves as a respiratory therapist without a valid license from the department of commerce and consumer affairs. Applicants must meet the following requirements for licensure:

1. Successfully complete a respiratory therapy training program at an accredited educational institution approved by the Committee on Accreditation for Respi-

ratory Care or its predecessor or successor agencies;

2. Pass the Certified Respiratory Therapist Examination of the National Board for Respiratory Care, within 90 days of submitting an application.

## Exemptions:

This chapter is not intended to restrict the practice of other licensed or credentialed healthcare practitioners practicing within their own recognized scopes of practice and shall not apply to:

1. A person working within the scope of practice or duties of another licensed profession that overlaps with the practice of respiratory care; provided that the person doesn't purport to be a respiratory therapist;

2. A person working as, or training to become, a sleep technologist or person who is enrolled in a Commission on Accreditation of Allied Health Education Programs, Accredited Sleep Technologist Education Program, or a program approved by the American Association of Sleep Technologists to become a sleep technologist, provided that a sleep technologist is defined as a person trained in sleep technology and relevant aspects of sleep medicine, evaluation and follow-up care of patients with sleep disorders;

3. A person enrolled as a student in an accredited respiratory therapy program where the performance of duties that are regulated by this chapter is an integral part of the student's program of study;

4. A person employed by a durable medical equipment provider who engages in the delivery, assembly, setup, testing, and demonstration of oxygen and aerosol equipment upon the order of a physician; provided that no person providing those services shall be authorized to assess patients, develop care plans, instruct patients in taking treatment, or discuss the hazards, administration, or side effects of medication with patients;

5. A person rendering services in the case of an emergency or in the domestic administration of family remedies; or

6. A person employed by a federal, state, or county government agency in a respiratory therapist position, but only in the course of carrying out the duties and responsibilities of government employment.

No person shall practice respiratory care except under the direct order and qualified medical direction of a licensed physician or osteopathic physician. "Qualified medical direction" means ready access by a respiratory therapist to a licensed physician who has specialty training or experience in the management of acute and chronic respiratory disorders and who is responsible for the quality, safety, and appropriateness of the respiratory services provided by the respiratory therapist.

## Volunteer medical assistance personnel

Chapter 321, HRS is amended by adding a new section to part I
SB 930 Act 134

This law provides immunity from liability for licensed medical personnel providing volunteer medical assistance services on behalf of the State or a county, except in cases of wilful or criminal misconduct, gross negligence, or reckless misconduct. The statute defines "volunteer medical assistance services" as "the rendering of professional medical services that are provided on behalf of and authorized by the State or a county, including participation during periods of volunteer medical assistance services and volunteer medical assistance services training; provided that services provided pursuant to section 321-23.3 [volunteer emergency medical disaster response personnel*] shall not be considered to be volunteer medical assistance services. Volunteer medical assistance services shall include providing professional medical services in support of vaccination campaigns or outreach clinics."
*volunteer emergency medical disaster personnel also enjoy immunity protections, which are defined in a separate statute.

## Immunization registry

Chapter 325, HRS is amended by adding a new part (Part number yet to be determined by the legislature) Act 113

The Department of Health is directed to establish and maintain an immunization information system to be designated as the Hawaii immunization registry. The pur-

pose of the registry is to maintain a single statewide repository of immunization records to aid, coordinate, and help promote efficient and cost-effective screening, prevention, and control of vaccine-preventable diseases, including pandemic influenza.

The establishment of an individual's record in the registry shall not require the prior consent of a patient or the consent of a patient's parent or legal guardian in the case of a minor dependent. The Department of Health shall make available to the patient or the patient's parent or legal guardian, via the patient's health care provider or birthing hospital, a written description of the purpose and benefits of the registry as well as the procedure for refusing inclusion in the registry. No registry information shall be established in the registry for any patient, parent, or legal guardian who in writing refuses to allow the information to be included in the registry. Each health care provider or birthing hospital shall maintain the records of refusal of inclusion and shall report any refusal to the Department of Health in a manner specified by rule.

