

EMERGENCY MEDICAL TECHNICIANS

7 AAC 26.040. SCOPE OF CERTIFIED ACTIVITIES.

(a) A state-certified EMT-I may perform basic life support as defined in 7 AAC 26.999, may use an automated external defibrillator if properly trained as defined in AS 09.65.090 (f), and, under the direct or indirect supervision of a physician, may

- (1) practice approved airway management techniques;
- (2) repealed 8/16/2002; and
- (3) use a manual defibrillator if certified as a manual defibrillator technician under 7 AAC 26.510 - 7 AAC 26.590.

(b) A state-certified EMT-II may perform the skills of an EMT-I and, under the direct or indirect supervision of a physician, may

- (1) practice approved airway management techniques;
- (2) start peripheral intravenous (I.V.) treatment;
- (3) obtain blood for laboratory analysis;
- (4) administer five-percent dextrose in water, crystalloid volume-replacement solutions, 50 percent dextrose in water, and naloxone hydrochloride (Narcan);
- (5) repealed 8/16/2002; and
- (6) use a manual defibrillator if certified as a manual defibrillator technician under 7 AAC 26.510 - 7 AAC 26.590.

(c) A state-certified EMT-III may, under the direct or indirect supervision of a physician, perform the skills of an EMT-II and may apply electrodes and monitor cardiac activity, countershock ventricular fibrillation and pulseless ventricular tachycardia, administer lidocaine, administer atropine, administer morphine, and administer epinephrine 1:1,000 and 1:10,000.

(d) An EMT-I, EMT-II, or EMT-III may use those additional medications or procedures that have been approved by the department and are on file with the department under 7 AAC 26.670.

(e) An EMT-II or EMT-III who is not under the supervision of a medical director may only perform those procedures defined as basic life support in 7 AAC 26.999.

(f) Repealed 8/16/2002. (History: Eff. 12/31/81, Register 80; am 10/14/84, Register 92; am 10/23/92, Register 124; am 5/22/96, Register 138; am 7/4/99, Register 151; am 8/16/2002, Register 163)

Authority: AS 09.65.090 AS 18.08.080 AS 18.08.082 AS 18.08.084

7 AAC 26.670. Approval of additional medications and procedures.

(a) In order for a medical director to authorize a state-certified EMT-I, EMT-II, or EMT-III to use additional medications or procedures not covered under 7 AAC [26.040\(a\)](#), (b), or (c), the medical director shall

(1) submit to the department a request for approval; the request must include a plan for training and evaluation covering the additional skills; and

(2) if the request is approved, following the training and evaluation, send the department a list of individuals who are authorized to use the additional medications or procedures.

(b) The department will maintain a list of the approved additional medications or procedures for an authorized EMT-I, EMT-II, or EMT-III.

History: Eff. 10/23/92, Register 124; am 5/22/96, Register 138

Authority: [AS 18.08.080](#)

MOBILE INTENSIVE CARE PARAMEDIC

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES.

(a) A licensed mobile intensive care paramedic, when under the supervision of a sponsor physician, may perform the activities listed in this subsection. The direct supervision of an activity may be delegated to another physician when the mobile intensive care paramedic is caring for a patient in a hospital, at the scene of a medical emergency when voice contact is monitored by a physician and direct communication is maintained, or when under the specific written standing order of a physician.

The activities are

- (1) electrocardiographic monitoring and defibrillation;
- (2) initiating and maintaining intravenous routes using approved intravenous techniques and solutions;
- (3) performing endotracheal intubation and pulmonary ventilation by approved methods;
- (4) performing gastric suction by intubation;
- (5) obtaining blood for laboratory analysis;
- (6) administering parenterally, orally, or topically any approved agents or solutions;
- (7) use of pneumatic antishock devices; and
- (8) performing other emergency procedures authorized by a sponsoring physician.

(b) A person enrolled in a mobile intensive care paramedic training program may perform the activities set out in (a) of this section insofar as:

- (1) the activities are required as part of the training program;
- (2) the activities that take place in a hospital are supervised by a physician, physician assistant, or nurse; and
- (3) the activities that take place outside a hospital are supervised by a licensed mobile intensive care paramedic, or a physician sponsor, or the physician sponsor's designee.

(c) While functioning as an intern in Alaska, a person may not perform the activities listed in (a) of this section for more than 480 hours, or for more than six calendar months, without becoming licensed as a mobile intensive care paramedic by the board.

(d) The scope of authorized activities for a mobile intensive care paramedic does not include primary patient care, such as dispensing nonemergency medications, performing physical examinations for nonemergency purposes, and treatment of nonemergency medical conditions included in the scope of practice for a physician, physician assistant, or nurse, unless specifically authorized by the board.

Authority: AS 08.64.100 AS 08.64.107

1
2 STATE OF ALASKA
3 DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
4 DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING
5 STATE MEDICAL BOARD

6
7 January 24 – 25, 2008
8
9

10 MINUTES OF MEETING
11

12
13 By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a scheduled meeting
14 of the Alaska State Medical Board was held on Thursday and Friday, January 24 – 25, 2008, in Room 1270
15 of the Atwood Building, 550 West Seventh Avenue, Anchorage, Alaska.
16

17
18 **Thursday, January 24, 2008**
19

20 **Call to Order**
21

22 The meeting was called to order at 9:00 am.
23

24 **Roll Call**
25

26 Present were: David M. Head, MD, Chair William Resinger, MD
27 John T. Duddy, MD Michael J. Tauriainen
28 Edward A Hall, PA-C Jean M. Tsigonis, MD
29 Nancy Puckett
30

31 Dr. Robert Breffeilh was not yet present but was expected.
32

33 Staff Members present were Linda Sherwood, licensing examiner, and Leslie Gallant, the board's
34 executive administrator.
35

