Approved 3-15-89
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p.m. on March 1, 1989 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
John L. Foster, Chief of Police, Lenexa Police Department
Bob Orth, Chairman, Board of Emergency Medical Services
Jack Pearson, Kansas Association of Chiefs of Police
John Torbert, Executive Director, Kansas Association of Counties
David Corliss, League of Kansas Municipalities
Dr. Charles Konigsberg, Director of Health, KDHE
Ken Gorman, Kansas Fraternal Order of Police
Mike Kill, Kansas City, Kansas Police Department
Senator Ed Reilly
Chip Wheelen, Director of Public Affairs, Kansas Medical Society
Kay Hale for Tom Bell, Vice President, Kansas Hospital Association
Sherman Parks, Executive Director, Kansas Chiropractic Association
Jim Edwards, DOC, Emporia, Kansas
Carolyn Bloom, V-Pres., Physical Therapy Examining Committee, Board of Healing Arts
Sandy K. Elliott, Instructor, Physical Therapy Education, KUMC
Chris Ringel, Legislative Chairman, Kansas Chapter, American Physical Therapy Association
Tuck Duncan, Kansas Occupational Therapy Association
Harold Riehm, Executive Director, KS Association of Osteopathic Medicine
Chip Wheelen, Director of Public Affairs, Kansas Medical Society
Written testimony, SB-196 Melvin Brose, Dairy Commissioner, Division of Inspection, State Board of Agriculture

John J. Foster, Police Chief, Lenexa, appeared in support of SB-286 and expressed concerns of law enforcement and other emergency providers due to exposure to reportable diseases in the line of duty and their inability to secure information about the individuals that they were coming in contact with because of certain privacy laws. Many have been exposed and are unable to confirm whether an infection exists or not which affects the provider and also his family. Passage of this bill with the amendment to be offered would permit the provider to seek medical assistance on a timely basis and relieve anxiety and stress connected concerning such an exposure. (Attachment 1)

Bob Orth, of the EMS board told the committee that his board was concerned with what diseases would be deemed "reportable" as the list from KDHE contained over 60. The conditions that would constitute "exposure" were also questioned. Mr. Orth presented members with a copy of the Maryland law regarding notification of firefighters, EMTs, Rescue Squad Personnel, and Law Enforcement Officers. (Attachment 2)

Jack Pearson, Kansas Association of Chiefs of Police, told the committee that it was not the intent to cause embarassment to any individual nor to breach any privacy rights of the citizens of Kansas. Their sole interest lies in the desire to provide for the safety and protection of those professionals who must be exposed to hazardous situations in the course of their duties. (Attachment 3)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

John Torbert, Kansas Association of Counties, told the committee that his organization supported SB-286 that would provide for the reporting to law enforcement and emergency personnel "reportable diseases" which come about because of the nature of their work which brings risk of accidental exposure. (Attachment 4)

David Corliss, League of Kansas Municipalities, appeared in support of SB-286 stating it would establish an effective procedure to notify emergency service personnel of possible exposure to certain diseases, while at the same time safeguarding the important privacy interests of patients. (Attachment 5)

Dr. Charles Konigsberg, Division of Health, KDHE, told the committee that the notification addressed in this bill could be of value to an exposed person when the disease in question is one for which there is a specific protective regimen that can be applied following exposure. In these areas timeliness is a critical factor and they are usually begun upon suspicion, rather than upon notification of positive laboratory tests. Concern was expressed that SB-286 could undermine the Universal Precautions procedures by implying that when exposure occurs then something can and should be done about it. Exposure in medical settings occurs more or less continuously, and the only protection against most infectious diseases, including AIDS, is Universal Precautions. (Attachment 6)

Ted McFarlane, Douglas County, appeared in support of SB-286. He stated that at the present time it is very difficult for pre-hospital emergency medical service providers to obtain available information about the infectious diseases they are exposed to by caring for patients. Mr. McFarlane suggested a revision to the bill, that being the facility turning over a patient to an ambulance service could provide information at that time so extra precautions could be taken. (Attachment 7)

Kenneth W. Gorman, Fraternal Order of Police, appeared in support of SB-286 stating that law enforcement officers were often the first persons on the scene of incidents involving traumatic injury. Through the administration of first aid or other duties these officers have a high risk of exposure to body fluids of persons in the high risk group of having a communicable disease. (Attachment 8)

Mike M. Kill, Kansas City, Kansas Police Department, told the committee that law enforcement officers accept the fact that they could be killed when they go to work. However, the fact that these diseases can be passed on to their families is not an acceptable fact. Patrolman Kill stated he could have a test run on himself but could not obtain results of a test on the suspect individual without his permission and even then they could not make the results of the test available to him under any circumstances. He further expressed a "need to know" and requested passage of SB-286. (Attachment 9)

Senator Reilly told the committee he introduced the bill to gain attention to this problem and called attention to the proposed amendment by John L. Foster. He further stated he hoped the committee could work the bill.

Staff questioned whether or not the legislation passed last year concerning HIV and Aids did not take care of the concerns addressed in SB-286 and was told by Bob Orth that up until last year information was made available to them but during the past year have been told a number of times that notification of any infectious or contagious disease has now become illegal. Staff suggested that it might be a good idea to seek an opinion from the Attorney General.

Chip Wheelen, Kansas Medical Society, told the committee he did not believe it was the intent of the Legislature to limit the ability of physicians to communicate with other health care personnel when last

year's SB-686 was passed and an Attorney General's opinion would be appropriate for clarification. Also, some law enforcement personnel would not be considered health care providers while others would be for purposes of physicians notifying them. He re-emphasized that even though a HIV test is negative he should have one or more tests in the future. Therefore, this bill would accomplish very little.

A reply was made to Mr. Wheelen's comments that this bill requires notification while last year's bill states "may." Concern was also expressed that the individuals being dealt with pronounce they have AIDS or Hepatitis B when that tests and notification be forthcoming.

Written testimony was presented by Tom Bell, Kansas Hospital Association, stated that regulations designate approximately sixty diseases that must be reported to the local health department. Current law requires that physicians and other health professionals who have information that a person is suffering from one of these diseases report this information to the local health department, therefore a system is in place for these reports. Consequently, SB-286 may duplicate efforts taking place. (Attachment 10)

Kay Hale, speaking for the Kansas Hospital Association, stated that the bill provides that the first responder should be notified of positive tests and then states certain conditions when that would take place. One of those is when the medical facility has a reason to believe that the patient has a reportable disease. In the case of HIV infection you can be positive for the test and not have the disease so there is an inconsistency in the language of the bill.

Sherman Parks, Kansas Chiropractic Association, appeared before the committee in support of SB-259. Mr. Parks told the committee that this bill was a direct outgrowth of a 1986 resolution by the Kansas Board of Healing Arts and SB-259 is an attempt to make said resolution the law of the state of Kansas. The Chiropractic Association has been made aware that there are people who have no or very limited training that are performing manipulation in the state and there is a need for a law to establish who should be performing this procedure. (Attachment 11)

Dr. James Edwards told the committee that he was present to offer several technical aspects of the bill. He spoke of malpractice problems and stated several DOC's were threatening to drop their malpractice insurance and continue doing what they are doing now only refer to it by another name. This bill could stop that problem. Concern was expressed about untrained persons such as coaches, masseuse, or therapists performing a procedure within passive limits of the human body and would not be in violation of this act. Dr. Edwards stated this bill would not infringe on the rights of rehabilitation or occupational therapists.

