Clinical Affiliation Agreements Workgroup

Project Report

November 2014

Health Professions and Facilities

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Executive Summary

Background

During the 2013 session, the legislature adopted a budget proviso in the 2013-15 budget bill (3SSB 5034, Section 219(6)). It asked the Department of Health (department) to convene a workgroup to study and recommend one standardized clinical affiliation agreement for allopathic, osteopathic and nursing professions, or to develop a separate affiliation agreement for each. The proviso set parameters for required members of the workgroup and directed it to report findings to the legislature by Nov. 15, 2014. The workgroup reflected a cross-section of the community that works with the agreements, or has an interest in the process of students being placed in clinical training situations.

Clinical affiliation agreements are contracts between educational or training institutions and health care facilities. Osteopathic and allopathic medical students and nursing students must have practical experience as part of their education. Consequently, the purpose of the agreements is to identify the responsibilities and liabilities for the parties and to ensure that the experiences students get meet educational standards and ensure an appropriate learning environment away from the students' home institution. In an attempt to address the increasing demand for health care professionals, the Workforce Training and Education Coordinating Board's Health Workforce Council (Workforce Council)[1] included in its 2012 annual report a recommendation to convene a statewide workgroup on clinical affiliation agreements.

The workgroup studied clinical affiliation agreements and learned the state can't mandate contractual terms between parties. The one exception is when it's necessary for the benefit of the public welfare under the state's police powers. Consequently, the workgroup recognized a single, mandatory model agreement could not be imposed upon contracting parties, and it didn't feel it could make recommendations about specific affiliation agreement language. However, the workgroup did develop recommendations about elements essential to effective agreements. This approach, developing consistent standards instead of actual language, is more closely aligned with a recently completed effort in Oregon (see appendix G).

The department approached this assignment by being as inclusive as possible. Department staff created multiple avenues for interested parties to actively participate and contribute to the process, including in-person meetings and teleconferences, e-mail participation, online updates and surveys.

Workgroup Study Methods

The workgroup gathered, reviewed and considered a variety of materials. Its data collection methods included:

- Interviews with workgroup members and subject matter experts on their experiences in developing standardized clinical affiliation agreement language.
- Researching agreements used by workgroup members and conducting internet searches of CAAs used by institutions and facilities in Washington and other states.

[1] Previously named the Healthcare Personnel Shortage Task Force. For the remainder of this report, except where the name of the Task Force is specifically mentioned in a reference, a previously published document, or the like, it will be referred to as the "Workforce Council".

- Conducting institution, facility, and student surveys to gauge the challenges faced with affiliation agreements.
- Soliciting related materials used in the process of matching students with undergraduate training opportunities, such as "passport-type" documents to facilitate transitioning students between educational programs and facilities.

While there have been few examples of efforts to create more universal agreements, the workgroup benefited from a process that was recently completed by a similar workgroup in Oregon. In its report, the Oregon workgroup recommended creating standards for affiliation agreements in a number of areas, including immunizations, screenings, training, liability insurance, health insurance, and other topics. The approach of the Oregon workgroup was to make the recommendations broadly applicable to all health professionals who engage in clinical training[2], and for those recommendations to be sufficient for most circumstances but allow for some individualization based on the type of facility.

Workgroup Observations and Assumptions

The workgroup attempted to review, assess and resolve existing stumbling blocks of CAAs in as globally applicable a manner as possible, unless it became apparent that doing so was unworkable for one or more of the professions. The workgroup identified a number of assumptions and observations that were important to highlight in order to place its work in the proper context for readers of this report.

1. **Clinical affiliation agreements are private contracts between educational institutions and mostly private health care facilities.** Because the state can't mandate contractual terms between parties, a single, mandatory model agreement couldn't be imposed on contracting parties.
2. **Affiliation agreements are necessarily complex and variable.** There is variability in how agreements are negotiated and the language and terms they contain. This variability requires time and resources to negotiate, which may adversely impact the willingness of some to enter into them.
3. **The Oregon model offers advantages over mandating agreement content.** The methodology used by Oregon had a number of advantages in trying to facilitate the growth of on-site physician and nursing training opportunities through these agreements. The Oregon model didn't attempt to create mandatory language and allowed the parties more flexibility.
4. **Operational detail letters are a useful method to tailor agreements to the needs of the parties and students.** Operational detail letters may be useful in tailoring agreements to the specifics of a particular training site or the special needs of a particular student.
5. **Meaningful differences exist between state-supported and private higher education institutions.** Independent and state-supported higher education institutions may enact affiliation agreements with health care facilities differently, making it difficult to craft a standard agreement useable by all.

[2] This includes physicians, physician assistants, nurses, physical and occupational therapists, pharmacists, dentists, dental hygienists, mental health and addiction treatment providers, and allied health professionals, such as respiratory therapists, phlebotomists, and medical assistants.

6. **Clinical affiliation agreements are applicable to other health professions' students.** Affiliation agreements are not only used for physician and nursing students, but also for physician assistants and other allied health professions.
7. **The workgroup didn't locate data to substantiate assumptions of cost savings.** The workgroup considered the assumption that reducing barriers could create a cost savings from improving the negotiation of agreements and better exchange of information. However, there is no direct evidence to support this. Streamlining the negotiation process will result in reduced administrative burden, which may reduce the reluctance of parties to enter into agreements and promote greater opportunities for onsite clinical training.
8. **Student privacy is dictated by federal law.** To ensure the safety of patients, the workgroup discussed at length a concern about students with health conditions that warrant special arrangements or considerations practicing in facilities. The group ultimately concluded that this information can only be released with the student's consent.
9. **Affiliation agreement negotiation may benefit from clearer communication between the parties.** A common theme of the group has been that there should be a means to better communicate about the use of clinical affiliation agreements and what is required of each party at different points in time.
10. **Clinical passport documents may be useful additions to affiliation agreements.** The workgroup chose not to explicitly recommend using standardized clinical "passport-type" documents. However, it was impressed by their usefulness, providing a "one-stop shopping" approach to simplify and organize the information gathered for student placement in a facility.
11. **Limitations with mandated student liability insurance and potential options.** Per RCW 28B.10.660, state institutions of higher education may make liability insurance available to students. However, state institutions can't compel students to buy it, and the cost must be borne by the students. A common option for student insurance is available through the Washington State Office of Risk Management. No information was presented to the workgroup suggesting this coverage was insufficient as an insurance option. There was concern that students opting to purchase insurance not offered through the risk management office would be insufficient, and monitoring individual policies is administratively burdensome. Regardless of liability insurance, some workgroup members preferred that institutions insure clinical sites for student actions. Consequently, there is a lack of workgroup consensus on satisfactory long-term solutions concerning student liability. Although no solution received workgroup consensus, several potential legislative changes were discussed.

Workgroup Recommendations

1. General Recommendations

    1-1. The workgroup recommends that future attempts to provide further guidance to institutions and facilities in the creation of clinical affiliation agreements be crafted more along the lines of Oregon's effort.

    1-2. Sufficient time, consistent with the experience of others nationally, should be allotted for any future work contemplated by the legislature.

2. Insurance/Indemnification/Liability Provisions

2-1. The workgroup agrees that many of the concerns about the adequacy and availability of liability insurance can be addressed by specifying that one of the following coverage provisions be included in these agreements:

- University of Washington (UW): The school agrees to cover the student (also a potential option for private or non-UW schools)
- Other Washington public educational institutions: Students either participate in the liability insurance procured through the Office of Risk Management, or purchase an equivalent policy on the commercial market.[3]

2-2. Strongly encourage students to obtain health insurance. The group believes that if the facility where the student is engaging in clinical training requires the student to purchase health insurance, that requirement may be passed on to the student. For private institutions, health insurance may be a requirement.

3. Auto-renewal Provisions

3-1. The workgroup generally recommends that agreements contain automatic renewal provisions and the provisions of the agreements be periodically reviewed.

4. Background Check Provisions

4-1. The workgroup recommends that a criminal background check for students beginning onsite clinical training be included as part of the application process. Checks should include a "cluster" of different checks using different methods, including a Social Security Number trace, through the Washington State Patrol, and national fingerprint-based check through the Federal Bureau of Investigation, a sex offender registry check, and a check of the List of Excluded Individuals and Entities (LEIE) through the U.S. Department of Health and Human Services Office of the Inspector General.

4-2. Checks should be done as part of the application and acceptance process with the educational institution or program.

4-3. Subsequent checks by the state patrol should be performed, if requested by the health care facility. Checks shouldn't happen more than once a year, unless the student hasn't maintained consistent/consecutive enrollment in the program.

5. Compliance with Training Plan Provisions

5-1. The workgroup recommends that institutions and facilities consider including affiliation agreement provisions for when facilities may remove a student from a clinical setting for not complying with site policies or endangering patient safety. Prior to permanently removing a student, the facility should have a discussion with the school about the episode, including whether a timely remediation plan that will allow the training to continue is possible. However, the workgroup doesn't recommend changes that would affect the ability to remove a student in an emergency situation. The workgroup agreed that the facility should have the authority to make the final decision regarding removal of a student.

[3] Note that the professional liability insurance procured through the ORM should contain limits of $1,000,000/ $3,000,000 and be an "occurrence-based" policy, meaning that the relevant time period for coverage of a claim is the date of the occurrence giving rise to the claim, even if the claim is made several years after the student has concluded his or her time at the clinical site. Thus, occurrence-based policies obviate the need for tail coverage or extended reporting periods that are intended to overcome the limitations in claims-based insurance policies.

6. Drug Screening Provisions

    6-1. The workgroup recommends that drug screenings take place no more than 60 days prior to initial school-directed clinical placement of any kind and then annually thereafter, or for cause.

    6-2. The workgroup recommends that initial and annual drug screens be performed consistent with current Washington Physicians Health Program recommendations. This should not preclude additional in depth drug (or alcohol) screening as warranted.

7. Immunization and Health Screening Provisions

    7-1. The workgroup recommends that affiliation agreements make reference to current immunization and health screening guidelines from the Centers for Disease Control and Prevention (CDC) as the standard for students prior to beginning clinical training.[4]

8. School Supervision of Students During Training Provisions

    8-1. While each case is different, roles and responsibilities of liaisons and preceptors need to be clearly laid out. The workgroup recommends that operational detail letters, incorporated by reference into the agreement, be used for that purpose.

    8-2. Facilities should advise schools of the required procedures to be followed by faculty liaisons and clinical preceptors to be onsite at the facility.

[4] www.cdc.gov/vaccines/schedules/hcp/adult.html

Report to the Legislature

Requirements of Third Engrossed Substitute Senate Bill 5034

During the 2013 session, the legislature adopted a proviso in the 2013-15 budget bill (3SSB 5034, Section 219(6)) directing the Department of Health to convene a workgroup to study and recommend one standardized clinical affiliation agreement for allopathic, osteopathic and nursing professions or to develop a separate agreement for each. The workgroup was directed to report its findings to the legislature by Nov. 15, 2014.

Specifically, the proviso:

- Allowed either one standard agreement usable for all three professions, or one standard agreement for each of the three professions.
- Directed the department to include, at a minimum, in the workgroup:
  - Two-year higher education institutions;
  - Four-year higher education institutions;
  - UW School of Medicine;
  - Pacific Northwest University (PNWU) College of Osteopathic Medicine;
  - Health Workforce Council;[5]
  - Statewide associations for hospitals and facilities that accept clinical placements;
  - Statewide organization for allopathic physicians;
  - Statewide organization for osteopathic physicians;
  - Statewide organization for nurses;
  - Labor organization for nurses; and
  - Any other groups deemed appropriate by the department in consultation with the Health Workforce Council.

Background

Clinical affiliation agreements are formal legal contracts between educational or training institutions and health care facilities. These agreements allow students who are participating in clinical or nursing educational programs to get practical experience in their field. The purpose is to identify the responsibilities and liabilities for the parties to the contract and ensure that the practical experiences students get meet educational standards and are in an appropriate learning environment away from students' home institution.

These agreements play an important role in the overall educational process for allopathic, osteopathic and nursing students, which remain in high demand in the United States. The federal Patient Protection and Affordable Care Act (ACA) projects that 32 million newly-insured Americans will enter the health care marketplace by 2019.[6] In addition, the nation continues to grow older and more populous. By 2050, U.S. Census numbers indicate the population will grow by over 85 million to 400 million. The over-65 population, which statistically tends to use more health care services, will nearly double from 43.1 million to 83.7 million and represent more than

[5] Previously named the Healthcare Personnel Shortage Task Force. For the remainder of this report, except where the name of the Task Force is specifically mentioned in a reference, a previously published document, or the like, it will be referred to as the "Workforce Council".

[6] Sisko, A., et al.; "National Health Spending Projections: The Estimated Impact of Reform Through 2019"; *Health Affairs*; Vol. 29, No. 10; September 2010, p, 1936.

20 percent of the overall population.[7] Finally, the Association of American Medical Colleges has estimated that the nation will face a shortage of more than 90,000 allopathic physicians by 2020 and more than 130,000 by 2025.[8] The osteopathic physician and nursing professions are growing, yet they may not be able to fully address this shortage. The nursing profession is still facing shortages despite a projected 19 percent growth rate between 2012 and 2022.[9,10]

These factors paint a picture of more Americans, more insured Americans, and older Americans taxing our health care system in the years to come. At the same time, there is likely to be a shortage of health care professionals, which may be exacerbated in certain clinical specialties and geographic areas, especially rural and underserved communities.

In an attempt to address the increasing demand for health care professionals, the Workforce Training and Education Coordinating Board's Health Workforce Council (Workforce Council) included in its 2012 annual report a recommendation to convene a statewide workgroup on clinical affiliation agreements. The Workforce Council's report notes that "…competition for clinical placements in many health fields is creating a barrier to increasing capacity of the health care workforce." The absence of standard affiliation agreement language creates unnecessary complexity and duplication of effort spent creating, editing, and negotiating similar agreements across the state."[11] According to the report, streamlining the agreement process would potentially improve the pipeline for students in health care fields to complete their professional training, benefiting both individual students and the broader health care system. The Workforce Council's 2012 report is included as Appendix C of this report.

As noted, the purpose of the agreements is to contractually define the responsibilities and liabilities for each party related to an educational training program for students in many health care professions. The terms of the affiliation agreements are decided by the parties, and tailored to the particular needs of the facilities and institutions. An educational institution or health care facility may have dozens of affiliation agreements in effect at any one time because a separate agreement is required for each training relationship. Nonetheless, clinical affiliation agreements typically share common features and structure.

In general, these agreements may spell out information such as:

- The amount of prior notification by the institution to the health care facility of the student's planned arrival;
- Location(s) that the clinical experience will occur;
- Beginning and end dates/length of the clinical experience;
- Specific days or hours of clinical experience;
- Number of students eligible to train in the facility at any one time;
- Learning objectives or performance expectations; and

[7] Ortman, J., Velkoff, V., and Hogan, H.; "An Aging Nation: The Older Population in the United States"; US Census Bureau; May 2014; *www.census.gov/prod/2014pubs/p25-1140.pdf*; visited May 12, 2014.
[8] "GME Funding: How to Fix the Doctor Shortage"; Association of American Medical Colleges; *www.aamc.org/advocacy/campaigns_and_coalitions/fixdocshortage/*; visited May 12, 2014.
[9] Growth in Osteopathic Physicians (DOs); American Osteopathic Association; *www.osteopathic.org/inside-aoa/about/aoa-annual-statistics/Pages/growth-in-osteopathic-physicians.aspx*; visited July 21, 2014.
[10] Nursing Shortage Fact Sheet: American Association of Colleges of Nursing; *www.aacn.nche.edu/media-relations/nrsgshortagefs.pdf*; visited July 21, 2014.
[11] Health Care Personnel Shortage Task Force 2012 Annual Report; Washington Workforce Training and Education Coordinating Board; December 2012; p. 7.

- Deadlines and formats for any progress reports or evaluation forms.

Most agreements contain provisions that apply particularly to training health care students, including:

- Liability insurance;
- Indemnification;
- Student background and criminal records checks;
- Student drug screening;
- Student immunization requirements;
- Responsibility for ensuring student compliance with training site policies; and
- Supervision of students during training.

Affiliation agreements also establish shared responsibilities between the institution and facility, as well as responsibilities of the student.[12] Agreements also contain general contractual terms, such as provisions on modification and termination, governing law, and the term of the agreement.

Convening and Facilitating the Clinical Affiliation Agreement Workgroup

The department, in assembling the workgroup, worked closely with representatives from the Workforce Council. Participants identified, in some cases, were former participants on the Workforce Council, or were interested parties to the discussions that led to the recommendation in the 2012 report.

The department approached this assignment with the goal of being as inclusive as possible, while maintaining the workgroup at a manageable level. Despite the large size of the workgroup, not everyone who was interested in formally participating could join. However, those who couldn't attend had multiple avenues to still actively participate and contribute to the process. In order to help communicate the activity of the workgroup, department staff:

- Developed a website and an email address to receive public questions.
- Created an interested parties list for the project to communicate information and meeting agendas to stakeholders.
- Requested that meeting notices be sent out to listservs for physicians, osteopathic physicians, nurses and hospitals.
- Offered a teleconferencing option for those interested parties seeking to monitor the workgroup meetings in response to stakeholder requests.

Below is a list of those members of the workgroup who were invited to participate either at the creation of the group or subsequently. These workgroup members attended at least one meeting; many were in attendance at multiple meetings and actively participated in the group's discussions.

[12] Although some CAAs do include sections that ascribe responsibilities to the student, students are not signatories to such agreements. Generally, the educational institution is responsible for informing its students of student responsibilities.

TABLE 2: Workgroup Participants

Name	Affiliation
Juan Acosta, DO	Pacific Northwest University College of Osteopathic Medicine
Sofia Aragon , JD, RN	Washington State Nurses Association
Taya Briley, RN, MN, JD	Washington State Hospital Association
Heather Carter, JD	Washington Office of the Attorney General
Frederick Chen, MD, MPH	Washington State Medical Association
Linda Dale DHEd, PA-C	Heritage University
Doug Duncan, JD	Seattle University
Linda Eddy PhD, RN, CPNP	Washington State University College of Nursing
Derek Edwards, JD	Washington Office of the Attorney General
Tom Fitzsimmons, MPA	Independent Colleges of Washington
Nova Gattman	Washington Workforce Training & Education Coordinating Board
Barbara Gumprecht, MSN, RN	Nursing Care Quality Assurance Commission
Kendra Hodgson	State Board for Community & Technical Colleges
Cindy Jacobs , RN, JD	University of Washington School of Medicine
Steven Leifheit, DO	Washington Osteopathic Medical Association
Mary McDonald, RN, MN	Inland Northwest Clinical Placement Consortium
Mariena Mears, MSN, RNC	Green River Community College
M Miller	Service Employees International Union
Kathryn Ogden, RN-BC, MN	Swedish Medical Center
Anita Showalter, DO	Pacific Northwest University College of Osteopathic Medicine
Zosia Stanley, JD, MHA	Washington State Hospital Association
David Stolier, JD	Washington Office of the Attorney General
Sally Watkins , PhD, RN	Washington State Nurses Association
Tracy Woodman	SEIU Healthcare 1199NW Multi-Employer Training & Education Fund
Jane Yung, JD	Washington Office of the Attorney General
Gail Yu, JD	Washington Office of the Attorney General
Marina Yu	Legacy Health System

In addition, the following stakeholders were invited to participate on the workgroup but were not able to attend at least one meeting, or expressed an interest in the work of the group and either attended as audience members or received meeting materials and updates to our interested parties list.