36 **Announcements**
37

38 Ms. Gallant advised the board members that the Dillingham meeting would be scheduled during a
39 busy time there and they should book their hotel and airline reservations soon.
40

41 Also, the meeting date for the April meeting was officially changed to be April 3 – 4 in order to
42 accommodate attendance at a program on physician assessment and re-entry into practice being
43 held by the Federation of State Medical Boards that the board wishes staff and a board member to
44 attend. The board members agreed that Dr. Breffeilh should attend this program as well as Ms. Gallant.
45

46 Ms. Gallant advised the board that she has been nominated to serve on the Federation of State
47 Medical Boards' board of directors. Final selection has not yet been made but it is an honor to be
48 nominated.
49

50 Additional late items for the board's consideration were distributed to be included in the meeting
51 agenda as possible.
52

53 Ms. Sherwood advised that the mileage reimbursement for the use of personal cars has been increased
54 to 50.5 cents and also that there will no longer be a state credit card used for car rentals.
55
56
57

1 **New Agenda Item In the Matter of Samuel H. Schurig, DO**

2
3 The board considered Dr. Ray Andreassen's request to add Dr. Jim Sanders as another supervising
4 physician for Dr. Schurig at the Delta Junction practice. There are times when he must be away from
5 the office and without another supervising physician, Dr. Schurig would not be able to continue to
6 practice.

7
8 The board members discussed Dr. Sanders and determined they had no objection to adding him as
9 long as he agrees to the requirements of a supervising physician.

10
11 **MOTION TAURIAINEN moved to approve Dr. Jim Sanders to be a second supervising**
12 **physician for Dr. Samuel H. Schurig.**
13 **2nd BREFFEILH**
14 **VOTE 8 Yea votes (Head, Breffeilh, Duddy, Hall, Puckett, Resinger, Tauriainen, Tsigonis)**
15 **0 Nay votes**
16 **0 Abstentions**
17

18 The board discussed the letter from the Alaska Family Practice Residency Program regarding Dr.
19 Shayhorn. Dr. Head advised that he determined that the board had no involvement in
20 Dr. Shayhorn's sitting for Step 3 of the USMLE unless she fails it more than once.

21
22 Off the record at 12:20 pm; on the record at 1:03 pm

23
24 All board members and staff were present.

25
26
27 **Section 5 Board Discussion - Expanded Paramedic Scope of Practice**

28
29 Dr. Head advised the board regarding Dr. David Vastola's letter requesting approval for an expanded
30 scope of practice for a paramedic. This matter was discussed at the October board but the board felt
31 it would be best to discuss it with Dr. Vastola personally. Dr. Vastola was connected to the board
32 meeting by telephone.

33
34 Dr. Vastola explained that they have a paramedic in Klawock they would like to work in an expanded
35 capacity assuming duties that might more commonly be performed by a nurse in the Alicia Roberts
36 Medical Center on Prince of Wales Island. It is now a physician and mid-level clinic with permanent
37 staffing of six physicians and six mid-levels. About six years ago, the private practice doctors on the
38 island decided they would not do call anymore so the SEARHC clinic became responsible for all after
39 hours and emergent care for the approximately 5,000 people on the island. They provide all the
40 emergency care in the clinic and also 24/7 operations with either a doctor or mid-level on call every
41 day.

42
43 The clinic uses a variety of health care providers including nurses, people who used to be health aids,
44 etc. They have had tremendous difficulty recruiting and retaining nurses for the island. They really
45 need to have staff on call with the doctors and the mid-levels who are ALS trained. They get a number
46 of myocardial infarctions, motor vehicle accidents, etc. They need two ALS-capable staff on call at all
47 times. This has been challenging with the nursing staff shortages. Some time ago, they hired a PA to
48 work in the clinic and her spouse is a paramedic with a two-year degree in paramedic science and an
49 extensive resume with a lot of experience.

50
51 Dr. Vastola is seeking clarification from the board regarding the regulation 12 AAC 40.370, scope of
52 authorized activities, specifically, paragraph (d). In their situation, they would like the paramedic to be
53 on call as the second, a mid-level, and would only be working with the physician as a medical support
54 staff similar to what a nurse would be doing.

1 Dr. Head clarified that his understanding was that the intent of the regulation is to allow the paramedic
2 to practice pre-hospital medicine in the emergency room but not routinely in a clinic. He further
3 clarified his understanding that Dr. Vastola was requesting permission to work the paramedic similar to a
4 nurse who would always be working under the supervision of a mid-level or a physician.
5

6 Dr. Vastola confirmed Dr. Head's understanding that the paramedics be allowed to practice their
7 scope of practice in the clinic setting. He stated that the clinic also functions much as an emergency
8 setting.
9

10 Ms. Gallant asked only that any motion be very specific to grant approval to a specific paramedic for a
11 specific practice, in a specific setting.
12

13 Dr. Breffeilh felt this would a precedent-setting action. The paramedic would be functioning very similar
14 to a community health aide.
15

16 Dr. Vastola disagreed in that a community health aide has a much more extensive scope as a primary
17 care giver. He noted that SEARHC has moved away from that model and has gone more to using mid-
18 levels. Although the CHA has a broad scope of things they are taught to do, the paramedic performs
19 tasks that health aides are not taught to perform such as intubation.
20

21 Mr. Hall recommended that the paramedic obtain the health aide training so that he could expand his
22 ability to work.
23

24 **MOTION** **TAURIAINEN moved to authorize Rusby Clinton Crites, paramedic, to work with Dr.**
25 **Myron Fribush at the Alicia Roberts Medical Center on Prince of Wales Island in**
26 **accordance with 12 AAC 40.370(d) and to perform all scope of practice for**
27 **emergency setting in a non-emergency clinical setting.**