Carolyn Bloom, Physical Therapy Examining Committee of Kansas State Board of Healing Arts told the committee her organization would support SB 259 providing the following amendment is added to the bill. "On lines 27,30, 31 and thereafter, add: "registered, and certified" to the term "licensed by the board." If this amendment is not added they cannot support this bill. (Attachment 12)

Sandra K. Elliott, University of Kansas Medical Center, told the committee that as a practicing Physical Therapist in the state of Kansas she was unable to support this bill as written as it would render much of the practice of Physical Therapy illegal. Addition of an amendment of persons "Registered and Certified" by the board would permit physical therapists to continue to practice. (Attachment 13)

Chris Ringel, American Physical Therapy Association, told the committee that in order to clarify the language in the bill, they recommended changing "licensed by the board (lines 27,30,31, 34) to "certified, registered and licensed by the board." (Attachment 14)

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S Statehouse, at 10:00 a.m./p.m. on March 1, 1989

The chairman requested other conferees to present written testimony as there was insufficient time to continue the hearings on SB-259.

Tuck Duncan presented written testimony for the Kansas Occupational Therapy Association stating SB-259 is a matter better suited for resolution by the Board of Healing Arts. He further stated the definition may be overly broad, and materially affect the established practices as recognized by the Board as being performed by occupational therapists. (Attachment 15)

Harold Riehm, Kansas Association of Osteopathic Medicine, presented written testimony stating the primary question of this bill appears to be the impact on those who practice the profession of physical therapy. It was felt the restriction for those with little or insufficient training in manipulation is fitting and proper. He further stated there is some question as to whether manipulation (as defined in SB-259) is currently within their scope of practice. (Attachment 16)

Richard G. Gannon, Board of Healing Arts, presented written testimony, stating that the board did not wish to take a formal position on SB-259. A review of the board's minutes. April, 1986, shows that the following position was taken: "Only licensees of this Board may perform manipulation of the articulations of the human body." (Attachment 17)

Chip Wheelen, Kansas Medical Society, presented written testimony concerning SB-259, stating opposition to this bill. As the bill is currently worded it would prohibit licensees of the healing arts from prescribing, authorizing, or delegating to any other person, the manipulation of the human body. This would prohibit physicians from referring patients to physical therapists. If the language were amended in line 31 to delete the word licensed and insert, in lieu thereof, credentialed, the problem would appear to be resolved. (Attachment 18)

Written testimony, concerning SB-196, was presented to the committee by Melvin Brose, Dairy Commissioner, Division of Inspections - Dairy, State Board of Agriculture, to provide information concerning salmonella enteritidis over a period of time. This information also included methods to deal with prevention. (Attachment 19)

The meeting adjourned at 11:00 a.m. and will convene at 10:00 a.m. on Thursday, March 2, 1989, in room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 1, 1989

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
John L. Foster		Lenexa Police Dept
Jack C. Pearson	3914 Rainbow, B711 Bell KC, Ks 66103	Ks Assoc. Chiefs Police
Ken Goodman	Topeka Ks	Kansas Fraternal Order of Police
Mike Kill	KCKs.	Fraternal Order of Police #4
Terry Stevens	Topeka	City of Topeka
Phil Hanes	Florence	Marion High School
Mike Greene	Florence	Marion High School
Jane Lucero	Topeka	Kansas Physical Therapy Ass.
Frances Kastner	Topeka	" " "
Chris Ringel	Topeka	" " "
Carolyn Bloom	Eudora	P.T. Examining Committee
Kay Hale	Topeka	Ks Hospital Assn.
Dave Corliss	Topeka	League of Municipalities
Ron Smith	"	Ks Bar Assoc.
Mary Jane Pfuetze, O.P. KS.		PARENT Blue Valley School Dist.
Tony Hett	Marion	Guest
Todd Swift	Marion	High School Government
Eric Thies	Marion	H.S. Gov't Class
Mike Meisinger	Marion	" "

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3/1/89

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Barbara Neff Route 2 Box 153 Lawrence	Visitor
Phyllis Siefker, 1735 W. 20th Ter., Lawrence 66046	Visitor
Cathy Holdeman	City of Wichita
Ted McFarlane	Douglas County
Sherman Parks, Jr	Ks Chiropractic Assn
Dr. Jim Edwards, D.C.	" " "
Kenneth Hobbs	Lenexa Fire Dept.
Chip Wheelen	Kansas Medical Society
Elizabeth E. Taylor	Asso of Local Health Dept
Harold Riehm	Ks. Assn. Osteopathic Med
Blaine Cleveland	UTU
Don Lindsey	UTU
Keith R Landis	Christian Science Committee on Publication for Kansas
John T. Torbert	Ks. Assn of Counties
Hazel Gibbs	Senate Intern

Testimony of John L. Foster
Chief of Police, Lenexa, KS
Conferee on SB 286

Thank you, Mr. Chairman, for the opportunity to participate as a conferee concerning Senate Bill 286 and I want to express my appreciation to the Committee for this bill.

Over the past several years a strong concern among law enforcement agencies and other emergency providers has surfaced because of our exposure to reportable diseases in the line of duty and inability to secure information about the individuals that we come in contact with during the course of our duties because of certain privacy laws. There are, at present, police officers and I am sure other providers, who have been exposed and are in limbo, unable to confirm whether an infection exists or not. This confusion affects not only the provider but the family of the provider as well as other members of his or her agency.

It is no longer unusual that an individual involved in an altercation with a police officer will announce to the officer that he or she has a reportable disease and attempt to bite or other wise inflict a wound in order for body fluids to be exchanged. It is for this reason that I would hope the Committee would amend Senate Bill 286 to include a mandatory test for reportable diseases when an individual announces to the provider that he or she is infected with a reportable disease and that the medical reception center be mandated to render the necessary tests. The medical reception center may not have prior knowledge of the individual's health record. Passage of this bill and the amendment offered will permit the emergency service provider to seek medical assistance on a timely basis and greatly relieve the anxiety and stress connected concerning such an exposure.

SPH&W
3-1-89
Attachment 1

(Continued from page 10)

Maryland Occupational Safety and Health Administration. *Proposed Standards for Occupational Exposure to Blood-Borne Infectious Diseases, Including Hepatitis B and AIDS*, 1988.

McCray E, The Cooperative Needlestick Surveillance Group. Occupational risk of the acquired immunodificiency syndrome among health care workers. *New England Journal of Medicine* 1986;314:1127-32.

McEvoy M, Porter K, Mortimer P, Simmons N, Shanson D. Prospective study of clinical, laboratory, and ancillary staff with accidental exposures to blood or other body fluids from patients infected with HIV. *British Medical Journal* 1987;294:1595-7.

Ramzy A. EMS & AIDS: An initial look. *Maryland EMS News* 1985;12(5):7-8.

Ramzy AI, Allen E, Caplan E. AIDS and EMTs: Sorting the facts. *JEMS* 1986;11(4):45-47.

Segal E. Infection control and prehospital care providers. *Maryland EMS News* 1987;13(10):6, 8.

Vlahov D, Polk BF. Transmission of human immunodeficiency virus within the health care setting. *Occupational Medicine State of the Art Reviews* 1987;2:429-50.

Maryland Law Regarding Notification Of Firefighters, EMTs, Rescue Squad Personnel, Law Enforcement Officers

The current Maryland law regarding notification of firefighters, emergency medical technicians, rescue squad personnel, and law enforcement officers is printed in its entirety in this special "update" on infectious diseases. A common question, which arises in training programs involving prehospital care providers, involves HIV testing for patients who are transported by prehospital care providers. The current law states that if individuals specified in the law (for example, firefighters, EMTs, rescue squad men, or law enforcement officers) come into contact with a patient who is subsequently diagnosed as having a specified disease or virus, as a result of information obtained in conjunction with the services provided during the visit to the facility, the attending physician or a designee at a medical facility shall notify the specified individuals.

Some prehospital care providers have presumed that this means that all patients are tested for HIV or other viruses by all hospitals. This is not, indeed, the case. The law specifies that, if a patient is found to be positive, the prehospital care providers are to be notified within 48 hours of diagnosis (not admission). The law, however, does not specify which patients are to be tested. In most situations, testing of the patient depends upon individual hospital policies. Therefore, if no information is provided to a prehospital care provider regarding a specific patient transport, this may mean that the patient was negative, or it may simply mean that the patient was not tested. The important point is that the safest and wisest policy is to manage all patients as being potentially infected and to follow established guidelines, which are reinforced in this update.