TABLE 3: Other Workgroup Invitees and Key Stakeholders

Name	Affiliation
Jacqueline Cabrera	Group Health Cooperative
Barbara Barronvan	MultiCare Health System
Alex Bogunicwicz	Washington State Hospital Association
Violet Boyer, MPA	Independent Colleges of Washington
Cody Eccles	Council of Presidents
Karen Foreman	MultiCare Health System
Paul Francis, MPA	Council of Presidents
Rose Gardner	Clark College
Anne Greer	Legacy Health System
Kim Haggard	Washington State Department of Enterprise Services
Theresa Heaton	Clark College
Kathie Itter	Washington Osteopathic Medical Association
Maryella Jansen	Department of Health, Medical Quality Assurance Commission
Kathryn Kolan, JD	Washington State Medical Association
Micah Matthews, MPA	Department of Health, Medical Quality Assurance Commission
Deb Murphy, MPA, JD	Leading Age Washington
Danette Negron	Pacific Northwest University
Mel Netzhammer, PhD	Washington State University Vancouver
Debra Ortiz, MS	Clark College
Charissa Raynor, MHA	SEIU Healthcare Northwest Training Partnership
Alyson Roush, JD	Providence Health & Services
Malinda Siegel, PA-C, JD	University of Washington MEDEX Northwest
Linda Simmons	Washington State Hospital Association
Jane Sherman. EdD	Council of Presidents
Tony Skaggs, MPAS, PA-C	University of Washington MEDEX Northwest
Emily Studebaker, JD	Washington Ambulatory Surgery Center Association
Rhonda Taylor, RN, MSN	Yakima Valley Community College
Linda Tieman, RN, MN, FACHE	Washington Center for Nursing
Jeff Wagnitz	Highline Community College
Larry Yok, MBA	Highline Community College
Judy Zybach, JD	King County Public Hospital District #2

The workgroup met seven times between January and July 2014[13] in geographically diverse locations. All meetings were open to the public. A majority of these meetings also had teleconference access. Below is a summary table of the workgroup's meeting schedule, locations, and key topics:

[13] An eighth meeting, scheduled for March 4, had to be cancelled.

TABLE 4: Summary of Workgroup Meetings and Topics

Date/Location	Key Topics
January 29, 2014 9 a.m. - noon Black River Training and Conference Center, Renton	• Overview of statutory directive and proposed project schedule. • Overview of clinical affiliation agreements and other standardized models developed. • Discuss scoping questions.
March 31 11 a.m. to 2 p.m. Pacific Northwest University of Health Sciences – College of Osteopathic Medicine, Yakima	• Discuss concept of institution, facility and/or student surveys. • Discussion of the role of clinical passport-type documents in clinical affiliation agreements. • Present and discuss identified issues and key models from January 29 meeting.
April 30 9 a.m. to 12:30 p.m. Attorney General's Office, University of Washington, Seattle	• Update on institution, facility and survey development. • Presentation by Taya Briley on perspectives of hospitals and facilities on affiliation agreements. • Background and perspectives on Attorney General's Office affiliation agreement model agreements.
May 13 9 a.m. to 12:30 p.m. DoubleTree by Hilton, Olympia	• Update on institution, facility and survey status. • Review matrix of key issues identified by workgroup. • Review preliminary draft/outline of workgroup report to the legislature.
June 10 11 a.m. to 2:30 p.m. Washington State University College of Nursing – Vancouver	• Update on institution, facility and survey status. • Discuss applicability of State of Oregon Health Care Workforce Committee recommendations. • Develop workgroup recommendations.
July 2 9 a.m. to 3 p.m. Renton Technical College	• Review and discussion of legislative mandate in 3ESSB 5034. • Institution, facility and student survey results. • Develop workgroup recommendations.
July 28 9 a.m. to 3 p.m. Black River Training and Conference Center, Renton	• Review workgroup recommendations. • Review draft workgroup report to the Legislature.

Study Methods

The workgroup gathered, reviewed and considered as part of its charge a variety of materials. Its data collection methods included:

Phone Calls/Interviews with Workgroup Members and Subject Matter Experts

In the early stages of the project, department staff contacted other organizations (such as the Association of American Medical Colleges and the South Metropolitan Higher Education Consortium) about their experiences in developing their own standardized affiliation agreement language, including the time commitment needed, what the major challenges were, and the willingness of various actors to participate. Staff also talked with several individuals especially interested in or involved with the development of the 2013 budget proviso (or underlying House Bill 1660) to better understand the intent of the Health Workforce Council and the Legislature.

In addition, prior to and during the course of the project, department staff periodically engaged with members of the workgroup by phone about their experiences with and critiques of agreements and, later, the progress of the workgroup. The calls also served as opportunities to gain historical perspective on models used in Washington, as well as insight about methods for facilitating the workgroup toward greater consensus on key issues.

Searches for CAAs used by Workgroup Members and Elsewhere

In the project's preliminary stages, department staff performed multiple internet searches to locate clinical affiliation agreements used by institutions and facilities in Washington and in other jurisdictions. Through querying for and reviewing agreements that have been used elsewhere in the U.S., department staff familiarized themselves with the purpose, format, and general content of the documents. They also looked for innovative language that could assist in Washington's effort. This search included affiliation agreements and related materials from institutions or facilities in Idaho, Indiana, Missouri, Wisconsin, Pennsylvania, Colorado, Tennessee, and the District of Columbia. The workgroup also spent considerable time analyzing the findings and recommendations of a similar taskforce convened in Oregon (see page 11).

Staff solicited agreements currently in use by workgroup members' affiliated institutions and facilities. A number of members responded and shared affiliation agreements from organizations such as the Swedish Health Services System, Valley Medical Center, the University of Washington, Green River Community College, and the Veterans Administration Puget Sound Health Care System, which were circulated to the workgroup for consideration.

Institution, Facility, and Student Surveys

1. Survey Development
   At the workgroup meeting on March 31, 2014, the workgroup decided to develop and distribute brief, non-scientific surveys to health care facilities and educational institutions throughout Washington State to gauge the challenges these entities face while adopting and working with agreements for the placement of osteopathic and allopathic medical students and nursing students. Because students are impacted by the provisions contained in affiliation agreements, the workgroup agreed to also survey students for insight into the challenges they face related to provisions commonly included in the agreements.

The larger workgroup appointed a survey subcommittee to develop three separate surveys for review, approval, and distribution: one survey of educational institutions, one survey of health care facilities, and one survey of osteopathic and allopathic medical students and nursing students. The survey subcommittee included Cindy Jacobs from the University of Washington, Sofia Aragon from the Washington State Nurses Association, Zosia Stanley from the Washington State Hospital Association, Mariana Mears from Green River Community College, and Brett Cain from the Department of Health.

With continuous guidance from the survey subcommittee, three surveys were developed with similar questions asked of the three groups – institutions, facilities and students. The institution and facility surveys focused on the challenges schools and health care facilities face when adopting agreements relating to drug testing requirements, immunization record requirements, background check requirements, and incongruent supervision responsibilities. The surveys consisted of mainly multiple choice questions and a few open-ended response questions. The survey instruments that were distributed, and their results, are attached as Appendix E to this report.

2. Survey Distribution
   The workgroup began distributing the surveys the week of June 2, 2014. The surveys were delivered to recipients via emails that contained a link to the appropriate survey. The workgroup requested that the surveys be distributed to email list subscribers and members of the following organizations:

   - Washington State Board for Community and Technical Colleges
   - Independent Colleges of Washington
   - Council of Presidents
   - The University of Washington School of Medicine
   - The Pacific Northwest University College of Osteopathic Medicine
   - Various college nursing student associations
   - Washington State Hospital Association
   - Washington Ambulatory Surgery Association
   - LeadingAge Washington
   - Students enrolled in osteopathic and allopathic medical programs and nursing programs

   The surveys were closed on June 30, 2014. Analysis after that date revealed that no responses were received from medical doctor or doctor of osteopathy students. In further discussion at its July 28 meeting, the consensus of the workgroup was that staff should make an additional attempt, working with UW and PNWU, to engage students at these institutions. The surveys were redistributed through the two institutions and were open to students between July 30 and August 18. Results for allopathic and osteopathic students are included in Appendix E.

3. Survey Responses and Observations
   This section discusses selected results of each survey followed by some response themes that were observed across all three surveys.

   - *Educational Institutions* – 41 Responses

     Responses were received from the University of Washington, Gonzaga University, and community and technical colleges throughout western, central, and eastern Washington.

Respondents included program directors, program assistants, deans, instructors, and other school faculty.

- *Health Care Facilities* – 39 Responses

  Responses were received from facilities in 18 counties with representation in western, central, and eastern Washington and included: integrated health care systems, acute care hospitals, critical access hospitals, community hospitals, skilled nursing facilities, long term care facilities, and assisted living facilities. Respondents included directors of nursing and education services, registered nurses, education specialists, training coordinators, quality officers, human resources directors, chief clinical officers, student services coordinators, recruitment coordinators, hospital counsel, and administrators, among others.

- *Students* – 301 Nursing student responses
  226 Allopathic medical student responses
  37 Osteopathic medical student responses

  Initially, responses were received only from nursing students, including students from the UW, Gonzaga University, and community and technical colleges throughout western, central and eastern Washington. All initial student responses were received from future, current, or recently graduated nursing students. Respondents ranged from nursing students who were just entering their nursing program to students who had recently completed their nursing education. Students who completed the survey were either affiliated with a licensed practical nurse program, associates registered nurse program, bachelors registered nurse program, or masters of nursing program.

  Because the first distribution of the survey did not yield any results from allopathic or osteopathic medical students, the workgroup made a second attempt to send surveys to the UW and PNWU. These survey questions were identical to the surveys sent in the first distribution.

  Respondents from UW were working on a medical doctor (MD) degree with a small number of respondents working on a MD/PhD degree. Respondents ranged from students entering their first year to completing their fourth year, with one respondent in their fifth year. The vast majority of respondents lives in Seattle and attends the UW School of Medicine, while two respondents attend school in Alaska, one in Idaho, and one in Montana through the UW's WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) Regional Medical Education Program.

  All respondents from PNWU were working on a doctor of osteopathic medicine (DO) degree and were in their third or fourth year of study. There is only one campus for PNWU which is located in Yakima.

4. Trends/Themes Observed
   As discussed earlier, the surveys asked questions about people's experiences with certain aspects of agreements. Keeping in mind this was an online survey, below are some general observations gleaned from the results we received.
   - According to the responses, drug testing is not required at half of the facilities that responded to the question. We also found that more recent or frequent drug screening

would not prevent 231 of 263, or 88 percent of students who responded from signing up for a clinical rotation.

- About half (13 of 24, or 54 percent of those who answered the question) of facility respondents said that background checks needed to be done at the beginning of the school year to be placed in their facility.
- We asked, generally, whether the requirements regarding immunizations, background checks, and drug screening differed between the facilities and schools. Both facilities and schools answered similarly, with between 60 – 70 percent of responses indicated the requirements were not different.
- Students generally pay for their drug screening and background checks.
- Most schools use a "clinical passport" and most facilities do not, although many facilities indicated they would consider using a passport if they knew more about them. Around 39 percent (99 of 257 who answered the question) of students indicated that they use the passport. See the next section for further discussion of "clinical passports."
- Seventy-two percent (186 of 258 who answered the question) of nursing students and 71 percent (25 of 35 who answered the question) of PNWU students did not know who provided their professional liability insurance.
- Sixty-nine percent (129 of 207 who answered the question) of UW students and 63 percent (22 of 35 who answered the question) of PNWU students indicated that they would be less likely to choose a rotation that required them to pay for their drug screening.
- Twenty-one percent (40 of 189 who answered the question) of UW students and 41 percent (14 of 34 who answered the question) of PNWU students answered that the lack of availability of clinical supervisors was a "moderate" barrier to their placement in a rotation.

Solicitation of Related Materials

In addition to clinical affiliation agreement documents, the workgroup also solicited and reviewed related materials used in the process of matching students with undergraduate training opportunities. One example of this is a paper checklist often referred to as a "clinical passport." Moreover, the workgroup carefully reviewed the recently completed work of another northwest state, Oregon, which has also been attempting to better standardize agreements.

1. Clinical Passports

   The workgroup gave careful consideration to "passport-type" documents as a useful mechanism for facilitating the process of transitioning students between educational programs. These passport documents capture for students, in one place, a variety of common training, immunization, background check, licensing and insurance information, and they are typically used in nursing programs. Two different documents exist, one for northwest Washington and the Inland Northwest region and one for southwest Washington and Oregon.

   While not identical, they are very similar, and they promote consistency and efficiency in what information is gathered and how it is captured and shared. While not specifically incorporated into the recommended elements discussed later in this report, the workgroup believed that the

clinical passport concept was one worthy of further consideration. Selected clinical "passport-type" forms are included in Appendix F.

2. Oregon Health Care Workforce Committee SB 879 Workgroup Report

   While there have generally been few examples of efforts to create more universal affiliation agreements, the workgroup benefited from a similar process that was recently completed in Oregon. In a strikingly parallel fashion to Washington's workgroup, Oregon's Healthcare Workforce Committee recommended to the Oregon Health Policy Board the "standardization of student background requirements for clinical training."[14] In 2011, the Oregon Legislature passed Senate Bill 879, which created a workgroup to develop these standards and report back to the legislature. Also similar to that of Washington, the impetus for the Oregon workgroup was the inefficiency and inconsistency of the existing process of negotiating agreements, and the report also cited the potential to "increase capacity."

   In its report, the Oregon workgroup recommended standards in a number of areas, including immunizations, screenings, training, liability insurance, health insurance, and other topics. However, the approach of the Oregon workgroup was to recommend development of common standards that are broadly applicable to all health professionals who engage in clinical training[15]. The Oregon workgroup also recommended that the standards serve as generally sufficient for most circumstances but allow for certain exceptions based on the type of facility. The report also recommended that the Oregon Health Authority place the standards in administrative rule. In response, rules were promulgated by the state of Oregon (Chapter 409, Division 30 OAR) and took effect on July 1, 2014.

   The report, rules, and other support documents are included in Appendix G.

Workgroup Observations and Assumptions

The workgroup engaged in wide-ranging conversations related to clinical affiliation agreements and attempted to review, assess and resolve existing stumbling blocks of agreements in as globally applicable a manner as possible, unless it became apparent that doing so was unworkable for one or more of the professions. It crafted a number of specific recommendations related to the common standards that these documents should contain. In addition, there were collateral benefits to the group's interaction. For instance, the group commented on multiple occasions that the awareness and understanding of agreement issues, particularly the perspectives of other parties, increased from the conversations, but also identified a number of assumptions and observations that were important to identify in order to place its work in the proper context for readers of this report.

1. **Clinical affiliation agreements are private contracts.** Affiliation agreements are contracts privately negotiated between two parties. Because the state can't mandate contractual terms between parties, except in limited instances necessary for the benefit of the public welfare under the state's police powers, the workgroup recognized a single, mandatory model agreement could not be imposed upon contracting parties. Consequently, the workgroup

[14] Recommendations to the Oregon Health Policy Board; Oregon Health Care Workforce Committee SB 879 Workgroup; June 30, 2012; p. 1.

[15] This includes physicians, physician assistants, nurses, physical and occupational therapists, pharmacists, dentists, dental hygienists, mental health and addiction treatment providers, and allied health professionals, such as respiratory therapists, phlebotomists, and medical assistants.

focused on developing recommendations on elements essential to creating effective agreements.

2. **Affiliation agreements are necessarily complex and variable.** All parties recognized there is variability in how these agreements are negotiated and the language and terms they contain, and the workgroup also acknowledged that this variability requires time and resources to negotiate, which may adversely impact the willingness of some to enter into them.

3. **Workgroup endorsed the Oregon model to develop common standards for affiliation agreements.** The workgroup came to consensus that the approach taken in Oregon to develop common standards for clinical placements by state agency rule is strongly preferable to recommending specific contract terms.[16] The methodology used by the state of Oregon has a number of advantages in seeking to facilitate the growth of on-site physician and nursing training opportunities through agreements. The Oregon model did not attempt to create mandatory language to which contracting parties must adhere. The workgroup felt that the focus should be on identifying the minimum standards which should be included in all agreements while still allowing the parties flexibility. This also allows parties the freedom to independently negotiate contracts as needed.

4. **Operational detail letters are a useful method to tailor agreements.** Given that some variability within affiliation agreements appears unavoidable, the workgroup believed that operational detail letters may be useful in tailoring agreements to the specifics of a particular training site or the special needs of a particular student. These letters, which are incorporated by reference into the each agreement, are used to identify, for example, start and end dates of clinical training, any special immunization or health screening requirements, or unusual requirements related to the supervision of students. While operational detail letters may somewhat reduce the level of consistency in agreements, that is more than outweighed by their appeal to the parties to allow customization of an agreement.

5. **Meaningful differences exist between state-supported and private higher education institutions.** During the workgroup's discussions, it became evident that differences exist between how independent higher education institutions and state-supported higher education institutions may enact agreements with health facilities. In several respects, as private entities, private institutions have greater flexibility to agree to certain terms with clinical training sites, such as the indemnification of students while in training, or requiring their students to purchase health insurance.

6. **Clinical affiliation agreements are applicable to other health professions' students.** Agreements are used for a number of allied health professions. While it did not delve into the needs of training for other types of health professionals, the work of this group in developing consistent standards may also provide possibilities and create impacts for agreements for other types of health professionals. It should be noted that a representative from the physician assistant community was formally invited, and participated on the workgroup in recognition of this.

7. **The workgroup did not locate data to substantiate assumptions of cost savings.** An assumption considered by the workgroup, and stated as a goal in its report by the Oregon workgroup, is that, in reducing barriers, there could be cost savings from improving the negotiation of agreements and from better exchange of information under the agreements.

[16] Some of the resulting Oregon administrative rules may not be amenable to duplication in Washington due to the increased personal autonomy guaranteed by Washington's state constitution.

However, the workgroup readily acknowledged that there is no direct evidence to validate this assumption. The workgroup believed a better argument can be made that streamlining the negotiation process will result in reduced initial and ongoing administrative burden for facilities, institutions and students. This, in turn, may reduce the reluctance of parties to enter into agreements, which should promote greater opportunities for onsite clinical training.

8. **Student privacy is dictated by federal law.** The workgroup discussed at length a concern about students practicing in facilities who may have health conditions requiring special arrangements or considerations in order to ensure the safety of patients. The workgroup discussed applicability of both FERPA (Family Educational Rights Privacy Act) and HIPAA (Health Information Portability and Accountability Act) in this context. Ultimately, the workgroup concluded that, in either case, it seems that this information can only be released with the student's consent.
9. **Clinical affiliation agreement negotiation may benefit from clearer communication between the parties.** A common theme was the need for better communication about the use of agreements. In particular, the workgroup believes there is benefit to clearly communicate what is required of each party in the process and at what point in time. Several members of the workgroup expressed a greater appreciation for the perspectives and the constraints of other parties in the process.
10. **Clinical passport documents may be useful additions to agreements.** The workgroup did not choose to explicitly recommend the development and use of a standardized clinical "passport-type" document for improving the organization of information needed for clinical placement of students. However, the workgroup was impressed by their utility. The workgroup's perspective was that providing a "one-stop shopping" approach to simplify and organize the variety of information that must be gathered for student placement in a facility, when it must be gathered, and how it must be documented was logical, and it encourages closer scrutiny of clinical "passport-type" documents for their applicability to agreements.
11. **Limitations with mandated student liability insurance and potential options.** Per RCW 28B.10.660, state institutions of higher education may make liability insurance available to students, but the state institutions cannot compel the students to make the purchase, and the cost must be borne by the students, not the institutions. A common option for student insurance has been made available through Washington State Office of Risk Management. There was no information presented to the workgroup suggesting that risk management office coverage was insufficient as an insurance option. But, there was concern that students opting to purchase insurance not offered through risk management would be insufficient and monitoring individual policies is administratively burdensome. Regardless of liability insurance, some workgroup members would prefer that institutions indemnify clinical sites for student actions. Consequently, there is a lack of workgroup consensus on satisfactory long-term solutions concerning student liability.

