DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
ASSISTED LIVING ADVISORY COUNCIL DRAFT
MINUTES
Date: April 21, 2015
Time: 10 AM Meeting locations
Videoconference to:

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
727 Fairview Drive, Suite E
Carson City, Nevada 89701

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance
4220 South Maryland Parkway, Building D, Suite 810
Las Vegas, Nevada 89119

Attendees:
Las Vegas ALAC Members:
Heather Lankford, Willow Creek Memory Care, Co-Chair
Linn Thome, Merrill Gardens
Lynn Homnick, Silver Horizon
Martha Hilario, Golden Home Care (teleconference)
Shawn McGivney, Tender Loving Care Senior Residence (teleconference)

Staff:
Julie D. Bell, Health Care Quality and
Compliance (HCQC) Don Sampson, HCQC
Selena Gray, HCQC

Carson City ALAC Members:
Dan Allmett, Mason Valley Residence, Co-Chair
Mary Ellen Padgett, Riverview Manor
Margaret McConnell, BELTCA
Diane Roberts, Washoe County
Gina Stuchman, Arbors Memory Care (teleconference)

Staff:
Kyle Devine, Bureau Chief, HCQC
M. Jeanne Hesterlee, HCQC
Sherry Crance, HCQC
Leticia Metherell, HCQC
Leslie Bittleston, Division of Health Care Finance and Policy (DHCFP)

Teleconference:
Terri Stricker, Aging and Disability Services Division (ADSD)
Sue Levinsky, ADSD
Julie Cryderman, ADSD

Other attendees:
Robert Kidd, Perry Foundation
Daniel Mathis, Nevada Health Care Association

Wendy Simons, Nevada Department of Veterans Services
Paul Bailey, Bailey's Group Home

Approval of minutes for the meeting of January 20, 2015. *Dan Allmett, Co-chair*

> **THERE WAS A FIRST AND SECOND TO THE MOTION TO APPROVE THE MEETING MINUTES OF JANUARY 20, 2015. MOTION PASSED UNAIMOUSLY.**

Recommendation of new board member for the Assisted Living Advisory Council. *Dan Allmet, Co-chair*

Paul Bailey was recommended as new board member. Paul Bailey presented a summary and his resume. Votes to be cast at the next meeting.

Update on Health Care Quality and Compliance tags related to assisted living. *Don Sampson, HCQC*

Don Sampson explained the top ten tags for assisted living facilities with the number one item being TB testing. He explained that he has been working with the State TB Coordinator in order to conduct new training sessions, as well as to continue his monthly training sessions for PCA's, Group Homes and HIRC Homes. Elder Abuse Training continues to be an issue with most individuals not being retrained on an annual basis.

Lynn Homnick asked if the elder abuse training had to be conducted on an employee's anniversary date of hire. She explained that there is nothing in the statutes reflecting that in her research. She stated that it is much easier for her to schedule one date and have everyone have the training at the same time. Don Sampson responded that practice is accepted and understandable. The only items that have a drop dead date are Medication Management; that has an actual expiration date, and CPR. Other than that it is understood that for a large facility it is okay to have one training for everyone. Julie Bell alsok agreed that was acceptable.

Shawn McGivney asked what tag 0431 State Fire Marshall referral was. Don Sampson responded that anytime the Division of Public and Behavioral Health finds an issue with smoke detector checks, problems with the sprinkler systems, or evacuation plans, a referral to the State Fire Marshall will be made. There is no scope and severity attached to those findings, and the facility does not lose any points when the deficiency has been reported to the State Fire Marshall. This practice was instituted a couple years ago since the Division of Public and Behavioral Health did not want to duplicate another agency that was overlooking that particular area, so a referral is made instead.