Companion bills SB215 and HB16 were passed during the 1988 session of the Maryland General Assembly. The final law appears as follows.

§18-213 Notification of firefighters, emergency medical technicians, rescue squadmen, and law enforcement officers of exposure to contagious disease or virus.

(a) *Definitions.* — (1) In this section the following words have the meanings indicated.

(2) "Contagious disease or virus" means:

(i) Human immunodeficiency virus (HIV);

(ii) Hepatitis B;

(iii) Meningococcal meningitis;

(iv) Tuberculosis;

(v) Malaria;

(vi) Rabies; or

(vii) Mononucleosis.

(3) "Law enforcement officer" means any person who, in an official capacity, is authorized by law to make arrests and who is a member of one of the following law enforcement agencies:

(i) The Maryland State Police;

(ii) The Baltimore City Police Department;

(iii) The police department, bureau, or force of any county;

(iv) The police department, bureau, or force of any incorporated city or town;

(v) The office of the sheriff of any county;

(vi) The police department, bureau, or force of any bicounty agency or the University of Maryland, Morgan State University, St. Mary's College, or of any institution under the jurisdiction of the Board of Trustees of State Universities and Colleges;

(vii) The State Aviation Administration police force of the Department of Transportation, the Mass Transit Administration police force of the Department of Transportation, the Maryland Toll Facilities police force of the Maryland Transportation Authority, and the Maryland Port Administration police force of the Department of Transportation;

(viii) The law enforcement officers of the Department of Natural Resources; or

(ix) The Maryland Alcohol and Tobacco Tax Enforcement Unit.

(b) *Fire fighter, emergency medical technician, or rescue squadman.* — While treating or transporting an ill or injured patient to a medical care facility or while acting in the performance of duty, if a paid or volunteer fire fighter, emergency medical technician, or rescue squadman comes into contact with a patient who is subsequently diagnosed as having a contagious disease or virus, as a result of information obtained in conjunction with the services provided during the visit to the facility, the attending physician or a designee of the medical care facility who receives the

(Continued on page 12)

SPH&W
3-1-89
Attachment 2

Maryland Law Regarding Notification Of Firefighters, EMTs, Rescue Squad Personnel, Law Enforcement Officers

(Continued from page 11)

patient shall notify the fire fighter, emergency medical technician, or rescue squadman, and the employer or employer's designee, of the individual's possible exposure to the contagious disease or virus.

(c) *Law enforcement officer.* — If, while treating or transporting an ill or injured patient to a medical care facility or while acting in the performance of duty, a law enforcement officer comes into contact with a patient who is subsequently diagnosed, as a result of information obtained in conjunction with the services provided during the visit to the facility, as having a contagious disease or virus, the attending physician or a designee of the medical care facility who receives the patient shall notify the law enforcement officer and the officer's employer or employer's designee of the officer's possible exposure to the contagious disease or virus.

(d) *When notice made; written confirmation; confidentiality.* — The notification required under subsection (b) or (c) of this section shall:

(1) Be made within 48 hours, or sooner, of confirmation of the patient's diagnosis;

(2) Include subsequent written confirmation of possible exposure to the contagious disease or virus;

(3) Be conducted in a manner that will protect the confidentiality of the patient; and

(4) To the extent possible, be conducted in a manner that will protect the confidentiality of the fire fighter, emergency medical technician, rescue squadman, or law enforcement officer.

(e) *Compliance with section.* — The written confirmation required under subsection (d) (2) of this section shall constitute compliance with this section.

(f) *Written procedures for implementation of section.* — Each medical care facility shall develop written procedures for the implementation of this section, and, upon request, make copies available to the local fire authority, the local fire authority's designee, the local law enforcement authority, or the local law enforcement authority's designee having jurisdiction.

(g) *Liability of medical care facility or physician — Breach of patient confidentiality.* — A medical care facility or physician acting in good faith to provide notification in accordance with this section may not be liable in any cause of action related to the breach of patient confidentiality.

(h) *Same — Failure to provide notice.* — A medical care facility or physician acting in good faith to provide notification in accordance with this section may not be liable in any cause of action for:

(1) The failure to give the required notice, if the fire fighter, emergency medical technician, rescue squadman, or law enforcement officer fails to properly initiate the notification procedures developed by the health care facility under subsection (f) of this section; or

(2) The failure of the employer or employer's designee to subsequently notify the fire fighter, emergency medical technician, rescue squadman, or law enforcement officer of the possible exposure to a contagious disease or virus. (1986, ch. 763; 1987, ch. 11, subsection 1; ch. 697; 1988, ch. 6, subsection 1; chs. 275, 276.)

Senate Committee on Public Health and Welfare
Senate Bill No. 286
March 1, 1989

My name is Jack Pearson and I am here to represent the Kansas Association of Chiefs of Police. The Chiefs Association would like the Committee to know that it supports and encourages passage of Senate Bill 286.

The Association's intent in this matter is not to cause embarrassment to any individual nor to breach any privacy rights of the citizens of Kansas. Our sole interest lies in our desire to provide for the safety and protection of those professionals who must be exposed to hazardous situations in the course of their duties.

First responders, including police, fire and medical personnel, must occasionally come in contact with human body fluids. Contact can occur at accidents, crime scenes and medical emergencies. While precautions are taken, this contact can and has resulted in the individual being exposed to a contagious disease. Having knowledge of this exposure will allow the responder to seek appropriate medical treatment, which may prevent spreading of the disease or serious effects for the responder.

Speaking strictly as a law enforcement official for a moment; police officers recognize that their chosen profession carries a certain amount of risk to their personal safety. This risk is accepted, but is minimized whenever possible. When the risk cannot be avoided, the aftermath must be dealt with. Passage of this bill would allow first responders an additional measure to cope with the aftermath of the risks they take, while maintaining as much confidentiality as possible for all concerned.

Thank you for the opportunity to speak today. I would be happy to answer any questions you may have.

SPH&W
3-1-89
Attachment 3

"Service to County Government"

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Wabaunsee County Commissioner
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Executive Director
John T. Torbert

Testimony

March 1, 1989

To; Senate Public Health and Welfare Committee

From; John T. Torbert
Executive Director

Subject; Senate Bill 286

The Kansas Association of Counties is in support of legislation that would provide for the reporting to law enforcement and emergency personnel of "reportable diseases" as designated by the Secretary of Health and Environment. Although the legislation does not specifically mention AIDS, we would hope that this disease would be one that would receive the appropriate designation. I think it is self evident that there is a great deal of concern about possible exposure to this disease. Medical personnel and law enforcement officers are in situations where, because of the nature of their work, their risk of accidental exposure increases. I urge the committee to report the bill favorably.

I would be happy to respond to any questions.

TSJSPHWC

SPHWC
3-1-89
Attachment 4

League
of Kansas
Municipalities

Municipal
Legislative
Testimony

An Instrumentality of its Member Kansas Cities. 112 West Seventh Street, Topeka, Kansas 66603 Area 913-354-9565

TO: Senate Public Health and Welfare Committee
FROM: David Corliss, League of Kansas Municipalities
RE: Senate Bill 286, Notifications to Emergency Service Personnel
DATE: March 1, 1989

The League of Kansas Municipalities appears in support of Senate Bill 286. We believe the bill would establish an effective procedure to notify emergency service personnel of possible exposure to certain diseases, while at the same time safeguarding the important privacy interests of patients.