    Although none received consensus endorsement, several potential legislative changes were discussed. Some workgroup members endorsed legislation granting non-UW Washington State educational institutions authority to insure and indemnify students, similar to the authority granted UW. A second option was legislation granting public institutions authority to purchase insurance for the students. The third suggestion was legislation granting the public institutions authority to compel clinical students to purchase malpractice and liability insurance necessary to participate in clinical training and to pass the cost on as a fee. Any such options must entail careful financial analysis to identify cost impacts to students and/or educational institutions.

Workgroup Recommendations

1. General Recommendations

1-1. The workgroup recommends that future attempts to provide further guidance to institutions and facilities in the creation of clinical affiliation agreements be crafted more along the lines of Oregon's effort.

1-2. If future work on agreements is contemplated by the legislature, the workgroup recommends that sufficient additional time, consistent with the experience of others nationally, be allotted for the process.

Commentary

The Oregon workgroup identified minimum standards that should be included in all agreements but it did not create mandatory language to be included. The workgroup recognized that Oregon's approach provides a more flexible approach, based on identifying the most relevant concepts for inclusion in agreements, as a more suitable method for addressing this issue.

In addition, in reviewing a number of other models, the workgroup consistently found that the process of forging more universal standards or agreements took at least two years. The workgroup believes that having a longer period to develop standards, or even language, is necessary to fully work through complicated contractual issues and fully involve the broader stakeholder community.

2. Insurance/Indemnification/Liability Provisions

2-1. The workgroup agrees that many of the concerns about the adequacy and availability of liability insurance can be addressed by specifying that one of the following coverage provisions be included in affiliation agreements:

- The school agrees to cover the student (UW, and potential option for private or non-UW schools).
- Other students either participate in the liability insurance procured through the Office of Risk Management, which is available only to non-UW Washington public educational institutions, or purchase an equivalent policy on the commercial market.[17]

Commentary

The majority of workgroup members expressed concerns regarding the issue of indemnification of the acts and omissions of students while training in health care facilities. Indemnification means that a party agrees to assume legal and financial responsibility for any liability resulting from the acts and omissions of another.

Under most agreements, each party agrees to accept responsibility for the acts or omissions of its own employees, officers, and agents via the party's own insurance. However, under Washington state law community colleges, technical colleges, and most state universities may not insure or

[17] Note that the professional liability insurance procured through ORM should contain limits of $1,000,000/$3,000,000 and be an "occurrence-based" policy, meaning that the relevant time period for coverage of a claim is the date of the occurrence giving rise to the claim, even if the claim is made several years after the student has concluded his or her time at the clinical site. Thus, occurrence-based policies obviate the need for tail coverage or extended reporting periods that are intended to overcome the limitations in claims-based insurance policies.

indemnify students.[18] The sole exception is UW, which has special statutory authority providing for its own self-insurance program and allowing it to indemnify for student conduct.[19]

Washington operates a self-insurance liability program, but state law excludes students from this insurance option. Thus, community and technical colleges and non-UW state universities cannot statutorily indemnify students or purchase insurance for students. Hospitals and health systems do not view providing liability insurance for students as an appropriate responsibility on the hospital's part. This has resulted in ongoing discussion and concern about how to adequately insure against the acts and omissions of students while they are training at a health care facility.

In response to the concerns raised by educational institutions and health care facilities, the Education Division of the Washington State Attorney General's Office, the State Board for Community and Technical Colleges, and the Washington State Hospital Association worked together in 2010 and 2011 to develop additional options for students to obtain insurance. Since 2012, students have had the option to purchase their own professional liability and general liability insurance. Per RCW 28B.10.660, state institutions of higher education may make liability insurance available to students, but the institutions cannot compel the students to make the purchase and the cost must be borne by the students, not the institutions.[20] In particular, a common option for student insurance has been made available through the risk management office.

While this is an important first step, concerns remain for some on the workgroup regarding the adequacy and availability of liability insurance for students who are not covered by the risk management insurance option.

- First, there are limited commercial carriers which offer professional liability and general liability insurance policies for purchase by students engaged in clinical training. Some of these commercial marketplace policies do not offer coverage at the minimum limits ($1,000,000/$3,000,000) typically required by most health care training facilities.
- Second, there are questions regarding whether these insurance policies contain tail coverage or an extended reporting period. These elements are necessary in order for the insurance to cover acts and omissions that occur while the student was training at the facility, but that were not reported or discovered until after the student had left the facility.
- Third, the quality and quantity of liability insurance purchased by students on the individual market is difficult to verify or confirm. It is administratively burdensome on health care facilities to verify the existence and adequacy of privately-purchased insurance coverage.

Through discussion, it became apparent that part of the concern surrounding indemnification and insurance stems from misunderstandings between educational institutions and health care facilities.

[18] RCW 28B.10.842.
[19] RCW 28B.20.250.
[20] Clinical affiliation agreements could specify that clinical site requirements include the student having occurrence-based liability insurance at the minimum limits specified above, or, at a minimum, a claims-made policy with an extended reporting period that would cover the applicable statute of limitations. Further, ideally the educational institutions would perform verification of coverage on individual student policies by requiring the student to produce a certificate of coverage containing and confirming the coverage type (professional liability), coverage limits (at least $1 million/$3 million), policy period, policy basis (occurrence or claims) and in the case of claims-made coverage, the extended reporting period.

The statutory limitations preventing indemnification may have not been clearly communicated or clearly understood and this has led to some friction in contracting. The hospital association and the Attorney General's Office intend to work together to better inform state educational institutions and health care facilities about insurance options for students available through the Office of Risk Management.

2-2. The workgroup recommends that state institutions strongly encourage their students to obtain health insurance. The group believed that if the facility where the student is engaging in clinical training requires the student to purchase health insurance, that requirement may be passed on to the student. For private institutions, health insurance may be a requirement.

Commentary

The workgroup weighed the question of the individual mandate requirements of the federal Affordable Care Act against restrictions in state law related to requiring students to purchase insurance; as a result, the workgroup does not believe that it could recommend that student health insurance be compulsory.

3. Auto-renewal Provisions

3-1. The workgroup generally recommends that clinical affiliation agreements contain auto-renewal provisions, and that the provisions of the agreements be periodically reviewed.

Commentary

In order to avoid renegotiating agreements every year, the workgroup believes it is preferable to have some form of auto-renew provision with a required periodic review of the agreement's terms. Generally, the group coalesced around a term of three to five years, with some periodic review. While this was discussed, with general consensus, at a high conceptual level at the April 30 meeting, further consideration at the June 10 meeting revealed important details that can complicate how auto-renewal provisions are incorporated into an agreement. There was no consensus as to the length of notice for termination, the frequency of review of agreement terms, or whether or not the agreement should include any "for cause" termination provisions.

For example, the workgroup struggled with identifying the appropriate prior notice requirements for termination of an agreement. At issue is how to handle students who may be in the midst of clinical training or committed to a particular facility for training. If an agreement allows too little time for notification, students may be left without training opportunities. Another aspect of this issue relates to whether "for cause" concerns might arise with the facility that would create a risk for patients. The workgroup acknowledged it may be difficult to identify all types of "for cause" issues.

4. Background Check Provisions

4-1. The workgroup recommends that a criminal background check for students beginning onsite clinical training should actually include a "cluster" of different checks using different methods, including a Social Security Number trace, a state (through the Washington State Patrol and national (through the Federal Bureau of Investigation) criminal background history, a sex offender registry check, and a check of the List of Excluded Individuals and Entities (LEIE) through the U.S. Department of Health and Human Services Office of the Inspector General.

4-2. Checks should be done as part of the application and acceptance process with the educational institution or program.

4-3. Subsequent checks may be performed, to be done at the request of the facility, but not more frequently than annually. This is limited to a state patrol check unless the student has not maintained consistent/consecutive enrollment in the program.

Commentary

Clinical affiliation agreements often require that the school/program ask students to obtain WSP checks and to release the results to the school and the facility. The training site may refuse to place a student with a criminal history.

The workgroup considered the question of whether facilities must run background checks in addition to those run by educational programs/schools. According to WAC, 246-320-126(2), hospitals must **require** (emphasis added) a state patrol background check "for each prospective employee, volunteer, contractor, student, and any other person applying for association with the licensed hospital" before allowing unsupervised access to certain populations. However, it does not stipulate who must **perform** the checks, only that hospitals must require them of personnel working on-site.

Because of the mobility of students in and out of the state, the workgroup gave special consideration to the matter of students coming into Washington from other states to study, as well as those who may temporarily go out of state during break or other periods. Recommendations 4-1 and 4-3 speak specifically to this issue, proposing that federal checks be performed to ensure that students entering or returning to Washington do not have criminal histories that go undetected.

5. Compliance with Training Plan Provisions

5-1. The workgroup recommends that institutions and facilities consider revising the provisions that allow facilities to remove a student from a clinical setting for failure to comply with site policies or where an emergent patient safety situation is created. Prior to permanently removing a student, the facility should engage in a discussion with the school about the episode, including whether a timely remediation plan is possible that will allow the training to continue. However, the workgroup does not recommend changes that would affect the ability to remove a student in an emergent situation. The workgroup agreed that the facility remain empowered to make the final decision regarding removal of a student.

Commentary

In considering this topic, the workgroup was in general consensus that students must comply with the requirements of the training plan in which they participate, and that the facility must be empowered to make decisions about whether a student must be removed from the facility. This is particularly important in situations where there may be a risk to patients, other facility staff, or the facility itself.

At the same time, the group discussed at length the potential benefits of a collaborative engagement between facilities and institutions. There may be instances, for example, where a remediation plan could be put in place that would allow the student to safely and effectively return to the facility to continue clinical training. Moreover, such discussions can promote better understanding on the institutions' part about preparing students for entering the training facility.

Finally, there seemed to be a consensus among the workgroup that it benefits all parties to gain clarity in the agreement as to when the facility's policies, procedures and related training plan materials will be provided. Providing the materials to the institution in advance of the students' arrival may help to better prepare students for beginning clinical training. However, this does not substitute for providing a proper orientation to facility policies and procedures once students arrive.

6. Drug Screening Provisions

6-1. The workgroup recommends that drug screenings take place no more than 60 days prior to initial school-directed clinical placement of any kind and then annually thereafter, or for cause.

6-2. The workgroup recommends that initial and annual drug screens be performed consistent with current Washington Physicians Health Program (WPHP) recommendations. This does not preclude additional in-depth drug (or alcohol) screening as warranted.

Commentary

Article I, section 7 of the Washington State Constitution states that "no person shall be disturbed in his private affairs, or his home invaded, without authority of law."[21] Historically, this has been interpreted as prohibiting the state from conducting drug testing without probable cause, limiting the ability of state schools/programs to require drug testing of students.[22] However, there is nothing to prevent this from being a requirement of the training facility. Consequently, in order to complete an educational program where onsite training in a facility is required, institutions may assist students in obtaining drug testing where it is required.

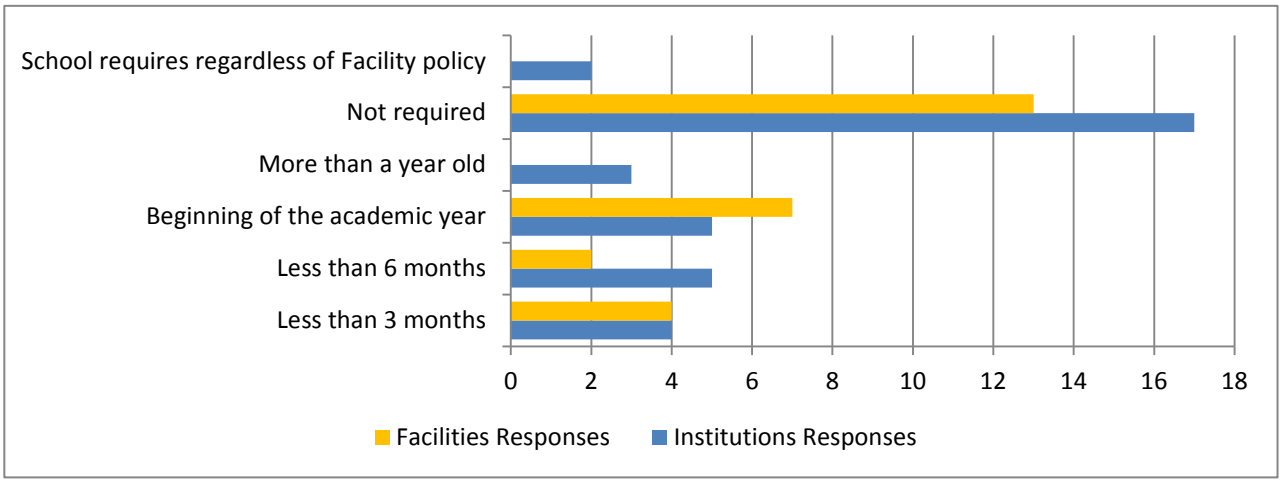
There is inconsistency in facility drug testing requirements. Figure 1 below displays the results of the institutions and facilities surveys when asked the question of required currency for drug testing for students engaged in clinical training. Two items are noteworthy: 1) there is considerable spread in how recent the drug screening must occur, from less than three months to more than a year; and 2) a large proportion of facilities and institutions responding indicated that the facilities where students are receiving onsite training have no drug screening requirements.

The workgroup elected not to address certain questions related to drug testing. It did not focus on the matter of how samples are obtained for drug testing, whether by urine, blood, swab, or other methods. In addition, the workgroup also chose not to comment on the practice of testing for use of marijuana, due to the passage of Initiative 502.

[21] http://www.leg.wa.gov/LAWSANDAGENCYRULES/Pages/constitution.aspx.

[22] Private institutions may have greater latitude in imposing requirements on students than do state-supported institutions. This may explain the results in Figure 1, where two institution respondents indicated they require drug testing regardless of any facility standards.

FIGURE 1: Facility and Institution Survey Results – Requirements for Drug Testing



7. Immunization and Health Screening Provisions

7-1. The workgroup recommends that agreements make reference to current guidelines from the Centers for Disease Control and Prevention (CDC) as the standard for students prior to beginning clinical training.[23]

Commentary

The workgroup identified and discussed how to address inconsistencies in how to ensure that students are sufficiently immunized to work in a clinical setting. Referencing CDC guidelines would provide a consistent standard to students in their clinical training.

A separate but related issue is that of students having the proper health screens for diseases, such as tuberculosis, in order to prevent risk of disease transmission to patients in facilities. Clinical "passport-type" documents may assist in facilitating student movement between training sites by clearly documenting the immunization and health screening record.

8. School Supervision of Students During Training Provisions

8-1. While each case is different, roles and responsibilities of liaisons and preceptors need to be clearly laid out. The workgroup recommends, rather than specify language, that operational detail letters, incorporated by reference into the affiliation agreement, be used for that purpose.

8-2. Facilities will advise schools of the required procedures to be followed by faculty liaisons and clinical preceptors to be onsite at the facility.

Commentary

In some cases, schools/programs have been reported to not provide sufficient on-site supervision to their students when engaged in onsite training. There are multiple possible reasons for this, from inadequate involvement on the institution's part to a facility requirement that the faculty supervisor be privileged (which may not occur). Another complication with this issue is how to provide adequate supervision of students enrolled in distance learning programs.

Rules promulgated by the Nursing Care Quality Assurance Commission establish the maximum ratio of faculty to students recommended in clinical areas involving direct care of patients or clients at one faculty member to ten students. The nursing commission may set a lower ratio for students in initial or highly complex learning situations, or when student/client safety warrant. Similarly, under certain conditions, the commission may set a higher ratio with the accompanying use of trained preceptors for students.[24] Neither the Medical Quality Assurance Commission nor the Board of Osteopathic Medicine and Surgery have set specific requirements for faculty supervision of students during undergraduate onsite clinical training.

A tangential issue the workgroup identified was confusion around the use of "supervisor", "preceptor" and similar terms. In some cases these terms are interchangeably used to describe the role and responsibility of the faculty member or of the facility person responsible for onsite training. While the workgroup does not have specific recommendations for these and other terms, it believes that agreements could be improved by more consistently defining these terms, and perhaps others that are used frequently.

[23] www.cdc.gov/vaccines/schedules/hcp/adult.html
[24] WAC 246-840-570.

Appendix A - Final Bill Report for 2013 HB 1660

HOUSE BILL REPORT
HB 1660

As Passed House:
March 5, 2013

Title: An act relating to convening a work group to develop a standardized clinical affiliation agreement for clinical placements associated with the education of physicians and nurses.

Brief Description: Convening a work group to develop a standardized clinical affiliation agreement for clinical placements for physicians and nurses.

Sponsors: Representatives Hansen, Cody, Clibborn, Green, Morrell, Riccelli and Ryu.

Brief History:
Committee Activity:
Health Care & Wellness: 2/19/13, 2/22/13 [DP].
Floor Activity:
Passed House: 3/5/13, 96-0.

Brief Summary of Bill

Requires the Department of Health to convene a work group to develop uniform clinical affiliation agreements for physicians, osteopathic physicians, and nurses.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 16 members: Representatives Cody, Chair; Jinkins, Vice Chair; Schmick, Ranking Minority Member; Hope, Assistant Ranking Minority Member; Angel, Clibborn, Green, Manweller, Moeller, Morrell, Riccelli, Rodne, Ross, Short, Tharinger and Van De Wege.

Staff: Jim Morishima (786-7191).

Background:

As part of their education and training, physicians, osteopathic physicians, and nurses are all required to complete clinical training. Institutions of higher education enter into agreements with the locations at which their students will complete their clinical training requirements.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

These agreements, known as clinical affiliation agreements, identify the duties and liabilities of both the school and the clinical site.

In its 2012 annual report, the Health Care Personnel Shortage Task Force (task force) recommended the establishment of a work group to develop standardized language to be used in clinical affiliation agreements. According to the task force, one of the barriers to expanded clinical placement capacity is the lack of a standardized clinical affiliation agreement; the lack of standardization creates unnecessary complexity and duplication of effort.

Summary of Bill:

The Department of Health must convene a work group to study and recommend language for standardized clinical affiliation agreements for clinical placements associated with the education and training of physicians, osteopathic physicians, and nurses. When choosing members of the work group, the department must consult with the task force and attempt to ensure that the membership is geographically diverse. The membership must include representatives of the following:

- two-year institutions of higher education;
- four-year institutions of higher education;
- the University of Washington medical school;
- the College of Osteopathic Medicine at the Pacific Northwest University of Health Sciences;
- the Health Care Personnel Shortage Task Force;
- statewide organizations representing hospitals and other facilities that accept clinical placements;
- a statewide organization representing physicians;
- a statewide organization representing osteopathic physicians;
- a statewide organization representing nurses;
- a labor organization representing nurses; and
- any other groups deemed appropriate by the department in consultation with the task force.

The work group must develop one recommended standardized clinical affiliation for each profession or one recommended standardized clinical affiliation agreement for all three professions and report its findings to the Governor and the Legislature no later than November 15, 2014.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill will help train more nurses and doctors by getting rid of burdensome

paperwork. The bill comes from recommendations from the task force. Clinical placements are an important part of training. There is currently a lot of competition for a limited number of clinical placement slots. One barrier to creating more clinical capacity is the lack of a standardized clinical affiliation agreement; people are renegotiating and reinventing the wheel every time they enter into one of these agreements. This bill will create a model agreement like model jury instructions used by lawyers. Simplification and standardization will better serve the system and the students who use it.

