Approved: March 20, 1995

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on March 16, 1995 in Room 423-S of the State Capitol.

All members were present except: Representative Gerald Geringer - excused

Committee staff present: Norman Furse, Revisor of Statutes
Emalene Correll, Legislative Research Department
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Senator Doug Walker
Elizabeth Saadi, Director of the KDHE Office of Health Care
Mary Ann Gabel, Executive Director, Behavorial Sciences Regulatory Board
Ronald Hein, for the Kansas Association for Marriage and Family Therapy
Patsy Johnson, Executive Administrator, Kansas State Board of Nursing
Carolyn Middendorf, President, Kansas State Nurses' Association
Joan Sevy, Chair of the Kansas Organization of Nurse Executives

Others attending: See Guest List, Attachment 1.

The minutes of the meeting held on March 15, 1995 were approved.

**Substitute for SB 293 - Annual report on health care data by secretary of health and environment**

The hearing was opened. Senator Doug Walker testified in support of the bill by describing K.S.A. 65-6801 which requires a Health Care Data Governing Board to report to the Legislature information that will enable improvement of the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services. **Substitute for SB 293** sets a date of February 1 of each year requiring the board to report its progress in meeting the requirements of the statute. Senator Walker directed the committee's attention to the article on the Pennyslvania Health Care Cost Containment Council, which is a part of his testimony. (See Attachment 2.)

Elizabeth Saadi, Director of the KDHE Office of Health Care, testified that the Department has no objection to the bill (see Attachment 3).

Questions were then directed to the conferees. Representative Freeborn asked Senator Walker if the Pennsylvania report is an example of the Kansas goal? He answered that's not the bill's intent especially, but speaking as a sponsor of the original legislation, this bill is designed to install a reporting date.

The hearing was closed.

**SB 216 - Marriage and family therapist registration without examination**

The hearing on the bill was opened. Mary Ann Gabel, of the Behavorial Sciences Regulatory Board, testified in support of the bill the board has requested. The bill extends the deadline to January 1, 1996 to grandparent the provision that waives the examination requirement for those professional individuals who failed to meet the first grandparent filing deadline of October 1, 1993. She described the efforts that despite the efforts of the board and interested groups, many did not become aware of that requirement. Ms. Gabel stated there are some 750 persons that wish to be registered via this bill (see Attachment 4).

Ronald Hein, speaking in behalf of the Kansas Association for Marriage and Family Therapy, supported **SB 216** (see Attachment 5).

Questions were then asked of the conferees. Representative Gilmore asked Ms. Gabel when was the law first in effect and what will be done to publish the extended date? Ms. Gabel answered that it was July 1, 1992 and that interested organizations, as well as the Board, will make every effort to notify those who may be

interested in the extended date. The cost of examination is $260; the application fee is $150; so it does have some economic impact on applicants.

Representative Rutledge asked if the Board will be returning in two years with this same request? Ms. Gabel replied "no," that this bill is an attempt to be user-friendly, responding to the needs of the constitutents. She said the original regulation is a voluntary registration act which restricts the use of certain titles relating to marriage and family therapists.

Chairperson Mayans indicated that written supporting testimony from Jeff Lane of the Family Psychological Center, P.A. in Wichita, has been distributed to each committee member (Attachment 6). The hearing was then closed.

**SB 151 - Licensure of nurses and mental health technicians; information from KBI**

The hearing was opened. Patsy Johnson, of the Kansas State Board of Nursing, testified in support of the bill which would exempt the continuing education requirement for license renewals for new graduates and those who have reinstated or have been endorsed within nine months of the renewal date. The bill also includes authority for the Board to assess a hearing fee to cover the various expenses incurred for a hearing involving nurses and mental health technicians, and to have those fees remitted to the agency's fee fund. Ms. Johnson recommended an amendment to Section 2, lines 12-19, to delete language which would have impacted the Board's use of criminal history information. After the amendment, the bill gives authority to the board to receive certain criminal record information on their applicants. Ms. Johnson also discussed other elements of the bill, including authority to regulate and define the delegation of nursing procedures to unlicensed individuals (see testimony, Attachment 7).

Carolyn Middendorf, for the Kansas State Nurses' Association, testified in support of **SB 151**. She stated the Association supports the bill in its current form with the Senate amendments and the proposed section on delegation of nursing procedures (see Attachment 8).

Joan Sevy, of the Kansas Organization of Nurse Executives, expressed support of the bill and the proposed amendments. She described the process the organization followed in considering the Senate amendments and their impact; and the consensus agreement the organization attained as to the meaning of certain words and concepts, including "nursing procedures." (See Attachment 9). There being no quesions about the bill, the hearing was closed.

**SB 8 - Definitions of adult care homes**

Representative Morrison presented the Subcommittee Report on **SB 8** and indicated the committee has developed a "balloon" amendment to further amend the bill. The "balloon" includes technical amendments and the inclusion of authority, definition, and parameters for practice of skilled nursing care in various long term care facilities including assisted living facilities. (See Attachment 10.)

Representative Morrison pointed out that a new Section 7 sets out a range of definitions and requirements for licensing and oversight of adult care home administrators; gives the board subpoena powers with respect to the exercise of its powers and directs the KBI to provide criminal history public record information for determining qualifications of licensees and applicants.

Representative Merritt asked if an amendment to change all references from nursing "tasks" to nursing "procedures" throughout the bill would be in order. Representative Merritt moved, and Representative Morrison seconded, that wherever "nursing tasks" are included in **SB 8**, it be amended to read "nursing procedures." The motion carried unanimously.

On motion of Representative O'Connor, seconded by Representative Howell, the committee adopted the Subcomittee Report on **SB 8**.

On motion of Representative Haley, seconded by Representative Merritt, the committee unanimously passed **SB 8**, as amended.

**Sub SB 293 - Annual report on health care data by secretary of health and environment**

On motion of Representative Henry, seconded by Representative Freeborn, the committee unanimously passed **Sub SB 293**.

**SB 216 - Marriage and family therapist registration without examination**

Representative Merritt moved, and Representative Hutchins seconded the motion, that **SB 216** be passed. In discussion, Representative Yoh questioned if new applicants should also be grandfathered to the year 2000 so they will be treated the same as those affected by this bill. Mr. Furse answered that the current law would not affect new people as a new applicant would be required to have practiced five years prior to application. After discussion, no amendment was offered. The call on the motion was made. The committee voted to pass **SB 216**.

**SB 151 - Licensure of nurses and mental health technicians; information from KBI**

On motion of Representative Morrison, seconded by Representative Rutledge, the committee amended **SB 151**, section 2(f) by allowing the State Board of Nursing to receive criminal history public information and deleting the language concerning disclosure or use of such information as shown on page 4, lines 12-19.

On motion of Representative Morrison, seconded by Representative Merritt, **SB 151** was unanimously passed, as amended.

Chairperson Mayans noted that the Committee's meeting on Monday, March 20, will be to hear **SB 57** (athletic trainers registration act) and **SB 263** (long-term care ombudsman access to records).

The meeting was adjourned at 2:50 p.m.

The next meeting is scheduled for March 20, 1995.

# HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE
## GUEST LIST
## MARCH 16, 1995

| NAME | REPRESENTING |
|---|---|
| Pat Johnson | Board of Nsg |
| Sidney Gleyn | KSBN |
| Josh Keene | KOHL |
| PAT MABEN | " " |
| Kay Hale | ILHA |
| Joan Seay | KONE |
| Carolyn Middendorf | KSNA |
| Dawn Reid | KSNA |
| KEITH R LANDIS | CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS |
| Michelle Peterson | Ks Governmental Consulting |
| Peggy Jarman | PCAL |
| Lou Saali | KDHE |
| Kinderknecht | BSRB |
| Mary Ann Gabel | BSRB |
| Stacey Campson | Heim, Ebert & Weir |
| Jon Frederick | Pete McGill & Assoc |
| TIM BRUNO | Allen Assoc. |
| Terri Roberts | KSNA |
| LORNE PHILLIPS | KDHE |

HOUSE H&HS COMMITTEE
3 - 16 - 1995
Attachment 1-1

# HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST MARCH 16, 1995

| NAME | REPRESENTING |
|---|---|
| Ron Heiu | KAHF7 |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

STATE OF KANSAS

DOUG WALKER
SENATOR, 12TH DISTRICT
ANDERSON, BOURBON, FRANKLIN,
LINN, MIAMI COUNTIES

TOPEKA

SENATE CHAMBER

OFFICE OF DEMOCRATIC WHIP

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER:
EDUCATION
PUBLIC HEALTH AND WELFARE
MEMBER: ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
HEALTH CARE DECISIONS FOR THE '90s

# TESTIMONY IN SUPPORT OF SUBSTITUTE FOR SB 293

In 1990, Governor Hayden by Executive Order created the Governor's Commission on Health Care to review and make recommendations on improving the Kansas Health Care system. After extensively reviewing reports from past commissions and the status of health care, the Commission made 46 different recommendations. All of its recommendations were designed to incrementally improve the market based health care system. Recommendation number 43 reads: " Require providers to make price information available to consumers of health care."

The 1993 legislature created the Health Care Data Governing Board to collect health care data. I have attached to my testimony a copy of the 1993 enabling legislation for the Health Care Data Governing Board which

212 FIRST STREET
OSAWATOMIE, KANSAS 66064
913-755-4192



STATEHOUSE 138-N
TOPEKA, KS 66612-1504
913-296-7380

reads in part: "The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. . . . It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all medical care facilities. . . . The information is to be compiled and made available in a form prescribed by the Governing Board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services."

The Health Care Data Governing Board has been in existence for almost two years and as yet we have not received any of the information mandated in the enabling legislation. Substitute for SB 293 sets a date of February 1 of each year for the Health Care Data Governing Board to report to the legislature as to its progress in compiling and disseminating the information they were established to compile and disseminate.

CASE ANNOTATIONS

1. Kansas residency not required for unemancipated pregnant minor to seek waiver of parental notification. In re Doe, 17 K.A.2d 567, 843 P.2d 735 (1992).

## Article 68.—HEALTH CARE DATA

**65-6801.** Health care database; legislative intent; use of information. (a) The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

(b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all medical care facilities as defined by subsection (h) of K.S.A. 65-425, and amendments thereto, and all other health care providers to the extent required by K.S.A. 1993 Supp. 65-6805 and amendments thereto.

(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

History: L. 1993, ch. 174, § 1; July 1.

**65-6802.** Same; request for and use of data by department of health services administration of university of Kansas. (a) The department of health services administration of the university of Kansas and any institute or center established in association with the department is hereby authorized to request data for the purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from public, private and quasi-public entities.

(b) The department of health services administration of the university of Kansas may request data for purposes of conducting research, policy analysis and preparation of reports describing the performance of the health care delivery system from any quasi-public or private entity which has such data as deemed necessary by the department.

History: L. 1993, ch. 174, § 2; July 1.

**65-6803.** Same; health care data governing board created; appointment of task force or task forces; meetings and duties of the board. (a) There is hereby created a health care data governing board.

(b) The board shall consist of seven members appointed as follows: One member shall be appointed by the Kansas medical society, one member shall be appointed by the Kansas hospital association, one member shall be appointed by the executive vice chancellor of the university of Kansas school of medicine, one member representing health care insurers or other commercial payors shall be appointed by the governor, one member representing adult care homes shall be appointed by the governor, one member representing the institute associated with the university of Kansas department of health services administration and one member representing consumers of health care shall be appointed by the governor. The secretary of health and environment, or the designee of the secretary, shall be a nonvoting member who shall serve as chairperson of the board. The secretary of social and rehabilitation services and the insurance commissioner, or their designees, shall be nonvoting members of the board. Board members and task force members shall not be paid compensation, subsistence allowances, mileage or other expenses as otherwise may be authorized by law for attending meetings, or subcommittee meetings, of the board. The members appointed to the board shall serve for three-year terms, or until their successors are appointed and qualified.

(c) The chairperson of the health care data governing board may appoint a task force or task forces of interested citizens and providers of health care for the purpose of studying technical issues relating to the collection of health care data. At least one member of the health care data governing board shall be a member of any task force appointed under this subsection.

(d) The board shall meet at least quarterly and at such other times deemed necessary by the chairperson.

