Approved: 3-6-96
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 23, 1996 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Jeff Chanay, Kansas Professional Nursing Home Administrators
Gary Robbins, Executive Director, Kansas Optometric Association
Jerry Slaughter, Executive Director, Kansas Medical Society
Dr. Linda Warren, President, Kansas Medical Society
Joseph Philip, M.D., President, Kansas State Ophthalmological Society
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine
Dee Bell, M.D., Ophthalmologist, Overland Park
David Hanzlick, Assistant Executive Director, Kansas Dental Association
Philip S. Zivnuska, D.D.S., President, Wichita District Dental Society
Nevin Water, D.D.S., President, Kansas Dental Association
Corinne Miller, D.D.S., Office of Epidemiologic Services, KDHE

Others attending: See attached list

SB 688 - Board of adult care home administrators and appointment of executive director

Jeff Chanay, representing the Kansas Professional Nursing Home Administrators, requested the Chair postpone the hearing on **SB 688** as KPNHA and the Kansas Department of Health and Environment are currently working on a compromise on proposed amendments to the bill that would be acceptable to both parties. The Chair noted that the bill would be sent to an exempt committee and a hearing rescheduled.

Hearing on SB 684 Practice of optometry defined

Gary Robbins, KOA, testified in support of **SB 684** and noted that this proposed legislation is the result of many hours of dialogue and discussion between the Kansas Optometric Association, the Kansas Medical Society and the Kansas State Ophthalmological Society. It was noted that the bill would allow Kansas law to more accurately reflect the training and education of optometrists. Mr. Robbins submitted a balloon of the bill showing two proposed amendments that would essentially define "glaucoma licensee" as a person that would manage and treat adult open-angle glaucoma by non-surgical means, including the prescribing, administering and dispensing of topical pharmaceutical drugs, but not other pharmaceutical drugs. (Attachment 1)

Jerry Slaughter, Kansas Medical Society, expressed his support for the bill and introduced Dr. Linda Warren, President, KMS, who also supported the bill and noted that many issues were presented by both ophthalmology and optometry during the series of meetings, and there were areas where the groups were in agreement and areas in which there was no consensus reached. (Attachment 2) Committee discussion related to the use of topical pharmaceutical drugs.

Dr. Joseph Philip, President, KSOS, testified in support of **SB 684** and noted that this bill contains activities that, by law, have never been done independently by optometrists in a clinical setting in Kansas, and although this bill is not perfect, the state ophthalmology society believes this collaborative approach to the expansion of optometry is in the best interest of our patients and the people of Kansas. (Attachment 3)

Harold Riehm, Kansas Association of Osteopathic Medicine, stated that KAOM would be in support of the bill with an amendment that would insure at least one osteopathic physician on the committee. The amendment would specifically expand the number of opthamologists' names submitted as nominees from six to eight, two of them submitted by KAOM as noted in the attached balloon of the bill. (Attachment 4)

Dr. Dee Bell, ophthalmologist, expressed opposition to **SB 684** stating that the bill would set a precedent for the state in that it would allow a limited licensed practitioner to fully control the medical disease adult onset chronic glaucoma without any additional medical supervision. (Attachment 5)

Hearing on 681 - Fluoridation required for pubic water supply systems

David Hanzlick, KDA, expressed support for **SB 681** and noted that this legislation will bring the benefits of community water fluoridation to approximately one million people who are served by unfluoridated public water systems. (Attachment 6)

Dr. Philip Zivnuska, Wichita District Dental Society, also expressed support for the bill and noted that fluoridation is one of the great public health measures of our time. (Attachment 7)

Dr. Nevin Waters, KDA, noted that fluoridated water would improve the lives of Kansans by reducing cavities by 40 to 60 percent in children and 15 to 35 percent in adults as noted in his written testimony. (Attachment 8)

Dr. Corinne Miller, KDHE, expressed support for **SB 681** and gave statistics showing that fluoridation of public water supplies is of great importance to the health of the nation. (Attachment 9)

Written testimony in support of the bill was received from SRS, (Attachment 10) and Robert C. Harder, (Attachment 11). Opponents to **SB 681** will be heard February 26th.

Action on SB 534 - Hearing aid examiners and revision of hearing aid act

Staff briefed the Committee on balloon amendments to **SB 534**. (Attachment 12) The balloon amendments were the result of a compromise between the State Board of Hearing Examiners and the Speech, Language and Hearing Association. It was noted that the balloon of the bill did not exempt audiologists from taking the written and practicum tests that are required to get a hearing aid license. Senator Walker made a motion the Committee adopt the balloon amendments to **SB 534**, seconded by Senator Langworthy. The motion carried. Senator Walker made a motion the Committee recommend **SB 534 as amended** favorably for passage, seconded by Senator Ramirez. The motion carried.

Action on SB 577 - Hospital liens upon personal injury damages recovered by patients

Staff briefed the Committee on balloon amendments to **SB 577**. The amendments would remove the lien cap and include physicians in the lien process. (Attachment 13) Senator Lee called the Committee's attention to a memorandum from the Kansas Medical Society that indicated there is no "primacy" in the statute which is the subject of **SB 577**. After Committee discussion, Senator Langworthy made a motion the Committee adopt the balloon amendments to **SB 577**, seconded by Senator Harrington. Senator Walker made a substitute motion to reinsert language regarding the amount of lien to $15,000. There being no second to the substitute motion, the substitute motion failed. Back on the original motion. The motion carried.

Senator Lee made a motion that **SB 577 as amended** be recommended favorably for passage, seconded by Senator Langworthy. The motion carried.

Action on SB 500 - Membership of Health Care Data Governing Board

The Chair and staff briefed the Committee on balloon amendments to **SB 500**. The balloon amendment would create an advisory panel appointed by the chairperson of the Health Care Data Governing Board. The Chair also requested an additional amendment that would allow the Board of Regents to appoint a member to the Health Care Data Governing Board on a rotating basis from one of the three regents' institutions - KU, K-State and Wichita State. Senator Walker suggested striking language in the balloon of the bill that makes reference to the number of persons appointed to the advisory panel that serve as a resource. (Attachments 14 and 15). Senator Ramirez made a conceptual motion the Committee adopt the balloon amendments to **SB 500**, seconded by Senator Hardenburger. The motion carried.

Senator Ramirez made a motion the Committee recommend **SB 500 as amended** favorably for passage, seconded by Senator Walker. The motion carried.

Subcommittee on SB 660 - Kansas medicaid fraud control act
The Chair appointed a subcommittee on **SB 660** with Senator Jones as the Chair, Senators Langworthy and Praeger as members.

Adjournment
The meeting was adjourned at 11:05 a.m.