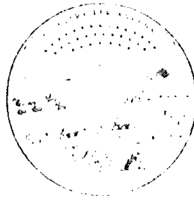
Municipal officials in Kansas, as in other states, are increasingly concerned that with the spread of acquired immune deficiency syndrome (AIDS) the jobs of municipal emergency service personnel who daily work in close physical contact with the public have taken on an added dangerous dimension. Some Kansas municipalities have already adopted policies and procedures which are specifically tailored to protect public employees from work-related exposures to AIDS. Firefighters, law enforcement officers, and first responders should be informed of exposure to diseases--such as AIDS--because the lack of notification is dangerous to the public servants involved, their spouses, and community public health. The lack of an exposure notification would also be harmful to other law, fire or EMS professionals who depend upon existing safeguards to protect themselves from exposure. In other words, if current safeguards and policies are not working to protect public servants from exposure -- but no one knows whether this is the case because no one is informed when an exposure occurs -- nothing will be done to improve the safeguards. Additionally, municipal employers need to be aware of shortcomings in exposure protections because of their concern for their employees and possible liability to exposed employees from AIDS-related work incidents.

Legislation mandating the sharing of medical information should have a clearly demonstrable public need necessitating the intrusion into the privacy interests of patients. Senate Bill 286 responsibly acknowledges the important public interest in protecting our emergency service personnel by allowing them to be informed of possible exposure to certain diseases, while minimizing the intrusion into the privacy of the patient.

SPH&W
3-1-89
Attachment 5

President: Douglas S. Wright, Mayor, Topeka * **Vice President: Irene B. French**, Mayor, Merriam * **Past President: Carl Dean Holmes**, Mayor, Plains * **Directors: Margo Boulanger**, Mayor, Sedan * **Nancy R. Denning**, Commissioner, Manhattan * **Ed Eilert**, Mayor, Overland Park * Greg Ferris, Councilmember, Wichita * **Frances J. Garcia**, Commissioner, Hutchinson * **William J. Goering**, City Clerk/Administrator, McPherson * Jesse Jackson, Commissioner, Chanute * **Richard U. Nienstedt**, City Manager, Concordia * **David E. Retter**, City Attorney, Concordia * **Judy M. Sargent**, City Manager, Russell * **Joseph E. Steineger**, Mayor, Kansas City * **Bonnie Talley**, Commissioner, Garden City * **Executive Director: E.A. Mosher**

STATE OF KANSAS



DEPARTMENT OF HEALTH AND ENVIRONMENT
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Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

Testimony Presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 286

Since the emergence of the AIDS epidemic, and the identification of the human immunodeficiency virus (HIV) which is the infectious agent of AIDS, emergency medical service attendants, first responders, law enforcement officers and firefighters have been concerned that they may be at risk of HIV infection and AIDS through performance of their duties. The principal concern involves exposure to blood, although other body secretions or excretions are also matters of concern. There are, of course, other infectious or contagious diseases which represent some risk to medical care personnel; these risks, which at a practical level are exceedingly minimal, have been recognized for many years. But AIDS has clearly brought this issue into focus, and in response to this concern, the Centers for Disease Control of the U.S. Public Health Service has compiled and broadly distributed a collection of recommendations known as "Universal Precautions" to establish standards of care and to inform persons at risk how to protect themselves from infection.

Senate Bill 286 would attempt to supplement Universal Precautions by requiring specific notification to an emergency caregiver that he or she has been exposed to an infectious disease. The notification would take place through a chain of reports involving medical care institutions, local health departments, and the exposed person's supervisor. The chain of reports would be initiated upon confirmation by laboratory test of the patient's infection.

This notification could be of value to an exposed person when the disease in question is one for which there is a specific protective regimen that can be applied <u>following</u> exposure. Examples of post-exposure measures include use of drugs such as rifampin for persons exposed to meningococcal meningitis, immune

SPH&W
3-1-89
Attachment 6

globulin for persons exposed to viral hepatitis, and vaccine for persons exposed to rabies. However, timeliness is a critical factor in the application of these measures, and they are usually employed or initiated empirically, meaning they are begun upon suspicion, rather than upon the notification of positive laboratory tests.

Unfortunately, there is no specific preventive drug, biologic, or process to protect medical caregivers including emergency and transport personnel that can be applied following exposure to AIDS or HIV infection. The objectives of S.B. 286 may be of limited value in protecting persons against certain other diseases, but it sacrifices timeliness for laboratory results and a chain of reports.

We believe these factors underscore the significance of Universal Precautions. Universal Precautions should be applied throughout the management of all patients, both in emergency and in routine medical care settings. The specific steps in Universal Precautions are not new--they have been known and applied for many years. They consist of employing appropriate barriers to infection, such as gloves, of preventing spread of disease agents by common items, and of processes for cleaning and disinfecting equipment and environments.

We are emphasizing the case for Universal Precautions because we believe that efforts such as S.B. 286 may undermine these procedures by implying that <u>when</u> exposure occurs <u>then</u> something can and should be done about it. The fact is, exposure in medical settings occurs more or less continuously, and the only protection against most infectious diseases, including AIDS, is Universal Precautions.

For the diseases for which there is a genuinely-effective post-exposure treatment rationale, our current practical problem is more often based on the need to limit such processes to persons who are truly at risk. Demand for such procedures frequently exceeds true risk.

We do not believe S.B. 286 is fundamental to the control of AIDS and other contagious diseases. The most positive feature of the bill would be to legitimize obtaining information necessary to protect against a limited number of infections, but not including AIDS. This minor gain may be offset by possible loss of confidentiality, with respect to AIDS, and the development of a false sense of security with regard to AIDS.

Presented by:

Charles Konigsberg, Jr., M.D., M.P.H.
Director, Division of Health
March 1, 1989

REFERENCE SB 286 - TESTIMONY IN SUPPORT OF THE BILL BEFORE THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

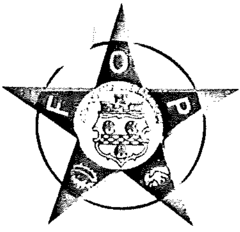
My name is Ted McFarlane. I represent Douglas County. I am the Director of the Ambulance Operation operated by the County. I encourage your favorable consideration of Senate Bill 286. At the present time it is very difficult for pre-hospital emergency medical service providers to obtain available information about the infectious diseases they are exposed to by caring for patients. It is not unusual for us bring a patient to the hospital and find out a few days later that the patient has been put in isolation for a disease he had at the time of admission. If we had not happened by the room we would never have known.

I think this bill is a common sense one. Shouldn't all known risks be shared with those people who are asked to take those risks? I recognize that the patient has a right of privacy which must be honored, and I think this bill addresses this concern.

I would like to suggest a revision in the bill. If a licensed medical care facility, either a nursing home or hospital, is aware that a patient has a reportable disease at the time a patient is turned over to an ambulance service this information should be shared at the time the service is provided so extra precautions can be taken. This would allow preventive measures above those routinely taken and increase the safety factor.

Ted McFarlane
3/1/89

SPH&W
3-1-89
Attachment 7



GRAND LODGE

FRATERNAL ORDER OF POLICE

NATIONAL HEADQUARTERS • 2100 GARDINER LANE • LOUISVILLE, KENTUCKY 40205
502-451-2700

DEWEY R. STOKES
NATIONAL PRESIDENT

CHARLES R. ORMS
NATIONAL SECRETARY

KENNETH W. GORMAN
KANSAS NATIONAL TRUSTEE
5424 W. 14th
Topeka, Ks. 66604
O - 913-354-9464

SB 286

The Kansas Fraternal Order of Police strongly urges the passage of SB 286.

As Law Enforcement officers we are often the first persons on the scene of incidents involving traumatic injury. Through the administation of first aid or other duties we run a high risk of exposure to the body fluids of persons in a high risk group of having a communicable disease.

It is quite often an officer's duty to respond to circumstances involving drug users, prostitutes, and others who are the most common carriers of deadly communicable diseases. I am personally aware of several instances where officers have experienced the burden of not knowing whether or not they have been exposed to a disease that can not only place themselves but also their loved ones in danger.

We would indeed be gratefull for your favorable consideration of SB 286.