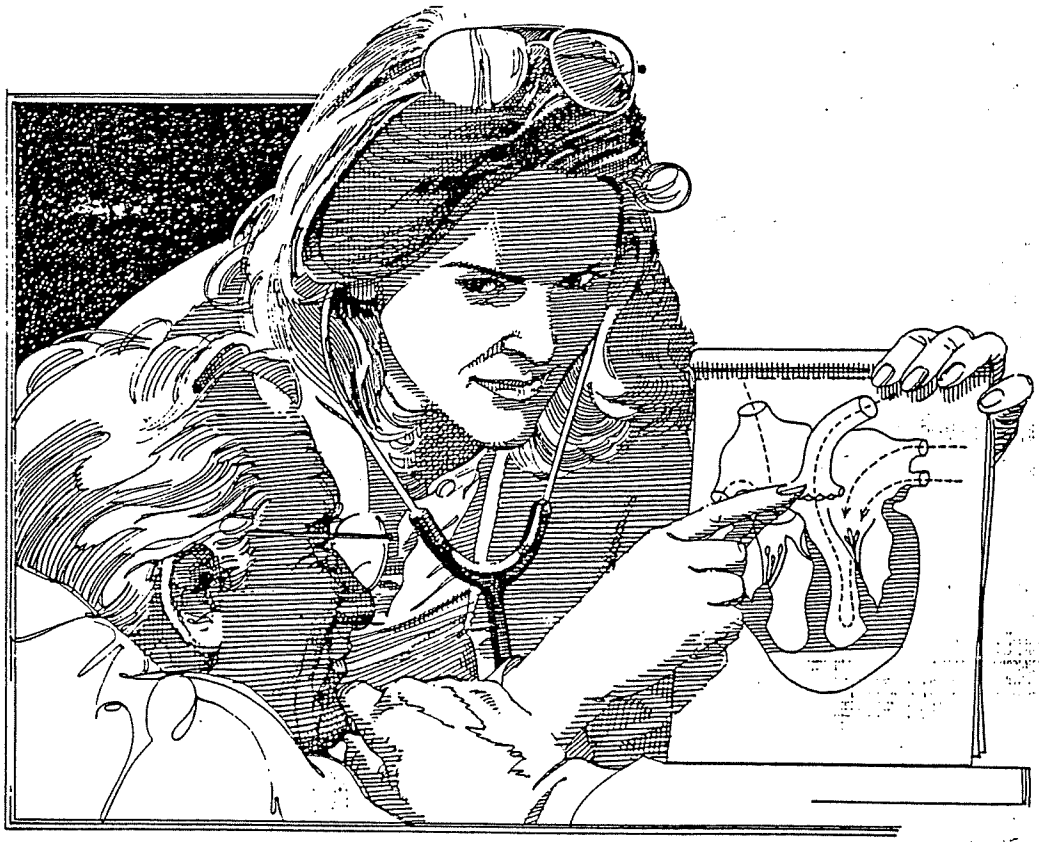
(e) The board shall develop policy regarding the collection of health care data and procedures for ensuring the confidentiality and security of these data.

History: L. 1993, ch. 174, § 3; July 1.

**65-6804.** Same; duties of secretary of health and environment; contract for data collection; rules and regulations. (a) The secretary

A Consumer Guide to

# Coronary Artery Bypass Graft Surgery



PENNSYLVANIA HEALTH CARE
COST CONTAINMENT COUNCIL

*Pennsylvania's Declaration of Health Care Information*

# Foreword

The Pennsylvania Health Care Cost Containment Council has prepared this booklet for people considering coronary artery bypass graft surgery. Ask your doctor questions about the information in it. If you have questions that aren't covered in this booklet, again, ask your doctor. You may also wish to discuss the contents of this booklet with your hospital representative and the insurance benefits person where you are employed.

The Pennsylvania Health Care Cost Containment Council is an independent state agency responsible for addressing the cost and quality of health care in Pennsylvania. The Council promotes health care competition through the collection, analysis, and public distribution of uniform cost and quality health care information.

In the mid-1980's, the major interest groups in Pennsylvania which were involved in health care financing became increasingly concerned about the rising cost of health care. Businesses were devoting an increasing portion of their resources to costly health benefits for their employees. Labor union members were struggling, often going on strike, to prevent the erosion of valued health care benefits. Health care providers were concerned that payments for services were not covering their costs. The Commonwealth also recognized that health care costs were consuming a staggering portion of the state's annual budget. These same groups were also concerned that efforts to contain costs should not undermine access to health care in Pennsylvania.

The combined support of these groups, as well as insurers and consumers, encouraged the Pennsylvania General Assembly to pass Act 89 in 1986 which created the Health Care Cost Containment Council. This report is the latest in a series of reports designed to assist the public in making more informed health care choices.

**A technical report with a detailed explanation of the research methods used to prepare this information may be obtained by contacting the Council office at the address listed below. In addition, hospitals and physicians may have elected to comment on the information presented in this booklet. A free copy of those comments may also be obtained by contacting the Council office.**

**Pennsylvania Health Care Cost Containment Council**
**Harrisburg Transportation Center**
**Harrisburg, PA 17101**
**(717) 232-6787**

# Table of Contents

# Introduction

About 68 million Americans have some form of heart-related disease. It is the leading cause of death in the United States. This booklet is designed to provide consumers with information on the surgical procedure used to treat one type of heart disease known as atherosclerotic coronary artery disease.

**This booklet will help you make comparisons among hospitals and cardiac surgeons should you require surgical treatment for coronary artery disease. It can also help you know which questions to ask your doctor, and to make a more informed choice when selecting a hospital or surgeon for coronary artery bypass graft surgery (CABG). Please use this information in conjunction with your doctor and hospital.**

The information is based on reports from the 35 of the 36 Pennsylvania hospitals certified to perform coronary artery bypass graft surgery during 1990. (Conemaugh Valley Memorial Hospital did not perform enough procedures in 1990 to be included in this report, since their coronary bypass surgical unit just opened that year.)

The charts show the average charge and the number of CABG surgery patient deaths for each hospital in Pennsylvania where at least 30 coronary bypass operations were performed. The charts also show the number of CABG surgery patient deaths for each cardiac surgeon who performed at least 30 coronary bypass operations. Thirty is considered a minimum number in order for the information to be statistically meaningful.

**What is athersclerotic coronary artery disease?**

Atherosclerotic coronary artery disease occurs when the arteries which supply blood to the heart muscle become lined with fatty deposits, harden, and become partially blocked. The amount of blood reaching the heart is reduced. This reduced flow of blood can cause chest pain (angina), or a heart attack.

**What is cardiac catheterization?**

Cardiac catheterization is a diagnostic test procedure performed with the aid of x-rays to identify blockages or narrowed areas in the heart vessels. This test helps determine if coronary artery bypass graft surgery is needed. A long, thin tube called a catheter is inserted into a blood vessel in the arm or groin and threaded into the coronary arteries. Dye is injected through the catheter, and x-rays of the vessels are taken.

**What methods are used to treat heart disease?**

It is important to discuss this with your physician. Depending on a patient's condition and the doctor's recommendation, the following are among treatment methods that might be used: changes in lifestyle habits such as diet or smoking, medication, balloon angioplasty, laser angioplasty, and coronary artery bypass graft surgery. This report deals with coronary artery bypass graft operations, which are performed by a cardiac surgeon. However, when seeking treatment for heart disease, a physician known as the cardiologist is usually involved in the diagnosis of heart disease. In general, it is the cardiologist who will diagnose the problem, and refer the patient to a cardiac surgeon if surgery is being considered or recommended. This report can be used in conjunction with the advice of your cardiologist in selecting a cardiac surgeon.

# Hospitals Performing Coronary Artery Bypass Graft Surgery
## Treatment Effectiveness & Average Charge

| Hospital | Total Patients | Patients Who Died | | | Average Charge (in dollars) |
|---|---|---|---|---|---|
| | | Actual Number | Expected Range | Statistical Rating | |
| *Hospitals with Fewer Number of Deaths than Expected* | | | | | |
| Allegheny General Hospital | 1,010 | 25 | 29.32 - 52.60 | + | $46,704 |
| Altoona Hospital | 332 | 4 | 5.35 - 18.08 | + | $27,333 |
| Hahnemann University Hospital | 847 | 26 | 29.44 - 53.49 | + | $65,825 |
| Reading Hospital and Medical Center | 526 | 12 | 15.99 - 33.76 | + | $21,063 |
| *Hospitals With Similar Number of Deaths as Expected* | | | | | |
| Albert Einstein Medical Center | 581 | 23 | 20.85 - 41.08 | Δ | $61,971 |
| Bryn Mawr Hospital | 300 | 15 | 5.63 - 17.69 | Δ | $49,309 |
| Central Medical Center & Hospital | 335 | 14 | 8.45 - 23.18 | Δ | $46,544 |
| Episcopal Hospital | 285 | 18 | 8.05 - 21.64 | Δ | $44,081 |
| Geisinger Medical Center /Danville | 323 | 15 | 3.91 - 15.30 | Δ | $30,202 |
| Hamot Medical Center | 444 | 16 | 6.21 - 19.82 | Δ | $34,769 |
| Lancaster General Hospital | 673 | 17 | 13.75 - 31.79 | Δ | $24,307 |
| Lankenau Hospital | 584 | 25 | 15.57 - 33.74 | Δ | $48,261 |
| Medical College Hospitals /Main Clinical Campus | 174 | 7 | 1.61 - 10.73 | Δ | $56,530 |
| Mercy Hospital of Pittsburgh | 682 | 20 | 17.62 - 36.42 | Δ | $39,002 |
| Montefiore University Hospital | 204 | 11 | 1.67 - 11.23 | Δ | $54,479 |
| Pennsylvania Hospital | 90 | 1 | 0.72 - 7.79 | Δ | $51,164 |
| Polyclinic Medical Center | 330 | 8 | 2.28 - 12.75 | Δ | $39,314 |
| Presbyterian Medical Center of Philadelphia | 478 | 14 | 13.58 - 30.74 | Δ | $42,408 |
| Presbyterian-University Hospital | 171 | 6 | 2.37 - 12.59 | Δ | $70,089 |
| Robert Packer Hospital | 386 | 10 | 5.04 - 17.96 | Δ | $21,246 |
| Saint Luke's Hospital of Bethlehem | 337 | 14 | 7.84 - 21.67 | Δ | $33,245 |
| Saint Vincent Health Center | 304 | 11 | 4.10 - 16.25 | Δ | $45,667 |
| Shadyside Hospital | 714 | 23 | 22.07 - 42.50 | Δ | $56,015 |
| Temple University Hospital | 258 | 20 | 8.12 - 22.44 | Δ | $65,303 |
| Thomas Jefferson University Hospital | 292 | 14 | 6.45 - 19.05 | Δ | $52,464 |
| University Hospital Milton S. Hershey Medical | 201 | 6 | 3.27 - 13.44 | Δ | $33,282 |
| Western Pennsylvania Hospital | 579 | 10 | 9.29 - 24.87 | Δ | $57,569 |
| Wilkes-Barre General Hospital | 214 | 4 | 2.32 - 12.23 | Δ | $29,746 |
| *Hospitals With Greater Number of Deaths Than Expected* | | | | | |
| Graduate Hospital | 287 | 20 | 4.71 - 17.00 | – | $83,851 |
| Harrisburg Hospital | 467 | 21 | 6.42 - 20.09 | – | $39,587 |
| Hospital of the University of Pennsylvania | 354 | 33 | 8.50 - 22.38 | – | $76,928 |
| Lehigh Valley Hospital | 920 | 46 | 20.67 - 40.69 | – | $39,186 |
| Mercy Hospital /Scranton | 415 | 27 | 7.90 - 21.79 | – | $23,885 |
| Saint Francis Medical Center | 463 | 31 | 13.26 - 29.03 | – | $48,808 |
| York Hospital | 335 | 13 | 2.23 - 11.96 | – | $26,334 |
| STATEWIDE TOTAL | 14,895 | 580 | | | $44,649 |

*Hospitals and Physicians may have commented on this report. Copies are available upon request.*
*Source: Pennsylvania Health Care Cost Containment Council, 1990 data.*

## "HOW TO READ THE CHARTS"

This chart is presented as a guide to help readers understand information in the charts. Please note that these are not actual data, but used for reference purposes only.

# Hospitals Performing Coronary Artery Bypass Graft Surgery

Treatment Effectiveness & Average Charge

| 1 Hospital | 2 Total Patients | Patients Who Died: 3 Actual Number | 4 Expected Range | 5 Statistical Rating | 6 Average Charge (in dollars) |
|---|---|---|---|---|---|
| 7 *Hospitals With Fewer Number of Deaths Than Expected* | | | | | |
| Hospital A | 150 | 8 | 8.44 - 12.23 | + | $59,438 |
| 8 *Hospitals With Similar Number of Deaths as Expected* | | | | | |
| Hospital G | 276 | 9 | 6.21 - 9.20 | Δ | $39,946 |
| 9 *Hospitals With Greater Number of Deaths Than Expected* | | | | | |
| Hospital M | 508 | 31 | 18.67 - 28.15 | – | $44,789 |

1. Name of hospital where surgery was performed.

2. Actual number of patients treated at the hospital in 1990 for coronary bypass surgery.

3. Actual number of patients admitted to the hospital for coronary bypass surgery, who died.

4. The expected range of patient deaths at the hospital, taking into account the age, sex, and medical condition of that hospital's patients.

5. Compares the actual number of patient deaths to the statistically expected number of patient deaths for that hospital:

   \+ hospital had significantly fewer deaths than expected;

   – hospital had significantly more deaths than expected;

   Δ the hospital's number of patient deaths was not significantly different than expected.