Update on Health Care Quality and Compliance feedback regarding the new Survey Monkey. *Don Sampson, HCQC*

Don Sampson explained that for many years whenever a facility received their Plan of Correction, there is a link in the letter asking administrators to fill out a survey detaining how their inspection was conducted. The survey had about ten (10) or eleven (11) questions available. For a period of time after Patty Chambers left the department, a new survey monkey was created because the old one could not be accessed. To date, there are about 21 responses which have all been positive.

Don Sampson explained that the Division of Public and Behavioral Health really wants people to give them feedback on how the inspection went, and if any issues and problems were present. Additionally, he stated that information is used for training and working with the inspectors. The feedback is actually provided during the monthly meetings with the inspectors to show the progress in the field, as well as other parameters. He encouraged the providers to fill out the surveys after their inspections, as it would be appreciated.

General Discussion of Medical Marijuana topics as related to assisted Living. *Julie Bell, HCQC*

Julie Bell explained that she did not have any updates related to the topic of Medical Marijuana. She stated that the Nevada Health Care Association would be providing some information on their research from other states, and asked that the meeting be moved forward to item number five (5) since there were no representatives of the States Medical Marijuana team present. The members agreed.

Summary on Medical Marijuana in other states. *Robert Kidd, Perry Foundation*

Robert Kidd explained that during the previous ALAC meeting he was asked to gather information based on other states in regards to medical marijuana. He spoke to state executives at the Health Care Association of Washington State, Colorado, as well as the National Center for Assisted Living. Robert Kidd stated that a lot of the information comes from Colorado, because they were the first state to legalize marijuana for both medical and recreational purposes. Brookdale/Emeritus Senior Living operates many assisted living and retirement communities in the country, and have a medical marijuana policy in all the states where it is legal that allows patients the storage, control and use of the drug. Resident's must have a valid physician's order that follows the states specific regulations if they want to store it, control or use it. While residents can possess and store marijuana, Brookdale communities will not store or manage medical marijuana for the residents because it remains illegal under federal law.

Robert Kidd explained that many other providers he spoke to will not allow use of the drug at all. Although resident's civil rights have been a concern in communities that do not allow use of the drug, there has not been any formally documented cases yet. Health Care Attorney Fred Miles of Denver, Colorado based law firm, Miles & Peters, states that providers that utilize Medicare, Medicaid or other federal funds run a risk of losing federal funding if they ever create policies that condone the usage of something federally classified as illegal. While those who lobby in favor of medical marijuana laws say federal action against senior living providers will align with state laws is highly unlikely. Miles says that even publishing procedures on the issues can engage in a slippery slope.

Robert Kidd further explained that last year 44 percent of Americans ages 50-64 and 17 percent of those 65 and older have tried marijuana according to a Gallup Poll. That is more than double the amount of seniors in 1999 that stated they had tried it, and this trend is expected to continue, sparking a need for action in our facilities. Many providers implement a don't ask, don't tell policy. That was heard over and over again. The attorney stated also that has been confirmed by the President of the Colorado Health Care Association. That is the stance that they take.

Possible questions operators must address if creating a policy are:

1. Are the premises private or public?
2. How can it be ingested? (Smoke, patch, oils)
3. What if residents have a roommate?

4. Who is going to be in charge of storage?
5. Will it be treated like a narcotic?

It is not expected that having a medical marijuana policy has notably impacted marketability of a facility as of yet. Some cities and Indian reservations have legalization policies separate from the surrounding states. Robert Kidd stated that he had a copy of the most widely used medical marijuana policy in the State of Washington that he would email to those interested in obtaining it.