The next meeting is scheduled for February 26, 1996.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2/23/96

NAME	REPRESENTING
Steve Osborn	KDHE
James O'Connell	KDHE
Henry Smith	SUNY A school of public Health
Sue Philipp	K.S.O.S
Wes DeTamble	KHAA
Anne Kimmel	AARP
Michelle Peterson	Peterson Public Affairs Group
Charles Bessant	Kansas Health Institute
Bill Henry	Ks Optometric Assn
Ron Hein	KHAA/KOA
Rebecca Rice	KSOS
Linda Warren, MD	Kansas Med. Society
Meg Henson	KMS
Dan Bell	self.
Pat Johnson	Board of Nursing
Gerald Kiehm	KAOM

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-23-96

NAME	REPRESENTING
Melissa Wangemann	Hein Elvet & Weir
Sherry DuFervier	Brd of H.A. Exam.
M. Day Kaufmann	Ks. Hearing Aid Assoc.
Lisa Bray	KDHE
Rick Mans	Ks. Health Institute
Sandy Strand	Ks Advocates for Better Care
Joseph Kroll	KDHE
Betty Wright	—
[illegible]	KAHSA
John Grace	" "
John Federico	Pete McGill + Assoc
Dave Waldo	KDHE
[illegible]	KPNHAA
[illegible]	KPNHAA
Connie Miller	KDHE
Nevin Waters	Kansas Dental Association
David Hazlett	KS Dental Assn
Mike Gordon, O.D	Kansas Optometric Assoc.
Carl Schmitthenner	Kansas Dental Assn.

Kansas Optometric Association

1266 SW Topeka Blvd., Topeka, KS 66612
913-232-0225

TESTIMONY
SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
February 23, 1996

I am Gary Robbins, Executive Director of the Kansas Optometric Association. I appreciate the opportunity to appear in support of Senate Bill 684. This legislation is the result of many hours of dialogue and discussion between our association, the Kansas Medical Society and the Kansas State Ophthalmological Society. Senate Bill 684 is a compromise which allows Kansas law to more accurately reflect the training and education of optometrists.

Briefly, I would like to provide some background about optometry and the origin of this legislation. Students wishing to attend optometry school are required to take a pre-med four-year undergraduate course of study which also includes an emphasis on mathematics. Students are required to pass an entrance examination before being admitted to optometry school. Optometry school is a four-year program with an emphasis on the clinical care and treatment of eye disease. Before entering practice, optometrists are also required to pass national board examinations which cover pharmacology, anatomy, diagnosis and treatment of eye disease and the symptoms of other serious diseases which may appear in the eye.

In 1977, Kansas optometrists were given the right to use diagnostic topical drugs to diagnose and detect eye disease. In 1987, Kansas optometrists were authorized by the Legislature to use topical drugs to treat eye disease and remove foreign bodies from the eye. The passage of the 1987 bill was the subject of intensive lobbying by optometry

and medicine in both health committees over a two year period. One of the key issues during 1987 was the treatment of glaucoma by optometrists. We were unsuccessful in obtaining the authority to treat glaucoma at that time. Currently, it is authorized in some form in over 30 states.

This bill will allow optometrists to treat their patients who have glaucoma. Glaucoma is a disease which is potentially sight threatening. These patients are treated with eye drops and must be monitored several times annually.

This act will enable patients to travel less and to receive care from their current eye doctor. It would improve accessibility to needed eye care for Kansans.

The Kansas optometry law has not remained current with the educational training provided to students in optometry school. This is an important step in that direction. Both medicine and optometry don't desire to repeat the 1986-87 battle. I should point out that signs were posted in many legislators offices stating that optometrists and ophthalmologists would be shot on sight if they attempted to enter. Seriously, neither side wanted to repeat the last legislative battle. We have taken a cooperative approach of constructive dialog and negotiation to keep this situation from developing again.

I want to commend the Kansas Medical Society for taking a strong leadership role over the past four months in facilitating discussion between optometry and ophthalmology. It was not an easy process to get everyone to the table. Jerry Slaughter did an excellent job in facilitating a cooperative approach to negotiations between the Kansas State Ophthalmological Society and the Kansas Optometric Association. One of

the keys to this successful negotiation process was that the President of the Kansas Medical Society, Dr. Linda Warren, served as the facilitator and moderator for these discussions. She did an excellent job in assuring that the tone was positive and that both groups stayed on the issues. We also want to commend Dr. Joe Philipp who is the President of the Kansas State Ophthalmological Society for his hard work in the negotiation process. He faced a diverse membership consisting of members with different concerns including some who would have preferred not to even negotiate with optometry. Kansas State Ophthalmological Society Executive Director Rebecca Rice has also been very supportive of all attempts to negotiate a resolution to our differences. Attendance at these sessions consisted of three doctors representing each side, along with Dr. Warren who acted as the moderator and the lobbyists for the respective associations. The result is Senate Bill 684.

There are several sections in Senate Bill 684 that I want to highlight. This legislation allows optometrists after appropriate education and clinical training to treat adult open-angle glaucoma with topical drugs. The law requires that an optometrist complete a course of instruction of at least 24 hours and co-manage with an ophthalmologist for at least two years and not less than 20 diagnoses of suspected or confirmed glaucoma. Currently, optometrists and ophthalmologists are already co-managing glaucoma, but this process will allow independent treatment after meeting the educational and clinical requirements outlined in this bill. We have attempted to address concerns of ophthalmology by providing for an Interprofessional Advisory Committee composed of optometrists and ophthalmologists to assist the State Board of Examiners in

Optometry in developing the education and review the co-management process. This committee will submit a report to the State Board of Examiners in Optometry to update the legislature on this process by January 1, 1999.

We have encountered resistance within the Kansas Optometric Association membership to the Interprofessional Advisory Committee concept from those who believe it is inappropriate. However, we strongly believe that this is a unique opportunity to continue constructive discussions and foster cooperation between both professions which is ultimately in the best interest of the patient. We have high expectations that this will be a positive process. The area with the most concern from my members is the lack of authority to use oral drugs with ocular applications. Various categories of oral drugs are authorized for optometrists in twenty-nine states. It is very difficult for me to explain to my members who have graduated over fifteen years ago why the State of Kansas hasn't allowed them to use all of their training in pharmacology and oral drugs to better serve their patients. We believe that the failure of the legislature to address this issue is placing us at a severe disadvantage in recruiting new optometrists to Kansas. Obviously, medicine has concerns and questions about the extent of our training and education to use oral drugs. We are pleased that this bill encourages the Interprofessional Advisory Committee to continue studying this issue and develop recommendations for the legislature within the next few years. It is possible that some of you may receive letters from some of the optometrists who are very frustrated about this delay in updating the

optometry law to allow oral drugs. We strongly believe that this is an excellent compromise, and it sets a mechanism in place to resolve the remaining issue of oral drugs. The bottom line is this is a compromise which can be sold to most of my members and addresses the concerns of most ophthalmologists. If both sides continue this constructive dialogue through the Interprofessional Advisory Committee, we believe it can further strengthen cooperation between optometrists and ophthalmologists which will benefit everyone.

Attached to my testimony are two amendments which were suggested by the State Board of Examiners in Optometry. Both these amendments are acceptable to the Kansas Optometric Association and the Kansas Medical Society. Harold Riehm, Executive Director of the Kansas Association of Osteopathic Medicine, also has a friendly amendment which is acceptable to us.

Thank you for the opportunity to appear in support of Senate Bill 684.

~~as anesthetics, mydriatics, cycloplegics, anti-infectives and anti-inflammatory agents, which anti-inflammatory agents shall be limited to a fourteen-day supply,~~ administered topically and not by other means for the examination, diagnosis and treatment of the human eye and its adnexae.

(i) "Dispense" means to deliver prescription-only medication or ophthalmic lenses to the ultimate user pursuant to the lawful prescription of a licensee and dispensing of prescription-only medication by a licensee shall be limited to a twenty-four-hour supply or minimal quantity necessary until a prescription can be filled by a licensed pharmacist.

(j) "Diagnostic licensee" means a person licensed under the optometry law and certified by the board to administer or dispense topical pharmaceutical drugs for diagnostic purposes.