6. The average amount billed for the stay in the hospital for coronary bypass surgery.

7. Hospitals with significantly fewer deaths than expected (plus symbol) are grouped together in this table.

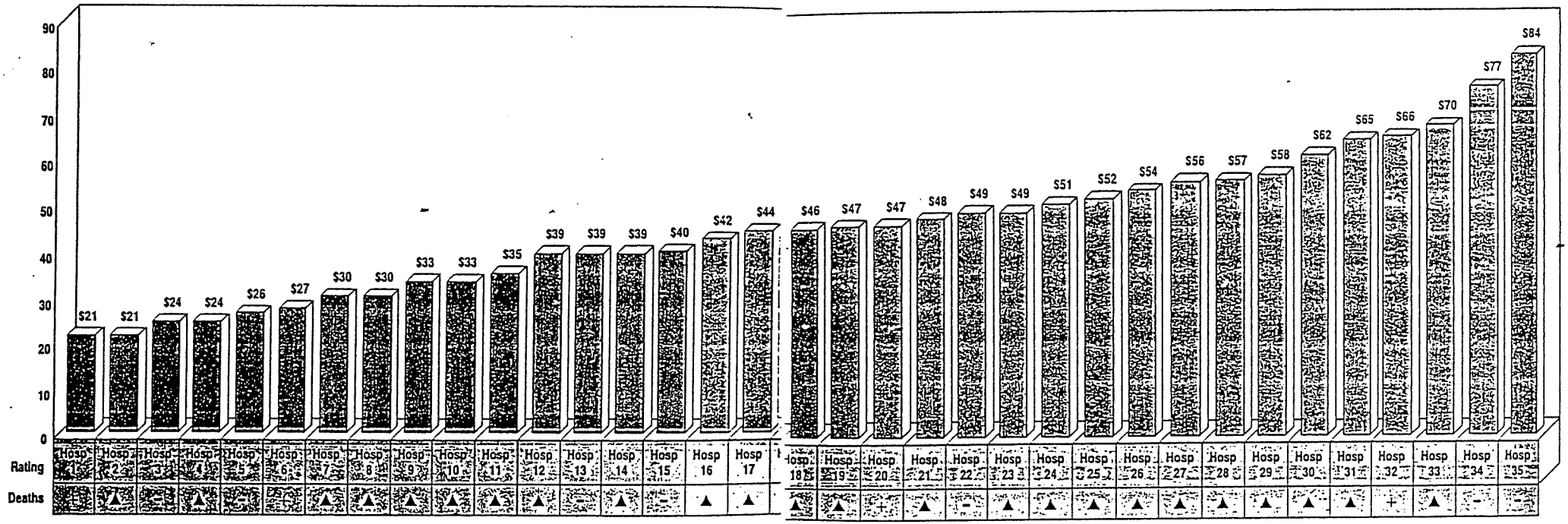
8. Hospitals with similar numbers of deaths as expected (triangle symbol) are grouped together.

9. Hospitals with greater number of deaths than expected (minus symbol) are grouped together.

# Chart of Hospital Average Charges and Patient Deaths

## Coronary Artery Bypass Graft Surgery

### Listed Lowest to Highest by Charge




**Hospital Key**

1 Reading Hospital and Medical Center
2 Robert Packer Hospital
3 Mercy Hospital/Scranton
4 Lancaster General Hospital
5 York Hospital
6 Altoona Hospital
7 Wilkes-Barre General Hospital
8 Geisinger Medical Center/Danville
9 Saint Luke's Hospital of Bethlehem
10 University Hospital Milton S. Hershey Medical Center
11 Hamot Medical Center
12 Mercy Hospital of Pittsburgh
13 Lehigh Valley Hospital
14 Polyclinic Medical Center
15 Harrisburg Hospital
16 Presbyterian Medical Center of Philadelphia
17 Episcopal Hospital
18 Saint Vincent Health Center
19 Central Medical Center & Hospital
20 Allegheny General Hospital
21 Lankenau Hospital
22 Saint Francis Medical Center
23 Bryn Mawr Hospital
24 Pennsylvania Hospital
25 Thomas Jefferson University Hospital
26 Montefiore University Hospital
27 Shadyside Hospital
28 Medical College Hospitals/Main Clinical Campus
29 Western Pennsylvania Hospital
30 Albert Einstein Medical Center
31 Temple University Hospital
32 Hahnemann University Hospital
33 Presbyterian-University Hospital
34 Hospital of the University of Pennsylvania
35 Graduate Hospital

**Statistical Rating Key**

+ fewer deaths than expected
▲ same as/similar to expected
- more deaths than expected





2 - 10

# "HOW TO READ THE CHARTS"

This chart is presented as a guide to help readers understand information in the charts.
Please note that these are not actual data, but used for reference purposes only.

## Western Pennsylvania Area Hospitals
## Physician Practice Groups and Cardiac Surgeons
## for Coronary Artery Bypass Graft Surgery

### Treatment Effectiveness Measure

| 5 Hospital Physician Practice Group *and* Surgeons | 1 Total Patients | Patients Who Died | | |
|---|---|---|---|---|
| | | 2 Actual Number | 3 Expected Range | 4 Statistical Rating |
| 6 HOSPITAL NAME | 367 | 14 | 11.25 - 18.62 | Δ |
| 7 Practice Group Name | 203 | 8 | 6.91 - 9.73 | Δ |
| 8 Physician 1 * | 190 | 6 | 6.20 - 8.64 | Δ |
| Physician 2 | 13 | *less than 30 patients treated* | | |
| 9 Solo Practitioner Name | 164 | 6 | 5.69 - 7.23 | Δ |

1. Actual number of patients treated by the hospital, practice group, and individual physician in 1990 with coronary bypass surgery. The number of patients treated by each individual physician is listed next to their name.

2. Actual number of patients treated with coronary bypass surgery, who died during hospitalization.

3. The expected number of patient deaths for the hospital, practice group, and individual physician taking into account the age, sex, and condition of that practice group's patients.

4. Compares the actual number of patient deaths to the statistically expected number of patient deaths for that hospital, practice group or individual physician:

   \+ significantly fewer deaths than expected;

   – significantly more deaths than expected;

   Δ the actual number of patient deaths was not significantly different than expected.

5. The physician information is grouped first by one of three geographic areas in Pennsylvania (example: Western Pennsylvania area). Secondly by hospital name, then practice group name (or physician name if surgeon is a solo practitioner). The physicians within a practice group are listed alphabetically, under the practice group name.

6. Name of the hospital in which the following practice groups and individual physicians performed surgery.

7. Name of the physician practice group responsible for the surgery, followed by the individual surgeons who belong to the practice group.

8. Individual surgeons who belong to the practice group. An asterisk means this physician performed surgery at more than one hospital.

9. Individual surgeons practicing alone - not in a group.

# Western Pennsylvania Area Hospitals
## Physician Practice Groups and Cardiac Surgeons for Coronary Artery Bypass Graft Surgery

### Treatment Effectiveness Measure

| Hospital / Physician Practice Group / and / Surgeons | Total Patients | Patients Who Died | | |
|---|---|---|---|---|
| | | Actual Number | Expected Range | Statistical Rating |
| ALLEGHENY GENERAL HOSPITAL | 1,010 | 25 | 29.32 - 52.60 | + |
| Cardio-Thoracic Surgical Assoc., Inc. | 1,004 | 24 | 29.05 - 52.23 | + |
| Benckart, Daniel H. * | 153 | 2 | 1.45 - 10.76 | Δ |
| Burkholder, John A. * | 121 | 2 | 1.72 - 10.01 | Δ |
| Liebler, George A. * | 146 | 5 | 0.76 - 8.92 | Δ |
| Magovern, George J. Jr. * | 147 | 4 | 1.55 - 10.30 | Δ |
| Magovern, George J. Sr. | 18 | *less than 30 patients treated* | | |
| Magovern, James A. | 133 | 4 | 1.34 - 10.31 | Δ |
| Maher, Thomas D. * | 151 | 5 | 1.94 - 10.99 | Δ |
| Park, Sang B. * | 135 | 2 | 1.26 - 9.58 | Δ |
| McCabe, John S., MD | 6 | *less than 30 patients treated* | | |
| CENTRAL MEDICAL CENTER & HOSPITAL | 335 | 14 | 8.45 - 23.18 | Δ |
| Three Rivers Cardiac Institute | 335 | 14 | 8.45 - 23.18 | Δ |
| Darrell, John C. * | 72 | 1 | 0.00 - 6.60 | Δ |
| DiMarco, Ross F. * | 14 | *less than 30 patients treated* | | |
| DiPaola, Douglas J. * | 81 | 3 | 0.57 - 8.15 | Δ |
| Grant, Kathleen J. * | 53 | 1 | 0.00 - 4.45 | Δ |
| Pellegrini, Ronald V. * | 23 | *less than 30 patients treated* | | |
| Woelfel, George Frederick * | 92 | 5 | 0.77 - 8.61 | Δ |
| HAMOT MEDICAL CENTER | 444 | 16 | 6.21 - 19.82 | Δ |
| D'Angelo Clinic | 413 | 10 | 5.62 - 18.79 | Δ |
| D'Angelo, George J. | 149 | 4 | 0.29 - 7.99 | Δ |
| Kish, George F. | 57 | 0 | 0.00 - 3.95 | Δ |
| Marshall, William Gene Jr. | 58 | 2 | 0.00 - 4.36 | Δ |
| Sardesai, Prabhaker G. | 55 | 1 | 0.00 - 4.12 | Δ |
| Tan, Wilfredo S. | 94 | 3 | 0.00 - 6.40 | Δ |
| Hanson & Associates, Inc. | 31 | 6 | 0.00 - 2.58 | – |
| Hanson, Elbert Lawrence | 15 | *less than 30 patients treated* | | |
| Kerth, William J. | 16 | *less than 30 patients treated* | | |

Statistical Rating Key
+ fewer deaths than expected
– more deaths than expected
Δ the number of deaths was not different than expected

* *This surgeon has privileges at another hospital and some of his/her patients are listed under that hospital. Refer to the tables on pages 8 through 15 to identify these hospitals.*

*Hospitals and Physicians may have commented on this report. Copies are available upon request.*

State of Kansas

Bill Graves Governor

# Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

House Health and Human Services Committee

by

The Kansas Department of Health and Environment

Senate Bill 293

The Health Care Data Governing Board and the Kansas Department of Health and Environment see no problem with specifying the Annual Report be made on or before February 1 as a specific date for the Annual Report to be made to the legislature.

Testimony presented by: Elizabeth W. Saadi, Ph.D.
Director
Office of Health Care Information
March 16, 1995

HOUSE H&HS COMMITTEE
3-16-1995
Attachment 3

Office of Health Care Information, 109 SW 9th Street, Suite 400A, Topeka KS 66612-2219
Telephone: (913) 296-8627-------Fax: (913) 296-7025

STATE OF KANSAS

MA N GABEL, MPA, *Executive Director*

BOARD MEMBERS:
*Public Members*
JOHN S. HOMLISH, Ph.D.
RONALD D. REINERT
EDWARD F. WIEGERS, JD

*Psychology Representatives*
JOHN G. RANDOLPH, Ph.D.
GERALD K. GENTRY, Ph.D.

*Social Work Representatives*
THELMA JOHNSON SIMMONS, LMSW
KATHLEEN W. WADDELL, LSCSW

LICENSED PROFESSIONALS:
*Psychologists*
*Social Workers*

REGISTERED PROFESSIONALS:
*Masters Level Psychologists*
*Professional Counselors*
*Marriage and Family Therapists*
*Alcohol and Other Drug Abuse Counselors*

BEHAVIORAL SCIENCES REGULATORY BOARD
712 S Kansas Avenue
Topeka, KS 66603-3817
913/296-3240 — FAX 913/296-3112

TESTIMONY BEFORE THE HOUSE HEALTH & HUMAN SERVICES COMMITTEE

SB 216

THURSDAY, MARCH 16, 1995

CHAIRPERSON REP. CARLOS MAYANS AND COMMITTEE MEMBERS:

I am Mary Ann Gabel, Executive Director of the Behavioral Sciences Regulatory Board. I am appearing before you today on behalf of the board to request your favorable action on SB 216. Accompanying me is Cheryl Kinderknecht, Credentialing Specialist with the board and who works with this credentialed group.

SB 216 amends the marriage and family therapy registration act (RMFT) by extending the grandparenting registration deadline to January 1, 1996. The grandparenting provision waives the examination requirement.

Prior to and during the time when the board began to implement this credentialing act, the board satisfied the legal notification requirement by publishing notice in the Kansas Register. The board further notified individuals on the mailing list who had notified the board office that they intended to seek this new registration. In addition to the legal requirement, the board also requested that professional associations publish information concerning the new credentialing act, including application filing deadlines, in the respective newsletters. The following professional associations published the requested article: Kansas Chapter-NASW (National Association of So-

cial Workers); KPA (Kansas Psychological Association); KAMFT (Kansas Association of Marriage and Family Therapists); and KAPP (Kansas Association of Professional Psychologists). The board attempted to identify and notify all known groups that may have an interest in this credential and more than exceeded the legal requirement for notice.

Regardless of the efforts the board expended in attempting to notify known interested professional groups and individuals, the board has continued to receive both requests and complaints from persons who failed to meet the grandparenting filing deadline. A portion of the board's agenda at each of its meetings (subsequent to the deadline for filing applications) has been spent on dealing with these requests and complaints.

Rather than continuing to deal with individual requests on a case-by-case basis, which subjects the board to the possibility of acting or being perceived as acting in a capricious manner, the board requests that the legislature extend the RMFT statutory grandparenting deadline to January 1, 1996. This statutory amendment will permit one final opportunity for persons to apply for registration with waiver of the examination, which represents a one-time $260 cost savings to the applicant.

I thank you for your time and I welcome any questions you may have.

[950315/TESTIMON/SB216T/#1]

**HEIN, EBERT AND WEIR, CHTD.**
*ATTORNEYS AT LAW*
5845 S.W. 29th Street, Topeka, KS 66614-2462
Telephone: (913) 273-1441
Telefax: (913) 273-9243

*Ronald R. Hein*
*William F. Ebert*
*Stephen P. Weir*
*Stacey R. Empson*

HOUSE HEALTH AND HUMAN SERVICES
TESTIMONY RE: SB 216
Presented by Ronald R. Hein
on behalf of
Kansas Association for Marriage and Family Therapy
March 16, 1995

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Association for Marriage and Family Therapy. KAMFT is the state chapter of the American Association for Marriage and Family Therapy (AAMFT). KAMFT's membership is comprised of persons who have met the educational and professional criteria for membership to the AAMFT, and includes Registered Marriage and Family Therapists, Licensed Social Workers, Licensed and Registered Psychologists, and Psychiatrists.