Robert Kidd shared the policy. The policy states that the community supports the client's right to use medical marijuana consistent with the provisions of Washington's medical marijuana statute as approved and directed by his or her health care professional under certain circumstances in this long-term care setting. The document that Mr. Kidd reviewed is below:

MEDICAL MARIJUANA POLICY

This community supports the client's right to use medical marijuana consistent with the provisions of Washington's Medical Marijuana statute, chapter 69.51A RCW, as approved and directed by his/her health care professional and under certain circumstances within this long term care setting

PROCEDURE:

1. A client who uses medical marijuana in this setting must :
    a. Be a "qualifying patient" under the provisions of RCW 69.51A. A "qualified patient" means a person who:
        i. Is a patient of a healthcare professional. "Health care professional," means a physician licensed under chapter 18.71 RCW, a physician assistant licensed under chapter 18.71A RCW, an osteopathic physician licensed under chapter 18.57 RCW, an osteopathic physicians' assistant licensed under chapter 18.57A RCW, a naturopath licensed under chapter 18.36A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW; and
        ii. Has been diagnosed by the health care professional as having a terminal or debilitating condition.

    b. Provide valid, signed and dated documentation by a health care professional, licensed in Washington State, stating that the person has, in the healthcare professional's opinion, a terminal or debilitating condition that may benefit from the use of medical marijuana.
    c. The "qualifying patient's" copy of the valid documentation must be retained by the individual, be easily accessible, and presented to facility staff and other appropriate authorities upon request.

d. The "qualifying patient" will identify a "designated provider", not affiliated with the long term care community, who will be responsible for providing the medical marijuana to the "qualifying patient". There shall be only one designated provider for each qualifying patient, and the designated provider cannot assist more than one qualifying patient.

e. The designated provider is responsible for bringing the medical marijuana to the qualifying patient and promptly removing the medical marijuana from the premises after client consumption.

   i. Upon arriving at the building, the designated provider must sign in at the front desk, including name, date, and time of arrival.
   ii. Just prior to leaving the building, the provider must sign out at the front desk, including name, date, and time of departure.
   iii. All medical marijuana consumed by the client must be in edible form only.
   iv. At no time will marijuana be grown or stored on the premises.

2. Staff involvement in the provision of medical marijuana is limited to:
   a. Confirming receipt of the qualifying patient's valid documentation of the client's illness, disease, or ailment as a condition that may benefit from the use of medical marijuana; and
   b. Confirming the healthcare professional's recommendation that the client's use of medical marijuana may ease symptoms associated with the illness, disease, or ailment.
   c. Ensuring no other clients are impacted by this client's use of medical marijuana.
3. Staff will not under any circumstances:
   a. Assist the client in obtaining or using the medical marijuana;
   b. Store the medical marijuana for the client;
   c. Ensure the client is properly using the medical marijuana as instructed by his/her healthcare professional;
   d. Take and/or use the client's medical marijuana;
   e. Serve as the client's designated provider of medical marijuana.
4. If, at any time, the administrator and/or designee determine that the client is not honoring this policy and procedure as written and presented to him/her, consequences up to and including discharge may be considered in order to maintain all clients' safety and wellbeing.

****

Robert Kidd explained that the Perry Foundation has put together a workshop in July that will be a panel discussion and training on medical marijuana. He explained that Julie D. Bell and Chad Westom of the DPBH will have staff in attendance as well as the Board of Nursing. The agenda will be forwarded to the ALAC members upon completion.

Shawn McGivney stated that as a doctor he is concerned in regards to the liability perspective, and the relationship between the doctor and the facility. He has concerns with a letter of authorization and a formal prescription and the legal difference between the two. He asked how is the supervision by the PCP (which is for all things medical) legally, ethically, and morally different from the supervision of the letter writer, if it's not the PCP who is doing everything. Robert Kidd responded by stating that he had this conversation with the Colorado attorney specifically, and the discussion between a letter and an actual prescription is going on right now. The DEA has not had a history of prosecuting or going after anyone that has provided a letter, but they will prosecute for scripts. Jeanne Hesterlee explained that in Nevada, a doctor's recommendation is used; not a script.

Dan Allmet asked Robert Kidd if he could get copies of some of the letters to see an example to get an idea. Shawn McGivney requested a copy as well. Shawn McGivney went on to ask if there has been any civil suits of malpractice against doctors who write the letters, which is another concern. Robert Kidd explained that topic did not come up in his conversations, and believes that if there would have been any concerns with that issue those he communicated with in his research would have brought it up.