(k) "Therapeutic licensee" means a person licensed under the optometry law and certified by the board to prescribe, administer or dispense topical pharmaceutical drugs for therapeutic purposes.

(l) "Glaucoma licensee" means a person described in subsections (j) and (k) of this section also licensed under the optometry law to ~~prescribe, administer and dispense topical pharmaceutical drugs for the treatment of adult open-angle glaucoma~~.

~~(l)~~ *(m)* "False advertisement" means any advertisement which is false, misleading or deceptive in a material respect. In determining whether any advertisement is misleading, there shall be taken into account not only representations made or suggested by statement, word, design, device, sound or any combination thereof, but also the extent to which the advertisement fails to reveal facts material in the light of such representations made.

~~(m)~~ *(n)* "Advertisement" means all representations disseminated in any manner or by any means, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of professional services or ophthalmic goods.

~~(n)~~ *(o)* "Health care provider" shall have the meaning ascribed to that term in subsection (f) of K.S.A. 40-3401 and amendments thereto.

~~(o)~~ *(p)* "Medical facility" shall have the meaning ascribed to that term in subsection (c) of K.S.A. 65-411 and amendments thereto.

~~(p)~~ *(q)* "Medical care facility" shall have the meaning ascribed to that term in K.S.A. 65-425 and amendments thereto.

(r) "Co-management" means confirmation by an ophthalmologist of a licensee's diagnosis of adult open-angle glaucoma together with a written treatment plan which includes (1) all tests and examinations supporting the diagnosis, (2) a schedule of tests and examinations necessary to treat the patient's condition, (3) a medication plan, (4) a target intraocular pressure, (5) periodic review of the patient's progress and (6) criteria for referral of the patient to an ophthalmologist for additional treatment or

manage and treat adult open-angle glaucoma by non-surgical means, including the prescribing, administering and dispensing of topical pharmaceutical drugs, but not other pharmaceutical drugs.

surgical intervention, except that any co-management plan may be modified only with the consent of both the ophthalmologist and the optometrist and the modification noted in writing on the patient's record.

(s) "Co-management period" means that period of time during which an optometrist co-manages patients either suspected of having or diagnosed as having adult open-angle glaucoma with an ophthalmologist.

(t) "Ophthalmologist" means a person licensed to practice medicine and surgery by the state board of healing arts who specializes in the diagnosis and medical and surgical treatment of diseases and defects of the human eye and related structures.

Sec. 3. K.S.A. 65-1505 is hereby amended to read as follows: 65-1505. (a) Persons entitled to practice optometry in Kansas shall be those persons licensed in accordance with the provisions of the optometry law. A person shall be qualified to be licensed and to receive a license as an optometrist: (1) Who is of good moral character; and in determining the moral character of any such person, the board may take into consideration any felony conviction of such person, but such conviction shall not automatically operate as a bar to licensure; (2) who has graduated from a school or college of optometry approved by the board; and (3) who successfully meets and completes the requirements set by the board and passes an examination given by the board. All licenses issued on and after the effective date of this act, to persons not licensed in this state or in another state prior to July 1, ~~1987~~ *1996*, shall be diagnostic and therapeutic licenses.

and glaucoma

(b) All applicants for licensure or reciprocal licensure ~~and all licensed optometrists at the time this act takes effect~~, except as provided in subsection (a) and ~~(e)~~ *(f)*, in addition to successfully completing all other requirements for licensure, shall take and successfully pass an examination required by the board before being certified by the board as a diagnostic and therapeutic licensee.

(c) All persons before taking the examination required by the board to be certified as a diagnostic and therapeutic licensee shall submit evidence satisfactory to the board of having successfully completed a course approved by the board in didactic education and clinical training in the examination, diagnosis and treatment of conditions of the human eye and its adnexae, totaling at least 100 hours.

(d) All applicants for glaucoma licensure, in addition to successfully completing all other requirements for licensure, shall submit evidence satisfactory to the board of: (1) Professional liability insurance in an amount acceptable to the board, (2) completion of a course of instruction approved by the board after consultation with the interprofessional advisory committee which includes at least 24 hours of training in the treatment and co-management of adult open-angle glaucoma and (3) co-management for

KMS
KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 23, 1996

To: Senate Public Health and Welfare Committee
From: Dr. Linda Warren
President
Subj: SB 684 - Practice of Optometry

I appreciate the opportunity to appear before you today, as the representative of the Kansas Medical Society, in support of Senate Bill 684, which relates to the practice of optometry. The legislation would permit optometrists to be licensed to treat a specific type of glaucoma after completing a co-management treatment period with an ophthalmologist.

After requests from legislators to have ophthalmologists and optometrists meet to discuss practice issues, the Kansas Medical Society organized a series of investigative sessions. Initially, the KMS called together a group of ophthalmologists to discuss the issues. This group was willing to meet with representatives from the optometry community to explore the topics, and KMS, in conjunction with the Kansas State Ophthalmological Society and the Kansas Optometric Association, formed a committee of ophthalmologists and optometrists from across the state to do so.

Many issues were presented by both ophthalmology and optometry during the series of meetings, and lengthy, probing discussions aided the group in finding areas in which we absolutely agreed, areas we were willing to discuss further, and areas in which we simply could not reach consensus.

Ongoing discussions led to the proposed development of a co-management of patients by ophthalmologists and optometrists in treating patients with adult open-angle glaucoma. KMS feels this is an ideal solution which allows the patient to have the benefit of complete and comprehensive evaluation, and it also facilitates communication and education between the ophthalmologist and optometrist.

It was the concern of the Kansas Medical Society - our only concern - that the quality of care given to Kansans not be compromised. Discussion and debate are healthy activities, but the KMS feels that if such discussions result in compromise, the outcome must likewise assure that quality of care is maintained. KMS feels that this legislation does this. The citizens of Kansas will not have their quality of care altered, and they may, in fact, have better access to care.

The Kansas Medical Society is pleased to be able to support this legislation and believes Kansans will profit from it. Thank you. I would be happy to answer any questions.

Senate Public Health and Welfare
Date: 2-23-96
Attachment No. 2

KSOS

Kansas State Ophthalmological Society

Joseph Philipp, M.D.
President
K. Dwight Hendricks, M.D.
Immediate Past President
Thomas McDonald, M.D.
Vice-President
Jemshed Khan, M.D.
Secretary-Treasurer
Perry Schuetz, M.D.
AAD Councillor
Rebecca Rice, J.D.
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TESTIMONY PRESENTED TO THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Re: SB 684

February 21, 1996

by Joseph Philipp, M.D., President
Kansas State Ophthalmological Society

Thank you, Madam Chair and members of the committee. I am Joe Philipp and a physician from Manhattan. I am a board certified ophthalmologist and currently president of the Kansas State Ophthalmological Society. I am here to speak in favor of SB 684. During the last three months, representatives of the state ophthalmological and optometric associations have been discussing the expansion of optometric practice. SB 684 is the result of those discussions.

Although this bill is not perfect, nor is it totally without certain risks, the state ophthalmology society believes this collaborative approach to the expansion of optometry is in the best interest of our patients and the people of Kansas. If the intent of this law is followed by ophthalmologists, optometrists, and the state board of optometry; we sincerely believe the potential for improving medical care can become a reality. The intent of this law is to provide an expansion of optometric practice through a collaborative effort. This law provides for experienced supervision and advice, as well as documented quality controls.