(Opposed) None.

Persons Testifying: Representative Hansen, prime sponsor; and Nova Gattman, Health Care Personnel Shortage Task Force.

Persons Signed In To Testify But Not Testifying: None.

Appendix B - Excerpted Language from 2013 3ESSB 5034

CERTIFICATION OF ENROLLMENT

THIRD ENGROSSED SUBSTITUTE SENATE BILL 5034

Chapter 4, Laws of 2013

(partial veto)

63rd Legislature
2013 2nd Special Session

OPERATING BUDGET

EFFECTIVE DATE: 06/30/13 - Except Section 952, which becomes effective 08/01/13, Sections 978 and 996, which become effective 07/28/13, and Sections 991 and 992, which become effective 07/01/13.

Passed by the Senate June 28, 2013
YEAS 44 NAYS 4

BRAD OWEN

President of the Senate

Passed by the House June 28, 2013
YEAS 81 NAYS 11

FRANK CHOPP

Speaker of the House of Representatives

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **THIRD ENGROSSED SUBSTITUTE SENATE BILL 5034** as passed by the Senate and the House of Representatives on the dates hereon set forth.

HUNTER G. GOODMAN

Secretary

Approved June 30, 2013, 4:20 p.m., with the exception of sections 103(10); 103 (11); 114(3); 124(2); 124(3); 124(4); 124 (5); 130(5); 148(4); 150 page 37, lines 33-36 and page 38, lines 1-7; 205(1)(e); 208(7); 213(35); 213(36); 217(5); 219 (25); 302(8); 307(15); 501(1)(a)(v); 610 (1); 610(2); 610(8); which are vetoed.

JAY INSLEE

Governor of the State of Washington

FILED

July 1, 2013

Secretary of State
State of Washington

THIRD ENGROSSED SUBSTITUTE SENATE BILL 5034

Passed Legislature - 2013 2nd Special Session

State of Washington 63rd Legislature 2013 2nd Special Session

By Senate Ways & Means (originally sponsored by Senators Hill and Hargrove; by request of Governor Gregoire)

READ FIRST TIME 04/05/13.

AN ACT Relating to fiscal matters; amending RCW 2.68.020, 2.28.170, 2.28.170, 13.40.466, 18.43.150, 18.85.061, 19.28.351, 28A.500.020, 28B.15.069, 28B.20.476, 28B.67.030, 28B.95.160, 28B.105.110, 28C.04.535, 28C.10.082, 38.52.540, 41.06.280, 41.06.280, 41.26.802, 43.08.190, 43.09.475, 43.10.150, 43.19.791, 43.24.150, 43.24.150, 43.79.445, 43.79.480, 43.82.010, 43.101.200, 43.155.050, 46.66.080, 46.68.340, 67.70.190, 70.42.090, 70.93.180, 70.96A.350, 70.105D.---, 70.105D.070, 70.148.020, 74.09.215, 74.13.621, 74.09.215, 77.12.201, 77.12.203, 79.64.020, 79.64.040, 82.08.160, 82.14.310, 86.26.007, and 74.09.215; reenacting and amending RCW 28B.15.067, 41.60.050, 41.80.010, 41.80.020, 43.325.040, 71.24.310, and 79.105.150; amending 2013 c 147 s 1 (uncodified); amending 2013 c 306 ss 517, 518, and 519; amending 2012 2nd sp.s. c 7 ss 111, 112, 114, 115, 118, 121, 127, 129, 131, 132, 136, 139, 142, 144, 149, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 216, 218, 219, 220, 221, 222, 303, 307, 308, 402, 502, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 602, 613, 615, 616, 617, 701, 702, 707, 801, 802, 803, and 804 (uncodified); amending 2011 2nd sp.s. c 9 ss 506 and 703 (uncodified); amending 2011 1st sp.s. c 50 s 804 (uncodified); amending 2011 1st sp.s. c 41 s 3 (uncodified); adding a new section to 2011 1st sp.s. c 50 (uncodified); creating new sections; making appropriations; providing effective

dates; providing expiration dates; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 219 EXCERPT:

*NEW SECTION. **Sec. 219. FOR THE DEPARTMENT OF HEALTH**

General Fund--State Appropriation (FY 2014) $60,230,000
General Fund--State Appropriation (FY 2015) $59,198,000
General Fund--Federal Appropriation $536,074,000
General Fund--Private/Local Appropriation $139,455,000
Hospital Data Collection Account--State Appropriation $222,000
Health Professions Account--State Appropriation $104,722,000
Aquatic Lands Enhancement Account--State Appropriation $604,000
Emergency Medical Services and Trauma Care Systems
Trust Account--State Appropriation $12,319,000
Safe Drinking Water Account--State Appropriation $5,267,000
Drinking Water Assistance Account--Federal
Appropriation $14,806,000
Waterworks Operator Certification--State
Appropriation $1,560,000
Drinking Water Assistance Administrative Account--
State Appropriation $339,000
Site Closure Account--State Appropriation $159,000
Biotoxin Account--State Appropriation $1,323,000
State Toxics Control Account--State Appropriation $3,949,000
Medical Test Site Licensure Account--State
Appropriation $4,737,000
Youth Tobacco Prevention Account--State Appropriation . . . $1,512,000
Public Health Supplemental Account--Private/Local
Appropriation $3,236,000
Accident Account--State Appropriation $304,000
Medical Aid Account--State Appropriation $50,000
Medicaid Fraud Penalty Account--State
Appropriation $987,000
TOTAL APPROPRIATION $951,053,000

The appropriations in this section are subject to the following conditions and limitations:

(1)(a) The department of health shall not initiate any services that will require expenditure of state general fund moneys unless expressly authorized in this act or other law. The department of health and the state board of health shall not implement any new or amended rules pertaining to primary and secondary school facilities until the rules and a final cost estimate have been presented to the legislature, and the legislature has formally funded implementation of the rules through the omnibus appropriations act or by statute. The department may seek, receive, and spend, under RCW 43.79.260 through 43.79.282, federal moneys not anticipated in this act as long as the federal funding does not require expenditure of state moneys for the program in excess of amounts anticipated in this act. If the department receives unanticipated unrestricted federal moneys, those moneys shall be spent for services authorized in this act or in any other legislation that provides appropriation authority, and an equal amount of appropriated state moneys shall lapse. Upon the lapsing of any moneys under this subsection, the office of financial management shall notify the legislative fiscal committees. As used in this subsection, "unrestricted federal moneys" includes block grants and other funds that federal law does not require to be spent on specifically defined projects or matched on a formula basis by state funds.

(b) The joint administrative rules review committee shall review the new or amended rules pertaining to primary and secondary school facilities under (a) of this subsection. The review committee shall determine whether (i) the rules are within the intent of the legislature as expressed by the statute that the rule implements, (ii) the rule has been adopted in accordance with all applicable provisions of law, or (iii) that the agency is using a policy or interpretive statement in place of a rule. The rules review committee shall report to the appropriate policy and fiscal committees of the legislature the results of committee's review and any recommendations that the committee deems advisable.

(2) In accordance with RCW 43.70.250 and 43.135.055, the department is authorized to establish and raise fees in fiscal year 2014 as necessary to meet the actual costs of conducting business and the

appropriation levels in this section. This authorization applies to fees required for newborn screening, and fees associated with the following professions: Agency affiliated counselors; certified counselors; and certified advisors.

(3) $150,000 of the state toxics control account--state appropriation is provided solely to provide water filtration systems for low-income households with individuals at high public health risk from nitrate-contaminated wells in the lower Yakima basin.

(4)(a) $64,000 of the medicaid fraud penalty account--state appropriation is provided solely for the department to integrate the prescription monitoring program into the coordinated care electronic tracking program developed in response to section 213, chapter 7, Laws of 2012, 2nd sp. sess., commonly referred to as the seven best practices in emergency medicine.

(b) The integration must provide prescription monitoring program data to emergency department personnel when the patient registers in the emergency department. Such exchange may be a private or public joint venture, including the use of the state health information exchange.

(c) As part of the integration, the department shall request insurers and third-party administrators that provide coverage to residents of Washington state to provide the following to the coordinated care electronic tracking program:

(i) Any available information regarding the assigned primary care provider, and the primary care provider's telephone and fax numbers. This information is to be used for real-time communication to an emergency department provider when caring for a patient; and

(ii) Information regarding any available care plans or treatment plans for patients with higher utilization of services on a regular basis. This information is to be provided to the treating provider.

(5) $270,000 of the general fund--state appropriation for fiscal year 2014 is provided solely for the Washington autism alliance to assist autistic individuals and families with autistic children during the transition to federal health reform.

(6) $6,000 of the general fund--state appropriation for fiscal year 2014 and $5,000 of the general fund--state appropriation for fiscal year 2015 are provided solely for the department to convene a work group to study and recommend language for standardized clinical

affiliation agreements for clinical placements associated with the education and training of physicians licensed under chapter 18.71 RCW, osteopathic physicians and surgeons licensed under chapter 18.57 RCW, and nurses licensed under chapter 18.79 RCW. The work group shall develop one recommended standardized clinical affiliation agreement for each profession or one recommended standardized clinical affiliation agreement for all three professions.

(a) When choosing members of the work group, the department shall consult with the health care personnel shortage task force and shall attempt to ensure that the membership of the work group is geographically diverse. The work group must, at a minimum, include representatives of the following:

(i) Two-year institutions of higher education;

(ii) Four-year institutions of higher education;

(iii) The University of Washington medical school;

(iv) The college of osteopathic medicine at the Pacific Northwest University of Health Sciences;

(v) The health care personnel shortage task force;

(vi) Statewide organizations representing hospitals and other facilities that accept clinical placements;

(vii) A statewide organization representing physicians;

(viii) A statewide organization representing osteopathic physicians and surgeons;

(ix) A statewide organization representing nurses;

(x) A labor organization representing nurses; and

(xi) Any other groups deemed appropriate by the department in consultation with the health care personnel shortage task force.

(b) The work group shall report its findings to the governor and the appropriate standing committees of the legislature no later than November 15, 2014.

Appendix C – Health Workforce Council 2012 Report Recommendations

Health Care Personnel Shortage Task Force

2012 Annual Report

December 2012

Workforce Training and Education Coordinating Board
12810th Avenue SW,PO Box 43105,Olympia,98504-3105
360-709-4600,www.wtb.wa.gov

I. Background

In 2001, the Workforce Training and Education Coordinating Board (Workforce Board) convened a Workgroup of health care stakeholders to address concerns about personnel shortages in the health care industry. In 2002, the Workforce Board created the Health Care Personnel Shortage Task Force (Task Force) at the request of Governor Gary Locke. The Task Force's first statewide strategic plan to address the severe shortages of personnel in the health care industry was presented in January 2003 to the Washington Legislature in the report Health Care Personnel Shortages: Crisis or Opportunity?

During the 2003 session, the Legislature passed legislation directing the Workforce Board to continue convening the Task Force. The Task Force's objective is to ensure an adequate supply of health care personnel that safeguards the ability of the health care delivery system to provide quality, accessible health care to residents of Washington. The bill also required an annual report to the Governor and Legislature on the statewide plan, including recommendations, to address health care personnel shortages.

The Workforce Board has continued to convene the Health Care Personnel Shortage Task Force and to annually provide a report to the Governor and Legislature which contains recommendations to address a variety of issues related to personnel shortages in the health care industry.

II. Membership

Michele Johnson, Ph.D., Task Force Chair, Chancellor, Pierce College
Suzanne Allen, M.D., Task Force Vice-Chair, Vice Dean for Regional Affairs, UW School of Medicine
Dan Ferguson, MS, Director, Allied Health Center of Excellence/ Yakima Valley Community College
Dana Duzan, Laboratory Director, Allied Health Professionals
Mary Looker, CEO, Association of Community and Migrant Health Centers
Vacant, Group Health Cooperative representative
Kathleen Lopp, Assistant Superintendent, Office of Superintendent of Public Instruction
Diane Sosne, President, Service Employees International Union (SEIU)
Charissa Raynor, Executive Director, SEIU Healthcare NW Training Partnership
Marty Brown, Executive Director, State Board for Community and Technical Colleges
Diane Zahn, Secretary/Treasurer, United Food and Commercial Workers Union
Deb Murphy, CEO, Washington Association of Housing & Services for Aging
Linda Tieman, Executive Director, Washington Center for Nursing
Lauri St. Ours, Dir. of Regulatory & Gov't Affairs, Washington Health Care Association
Nancy Alleman, RDH, BS, Washington Rural Health Association
Bracken Killpack, Director of Government Affairs, Washington Dental Association

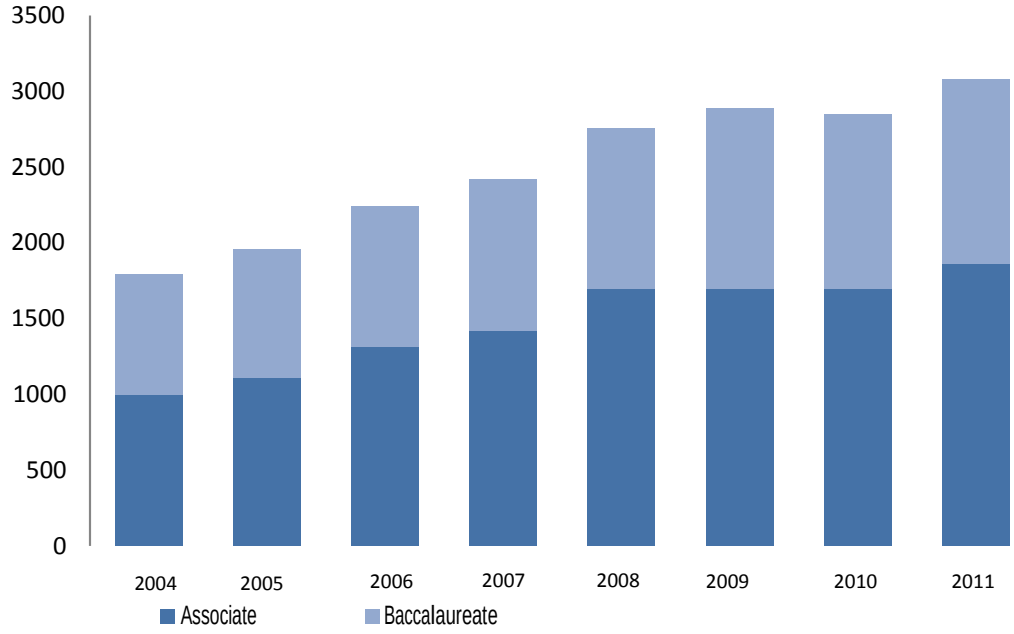
Mary Selecky, Secretary, Washington Department of Health
Vergil Cabasco, Policy Director. Washington Hospital Association
Roger Rosenblatt, MD, MPH, Washington Medical Association
Sally Watkins, MN, RN, Assistant Executive Director, Washington Nurses Association
Don Bennett, Executive Director, Washington Student Achievement Council
Eleni Papadakis, Executive Director, Workforce Training and Education Coordinating Board

III. Progress

Since the inception of the Task Force, a great deal of progress has been made in many areas to address severe personnel shortages that had existed, and progress continues to be made. Here are a few highlights in addressing the health care personnel shortage.

- Demonstrable progress can be seen in the increase in supply of registered nurses in Washington. Since 2004, the state has increased the annual number of Associate and Bachelor's level nursing graduates by 72 percent. (See Figure 1)

Figure 1. Annual Registered Nursing Program Completions, 2004-2011



Source: Health Professions Education in Washington: 2004-2011 Completion Statistics. Workforce Training and Education Coordinating Board, 2012

- The Department of Health received funding in the 2011-13 biennium to move forward with online renewals for health care providers. Online renewal became available to the first four professions in January 2012 and all primary care providers were able to renew online by November 1, 2012. The service continues to be phased in for the remaining professions and will be complete by June 2013 for all 380,000 health professionals in over 80

professions. Work during the 2011-2013 biennium also included a pilot project for online applications for eight professions.

The move to online renewals for health professionals sets the stage for collecting additional demographic and practice information on health care providers for use in assessing and planning health care across the state. If funded, the department plans to develop and implement demographic surveys during the 2013-2015 biennium. Making applications available online is planned for the 2013-2015 biennium as well.

- The Center of Excellence for Allied Health is leading an effort to design a model Allied Health Program of Study. This work includes identifying common core requirements for allied health programs and developing secondary to postsecondary articulation agreements. Other aspects of the model under development include assessing and providing credit for prior learning experience, and creating a certificate for completing program prerequisites.

- The State Board for Community and Technical Colleges approved three Hospital Employee Education and Training (HEET) projects for the current fiscal year.
  1) Bellingham Technical College, Whatcom Community College and Skagit Valley College are continuing their "Moving Forward" partnership with area hospitals. "Moving Forward" offers a health care pathway for low-earner, diverse, and first generation hospital workers, and those facing job elimination.
  2) North Seattle Community College is leading an effort with the other colleges in the Seattle District and the Swedish Medical Center and SEIU 1199NW. The project provides pre-college and college-level math and English learning for hospital employees.
  3) Bellevue College is partnering with Evergreen Health and SEIU 1199 NW to offer a pathway to Registered Nursing. The pathway includes prerequisite coursework at the worksite or in a hybrid format, and offers students tutoring and flexible work scheduling.

- Looking ahead to the 2013 fiscal year, the colleges will be funding new HEET projects to respond to the Affordable Care Act. These new projects are expected to include developing:
  - Career pathways for medical assistants;
  - Curriculum to address community-based health care;
  - Curriculum to facilitate medical billing and coding changes, and
  - Capacity for using simulation training.

IV. Health Care Personnel Data

Although progress has been made in many areas, health care personnel shortages continue to be anticipated in the health care industry. Additionally, while the full impacts of the federal Affordable Care Act on health care personnel are not known yet, there will be significant

impacts on non-urban areas of the state.[1] The following data on the anticipated health care personnel shortages does not account for any increased demand created by implementation of the Affordable Care Act.

A. Health Care Personnel Gaps

On behalf of the Task Force, the Workforce Board analyzes the supply and demand for selected health care occupations. The analysis compares the projected job openings to supply from new entrants completing health care education programs and estimates a gap over time. Below are the top 16 health care occupations with the greatest projected gap in supply. For the full table of health care occupations and the projected skill gap for 2015 – 2020, see: www.wtb.wa.gov/Documents/2012healthoccupationskillgap.pdf

Occupation	2012 - New Supply	Projected Annual Net Job Openings 2015 - 2020	Annual Gap Between Supply & Projected Demand
Home Health Aides *	58	436	-378
Physicians and Surgeons, All Specialties	173	545	-372
Vocational Rehabilitation Counselors	17	385	-368
Registered Nurses **	2411	2588	-177
Medical, Clinical Lab Technologists	45	175	-130
Mental Health Counselors	48	176	-128
Medical Scientists, Except Epidemiologists	103	216	-113
Dentists, General and All Specialties	88	200	-112
Physical Therapists	108	198	-90
Occupational and Vocational Therapists	56	106	-50
Respiratory Therapists	40	89	-49
Radiologic Technologists/Radiographer	152	199	-47
Medical and Clinical Lab Assistants & Technician	74	120	-46
Physician Assistants	64	109	-45
Dental Lab Technicians	16	56	-40
Med Transcriptionists	105	144	-39

* Includes Department of Health licensed Home care aides, but not Medicaid home care aides.

** Demand for nurses is currently down as result of the recession and aftermath but is expected to grow as recovery strengthens.