Registry information shall be limited to patient name, demographic information, and contact information; information specific to immunizations or medications received by the patient, including types, manufacturers, lot numbers, expiration dates, anatomical sites of administration, routes of administration, vaccine information statement publication dates, doses, dates administered, and adverse reactions to immunizations or medications; and the name and contact information of the vaccination administrator or medication provider and the patient's health care provider.

Registry information regarding specific individuals in the registry may be accessed by health care providers (e.g., physician, advanced practice registered nurse, physician assistant, pharmacist) who are treating, have treated, or have been assigned to treat those individuals and by employees of these health care providers for the purposes of:

1. Recording the administration of any vaccination;

2. Determining the immunization history of a patient to deliver health care treatment accordingly;

3. Notifying individuals or parents or legal guardians of the need to schedule a visit for an immunization;

4. Generating official immunization records;

5. Ensuring compliance with mandatory immunization requirements; or

6. Recording the distribution of prophylactic and treatment medications administered or dispensed in preparation for and in response to a potentially catastrophic disease threat.

Registry information regarding specific individuals may also be accessed by certain school personnel and the department of health for specified purposes.

All immunization records and reports that directly or indirectly identify a person shall be kept confidential and shall not be disclosed unless:

1. The person identified, or the person's parent or legal guardian consents;
2. Disclosure is deemed necessary by the director of health for the purposes described in the statute;

3. A court directs that disclosure is necessary for the conduct of proceedings before it;

4. The disclosure is made between the person's health care provider and payor to obtain reimbursement for services rendered; provided that disclosure shall be made only if the provider informs the person that a reimbursement claim will be made to the person's payor, the person is afforded an opportunity to pay the reimbursement directly, and the person does not pay; or

5. The Department of Health releases aggregate immunization information that does not disclose any identifying information of persons in the registry.

Registry information for any individual included within the registry shall be retained as part of the registry for twenty-five years after the last entry, except in the case of minors, whose records shall be retained during the period of minority plus twenty-five years after the minor reaches the age of majority. At the conclusion of the retention period, the data stored in the regis-

try for that individual will be archived.

## Child Protective Act

Chapter 350, HRS, is amended by adding two new sections
SB 2716 Act 116

§350- Authorization for color photographs, x-rays, and radiological or other diagnostic examination: Any health professional or paraprofessional, physician, registered nurse or licensed practical nurse, hospital or similar institution's personnel engaged in the admission, examination, care, or treatment of patients, and any medical examiner, coroner, social worker, or police officer, who has before the person a child the person reasonably believes has been harmed, shall make every good faith effort to take or cause to be taken color photographs of the areas of trauma visible on the child.

If medically indicated, such person may take or cause to be taken x-rays of the child or cause a radiological or other diagnostic examination to be performed on the child. Color photographs, x-rays, radiological, or other diagnostic examination reports that show evidence of imminent harm, harm, or threatened harm to a child shall immediately be forwarded to the Department of Human Services.

§350-Disclosure of records: If a child is active in the Child Protective Services system, physicians may share with other physicians, orally or in writing, or both, medical information without parental consent

"Harm" means damage or injury to a child's physical or psychological health or welfare, where:

(1) The child exhibits evidence of injury, including, but not limited to:

a. Substantial or multiple skin bruising;

b. Substantial external or internal bleeding;

c. Burn or burns;

d. Malnutrition;

e. Failure to thrive;

f. Soft tissue swelling;

g. Extreme pain;

h. Extreme mental distress;

i. Gross degradation;

j. Poisoning;

k. Fracture of any bone;

l. Subdural hematoma; or

m. Death;

and the injury is not justifiably explained, or the history given concerning the condition or death is not consistent with the degree or type of the condition or death, or there is evidence that the condition or death may not be the result of an accident;

(2) The child has been the victim of sexual contact or conduct, including sexual assault; sodomy; molestation; sexual fondling; incest; prostitution; obscene or pornographic photographing, filming, or depiction; or other similar forms of sexual exploitation;
(3) The child's psychological well-being has been injured as evidenced by a substantial impairment in the child's ability to function;
(4) The child is not provided in a timely manner with adequate food; clothing; shelter; supervision; or psychological, physical or medical care; or
(5) The child is provided with dangerous, harmful, or detrimental drugs, except when a child's family administers drugs to the child as directed or prescribed by a practitioner.