28 **2nd** **TSIGONIS**
29 **VOTE** **7 Yea votes (Head, Breffeilh, Duddy, Puckett, Resinger, Tauriainen, Tsigonis)**
30 **1 Nay votes (Hall)**
31 **0 Abstentions**
32
33

34 **Section 6 Full Board Interview – Elizabeth A. Clawson, MD**

35
36 Dr. Clawson was present to meet with the board to discuss her application.
37

38 **MOTION** **TAURIAINEN moved that in accordance with AS 44.62.310(c) (2), the board go into**
39 **executive session for the purpose of discussing the application of Elizabeth A.**
40 **Clawson, MD.**

41 **2nd** **PUCKETT**
42 **VOTE** **8 Yea votes (Head, Breffeilh, Duddy, Hall, Puckett, Resinger, Tauriainen, Tsigonis)**
43 **0 Nay votes**
44 **0 Abstentions**
45

46 Off the record at 1:34 pm; on the record at 1:45 pm.
47

48 **MOTION** **BREFFEILH moved to grant an unrestricted license to Dr. Elizabeth A. Clawson.**

49 **2nd** **TAURIAINEN**
50 **VOTE** **8 Yea votes (Head, Breffeilh, Duddy, Hall, Puckett, Resinger, Tauriainen, Tsigonis)**
51 **0 Nay votes**
52 **0 Abstentions**
53
54

55 While the board awaited the arrival of the next appointment, members reviewed license application
56 files.
57

**APPENDIX A
POSITION STATEMENT
ALASKA BOARD OF NURSING
SCOPE OF PRACTICE FOR LICENSED PRACTICAL NURSES**

**Readopted without change September 2004
(Adopted August 1991)**

Authority

The Alaska Board of Nursing has statutory authority pursuant to AS 08.68.100 to issue opinions and to develop and publish standards of practice for the nurses regulated by the Board.

The Board of Nursing remains committed to consumer rights to safe services and will continue to monitor safe and appropriate utilization of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) in the absence of specific legislation or regulations restricting LPNs from assuming responsibilities for additional acts.

The board notes that AS 08.68.265 provides that "A practical nurse shall work under the supervision of a licensed registered nurse, a licensed physician, or a licensed dentist." AS 08.68.270(7) and AS 08.68.275 also make "unprofessional conduct" grounds for disciplining a nurse, or revoking or suspending licenses. "Unprofessional conduct" is defined in the board's regulation 12 AAC 44.770 to include:

- (1) failing to use sufficient knowledge, skills or nursing judgment in the practice of nursing as defined by the level of licensure;
- (2) assuming duties and responsibilities, on repeated occasions, without sufficient preparation or for which competency has not been maintained;
- (3) knowingly delegating a nursing care function, task, or responsibility to another who is not licensed under AS 08.68 to perform that function, task, or responsibility, when the delegation is contrary to AS 08.68 or 12 AAC 44 or involves a substantial risk or harm to a client;
- (4) failing to exercise adequate supervision over persons who are authorized to practice only under the supervision of the licensed professional;
- (5) failing to perform acts within the nurse's scope of competence which are necessary to prevent substantial risk or harm to a client;
- (6) violating the confidentiality of information or knowledge concerning a client;
- (7) physically or verbally abusing a client;
- (8) using alcohol or other drugs to the extent that the use interferes with nursing functions;
- (9) violating state or federal laws regulating drugs, including but not limited to forging prescriptions or unlawfully distributing drugs or narcotics;
- (10) failing to maintain a record for each client which accurately reflects the nursing problems and interventions for the client, or falsifying a client's records or intentionally making an incorrect entry in a client's chart;
- (11) leaving a nursing assignment without properly notifying appropriate personnel;
- (12) permitting another person to use his or her nursing license or permit for any purpose;
- (13) failing to report, through proper channels, facts known to the nurse regarding incompetent, unprofessional, or illegal practice of a health care provider unless it has already been reported and the provider is already participating in a treatment or educational program approved by the appropriate board;
- (14) engaging in fraud, misrepresentation, or deceit in writing the licensing examination;
- (15) for any person not authorized to practice acts of medical diagnosis or medical therapeutics as an advanced nurse practitioner, to use the title nurse practitioner or advanced nurse practitioner, or the abbreviation NP or ANP or any other words, letters, signs, or figures to indicate that the person is an advanced nurse practitioner;
- (16) for an advanced nurse practitioner to perform duties other than those specified in 12 AAC 44.430;
- (17) for any person not authorized to practice as a registered nurse anesthetist to use the title registered nurse anesthetist, nurse anesthetist or certified registered nurse anesthetist or the abbreviation CRNA or any other words, letters, signs, or figures to indicate that the person is a registered nurse anesthetist;
- (18) for a registered nurse anesthetist to perform duties outside the scope of practice described in 12 AAC 44.510.
- (19) discrimination on the basis of race, religious creed, color, national origin, ancestry or sex in the provision of nursing services;
- (20) signing a record as a witness attesting to the wastage of controlled substances which the nurse did not actually witness;
- (21) exploiting the patient for financial gain or offering, giving, soliciting or receiving fees for referral of a patient or client;
- (22) intentionally misappropriating medications, property, supplies, equipment or other resources of the client or agency for personal or unauthorized use;
- (23) removal of a patient's life support system without appropriate medical or legal authorization;

- (24) untruthful or misleading advertising of nursing services;
- (25) knowingly violating laws regulating health insurance including those laws established in AS 21.36.360;
- (26) engaging in activities that constitute the unlicensed practice of pharmacy; and
- (27) for an advanced nurse practitioner with prescriptive and dispensing authority to dispense a prescription outside of the advanced nurse practitioner's scope of practice.