Jeanne Hesterlee advised that Shawn McGivney to contact the Board of Medical Examiners for answers to those questions as they oversee physicians. Shawn McGivney stated that the Board of Medical Examiners issued a policy statement that could be found on their website which states that doctors should not participate on focusing on distributors and basically stated to do it at your own risk.

Margaret McConnell asked if Board of Medical Examiners would be attending the Perry Foundation Workshop in July, and Robert Kidd responded with a yes. Shawn McGivney suggested that a doctor who writes letters of authorization should be asked to attend the workshop as well.

Daniel Mathis of the Nevada Health Care Association explained that everyone he has talked to on a federal and state level are moving towards access, coming from a structure of regulatory denial not that many years ago and could get a federal indictment over marijuana. The trend nationwide and in the state is to provide access, so although there are some concerns he expects that they will be dealt with and policies will need to exist when the distribution hits because the families are going to show up for medical marijuana. He explained that as a provider and as regulators it will have to be figured out, there should be some caution, but he is of the opinion, there will be access. Shawn McGivney agreed, and stated that the letter writer needs to be backed.

Lynn Homnick asked Robert Kidd to explain what was considered an edible form of medical marijuana. Robert Kidd responded by saying that the edible form came from the Washington State policy, and the edible form is most widely used. Due to the various ways to ingest it, if you define your parameters and they chose edibles only, then it gives you more control is my guess. Lynn Homnick asked, so there is no outside smoking? Robert Kidd responded by stating she was correct.

Daniel Mathis stated that many of the facilities felt that the no smoking policy would cover them with medical marijuana, but because there are edibles available it does not. So there had to be some education around the Skilled Nursing Facility arena that the no smoking policy does not cover it because not everyone is smoking it. Robert Kidd explained that there are a lot of other ways marijuana is used that

were dismissed in this form. He explained that oils and vapor are also extremely popular, and vapor is an alternative to smoking without the combustion so if you think a no smoking policy will cover vapor it does not. A policy would have to be specific which is what airlines are doing with e-cigarettes. Being in Colorado and discussing these policies has shown that edibles and other ways of ingesting medical marijuana are just as popular, if not more popular than smoking it.

Nevada Health Care Association national trends and data. *Daniel Mathis, Nevada Health Care Association (NVHCA)*

Daniel Mathis explained that he was unable to provide an update on the Behavioral Program, but the hearing has been pushed until the end of the month. The SNF providers are ready to start admitting the behavioral clients, the draft form is ready they are just waiting on the go ahead. Once started they will be interested in discharge locations. He invited the ALAC members to attend the hearing on the 30th. Richard Whitley and crowd are looking at how behavior facilities are staffed and operate in other states. They are even organizing a tour to take a look at those facilities.

Daniel Mathis explained that AB242 was a bill aimed at skilled nursing that was going to have mandatory staffing requirements and a call light requirement. He has been working with the authors who have gutted the language of that bill, and now the language is up calling for a legislative interim study to be done. Daniel Mathis encouraged them to use the language "Post-Acute Care Providers" because of the federal governments Impact 14 Act, and the states SIM Grant for DHCFE they are looking at different ways to deliver health care in the post-acute care arena. AB242 does study on how best to do that, and it is encouraged that all get involved. It could be rights that include waivers for the assisted living and hopefully it will be through the senate soon.

Updates on Centers for Medicare and Medicaid Services (CMS) settings and changes related to assisted living. *Leslie Bittleston, Division of Health Care Financing and Policy (DHCFP)*

Leslie Bittleston explained that the state spent most of 2014 working on a methodology to submit to CMS to show how we as a state will come into compliance with the new rules and regulations that they pass on what actually defines a residential setting that came out in January 2014. That transition plan has been completed and sent to CMS on February 24, 2015. No word has come from CMS at this time. It can take up to 90 days to review anything submitted. No questions, or documentation has been requested. At this time, it has not been heard that any state's transition plan has been approved as of yet. About three weeks ago there was a statewide call with CMS to talk specifically about posting for public comment for things that affect providers and the general public. One question that was posed was, has any state's transition plan been approved. CMS responded stating that they do not talk about any other states progress.