Sincerely,

Kenneth W. Gorman
National Trustee
Fraternal Order of Police
Kansas

SPH&W
3-1-89
Attachment 8

LODGE NO. 4

KANSAS CITY, KANSAS

Legislators:

The Law Enforcement Officers in the State of Kansas know, without a doubt, that when they go to work there is a chance that they could be killed. Every Officer knows this to be a fact. An acceptable fact.

What is not an acceptable fact is that this fear can now be transformed to the Officers homes. To their wives. To their families.

Let me relate to you an incident that occurred to me. Last summer, while riding a patrol unit, I was dispatched on an attempted suicide. Myself and one other Officer arrived at an apartment and found a man with a knife at his throat. After a few moments of negotiations the individual started to lower the knife away from his throat. As I reached for the knife the individual became combative and subsequently I was cut on the knuckle by the knife. The same knife that had his blood on it.

Myself and the other Officer were able to subdue the individual without further incidence. However, the damage had already been done.

We then took the individual to a local hospital for psychiatric treatment. This is a normal procedure for someone that had just attempted suicide.

During the evaluation by the psychiatrist it was determined that this subject was a drug I.V. user and had been for over six months. The individual was also found to have hepatitis A and B.

Once I learned of this individuals narcotics history, I of course wanted the individual checked for A.I.D.S. Now is where we run into our problem. The hospital staff told me that they could do a test on me without any problem but the

SPH&W
3-1-89
Attachment 9

results would be inconclusive since the incident had just occurred. I asked them to do a test on the individual that had cut himself with the knife. They said they could not do a test on him without his permission. Furthermore, they could not make the results of that test available to me under any circumstances.

I have since gone through a series of heptavax vaccines for the hepatitis possibility. Although not enjoyable, we as L.E.O.'s, can live with that. What we can't live with is the fear that through an incident like the one I have described is the uncertainty. I know for a fact that this is not an isolated incident. We need to know. Not for us, because by the time we find out it's too late for us. But we need to know for our wives, for our families.

Please pass a bill requiring that L.E.O.'s can request A.I.D.S. testing and have access to the results. Again I stress, not for us, but for the wives, husbands, and families of the L.E.O.'s.

Sincerely,

Ptl. M. Kill
K.C.K.P.D.

Donald A. Wilson
President

TO: Senate Public Health and Welfare Committee

FROM: Thomas L. Bell

DATE: March 1, 1989

RE: Senate Bill 286

Thank you for the opportunity to comment regarding S.B. 286. This bill would enact new requirements for reporting and notification of positive test results for certain diseases. It provides that medical care facilities must make certain notifications to the local department of health, which in turn must notify the entity employing the emergency medical services attendant, first responder, or law enforcement officer of the potential exposure.

Notification requirements under S.B. 286 apply when three conditions are met: 1) a person is delivered to a medical care facility by an EMS attendant, first responder, law enforcement officer or firefighter; 2) the medical facility has knowledge the person has a reportable disease which was present at the time of admittance; and 3) the EMS attendant, first responder, law enforcement officer or firefighter was exposed to the reportable disease.

Regulations developed pursuant to K.S.A. 65-118 designate approximately sixty diseases that must be reported to the local health department. Current law requires that physicians and other health professionals who have information that a person is suffering from one of these diseases report this information to the local health department. Therefore, we already have a system in place for these reports. In our opinion, S.B. 286 may duplicate

SPH&W
3-1-89
Attachment 10

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436

efforts that are already taking place.

We certainly understand the motivation for this type of legislation. It should always be remembered, however, that universal precautions as recommended by the Centers for Disease Control are the best method of prevention against the types of diseases contemplated by S.B. 286.

Kansas Chiropractic

ASSOCIATION

TESTIMONY ON SB 259

Presented to the Senate Public Health & Welfare Committee

MARCH 1, 1989

Mr. Chairman, Madam vice chairman, members of the committee, my name is Sherman A. Parks, Jr., Executive Director of the Kansas Chiropractic Association. I would like to thank the chairman and the committee for introducing SB 259 on behalf of the Kansas Chiropractic Association and for allowing me the opportunity to testify on SB 259 today.

This morning I have some brief comments about the positive merits of SB 259 and and in addition, I have Dr. James D. Edwards, a Doctor of Chiropractic, from Emporia, Kansas, who will also testify on this bill. After Dr. Edwards' and my testimony are completed we will be happy to respond to any questions that the committee or staff have at that time.

In April of 1986, the Kansas Board of Healing Arts passed a resolution that stated that the only persons in Kansas who shall be allowed to perform manipulation on the human living body shall be persons who are licensed by the Kansas Board of Healing Arts. This resolution establishes that Doctors of Chiropractic, Doctors of Osteopathic Medicine, Doctors of Medicine and Doctors of Podiatrist Medicine would be those persons who could perform manipulation. SB 259 is a direct outgrowth of that 1986 resolution by the Kansas Board of Healing Arts. SB 259 is an attempt to make that said resolution the law of the state of Kansas.

The purpose and the reason why SB 259 was introduced was to establish that only persons who have diagnostic ability and who have extensive training and are licensed by the state of Kansas to be able to perform the sophisticated procedure of manipulation. The Kansas Chiropractic Association has been made aware that there are people who have no or very limited training that are performing manipulation in the state. Doctors of Chiropractic across the state have informed me that athletic coaches, trainers, barbers, and masseuses are performing the procedure of manipulation on a daily basis. When attempts are made by the Kansas Chiropractic Association to inform school districts of the liability of allowing this, in most situations the problem is corrected. However, it is apparent that there is a need for a law to establish who should be performing this procedure. The American Medical Assoc-

SPHW
3-1-89
Attachment 11

1334 S. TOPEKA • TOPEKA, KANSAS 66612 • (913) 233-0697

iation has used the fear tactic that manipulation can be a dangerous procedure. The Kansas Chiropractic Association agrees in part with that theory. In that, when manipulation is performed by individuals who are not properly trained it can cause harm to the general public. When performed by properly trained individuals such as Doctors of Chiropractic, Osteopathic Doctors or MDs it is a procedure that can heal the incidence and the severity of physical disability and pain.

The purpose of the Kansas Healing Arts Act, as established by KSA 65-2801, is to recognize that the practice of the healing arts is a privilege granted by legislative authority and is not a natural right of an individual. As a matter of public policy in the interest of public health, safety and welfare, it is essential to provide laws covering the gravity of that privilege. The statute further states that the "public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice.." by individuals who are not licensed by the Kansas Board of Healing Arts. This has been the purpose of the Kansas Healing Arts Act for the past 32 years. SB 259 establishes clearly the public policy of who should be allowed to perform manipulation in Kansas.

The intent of SB 259 is not to restrict the scope of practice pf registered physical therapist, registered physical therapist assistants, registered occupational therapists, registered occupational therapist assistants, hospitals who specialize in rehabilitation services, the KU Medical center, or other registered therapists who are registered by the Kansas Board of Healing Arts. In fact numerous conversations have been made by the Kansas Chiropractic Association to explain clearly the impact of SB 259 so that Physical therapists, occupational therapists and other health care providers will realize that SB 259 does not restrict their ability to deliver health care services.

There are three key elements to SB 259 that need to be briefly indentified. Since I had the privilege of serving this legislative committee as an assistant revisor of statutes, I know the importance of how the definition is worded. In working with the staff of this committee, I attempted to achieve a definition that was a workable and not a restrictive definition. The definition of manipulation can be found between lines 21 thru 24 of this bill.

The key phrase of this definition can be found on line 23. That is "....to achieve joint motion beyond the passive limit.." Any therapist, coach, masseuse, or person who performs a procedure within the passive limits of the human body would not be in violation of this act. This means the normal range of motion of the body.

What this means is that the normal scope of practice of a therapist would not be restricted. However, when a person forces a joint beyond the passive limits, then that procedure should only be performed by a person licensed by the Board of Healing Arts. This is the second key element. The third and final element of SB 259, is only licensed persons of the Kansas Board of Healing Arts can perform manipulation, there must be restrictions on who else can do this procedure. Meaning if an Osteopath, MD, or Podistrist wants to prescribe therapy, they can do such. However, if these licensed persons want to prescribe manipulation for a patient, then only those licensed by the Kansas Board of Healing Arts would be allowed to perform manipulation. SB 259 will not restrict the delivery of health care as it pertains to manipulation by Osteopaths, Poditrists or MDs. This is constant with the 1986 Board of Healing Arts resolution.