In interpreting and applying these statutes and regulations, the board has held and will continue to hold each Registered Nurse responsible for the totality of nursing care. This responsibility and accountability includes nursing activities which are delegated to and carried out by the Licensed Practical Nurse and all others who work under the direction of the RN. The board has held and will continue to hold each Licensed Practical Nurse responsible for accepting only those task assignments for which the nurse has been fully prepared. The LPN task assignments must be carried out under the supervision of a Registered Nurse, Physician or Dentist. Both RNs and LPNs should recognize the level and depth of knowledge and decision making that various nursing activities demand. This accountability and responsibility of the level of licensure granted by the board exists regardless of directives, policies, protocols or staffing patterns implemented by employing agencies.

The following definitions are germane to any discussion of LPN scope of practice and are used throughout this paper:

Delegation means the transfer of authority to perform selected nursing functions in a specific situation to a competent individual.

Supervision means provision of guidance by a qualified nurse for the accomplishment of a nursing function with initial direction and periodic inspection of the activity.

Background

The impact of limited registered nurse resources has continued to be a concern to Alaska nursing employers as well as the Board of Nursing. The health and safety of the public requires that nursing resources be used as efficiently as possible to provide the safest level of nursing service. Because the acuity of care being provided by licensed nurses in all types of settings has increased substantially in recent years, the responsibilities of registered nurses and, consequently of practical nurses, have also increased. Thus, nursing employers have been required to make difficult decisions about how to meet the increased demand for quality nursing care.

Information from the NCSBN and from nursing boards in other jurisdictions, makes it clear the role of the practical nurse in the delivery of health care services has expanded beyond that identified for the LPN beginning practice. It is the duty of the Board of Nursing, to define the role of the practical nurse in the delivery of health care services. These standards of practice are intended to promote the public health and safety by ensuring nursing care services are available and are provided by qualified care givers.

Competency Based Practice Criteria

The scope of practice for practical nurses can be divided into two levels of practice. The first level is that defined for the entry level nurse beginning practice. The NCSBN defines entry level as the first six months of practice after completion of a program. An appropriate reference for this level of practice is the detailed test plan statements used for the National Council Licensure Exam for Practical Nurses. The NCLEX-PN is used in Alaska and the rest of the United States to document that practical nurses entering practice are minimally competent with the necessary knowledge, skills and abilities to perform safely.

The second level of practice defines advanced practice for practical nurses which entails knowledge and skills obtained through additional formal education, continuing education or on the job training.

Critical elements are necessary for the experienced LPN to safely expand the scope of practice;

1. Education beyond that required for licensure which is documented and includes a curriculum based on behavioral objectives and an assessment of learning including demonstration of clinical skills;
2. Policies and procedures established by the employer which allow the practice being done by the LPN and which give guidance regarding the conditions under which the procedure or service is accomplished;
3. Supervision of the LPNs performance by the registered nurse, physician or dentist. While directly observed supervision is necessary when a practical nurse undertakes additional responsibilities initially, once the LPN has been determined competent, directly observed supervision may not be necessary.

4. There is provision for assuring the continuing competence of the experienced LPN to perform the expanded role activity.

The **Licensed Practical Nurse** is legally responsible and accountable for individual practice. Each nurse is accountable for accepting delegation of acts and for one's own actions in carrying out the act. The nurse may incur liability if the nurse deviates from safe practice.

The **Registered Nurse** is legally responsible and accountable for assessing the patient care situation and for the decision to delegate. The RN is expected to monitor the care provided and evaluate the outcome of care as the supervisory person. The RN remains accountable for the acts which are delegated and may incur liability if found to be negligent in the process of delegating and supervising.

Guidelines for Delegation

The Registered Nurse assesses the client care situation which encompasses the stability of the clinical environment and the clinical acuity of the client which includes the overall complexity of the client's health care problems. This assessment will help determine what can be delegated and the amount of supervision which would be required.

It is imperative that RNs and employers of LPNs recognize the wide variations in the abilities of individual LPNs to accept expanded role responsibilities. Thus, the decision to delegate expanded responsibilities must be based on an assessment of the delegatee's abilities.

Often patient care situations encompass a variety of components. Nursing care embraces a variety of clinical situations, components and nursing responsibilities. Some components and responsibilities are simple and easily standardized as procedures and protocols. Those procedures are carried out in the same manner each time they are performed and demand skill proficiency and efficiency. Such situations fit the decision making model depicted in Figure 1 on the following page and can be exemplified by such a task as hanging a premixed medicated intravenous solution. That task would require the nurse to 1) check to be certain that the correct solution was being administered to the correct client; 2) hang the solution using proper aseptic technique; 3) infuse the solution at the prescribed rate; and 4) observe the client for adverse effects. Activities that fit the decision making model depicted in Figure 1 are appropriate areas for expanded practice by experienced LPNs.

Other aspects of care are complex, and highly variable, requiring skill proficiency and also a high degree of critical judgment and decision making if they are to be performed consistently with safety. Such activities more closely fit the "decision-tree" model depicted in Figure 2. The hanging of a dopamine drip exemplifies an activity that falls into the complex decision making model; in that situation, the nurse would be required to 1) calculate the dilution; 2) mix the solution and medication properly; 3) administer the correct medicated solution to the correct client; 4) regulate the flow rate of the solution in relation to the client's blood pressure and pulse (rate and quality); 5) observe the client for therapeutic and adverse responses and make appropriate adjustments.

In general, highly complex and variable situations are most appropriately placed within the RN scope of practice and outside the scope of even experienced, practical nurses.