These demand estimates are from occupational projections for Washington that were developed by the Employment Security Department under a contract from the U.S. Department of Labor. This national methodology relies heavily on recent trends and on national averages. Therefore, it may underestimate emerging overall changes or effects

[1] Washington State Office of Financial Management, Availability of Primary Care Physicians to Serve the Affordable Care Act's Medicaid Expansion Population, Washington State Health Services Research Project Research Brief No. 65, Wei Yen and Thea Mounts, www.ofm.wa.gov/researchbriefs/2012/brief065.pdf (June 2012); University of Washington Center for Health Workforce Studies, Washington State Primary Care Provider Survey, 2011-2012: Summary of Findings, Susan M. Skillman, MS, Meredith A. Fordyce, PhD, Wei Yen, PhD, Thea Mounts, MA, http://depts.washington.edu/uwrhrc/uploads/OFM_Report_Skillman.pdf (August 2012).

specific to Washington. In general, this methodology tends to be conservative in predicting changes to recent trends.

Accurately predicting future changes in health care labor demand resulting from national health care reform is very challenging. It will be important to carefully monitor changes in the health care system for labor market effects that were not predicted in the official projections.

B. Health Care Completions

Washington has been very successful in increasing the number of students completing health care programs. The summary of Health Professions Education Completions contained as an attachment to this report shows the number of completions statewide from 2004 to 2011 for 35 health care fields. The next table shows some of the programs with the most notable increases. Bear in mind percentages don't reflect the amazing growth that has occurred in some of these educational fields. For instance, the 241 percent growth in Physical Therapy Assistant represents roughly 100 extra completions per year whereas the relatively more modest sounding increase of 73 percent of Registered Nurses represents about 1,300 more completions per year.

Health Care Programs with Substantial Increases in the Number of Completers

Program of Study	Percentage Increase in the Number of Completers from 2004 to 2011
Physical Therapy Assistant	241 %
Nursing Assistant/Aide	127 %
Surgical Technology	73 %
Registered Nurse (ADN and BSN)	73 %
Advanced Registered Nurse Practitioner	57 %
Medical Imaging	42 %
Dental Hygiene	39 %
Pharmacy	26 %
Physician Assistant	16 %

V. 2012 Task Force Recommendations

In 2012, there was a great deal of uncertainty in the health care field due to the legal challenge to the Patient Protection and Affordable Care Act (ACA) which was passed by Congress in 2010. In June 2012, the U.S. Supreme Court held that the vast majority of the ACA was constitutional. Following this decision, state governments began the work of determining how to implement the provisions of the Act, including the expansion of eligibility for Medicaid.

Task Force planning and decision-making in 2012 was greatly influenced by the ACA and its potential impacts on health care demand. The Task Force held its 2012 meetings in June and October. The June meeting was held prior to the U.S. Supreme Court decision on the ACA; therefore, the meeting focused on learning more about the Act and the efforts in Washington to meet its requirements. In October the Task Force heard an overview of the decision handed down by the U.S. Supreme Court and learned more about the potential increase in demand for health care services forecasted as a result of the changes established in the ACA. In preparing its recommendations, the Task Force focused on the health care personnel shortages that are anticipated from the increased demand for health care, particularly in rural areas of the state.

Recommendations

1. Support health care career pathways, Programs of Study, and other opportunities that move students along their pathways and into health care careers more efficiently and effectively.

   a. Career Pathways and Programs of Study

   The Legislature should support the development of career pathways and should encourage the secondary and postsecondary education systems to better align the Programs of Study, as well as to increase opportunities for dual credits and articulations. Health care career pathways enable a student to identify health care as an occupational area of interest to the student. Once a student has chosen the career pathway, the student is able to choose a Program of Study within the pathway that integrates academic and career and technical education, and also provides greater opportunities for work-integrated learning experiences. Programs of Study align secondary education with postsecondary education and provide for increased opportunities for dual credits. Programs of Study within the health care career pathways will allow a student to move through his or her education and training program into a health care career more efficiently and quickly.

   b. High Employer Demand Programs of Study Funding

   The Legislature should continue to target and fund high employer demand Programs of Study which are programs in areas where the in-state supply of graduates is less than employer demand.

   c. Career and Technical Education and Support Services

   The Legislature should support programs and services that move students to completion of their education and training programs and into careers. Career and Technical Education

programs provide valuable training to students that enable them to gain skills and abilities needed in their career of choice. Federal funding has been stagnant for Career and Technical Education programs, and students are losing access to valuable education and training programs.

Support services are another area that is extremely important to the success of many students. Budget cuts in recent years have reduced many of the services that enabled students to complete their education and training. Programs such as career navigators assist students in moving more quickly into their career with help identifying their pathway and accessing the necessary education and training programs, as well as support services. Though there has been some federal grant funding for this type of activity, the State of Washington should continue to provide funding for those programs that are showing results in moving students to completion of their education and training programs such as the Navigator programs.

2. Increase residency opportunities for medical students to increase the number of medical students who remain in Washington to practice, the state needs to increase opportunities in residency training programs. Where a medical student engages in his or her residency training program is a significant predictor of where the student will practice once training is completed. Investments in increasing in- state residency opportunities will likely have a positive impact on increasing the numbers of health care personnel in the state, especially in medically underserved regions.

   Washington has benefitted from federal grants to increase family medicine residency programs and Physician Assistant training opportunities. This funding will result in an increase in primary care providers in Washington. Unfortunately, once the federal funding is no longer available, the state is in danger of losing the increased training positions. Washington should continue funding of the residency and training opportunities created through the federal grants under the Affordable Care Act.

3. Establish a Workgroup to develop a standardized language to be used in clinical affiliation agreements.
   Clinical placements are an integral part of the education and training in many health care professions. Currently, competition for clinical placements in many health care fields is creating a barrier to increasing capacity of the health care workforce. One of the difficulties faced in developing greater clinical placement capacity is the lack of standard language for the management of clinical affiliations. The absence of standard language creates unnecessary complexity and duplication of effort spent creating, editing, and negotiating similar agreements across the state. Standardization of the language would

greatly increase the efficiency with which the agreements could be created. Additionally, gaps in language have occurred to the disadvantage of some schools. Simplification and standardization would better serve students and the system. The Legislature should form a Workgroup to address the development of a standardized language for affiliation agreements.

4. Encourage the adoption of common course numbering and increased articulation in the postsecondary system.

   Students today are highly mobile and it is possible for students to earn a certificate or degree with credits from multiple institutions. When credits do not transfer between postsecondary institutions, students spend extra time and money to complete their educational programs. Additionally, students attending multiple colleges can easily repeat classes or misunderstand how a class applies to core requirements, distribution requirements, electives, or major requirements.[2] This situation may discourage some students who then leave the educational system without completing their program to obtain a certificate or degree. The current system is complex for students, faculty and staff to understand and navigate, and impedes efforts for colleges to communicate and collaborate to serve students across institutions. Finally, state and local resources are not used as efficiently as possible. Common course numbering makes course transfer between the postsecondary education institutions more efficient and effective for students, advisors and receiving institutions. The Legislature should encourage common course numbering and increased articulation in the postsecondary system.

5. Support growth and development of online education and training opportunities for all areas of the health care workforce as well as the increased utilization of telemedicine.

   Technology provides opportunities for access to education and training for a greater number of students in health care fields. The growing field of telemedicine which involves the remote delivery of health care services using telecommunications technology is an excellent example. Technology allows for greater efficiencies as educational institutions are able to share faculty and educational content. Online education programs are also particularly valuable for students in rural or remote areas as they allow access to education and training that might not otherwise be available. Part of the answer to increasing the number of health care personnel practicing in the non-urban areas of the state is developing online education and training that is based on evidence-based data

[2] Feasibility Study – Improving Course Articulation, A report prepared for WACTC Education Services Committee, May 27, 2004

and information. The Legislature should fund increased online education and training opportunities and support efforts to increase utilization of telemedicine.

6. Restore funding for the State Loan Repayment Program

The Health Professional Loan Repayment Program helps the state attract and retain licensed health professionals to serve in critical shortage areas in Washington by providing educational loan repayment assistance. In return for financial assistance, program participants agree to provide primary health care services in rural or underserved urban areas that are designated as health professional shortage areas.[3] The Loan Repayment Program is funded at the state level in the federally matched State Loan Repayment Program (SLRP). Since 2010, the state's funding for this program has been reduced. The Legislature should fund the State Loan Repayment Program to increase health care personnel practicing in critical shortage areas of the state.

7. Provide funding for a survey of health care professionals in order to accurately determine the supply of health care workers in the State

To understand the full extent of the health care personnel shortage, we need to be able to calculate the supply of health care workers in the state. Currently, there is no reliable method for calculating the supply. The Department of Health licenses many health care workers and is transitioning to an online license renewal process. The Task Force recommends the funding of ongoing data collection connected to the online license renewal. We also need to provide funding for the analysis of the data collected in the survey. This information is critical to identifying where resources should be allocated to meet the greatest demand for health care personnel.

Issues for the Task Force to Consider in 2013

1. Impacts of health care reform efforts in Washington on home care workers.

Washington has approximately 40,000-50,000 home care workers. This is one of the fastest growing areas of health care in the state. An important consideration of many home care workers who choose this career is the availability of health care. Health care reform under the Affordable Care Act will make access to health care available to many current home care workers, or those who might have chosen this profession due to the availability of health care. With more options for access to health care, health care as a benefit for home care workers is no longer the incentive it was prior to health care reform.

[3] Washington Student Achievement Council, Health Professions Program, www.wsac.wa.gov/PayingForCollege/FinancialAid/HealthProfessional (2012).

Due to this change, there is potential for a reduction in the number of people who choose to enter the home care profession. This could potentially create a significant home care worker shortage. The Task Force will monitor this situation and whether it is an issue the Task Force should address in 2013 or beyond.

2. Consideration of health care disparities in the workforce.
   In many of the previous years, the Health Care Personnel Shortage Task Force has looked at the issue of disparities in race, ethnicity and gender in the health care workforce. The Task Force will collaborate with the Governor's Interagency Council on Health Disparities and consider this issue for possible recommendations in 2013.

3. Consider funding models to support efforts to reduce the health care personnel shortage.
   Washington has faced severe budget shortfalls for several years resulting in funding impacts in all areas including health care, secondary education, higher education, and social services. The state is not likely to see significant changes in revenue due to improvements in the economy for some time. Therefore, we should consider how to provide the needed resources to meet the health care personnel shortages. In 2013, the Task Force may explore models to fund efforts to reduce the health care personnel shortage.

4. Regional partnerships to address the health care personnel shortage.
   The exact nature of health care personnel shortages varies from one area of the state to another. For example, the Office of Financial Management's analysis of the availability of primary care physicians to serve the ACA's Medicaid expansion population shows that some areas of the state will have an ample supply of primary care physicians while other areas will have a shortage. To address such regional differences, representatives of health care organizations, health care workers, and education institutions should gather to analyze and devise solutions for their area. In many areas of the state, health care industry Skill Panels have served this purpose. In 2013, the Task Force will examine ways of promoting these types of regional partnerships.

To find this report online, see: www.wtb.wa.gov/HCTFIntro.asp.

Appendix D – Selected CAA Models Reviewed by the Workgroup

Insert models here—to be determined by CAA Workgroup

Appendix E – Educational Institution, Health Care Facility, and Student Survey Instruments

- **E1. Notification to Survey Respondents**
- **E2. Facilities Survey Instrument/Results**
- **E3. Institutions Survey Instrument/Results**
- **E4. Nursing Student Survey Instrument/ Results**
- **E5. Allopathic Medical Student Survey Instrument/Results**
- **E6. Osteopathic Medical Student Survey Instrument/Results**

E1. Notification to Survey Respondents

Dear _____,

The 2013 Washington State Legislature directed the Department of Health to form a Workgroup with representatives from professional associations, facilities, and institutions of higher education to develop model clinical affiliation agreement (CAA) language for medical, osteopathic, and nursing professions or to develop separate model CAAs for each profession.

A CAA is a contract between a school and a health care organization that establishes the duties and liabilities of both parties and delineates the requirements for a student to receive training at the health care organization. As medical, osteopathic or nursing students must have practical experience as part of their education, CAAs ensure that the experience meets national standards, and that the schools and facilities have clearly laid out roles and responsibilities.

As a part of this project, the Department of Health and CAA work group, is distributing this brief survey to gauge the challenges students, educational institutions, and health care facilities experience when developing and working with CAAs.

Please take a moment to click on the link below and take the survey. It should only take you 5 to 10 minutes. If applicable, please also distribute the 'student' survey to relevant students—students who are in a DO, MD, or nursing program—within your institution. We ask that responses be submitted by **Wednesday, June 25**.

Thank you for your time,

Survey title with link here

E2. Facilities Survey Instrument/Results

E3. Institutions Survey Instrument/Results

E4. Nursing Student Survey Instrument/Results

E5. Allopathic Medical Survey Instrument/Results

E6. Osteopathic Medical Student Instrument/Results

Appendix F – Selected Clinical Passports

Clinical Placements Northwest Collaborative
Student/Faculty
Clinical Passport Requirements

Student/Faculty Name (include middle initial):

College:
Program:

These requirements are in place for the health and safety of students, faculty and their patients.

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met **prior** to participation in patient care/clinical experience. Records will be kept at the academic institution and random review by the clinical affiliates will occur on a regular basis. *Documentation must meet requirements at all times.* Required immunizations must include mm/dd/yyyy if available.

SUBMITTED ONCE

TUBERCULIN STATUS

- If no previous records or more than 12 months since last TST → 2 step TST **OR**
- QuantiFERON (QFT) TB Gold test within 12 months **OR**
- If negative TST within 12 months → one step TST **OR**
- If newly positive TST → F/U by healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and need to complete health questionnaire
- If history of positive TST → provide documentation of TST reading, provide proof of chest X-ray documenting absence of M. TB, medical treatment and negative symptom check **OR**
- If history of BCG vaccine → QFT. If negative → OK; If positive → do Chest X-Ray

HEPATITIS B

- Series of 3 vaccines completed at appropriate time intervals and post vaccination titer at 6-8 weeks after series completion
- If negative titer, then repeat series (consisting of doses 4-6) and repeat titer 6-8 weeks after #6 dose. **OR**
- Provide documentation of positive titer (anti-HBs or HepB SAb) **OR**
- **IF** post vaccination titer is not completed 6-8 weeks after series completion - repeat Series of 3 vaccines (doses #4 - #6) & obtain post vaccination titer at 6-8 weeks after series #2 completed.
- Signed declination for students/faculty who decline vaccination
  Specific healthcare institutions may require vaccination without exception (i.e., no declination)

MMR (Measles, Mumps, Rubella)

- Proof of immunity by titer **OR**
- Proof of vaccination (2 doses at appropriate intervals)

VARICELLA (Chicken Pox)

- Proof of immunity by titer **OR**
- Proof of vaccination (2 doses at appropriate intervals)

TETANUS, DIPTHERIA, PERTUSSIS (Tdap)

- Tdap **required** once
- Td required every 10 years after Tdap

CPR

- American Heart Association BLS Healthcare Provider Certificate

AUTHORIZATION FOR RELEASE OF RECORD

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTY AND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN CLINICAL PLACEMENT CONSORTIUM # 1(CPC1) AND INLAND NORTHWEST CLINICAL PLACEMENT (INCPC) CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR PROGRAM.

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

- Annual TST **OR**
- Annual QuantiFERON TB Gold test **OR**
- If newly positive TST results→ F/U with healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and may need to complete health questionnaire.
- Previously documented +TST results and prior negative chest X-ray results: submit annual symptom check completed within one year from healthcare provider

INFLUENZA

- Proof of seasonal vaccination(s) **OR**
- Signed declination for student/faculty who decline vaccination
  Specific healthcare institutions may require vaccination without exception (i.e., no declination)

BACKGROUND CHECKS

- National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/readmission and reentry/hire to program to include all counties of residence, all Washington State counties per RCW 43.43.830 and OIG and GSA screens. Excluded provider search on OIG
  http://exclusions.oig.hhs.gov/
  GSA http://www.sam.gov
- Washington State Patrol Background Check (WATCH) annually thereafter

LICENSE (if faculty licensed or certified as any healthcare provider (RN, LPN, NAC, etc in Washington State)

- Current
- Unencumbered

INSURANCE

- Professional Liability $1,000,000/3,000,000 policy

ADDITIONAL REQUIREMENTS (if applicable)

Some healthcare settings may have additional requirements, such as the following:

- Vehicle Insurance (for access to VA & Military Facilities)
- Personal Health Insurance
- Drug Screen
- Hepatitis A Vaccine
- Current First Aid Card
- Proof of U.S. Citizenship
- Color Vision Test
- Food Handlers License

Students and Faculty will be informed prior to clinical experience if optional or additional requirements need to be met.

Clinical Placements Northwest Collaborative Student/Faculty Clinical Passport Requirements

Student/Faculty Name
First,Middle Initial, Last: _____ DOB

College: _____

Program: _____

Form verified by: _____

Name _____ Date _____

Name _____ Date _____

Name _____ Date _____

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met **prior** to participation in patient care/clinical experience. Records will be kept at the academic institution and random review by the clinical affiliates will occur on a regular basis. *Documentation must meet requirements at all times.* Required immunizations must include mm/dd/yyyy if available.

SUBMITTED ONCE

Circle the applicable letter in each box.

☐ **TUBERCULIN STATUS**

A. Two-step TST 1) Skin Test #1Date_____Result: Neg____Pos____mm_____
2)Skin Test #2 Date_____Result: Neg____Pos____mm_____
OR
B. QuantiFERON (QFT) Date_____ Result:_____
OR
C. If New Positive/Exam/X-ray Date_____
OR
D. Positive TST/Negative X-ray Date_____

☐ **HEPATITIS B** (3 primary series shots: (at 0,1,6 mo) plus titer confirmation (6-8 weeks later)

A. Vaccination Dates
1) _____
2) _____
3) _____
Immunity confirmed by titer Date _____ **OR**
B. If negative titer after initial series of 3 vaccines, then vaccines #4-#6
4) _____
5) _____
6) _____
Immunity confirmed by titer Date _____
C. Immunity confirmed by titer (anti-HBs or HepB SAb)Date_____ **OR**
D. Signed declination Date _____
E. Had the disease Date_____

☐ **MMR (Measles, Mumps, Rubella)**

A. Immunity by titers: Measles Date_____
Mumps Date_____ Rubella Date_____ **OR**
B. Vaccination Dates
1)_____ 2) _____

☐ **VARICELLA (Chicken Pox)**

A. Immunity by titer Date_____ **OR**
B. Vaccination Dates
1) _____ 2)_____

☐ **TETANUS/DIPTHERIA/PERTUSSIS**

A. Tdap Date _____
B. Td Date_____

☐ **AHA BLS Healthcare Provider Certificate**

Expiration Date _____

☐ **Authorization for Release of Record**

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTYAND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN CPC#1 AND INCPC CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR PROGRAM.

SUBMITTED EVERY YEAR

Circle the applicable letter in each box.