The Kansas Association for Marriage and Family Therapy supports SB 216, which extends the period of time that Marriage and Family Therapists may register pursuant to the grandfather clause set out in the Registration Act.

When the act providing for registration of Marriage and Family Therapist was enacted, the grandfather clause provided for applications to be filed on or before January 1, 1993. Despite the efforts of the Board of Behavioral Sciences and their staff, it was impossible for everyone in the state who had an interest in this legislation to be notified. In many cases notice was given through association newsletters. Inadvertently, some individuals who desired to register were precluded from doing so within the time frame provided.

SB 216 would rectify that situation, and enable these professionals to register pursuant to that clause.

The Kansas Association for Marriage and Family Therapy strongly urges the committee to approve SB 216.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

# Family Psychological Center, P.A.

804 South Oliver / Wichita, Kansas 67218 / 316 685-9311 / Fax 316-685-6101

*Director*
**Jeff Lane, Ph.D.**
Forensic Psychologist
Diplomate American Board of Family Psychology
AASECT Certified Sex Therapist

Licensed Psychologists
Jeff Lane, Ph.D.
Linda McDonough, Ph.D.

Licensed
Clinical Social Workers
Beverly Becker, LSCSW
John Thele, LSCSW
Patricia Jones, LSCSW

Psychology Associates
Beverly Dixon Martin, M.Ed.
Linda Sullivan, Ed.S.
Tamara Patterson, Ed.S.

Primary Services
Forensic Psychological Evaluations
Counseling & Psychotherapy
*Abused*
*Divorce Mediation*
*Family*
*Individual*
*Children*
*Adolescents*
*Adults*
Psychological Testing and Evaluation
Workshops / Lectures

March 14, 1995

Lois Hedrick,
Secretary to the House Committee on Health and Human Services
(913) 296-1985

Dear Ms. Hedrick:

RE: Senate Bill 216

It is my understanding that a vote will occur on this in the House on the 16th of March, 1995. I want to encourage that this bill be passed.

I have been a licensed psychologist and marriage and family counselor, here in Wichita, for the past nineteen years. At the time the application deadline occurred to be registered as a marriage and family therapist, I had contracted pneumonia and was unable to send in the application until seventeen days after the deadline. Since that time, I have written back and forth, on numerous occasions, to the Behavioral Sciences Regulatory Board, requesting that my application be accepted because of medical reasons. Medical proof of the condition was provided. The BSRB, apparently because there were numerous other people in some sort of similar situation, did not approve the acceptance of my late application.

Consequently, I will be unable to be grandfathered in as a marriage and family therapist unless SB 216 is approved. My practice has consistently included marriage and family therapy, and I have held myself out to the public as such for the past nineteen years. Should I be unable to obtain registration, this will definitely effect and hurt my ability to provide and/or advertise these services, and to earn a living as a marriage and family therapist.

Consequently, I strongly ask that this Senate bill be approved so that my application will be processed.

Sincerely,

Jeff Lane, PhD

Jeff Lane, Ph.D., Kansas Licensed Psychologist #391
Diplomate, American Board of Family Psychology
AASECT Certified Sex Therapist

JL/vdj

HOUSE H&HS COMMITTEE
3 -16 - 1995
Attachment 6

# Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929
FAX 913-296-3929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-5752

To: The Honorable Representative Carlos Mayans, Chairperson
and Members of the Health & Human Services Committee

From: Patsy L. Johnson, M.N., R.N., A.R.N.P.
Executive Administrator
Kansas State Board of Nursing

Date: March 15, 1995

Re: SB 151

Thank you for allowing me to testify on SB 151 for the Board of Nursing.

In Section 1 (a), (page 1, lines 29-31), the Board requests an exemption of the continuing nursing education requirements for license renewal for new graduates and those individuals who have reinstated or endorsed within nine months of the renewal date. This exemption has been given in the past based on regulation. After review of the regulations, it was decided that the exemption needed to be put in statute. This same exemption has been put in the Mental Health Technician Act, Section 5, (page 6, lines 36-38.)

Two additions have been added to K.S.A. 65-1120 which is the discipline section of the Nurse Practice Act. Upon the suggestion of the agency's Assistant Attorney General, a hearing fee will be assessed for each hearing procedure. The agency has various expenses when conducting a hearing including mailing, copying, recording, and hearing officer. Under current statute, K.S.A. 74-1108, (Appendix A), twenty percent of all moneys received by the Board have to go into the general fund. Since there are specific costs attributed to the hearing process, the Board would like to have all moneys received remitted to the agency's





Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Patricia McKillip, R.N., Ph.D.
Education Specialist
296-3782

Diane Glynn, R.N., J.D.
Practice Specialist
296-4325

Mark S. Braun, J.D.
Assistant Attorney General
Disciplinary Counsel
296-4325

fee fund to defray those hearing costs, Section 2, (page 2, lines 36-38). This same language has been added to the Mental Health Technician Act, Section 6, (page 8, lines 38-40.)

The Board of Nursing has had an increasing number of applicants who have felony convictions. Currently, the agency is limited in the amount of information that can be obtained from the Kansas Bureau of Investigation. While conducting an investigation it is helpful to have access to criminal records. The Board requests information from the KBI about 10-12 times per year. Some of the new language which was added in order to receive more in depth information from the KBI, Section 2, (page 4, lines 5-19) has been amended out of the bill. Although the same language is found in the Healing Arts Act, K.S.A. 65-2839a (c), (Appendix B), Mr. Kyle Smith, an attorney for the KBI, informed me that the KBI would not release arrest and nonconviction data or criminal intelligence information to either the Board of Healing Arts or the Board of Nursing. Because of his insistence on this topic, the Board has agreed to the amendment, but will refer the issue to Attorney General Carla Stovall for further discussion. The Board does offer an additional balloon to delete language on lines 12-19 (next page). Because of the amended language all that the Board receives from the KBI is open record information. This same provision has been added to the Mental Health Technician Act, Section 6, (page 9, lines 7-20.)

Section 4, (page 6, line 21) has been updated to allow for the mental health technician to have a temporary permit for a maximum of 120 days. This provision was missed when it was added to the Nurse Practice Act.

Three changes are proposed for K.S.A. 65-1124, acts which are not prohibited. Provisions (k) and (l), Section 3, (page 5, lines 19-24), allow nurses in schools to delegate nursing procedures to unlicensed individuals. With input from school nurses, the Board asks that "handicapped" be removed from (k) and proposes that (l) be revoke entirely. There is only a minimal difference in the meanings of (k) and (l). Since there are nursing tasks being delegated for all students, it is believed that no specific reference is needed to handicapped students.

(2) repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board; or

(3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

*(f) Criminal justice information. The board may receive from the Kansas bureau of investigation or other criminal justice agencies such criminal history record information* ~~*(including arrest and nonconviction data), criminal intelligence information*~~ *and information relating to criminal* ~~*and background*~~ *investigations as necessary for the purpose of determining initial and continuing qualifications of licensees* ~~*and registrants*~~ *of and applicants for licensure* ~~*and registration*~~ *by the board. Disclosure or use of any such information received by the board or of any record containing such information, for any purpose other than that provided by this subsection is a class A misdemeanor and shall constitute grounds for removal from office, termination of employment or denial, revocation or suspension of any license* ~~*or registration*~~ *issued under this act. Nothing in this subsection shall be construed to make unlawful the disclosure of any such information by the board in a hearing held pursuant to this act.*

delete

Sec. 3. K.S.A. 1994 Supp. 65-1124 is hereby amended to read as follows: 65-1124. No provisions of this law shall be construed as prohibiting:

(a) Gratuitous nursing by friends or members of the family;

(b) the incidental care of the sick by domestic servants or persons primarily employed as housekeepers;

(c) caring for the sick in accordance with tenets and practices of any church or religious denomination which teaches reliance upon spiritual means through prayer for healing;

(d) nursing assistance in the case of an emergency;

(e) the practice of nursing by students enrolled in accredited schools of professional or practical nursing or programs of advanced registered professional nursing approved by the board nor nursing by graduates of such schools or courses pending the results of the first licensure examination scheduled following such graduation but in no case to exceed 90 days, whichever comes first;

(f) the practice of nursing in this state by legally qualified nurses of any of the other states as long as the engagement of any such nurse requires the nurse to accompany and care for a patient temporarily residing in this state during the period of one such engagement not to exceed six months in length, and as long as such nurses do not represent or hold themselves out as nurses licensed to practice in this state;

(g) the practice by any nurse who is employed by the United States government or any bureau, division or agency thereof, while in the dis-

2-7-95

The general provision (m), Section 3, (page 5, lines 29-34) was added in 1992 to allow nurses to delegate nursing tasks to unlicensed individuals. The Board originally asked for an amendment of this exception which would give the Board rule and regulation authority over delegation. Problems which exist are:

1. Nurses do not know how to delegate,
2. There has been an increase in disciplinary actions for inappropriate delegation,
3. There is an explosion of situations where unlicensed assistive personnel are being used,
4. Employers are mandating that nurses delegate, and
5. There is an increased potential for patient harm.

The number of disciplinary actions due to inappropriate delegation have grown since the law became effective in 1992 (Appendix C). A large majority of those cases involve nurses delegating to unlicensed assistive personnel the administration of medication. In 1992, there was an agreement between several groups including the Board that administration of medication could be a task. The agreement centered on the understanding that the client was stable medically with the same medications given on a routine basis. No nursing judgement was needed. The use of unlicensed personnel to administer medications is very limited with a nurse developing a plan for it. However, the limits are continually being exceeded with problems resulting.

The Board has identified a growing number of settings that unlicensed assistive personnel are being utilized. In 1992, the use of unlicensed persons was needed in home situations for the mentally retarded and handicapped. These were small group homes with around the clock use of unlicensed personnel to care for these clients. Nurses supervised the care which included medication administration. Currently there are many other settings in which delegation is needed such as the assisted living facilities, youth and adult correctional facilities, group homes for a variety of individuals including psychiatric youths, and day cares. Hospitals are totally reorganizing with increased use of unlicensed assistive personnel. A variety of titles are used for these unlicensed individuals; however, those titles do not

include the word "unlicensed" so patients and clients are unaware of the education level of those giving them care.

The last but the most important issue in this discussion is patient safety. The National Council of State Boards of Nursing just published an article which addressed the use of unlicensed assistive personnel (Appendix D). The Board also received a new release from the American Nurses Association which notes that loss of nursing jobs diminishes patient safety (Appendix E). Quality of care and patient safety is being directly affected. An article in the February 13, 1995, issue of Newsweek also emphases that this a growing national problem (Appendix F).

Because of all these reasons, the Board felt that a rule and regulation provision in K.S.A. 65-1124 (m) would provide for the direction of nursing delegation. Because of the objections to the Board writing rules and regulations, the Board convened a group of some 30 nurses who represented many areas of practice. The product of that meeting is the amended language in K.S.A. 65-1124 (m) as well as new section 7 defining the process of delegation (page 9, lines 23-40). The group favored the use of "procedure" rather than "task" since procedure would be a little broader term (Appendix G). A specific reference is made to administration of medication which would allow the procedure to be delegated. The definition of supervision was also added from K.S.A. 65-1136 (Appendix G).

In summary, most of the changes in SB 151 are updates to the Nurse Practice Act. Although not totally in agreement with the deletion of language on KBI information, we will leave as amended. Growing problems with nurses' delegating inappropriately stimulated the most controversial change. With excellent input and cooperation, the Board feels the amended language on delegation is a good compromise.

I hope the committee will pass SB 151 favorably. Thank you. I am available for questions.

1975, ch. 316, § 12; L. 1978, ch. 308, § 54; L. 1980, ch. 235, § 1; L. 1986, ch. 233, § 5; L. 1987, ch. 234, § 2; L. 1988, ch. 331, § 7; L. 1992, ch. 116, § 34, L. 1993, ch. 194, § 7; July 1.

**74-1108. Board of Nursing fee fund.** The executive administrator of the board of nursing shall remit all moneys received by the board from fees, charges or penalties, other than moneys received under K.S.A. 1986 Supp. 74-1109, to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury. Twenty percent of each such deposit shall be credited to the state general fund and the balance shall be credited to the board of nursing fee fund. All expenditures from such fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the president of the board or by a person or persons designated by the president.

History: L. 1973, ch. 309, § 26; L. 1983, ch. 206, § 13; L. 1986, ch. 286, § 1; July 1.

**74-1109. Fees for institutes, conferences and other educational programs offered by board; education conference fund.** The board of nursing is hereby authorized to fix, charge and collect fees for institutes, conferences and other educational programs offered by the board under subsection (c)(*4) of K.S.A. 74-1106 and amendments thereto. The fees shall be fixed in order to recover the cost to the board for providing such programs. The executive administrator of the board shall remit all moneys received by the board from fees collected under this section to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury, and such deposit shall be credited to the education conference fund which is hereby created. All expenditures from such fund shall be for the operating expenditures of providing such programs and shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the president of the board or by a person designated by the president.

History: L. 1986, ch. 286, § 2; July 1.