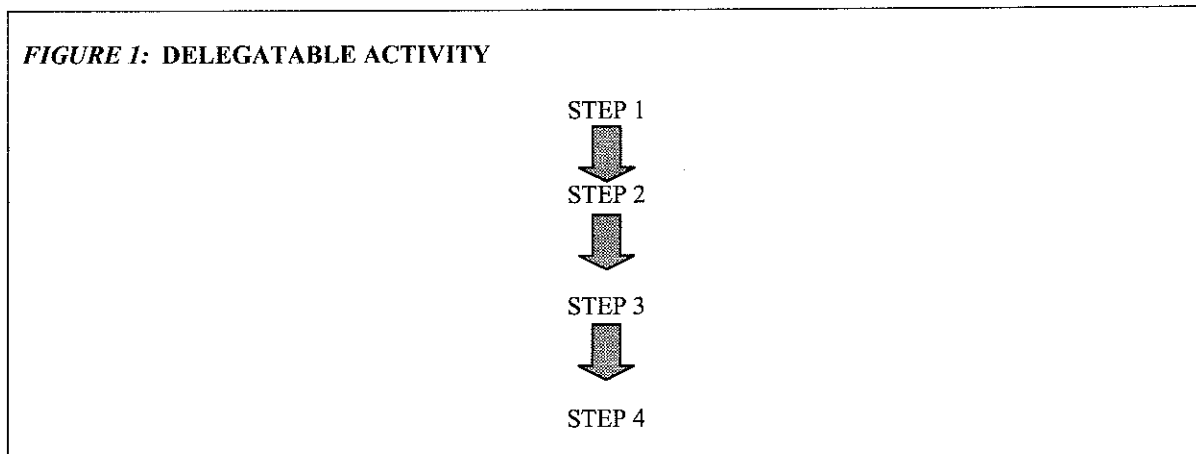
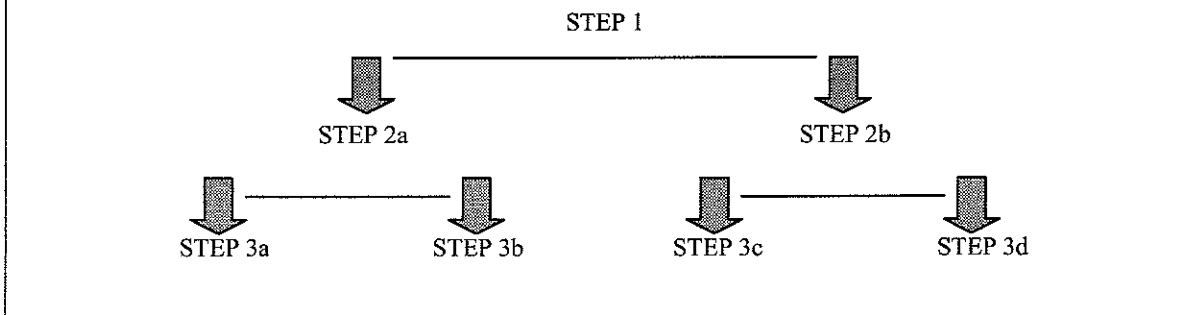


FIGURE 2: NONDELEGATABLE ACTIVITY



Using these models the following activities emerge as being appropriately delegated to experienced LPNs who have completed additional educational experiences:

- management of chronic dialysis care in the health care facility setting
- vaginal examinations of noncomplicated active labor patients
- management of chronic stable patients on ventilators
- reinsertion and changing gastrostomy and cystostomy tubes through healed stomas or buttons
- remove staples and sutures from healed wounds

Using the same model, the following examples would be activities that are not appropriately delegated to experienced LPNs.

- expanded role responsibilities outside of a health care facility
- performance of a full physical assessment
- collection of a complete medical history
- performance of advanced cardiac life support skills¹
- leading or directing group psychotherapy sessions
- arterial punctures
- management of arterial lines

It should be noted that the above list is not exhaustive and is provided only as an example of model implementation.

The same approach can be used to analyze the possible range of activities that nurses may be required to perform in the clinical setting to develop differentiated practice guidelines for beginning and experienced LPNs and RNs. An example of such an activity differentiation is presented below:

Example of Differentiated Practice Guidelines for Intravenous Therapy

Beginning LPN Practice	Experienced LPN Practice	RN Only
Monitor rate of infusion	Initiate peripheral IV therapy	Administer IV fluids and medications to neonates
Discontinue IV therapy	Hang premixed solutions including piggyback medications	Mix IV solutions Administer IV push medications Administer blood products
Monitor flow rate of TPN solutions	On going administration of TPN Solutions including lipids, via peripheral lines	Initiate administration of TPN solutions in peripheral and central lines Ongoing administration of TPN solutions in central lines

Monitor client
to analgesia

Change premixed PCA
cartridges

Change rate and dose of response
PCA pumps

) N/A

Summary

It is clear there is a potential difference in the scope of practice of beginning and experienced LPNs. However, expansion of the scope of practice of experienced LPNs must be based on a conscious decision making process that includes the development of policies and procedures for performance of specific activities, the provision of structured educational programs and supervised clinical practice, and an evaluation of the clinical competence of the individual LPN. Further, practice expansion is not automatically transferable to a new employment situation. Finally, it is critical that LPNs who practice in an expanded role recognize their personal accountability for acts they perform and that supervising RNs recognize their responsibility for providing direction and supervision.