☐ **TUBERCULIN STATUS**

A. Annual TST
Date_____ Result: Neg____Pos____mm_____
Date_____ Result: Neg____Pos____mm_____
Date_____ Result: Neg____Pos____mm_____ **OR**

B. Annual QuantiFERON (QFT)
Date_____Result:_____Date_____Result:_____
Date_____Result:_____ **OR**

C. If New Positive/Exam/Chest X-ray
Exam Date_____ X-ray Date_____**OR**

D. Known Positive/Possible Treatment/ Annual Symptom Check from Health Care Provider Date_____

☐ **INFLUENZA**

A. What healthcare provider administered vaccine?
B. Proof of seasonal vaccination
Date 1_____Date 2_____ Date 3_____ **OR**
C. Signed declination
Date 1_____Date 2_____ Date 3_____

☐ **BACKGROUND CHECK (including Disclosure Statement)**

A. National Criminal Background Check including Excluded Provider Search on OIG and GSA upon admission
Date_____
B. Washington State Patrol Check (WATCH) upon admission and annually
Dates_____,_____,_____,_____

☐ **LICENSE (Any healthcare license: RNs, LPNs, NACs…)**

A. WA State #_____Exp. Date_____
OR
B. Not Applicable

☐ **INSURANCE**

A. Professional Liability Policy Date: _____

☐ **ADDITIONAL REQUIREMENTS (if applicable)**

A. Vehicle Insurance Date_____
B. Personal Health Insurance Date_____
C. Drug Screen Date_____
D. Hepatitis A Vaccine Two doses
Dates: 1)_____2)_____
E. Current First Aid Card Date_____
F. Proof of U.S. Citizenship Date _____
G. Confidentiality Statement Date_____
H. Color Vision Test Date _____
I. Food Handlers License Date _____

This is not a comprehensive list; there may be more items.

WSU Grad (or undergrad) Student Passport

These requirements are in place for the health and safety of Washington State health care students and their patients.

TB Skin Test

- Documentation of 2-step TST, if two step TST is more than 12 months old, must submit proof of Annual TST within the last 12 months **OR**
- QuantiFERON (QFT) serum test (within 12 mos.) **OR**
- **IF** New +TB Test results → F/U by healthcare provider (chest X-ray, symptoms check and possible treatment,) may need to complete health questionnaire **OR**
- **IF** History of +TB results → provide proof of chest X-ray and submit negative symptom check from health care provider in past 12 months **OR**
- **IF** no proof of +TB Test available, then chest X-ray **OR**
- **IF** History of BCG vaccination → 2-Step TB Test or QFT **OR**
- **IF** History of +TB Test and +chest X-ray and symptoms: must see healthcare provider for treatment before school entry

Hepatitis A

- Proof of immunization dates
- **OR** proof of immunity with positive titer
- Signed waiver for students who decline vaccination

Hepatitis B

- Proof of immunization dates
- **OR** proof of immunity with positive titer
- Signed waiver for students who decline vaccination

MMR (Measles, Mumps, Rubella)

- Proof of vaccination (2 doses) **OR**
- Proof of immunity by titer

Varicella (Chicken Pox)

- Proof of vaccination (2 doses) **OR**
- Proof of immunity by titer.

Tetanus, Diphtheria, Pertussis (Tdap Vaccine)

- Tdap required one time after age 12.

Influenza

- Proof of annual vaccination(s) **OR**
- Signed waiver for students who decline vaccination

CPR Certificate

- Health provider level (adult, infant, child, AED)

Notes: Hep A, Hep B, and Influenza waivers available upon request

COMPLETED BEFORE STUDENT BEGINS PROGRAM

- **WA RN License** – Required
- **Background Checks -**
  Complete the following steps:
  1. Go to *www.certifiedbackground.com.*
  2. Click the student link
  3. In the "package code" box enter **AS54** (case sensitive).
  4. Enter information and finish by selecting payment.
- **WSU Student Liability Insurance -** Effective through August. This is the only liability insurance WSU Nursing accepts and must be kept in effect continually, while enrolled in any nursing course. Payment form is included in this mailing. Please send to the Spokane address that appears on the form or WSUV students who pay the cashier in Vancouver must turn in the receipt to WSUV Nursing as proof of payment.
- **Responsible Conduct Training -** The Graduate School requires all graduate students to complete the Responsible Conduct of Research online training, which takes about 20 minutes, before or during their first semester as a graduate student.
  http://www.gradschool.wsu.edu/CurrentStudents/ResearchIntegrity/
- **CITI Training** - PhD Students Only
  http://www.irb.wsu.edu/citi.asp
- **10-Panel Urine Drug Screen -** *VANCOUVER ONLY*

You may complete your UDS via CertifiedBackground.com or through a testing agency of your choice.

To use CertifiedBackground.com:

1. CertifiedBackground.com offers drug testing through LabCorp. To start the process, go to *www.certifiedbackground.com.*
2. Click the student link
3. In the "package code" box enter **AS54dt** (case sensitive).
4. You will then be directed to set up or login to your Certified Profile account.
5. Within 24-48 hours after placing your order, the electronic chain of custody form (e-chain) will be placed directly into your CertifiedProfile account. This e-chain will explain where to go to complete your drug test. By entering your zip code, you can find a LabCorp location convenient to you.
6. Once the test is complete, the Nursing Office will be able to view the results online.

Some Local Agencies Offering Urine Drug Screen (call agency for (other) locations and costs):

- ADC Test Clinics, Inc. 5501 NE 109th Ct. Suite E, Vancouver, WA, 98662 (360) 256-0322
- Advanced Diagnostic Services, Inc. 9106 NE Highway 99 #F, Vancouver, WA 98665 360-546-1986
- Columbia River Occupational Health, 2105 NE 129th St. Suite 107; Vancouver, WA 360-891-4900
- Legacy Metro Lab, 1225 NE 2nd Ave, Portland, OR 97232; 503-413-5295
- Workplace Wellness Services, 1405 Delaware St., Longview, WA 98632; 360-414-2824
  The agency will fax results directly to the Nursing Office at 360-546-9398.

Congratulations on your acceptance, and please contact us if you have questions or concerns!

Spokane/TC/WW/Yakima:
Tami Kelley 509-324-7334 kelleyt@wsu.edu
Rychelle Wagner 509-324-7445 rmwagner@wsu.edu
Vancouver:
Kathleen Johns 360-546-9752 kathleen.johns@vancouver.wsu.edu
Susan Shaw 360-546-9473 susan.shaw@vancouver.wsu.edu
PhD Spokane and Vancouver:
Eileen Swalling 509-324-7297 eswalling@wsu.edu

A Note to WSU Vancouver Students:

To all students seeking clinical placements in Oregon and Southwest Washington, the ***Total Clinical Placement System (TCPS)*** online orientation must be completed prior to starting clinical and renewed, annually. The link is: http://tcps-ocn.org/index.htm.

Students seeking preceptors in Oregon, must maintain a current Oregon RN license and complete the ***Advanced Practice Student Verification of Supervised Practice in Oregon in a Non-Oregon Based Graduate Program,*** prior to starting clinical.

Questions or more information contact Barbara Maddox at 360-546-9164 barbara.maddox@vancouver.wsu.edu

WSU NURSING STUDENT PASSPORT

Name _____ ID# _____

Program _____ **Campus** _____

Database last updated: (for WSU staff) _____

TB Tuberculin Skin Testing

Documentation of Two-Step TST: Date _____ Date _____ **OR**

QuantiFERON (QFT) Date _____

OR if Positive TB Lab testing

Negative chest X-ray Date _____ **OR** Negative Symptom Check Date _____

Hepatitis A

Vaccination Dates: 1) _____ 2) _____ **OR**

Immunity confirmed by titer: Date _____ **OR**

Signed waiver Date _____

Hepatitis B

Vaccination Dates: 1) _____ 2) _____ 3) _____

Immunity confirmed by titer Date _____

Signed waiver Date _____

MMR (Measles, Mumps, Rubella)

Vaccination Dates: 1) _____ 2) _____ **OR**

Immunity confirmed by titers (dates):

Measles _____ Mumps _____ Rubella _____

Varicella (Chicken Pox)

Vaccination Dates: 1) _____ 2) _____ **OR** Immunity confirmed by titer (date): _____

Tetanus, Diphtheria, Pertussis (Tdap)

Date of immunization: _____ (good for 10 years)

Influenza

Proof of annual vaccination (date): _____ **OR** Signed waiver (date): _____

Nursing License

WA RN License Number (required) _____ Expires _____

Other RN License Number (optional) _____ Expires _____

CPR Health Care Provider Certification

Expiration Date _____

WSU Professional Student Liability Insurance Policy

Expiration date: _____ *Form enclosed - good for one academic year Sept 1—Aug 31*

Total Clinical Placement System Annual Online Orientation

Date Completed _____

Background Check Date Submitted _____

10 panel Urine Drug Screen (Vancouver students only) Date _____

Appendix G – State of Oregon Health Care Workforce Committee SR 879 Workgroup Report and CAA Standards Materials

G1. Workgroup Report
G2. Updates and Quick Reference Guide
G3. Oregon Administrative Rules Chapter 409-030

G1. Workgroup Report

Oregon Health Care Workforce Committee
SB 879 Workgroup

Recommendations for the
Oregon Health Policy Board

June 30, 2012

I. Introduction

In its 2010 report to the Oregon Health Policy Board, the Healthcare Workforce Committee (Workforce Committee) recommended standardization of student background requirements for clinical training (drug testing, criminal background check, HIPAA training, etc.). SB 879 (2011) directed the Oregon Health Authority, in collaboration with the Oregon Workforce Investment Board, to convene a Workgroup to develop these standards and to report back to the Oregon Health Policy Board and the Legislature. A copy of SB 879 is included with this report.

SB 879 specified that:

- The standards must apply to students of nursing and allied health professions, at a minimum, and may apply to students of other health professions;
- The standards must pertain to clinical training in settings including but not limited to hospitals and ambulatory surgical centers;
- The Workgroup shall make recommendations for standards and for initial and ongoing implementation of those standards. The authority [OHA] may establish by rule standards for student placement in clinical training settings that incorporate the standards developed under this section and approved by the Oregon Health Policy Board.
- The Oregon Health Authority must report to an interim legislative committee related to health on Workgroup progress on or before June 30, 2012.

Over the past several months, the Workforce Committee convened three large stakeholder meetings to identify what is currently working well and what is not, to develop a draft list of standard requirements, to consider options for implementing the standards, and to develop a system to track compliance with the standards. Participants in those meetings included representatives from:

- Universities, community colleges, and proprietary schools with health care professional educational programs;
- Hospitals and health systems (student placement or residency coordinators as well as legal or risk management departments);
- A wide range of disciplines including nursing, medicine (physician and physician assistant programs) PT, OT, lab and imaging technology, and medical assisting;
- Other interested parties such as licensing boards, the Oregon Center for Nursing, and the Oregon Primary Care Association.

See Appendix A for a full list.

A preliminary set of recommendations was produced in May and presented to the Senate Health, Human Services, and Rural Health Policy Committee during interim legislative days in that month. In late May and early June, stakeholders who had participated in the Workgroup process were asked to review the material and to solicit feedback from their colleagues and their organizations' leadership. Many groups responded and their comments have been

incorporated into this report as part of the recommendations or--in the case of specific operational details--as notes of issues to be finalized in implementation.

This brief report describes the issue and key questions related to standardization and outlines the Workgroup's recommendations for a set of common requirements and their implementation. The final section addresses the next steps that the Workforce Committee believes are necessary to move the standards forward.

II. Background and Approach

The Workforce Committee initially recommended that clinical placement requirements be standardized because the inconsistencies that currently exist across health care organizations increase students' education expenses and create costly inefficiencies for schools and clinical sites. The demand for clinical experiences already threatens to exceed the supply, so streamlining the process for everyone involved would help to increase capacity. Testimony provided while the bill was being considered in the Legislature expressed the urgent need for and benefits of standardization:

> *"Because educational institutions enter into contractual agreements with each clinical site, sometimes for each program at each clinical site, we are obliged to manage literally hundreds of contracts that may have differing pre-placement requirements for students in need of clinical training. One year we reviewed a clinical education contract that involved 4 health professions programs. We began to review the contract 4 weeks in advance of the expiration date. Pre-placement requirements (trainings, immunizations, drug screenings, etc.) were among the issues that required review and negotiation. It took 4 months to resolve the pre-placement requirements issue and involved 37 email threads, 3 faculty members, 5 staff members, 1 director of legal affairs and 1 executive dean."* ***Ann E. Barr PT, DPT, PhD Executive Dean and Vice Provost at Pacific University***

> *From a student's perspective, the varied requirements are confusing and often frustrating. Students wait from one to six months and spend between $100 to $200 on the appropriate set of immunizations, drug tests, and background checks in order to become eligible to attend clinical training at one hospital or clinic. Then, when a student is rotated to another site, he or she once again could wait one to six months and possibly spend another $100 to $200 on another set of required checks and tests. Each time, a student moves, the process begins again."* ***Ann Malosh, M.Ed, Dean, Business, Healthcare, and Workforce, Linn Benton Community College***

> *"This bill has the potential to not only reduce administrative costs across Oregon's health care system by eliminating duplication, but it will also contribute to laying the necessary groundwork to expand Oregon's training capacity, which is an essential*

aspect of meeting Oregon's future health care workforce needs." ***Mark A. Richardson MD, MBA, Dean of OHSU School of Medicine***

The Workgroup formed to address these issues agreed that ensuring patient and student safety should be the priority. In undertaking their task, the Workgroup's approach was to value simplicity and to attempt to develop efficient solutions that would benefit all three constituencies: students, schools, and clinical facilities.

III. Key Questions and Recommendations

In the course of their meetings, participants in the SB 879 Workgroup process addressed four questions:

- What should the standards be?
- To whom should they apply?
- How should the standards be implemented?
- How should students' compliance with the standard requirements be tracked?

Key considerations and the Workforce Committee's recommendations on each are described below.

Standards

➢ The recommended standards address immunizations, screenings, training, and other topics (liability, health insurance, etc.), as well as the timing for these standards. See Table 1 for the specific recommendations in each area.

As noted in the Table, some operational details remain to be finalized, e.g. the particular list of sources that should be checked and types of offenses that should be considered as part of a criminal background check. Workgroup participants suggested the Department of Human Services' criminal background check process as the best starting point, but this and a few other details should be settled during planning for implementation of the standards (see *Implementation* below).

In addition to trying to identify specific standards that would be broadly acceptable, participants in the Workgroup process wrestled with the key question of whether the standards should be considered a floor or a ceiling. Setting standards as a floor would allow each clinical facility to add their own requirements on top; many stakeholders felt strongly that this would replicate the problem the group was trying to solve. On the other hand, several noted that setting the standards as a ceiling could put clinical sites in a difficult situation if updated guidelines are subsequently issued by regulatory and accrediting agencies.

➢ The recommendation of the Workforce Committee is that the standards be implemented as a ceiling for the relevant professions and settings (see *Applicability* below) but that a process be developed to update the standards in a timely manner in response to significant changes. This

process may include an automatic incorporation of guidance issued by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), or other relevant bodies (see *Implementation* below).

Applicability

SB 879 specifics that, at a minimum, the standards should pertain to nursing and allied health students doing clinical placements in hospitals and ambulatory surgical center settings. However, the bill allows the standards to apply more widely and the draft recommendations were developed by a much broader range of stakeholders.

➢ The Workforce Committee recommends that the standards apply to any student with clinical or therapeutic contact with patients in a health care setting. Specifically, the standards should apply to students of these professions (whose clinical placement meets the definition above):

- Medicine (including Physician Assistants)
- Nursing
- Physical and Occupational Therapy
- Pharmacy
- Dentistry and Dental Hygiene
- Mental health and addictions treatment
- Allied health (e.g. respiratory therapists, phlebotomists, medical assistants, etc.

And the standards should apply to students working in the following settings, when their work/internship involves clinical contact:

- Hospitals
- Ambulatory care centers and offices
- Long term care settings, including but not limited to nursing facilities, assisted living, and residential care
- Hospice

Note that Department of Veterans' Affairs (VA) facilities are explicitly excluded from this list because their standards for student clinical placement are set at the federal level. However, representatives from the Portland VA participated in the SB 879 Workgroup and the proposed standards are largely consistent with the VA's requirements.

➢ Based on stakeholder input, the Committee recommends that the standards allow for exceptions when students are placed in a facility or setting where the employed professionals do not have similar requirements. The need for this was raised in the context of behavioral health professions students (e.g. social work, psychology), whose level of clinical patient contact varies, but the exception may be relevant for others as well.

➢ The Committee is *not* suggesting that the proposed standards extend to students who will not have direct patient contact as part of their internship or placement. Under most circumstances, this would include students in programs for health management or administration, clinical informatics, research, and medical transcription, among others. While

some facilities may require students from these fields to meet one or two of the prerequisites (e.g. a background check), the standards were not developed with non-clinical students in mind. Similarly, the standards are not intended to apply to research or medical services settings (e.g. a clinical research laboratory or a blood bank). Finally, the standards are not intended to supersede requirements that apply to specialty services (e.g. requirements set by the Nuclear Regulatory Commission for students involved in radiosurgery).

In more than one meeting, Workgroup participants discussed to what extent the standards should apply to students enrolled in out-of-state training programs who do clinical placements in Oregon. These students include Oregon residents enrolled in online programs or attending schools just across state lines in Washington, Idaho, or California, as well as non-Oregon residents who want to come to Oregon for clinical rotations. The question is an important one because distance learning programs are growing rapidly and are creating additional demand for limited clinical placement sites in Oregon. Anecdotally, participants in the Workgroup process relayed that some distance programs to do not assist their students to obtain clinical placements or supervise them adequately while they are in place.

➢ The Workforce Committee recommends that the standards apply to *all* students seeking clinical placements in Oregon, including those enrolled in out-of-state schools or distance training programs. This consistency should benefit both host facilities and students. The question of how to incorporate verification and tracking for out-of-state students is one that should be addressed during implementation planning.

Implementation

The third key question addressed by the Workgroup was how to secure agreement with and use of the proposed standards. Stakeholders discussed a range of options, from voluntary adoption to compliance enforced via statute. In general, the group felt that voluntary adoption would not address the problem effectively and that statutory enforcement would be unnecessarily heavy-handed.

➢ The Workforce Committee recommends that the standards be articulated in administrative rule by OHA, as provided by SB 879. The effective date of the rules should be far enough in the future that training programs and clinical sites have time to amend their entry requirements and contracts as needed (e.g. effective for students admitted as of September 2014). As emphasized under *Applicability* above, the administrative rules must include a process by which the standards can be re-considered and updated in a timely manner when regulatory or accrediting bodies issue new guidance. This process may include an automatic incorporation of guidance issued by TJC, the CDC, or other relevant bodies.

Tracking

Documenting and communicating that each student has satisfied the prerequisites for clinical placement currently creates a significant workload for students, schools, and clinical sites.

Many schools and institutions employ full-time placement coordinators to facilitate the process. In some areas, systems have been developed to centralize this tracking and facilitate scheduling of clinical placements, such as StudentMAX in the Portland metro area for nursing students (now expanding beyond nursing) or the Student Health Professional Scheduler offered by the Area Health Education Center of Southwest Oregon. Participants in the SB 879 Workgroup process debated the merits of a range of tracking options and identified two primary candidates:

1. A common format checklist or other high-level paper document (e.g. a "passport") that attests to students' good standing; or
2. A passport along with a centralized, web-accessible database that allows students and schools to upload relevant source documents (e.g. proof of immunization). The database would have to be built with appropriate safeguards for information security and only allow clinical sites to view source documents with students' permission.

The benefits of a centralized database are many: it would reduce the exchange of paperwork between schools and clinical sites; facilitate access to the primary source documentation that clinical sites are increasingly demanding; and would allow students who transfer between schools or who continue on to a second degree to preserve their information. Many Workgroup participants argued that a centralized database would be essential for an effective system. It was widely acknowledged, however, that the cost of creating and maintaining a centralized database, even one built on top of an existing system, was a significant logistical barrier. A centralized database has the potential to create savings in the long term by simplifying contractual negotiations, facilitating communication, and reducing duplication but would require an up-front investment and an ongoing operating budget. Cost aside, some participants also expressed concern about the security of confidential information and how to incorporate students coming from out-of-state programs.