This bill contains activities that, by law, have never been done independently by optometrists in a clinical setting in Kansas. The expansion by any group of non-physicians into the practice of medicine must be accomplished with caution and in a slow, supervised manner to assure appropriate public safeguards. The Kansas State Ophthalmological Society believes SB 684 accomplishes these objectives and is the best approach to the expansion of optometric practice. We urge your support of this bill.

Thank you for your attention. I will stand for questions at the committee's request.

Senate Public Health and Welfare
Date: 2-23-96
Attachment No. 3

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

February 23, 1996

To: Chairperson Praeger and Members, Senate Public Health Committee

From: Harold Riehm, Executive Director, KAOM

Subject: Testimony and Suggested Amendment - S.B. 684

Thank you for this opportunity to present our views on S.B. 684.

Though not an invited participant in the provider deliberations that led to the introduction of this Bill, KAOM is in support of S.B. 684, with the amendment we propose. This is an example of provider groups (minus one) working together to resolve a problem outside the legislative arena. Sometimes it will work; at times it will not. It is always worth an attempt.

Our suggested amendment is attached, in a balloon, to this written testimony. Though there are only a few osteopathic physician opthamologists practicing in Kansas, we think it important that they be given an opportunity, by law, to be a member of the "interprofessional advisory committee" provided for in New Sec. 5 of the Bill.

Normally, we would be inclined to seek language that would insure at least one osteopathic physician (opthamologist) on the committee. Given the present small number of D.O. opthamologists practicing in Kansas, our suggested language only requires that there be an opportunity for a D.O. member. Specifically, it expands the number of opthamologists' names submitted as nominees from six to eight, two of them submitted by KAOM.

I will be pleased to respond to questions.

Senate Public Health and Welfare
Date: 2-23-96
Attachment No. 4

the list of persons last submitted. Each member of the board shall hold office until a successor is duly appointed and qualified. The governor shall have the power to remove from office any member of the board for neglect of duty, incompetency, improper or unprofessional conduct.

New Sec. 5. (a) No later than 30 days following the effective date of this act, the board shall appoint a seven-member committee to be known as the interprofessional advisory committee which, subject to approval of the board, shall have general responsibility for the establishment, review and monitoring of the procedures for co-management by optometrists and ophthalmologists of adult open-angle glaucoma.

(b) The interprofessional advisory committee shall consist of one member of the board appointed by the board who shall serve as a non-voting chair, together with three optometrists licensed to practice optometry in this state chosen by the board from those nominated by the Kansas optometric association and three ophthalmologists licensed to practice in this state chosen by the board from those nominated by the Kansas medical society. ~~Each nominating organization shall submit six nominees to the board.~~ Persons appointed to the committee shall serve terms of three years and without compensation. All expenses of the committee shall be paid by the board.

and the Kansas association of osteopathic medicine. The Kansas optometric association and Kansas medical society shall submit six nominees to the board. The Kansas association of osteopathic medicine shall submit two nominees to the board.

Note: Does not require a D.O. member.

(c) The committee shall submit recommendations to the board on the following:

(1) An ongoing quality assessment program including the monitoring and review of co-management of patients pursuant to subsection (d) of K.S.A. 65-1505 and amendments thereto;

(2) requirements for the education and clinical training necessary for glaucoma licensure, which shall be submitted to the board within 90 days following appointment;

(3) criteria for evaluating the training or experience acquired in other states by applicants for glaucoma licensure;

(4) requirements for annual reporting during a glaucoma licensee's co-management period to the committee and the board which shall be submitted to the board within 90 days following appointment;

(5) the classes and mix of patients either suspected of having or diagnosed as having adult open-angle glaucoma who may be included in the number of co-management cases required by subsection (d) of K.S.A. 65-1505 and amendments thereto, which shall be submitted to the board within 90 days following appointment; and

(6) requirements for annual continuing education by glaucoma licensees.

(d) After considering the recommendations of the committee pursuant to subparagraph (c), the board shall proceed to adopt procedures to confirm that each applicant has completed the requirements for glau-

SENATE

STATE OF KANSAS

Senate Bill 684

Senate Public Health and Welfare Committee

Friday, February 23 1996 10:00 AM

Dee Bell, M.D.

Senate Public Health & Welfare
Date: 2-23-96
Attachment No. 5

D. W. BELL, M.D., P.A.
OPHTHALMOLOGY

7000 WEST 121ST STREET
OVERLAND PARK, KANSAS 66209-4000

SUITE 100
TELEPHONE (913) 469-1020

February 23, 1996
10:00 AM

Good morning

Senator Praeger, Senator Langworthy, and members of the Committee, thank you. My name is Dee Bell. I'm a Kansan, a parent, a physician, a patient. I would like to discuss Senate Bill 684 with you this morning. As you know this bill will set a precedent for the state of Kansas in that it will allow a limited licensed practitioner to fully control the medical disease adult onset chronic glaucoma without any additional medical supervision. In my mind it would appear that the two questions that need to answered about this bill are:

1. Is there a significant public health threat that it addresses?

and

2. Will any patient go blind if this bill is not passed?

In the state of Kansas it is estimated that there are 16,000 people with adult onset chronic open glaucoma, the most common type of glaucoma. It is estimated that approximately 5-10% of those people will go blind from their disease. The incidence of glaucoma in whites is 1-1 1/2% per year and for blacks 5% per year. It is stated that probably half the people who have glaucoma are not aware that they have it. Will this bill increase the number of people diagnosed and treated with glaucoma?....no it will not. People who are seen today for eye examinations, whether it be from a limited licensed practitioner or a physician, have the right to have the diagnosis of glaucoma made and be treated. This bill will not increase the number of patients helped.

Are people in the state of Kansas being denied glaucoma treatment because of access, affordability ? The answer is no. All known patients who have adult onset glaucoma are being treated by a physician. If this bill is passed the precedent will be set in the state of Kansas that glaucoma won't necessarily be treated by a physician.

Despite nine (9) years of medical training, despite 25 years of practice, despite treating hundreds of glaucoma patients, I am still humbled by this disease. I cannot begin to comprehend allowing limited licensed practitioners to treat glaucoma following 24 hours of additional study, and two (2) years of co-management with 20 patients. This doesn't seem to be beneficial for the health and safety of Kansans.

Every Kansan resides within one hours drive of an ophthalmologist. Chronic open angle glaucoma is a chronic disease, not an emergency. One hours worth of driving does not seem much to see an ophthalmologist once a year to assess how they are doing with their disease and prevent blindness.

Some of the drugs used to treat chronic open angle glaucoma can be threatening to one's general health; in fact drugs called beta-blockers have actually helped kill people. Without a thorough background in medical knowledge in order to treat the entire patient, and the ability to recognize early and quickly, side effects from the medication, there could be an increased mortality from the treatment of this disease.***

The people of Kansas trust their legislators to do the best thing in looking out for the common good.

If the Committee believes that it is necessary to address public health concerns of Kansas to pass this bill, I would ask the Committee consider adding one statement to it which is; "if a person is diagnosed with adult onset chronic open glaucoma that they see an ophthalmologist once a year indefinitely, not just for 2 years".

Thank you very much for hearing my comments. If you have questions, I will be happy to try to answer them.

D.W. Bell, M.D.