References:

Arizona Board of Nursing Proposed Rules, April, 1991

Concept Paper on Delegation, National Council State Boards of Nursing, August, 1990

Guidelines for NCLEX-PN Item Writers (Detailed Test Plan) National Council State Boards of Nursing Examination Committee, 1990

Statement on the Nursing Activities of Unlicensed Persons, National Council State Boards of Nursing, August 1987

Summary of Responses to LPN Scope of Practice Survey, prepared by Tina DeLapp, RNC, EdD, and Kathi Hewitt, LPN, Alaska Board of Nursing, 1991

Survey of Experienced Licensed Practical/Vocational Nurses who are members of Boards of Nursing, National Council State Boards of Nursing, 1990

APPENDIX B

**REPEALED
AND INCORPORATED
INTO APPENDIX A
AUGUST 1991.**

Much of the following was written for the 1984 CHA Basic Training Curriculum. Some changes and additions have been made, in order to update the information.

THE COMMUNITY HEALTH AIDE PROGRAM (CHAP): BACKGROUND INFORMATION

Alaska is a very large state whose character is derived from its arctic environment, natural resources, and Native people and their subsistence lifestyles. Outside of a few major cities, much of the population is located in small villages scattered along the state's many rivers and waterways. Alaska's rural population is predominantly composed of Native Alaskans: Aleuts, Eskimos, and Indians.

RECOGNIZING THE NEED FOR COMMUNITY HEALTH AIDES

Delivery of health care to the people living in rural villages has long been recognized as a challenge in Alaska. Travel and communication difficulties make access to regional hospitals and medical centers an obstacle to routine episodic and preventive primary care. As early as 1956, rural public health officers saw a need for local individuals to be trained to deliver basic primary health care to rural residents in the villages.

Although there was support among rural Alaskan practitioners and village residents for hiring local people to deliver health care in the villages, there remained some skepticism among some public health officials. In the 1950's and early 1960's, the concept of "physician extenders" practicing medicine with less training than a physician did not exist in the United States. Alaskan rural residents just knew that there was, in nearly every village, an unpaid volunteer who could be called upon to care for them when they were ill and communicate their problem to the regional hospital for help when it seemed necessary.

After trial training programs for "medical aides" in Kotzebue, Bethel, and Mount Edgecumbe proved successful and well-accepted by village residents in the mid-1960's, the appeal to the federal government for funding for this rural health care program was successful. In 1968, the federal

government granted funding to the Indian Health Service, a branch of the U.S. Public Health Service, for the purpose of hiring, paying, and training 185 aides in 157 Alaskan communities. The title for these aides, many of whom were already established volunteers in their communities, became "Community Health Aide."

The CHA Program has been very successful. There are now approximately 500 full-time, federally funded CHA positions plus some part-time CHA positions in 171 villages. The population of rural Alaskans served by CHAs is nearly 40,000. CHA/Ps document over 250,000 patient encounters yearly.

DEVELOPMENT OF A TRAINING PROGRAM FOR COMMUNITY HEALTH AIDES

Community Health Aides are taught what they need to know to practice basic primary care specifically in rural Alaskan communities. They work under the supervision of a distant physician linked to them by telephone. Because this was the first program of its kind in rural America, a lot of creative thinking has been directed into the development of the CHA training process.

There was much creativity and experimentation during the first few years of the CHA training program. The Alaska Area Native Health Service (Indian Health Service) opened the first training center in 1968, in Anchorage. The training was directed and performed by public health nurses and was oriented toward hygiene and preventive health measures, with limited clinical emphasis. CHAs from all parts of the state, from Mount Edgecumbe to Barrow, attended training in Anchorage for three sessions of 2-4 weeks each. This was followed by a one-week follow-up visit to the CHA in her home village by an instructor. The CHA consulted with a physician by shortwave radio, where available.

Between 1969 and 1971, training centers for CHAs were established at Bethel and Nome with funds available from the United States Office of

Economic Opportunity. These programs offered training which was located nearer to home and which was more closely tailored to the health care needs of the region. The Native regional health corporations which were established following enactment of the Alaska Native Land Claims Settlement Act in 1971 assumed responsibility for the training programs in Bethel and Nome. In 1975, the training program in Bethel was subcontracted to the developing Kuskokwim Community College by the regional Native health corporation. The ten other Native health corporations continued to send their CHAs to Anchorage for training.

By 1971, the Bethel and Nome training centers were working on orienting their CHA training specifically towards the recognition and treatment of the most common health problems seen in villages in their regions. These two centers hired a medical education consultant to review their teaching programs. His criticism was helpful in changing the orientation of the early Bethel "mini-medical school" curriculum which emphasized the basic sciences to a new focus on the teaching of the "hands-on" skills needed to care for locally identified problems.

Bethel experimented with moving the CHA students from the villages to Bethel with their families for an intensive 8-month training period. This was found to be culturally disruptive to some of the students and their families. The 8-month program was of limited success and was readjusted to fit into three one-month-long sessions of Bethel-based training taken over several months. This method of intermittent training sessions is used by all five training centers today.

Another training technique expanded by the training centers was individualized field teaching in the CHA's village. This was very successful with the CHAs and was satisfying to the instructors as well. However, a completely individualized field medical instruction program was felt to be a very expensive and inefficient way to teach a large number of CHAs. Village-based teaching remains an essential part of the current day curriculum, for providing reinforcement, continuing evaluation, and training in additional skills.

Communication about the training curriculum

between the three training centers in Nome, Bethel, and Anchorage became frequent and productive after 1972. The Program Advisory Committee for Health Aide Training Programs in Alaska (PAC-HA-PA) was formed in 1974, and the increased sharing between programs helped guide the three training centers in developing similar goals and curricula. The Academic Review Committee (ARC) began as a subcommittee of the PAC-HA-PA as its forum for educational affairs. Development of a statewide CHA curriculum also began at this time.

The first statewide curriculum was compiled by Rosaire Kennedy, R.N., and was published by the Alaska Federation of Natives in 1976. That curriculum described both basic and advanced courses for a CHA's complete education. Over the next several years, some of the advanced courses described in the curriculum were not offered and became obsolete. The curriculum published in 1984 updated and refined the information covered in CHA Basic Training, and it continued to help standardize Basic Training content among the three Basic Training centers.