"Imminent harm" means that without intervention within the next 90 days, there is reasonable cause to believe that harm to the child will occur or reoccur.

## DEA allows electronic prescriptions for controlled substances

Effective June 1, 2010, DEA's rule, "Electronic Prescriptions for Controlled Substances" revised DEA's regulations to provide practitioners with the option of writing (and transmitting) prescriptions for controlled substances electronically. The electronic health record application used by the practitioner must be certified as meeting the requirements of the DEA's rule, and two-factor identity proofing of individual prescribing providers is required (two of the following: something you know, something you have, something you are). "Something you know" refers to a password; an example of "some-

thing you have" could be a cryptographic key stored on a hardware device such as a PDA. It must remain in the provider's sole possession. "Something you are" indicates biometric identifiers such as a fingerprint.

For more information, please see the Frequently Asked Questions on the DEA web site: http://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/faq.htm

State laws must be obeyed if they are more stringent than the DEA rule. HRS 329-38 indicates that 'no controlled substance in schedule III, IV, or V may be dispensed without a written, facsimile of a written, or oral prescription of a practitioner" and includes requirements such as being written in indelible ink. It does not appear that Hawaii law, as currently written, would allow practitioners to prescribe controlled substances electronically per the DEA's rule.

*We thank Thomas E. Cook, Esq., of Lyons, Brandt, Cook and Hiramatsu, Honolulu, Hawaii, for his review of this edition of New Law Alert*

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**www.miec.com**

# MIEC enhances its policyholder services by offering "Added Benefits"

Medical Insurance Exchange of California (MIEC) is pleased to announce the addition of the following "Added Benefits" that will assist policyholders obtain CME credits, manage diagnostic test results, and improve patient education.

**Free-online CME:** MIEC has partnered with **Advanced Practice Strategies (APS**) to offer policyholders access to its extensive library of CME core and specialty-specific courses developed with nationally recognized experts. A core set of curriculum modules, applicable across all areas of practice, address general topics in risk and safety. Specialty-specific courses nearly all areas of medicine. **MIEC policyholders can obtain *AMA PRA Category 1* CME credits *free of charge*.**

**Automated patient notification system:** MIEC is facilitating policyholder introduction to **SecuReach,** an automated system that tracks referrals, laboratory and other tests from the time they are ordered until your patients are notified of their results. It offers a personalized message system created in the physician's (or representative's voice) and preserves the communication indefinitely. It increases office efficiency and reduces the potential for patient injury by facilitating convenient communication between physicians and their patients. **MIEC policyholders who purchase SecuReach are eligible to receive a ten-percent (10%) discount off SecuReach's standard monthly fee.**

**Multilingual patient education:** MIEC has partnered with **The Exchange,** a partnership of health plans, health care delivery entities, and corporate affiliates who exchange health communication, information and resources, and shares online **multilingual** health materials. The Exchange website (www.health-exchange.net) is open to everyone, but its online library of translated health materials is available to partners or corporate affiliates only. **MIEC policyholders receive *free* unlimited access to The Exchange's online pdf archive of nearly 4,000 translations of health education materials.**

**Animated 3D patient education:** MIEC has partnered with **Visible Productions,** to allow policyholders access to its library of anatomically structured 3D models of the human body, complete multi-part multimedia programs, 3D medical animations, and topic segments. This media compliments the physician-patient informed consent discussions. **MIEC policyholders have unlimited access to this amazing resource.**

**To access these resources**, go to MIEC's website at **www.miec.com**, log in (your username and password is available by calling your MIEC Underwriter) to explore and review all of the resources available to you.