***"Side effects from eye drops can be serious, even fatal. Between 1978 and 1985, the FDA and the National Registry of Drug-Induced Ocular Side Effects received more than 500 reports of adverse effects to a commonly used glaucoma medication, timolol maleate (also known as timoptic). Cases involved respiratory and cardiovascular problems, and some 32 deaths were attributed to this topical drug."

from: "Decreasing Drop Size Reduces Absorption Risks," Medical World News, November 14, 1988, p. 39.

GLAUCOMA

2001

GLAUCOMA 2001

A Public Service Project of the American Academy of Ophthalmology

Information and Referral Line for Uninsured Patients Seeking Help for Glaucoma

1-800-391-EYES

Pilot Project supported in part by Otsuka America Pharmaceutical, Inc.

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RISK-FACTOR ANALYSIS

History-Based Risk Factor Weights

Variable	Category	Weight
AGE	<50 YEARS	0
	50-64 years	1
	65-74 years	2
	>75 years	3
RACE	Caucasian/other	0
	African American	2
FAMILY HISTORY OF GLAUCOMA	Negative or positive in non-first degree relatives	0
	Positive for parents	1
	Positive for siblings	2
LAST COMPLETE EYE EXAMINATION	Within past 2 years	0
	2-5 years ago	1
	>5 years ago	2

Other historical variables such as high myopia or hyperopia, systemic hypertension, steroid use, and perhaps diabetes are not strong enough to be assigned a weight, but may be considered in the overall assessment of glaucoma risk.

Level of Glaucoma Risk	Weighting Score
HIGH	4 or greater
MODERATE	3
LOW	2 or less

Glaucoma

What is glaucoma?

Glaucoma is a group of diseases usually associated with an increased pressure within the eye. (Some types of glaucoma are primary open-angle, angle-closure, secondary, congenital, juvenile and low tension.) This pressure can cause damage to the cells that form the optic nerve, the structure responsible for transmitting visual information from the eye to the brain. The damage is progressive with loss of peripheral vision first, followed by reductions in central vision and, potentially, blindness. This section deals with primary open-angle glaucoma, the most prevalent type.

How many people have glaucoma?

Between 2 and 3 million Americans age 40 and over, or about 1 in every 30 people in that age group, including those who are unaware they have the eye disease. (Estimates of total cases by state are given in the accompanying table on p. 16.)

How many people have glaucoma and don't know it?

At least one half of all those who have glaucoma are unaware of it.

How many people are blind due to glaucoma?

Between 89,000 and 120,000 persons are blind from glaucoma. It is a leading cause of blindness, accounting for between 9 percent and 12 percent of all cases of blindness. The rate of blindness from glaucoma is between 93 and 126 per 100,000 population 40 years or older.

Who is at highest risk of developing glaucoma?

People who are more likely to develop glaucoma include those who are any one or more of the following: African-American; related to someone with glaucoma; over 50 years of age if Caucasian and 35 years of age if African-American; very nearsighted; have had eye surgery or an eye injury; are diabetic; are taking steroid medications for a long period of time.

How many visits are made each year to doctors' offices?

More than 7 million office visits were made for glaucoma and glaucoma-related diagnoses in 1990.

How many people undergo surgery for glaucoma?

As of 1988, more than 255,000 surgical procedures were done for glaucoma in the U.S. Of these, 180,000 were laser procedures and 75,000 were incisional surgical procedures.

How many people are hospitalized for glaucoma each year?

Approximately 12,000 people were hospitalized with a primary diagnosis of glaucoma in 1990. They stayed a total of 22,000 days.

Is race an important factor?

Yes. African-Americans have glaucoma 4 to 5 times more frequently than Caucasian Americans.

5-5

What about age?

Yes. The older the person, the greater the risk of having glaucoma. Among Caucasians, 3 percent of those 65 or older have glaucoma, whereas among African-Americans, about one in 10 people 65 and older are afflicted with this disease.

Can young people get it?

Glaucoma can occur at any age. Many cases in babies and young children result from prenatal and hereditary factors. Some 5,800 people have been blinded by congenital glaucoma, with approximately 170 new cases each year.

Does it run in families?

Yes. There is a hereditary tendency. Glaucoma occurs at least twice as frequently among people who have blood relatives with glaucoma.

How is it detected?

Unfortunately, there is no simple test for glaucoma. Measurement of the pressure alone within the eye is *not* adequate to detect glaucoma. Only a complete eye examination through dilated pupils along with other specialized testing is adequate to detect and diagnose this disease.

What are the signs and symptoms?

In the vast majority of cases, especially in the early stages, there are few signs or symptoms. In the later stages of the disease, symptoms can occur and include loss of side vision, an inability to adjust the eyes to darkened rooms, difficulty in focusing on close work, rainbow colored rings around lights and frequent changes of prescription glasses.

Can glaucoma be cured?

No. Any sight that has been destroyed cannot be restored, but medical and surgical treatment can help stop the disease from progressing.

Can glaucoma be prevented?

Not yet, but blindness from glaucoma can be prevented through early detection and appropriate treatment.

What is the best defense against glaucoma?

A complete eye examination on a regular basis, the frequency of which will depend on a person's age and history (see chart on page 17).

What is angle-closure glaucoma?

Angle-closure glaucoma is sometimes seen in patients who are farsighted and can be associated with the symptoms of pain and sudden decreased vision. It is caused by closure of the drainage channels and is treated with laser iridotomy.

People at high risk need to have their eyes examined more frequently and regularly than others.

DATA SOURCES

■ *1990 population data by state were obtained from Summary Tape File 1C issued on CD-ROM from the Bureau of the Census, U.S. Department of Commerce.*

■ *Estimated numbers of cases of glaucoma were obtained from fitted values applied to the mid-point of the census age intervals. Fitted values were determined by logistic regression models fit to data from the Baltimore Eye Survey for glaucoma of all types. These estimates do not include cases that occur among persons less than 40 years of age. Baltimore Eye Survey definitions of glaucoma were conservative, and highly suspect cases or additional cases thought to need clinical management that did not meet Baltimore Eye Survey definitions could add another 41% to the total burden of illness caused by glaucoma.*

■ *Persons with symptoms should see an eye care professional immediately and those with special risk factors such as a family history of glaucoma, diabetes or previous eye trauma may need to be seen more frequently. The patient should follow the eye doctor's recommendations for examination intervals.*

•OTHERS MAY INCLUDE HISPANICS, ASIANS AND NATIVE AMERICANS. FURTHER SEGMENTATION OF THESE GROUPS IS NOT AVAILABLE THROUGH THIS STUDY.