Shawn McGivney asked Leslie Bittleston if she had heard of any issues he's been hearing about in the community in regards to finding beds for those with Medicaid or any of those types of services. Leslie Bittleston responded that she had not heard anything about that, but stated that the ongoing issue with individuals who are Medicaid eligible in finding placement is what Daniel talked about just a few minutes ago, are those with severe behavioral problems. Those are the people that we always have issues finding beds for, and it's due to their behavioral problems but those with low needs she is not aware are having problems finding beds.

Daniel Mathis explained that he does get very specific phone calls for patient requests. The most recent being for vent and dialysis, for behaviors, and very infrequently he'll get a call from a hospital complaining that a facility won't take a Medicaid unless they get a Medicare referral with them, which is more an ethics dilemma than a bed availability.

Update on the Northern Nevada Veterans Home Project. *Wendy Simons, Nevada Department of Veterans Affairs*

Wendy Simons explained that the estimated timeline for the CIP, Public Works Budget Submission for Capital Improvement Projects which is fourteen million (14,000,000) from the must be approved. This project is currently sitting at number 95. Senator Heller's team came to the office to view the plan book which is at 50% drawings. During the CIP Presentations at the Legislature the Veteran's Community turned out in force, and all branches of government was in attendance. It was her opinion that this project is going to be approved. If in fact the project is approved on the state and federal funding, construction would break ground February of 2016 and eighteen (18) months later taking residents.

Wendy Simons showed how the facility sat on 14 acres on the map. She explained that there would be a court ground for military ceremonies, a core building in the middle and the three wing buildings. She added that there will be a town hall, which is a concept that has not been introduced in any other state to the level that this town hall will be. Each of the houses will hold the residents and they will journey to the town hall as a destination. In this hall they will have a gymnasium, bistro, barber shop, restaurant style dining, sports bar, a store and the capacity to have 300 to 400 people there for events. The kitchen is the most costly item, with each budgeting in at $100,000 each for all six.

A list is being created for what individuals can sponsor, for example, golf carts, or the gator that is going to plow the snow. Someone has already sponsored a rose garden. This not a Federal VA program, this is a State section of Veteran Affairs.

Margaret McConnell asked if there is any thought to having any sort of continuum care where there would be an assisted living or retirement living recognized. Wendy Simons responded that one item that is forecasted for the future is an adult day care element. There has been some land set aside for that. There are current VA funds to encourage placement or community based services, but nothing as far as a continuum of this. The physical model of this does allow for that adaptability down the road, in order to go with the change of culture and time.

Wendy Simons asked Sherry Crance if she was contacted by a representative of the VA. Sherry Crance responded that she had not as of yet, but would be next month. Wendy Simons went on the explain that the Federal VA hospital is beginning a real push in Nevada as in other states for the medical model group home concept of up to three (3) residents; this may have to go down the SLA path due to the regulations in Nevada. The Federal VA is actively pursuing placements for those who would normally meet the criteria for a nursing home, and they could be in the nationally two to three resident home that the owner lives in and provides the care and services, and are actively out recruiting for those individuals and then they do heavy duty case management with a team at the hospital that goes out and does social services, and physiological and counseling services, clinical nursing services to that residential model of home. Wendy Simons shared that she has asked for a football field to be included in the model for therapy, in order to walk the distance of a goal, and a metal wall in the therapy center to move pipes around and move balls through as well. The Division of Public and Behavioral Health will be utilized for guidance

on this model. The biggest challenge is that the Federal VA wants the facility to be like a house and not like a nursing home. They do not like the idea of commercial refrigerators in the houses, but 446 requires that.