➢ While recognizing the value of a centralized database and urging stakeholders to conduct a financial feasibility study, the Workforce Committee recommends a simpler, paper-based "Passport" tracking system initially. Schools would continue to verify source documents and would issue a common format passport to students in good standing. With the student's permission, schools could release copies of the source documentation to clinical sites upon request.

IV. Next Steps

The Healthcare Workforce Committee respectfully submits the draft recommendations in this report to the Oregon Health Policy Board for review and feedback. If the Board agrees with the substance of the recommendations, the Committee would suggest the following as next steps:

1. OHA convenes a Rules Advisory Committee and develop the administrative rules necessary to implement the common standards. As noted, the effective date of the standards should allow all constituencies adequate time to prepare. The rules should

address the details that were not finalized by the SB 879 Workgroup (e.g. particular elements of a criminal background check) and specify when and how the standards can be updated in response to national and regional guidelines or issues identified by Oregon institutions.

By default, the process of administrative rule development includes notification of interested parties and opportunities for public comment. The Committee suggests that these be expanded in this case to encourage participation from stakeholders who may not have engaged in the SB 879 Workgroup.

2. Stakeholders commission a small feasibility study for a self-sustaining, centralized database to track and document students' satisfaction of the prerequisites. The study should estimate the expenses incurred now by students, schools and clinical sites, the degree to which use of common standards and a centralized database could be expected to reduce those expenses, and the cost of building and maintaining a database.

Table 1. Standards that health professions students should meet before clinical placements

Developed for the Oregon Health Policy Board by the Oregon Healthcare Workforce Committee

June 2012

Standard	Timing	Notes
Immunizations (documented receipt of vaccine or documented immunity via titer or valid history of disease)		
Hepatitis B (Hep B)	Per CDC guidelines	
Measles, mumps and rubella (MMR)		
Tetanus, diphtheria, pertussis (Tdap)	Per CDC guidelines	
Varicella		
Recommended -- Influenza (seasonal flu)		Follow state law requirements[1]/recommend mask or other precaution if not immunized
Recommended -- Polio		CDC recommends for health care workers with special conditions (i.e., pregnant, diabetic, etc.)
Screenings		
Tuberculosis (TB)	Before first placement; after that only in case of known exposure	Facility choice of skin test or Quantiferon Gold
Substance Abuse - 10-panel drug screen as minimum, *unless profession requires more (e.g. BOP intern license)*	Matriculation contingent on acceptable drug screen results; subsequent screens only for cause	School/training program should verify that screening is performed by a reputable vendor
Criminal Background Check - E.g. local and national criminal search, OIG provider exclusion list, sex offender registry, etc.	Matriculation contingent on acceptable criminal background check results	Elements of check should be standardized (see at left) and check should be performed by a reputable vendor, criteria TBD.
Training		
Basic Life Support (BLS) for health care providers	Before first placement; maintain current certification during placement	Recommend American Heart Association training
Bloodborne Pathogen training (OHSA)		
Site-specific privacy and confidentiality practices	With *each* placement	
Site-specific orientation (facility-specific protocols for safety, security, standards of behavior, etc.)		
Other		
Professional liability	Prior to clinical rotation	Students are typically covered by school
General liability		Students are typically covered by school
Non-disclosure agreement		
Current health insurance (or coverage via Workers' Compensation insurance extended to students by school)		

Appendix A
Stakeholders Consulted

Participated in one or more meetings:

Lucy Andersen	Northwest Permanente, P.C.
Jen Baker	Oregon Nurses Association
Jo Bell	Department of Community Colleges and Workforce Development
Jana Bitton	Oregon Center for Nursing/Student Max
Peg Bodell	Legacy Good Samaritan
Debra K. Buck	Oregon State Board of Nursing
Michelle Cooper	Portland VA Medical Center
John Custer	Legacy Health Systems
Denise Dallman	Carrington College
Marcia Decaro	OHSU
Jennifer Diallo	Oregon Student Assistance Commission
Deb Disko	Oregon Institute of Technology
Amy Doepken	Legacy Health Systems
Michelle Eigner	OHSU
Mark H Ellicott	Portland VA Medical Center
Vicki Fields	OHSU
Jesse Gamez	FamilyCare
Leslie Gonzales	Carrington College
Jalaunda Granville	Oregon Primary Care Association
Weston Heringer, Jr.	Oregon Dental Association
Felicia Holgate	Oregon Occupational Therapy Licensing Board
Kim Ierian	Concorde Career College
Joy Ingwerson, RN	Oregon State Board of Nursing
Jo Johnson	Office of Rural Health
Carlie Jones	Sumner College
Julie Kates	Portland State University
Jenny Kellstrom	Oregon Institute of Technology
Troy Larkin	Providence Health & Services
Donna Larson	Mt. Hood Community College
Ann Malosh	Linn-Benton Community College
Linda Meyer	OHSU

Teresa Moeller	Breckenridge School of Nursing
Judy Ortiz	Pacific University
Skip Panter	Samaritan Health Services
Sandra Pelham Foster	Pacific University
Launa Rae Mathews	OHSU Juancho
Ramirez	OSU/OHSU
Rebecca Reisch	Pacific University
Mary Rita Hurley	Oregon Center for Nursing
Pamela Ruona	Oregon Health Care Association
Karan Serowik	Heald College
Leslie Soltau	Samaritan Lebanon Community Hospital
John Thompson	Providence Health & Services
Kirt Toombs	Eastern Oregon Center for Independent living (EOCIL)
Linda Wagner, RN, MN	Rogue Community College
Greg White	Oregon Workforce investment Board
Anne Wilson	Legacy Health Systems
Saydee Wilson	Pioneer Pacific College
Marina L. Yu	Legacy Health Systems

Received meeting materials, summaries, and other review material

Ann Barr	Pacific University
Nancy Bensen	Tuality Healthcare
Alisa Beymer	Sacred Heart Medical Center
Jan Brooke	PeaceHealth
Genevieve Derenne	Providence Health & Services
Julie Ebner	Providence Health & Services
Coleen Fair	Samaritan Lebanon Community Hospital
Ilene Gottesfeld	ITT Technical Institute
Jennifer Hanson	Kaiser Foundation Health Plan
Connie Hector	Douglas County Educational Service District
Diana Kimbrough	Providence Health & Services
Linda Lang	Oregon Association of Hospitals and Health Systems
Karen MacLean	Oregon Board of Pharmacy
Susan Mahoney	Tuality Healthcare
Sue Naumes	Rogue Community College

Patty O'Sullivan	Oregon Association of Hospitals and Health Systems
Matthew Schmoker	Carrington College
Elaine Seyman	Everest College
Roxanne Stevens	Pioneer Pacific University
Judy Tatman	Providence Health & Services
Amparo Williams	Providence Health & Services

Enrolled
Senate Bill 879

Sponsored by Senators MONNES ANDERSON, WINTERS

CHAPTER .....

AN ACT

Relating to administrative requirements for student placement in clinical training settings; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) The Oregon Health Authority, in collaboration with the State Workforce Investment Board, shall convene a work group to develop standards for administrative requirements for student placement in clinical training settings in Oregon. The work group may include representatives of:

(a) State education agencies;

(b) A public educational institution offering health care professional training;

(c) Independent or proprietary educational institutions offering health care professional training;

(d) An employer of health care professionals; and

(e) The Health Care Workforce Committee established under ORS 413.017.

(2)(a) The work group shall develop standards for:

(A) Drug screening;

(B) Immunizations;

(C) Criminal records checks;

(D) Health Insurance Portability and Accountability Act orientation; and

(E) Other standards as the work group deems necessary.

(b) The standards must apply to students of nursing and allied health professions. The standards may apply to students of other health professions.

(c) The standards must pertain to clinical training in settings including but not limited to hospitals and ambulatory surgical centers, as those terms are defined in ORS 442.015.

(3) The work group shall make recommendations on the standards developed under this section and the initial and ongoing implementation of the standards to the Oregon Health Policy Board established in ORS 413.006.

(4) The authority may establish by rule standards for student placement in clinical training settings that incorporate the standards developed under this section and approved by the Oregon Health Policy Board.

SECTION 2. The Oregon Health Authority shall report on the progress of the work group convened under section 1 of this 2011 Act to an interim legislative committee related to health on or before June 30, 2012.

SECTION 3. Section 2 of this 2011 Act is repealed on January 1, 2013.

SECTION 4. **This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.**

Passed by Senate April 5, 2011

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Robert Taylor, Secretary of Senate

.....
Peter Courtney, President of Senate

Passed by House May 11, 2011

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Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Received by Governor:

.....M.,....., 2011

Approved:

.....M.,....., 2011

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2011

.....
Kate Brown, Secretary of State

G2. Updates and Quick Reference Guide

Important updates for hospitals, clinics, and other entities that provide clinical training opportunities for students

If your facility provides clinical training opportunities for students in the health professions (e.g., those training to become nurses, medical assistants, physicians, etc.), please review the following for information on the new standardized administrative requirements established under Oregon Administrative Rules 409-030-0100.

Beginning July 1, 2014, health profession students will need to meet a standardized, universal set of administrative requirements prior to doing clinical training in Oregon. For most students, satisfying the requirements once will be sufficient for all subsequent clinical training experiences. The requirements include immunizations, screenings, trainings, and proof of coverage under insurance policies (see the attached Quick Reference Guide) and will replace any similar requirements that each facility had previously established. The consensus requirements were developed with input from a wide range of training programs, clinical sites, and regulatory agencies.

The hope is that with these standardized requirements, your facility will be able to reduce the administrative burden that comes with training students in a clinical setting. Students and health profession programs will be clear about the basic expectations prior to any training experiences, you can expect consistent preparation of the requirements across all programs, and less time will be needed to review requirements and negotiate with or educate the health profession programs on your specific requirements.

Record keeping
Each health profession program (e.g., college or training program) will be responsible for verifying and maintaining the evidence and documentation of the administrative requirements for each student, with documents available to you at your request. Out-of-state students are also subject to these rules, and efforts are being made to notify programs nationwide of the requirements for Oregon students.

Completion of the administrative requirements only ensures administrative clearance for students. Your facility will still make all final clearance and placement decisions.

Setting additional requirements
If you are responsible for reviewing students' administrative requirements, please note that you cannot set additional requirements within the categories covered under the new standard requirements. For example, you cannot require proof of an immunization that is not listed in the requirements or require that students utilize a 12-panel drug screen instead of a 10-panel drug screen. However, any in-house preparations for students or unique onboarding procedures, trainings or orientation sessions at your facility can continue.

In rare and extenuating circumstances (e.g., a public health emergency situation, such as an outbreak that requires a new or different vaccination) your facility may temporarily institute a site-specific variation or change to a standard requirement, provided that you notify all affected parties and the Oregon Health Authority in advance of any changes. Once instituted, a change or variation will remain in place until next annual review of the rules, at which point a decision will be made to spread the change or variation to all students at all facilities, or to strike down the change.

Exemptions for clinical sites
A number of facilities have requirements that are set at the federal level (e.g., Department of Veterans' Affairs facilities) or are otherwise separately developed (e.g., state prisons and correctional facilities).

Students wishing to do a clinical rotation at those sites will need to meet the administrative requirements set forth by those facilities. Please see the attached Quick Reference Guide.

Additionally, if your facility has fewer or less stringent requirements for newly hired, non-student employees, you may be able to request an exemption from specific categories of these rules. For example, if you do not require a new hire at your facility to complete a background check, you may request an exemption from the rules so that students do not have to complete a background check either. However, students would still need to follow these requirements for the other categories (immunizations, trainings, and evidence of insurance policies). If you think you may qualify, please follow the steps in OAR 409-030-0150 to submit a written request.

Affected students

These new requirements apply to students training in the selected professions who are participating in clinical training experiences at an off-site facility that is listed in these rules (see attached Quick Reference Guide for details on both). Out-of-state students are also subject to these rules, and efforts are being made to notify programs nationwide of the requirements for students doing clinicals in Oregon.

Requirements for instructors

It is up to you to determine if you will require instructors from the health profession program who physically accompany students during clinical training at your facility to abide by these rules as well. However, you cannot require instructors to meet requirements that are above and beyond those listed in the rules (e.g., additional immunizations or a more extensive background check).

Background

As dictated in SB 879 (2011), the standardized set of administrative requirements was determined through a comprehensive and extensive process that involved experts, a wide variety of stakeholders, and public input. The intention of SB 879 was: to mitigate inconsistencies that currently exist across clinical facilities; to promote efficient solutions to reduce costs for students, health profession programs and clinical facilities; and to ensure patient, clinical staff and student safety.

For more background information, including a list of FAQs, please visit: http://www.oregon.gov/oha/OHPR/Pages/sct.aspx.

If you have additional questions, please email: Clinical.TrainingReq@state.or.us

Oregon Administrative Requirements for Health Profession Students
Quick Reference Guide

Facilities:

Clinical facilities that must accept the standardized administrative requirements include:

- Ambulatory care settings (e.g., clinics, private practices, FQHCs, and primary care homes)
- Ambulatory surgical centers
- Hospice settings
- Hospital and emergency departments
- Long term care facilities
- Residential care facilities
- Skilled nursing facilities

Clinical facilities that are exempt from these rules include:

- chiropractic, acupuncture, and massage therapy clinics
- federal facilities, including Department of Veterans' Affairs, Indian Health Service facilities, and federal prisons
- health management or administrative departments;
- public elementary and secondary schools (grades K-12);
- radiosurgery clinical placements
- state prisons and correctional facilities

Students:

Students in the following health professions must complete the requirements prior to undergoing any clinical training.

- Audiologists
- Clinical laboratory science specialists, including medical technologists, clinical lab scientists, medical lab technologists, and clinical lab assistants
- Dental hygienists
- Dentists and dental assistants
- Denturists
- Dieticians
- Emergency medical services providers
- Hemodialysis technicians
- Marriage and family therapists
- Medical assistants
- Medical imaging practitioners and limited x-ray machine operators
- Nurses, including registered nurses, practical nurses, advanced practice nurses, nurse practitioners, nursing assistants, medication aides and any other licensed assistive nursing personnel
- Occupational therapists and occupational therapy assistants
- Optometrists
- Pharmacists and pharmacy technicians
- Physical therapists, physical therapist aides, and physical therapist assistants
- Physician assistants
- Physicians (Medical/Osteopathic and Naturopathic)
- Podiatrists
- Polysomnographic technologists
- Professional counselors
- Psychologists
- Regulated social workers
- Respiratory care practitioners
- Speech-language pathologists and speech-language pathologist assistants
- Surgical technologists

List of Administrative Requirements:
For additional information, documentation requirements, and exceptions please see Oregon Administrative Rules 409-030-0100 to 409-030-0250.

Immunizations:
Evidence requires documented receipt of vaccine or documented immunity via titer or valid history of disease, or a record from the Oregon ALERT Immunization Information System. Per CDC guidelines.

- ✓ *Required* Hepatitis B (Hep B)
- ✓ *Required* Measles, mumps and rubella (MMR)
- ✓ *Required* Tetanus, diphtheria, pertussis (Tdap)
- ✓ *Required* Varicella
- ✓ *Recommended* Polio
- ✓ *Recommended* Influenza (seasonal flu)

Screenings:

- ✓ Tuberculosis (TB)
  - Facility choice of skin test or IGRA Blood test in accordance with CDC guidelines
- ✓ Substance Abuse
  - 10-panel drug screen, which must include screens for the following eight substances: Amphetamines, including methamphetamines; Barbiturates; Benzodiazepines; Cocaine; Marijuana; Methadone; Opiates; Phencyclidine.
- ✓ Criminal Background Check:
  - Must include Social Security Number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check.

Trainings:

- ✓ CPR/Basic Life Support (BLS) for health care providers. It is recommended that trainings comply with the American Heart Association standard
- ✓ Blood borne Pathogen training (OSHA)
- ✓ OSHA-recommended safety guidelines, including the following. Schools must verify student familiarity or exposure to topics:
  - Fire and electrical safety;
  - Personal protective equipment;
  - Hazard communications; and
  - Infection prevention practices.
- ✓ *Site-specific* privacy and confidentiality practices. Will occur at EACH facility.
- ✓ *Site-specific* orientation and on-boarding. For example, facility-specific protocols for safety, security, standards of behavior, etc. Will occur at EACH facility.

Insurance and Liability Coverage:
Students or health profession programs must demonstrate that students have:

- ✓ Professional liability insurance coverage and general liability insurance coverage, or
- ✓ A combined policy that includes professional and general liability coverage

The coverage must remain in place for the entire duration of each placement. The health profession program may offer coverage for students through a self-insurance program or the student may obtain coverage individually. It is also recommended but not required that the student obtain some form of health insurance coverage.

G3. Oregon Administrative Rules Chapter 403-090

OREGON HEALTH AUTHORITY,
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

DIVISION 30
ADMINISTRATIVE REQUIREMENTS FOR HEALTH PROFESSION STUDENT CLINICAL TRAINING

409-030-0100
Purpose

These rules (OAR 409-030-0100 to 409-030-0250) establish standards for administrative requirements for health professional student placements in clinical training settings within the state of Oregon. The purpose of these rules is to mitigate inconsistencies that currently exist across clinical placements; to promote efficient solutions to reduce costs for students, health profession programs and clinical placement sites; and to ensure patient, clinical staff and student safety. These rules pertain to credentials that students must obtain and requirements that clinical placement sites may set. These rules are effective July 1, 2014.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0110
Definitions

The following definitions apply to OAR 409-030-0100 to 409-030-0250:

(1) "Administrative requirements" means those requirements that must be documented and verified before health professions program students may begin clinical placements, and includes criminal background checks, drug testing for substance abuse, health screenings, immunizations, and basic training standards.

(2) "Advanced practice nurse" means nursing practice areas inclusive of nurse practitioners, nurse midwives, clinical nurse specialists, and nurse anesthetists.

(3) "Authority" means the Oregon Health Authority.

(4) "CDC" means the federal Centers for Disease Control and Prevention.

(5) "Clinical placement" means any clinical rotations, internships, residencies, fellowships, and any other clinical training experience that a student undergoes as part of their health professions program.

(6) "Clinical setting" or "clinical site" means the clinical facility at which a student undergoes training during a clinical placement.

(7) "Direct contact with patients" means clinical or therapeutic interaction with a patient, in a one-on-one or group setting at the clinical placement setting or an associated location, including but not limited to meetings, examinations, or procedures.

(8) "Evidence of Immunization" means a statement signed and dated by a licensed practitioner who has within the scope of the practitioner's license the authority to administer immunizations or a representative of the local health department certifying the immunizations the student has received.

(9) "For cause" means that the behavior of a student or instructor gives the health profession program or clinical site reason to believe that the individual is not complying with established standards set forth in these rules.

(10) "Health profession program" means a post-secondary course of study that concentrates on a health profession discipline as described in OAR 409-030-0130 and offers students instruction and training for becoming a health care professional.

(11) "Immunization" means receipt of any vaccine licensed by the United States Food and Drug Administration or the foreign equivalent for the prevention of a disease; proof of immunity to the disease via titer; or confirmed history of the disease.

(12) "Individually identifiable health information" has the meaning given that term in ORS 433.443.

(13) "Instructor" means a teacher, trainer, or advisor on the faculty of the educational institution who is overseeing a student onsite during clinical training on behalf of the training program which the student attends. The degree of involvement of instructors in a student's clinical training experience may vary between programs, and may include but is not limited to observation, demonstration of technique, modeling of behavior, and regular feedback.