The Kansas Chiropractic Association in requesting this legislation could have requested that the only doctors who could perform manipulation would have been osteopaths and chiropractors. Manipulation is the specialty of chiropractic and the philosophy of manipulation is an important element of osteopathic medicine. In fact, the philosophy of manipulation by osteopaths is one of the main factors that distinguishes an osteopath from an MD. However, that would be to restrictive and would not be a realistic approach.

There is a state examing committee for physical therapy to assist the state Board of Healng Arts in carrying out the provisions of the PT's law. One member of this committee is a member of the state board of healing arts. I have talked with this member, Dr. Harold Bryan of Fort Scott, and he supports SB 259.

In conclusion, the KCA is happy with SB 259, in its present form. Any attempt to amend the bill will only delute the purpose of the bill.

In conversations with physical therapists and other health care providers there may be attempts to amend the bill to include on line 27 those persons who are registered by the board of healing arts. Any attempt to amend SB 259 with this type of amendment will not help SB 259 but only expand the scope of practice of those registered individuals. Just like our position not to restrict health care - it is not the KCA's position to expand the scope of practice of those registered health care providers.

Mr. chairman, and members of the committee, the Kansas Chiropractic Association supports SB 259 in its present form and we ask that SB 259 be passed out of committee as presented.

As stated earlier, after a short presentation by Dr. Edwards, I will be available to answer any questions that the committee or staff may have.

Thank you.

Kansas Chiropractic

ASSOCIATION

OUTLINE OF THE TESTIMONY

OF

DR. JAMES D. EDWARDS, D.C.

on SB 259

presented to the Senate Public Health & Welfare Committee

MARCH 1, 1989

I. The Chiropractic profession wanting to protect the public from unlicensed Doctors of Chiropractic.

II. The problems and dangers of untrained persons performing manipulation.

III. Brief discussion of what the difference is between passive limits and manipulation.

IV. Appreciation of the opportunity to testify on behalf of SB 259.

V. Response to questions by Mr. Parks and Dr. Edwards.

1334 S. TOPEKA • TOPEKA, KANSAS 66612 • (913) 233-0697

March 1, 1989

Carolyn Bloom, PT
Vice-President
Physical Therapy Examining Committee
of the Kansas State Board of Healing Arts
235 SW Topeka Blvd.
Topeka, Ks. 66603
913-233-2225

SENATE BILL NO. 259

Mr. Chairman and Members of the Senate Public Health and Welfare Committee:

My name is Carolyn Bloom and I am a physical therapist and Vice-President of the Physical Therapy Examining Committee of the Kansas State Board of Healing Arts. My purpose today is to offer support to SB 259 but only if the following amendment is added to the bill.

On lines 27, 30, 31 and thereafter, add: " registered, and certified" to the term "licensed by the board."

If this amendment is not accepted, the P.T. Examining Committee opposes SB 259.

The rational is that my discussion with the chiropractic representative indicated the intent of this bill is to limit the practice of manipulation by non-medical personnel. In order to avoid future problems with the interpretation of the definition of the term "manipulation" in the scope of standard practice of physical therapy and other regulated health care professions, this language addition is required.

S PH&W
3-1-89
Attachment 12

This amendment will not change the stated intent of this bill as presented by the chiropractic profession, but will preserve the current scope of practice of physical therapy and other related professions under the board. Physical therapists are well trained to move joints and the adjacent tissues through the ranges of the joint in human living bodies.

If there is a need to protect the public by limiting the practice of manipulation by non-medical persons, and the amendment is added as stated above, the P.T. Examining Committee will support passage of SB 259. If the amendment is not added, the Committee opposes this bill.

Thank you for the opportunity to speak before this Committee. I will answer any questions at this time.

REFERENCE: SENATE BILL NO. 259
By Committee on Public Health and Welfare

As a practicing Physical Therapist in the State of Kansas and as a faculty member in Physical Therapy Education at the University of Kansas, I am unable to support this bill as written, as it would render much of the practice of Physical Therapy illegal. Physical therapists in Kansas are registered by the State Board of Healing Arts, not licensed. As the bill is written, only those persons licensed by the board would be allowed to perform manipulation on the human body in the state of Kansas. I would be willing to support the bill ONLY with an amendment of adding that persons Registered and Certified by the board shall also be allowed to perform manipulation on the human living body in the state of Kansas.

Physical therapists are well-trained in the application of directed manual and mechanical forces to the human living body's joints and adjacent tissues to achieve joint motion beyond the passive limit, also well-trained in avoiding a pathological range which could damage tissues. The amount of motion that is available at a specific joint is called the range of motion. Active range of motion refers to the amount of joint motion that is attained by an individual during the performance of unassisted voluntary joint motion. Passive range of motion is the amount of motion attained by an examiner (Physical therapist, for instance) without any assistance from a subject during the performance of a joint motion. The extent of the passive range of motion is determined by the unique structure of the joint being tested. Some joints are structured so that the joint capsules limit the end of the range of motion in a particular direction, while other joints are structured so that ligaments limit the end of a particular range of motion. Other limitations to motion include contact of joint surfaces, passive or reflexive muscle tension, and soft tissue approximation. Each specific structure that serves to limit a range of motion has a characteristic feel to it, which is detected by the examiner who is performing the passive range of motion. The examiner's ability to distinguish between a normal therapeutic and a pathological end range requires practice and sensitivity.

The education of the physical therapist at the University of Kansas in this area consists of 1425 hours in Gross Anatomy lectures and dissection labs whereby the student physical therapist learns muscle origins and insertions, innervations, and related circulation, as well as

S PH&W
3-1-89
Attachment 13

joint structure including ligamentous and other soft tissue components; a weekly Radiology seminar for a semester where joint and bone integrity is radiographically evaluated; 75 hours in Applied Kinesiology and Biomechanics, whereby the student physical therapist relates joint structure to joint function; 16 hours in the laboratory learning basic extremity passive range of motion techniques; 25 hours in a Peripheral Joint Evaluation and Integration class, where further extremity joint evaluation and range-of-motion treatment techniques are learned; 46 hours in Musculoskeletal Spinal Disorders where evaluation and treatment of spinal pathology , including intensive one-on-one laboratory training in active and passive range of motion technques and application of mechanical forces (traction) to the spine; 7 hours on Sports Injuries, Sprains and Strains; 6 hours on skeletal traction and fractures; 11 hours on general connective tissue disorders (includes arthritis and joint replacement); 24 hours of lecture and 32 hours of laboratory in special range of motion techniques for the neurologically involved patient; 15 hours of lecture and laboratory on Proprioceptive Neuromuscular Facilitation which is a special range of motion technique utilizing neuro-physiological principles; 8 hours on the burn patient, including special range of motion requirements of this patient population.

In summary I would like to re-state that the physical therapist is well-trained in all manner of passive range of motion techniques and should not be exluded from performance of this critical component of the neuromusculoskeltal patient's rehabilitation.

Respectfully submitted,

Sandra K. Elliott, P.T., M.S, Ph.C.
Instructor
Physical Therapy Education
University of Kansas Medical
Center

THE KANSAS CHAPTER

AMERICAN PHYSICAL THERAPY ASSOCIATION

MARCH 1, 1989

Chris Ringel
Legislative Chairman
Kansas Chapter,
American Physical Therapy Association
1237 S.W. Bell Terrace
Topeka, KS
(913) 272-4121

Mr. Chairman and Members of the Senate and Public Health and Welfare Committee:

My name is Chris Ringel, and I am the current Legislative Chairman for the Kansas Physical Therapy Association which serves over 90% of the practicing Physical Therapy personnel in this state. My purpose today is to address Senate Bill 259 - a bill that limits the practice of manipulation to persons licensed by the Board of Healing Arts.