**74-1110 . Administrative fines.** The board of nursing, in addition to any other penalty prescribed by law, may assess a civil fine, after proper notice and an opportunity to be heard, against any person granted a license, certificate of qualification or authorization to practice by the board of nursing for a violation of a law or rule and regulation applicable to the practice for which such person has been granted a license, certificate of qualification or authorization by the board in an amount not to exceed $1,000 for the first violation, $2,000 for the second violation and $3,000 for the third violation and for each subsequent violation. All fines assessed and collected under this section shall be remitted promptly to the state treasurer. Upon receipt thereof, the state treasurer shall deposit the entire amount in the treasury and credit it to the state general fund.

History: L. 1992, ch. 151, § 6; April 30.

**74-1111. Attorney; appointment; salary; duties.** (a) The attorney general shall appoint, with the approval of the board of nursing, an assistant attorney general who shall carry out the duties under subsection (b). The attorney shall receive an annual salary fixed by the attorney general with the approval of the board of nursing. The salary shall be paid from moneys appropriated to the board of nursing in the board of nursing fee fund.

(b) The assistant attorney general appointed under subsection (a) shall represent the board of nursing in any proceedings or litigation that may arise in the discharge of the duties of the board of nursing and shall perform such other duties of a legal nature as may be directed by the board of nursing.

History: L. 1993, ch. 194, § 19; July 1.

ch. 313, § 118; L. 1986, ch. 229, § 43; July 1.

**Research and Practice Aids:**
Physicians and Surgeons ⇐ 11 et seq.
C.J.S. Physicians, Surgeons and Other Health-Care Providers § 35.

**Law Review and Bar Journal References:**
"Malpractice '87: Status and Solutions," M. Martin Halley, M.D., J.D., 88, No. 9, Kan.Med. 261, 263, 264 (1987).

CASE ANNOTATIONS

1. Findings of board supported by substantial evidence; district court may not substitute its judgment for that of the board; revocation of license upheld. Kansas State Board of Healing Arts v. Foote, 200 K. 447, 451, 436 P.2d 828.
2. "Suspension" and "revocation" differentiated; board may suspend, for temporary period, and later revoke license permanently. Kansas State Board of Healing Arts v. Seasholtz, 210 K. 694, 696, 504 P.2d 576 (1972).
3. Cited in opinion holding that 17-2708 of professional corporation law does not authorize medical practice by general corporation. Early Detection Center, Inc. v. Wilson, 248 K. 869, 877, 811 P.2d 860 (1991).

**65-2839.**

**History:** L. 1957, ch. 343, § 39; L. 1976, ch. 273, § 17; Repealed, L. 1984, ch. 238, § 17; July 1, 1984; Repealed, L. 1984, ch. 313, § 157; July 1, 1985.

**65-2839a. Investigations and proceedings conducted by board; access to evidence; subpoenas; access to criminal history; confidentiality of information.** (a) In connection with any investigation by the board, the board or its duly authorized agents or employees shall at all reasonable times have access to, for the purpose of examination, and the right to copy any document, report, record or other physical evidence of any person being investigated, or any document, report, record or other evidence maintained by and in possession of any clinic, office of a practitioner of the healing arts, laboratory, pharmacy, medical care facility or other public or private agency if such document, report, record or evidence relates to medical competence, unprofessional conduct or the mental or physical ability of a licensee safely to practice the healing arts.

(b) For the purpose of all investigations and proceedings conducted by the board:

(1) The board may issue subpoenas compelling the attendance and testimony of witnesses or the production for examination or copying of documents or any other physical evidence if such evidence relates to medical competence, unprofessional conduct or the mental or physical ability of a licensee safely to practice the healing arts. Within five days after the service of the subpoena on any person requiring the production of any evidence in the person's possession or under the person's control, such person may petition the board to revoke, limit or modify the subpoena. The board shall revoke, limit or modify such subpoena if in its opinion the evidence required does not relate to practices which may be grounds for disciplinary action, is not relevant to the charge which is the subject matter of the proceeding or investigation, or does not describe with sufficient particularity the physical evidence which is required to be produced. Any member of the board, or any agent designated by the board, may administer oaths or affirmations, examine witnesses and receive such evidence.

(2) Any person appearing before the board shall have the right to be represented by counsel.

(3) The district court, upon application by the board or by the person subpoenaed, shall have jurisdiction to issue an order:

(A) Requiring such person to appear before the board or the boards duly authorized agent to produce evidence relating to the matter under investigation; or

(B) revoking, limiting or modifying the subpoena if in the court's opinion the evidence demanded does not relate to practices which may be grounds for disciplinary action, is not relevant to the charge which is the subject matter of the hearing or investigation or does not describe with sufficient particularity the evidence which is required to be produced.

(c) The board may receive from the Kansas bureau of investigation or other criminal justice agencies such criminal history record information (including arrest and nonconviction data), criminal intelligence information and information relating to criminal and background investigations as necessary for the purpose of determining initial and continuing qualifications of licensees and registrants of and applicants for licensure and registration by the board. Disclosure or use of any such information received by the board or of any record containing such information, for any purpose other than that provided by this subsection is a class A misdemeanor and shall constitute grounds for removal from office, termination of employment or denial, revocation or suspension of any license or registration issued under this act. Nothing in this subsection shall be construed to make unlawful the disclosure of any such information by the board in a hearing held pursuant to this act.



7 - 7

Appendix C

# KANSAS STATE BOARD OF NURSING

## CASES ON INAPPROPRIATE DELEGATION

## (BY CALENDAR YEAR)

### PRIOR TO HAVING DELEGATION AUTHORITY

| | | |
|---|---|---|
| 1989 | 7 | |
| 1990 | 5 | |
| 1991 | 2 | |
| 1992 | 2 | (January through June) |

### AFTER DELEGATION AUTHORITY GIVEN IN STATUTE

| | | |
|---|---|---|
| 1992 | 10 | (July through December) |
| 1993 | 17 | |
| 1994 | 18 | |
| 1995 | 2 | (To date) |

# ional Council Unlicensed Assistive Personnel Letter Elicits Responses

*[The following is the text of a letter written by National Council President Marcia M. Rachel to government agencies and organizations involved in the provision of care by unlicensed assistive personnel. The letter, written at the direction of National Council's 1994 Delegate Assembly, was dated August 24, 1994. Responses to the letter appear on this and the following page.]*

Representatives of 55 boards of nursing recently met in Chicago for the National Council of State Boards of Nursing's Annual Meeting. At that meeting, the delegates adopted, with strong support, a motion that the National Council express its position in unequivocal terms that the inappropriate use of unlicensed personnel in lieu of licensed nurses is a detriment to the delivery of quality health care for the consumer. The National Council and all of its member boards of nursing hold as their highest goal the protection of the public health, safety, and welfare. In keeping with this commitment, the National Council urges you to consider the meaning of licensure, and the assurance of quality that it provides to patients, residents, and clients to whom nursing care is provided.

The use of unlicensed personnel has increased dramatically over the past decade and is projected to continue to grow. The Bureau of Labor Statistics predicts that by the year 2000, the number of home health aides will increase by 80 percent and nursing assistant positions by 33 percent. Although unlicensed persons can be trained to perform a variety of nursing tasks, a nurse's supervision of each unlicensed person who performs nursing tasks is essential to both coordination and safety of patient care.

In a 1990 position on delegation, the National Council defined acceptable delegation by nurses to others, including unlicensed personnel. Essential premises of that paper included: (1) that quality nursing care cannot be provided in isolation by unlicensed persons functioning independently of the nurse if the health, safety, and welfare of the public is to be assured; and (2) that a limited [or costly] supply of licensed nurses must not be used as an excuse for inappropriate delegation to unlicensed persons.

Delegation is an appropriate means, and a useful tool, to maximize the contributions of various members of the health care team to the well-being of the patient/client/resident when performed according to well-reasoned principles. The National Council's delegation paper sought to set out such principles. First, nurses should avoid delegating the practice-pervasive functions of assessment, evaluation, and nursing judgment. Second, the delegating nurse assumes responsibility for determining that the delegate is indeed competent to perform the delegated act and provides appropriate supervision. Third, boards of nursing must clearly define delegation in regulation, promulgate clear rules for its use, and follow through with disciplinary action when there is evidence that the rules are violated.

Underlying all of the above principles relative to delegation is a central tenet of professional regulation: that a license is a mechanism to assure the public of the competence of the licensee to practice safely and effectively. The process leading to licensure is therefore rigorous, including requirements for education (didactic and clinical) and examination. Such assurance cannot be replicated by training programs typically provided to unlicensed personnel. Nor can the accountability of unlicensed personnel match the accountability of the licensed nurse. The licensee is accountable not only to the employer, but also to the state authorities issuing the license. The licensee stands to lose not only his or her job, but also license, should the care provided not meet the standards for safety and effectiveness.

The National Council urges all who participate in the provision of health care to the public to consider and endorse the value of a license as an essential mechanism to assure the delivery of quality nursing care for the consumer.

Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

I am responding to [National Council's] letter urging us to safeguard public health and safety through prohibiting the use of unlicensed individuals instead of licensed nurses.

I would like to assure you that public health and safety is our paramount concern in setting standards for individuals and institutions that furnish care to Medicare and Medicaid beneficiaries. In establishing standards, we give heavy weight to the value of licensure. Nevertheless, there may be situations under which we are compelled (e.g., for statutory reasons) to permit unlicensed personnel to perform services that some might prefer to have performed by licensed nurses. Thus, while we will always strive to set the most appropriate rules and requirements, I cannot promise that we will always require the use of licensed nurses instead of other personnel.

Thomas Hoyer
Acting Director
Office of Coverage and Eligibility Policy
Bureau of Policy Development

7-9



Insight: Nurse Aide - C.N.A. Nurse Aides Assistive Personnel

American Association of Colleges of Nursing
One Dupont Circle, NW, Suite 530
Washington, DC 20036

American Association of Colleges of Nursing

September 12, 1994

AACN and other members of the Tri-Council for Nursing have had extensive discussions on the growing use of unlicensed personnel for the delivery of nursing care.

As you may be aware, in 1990 the Tri-Council did develop and adopt a position statement on personnel who are serving in roles that are assistive to the professional nurse. The position statement still stands the test of time and is pertinent to the issues you have raised in your letter.

AACN is aware of the need to assure the appropriate oversight and monitoring of nursing care delivery. Moreover, in keeping with the position statement, the AACN supports the view that it is incumbent upon the nursing profession to define the appropriate educational preparation for individuals delivering nursing care and that professional nurses retain the ultimate responsibility for tasks delegated to unlicensed personnel.

We applaud [National Council's] efforts to raise awareness of concerns for public health, safety, and welfare that could be generated through the inappropriate use of unlicensed personnel. AACN also maintains as one of its primary goals the assurance of public safety through the preparation of highly skilled and knowledgeable professional nurses. To that end, we will continue to discuss this issue.

Geraldine Polly Bednash, PhD, RN, FAAN
Executive Director

American Medical Association
515 North State Street
Chicago, Illinois 60610

American Medical Association
Physicians dedicated to the health of America

September 27, 1994

The American Medical Association (AMA) shares [National Council's] concerns about maintaining the quality of patient care in all settings, especially during the rapid changes that are occurring in the health care system. The AMA has long recognized that nurses are very important in maintaining the quality of medical care, and I know [National Council's] efforts will continue in the future.

The AMA continues to be a supporter of enhanced education for nurses and also for other personnel as a method of improving the quality of patient care. At the present time AMA supports all levels of nursing education, including the education of licensed practical nurses (LPN) who meet a vital need of patients for basic bedside care. I applaud the initiatives of the nursing profession in preparing and licensing LPNs who can appropriately work to answer the needs of health care reform for a multiskilled, economic, nursing workforce.

The complexity of patient care demands the full cooperation of the health care team, including physicians and nurses working together to ensure the safety of our patients. In these times of increasing cost consciousness, the system seems to be demanding that both our professions work to conserve resources and mentor and supervise unlicensed personnel that assist both physicians and nurses in the delivery of patient care at less cost. Physicians accept the responsibility of delegating to other health care workers, many of whom we help to educate. It is this sense of responsibility and collaboration that promotes the welfare of the patients we all serve. Whether money is truly saved is another matter, but nurses and physicians will need to be especially vigilant as more unlicensed helpers are having direct contact with patients.

James S. Todd, MD
Executive Vice President



7 - 10

American Nurses Association
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
TEL 202 651 7000
FAX 202 651 7001

NEWS RELEASE

**EMBARGOED UNTIL:**
9:30 a.m. (EST)
February 7, 1995

**CONTACT:** Sara Foer (202) 651-7023
Joan Meehan (202) 651-7020
Lisa Wyatt (202) 651-7019

## LOSS OF NURSING JOBS IS DIMINISHING THE SAFETY OF CARE PATIENTS RECEIVE, NEW SURVEY FINDS

WASHINGTON, DC -- A reduction of registered nurses (RNs) in hospitals is causing unsafe conditions for some patients and massive increases in the workload of the remaining RNs, according to many respondents of a new survey of 1,835 registered nurses conducted for the American Nurses Association (ANA).

The survey found more errors occurring in hospitals including medication errors; more accidents, such as patient falls and fractures; and numerous unnecessary patient inconveniences.

Cutting nursing budgets is a prime target of many hospitals to boost the bottom line. This is occurring despite record double-digit profits for the hospital industry for five straight years (Modern Healthcare, August 8, 1994).