Shawn McGivney asked how SLA is in a completely different NRS than 449, and how the rules are different. Wendy Simons stated that she would not speak on that as she is not a subject matter expert on SLA's.

Leslie Bittleston responded that under the waiver for individuals with intellectual disabilities that they use the SLA and the ISLA model throughout that waiver, and it does have its own NRS and NAC sections. Those homes are not licensed by the Bureau of Health Care Quality and Compliance. They are reviewed and certified by the Aging and Disabilities Services Division, and have a very strict set of guidelines. ADSD conducts the reviews, provider training and provide a certification and it's up to ADSD and the Regional Centers to manage. Those SLA's used under the Bureau are also no licensed. They are very different and do not have to adhere to BHCQC's standards.

Public Comment.

Wendy Simons asked if Bill SV210 could be discussed under public comment. Dan Allmett agreed.

Update on the Bill SV210 for Reduced Licensure Fees. *Wendy Simons, Nevada Department of Veterans Affairs*

Wendy Simons explained that SV210 is in legislature, and as written was originally meant to propose a licensure fee reduction for good performance, and to allow a longer periodicity. The conceptual amendments were crafted with BHCQC, Laura Freed of DPBH, Barry Gold and Pecan Representatives. The bill is sitting until the budget is pulled out. Per Barry Gold, the Hospital Association wants to be excluded because it meets different criteria. Wendy Simons recommended an amendment to the bill that would allow a grading system for all facility types licensed by the Bureau, on a separate level than the current residential care grading system. It is proposed that this grading system be provider specific and handled through regulations. The conceptual amendment states that the BHCQC would be required to develop the grading system for all facility types, and if facilities meet a higher standard achieving a good grade for two years they would receive up to a 25% reduction in their annual licensure fee. The is also a provision in that amendment that states if a facility has repeated complaint activity, substantiated or unsubstantiated, that would affect either their grade and result in a lower than up to 25% reduction in their annual licensure fee. AARP is in strong support.

Shawn McGivney asked if there were any residential care homes presented upon drafting of SB210. Wendy Simons responded that the bill was drafted by Ben Kieckhefer, and through testimony were the recommended amendments. The residential care home grading system was used as a model, due to its demonstrated success.

Updates on the Assisted Living Industry to include trends, census/occupancy mix, top three business issues and successes deserving recognition were not discussed. The meeting was moved forward by Dan Allmett.

General discussion on proposed standardized training for facilities with Mental Health endorsements. *Linn Thome, Merrill Gardens*

Linn Thome stated that as Nevada grapples with the provision of care and services for people with mental health issues, and as more care homes, and assisted living facilities consider taking on a mental health endorsement on their license she would like to propose that ALAC look at creating a standardized training format. Managing a mental health endorsed facility in the past, she feels the training provided was not adequate. A very short video with an overview of mental illness was all that was provided. The training did not focus on triggers, or behavioral interventions. Linn Thome explained that she recently had the opportunity to talk with group home caregivers with a mental health endorsement, and they expressed concerns that there were not trained to handle the behaviors they were experiencing.

Shawn McGivney also agreed that it was a great idea, and suggested that the search be expanded to the SLA industry as well since they focus on mental illness. Linn Thome responded that would not be something ALAC would be involved in, and her concern at this time is on the facilities that have the endorsement to provide them with the tools they need to successfully care for their residents.

Julie Bell stated that it this is something the Bureau could look at in terms of adding some requirements and components. She suggested that it be structured differently than the Medication Management Training Program, but it could be used as a starting point. Don Sampson agreed with those suggestions.

Julie Bell asked for talking points and topics be created for the next meeting.

Daniel Mathis explained that skilled nursing facilities are facing the same kind of return to acute penalties that the hospital has now and coming in to effect in 2017-2018. The skilled nursing facilities would be willing to participate and provide programming, and training as well once the format and curriculum is developed.