Current language in Senate Bill 259 would restrict the practice of manipulation to licensed medical professionals regulated by the State Board of Healing Arts. Three issues exist with current language in this bill: (1) the intent of the bill is to limit the practice of manipulation by untrained nonmedical persons, (2) Physical Therapists and other medical professionals trained to perform manipulation may be either certified, registered or licensed by the State Board of Healing Arts, (3) future interpretation of licensed could limit the scope of practice of these certified and registered medical professionals that currently practice manipulation as defined. This interpretation could limit the entire scope of practice of such trained professionals, versus limiting the practice of untrained nonmedical persons as this bill intends.

SPH&W
3-1-89
Attachment 14

To clarify this language issue, our association suggests amending the bill. We would recommend changing **licensed by the board** (lines 27, 30, 31, 34) to **certified, registered and licensed** by the board. Such amendments would clearly resolve the issues previously mentioned by - (1) clearly defining the intent of the bill by actually limiting the practicing of manipulation by untrained nonmedical personnel, (2) allowing physical therapists and other registered, certified and licensed professionals that are trained and that are currently practicing manipulation to continue their practices and (3) resolve interpretation issues that could cost legislators future time and dollars.

Our Association will not oppose this bill if these suggested amendments to lines 27, 30, 31 and 34 are made. Public safety is always a concern of our association. Thank you for your attention and the opportunity to testify.

KOTA
KANSAS OCCUPATIONAL THERAPY ASSOCIATION
SERVING KANSAS AND WESTERN MISSOURI

To: Senate Committee on Public Health and Welfare
From: Kansas Occupational Therapy Association
RE: Senate Bill 259

Date: March 1, 1989

The K.O.T.A. respectfully suggests that the subject of S.B. 259 is a matter better suited for resolution by the Board of Healing Arts. Questions regarding this scope of practice issue can be handled on a case-by-case review when the alleged misconduct is brought to the Board's attention. This definition may be overly broad, and materially effect the accepted practices as recognized by the Board being performed by occupational therapists. If the Board has concerns in this area it may conduct hearings and promulgate acceptable regulations. Thank you for your attention to this matter.

SPH&W
3-1-89
Attachment 15

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

SENATE PUBLIC HEALTH COMMITTEE

TESTIMONY ON SENATE BILL 259

MARCH 1, 1989

Mr. Chairman and Members of the Senate Public Health Committee:

If it appears today that my testimony reflects a lack of consensus on SB 259 among members of the Association I represent, that is the case.

We favor the general intent of this Bill. We think that manipulation, as defined, is a complex medical procedure that, if done with medical precision, requires extensive training. We favor a restriction on the use of such manipulation by coaches, athletic trainers, etc.

The primary question of this Bill appears to be the impact it has on those who practice in the profession of physical therapy. Here too, I represent physicians who think physical therapists should not be practicing manipulation as defined. Others have close working relationships with physical therapists and question whether the definition of manipulation is precise enough to keep them from not violating the delegation prohibition found in Section 2 of the Bill.

This ambiguity among members of the osteopathic profession not only reflects the importance of manipulation to this profession throughout its history, but also a wide variance in the extent to which osteopathic physicians today practice manipulation in their respective practices. Today, and for some time past, D.O.s receive the same training and schooling as M.D.s, but they also receive additional instruction in osteopathic manipulation. Some, in practice, use it extensively; others occasionally; a few, not at all; and, some use it exclusively.

Perhaps, I can characterize our stand on this Bill by stating that we think that the restriction for those with little or insufficient training in manipulation is fitting and proper. Regarding physical therapists, there is some question as to whether manipulation (as defined in this Bill) is currently within their scope of practice. If it is, we see no need for change. If it is not, we see no need for change. Few of the physicians I represent can recall an instance in which the current state of practice by physical therapists has presented a problem.

I will be pleased to respond to any questions.

SPH&W
3-1-89
Attachment 16

Office of
RICHARD G. GANNON, EXECUTIVE DIRECTOR
CHARLENE K. ABBOTT, ADMINISTRATIVE ASSISTANT
LAWRENCE T. BUENING JR., GENERAL COUNSEL
JOSEPH M. FURJANIC, DISCIPLINARY COUNSEL

State of Kansas

Board of Healing Arts

Landon State Office Building
900 S.W. JACKSON, SUITE 553
TOPEKA, KS 66612-1256
(913) 296-7413

TO: Senate Committee on Public Health & Welfare

FROM: Richard G. Gannon, Executive Director

DATE: March 1, 1989

RE: SENATE BILL NO. 259

At this time, the Board does not wish to take a formal position on SB 259.

A review of the Board's minutes reflects that in April 1986, the Board did take the following position:

> "Only licensees of this Board may perform manipulation of the articulations of the human body."

However, the Board at that time did not define what was meant by the term manipulation.

Certainly, the Board feels that manipulation and adjustment of the musculoskeletal system should be performed only by those persons who are competent to perform such. The question the Board has on sections 1 and 2 of SB 259 and the reason for no formal position being taken on this proposed legislation is that there is uncertainty whether these two sections merely serve to protect the citizens of the State of Kansas from incompetent and unqualified individuals or if they are too restrictive and would preclude individuals, otherwise qualified, from performing manipulation and adjustment.

No oral testimony is being offered. However, if the Committee has any questions, I would be happy to respond.

RGG:LTB:sl

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JOHN B. HIEBERT, M.D., LAWRENCE
GLENN I. KERBS, D.C., [illegible]
CAMERON D. KNACKSTEDT, D.O., PHILLIPSBURG
GRACIELA MARION, EUDORA
TOM REHORN, SHAWNEE MISSION
IRWIN WAXMAN, D.P.M., PRAIRIE VILLAGE
KENNETH D. WEDEL, M.D., MINNEAPOLIS
JOHN P. WHITE, D.O., PITTSBURG

SPHW
3-1-89
Attachment 17

KANSAS MEDICAL SOCIETY

1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

March 1, 1989

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society

SUBJECT: Senate Bill 259, As Introduced

The Kansas Medical Society appreciates this opportunity to express our opposition to the provisions of SB259. The bill, as it is currently worded, would prohibit licensees of the healing arts from prescribing, authorizing, or delegating to any other person, the manipulation of the human body. This would, of course, prohibit physicians from referring patients to physical therapists. It is for this reason that we must oppose the bill in its current form.

If, however, the language were amended in line 31 to delete the word licensed and insert, in lieu thereof, credentialed, the problem would appear to be resolved. As you are probably aware, physical therapists are registered by the State Board of Healing Arts, rather than licensed. For these reasons, we would respectfully request that you not recommend SB259 for passage, unless the bill is amended to allow for the delegation by a physician to a physical therapist. Thank you for your kind attention.

CW:lg

SPHW
3-1-89
Attachment 18

STATE OF KANSAS

STATE BOARD OF AGRICULTURE

SAM BROWNBACK, Secretary **DONALD L. JACKA, JR., Assistant Secretary**

February 28, 1989

Senator Ehrlich
State Capital Building
Topeka, Kansas 66612

Dear Senator Ehrlich:

Attached is a copy of a report from the Center for Disease Control which I feel helps substantiate the position which I have taken on the home made ice cream issue.

If there are any questions please call.

Sincerely,

Melvin Brose

Melvin Brose
Dairy Commissioner
Division of Inspections - Dairy
(913) 296-3786

MB:jr
attachment

SRH&W
3-1-89
Attachment 19

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

Dr. Archer Reid

HB-2293
SB-196

DEC 21 1988

TO: State and Territorial Epidemiologists
State and Territorial Public Health Laboratory Directors
Through: Director, Center for Infectious Diseases

Subject: Precautions to reduce the risk of institutional outbreaks of *Salmonella enteritidis*.