Cases of Glaucoma by State and Race, Among Persons 40 Years and Older, 1990

STATE	CAUCASIANS & OTHERS*		AFRICAN-AMERICANS	
	POPULATION 40 AND OVER	CASES OF GLAUCOMA	POPULATION 40 AND OVER	CASES OF GLAUCOMA
Total U.S.	86,264,868	1,477,904	8,963,758	500,360
Alabama	1,268,719	21,470	315,418	19,935
Alaska	147,590	1,675	3,529	140
Arizona	1,345,958	23,170	27,807	1,457
Arkansas	853,529	15,332	110,315	7,502
California	9,769,573	158,090	640,146	33,468
Colorado	1,144,932	17,823	34,764	1,692
Connecticut	1,264,296	21,976	78,157	3,852
Delaware	222,025	3,709	33,171	1,783
Washington, D.C.	79,223	1,371	155,352	9,464
Florida	5,287,851	103,053	494,509	26,769
Georgia	1,822,767	28,447	483,047	26,808
Hawaii	407,616	6,523	2,824	109
Idaho	366,816	6,220	587	29
Illinois	3,857,535	67,016	513,637	27,757
Indiana	2,002,356	34,238	131,885	7,481
Iowa	1,121,376	21,242	12,047	666
Kansas	914,596	16,824	37,886	2,203
Kentucky	1,351,811	22,929	80,674	4,997
Louisiana	1,128,201	18,756	369,283	21,629
Maine	487,199	8,469	854	41
Maryland	1,444,586	23,265	362,172	17,952
Massachusetts	2,287,683	40,695	80,814	4,082
Michigan	3,110,940	52,109	397,450	22,104
Minnesota	1,605,917	28,385	18,573	885
Mississippi	691,007	11,901	256,680	16,550
Missouri	1,875,364	33,954	168,025	9,817
Montana	315,296	5,442	412	22
Nebraska	597,817	11,173	14,683	784
Nevada	442,402	6,641	20,243	940
New Hampshire	409,823	6,709	1,527	69
New Jersey	2,840,661	48,693	327,267	16,868
New Mexico	529,908	8,552	7,884	431
New York	6,284,445	110,193	928,388	48,232
North Carolina	2,121,311	34,864	448,325	26,173
North Dakota	241,144	4,574	270	9
Ohio	3,889,713	66,778	372,575	21,172
Oklahoma	1,174,732	20,767	63,595	3,852
Oregon	1,135,746	19,602	12,178	639
Pennsylvania	4,654,116	84,215	370,468	21,606
Rhode Island	395,747	7,276	9,469	484
South Carolina	986,566	15,835	306,373	17,629
South Dakota	267,054	5,106	436	19
Tennessee	1,702,830	28,542	231,448	13,931
Texas	5,237,228	84,371	563,907	31,748
Utah	493,905	7,970	2,408	125
Vermont	211,837	3,534	358	17
Virginia	1,943,687	30,403	360,256	20,575
Washington	1,797,918	29,633	35,970	1,768
West Virginia	746,323	13,111	20,700	1,473
Wisconsin	1,824,543	32,719	54,195	2,577
Wyoming	160,650	2,559	817	45

KANSAS DENTAL ASSOCIATION

David Hanzlick
Assistant Executive Director
S.B. 681
February 22, 1996

Chairman Praeger and members of the Committee, I am David Hanzlick, Assistant Executive Director of the Kansas Dental Association. I am pleased to have the opportunity to express the KDA's support of one of the greatest public health successes of this century -- community water fluoridation.

S.B. 681 will bring the benefits of community water fluoridation to approximately one million people who are served by unfluoridated public water systems. This legislation addresses a steady erosion in the percentage of Kansans who are served by fluoridated water. Recent data indicates that about only one-half of Kansans who get their waters from public water systems have fluoridated water. That's down from 58 percent in the recent past. The national "Healthy People 2000" objectives call for providing access to fluoridated water for 75 percent of the population served by public water systems.

I am pleased that the Kansas Dental Association is joined by a number of health, government, business, education and insurance organizations in support of improving the public health through community water fluoridation. These organizations include:

Kansas Dental Hygienists Association
Kansas State Nurses Association
Kansas Department of Social and Rehabilitation Services
Kansas Department of Health and Environment
Kansas Association of Osteopathic Medicine
Delta Dental Plan of Kansas
Kansas Chamber of Commerce and Industry
Kansas-National Education Association
Kansas Hospital Association
Kansas Medical Society
Kansas Pharmacists Association
Kansas Academy of Family Physicians

Attached to my testimony is a publication of the American Dental Association entitled "Fluoridation Facts". It provides a comprehensive review of all aspects of community water fluoridation.

I am pleased to have with me today two members of the dental profession who will provide you with valuable information on the importance of adequate fluoridation. Dr. Philip Zivnuska is Chairman of the KDA Committee on Water Fluoridation and President of the Wichita District Dental Society. He is a dentist in general practice in Wichita. Dr. Nevin Waters is the President of the Kansas Dental Association and a dentist in general practice in Olathe.

Thank you.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

Statement by Philip S. Zivnuska D.D.S.
In Support of SB 681
February 23, 1996

Senator Praeger and Members of the Committee:

My name is Dr. Philip Zivnuska. I have been a practicing general dentist in Wichita for 18 years and currently serve as President of the Wichita District Dental Society and Chairman of the Fluoridation Committee of the Kansas Dental Association (KDA).

The Kansas Dental Association strongly supports the adoption of Senate Bill 681. Fluoridation is one of the great public health measures of our time. A half century of experience has proven fluoridation to be the single most effective action to prevent tooth decay and to improve oral health over a lifetime. In all of medicine, there are only a few advances (pasteurization, water purification, and immunization) that can compare with the success of fluoridation.

Twenty five years ago, 28% of children aged 5-17 years had no dental decay in their permanent teeth. In 1980, that number had risen to over 36%. In June 1988, the National Institute of Dental Research reported the 49.9% of children in this age group were caries(decay) free, largely because of water fluoridation.

The benefits are not limited to one age group. A review of 113 studies in 23 countries showed average reductions of caries in primary teeth was 40-49%, and 50-59% in permanent teeth. It is important to note that adults and seniors show a reduction in caries of 15 to 35%. Seniors are keeping teeth longer and since older people tend to take more prescription drugs they also suffer the side effects. These include reduced saliva flow and subsequent cavities on the roots of their teeth that can be reduced by fluoridation. Water fluoridation benefits everyone with teeth.

Other sources of fluoride are helpful adjuncts but not suitable replacements. Fluoride toothpastes, gels, rinses, and tablets have reduced the decay rate. Nonetheless, studies continue to show the need for water fluoridation even with declining decay levels. Because Wichita has insufficient fluoride levels, I will be giving fluoride tablets to my four year old for 12 more years, and my one year old will be taking fluoride until 2011. I possess the determination to do this, but even with my training and motivation, there is no way that I can tell you that my kids will take their tablet every day. Other children in my community may not have parents with the financial resources to afford this prescription item.

Fluoridation saves money. The benefit/cost ratio for fluoridation is 80/1. At a national average of 51 cents per year, a lifetime of protection will cost less than one filling. Lack of an optimally fluoridated water supply hits the poor especially hard. Alternative sources of fluoride are more expensive and the poor have the least access to dental care when

excessive decay does occur. Kansas currently spends $7.2 Million on children's dental care programs. California projects the savings in state dental programs for children will more than pay for costs of fluoridation in that state.

Fluoride is a naturally occurring constituent of food and water. Fluorine ranks thirteenth in abundance in the earth's crust and in the human body. It is the twelfth most abundant element in the oceans. Natural sea water has a higher concentration of fluoride (1.2-1.5 ppm) than would be needed for Kansas water supplies. Fluoride is a natural nutrient for the prevention of disease.

Fifty years of success has allowed for numerous studies of fluoride's success in preventing cavities. Fluoridation is endorsed by a remarkable number of organizations (see attached). The CDC, FDA, AMA, NIH and dozens of other leading national and international organizations support water fluoridation. Please note the lack of opposing organizations with anywhere near the credibility of the proponents.