(14) "Licensed independent practitioner" means an individual permitted by Oregon law to independently provide care and services, without direction or supervision, within the scope of the individual's license.

(15) "Matriculated" means to be enrolled or registered for classes, as a student.

(16) "Patient" means an individual who is seeking care, guidance or treatment options at a clinical location.

(17) "School" or "educational institution" means the post-secondary college, university or other training program in which the student is matriculated for a health professions program.

(18) "Student" means an individual enrolled as a student or registered for a post-secondary school or training programs required minimum credit hours in an accredited health professions program of study.

(19) "Supervisor" means a staff member at a clinical facility who is delegated to provide supervision, to monitor student performance and to provide feedback to the student and the clinical educator and other educational training program faculty.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0120
General applicability

(1) These rules apply to all students who:

(a) Plan to undergo clinical training at a setting listed in OAR 409-030-0140 within the state of Oregon; regardless of the location of the health profession program in which the student is matriculated;

(b) Concentrate on a health professional discipline listed in OAR 409-030-0130;

(c) Have direct contact with patients at any point during the clinical placement; and

(d) Are matriculated into and currently enrolled in a health professional training program as described in OAR 409-030-0130.

(2) Clinical sites may require instructors from the health profession program to satisfy the same requirements for immunizations, screenings, trainings, and other requirements set forth in these rules, if the instructor accompanies students onsite during clinical training and engages in direct contact with patients on behalf of or in support of the student.

(3) Except as provided in OAR 409-030-0150, covered clinical sites may not create additional or more stringent administrative requirements within the categories addressed by these rules for students and instructors covered by these rules.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0130
Health Professional Disciplines

(1) Except as provided in OAR 409-030-0150, these rules apply to students of the following health professions:

(a) Audiologists, as defined in ORS 681.205;

(b) Clinical laboratory science specialists, including medical technologists, clinical lab scientists, medical lab technologists, and clinical laboratory assistants, as defined in ORS 438.010;

(c) Dental hygienists, as defined in ORS 679.010;

(d) Dentists and dental assistants, as defined in ORS 679.010;

(e) Denturists, as defined in ORS 680.500;

(f) Dieticians, as defined in ORS 691.405;

(g) Emergency medical services providers, as defined in ORS 682.025;

(h) Hemodialysis technicians, as defined in ORS 688.635;

(i) Marriage and family therapists, as defined in ORS 675.705;

(j) Medical assistants (trained medical office and ancillary health care personnel who perform clinical tasks such as taking vital signs, preparing patients for examinations, or recording medical histories of patients, administrative duties, and other duties);

(k) Medical imaging practitioners and limited x-ray machine operators, as defined in ORS 688.405;

(l) Nurses, including registered nurses, practical nurses, advanced practice nurses, nurse practitioners, nursing assistants, medication aides and any other assistive nursing personnel licensed or certified under ORS 678.010 to 678.445;

(m) Occupational therapists and occupational therapy assistants, as defined in ORS 675.210;

(n) Optometrists, as described in ORS 683.010 to 683.310.

(o) Pharmacists and pharmacy technicians, as defined in ORS 689.005;

(p) Physical therapists, physical therapist aides, and physical therapist assistants, as defined in ORS 688.010;

(q) Physician assistants, as defined in ORS 677.495;

(r) Physicians (Medical/Osteopathic and Naturopathic), as defined in ORS 677.010 and 685.010;

(s) Podiatrists, as defined in ORS 677.805;

(t) Polysomnographic technologists, as defined in ORS 688.800;

(u) Professional counselors, as defined in ORS 675.705;

(v) Psychologists, as defined in ORS 675.010;

(w) Regulated social workers, as defined in ORS 675.510;

(x) Respiratory care practitioners, as defined in ORS 688.800;

(y) Speech-language pathologists and speech-language pathologist assistants, as defined in ORS 681.205; and

(z) Surgical technologists (allied health professionals under the supervision of a surgeon who are trained in advanced sterile techniques and theories and facilitate safety throughout the operative procedure).

(2) These rules do not apply to students engaged in a field of study that is not explicitly listed in section (1). Academic institutions and clinical placement settings should individually negotiate the terms of placement for students not covered by these rules. Clinical facilities may choose to require that such students follow the standards set forth in these rules but are not required to do so.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0140
Clinical Settings

(1) Except as provided in section OAR 409-030-0140 (2) and 409-030-0150, these rules apply to the following clinical facilities hosting health professions students in the disciplines described in OAR 409-030-0130:

(a) Ambulatory care settings, including but not limited to clinics, private practices, Federally Qualified Health Centers, and primary care homes;

(b) Ambulatory surgical centers, as defined in ORS 442.015;

(c) Hospice, as defined in ORS 443.860;

(d) Hospitals and emergency departments, as defined in ORS 442.015;

(e) Long term care facilities, as defined in ORS 442.015;

(f) Residential care facilities, as defined in ORS 443.400; and

(g) Skilled nursing facilities, as defined in ORS 442.015.

(2) In addition to the exceptions provided in OAR 409-030-0150, these rules do not apply to the following clinical facilities hosting health professions students in the disciplines described in OAR 409-030-0130 for a clinical placement:

(a) Chiropractic, acupuncture, and massage therapy clinics or offices that are independent and not associated with a clinical placement setting listed in OAR 409-030-0140 (1).

(b) Federal facilities, including Department of Veterans' Affairs facilities, Indian Health Service facilities, and federal prisons. Standards for clinical placement in federal facilities are set at the federal level.

(c) Health management or administration departments.

(d) Public elementary and secondary schools (grades K-12).

(e) Radiosurgery clinical placements. The Nuclear Regulatory Commission sets requirements for students involved in radiosurgery.

(f) State prisons and correctional facilities.

(3) Completion of the administrative requirements in these rules only ensures administrative clearance for students. Clinical placement settings shall make all final clearance and placement decisions.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0150
Exceptions

(1) In addition to the exceptions listed in OAR 409-030-0130 (2) and 409-030-0140 (2), the standards in these rules does not apply to:

(a) Students who will not have direct patient contact as part of their clinical placement.

(b) Students who are undergoing training overseen by their employer, academic institution, or training program at facilities that are located on the premises of or operated solely by the employer, academic institution or training program, or are otherwise considered "in-house" clinics.

(2) Clinical placement sites that have fewer or less stringent administrative requirements for newly hired non-student employees may request exemption from specific provisions of OAR 409-030-0170 through 409-030-0240 for students performing clinical placements at that site. For example, a clinical placement site that does not require regular employees to take a drug screen prior to being hired may request exemption from the section of these rules that require students to take a drug screen prior to being placed at that clinical site. However:

(a) All exemptions must be documented with the Authority prior to implementation of the exemption; and

(b) Clinical placement sites may only request exemptions from the specific category or section of these rules in which their requirements for newly-hired non student employees

are less (such as immunizations, screenings, trainings or other listed in Table 1). Clinical placement sites with an exemption to a specific category of the administrative requirements must still abide by all other sections of these rules.

(3) Exemption requests may be submitted by:

(a) Clinical placement sites; or

(b) Educational institutions, on behalf of and in consultation with the clinical placement sites with which they contract and place students for clinical training.

(4) A request for exemption must include:

(a) The name and mailing address of the clinical placement setting.

(b) The supervisor or manager of student clinical placements on site, and email address and a phone number.

(c) A request for exemption from a specific section of the rules, that includes a description of the clinical placement setting's requirements for newly hired non-student employees, and how they differ from the requirements set forth in these rules.

(5) Clinical placement settings may temporarily institute a site-specific variation or change to a requirement listed in OAR 409-030-0170 through 409-030-0240 in extenuating circumstances including but not limited to a public health emergency situation, such as an outbreak that requires new or different vaccination or a safety breach that requires immediate action, provided that the clinical placement setting clearly notifies all affected parties and the Authority in advance of the changes.

(6) Once instituted, a change or variation of these rule requirements may remain in place at the individual clinical training placement setting until the next annual review of the rules, at which point a decision will be made that:

(a) The change or variation is one mandated by a federal or state regulatory agency and will therefore be incorporated into these rules for all affected clinical placement settings and health profession students; or

(b) The change or variation would improve student and patient safety significantly and should be applied widely to clinical placement settings and health profession students in the state of Oregon, through an amendment to these rules; or

(c) The change or variation is not appropriate for widespread application to clinical placement settings and health professions students in the state of Oregon. In this case, the change or variation may not be re-instated by the clinical placement site after the annual review of the rules.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0160
Regular Review of Clinical Placement Standards

(1) The Authority shall convene an advisory group that may include representatives of affected students, health profession programs, clinical settings, and health care boards that regulate health profession programs. The Authority and the advisory group shall review the standards set forth in sections OAR 409-030-0170 through 409-030-0240 of these rules annually. Affected parties may bring proposed changes to the annual review process.

(2) Standards for immunizations are based on the CDC Advisory Committee on Immunization Practices guidance and other state and federal regulatory bodies overseeing immunization and vaccinations. Rules shall be updated as needed to remain in compliance with suggested vaccination schedules and other recommendations from these regulatory bodies related to the applicable immunizations and screenings listed in Table 1.

(3) State and nationwide criminal background check standards are based on rules determined by authorized state and federal regulatory bodies, including but not limited to the Joint Commission.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0170
Administrative Requirements for Clinical Placement

(1) To qualify for a clinical placement at a covered site within the state of Oregon, covered students must satisfy requirements for each of the following categories prior to the start of the intended placement period. See Table 1 for an expanded list relating to:

(a) Immunizations; and

(b) Screenings;

(c) Trainings; and

(d) Evidence of coverage for professional liability and general liability

(2) Health profession programs and clinical placement settings are not required to pay for or otherwise administer any screenings or tests listed in these rules.

(3) Health profession programs must verify and retain evidence demonstrating that a student has completed all requirements listed in these rules prior to starting a placement for the student at a clinical setting. The health profession program shall provide evidence of completed requirements to clinical sites, as requested.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0180
Immunization Standards

(1) Table 1 lists the diseases and the corresponding required immunizations that students must have in order to receive a clinical placement or the immunizations that students are recommended to have but that are not required in order to receive a clinical placement.

(2) Evidence of immunization may be demonstrated through the following:

(a) A document appropriately signed or officially stamped and dated by a qualified medical professional or an authorized representative of the local health department, which must include the following:

(A) The month and year of each dose of each vaccine received; or

(B) Documentation of proof of immunity to the disease via titer; or

(C) The month and year the diagnosis of the disease was confirmed.

(b) An official record from the Oregon ALERT Immunization Information System.

(3) Individual student exemption to specific immunization requests are possible and must be maintained by health profession programs as part of the overall record of the student. Documentation for exemption requires one or more of the following:

(a) A written statement of exemption signed by a licensed independent practitioner; or

(b) A written statement of religious exemption, signed by the student.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-040-0190
Screening Standards

Table 1 provides detailed information related to required screenings for students' clinical placements. Required screenings consist of:

(1) Tuberculosis (OAR 409-030-0200);

(2) Substance abuse or misuse (OAR 409-030-0210); and

(3) State and nationwide criminal background check (OAR 409-030-0220).

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0200
Tuberculosis Screening

(1) A student must obtain and provide documentation for TB screening consistent with the requirements for immunization in OAR 409-030-0180.

(2) TB screening must be conducted in a manner consistent with the CDC guidelines available at http://www.cdc.gov/tb/topic/testing/ or other state or federal health authority guidelines prior to the start date of the initial clinical placement.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0210
Drug Testing for Substance Abuse and Misuse

(1) A student must undergo a drug test prior to the start date of initial placement at a covered clinical setting. Subsequent drug screenings may not be required except for cause. These rules do not aim to define an "acceptable" result to a drug screen. These rules ensure completion of the administrative requirements necessary for administrative clearance for students. Clinical placement settings shall make all final clearance and placement decisions.

(2) At a minimum, a covered student seeking a clinical placement at a covered clinical site must undergo a standard 10-panel drug test and must sign any necessary authorizations. Screens for the following eight (8) substances must be included in the 10-panel drug screen:

(a) Amphetamines (including methamphetamines)

(b) Barbiturates

(c) Benzodiazepines

(d) Cocaine (e)

Marijuana

(f) Methadone

(g) Opiates, and

(h) Phencyclidine.

(3) All drug testing must be conducted by a laboratory licensed and operated in accordance with ORS 438.010 and OAR 333-024-0305 through 333-024-0350. The health profession program must verify that screening is performed by a reputable vendor.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0220
State and Nationwide Criminal Background Checks

(1) Students must undergo a state and nationwide criminal background check in advance of the start of their initial clinical placements.

(2) These rules do not aim to establish or define the composition of an “acceptable” result to a state and nationwide criminal background check. These rules ensure completion of the administrative requirements necessary for administrative clearance for students. Clinical placement settings shall make all final clearance and placement.

(3) State and nationwide criminal background checks must be:

(a) Performed by a vendor that is accredited by the National Association of Professional Background Screeners (NAPBS); or

(b) Performed by a vendor that meets the following criteria:

(A) Has been in the business of criminal background checks for at least two years;

(B) Has a current business license and private investigator license, if required in the company’s home state; and

(C) Maintains an errors and omissions insurance policy in an amount not less than $1 million; or

(c) Conducted through an Oregon health professional licensing board, if required for students by such Board. (For example students of pharmacy are required by the Oregon Board of Pharmacy to obtain an intern license prior to engaging in clinical training and must undergo a national fingerprint-based background check.)

(4) A criminal records check must include the following:

(a) Name and address history trace;

(b) Verification that the students' records have been correctly identified, using date of birth and a Social Security number trace;

(c) A local criminal records check, including city and county records for the student's places of residence for the last seven years;

(d) A nationwide multijurisdictional criminal database search, including state and federal records;

(e) A nationwide sex offender registry search;

(f) A query with the Office of the Inspector General's List of Excluded Individuals/Entities (LEIE);

(g) The name and contact information of the vendor who completed the records check;

(h) Arrest, warrant and conviction data, including but not limited to:

(A) Charges;

(B) Jurisdictions; and

(C) Date.

(i) Sources for data included in the report.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0230
Training Standards

(1) Students must complete all listed trainings in advance of the start date of the students' initial clinical placement. See Table 1 for additional descriptions and recommended training resources.

(2) Students must complete the following steps for trainings that require certification:

(a) Complete training program in cardiopulmonary resuscitation (CPR), also known as Basic Life Support (BLS), at the health care provider level. Recommended trainings for CPR/BLS should comply with the standards set by the American Heart Association.

(b) Provide verified documentation as to the successful completion of CPR/BLS training, and

(c) Maintain current certification for CPR/BLS during the clinical placement.

(3) Health profession programs must provide documentation or a signed statement that the student has received prior training, taken educational courses, or is otherwise familiar with the following:

(a) The Health Insurance Portability and Accountability Act (HIPAA)

(b) Blood borne Pathogen training that is compliant with the federal Occupational Safety and Health Administration (OSHA) requirements.

(c) Federal OSHA recommended safety guidelines, including:

(A) Fire and electrical safety;

(B) Personal protective equipment;

(C) Hazard communications; and

(D) Infection prevention practices.

(4) Health profession programs shall provide documentation of completed trainings, as requested by clinical sites.

(5) Clinical sites may require students to complete additional site-specific trainings or on-boarding procedures, including:

(a) Site-specific privacy and confidentiality trainings.

(b) Site-specific orientation trainings and on-boarding procedures, such as facility-specific protocols for safety, security, documentation systems, and standards of behavior or signing a non-disclosure statement.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0240
Insurance and Liability Coverage

(1) Prior to clinical training, students or health profession programs must demonstrate that students have one of the following types of coverage and that the coverage will remain in place for the entire duration of each placement:

(a) Professional liability insurance coverage, and

(b) General liability insurance coverage; or

(c) Coverage under a combined policy for professional and general liability insurance.

(2) A health profession program may offer coverage for students through a self-insurance program or the student may obtain coverage individually.

(3) Health profession programs shall maintain records related to insurance and provide them to clinical sites, as requested.

(4) Prior to clinical placement, it is recommended but not required that students obtain some form of health insurance coverage, such as personal major medical insurance or Workers' Compensation insurance provided by the health profession program, and that the coverage remain in place for the entire duration of each placement.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

409-030-0250
Information Sharing or Use of Data

(1) Only clinical sites that have a contractual agreement with a student's training program may access the documentation and evidence related to completion of the administrative requirements.

(2) Students must provide written, signed permission that explicitly allows the sharing of required documents and necessary evidence with clinical sites, including but not limited to any release required under HIPAA or other applicable laws in order to disseminate the student's personal health information under these rules.

(3) Dissemination of information received under these rules may only be made to individuals with a demonstrated and legitimate need to know the information.

Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435

Table 1. Standards that health professions students must meet before clinical placements

Standard	Timing	Notes
Immunizations (documented receipt of vaccine or documented immunity via titer or valid history of disease, or via a record from the Oregon ALERT Immunization Information System)		
Hepatitis B (Hep B)	Per CDC guidelines[1] – follow child and adolescent schedules for students 0-18 years of age; follow health care professional schedule for students greater than or equal to 18 years of age.[2]	
Measles, mumps and rubella (MMR)		
Tetanus, diphtheria, pertussis (Tdap)		
Varicella		
Recommended but not required -- Polio		CDC recommends for health care workers treating patients who could have polio or have close contact with a person who could be infected with poliovirus.[3]
Recommended but not required -- Influenza (seasonal flu)	Follow state law requirements[4] /recommend mask or other precaution if not immunized.	
Screenings		
Tuberculosis (TB)	Prior to initial placement; after that only in case of known exposure.	Facility choice of skin test or IGRA Blood test in accordance with CDC guidelines.[5]
Substance Abuse - 10-panel drug screen	Prior to initial placement; subsequent screens only for cause	School/training program is responsible for verifying that screening is performed by a reputable vendor
Criminal Background Check (including Social Security Number trace, state/national criminal background history, sex offender registry check, and OIG LEIE check)	Prior to initial placement	Elements of check should be standardized and check should be performed by a reputable vendor (per OAR 409-030-0220)

[1]The full list of CDC guidelines can be found at: http://www.cdc.gov/vaccines/schedules/index.html
[2] The CDC guidelines for recommended vaccinations for health care professionals can be found at: http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
[3] Explanation of CDC recommendations can be found at: http://www.cdc.gov/vaccines/vpd-vac/polio/in-short-both.htm#who
[4] Currently, Oregon law (ORS 433.407) states that facilities employing health care workers must offer flu vaccine but may not require employees to be immunized unless a state or federal rule requires it.
[5] http://www.cdc.gov/tb/topic/testing/

Standard	Timing	Notes
Training		
CPR/Basic Life Support (BLS) for health care providers	Prior to initial placement; maintain current certification during placement	Recommend trainings that comply with the American Heart Association standards
Blood borne Pathogen training (OSHA)	Prior to initial placement	
OSHA recommended safety guidelines (including fire and electrical safety; personal protective equipment; hazard communications; and infection prevention practices).	Prior to initial placement	Schools must verify student familiarity or exposure to topics
Site-specific privacy and confidentiality practices	With *each* placement	May include review of clinical site policies and procedures, phone numbers, and emergency codes, signing a non-disclosure agreement, etc.
Site-specific orientation (facility-specific protocols for safety, security, standards of behavior, etc.)		
Insurance and Liability Coverage and Other Standards		
Professional liability insurance	Prior to initial placement	If student is covered by school, school can provide written statement and documentation of insurance or self-insurance
General liability insurance		If student is covered by school, school can provide written statement and documentation of insurance or self-insurance
Recommended but not required -- Current health insurance (or coverage via Workers' Compensation insurance extended to students by school)		Coverage must protect student against on the job accidents, illness, or injury.