In 1987, 6,950 isolates of *Salmonella enteritidis* (*SE*) were reported to the National Salmonella Surveillance System, representing 16% of all *Salmonella* isolates reported in that year. As summarized in the August 18, 1988, issue of MMWR, isolation rates of *SE* remain high in the northeastern part of the United States and are beginning to increase in Mid-Atlantic and East North Central regions as well. Reports of documented *SE* infection in egg-laying flocks in the Midwest, West, and South suggest that further spread of the *SE* epidemic to the rest of the United States could occur. Attempts to reduce the amount of infection by voluntary serologic screening of multiplier and layer flocks have begun, but it is too early to tell whether they will be successful. In the interim the importance of preventing outbreaks in nursing homes and hospitals, with the population at highest risk for severe outcome, cannot be overemphasized.

We reviewed reported outbreaks of *SE* infections from 1985 to 1988. During this time, eighteen outbreaks occurring in nursing homes and hospitals were reported, affecting 658 persons with 24 deaths (3.6% case fatality rate). A vehicle was determined for eight of the 18 outbreaks, accounting for 477 cases. Two outbreaks were associated with raw eggs (which were used in a mayonnaise substitute in one outbreak, and added to hot cereal in the other), three outbreaks were associated with undercooked scrambled eggs and three outbreaks were associated with pureed foods in settings where cross-contamination in the blender with raw egg was likely.

In most parts of the country where *SE* has emerged in epidemic form, the safest alternative for nursing homes and hospitals is to use pasteurized liquid egg products for all recipes calling for bulk pooled egg. Pasteurized egg is commercially available in 10 pound containers.

In all parts of the country, we recommend that menus, recipes, and food handling practices in nursing homes, hospitals, and food services for the home-bound elderly be reviewed and modified to prevent exposure to undercooked eggs. The following specific points merit special emphasis to reduce the risk of institutional outbreaks:

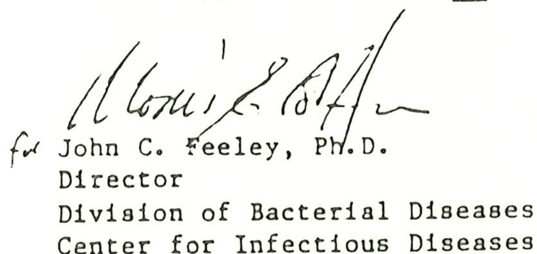
1) Recipes and practices which expose the consumer directly to raw egg are particularly hazardous. This includes home-made eggnog, home-made mayonnaise or home-made ice-cream, hollandaise sauce, and Caesar salads as well as the addition of raw egg to a food which has already been cooked.

2) Any recipe that calls for a large pool of eggs that are cracked ahead of time and held in a large container before cooking is of particular concern. A single infected egg can contaminate the whole pool. Rapid bacterial growth may then occur if the pooled egg mass is held above refrigerator temperature. Pooled separated egg yolk is likely to be more hazardous than pooled white or mixed egg, because of the lack of the bacteriostatic effects of albumin. Careful attention to holding times and temperatures and to thorough cooking are warranted.

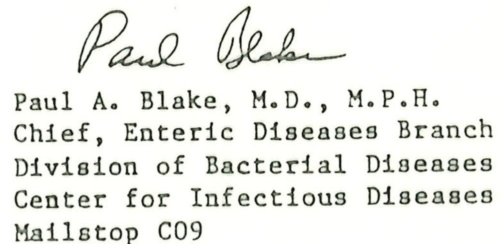
3) Routine disassembly and sanitization of blenders after blending raw egg is a critical step that warrants special attention. The use of separate blenders to scramble raw eggs and to puree cooked foods would reduce the risk of cross-contamination.

Responsibilities for the inspection and certification of food service facilities in hospitals and nursing homes vary by State and may be diffuse. Accreditation by the Joint Commission on the Accreditation of Health Care Organizations does not guarantee regular food service inspections nor food-handler training to reduce the risk of nosocomial food-borne disease. Collaborative efforts by several State agencies may be necessary to ensure the continued safety of food service in hospitals and nursing homes.

The enclosed table summarizes the national SE surveillance data by state. The expansion of the SE epidemic into areas in the country that have been previously unaffected will require continous collaborative efforts to identify the sources of outbreaks and to control them. Intensive investigation of foodborne outbreaks of salmonellosis and laboratory-based serotype surveillance of salmonellosis remain the foundation of our efforts to control this problem. The Enteric Diseases Branch (404-639-3753) would appreciate learning of any outbreaks of salmonellosis traced to shell eggs regardless of the serotype, and of any SE outbreaks regardless of the vehicle.



for John C. Feeley, Ph.D.
Director
Division of Bacterial Diseases
Center for Infectious Diseases



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Salmonella enteritidis isolates as a percentage of all Salmonella isolates reported to the National Salmonella Surveillance System by State, 1986 and 1987, in ranked order.

1986 State	#SE isolates	% of all isolates	1987 State	#SE isolates	% of all isolates
New Jersey	635	37.0	Delaware	19	43.2
Pennsylvania	948	31.4	Connecticut	567	39.6
Maryland	401	29.4	New York	1390	38.6
New York	1124	29.3*	New Jersey	616	38.2
Connecticut	252	24.2	Utah	41	35.0
Massachussetts	551	22.5	Pennsylvania	880	32.5
Vermont	26	19.8	Maryland	602	26.5
Ohio	208	17.8	Mississippi	29	23.6
Maine	28	16.7	Maine	46	22.6
Indiana	84	14.5	Massachussetts	470	22.1
North Dakota	11	14.1	Vermont	26	22.0
Montana	9	13.2*	South Dakota	18	19.1
Washington	101	12.8	Florida	3	16.7
Minnesota	53	12.8	Oregon	39	14.8
South Dakota	11	12.5	North Dakota	12	14.8
Utah	15	12.3	Ohio	196	14.5
West Virginia	23	12.2	Iowa	23	12.3
Delaware	7	11.3	Virginia	193	12.3
Oregon	20	10.7	Michigan	190	12.1
Wisconsin	89	9.7	Colorado	67	11.6*
Kentucky	23	9.4	Washington, DC	32	11.2
Tennessee	85	9.0	Illinois	320	11.1
Virginia	106	8.9	Indiana	64	10.3
Iowa	24	8.9	Minnesota	58	10.2
South Carolina	49	8.5	West Virginia	25	10.2
Michigan	120	8.1	Washington	61	9.6
Illinois	238	7.8	Wisconsin	79	8.4
North Carolina	117	7.3	Rhode Island	21	8.1
Arizona	26	7.2	Missouri	48	7.6
Colorado	23	7.0	Tennessee	72	7.1
Missouri	47	6.9	Kansas	25	7.0
Alabama	47	6.6	Alaska	7	6.6
Rhode Island	15	5.7*	California	361	6.2
Georgia	72	4.7*	North Carolina	87	5.2
Alaska	8	4.5	New Mexico	22	5.1
California	261	4.5	Kentucky	12	4.6
Arkansas	16	4.3	South Carolina	30	4.5
New Mexico	13	3.9	Oklahoma	13	4.2
Louisiana	16	3.3	New Hampshire	9	3.6*
Hawaii	15	3.2	Texas	59	3.5
Texas	54	3.2	Alabama	28	3.4*
Kansas	6	1.8	Arizona	12	3.0
Oklahoma	2	0.6	Montana	2	2.8*
Washington, DC	1	0.5	Louisiana	27	2.6
New Hampshire	0	0.0*	Hawaii	12	2.3
Nebraska	0	0.0	Georgia	35	2.2*
Nevada	0	0.0	Arkansas	2	0.6
Mississippi	0	0.0*	Nevada	0	0
			Nebraska	0	0
			Idaho	0	0
			Wyoming	0	0

*Greater than 20% (up to 100%) of reported isolates included in the denominator for this calculation were not serotyped, so that the proportional contribution of SE could be substantially greater than indicated here.