Julie Bell pointed to comment by Shawn McGivney suggesting that members of the SLA community should be invited to find out their training components, and to ask them what they are doing that could be adapted to the BHCQC program. The Division cannot regulate the SLA's, but can surely get some input that could assist in creating a program. Julie Bell suggested that Nenita invite SLA members to the table for a discussion at the next meeting if the members were in agreement. The suggestion was accepted.

Medical Laboratory Regulations Review. *Letcia Metherell, HCQC*

Leticia Metherell explained how the medical laboratory proposed regulations were moving forward. She explained that NAC 449.2726 allows glucose testing be performed if there is a medical laboratory license, only speaking of 1A the actual performance of the test, not the administration of the medication. Those are two different issues to clarify. There is certain criteria required to become an exempt laboratory. The goal in creating the regulations was to help reduce the burden, and make it easier to obtain an exempt laboratory license. Currently, there is a federally required CLIA certificate needed when testing is done for medical reasons. A CLIA certificate is $150 and is valid for two years; $75 a year. The State requirement is a license by the BHCQC. An Initial License is $500, valid for two years. The Renewal License is $300 valid for two years; $150 a year. If there are licensed personnel on staff, they do not need any extra personnel certification. If there are unlicensed staff onsite who are to perform glucose testing, they can obtain an Office Laboratory Assistant License which is $60 for an Initial License of two years, and $45 for every two year renewal; $22.50 a year. The major barrier heard from facilities that want to

perform one test is the current requirement that the laboratory director be a licensed physician, and that fee is expensive. What the regulations have done to release that burden is expand the types of individuals who can serve as a laboratory director in an exempt laboratory. This information can be found on page two (2) of the Proposed Regulations of The State Board of Health Packet, listed at number five (5).

If a facility is only administering glucometers, the regulations have been broadened to allow the laboratory director to be a registered nurse, and any office laboratory personnel except an office laboratory assistant.

Shawn McGivney asked if a medical graduate, just through experience has the equivalent skills of a doctor and could become a laboratory director, assuming the liability of supervising a one test CLIA endorsed lab. Leticia Metherell responded by stating that the law or regulation does not in any way state that a nurse is the same as a physician. She explained that for glucometer testing, which nurses perform many times in the field and are comfortable performing glucometer tests; that is why the regulation only allows one. It is also precedents in other states that don't require that physicians be the laboratory director. She suggested that the liability company be contacted to address those concerns.

Robert Kidd suggested that verbiage in section six (6) of page two (2) which reads "that only performs one waived test" be changed show "disease specific testing".   That way it leaves it open if a facility has a disease specific protocol and there is more than test available they wouldn't have to choose. For example, if someone wanted to have a disease specific program around diabetes, but what if they can have a disease specific programming around another disease that has a test. Leticia Metherell explained that section number five (5) would be used in that instance and the facility still would not be required to have the licensed physician.

Robert Kidd also suggested that the term registered nurse, in section six (6) of page two (2) be changed to show "licensed nurse" or "LPN". Leticia Metherell stated she would run that suggestion by the Board of Nursing to see if it is within the LPN's scope of practice and update the group.   The Board of Nursing was consulted when creating the regulations. Robert Kidd explained that the Board of Nursing is currently updating the LPN scope of practice, and this may be something they decide to make adjustments to.

Shawn McGivney asked if the regulations were sent to the Medical Board in addition to the Board of Nursing. Leticia Metherell responded that the Medical Board was contacted via phone, and they provided input. The Pharmacy Board was contacted as well. The general consensus of the ALAC members was that the proposed regulations were reasonable.

In response to Wendy Simon's question if the proposed regulations had been taken to workshop, Leticia Metherell stated that they had not, but hoped they would be in June. Wendy Simons asked if the application would have to be amended with these changes. Leticia Metherell responded that they would.

Adjournment.

Meeting adjourned 11:47 a.m.