"But these cutbacks are often achieved at the bedside of sick patients where they are being cared for by too few overworked registered nurses and this is degrading patient care and safety," Geri Marullo, MS, RN, executive director of ANA, said.

MORE...

ANA
AMERICAN NURSES ASSOCIATION

"It is ironic that the same industry that raced to end the nursing shortage a few years ago because of its devastating effect on sick patients, is now willing to substitute safe and quality nursing care for the goal of dramatic profit margins," Marullo added. "We, with the American people will hold those who choose this unsafe and dangerous policy publicly accountable."

More than two-thirds (68.4%) of the 1,835 respondents said that the number of RN's employed in their facilities had been cut back (whether by layoffs or attrition) in the past 12 months. No other staff or service area was named nearly as often as this. Seventy percent of the respondents to that question said that their employers were cutting back on RN staffing by leaving vacated positions unfilled. Sixty-six percent said that their employers had instituted overall reductions in staff, or had announced plans to do so.

More than three-fourths of those respondents (78.6%) who reported reductions in RN's said that the quality of patient care had, in their estimation, been degraded as a result of those cutbacks. And nearly two-thirds of this group (64.0%) said they feel that patient safety has been affected adversely, as well.

Two factors, apparently working in tandem, were identified by the nurses as having the primary influences in the deterioration of safety and quality of care. These are that the remaining nurses are "taking care of more patients than before (53.9%) and "that there is less time to provide patient care" (53.7%).

Increased use of unlicensed assistive personnel (UAPs), which are minimally skilled workers with as little as 4 - 6 weeks of training, to provide direct patient care was reported by 44.7% of all respondents. In just over a quarter of all employing facilities (25.4%), it was reported that replacement of RN's with UAPs had been implemented or had been announced as a future course of action.

MORE...

SAFETY OF CARE/3...

One third of all survey respondents volunteered detailed descriptions of their patient safety concerns. The most frequently mentioned category of response about patient safety has to do with insufficient time to spend with patients (35.5%). Another area of concern by these nurses was the lack of time to adequately assess and monitor patients condition (19.5%).

One hundred-sixty respondents (26.2%) described various aspects of their work situations that they believe contribute to lowered safety standards for patients. An increase in the number of errors committed by nursing and non-nursing staff was reported by (17.5%) of the respondents to the patient safety question. Medication errors were reported far more frequently than other types of errors (13.7%), including late delivery of prescribed medications, administration of medication to the wrong patient, failure to remember to give medication at all (including pain medication), and so forth.

Patient impacts reported in the survey range from the minor inconvenience of a meal being delivered late, through such things as the pain and inconvenience of being "stuck" multiple times during the drawing of blood by an inexperienced assistive staffer. Other examples include recent post-op patients being left alone in the bathroom and falling, to a patient turning blue from lack of oxygen while a UAP continues to feed her, all the way to death resulting from the failure of an unlicensed assistant to report a critically low oxygen level to the RN responsible for the patient.

The most frequently reported result of reduced nursing staff is accidents, such as falls, involving patients, and fractures from those falls. Increases in falls and fractures of patients were reported by 13.6% of this subgroup of respondents. Longer waits for routine care (trips to the bathroom, baths, and so forth) were also reported, as were early re-admissions and re-injuries resulting from inadequate patient education, increased numbers of nosocomial infections and illnesses, and longer waits for lab draws, lab results, and other procedures, even under emergency conditions.

MORE...

In some instances reported by the RNs (2.3%), certain situations attributed to the reduction in RN staffing were reported to have led to death or near death of a patient. In all, 14 respondents to this question reported patient deaths, although at least three of these reports were recognizable as describing the same incident in the same hospital.

RNs who said their facilities reduced the number of RN's during the previous 12 months gave several reasons. The most frequently reported explanations for the nurse cutbacks were economic reasons (60%) including: increased profitability (43%), budget cuts and/or reduced revenues (14.3%) and to become/remain competitive (2.7%). A decrease in patient census (filled hospital beds) was the second at (58.2%) of respondents. A weak local economy was given as a reason for staffing cuts by (21.6%) of the respondents. Mergers with or acquisitions by other facilities (16.4%); loss of managed care contracts (11.2%); and reorganization, restructuring, and/or implementing a new patient care model was answered by (6.6%) of the respondents.

The executive summary of the survey, written by Decision Data Collection, Inc., contains the following statements:

"A worst-case scenario would have the RN's who have not been laid off working longer shifts, with less professional backup, having to rely upon and oversee the activities of either "float" or agency RN's who are unfamiliar with the procedures employed on the units to which they are assigned, or UAP's who are often described as poorly trained, inexperienced in patient care, and either unaware of or willing to disregard the limits of their capabilities and authority."

"In addition, the nurse-to-patient ratio may become more burdensome, with the RN having insufficient time to monitor and assess any but the most acutely ill patients. As a result, the RN moves from crisis to crisis, unable to anticipate the next impending emergency, but

MORE...

having to react instantaneously when an emergency does arise, leaving still less time for attention to the general patient population. Meanwhile, patient education suffers, and re-injuries or early re-admissions follow, due to poor at-home care."

"Physical and emotional stress take their toll on the RN. The ultimate effects on the patient can range from mere inconvenience (a cold meal) to more serious consequences, such as medication errors, injuries resulting from frustrated patients trying to do too much on their own, failure to carry out procedures ordered by doctors, more numerous nosocomial illnesses, and even deaths that are perceived as having been preventable if more RN's had been available."

"While this worst-case scenario cannot be viewed as typical even of the most understaffed facility, let alone the totality of settings in which professional nurses are employed, there is no mistaking the intensity and sincerity with which survey respondents reported these conditions as affecting their lives and those of the patients they serve."

Decision Data Collection, Inc., of McLean, Virginia, conducted the survey which was self-administered, in which any ANA member who received the September 1994 issue of The American Nurse had the opportunity to take part by completing the questionnaire and returning it for analysis. Approximately 210,000 copies of The American Nurse are distributed monthly, of these, 1,835 were analyzed and included in the survey analysis. Because the survey was available to all ANA members, rather than a pre-selected sample, there is no formula that can be applied to determine that "the results of this survey are accurate within plus or minus X percent."

Responses were received from all 50 states and the District of Columbia in rough proportion to the population distribution of the United States. Nearly three-fourths (73.4%) of the

MORE...

survey respondents are employed in hospitals. Two-thirds (64.7%) described themselves as staff nurses. Thirteen percent hold supervisory positions and 6.3% described their positions as administrative in nature. In total, 9.0% reported having personally experienced a lay off this year. More than half were employed by non-profit facilities (58.3%), government-operated facilities (23.6%), for-profit facilities (19.8%), with 14.4% being described as being affiliated with an HMO.

The American Nurses Association has also published a consumer brochure to assist consumers in choosing an appropriate and safe hospital. Included in the document is a "pre-hospitalization" checklist of questions to ask about a hospital before considering admission there. To obtain a single copy of "Every Patient Deserves a Nurse" call 1-800-637-0323 and request item #NP-92.

A full copy of The Report of Survey Results: the 1994 ANA Layoffs Survey is available for free to credentialed members of the news media by calling Jeanine Williams at the American Nurses Association, at (202) 651-7022.

All others may obtain a copy by sending a check for $10.00 payable to : [The American Nurses Association], c/o Communications Department, 600 Maryland Avenue, SW, Washington, DC 20024.

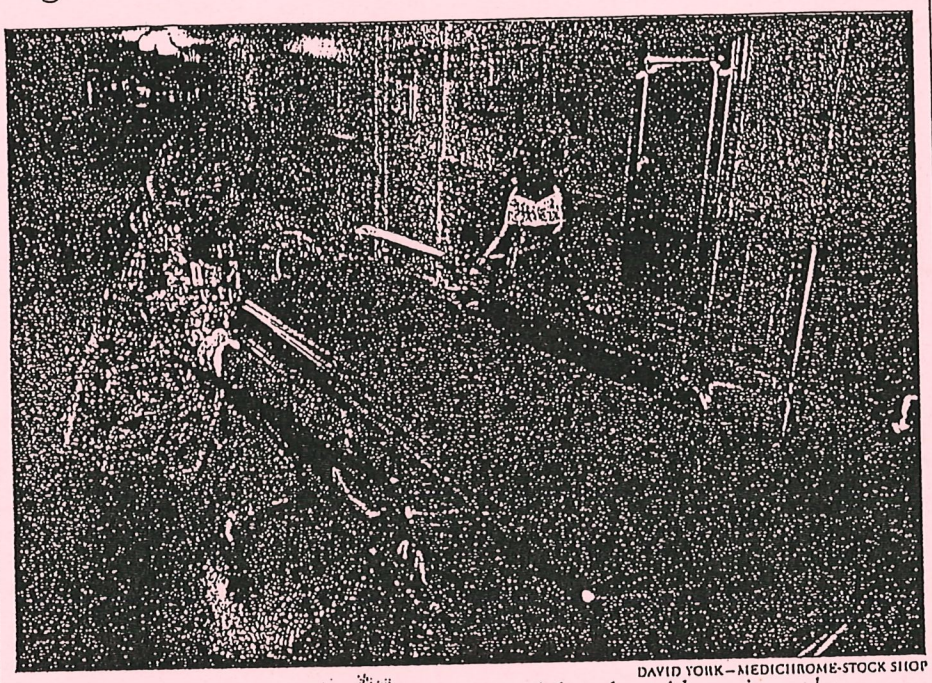


###

g:\releases.95\survey

# Intensive Care on a Budget

## Health: Do patients suffer when hospitals replace registered nurses with unskilled assistants?



DAVID YORK—MEDICHROME-STOCK SHOP

Life on the edge: *Nurses say layoffs are a hazard, but the evidence is murky*

As an intensive-care nurse, Barbara Grady knows the buzz of a bedside alarm like the ring of a telephone. When it sounds, she straightens a ventilator hose or fixes an IV line, often easing someone back from the edge of death. Grady used to work one-on-one with her patients, but she now often handles two or more. When she can't respond to an alarm and there's not another nurse nearby, she summons one of the unlicensed nurse's aides her Boston hospital has hired. Not long ago, Grady recalls, an aide responded to an alarm in her unit and noticed only that there was a little blood on the patient's bed. Seconds later the alarm sounded again, and Grady rushed over to find that the patient's arterial line was detached, and her sheets were drenched with blood. The aide, though well-meaning, hadn't known to check the line.

Across the nation, hospitals are cutting back on registered nurses—and delegating some of their chores to aides who average only two to six weeks of training. No one knows how many RNs have been lost or how the trend will affect patients. The scant available evidence comes mainly from nurses' groups that have a stake in the status quo. But health workers do seem worried. Of 1,800 who were polled recently by the American Nurses Association, 68 percent said their RN staffs had been cut in the past year, through attrition or layoffs. And two thirds of those reporting cutbacks thought the changes were jeopardizing patients. Doctors are voicing similar concern. "If I were really worried about one of my patients, I would set my alarm and go check myself," says Dr. Christopher Greeley, a pediatric resident in Nashville, Tenn. "Some of the people I'm relying on to be my eyes and ears have less training than the person running the slushy machine at 7-Eleven."

Hospital administrators say they're merely trying to adapt to a changed market. Hospital admissions have plummeted since the early 1980s, when insurers began treating inpatient care as the costly luxury it is. The shift has put many institutions out of business and forced survivors to cut expenses wherever they can. Nurses, as the largest group of hospital employees, are an obvious target for savings. The idea isn't to do away with them, administrators say, but to deploy them more efficiently—by hiring $15,000-a-year "care associates" to handle mundane tasks, such as changing linen, bathing patients and helping doctors with routine technical procedures. As Barry Horn of Berkeley's Alta Bates Medical Center explains, "I don't need to take a nurse out of commission to assist in a spinal tap. The assistance it requires is simple."

The problem, critics say, is that these aides are performing feats for which they're unqualified. State and national nurses' associations have been particularly outraged by reports that unlicensed attendants are handling catheters in cardiac patients at UCLA Medical Center and suturing surgery patients at some of California's Kaiser hospitals. "They shouldn't be doing invasive procedures," says Grady, the Boston intensive-care nurse. "Many don't even know to bring an unstable vital sign to somebody's attention." UCLA and Kaiser both acknowledge letting unlicensed aides perform these drills, but both defend the practice, saying that doctors are always on hand to supervise. "We think it's very clear that this is legal," says Frances Ridle Hoover, director of ambulatory care and cardiodiagnostic services at UCLA.

Aside from anecdotes, there is little evidence that the move away from RNs has harmed patients. A few studies have found that hospitals with low nurse-to-patient ratios have slightly elevated mortality rates. And nurses at Boston College noted in a 1994 survey that nursing staffs had been cut at several Massachusetts hospitals where patients later died in mishaps. "This should tell us that we have to be very careful," says study leader Judith Shindul-Rothschild. But there is no direct link between the cutbacks and the deaths. As Massachusetts Hospital Association spokesman Andrew Dreyfus says, any number of factors could have contributed.

The nurses' concerns are no doubt parochial in part. "One has to wonder whether this has more to do with traditional union work protection than with real concern about patient care," says Mark Speare, associate director of the UCLA Medical Center. For years, he recalls, RNs disdained many of the tasks they're now fighting to keep. Yet no one denies that nursing cuts *could* have dire effects. "Somewhere down the line," says Horn of Alta Bates, "the dollars could dry up to the point where care will be affected." Where that point lies is anyone's guess. The Institute of Medicine, a federal advisory group, may help clarify the hazards in a forthcoming study of hospital nursing trends. But if the nurses' associations expect to save the status quo, they're sure to be disappointed. The revolution is already here. The question is how happily it will play out.