Through the years the training centers, regional health corporations, and interested others have continued to work together to discuss and modify the curriculum's content and delivery. The forum through which much of the work takes place continues to be the Academic Review Committee (ARC). In the past, this committee operated through the University of Alaska, Division of Rural Education, funded by a series of Robert Wood Johnson Foundation grants. Now this committee is a subcommittee of the statewide Association of CHAP Directors (often called the "CHAP Directors"), which includes a representative from all of the CHAP contractors around the state.

Both the 1976 and the 1984 curricula included learning objectives that a CHA should achieve by the end of Basic Training (three sessions of 3-4 weeks each). Since each training center approached the objectives and the training sessions differently, Sessions I, II, and III differed from one training center to the next. In order for a CHA to receive the standardized training, it was necessary for the CHA to finish Basic Training at the same training center where she began. The demand for Basic Training has changed through the years, however, which has necessitated changes in the curriculum:

- In 1985, the Session I curriculum was standardized in order for CHAs to be able to take Session I at any training center. Next, alternate (or part-time) CHAs were required to complete Session I. Additional Session I training became available through a training center in Seward, begun by The North Pacific Rim regional health corporation.
- In 1988, additional funding for CHAP nearly doubled the number of CHA positions (basically, alternate CHA positions were converted to primary CHA positions). As a result:
 - a total of five training centers were funded: in Anchorage, Bethel, Nome, Seward, and Sitka. (Seward closed in 1993)
 - it became desirable for a CHA to be able to attend a session at whatever training center had a student opening.

The 1993 curriculum describes a Basic Training program of four sessions, one more session than in the past. An additional session has been added to allow time for reinforcement of many skills which have increased in complexity through the years. This curriculum is the result of a statewide effort to standardize all four Basic Training sessions within all of the training centers. Focus of the revision process has also been:

- To concentrate Session I and II on the primary skills needed for patient evaluation and recording/reporting a patient visit.
- To limit the total curriculum content to what a CHA must know in order to provide good primary health care.
- To use the same language that should be taught to the CHA.
- To recommend CHA performance levels for each objective.
- To recommend a time schedule in each subject for class, skills practice, and clinical training.

The 1997 and 2005 curricula are a refinement of the 1993 curriculum.

DEVELOPMENT OF TEXTBOOKS AND RESOURCES

Specific guidelines were needed to standardize training and health care in village clinics, as well as to simplify communications between the referral doctor and the CHA/P. In 1976, the

Health Aide manual, Guidelines for Primary Health Care in Rural Alaska, was published. This helpful and widely used manual contained consistent statewide treatment guidelines for the CHA/P and referral person to use in dealing with village health problems. In 1987, this "how to" book was completely rewritten into the Alaska Community Health Aide/Practitioner Manual (CHA/P Manual). In 1998, the CHA/P Manual (CHAM) was completely revised by the Association of Community Health Aide Program Directors, in cooperation with Alaska Area Native Health Service. An updated edition will be released soon.

The CHA/P uses the manual as a guide for providing health care. The CHA/P Manual is easy to understand, gives consistent advice throughout, and reflects a realistic standard of village health care. It is written with a standardized format and multiple cross-references, and it contains current treatment guidelines agreed upon by a wide variety of health care providers.

Another resource that has been developed for the CHA/Ps is the Village Medicine Reference (VMR), a compilation of descriptions, uses, warnings, storage and dispensing instructions for medicines frequently used in village care. If a doctor or pharmacist orders a medicine that is not in the VMR, it is his/her responsibility to provide information to the CHA/P about that medicine.

INTRODUCTION TO THE COMMUNITY HEALTH AIDE PROGRAM, Unit 1

Session	Class hrs
Session I	1.5
Session II	1.5

Performance level at end of session:				Objective:
I	II	III	IV	The CHA will:
2	3			1. Discuss the CHA as a primary health care provider in the village: <ul style="list-style-type: none"> • Concept of a primary health care provider. • Role within the health care system as a physician extender. • Relationship with other health care providers, including emergency care givers. • Relationship with the village council, the employer (regional health corporation) and the referral hospital.
2	3			2. Discuss the CHA's general scope of work to provide primary health care, including to: <ul style="list-style-type: none"> • Provide and assist in providing emergency medical care and transport. • Provide other acute health care services: <ul style="list-style-type: none"> – Provide health care according to standardized guidelines (CHAM and others) as appropriate to the CHA's level of training and experience. – Provide initial management of acute mental health problems; refer patient/family for treatment /counseling (see also Unit 20a, objective 4). – Provide home visits for elderly, chronically ill, or very young patients who are acutely ill and cannot come to clinic.
2	3			<ul style="list-style-type: none"> • Provide, assist with or arrange for follow-up care of patients after having an illness, surgery, or other acute health problem.
2	3			<ul style="list-style-type: none"> • The CHAM by itself does not determine the specific scope of practice of the CHA/P. This is also determined by the Basic Training Curriculum, the level of training and experience of the CHA/P, and the employer/regional guidelines.
2	3			<ul style="list-style-type: none"> • Assist in providing additional follow-up or long-term medical care for chronically or terminally ill patients as needed. Home health care is not the responsibility of the CHA.
2	3			<ul style="list-style-type: none"> • The CHAM includes descriptions of skills not routinely taught in CHAP Basic Training. These descriptions are to reinforce skills learned by CHA/Ps in additional training or to assist a doctor in talking a CHA/P through an emergency procedure.