Senator Praeger, members of the committee, I am proud to be a member of a profession that attempts to prevent disease and improve the health of the public. It is rare that a group will work against its own economic interest to serve the public interest. I enjoy dentistry, but there is nothing enjoyable about performing dental treatment that could have been prevented so easily and inexpensively. Save the citizens of Kansas money and discomfort. Improve their health. Please approve this bill to bring to nearly 700,000 more Kansans the benefits of fluoride, benefits that most Americans, including residents of Topeka, currently enjoy.

Thank you.

Philip S. Zivnuska D.D.S.
2424 N Woodlawn #119
Wichita, KS 67220
H-316-744-9909
O-316-683-0411

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NATIONAL AND INTERNATIONAL ORGANIZATIONS THAT ENDORSE OR SUPPORT WATER FLUORIDATION:

American Academy of Pediatrics
American Academy of Pediatric Dentistry
American Association for the Advancement of Science
American Association for Dental Research
American Association of Dental Schools
American Association of Public Health Dentistry
American College of Dentists
American Council on Science and Health
American Dental Assistants Association
American Dental Association
American Dental Hygienists Association
American Dietetic Association
American Federation of Labor and Congress of Industrial Organizations
American Hospital Association
American Institute of Nutrition
American Medical Association
American Nurses' Association
American Osteopathic Association
American Pharmaceutical Association
American Public Health Association
American Public Welfare Association
American School Health Association
American Society of Clinical Nutrition
American Society for Dentistry for Children
American Veterinary Medical Association
American Water Works Association
Association for Academic Health Centers
Association of State and Territorial Dental Directors
Association of State and Territorial Health Officials
British Dental Association
British Fluoridation Society
British Medical Association
Canadian Association of Accident and Sickness Insurers
Canadian Dental Association
Canadian Medical Association
Canadian Nurses Association
Canadian Public Health Association
Center for Science in the Public Interest
Consumer Federation of America
Department of National Health and Welfare (Canada)
Delta Dental Plans Association
European Organization for Caries Research
Federation of American Societies for Experimental Biology
Federation Dentaire Internationale
Food and Nutrition Board
Great Britain Ministry of Health
Health Insurance Association of American
Health League of Canada
International Association for Dental Research
Mayo Clinic
National Academy of Sciences
National Cancer Institute
National Confectioners Association
National Congress of Parents and Teachers
National Health Council
National Institute of Dental Research
National Research Council
New York Academy of Medicine
Royal College of Physicians (London)
Travelers Insurance Company
U.S. Department of Agriculture
U.S. Department of Defense
U.S. Environmental Protection Agency
U.S. Junior Chamber of Commerce
U.S. Public Health Service:
- Centers for Disease Control and Prevention
- Food and Drug Administration
- Health Resources and Services Administration
- Indian Health Service
- National Institutes of Health

World Health Organization
Pan American Health Organization

7-3

KANSAS DENTAL ASSOCIATION

Statement by Nevin Waters, D.D.S.
President of the Kansas Dental Association
In Support of S.B. 681
Before the Senate Committee on Public Health and Welfare
February 23, 1996

Chairman Praeger and members of the Committee, I am Dr. Nevin Waters. I am President of the Kansas Dental Association and a dentist in general practice in Olathe, Kansas. I very much appreciate having the opportunity to express my strong support of improving the oral health of Kansans by increasing access to fluoridated water. Thank you, Chairman Praeger, for your willingness to hold hearings on this important public health issue.

I would like to highlight three important points for the Committee's consideration:

1. **Increasing access to adequately fluoridated water will improve the lives of Kansans by reducing cavities by 40 to 60 percent in children and 15 to 35 percent in adults.** All reputable research on fluoridation over the past half-century shows that adequately fluoridated public water is safe and effective in reducing tooth decay rates. While there are some individuals and organizations that will make claims to the contrary, all reputable scientific studies reaffirm the effectiveness and safety of community water fluoridation.

2. **Adequately fluoridated water improves the health of children and improves the quality of their lives.** Largely due to water fluoridation, nearly half of all children from 5 to 17 years of age in the U.S. showed no tooth decay in 1988. Twenty-five years ago, only 28 percent of children in that age group had no decay. We believe it is high time to extend these benefits to additional Kansans who do not currently have access to fluoridated water. This is a public health measure. A state requirement is justified.

3. **Adequately-fluoridated water is fiscally-responsible public policy.** Initial estimates indicate that the cost of fluoridating the unfluoridated public water systems that serve more than 3300 people will be less than $350,000. That is an extremely small price to pay for bringing the tremendous benefits of fluoridated water to nearly 700,000 more Kansans.

   That small cost is greatly outweighed by the cost savings fluoridation will provide to the State, to employers who provide dental benefits, and to the general public in lower treatment costs. SRS estimates that fluoridation in Sedgwick County alone will save the state $177,000 annually in Medicaid dental expenditures. Over two years, the Medicaid savings just in Sedgwick County will nearly equal the cost of fluoridating all the unfluoridated systems that serve more than 3300 people.

Again, we thank you for your consideration of the benefits of fluoridation -- reduced tooth decay, improved health, and savings to the state and the public. Thank you.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

State of Kansas

Department of Health and Environment

Testimony presented to
Senate Public Health and Welfare Committee
by
The Kansas Department of Health and Environment
Senate Bill 681

The Kansas Department of Health and Environment appreciates this opportunity to present testimony regarding fluoridation of public water supplies to improve the oral health of Kansas children.

Numerous studies have shown the causal relationship between fluoride and prevention of dental decay. Early studies indicated that water fluoridation decreased decay by 40% to 60%. The most recent national study (using a multi-stage probability sample including 39,206 children) indicates that community water fluoridation continues to be beneficial. When all sources of fluoride were adjusted for, children living in fluoridated communities had a mean caries score that was 25% lower than children living in non-fluoridated communities. And although tooth decay is reduced by fluoridated toothpaste, mouth rinses, professional fluoride treatments and fluoride dietary supplements, fluoridation of water is the most cost-effective method. The United States Public Health Service considers water fluoridation the most important and the first source of fluoride that should be considered in any prevention program.

Fluoride's effects on reducing decay were first noted more than 60 years ago. Some cities have naturally occurring fluoride in their water at levels that prevent tooth decay. Over 50 years ago, the first city added fluoride to its drinking water to prevent dental decay. As other cities fluoridated their water, information was published in dental journals on the dramatic reduction in tooth decay. Marked differences in the proportion of children with dental decay were noted between fluoridated and unfluoridated communities, both in this country and around the world.

The public health impact of water fluoridation has been profound. Prior to community water fluoridation close to one half of 15 year olds were missing at least one permanent tooth due to decay. Results were similar in Kansas. Today, after many U.S. communities have fluoridated their water, nearly 50% of children have no dental decay. These benefits have been specifically demonstrated in community after community in the United States.

Fluoridation has prevented needless pain, infection, suffering and loss of teeth, as well as saving billions of dollars. A recent study of 1993 Medicaid expenditures in Nebraska indicated annual dental costs for children living in unfluoridated communities were $120 to $150 per child, while dental costs for children living in fluoridated communities were $60 - $80. They found that the annual Medicaid costs for children's oral health

were twice as high in unfluoridated communities as in fluoridated ones. Clearly, individuals making out-of-pocket payments for oral health care, or those having dental insurance, also save money. Once a tooth becomes carious, Public Health Service estimates show that, over a lifetime, $1,000 will be required to maintain that tooth. Participants in the last national oral health survey (1985-1986) of employed adults and seniors had on average 9.8 decayed or filled teeth. If dental decay in even half of these adults could have been prevented, cost savings to the individual would have been significant.