**'Dollars could dry up to the point where care will be affected'**

GEOFFREY COWLEY *with* SUSAN MILLER *in New York and* MARY HAGER *in Washington*

7 - 17

Webster definitions:

Task means a usual assigned piece of work often to be finished within a certain time.

Procedure means a particular way of accomplishing something or of acting; a series of steps followed in a regular definite order; a traditional or established way of doing things.

**65-1136 Intravenous fluid therapy; definitions.** (a) As used in this section.

(1) "Provider" means a person who is approved by the board to administer an examination and to offer an intravenous fluid therapy course which has been approved by the board.

(2) "Person" means an individual, organization, agency, institution or other legal entity.

(3) "Examination" means an intravenous fluid therapy competency examination approved by the board.

(4) "Supervision" means provision of guidance by a qualified nurse for the accomplishment of a nursing task or activity with initial direction of the task or activity and periodic inspection of the actual act of accomplishing the task or activity.

(b) A licensed practical nurse may perform a limited scope of intravenous fluid therapy under the supervision of a registered professional nurse.

KSNA
the voice of Nursing in Kansas

KSNA & You
A Powerful Match

FOR MORE INFORMATION CONTACT:
Terri Roberts JD, RN
Executive Director
700 SW Jackson, Suite 601
Topeka, KS 66603-3731
(913) 233-8638

**March 16, 1995**

**SB 151 NURSE PRACTICE ACT CHANGES**

Representative Mayans and members of the House Health and Human Services Committee, my name is Carolyn Middendorf MN, RN, and I am the current president of the Kansas State Nurses Association.

As you know, S.B. 151 makes a number of changes to the Kansas Nurse Practice Act, affecting licensees of the Board of Nursing, and operations at the Board of Nursing. For purposes of simplicity, I will speak to the changes in the act in the order in which they appear in the bill.

**Continuing Education Exemption for New Licensees**

The changes embodied in lines 27-29, which exempt the licensees newly licensed by examination (New Graduates) and RN & LPN's coming to Kansas from other states where they are licensed for essentially their first renewal period, has been the practice of the Board of Nursing since the inception of mandatory continuing education for nurses in 1978. While this practice has been in rules and regulations, this statute provides the necessary statutory authorization to the Board. This issue came to the attention of the Board of Nursing as they were considering requests from several licensees to complete all of their Continuing Education by independent study, due to illnesses which prevented them from physically attending programs offered in the community. One of the licensees was immunosuppressed and could not be in large public crowds. The Board is taking a serious look at making provisions for licensees to take **all** their continuing education by independent study on an individual basis. Currently, out of the thirty hours of required CE (every two years), only twelve (12) hours can be accumulated from independent study. Only nurses licensed by the Kansas Board of Nursing, but residing in foreign countries are permitted to submit all of their CE by independent study. The quality of independent study has increased significantly over the past 17 years.

KSNA supports the statutory amendment being proposed that would provide the statutory authorization for the exemptions and the Board of Nursings attempt to address the issue of independent study in rules and regulations.

**Board Proceedings: Retention by the Agency of 100% of Monies Collected**

KSNA supports the Boards request to retain 100% of the monies collected by the agency for costs associated with licensees who have been formally disciplined. The Board just this month implemented a 20% fee increase for RN's and LPN's renewal fees, from forty dollars ($40) to fifty dollars ($50), which should generate and additional $50,000 to the agency in their FY 1995 budget. These fee increases were needed to support the agencies role in investigating and disciplining licensees.

We believe that licensees who violate the Nurse Practice Act should bear a share of this financial cost to the agency. We support the proposed amendment. The Board of Nursing has not routinely and systematically charged disciplined licensees for these costs, currently permited by this statute. We support the Boards immediate implementation of this section in all disciplinary proceedings where applicable, the agency will be able to keep 80% of the collected monies (20% to the state under current statute), and if this bill passes, then 100% of the monies collected after July 1 will be credited to the agency fee fund. These monies should increse the length of time between the most recent license renewal fee increase and the next fee increase.

**School Setting and Delegation Exception to the Nurse Practice Act**
**School Setting Issue**

Current (k) and (l) in the exception clause of the Nurse Practice Act were added in 1989 to provide latitude to school nurses to delegate to unlicensed persons "selected nursing procedures". The language proposed, may appear to be substantive, is really a recognition that any student can have such services performed on their behalf, pursuant to delegation by a nurse. The language proposed simplifies the statute, making the language applicable to all students, instead of having two separate sections, one for handicapped and describing a specific set of criteria when delegation can occur. Currently, the two exemptions are covered in one set of regulations. KSNA supports the changes proposed in (k) and (l).

**Delegation**

The Kansas State Nurses Association continues to support the statutory language of delegation, in which nurses have the professional responsibility to delegate appropriately.
The language added in the Senate to further delineate the role of the licensed nurse in delegation was reached after considerable deliberation by a number of nursing organizations, including KSNA. We are pleased to support S.B. 151 in its current form and with the Senate amendments to the delegation exception and the new section added. KSNA believes that the statute will protect individuals from inappropriate delegation, but will permit an alternative in settings where delegation can occur safely and responsibly.

We urge this committee to recommend S.B. 151 favorably for passage in its current form. With over 25,000 Registered Nurses in the state, and this issue being one of great importance, we are hopeful that it can be passed this legislative session.

Thank you for the opportunity to speak.

b:leg95/yellow/sb151/la

Testimony

Presented to

House Health and Human Services Committee

by the Kansas Organization of Nurse Executives

March 16, 1995

Good afternoon. My name is Joan Sevy. I am employed as Vice President of Patient Care Services at St. Francis Hospital and Medical Center in Topeka. I am a registered professional nurse who has practiced nursing for more than 20 years. I am a member of the Kansas Organization of Nurse Executives and Chair of the KONE Legislative Committee. I am here to represent the organization's support of Senate Bill 151 as amended by the Senate Committee..

The amendments to S.B. 151, added by the Senate Committee, have been thoroughly discussed and agreed upon by nursing organizations and health care providers in this state. On February 20, 1995, I had the privilege of representing KONE at a consensus building task force convened by the Kansas State Board of Nursing. The task force was comprised of representatives from the Kansas Department of Social and Rehabilitation Services, the Kansas Department of Health and Environnment, the Kansas Department of Corrections, the Kansas Hospital Association, two long-term care associations, child care facilities and three major nursing associations. All parties present agreed that the amended language in paragraph (m) and in the new Section 7 will allow health care providers to effectively use unlicensed personnel to perform nursing procedures when delegated by a licensed nurse. This language also provides a mechanism for protecting the public from unsafe delegation practices.

Also, during the consensus building meeting the participants agreed to the meaning of certain words and concepts. Specifically, the definition of "nursing procedure" refers to the nursing process as defined in K.S.A. 65-1113. and includes the administration of medications.

In closing we encourage your favorable consideration of S.B. 151. I want to thank you for the opportunity to address the committee. I'll be happy to answer any questions.

..

*As Amended by Senate Committee*

*Session of 1995*

# SENATE BILL No. 8

By Special Committee on Public Health and Welfare

12-16

AN ACT concerning ~~adult care homes~~ *certain care facilities*; defining certain terms; amending K.S.A. *19-4601*, 39-1501, 40-2,116 ~~and~~, 65-3501 *and 75-3307b* and K.S.A. 1994 Supp. 39-923 and repealing the existing sections

*Be it enacted by the Legislature of the State of Kansas:*

Section 1. K.S.A. 1994 Supp. 39-923 is hereby amended to read as follows: 39-923 (a) As used in this act:

(1) "Adult care home" means any nursing facility, *nursing facility for mental health*, intermediate ~~personal care home, one to five bed adult care home and any~~ *care facility for the mentally retarded, assisted living facility, residential health care facility, home plus*, boarding care home *and adult day care facility*, all of which classifications of adult care homes are required to be licensed by the secretary of health and environment. ~~Adult care home does not mean adult family home.~~

(2) "Nursing facility" means any place or facility operating ~~for not less than~~ 24 hours ~~in any week and~~ *a day, seven days a week*, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who ~~by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care,~~ *due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations.*

~~(3) "Intermediate personal care home" means any place or facility operating for not less than 24 hours in any week and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently properly care for themselves and for whom reception, accommodation,~~

**SUBCOMMITTEE RECOMMENDATIONS**

qualifications of administrators and operators;

and 65-3503

HOUSE H&HS COMMITTEE
3-16-1995
Attachment 10-1

~~board, personal care and treatment or simple nursing care is provided, and which place or facility is staffed, maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care, nursing facility care or moderate nursing care but who require domiciliary care and simple nursing care.~~

~~(4) "One-to-five-bed adult care home" means any place or facility which place or facility may be a private residence and which place or facility is operating for not less than 24 hours in any week and caring for not more than five individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board, personal care and treatment and skilled nursing care, supervised nursing care or simple nursing care is provided by the adult care home, and which place or facility is staffed, maintained and equipped primarily for the accommodation of individuals not acutely ill or in need of hospital care but who require domiciliary care and skilled nursing care, supervised nursing care or simple nursing care provided by the adult care home. When the home's capabilities are questioned in writing, the licensing agency shall determine according to its rules and regulations if any restriction will be placed on the care the home will give residents.~~

*(3) "Nursing facility for mental health" means any place or facility operating 24 hours a day, seven days a week caring for ~~three~~ **six** or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need special mental health services to compensate for activities of daily living limitations.*

*(4) "Intermediate care facility for the mentally retarded" means any place or facility operating 24 hours a day, seven days a week caring for ~~three~~ **six** or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments caused by ~~developmental disabilities~~ **mental retardation or related conditions** need services to compensate for activities of daily living limitations.*

*(5) "Assisted living facility" means any place or facility caring for ~~three~~ **six** or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, **by choice or** due to functional impairments, **may** need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services including personal care, supervised ~~or skilled~~ nursing care available*

skilled nursing care and

or

10 - 2

*24 hours a day, seven days a week for the support of resident independence.*

*(6) "Residential health care facility" means any place or facility caring for six or more individuals not related within the third degree or relationship to the administrator, operator or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes individual living units and provides or coordinates a ~~range of~~ personal care ~~and supervised or skilled~~ nursing care ~~services~~ available on a 24-hour, seven-day-a-week basis for the support of resident independence.*

*(7) "Home plus" means any residence or facility caring for not more than five individuals not related within the third degree of relationship to the operator or owner by blood or marriage unless the resident in need of care is approved for placement by the secretary of the department of social and rehabilitation services, and who, due to functional impairment, needs personal care and may need supervised nursing care to compensate for activities of daily living limitations. The level of care provided residents shall be determined by preparation of the operator and rules and regulations developed by the department of health and environment.*

~~(5)~~ *(8)* "Boarding care home" means any place or facility operating ~~for not less than~~ 24 hours ~~in any week and~~ *a day, seven days a week,* caring for ~~three or~~ *not* more *than 10* individuals not related within the third degree of relationship to the ~~administrator~~ *operator* or owner by blood or marriage and ~~who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves and for whom reception, accommodation, board and supervision is provided and which place or facility is staffed, maintained and equipped primarily to provide shelter to residents who require some supervision, but~~ who, *due to functional impairment, need supervision of activities of daily living but who* are ambulatory and essentially capable of managing their own care and affairs.

*(9) "Adult day care" means any place or facility operating less than 24 hours a day caring for individuals not related within the third degree of relationship to the operator or owner by blood or marriage and who, due to functional impairment need supervision of or assistance with activities of daily living.*

~~(6)~~ *(10)* "Place or facility" means a building or any one or more complete floors of a building, or any one or more complete wings of a building, or any one or more complete wings and one or more complete floors of a building, and the term "place or facility" may include multiple buildings.

~~(7)~~ *(11)* "Skilled nursing care" means services ~~commonly~~ performed by or under the immediate supervision of a registered ~~professional~~ *pro-*

The provision of skilled nursing tasks to a resident in an assisted living facility is not prohibited by this act. Generally, the skilled services provided in an assisted living facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis.

or

The provision of skilled nursing tasks to a resident in a residential health care facility is not prohibited by this act. Generally, the skilled services provided in a residential health care facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis.

3
10

*fessional* nurse and additional licensed nursing personnel ~~for individuals requiring 24 hour a day care by licensed nursing personnel including: Acts of observation, care and counsel of the ill, injured or infirm; the~~ *Skilled nursing includes* administration of medications and treatments as prescribed by a licensed physician or dentist; and other nursing functions ~~requiring~~ *which require* substantial ~~specialized~~ *nursing* judgment and skill based on the knowledge and application of scientific principles.

~~(8)~~ *(12)* "Supervised nursing care" means services ~~commonly performed by or under the immediate onsite supervision of licensed nursing personnel at least eight hours a day for at least five days a week including: Acts of observation, care and counsel of the ill, injured or infirm; the a licensed nurse or through delegation by a licensed nurse, including but not limited to,~~ ***provided by or under the guidance of a licensed nurse with initial direction for nursing task and periodic inspection of the actual act of accomplishing the task;*** administration of medications and treatments as prescribed by a licensed physician or dentist; and ~~other selected functions requiring specialized judgment and certain skills based on the knowledge of scientific principles~~ *assistance of residents with the performance of activities of daily living.*

~~(9) "Simple nursing care" means selected acts in the care of the ill, injured or infirm requiring certain knowledge and specialized skills but not requiring the substantial specialized skills, judgment and knowledge of licensed nursing personnel.~~

~~(10)~~ *(13)* "Resident" means all individuals kept, cared for, treated, boarded or otherwise accommodated in any adult care home.