INTRODUCTION TO THE COMMUNITY HEALTH AIDE PROGRAM, Unit 1

I	II	III	IV	The CHA will:
2	3			<ul style="list-style-type: none"> • Cooperate in providing preventive health services based on regional guidelines, which include: <ul style="list-style-type: none"> - Well child care; - Prenatal care; - Post-partum care; - Fluoride treatment; - Family planning; - Health surveillance; - Immunizations; - Participation in health education/promotion measures and participation in community health care problem-solving.
3	3			<ul style="list-style-type: none"> • Consult with the referral doctor or her/his designee for: <ul style="list-style-type: none"> - Care of all patients requiring intervention not covered by written medical standing orders. - Care beyond the CHA's comfort/skill level.
1	2			<ul style="list-style-type: none"> • Cooperate with itinerant health care providers in the provision of specialized health care services.
1	2			<ul style="list-style-type: none"> • Perform clinic management functions necessary for the delivery of village health services.
3	3			<p>3. Acknowledge that the CHA's specific scope of work is determined by the following:</p> <ul style="list-style-type: none"> • Basic Training Curriculum. • His/her level of training and experience. • Authority to work under the direction of a licensed referral doctor or the doctor's designee (such as a mid-level practitioner). • Written standing orders as given to a CHA by her/his referral doctor. • Use of the CHAM. • Other employer/regional guidelines.
2	3			<p>4. Discuss CHA professional conduct, including:</p> <ul style="list-style-type: none"> • Courtesy and respect for others. • Appearance and dress code in accordance to regional policy. • Responsibility and reliability. • Punctuality. • Sobriety while on duty. • Respect patient privacy. • Honesty in documentation, as well as reporting. • Recognize when help is needed and have the ability to ask for help. • Follow regional policies and procedures. • Adhere to Training Center's Culture of Responsibility (see Training Center document). • Review CHAPCB Standard 4.10.010, Grounds for Discipline.

Level 1: Familiarity, Awareness

Level 2: Knowledge: recall; Skills: with limited guidance from instructor

Level 3: Knowledge: application; Skills: without guidance from instructor

Revised 9/2006 Approved by CHAP Directors

INTRODUCTION TO THE COMMUNITY HEALTH AIDE PROGRAM, Unit 1

I	II	III	IV	The CHA will:
3	3			5. Practice medical ethics when providing patient care: <ul style="list-style-type: none"> • Patient confidentiality. • Patient's rights • HIPAA/Compliance issues • Handling of Controlled Substances.
				6. Identify the medical-legal coverage of the CHA within her/his scope of work: <ul style="list-style-type: none"> • Use of CHAM as the CHA's guidelines for health care. • Use the CHAM for every patient encounter. • The CHAM can only be used as standing orders if specific standing orders are signed off by the referral doctor. • The CHAM can be used to guide emergency care while trying to reach the doctor (see also Using the CHAM, Unit 4e). • Malpractice coverage by the Federal Torts Claim Act. • Good Samaritan Act. • Treating minors only with permission of parent, except in emergency. Minor = less than 18 years old unless emancipated or unless care is related to pregnancy or family planning (state statute). • Other employer policies and procedures. • Patient records viewed as legal documents: <ul style="list-style-type: none"> – Importance of accurate, complete charting. – Release of information only when authorized by court order or by the patient after signing appropriate paperwork. • Legal obligation to report all cases of suspected or known: <ul style="list-style-type: none"> – Child abuse/neglect/sexual assault (any child younger than 18 years old). – Elder abuse/neglect/sexual assault (over 65 years old). – Abuse/neglect/sexual assault of vulnerable adults. – Reportable diseases. – Injury from a gun. – Intentional injuries caused by a sharp object. – Animal (e.g. dog/fox) bites. – Serious burns.
3	3			
3	3			
2	3			
3	3			
1	2			
	2			
1	2			
1	1			
3	3			
2	3			
	1			7. Discuss the history of the CHA program, the functions of the CHA program-related statewide groups, and the role of the CHA representatives on those groups: <ul style="list-style-type: none"> • Association of Community Health Aides/Practitioners. • CHAP Directors. • Academic Review Committee. • Review and Approval Committee. • CHAM Revision Committee. • Certification Board.

HEALTH AND DISEASE CONCEPTS
 General Health and Disease Concepts, Unit 2a

Session	Class hrs.
Session 1	2

Performance level at end of session: Objective:

I	II	III	IV	The CHA will:
1				1. Define health/wellness: "A state of complete physical, mental and social (family/community) well-being, not merely an absence of disease or infirmity" (World Health Organization definition): <ul style="list-style-type: none"> ● State of balance within the body. ● Concept of patient as a whole person.
1				2. Discuss disease and recognize causes: <ul style="list-style-type: none"> ● Disease: <ul style="list-style-type: none"> - an imbalance (abnormal functioning, "dysfunction") in the person (physical, mental, social, family/community). - recognize "acute" vs "chronic" disease. <ul style="list-style-type: none"> ● acute: approach to acute (short term) problem is toward a cure/elimination of problem. ● chronic: approach to chronic disease is control through follow-up and long-term care. ● Major causes include: <ul style="list-style-type: none"> - a breakdown of natural defenses. - poor nutrition (lack or overabundance of nutrients). - an invasion by infectious agents (germs: bacteria, viruses, fungi). - damage by chemical agents (including alcohol and tobacco) or physical agents (including tobacco smoke, accidents/injuries). - response to stress. - uncontrolled growth (cancer). - birth defects. ● Contributing causes include: <ul style="list-style-type: none"> - age. - sex. - heredity. - living conditions and habits. - occupation. - physical exposure, trauma. - pre-existing illness. - psychological influences.

Level 1: Familiarity, Awareness

Level 2: Knowledge: recall; Skills: with limited guidance from instructor

Level 3: Knowledge: application; Skills: without guidance from instructor