~~(11)~~ *(14)* "Person" means any individual, firm, partnership, corporation, company, association or joint-stock association, and the legal successor thereof.

~~(12)~~ *(15)* "Operate an adult care home" means to own, lease, establish, maintain, conduct the affairs of or manage an adult care home, except that for the purposes of this definition the word "own" and the word "lease" shall not include hospital districts, cities and counties which hold title to an adult care home purchased or constructed through the sale of bonds

~~(13)~~ *(16)* "Licensing agency" means the secretary of health and environment.

~~(14) "Skilled nursing home" means a nursing facility.~~

~~(15) "Intermediate nursing care home" means a nursing facility.~~

*(17) "Apartment" means a private unit which includes, but is not limited to, a toilet room with bathing facilities, a kitchen, sleeping, living and storage area and a lockable door.*

*(18) "Individual living unit" means a private unit which includes, but is not limited to, a toilet room with bathing facilities, sleeping, living and*

10 - 4

the

(17) "Skilled nursing home" means a nursing facility.

(18) "Intermediate nursing care home" means a nursing facility.

And by renumbering subsections accordingly

*storage area and a lockable door.*

*(19) "Operator" means an individual who operates an assisted living facility or residential health care facility with fewer than ~~45 beds~~ 61 residents, a home plus or adult day care facility and has completed a course approved by the secretary of health and environment on principles of assisted living and has successfully passed an examination approved by the licensing agency on principles of assisted living*

(20) "Activities of daily living" means those personal, functional activities required by an individual for continued well-being, including but not limited to eating, nutrition, dressing, personal hygiene, mobility, toileting ~~*and other activities such as meal preparation, shopping and management of personal finances*~~

(21) "Personal care" means care provided by staff to assist an individual with, or to perform activities of daily living.

(22) "Functional impairment" means an individual has experienced a decline in physical, mental and psychosocial well-being and as a result, is unable to compensate for the effects of the decline.

***(23) "Kitchen" means a food preparation area that includes a sink, refrigerator and a microwave oven or stove.***

(b) The term "adult care home" shall not include institutions operated by federal or state governments, hospitals or institutions for the treatment and care of psychiatric patients, child care facilities, maternity centers, hotels, offices of physicians or hospices which are certified to participate in the medicare program under 42 code of federal regulations, chapter IV, section 418.1 *et seq.* and amendments thereto and which provide services only to hospice patients.

***(c) Facilities licensed under K.S.A. 39-1501 et seq. and amendments thereto or K.S.A. 75-3307b and amendments thereto or with license applications on file with the licensing agency as intermediate personal care homes on or before January 1, 1995, shall have the option of becoming licensed as either an assisted living facility or a residential health care facility without being required to add kitchens or private baths.***

***(d) Nursing facilities in existence on the effective date of this act changing licensure categories to become residential health care facilities shall be required to provide private bathing facilities in a minimum of 20% of the individual living units.***

***(e) Facilities licensed under the adult care home licensure act on the day immediately preceding the effective date of this act shall continue to be licensed facilities until the ~~expiration~~ of such license d may renew such license in the appropriate licensure category ler the adult care home licensure act subject to the payment of es and other conditions and limitations of such act.***

and such other requirements as may be established by the licensing agency by rules and regulations

except institutions operated by the Kansas commission on veterans affairs,

K.S.A. 39-923 as an intermediate personal care home or

annual renewal date

10 - 5

~~(e)~~ *(f)* The licensing agency may by rule and regulation change the name of the different classes of homes when necessary to avoid confusion in terminology and the agency may further amend, substitute, change and in a manner consistent with the definitions established in this section, further define and identify the specific acts and services which shall fall within the respective categories of facilities so long as the above categories for adult care homes are used as guidelines to define and identify the specific acts.

Sec. 2. K.S.A. 65-3501 is hereby amended to read as follows: 65-3501. As used in this act, or the act of which this section is amendatory, the following words and phrases shall have the meanings respectively ascribed to them in this section:

(a) "Adult care home" means nursing facility ~~and intermediate personal care home as the terms nursing facility and intermediate personal care home are~~, *nursing facilities for mental health, intermediate care facilities for the mentally retarded, assisted living facility licensed for more than ~~45 beds~~ 60 residents*, and residential health care facility licensed for more than ~~*45 beds*~~ *60 residents as* defined by K.S.A. 39-923 and amendments thereto or by the rules and regulations of the licensing agency adopted pursuant to such section for which a license is required under article 9 of chapter 39 of the Kansas Statutes Annotated, or acts amendatory thereof or supplemental thereto, except that the term "adult care home" shall not include a facility that is operated exclusively for the care and treatment of the mentally retarded and is licensed for ~~15~~ *16* or fewer beds.

(b) "Board" means the board of adult care home administrators established by K.S.A. 65-3506 and amendments thereto.

(c) "Administrator" means the individual directly responsible for planning, organizing, directing and controlling the operation of an adult care home.

(d) "Person" means an individual and does not include the term firm, corporation, association, partnership, institution, public body, joint stock association or any group of individuals.

Sec. 3. K.S.A. 39-1501 is hereby amended to read as follows: 39-1501. As used in this act:

(a) "Adult family home" means a private residence in which care is provided for not less than 24 hours in any week for one or two adult clients who (1) are not related within the third degree of relationship to the owner or provider by blood or marriage, (2) by reason of aging, illness, disease or physical or mental infirmity are unable to live independently but are essentially capable of managing their own care and affairs. The home does not furnish skilled nursing care, supervised nursing care or ~~simple nursing~~ *personal* care. Adult family home does not mean adult

6
10

care home.

(b) "Skilled nursing care," "supervised nursing care" and "~~simple nursing~~ ***personal*** care" have the meanings respectively ascribed thereto in K.S.A. 39-923, and amendments ~~thereof~~ *thereto*.

(c) "Physician" means any person licensed by the state board of healing arts to practice medicine and surgery.

(d) "Secretary" means the secretary of social and rehabilitation services.

Sec. 4. K.S.A. 40-2,116 is hereby amended to read as follows: 40-2,116. As used in this act:

(a) "Contracting facility" means a health facility which has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

(b) "Contracting professional provider" means a professional provider who has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

(c) "Health facility" means a medical care facility as defined in K.S.A. 65-425 and amendments thereto; psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto; adult care home, which term shall be limited to nursing facility ~~and intermediate personal care home~~, *assisted living facility and residential health care facility* as such terms are defined in K.S.A. 39-923 and amendments thereto; and kidney disease treatment center, including centers not located in a medical care facility.

(d) "Professional provider" means a provider, other than a contracting facility, of services for which benefits are provided under contracts issued by a service corporation.

(e) "Service corporation" means a mutual nonprofit hospital service corporation organized under the provisions of K.S.A. 40-1801 *et seq.*, and amendments thereto, a nonprofit medical service corporation organized under the provisions of K.S.A. 40-1901 *et seq.*, and amendments thereto or a nonprofit medical and hospital service corporation organized under the provisions of K.S.A. 40-19c01 *et seq.*, and amendments thereto.

***Sec. 5. K.S.A. 19-4601 is hereby amended to read as follows: 19-4601. As used in this act:***

***(a) "Board" means a hospital board which is selected in accordance with the provisions of this act and which is vested with the management and control of a county hospital;***

***(b) "commission" means the board of county commissioners of any county;***

***(c) "hospital" means a medical care facility as defined in K.S.A. 65-425 and amendments thereto and includes within its meaning any clinic, school of nursing, long-term care facility, limited care residential facility and child-care facility operated in connection with***

*the operation of the medical care facility.*

*(d) "hospital moneys" means, but is not limited to, moneys acquired through the issuance of bonds, the levy of taxes, the receipt of grants, donations, gifts, bequests, interest earned on investments authorized by this act and state or federal aid and from fees and charges for use of and services provided by the hospital.*

*(e) As used in this section, a "limited care residential facility" means a facility, other than an adult care home, in which there are separate apartment-style living areas, bedrooms, bathrooms and individual utilities and in which some health related services are available.*

*Sec. 6. K.S.A. 75-3307b is hereby amended to read as follows: 75-3307b. (a) The enforcement of the laws relating to the hospitalization of mentally ill persons of this state in a psychiatric hospital and the diagnosis, care, training or treatment of persons in community mental health centers or facilities for the mentally ill, mentally retarded or other handicapped persons is entrusted to the secretary of social and rehabilitation services. The secretary may adopt rules and regulations on the following matters, so far as the same are not inconsistent with any laws of this state:*

*(1) The licensing, certification or accrediting of private hospitals as suitable for the detention, care or treatment of mentally ill persons, and the withdrawal of licenses granted for causes shown;*

*(2) the forms to be observed relating to the hospitalization, admission, transfer, custody and discharge of patients;*

*(3) the visitation and inspection of psychiatric hospitals and of all persons detained therein;*

*(4) the setting of standards, the inspection and the licensing of all community mental health centers which receive or have received any state or federal funds, and the withdrawal of licenses granted for causes shown;*

*(5) the setting of standards, the inspection and licensing of all facilities for the mentally ill, mentally retarded or other* ~~handicapped~~ *developmentally disabled persons receiving assistance through the department of social and rehabilitation services which receive or have received after June 30, 1967, any state or federal funds, or facilities where mentally ill, mentally retarded or other* ~~handicapped~~ *developmentally disabled persons reside who require supervision or require limited assistance with the taking of medication, and the withdrawal of licenses granted for causes shown. The secretary may adopt rules and regulations that allow the facility to assist a resident with the taking of medication when the medication is in a labeled container dispensed by a pharmacist. No license for a residential facility for eight or more persons may be issued under this*

10-8

*paragraph unless the secretary of health and environment has approved the facility as meeting the licensing standards for a lodging establishment under the food service and lodging act. No license for a residential facility for the elderly or for a residential facility for persons with disabilities not related to mental illness or mental retardation, or both, or related conditions shall be issued under this paragraph;*

*(6) reports and information to be furnished to the secretary by the superintendents or other executive officers of all psychiatric hospitals, community mental health centers or facilities for the mentally retarded and facilities serving other handicapped persons receiving assistance through the department of social and rehabilitation services.*

*(b) An entity holding a license as a community mental health center under paragraph (4) of subsection (a) on the day immediately preceding the effective date of this act, but which does not meet the definition of a community mental health center set forth in this act, shall continue to be licensed as a community mental health center as long as the entity remains affiliated with a licensed community mental health center and continues to meet the licensing standards established by the secretary.*

Sec. ~~5~~ 9. K.S.A. 39-1501, 40-2,116 ~~and~~, 65-3501 *and 75-3307b* and K.S.A. 1994 Supp. 39-923 are hereby repealed.

Sec. ~~6~~ 10. This act shall take effect and be in force from and after its publication in the statute book.

See attached

and 65-3503

9

10

ATTACHMENT

Sec. 7. K.S.A. 1994 Supp. 65-3503 is hereby amended to read as follows: 65-3503. (a) It shall be the duty of the board to:

(1) Develop, impose and enforce standards which shall be met by individuals in order to receive a license as an adult care home administrator, which standards shall be designed to ensure that adult care home administrators will be individuals who are of good character and are otherwise suitable, and who, by training or experience in the field of institutional administration, are qualified to serve as adult care home administrators;

(2) develop examinations and investigations for determining whether an individual meets such standards;

(3) issue licenses to individuals who meet such standards, and revoke or suspend licenses issued by the board or reprimand, censure or otherwise discipline a person holding any such license as provided under K.S.A. 65-3508 and amendments thereto;

(4) establish and carry out procedures designed to ensure that individuals licensed as adult care home administrators comply with the requirements of such standards; and

(5) receive, investigate and take appropriate action under K.S.A. 65-3505 and amendments thereto and rules and regulations adopted by the board with respect to any charge or complaint filed with the board to the effect that any person licensed as an adult care home administrator may be subject to disciplinary action under K.S.A. 65-3505 and 65-3508 and amendments thereto.

(b) The board shall also have the power to make rules and regulations, not inconsistent with law, as may be necessary for the proper performance of its duties, and to have subpoenas issued pursuant to K.S.A. 60-245 and amendments thereto in the board's exercise of its power and to take such other actions as may be necessary to enable the state to meet the requirements set forth in section 1908 of the social security act, the federal rules and regulations promulgated thereunder and other pertinent federal authority.

(c) The board shall fix by rules and regulations the licensure fee, temporary license fee, renewal fee, late renewal fee, reinstatement fee, reciprocity fee and, if necessary, an examination fee under this act. Such fees shall be fixed in an amount to cover the costs of administering the provisions of the act. No fee shall be more than $200. The secretary of health and environment shall remit all moneys received from fees, charges or penalties under this act to the state treasurer at least monthly. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury and credit the same to the state general fund.

(d) The board upon request shall receive from the Kansas bureau of investigation, without charge, such criminal history record information relating to criminal convictions as necessary for the purpose of determining initial and continuing qualifications of licensees of and applicants for licensure by the board.

New Sec. 8. (a) The licensing agency shall upon request receive from the Kansas bureau of investigation, without charge, such criminal history record information relating to criminal convictions as necessary for the purpose of determining initial and continuing qualifications of an operator.

(b) This section shall be part of and supplemental to the adult care home licensure act.