Fluoridation of public water supplies continues to have significant oversight. Continuous and considerable efforts have been made to document the health benefits of fluoride, assess the potential side effects, and to improve fluoride technology. Fluoridation has received very close scrutiny. Given the concerns expressed by some over water fluoridation, numerous reviews by public health agencies and researchers have been conducted to assess the health benefits and risks of fluoridation, and there is no evidence to suggest that the Public Health Service should change its recommendations. The U.S. Public Health Service continues to endorse water fluoridation as safe and effective. Based on history, we anticipate that questions will be raised about fluoridation. The critical point to remember, however, is that no single finding should be interpreted alone given the enormous amount of scientific evidence available.

Today, there is great public concern regarding the cost of health care. It seems quite appropriate that emphasis be placed on prevention which reduces such expenditures. Economic studies have estimated that for every $1 spent on water fluoridation, the community saves $80 in dental care costs. Teeth becoming decayed rarely need one treatment. Dental restorations are not permanent and require repair or replacement as they are placed under constant stress.

To date, over 144 million people in the United States are supplied with drinking water containing enough fluoride to protect teeth. Currently, 51% of Kansans who get their water from public water systems (PWS) receive fluoridated water. Oklahoma, Nebraska, Missouri and Colorado all have a larger proportion of their population served with fluoridated water. The importance of community water fluoridation to the health of the Nation is evidenced by the U.S. Department of Health and Human Service's goals for Healthy People 2000. These goals include having fluoridated water available to 75 percent of a state's population by the year 2000. Senate bill 681 would help Kansans achieve that goal. Since 1951, every U.S. Surgeon General has strongly endorsed water fluoridation as a preventive public health measure. The U.S. Public Health Service considers water fluoridation the most important prevention program in dental health for children. For example, former U.S. Surgeon General Koop stated:

> "Over the past 30 years, detailed reports have been published in scientific journals on all aspects of fluoridation. The accumulated dental, medical, and public health evidence concerning fluoridation has been reviewed and judged numerous times by committees of experts and special councils on most of the major national and international organizations. Although a few individuals continue to object to fluoridation, there is no basis for doubting the medical safety, oral health effectiveness, and practicality as a public health measure. The overwhelming consensus of the scientific community is that the fluoridation of public water supply systems at optimal level provides major dental benefits without adverse health effects"...."I urge all health officials and concerned citizens to join me in supporting this commitment for drinking water supplies which lack the fluoride content needed for the prevention of dental caries."

We fully support the intent of this bill which is to reduce health care costs, improve dental health, and alleviate unnecessary pain and suffering in all Kansans, especially children.

Testimony presented by: Corinne Miller, D.D.S., Ph.D.
Assistant State Epidemiologist & State Dental Director
Office of Epidemiologic Services
February 23, 1996

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

Senate Committee on Public Health and Welfare
Testimony on Senate Bill 681
Pertaining to Adding Fluoridation to the Public Water Supply Systems in Kansas

February 23, 1996

Madam Chairman and members of the committee, thank you for the opportunity to submit written testimony concerning Senate Bill 681. This bill would add fluoridation to public water systems in Kansas that serve more than 3300 people. This would affect approximately 680,000 Kansans.

The Kansas Department of Social and Rehabilitation Services (SRS) supports this bill along with the American Dental Association (ADA), and national "Healthy People 2000" goals which are to have fluoridated water available to 75% of a state's population by the year 2000. In addition, we want to work with public health and the Kansas Dental Association in an effort to improve the lives of all Kansans and the oral health of the Kansas Medicaid population.

National studies on the addition of fluoride to public water systems have shown that fluoridation reduces tooth decay rates. The most recent studies supported by the American Dental Association shows tooth decay rates in children are reduced by as much as 40%, with the addition of fluoridation to drinking water.

In FY95, Kansas Medicaid expended $443,000 on dental fillings for Sedgwick County Medicaid beneficiaries. Based on the above mentioned studies, if Sedgwick County water had been fluoridated, SRS would have saved $177,000 in Sedgwick County on dental procedures. With the addition of fluoride to the drinking water in many other Kansas cities besides Wichita, such as Leavenworth, Liberal, and Abilene, SRS could realize considerable cost savings in the Medicaid children's dental program. However, any reduction in SRS dental expenditures is a secondary benefit to the overall improvement of oral health to all Kansans we believe would occur with the passage of Senate Bill 681.

2/22/96

Robert C. Harder
1420 Ward Parkway
Topeka, Kansas

February 22, 1996

Senator Sandy Praegar
The State House
Topeka, Kansas 66612

Dear Senator Praegar:

I am writing to support S.B. 681. This bill calls for the fluoridation of all public water supplies which serve more than 3300 people.

The use of fluoridation is a preventative health measure for all citizens at a minimum cost. My family has had the advantage of fluoridation being available to them. We are a family with few cavities. We are pleased with those results.

Please keep in mind:

1. Nationwide fluoridation is viewed as one of the most effective public health measures available to our citizens.

2. Because of fluoridation, nearly half of the children entering first grade have not experienced tooth decay.

3. Children who live in communities without fluoridated water can be expected to have up to 40% more cavities than children in communities with fluoridated water.

4. Water fluoridation has an average annual estimated cost of just 51 cents per person.

Thank you for your consideration of this important matter.

Sincerely, yours,

Robert C. Harder

Senate Public Health and Welfare
Date: 2-23-96
Attachment No. 11

SENATE BILL No. 534

By Committee on Public Health and Welfare

1-25

AN ACT relating to hearing aids; board of examiners for hearing aids; amending K.S.A. 74-5801, 74-5802, 74-5803, 74-5804, 74-5805, 74-5806, 74-5807, 74-5808, 74-5809, 74-5810, 74-5810a, 74-5811, 74-5812, 74-5813, 74-5814, 74-5815, 74-5816, 74-5818, 74-5819, 74-5820, 74-5821, 74-5822, 74-5823 and 74-5824 and repealing the existing sections.

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

Section 1. K.S.A. 74-5801 is hereby amended to read as follows: 74-5801. There is hereby established the Kansas board of examiners in fitting and dispensing of hearing aids constituted as provided in this act ~~and hereinafter called the "board."~~

Sec. 2. K.S.A. 74-5802 is hereby amended to read as follows: 74-5802. ~~Within sixty (60) days after the effective date of this act~~ The governor shall appoint a board of examiners of hearing aid dispensers, consisting of five ~~(5)~~ persons. No person shall be eligible for appointment as a member of ~~said~~ *the* board unless ~~he~~ *such person* is a resident of Kansas. Three ~~(3)~~ members of ~~such~~ *the* board shall ~~be members of a Kansas hearing~~ *and association affiliated with a national hearing aid association having affiliations in not less than ten (10) states, shall be certified by a national hearing aid association having affiliations in not less than ten (10) states, healthcare association, and* have been engaged in the actual practice of fitting and dispensing hearing aids in this state continuously for the last five ~~(5)~~ years. Two ~~(2)~~ members of such board shall be individuals not engaged in the practice of fitting and dispensing hearing aids in the state of Kansas, *and shall not be related to an individual who currently, or previously, is or was employed by a hearing healthcare organization or establishment*. Two members shall be appointed for terms of three years; two members shall be appointed for terms of two years; and one member shall be appointed for a term of one year; thereafter successors shall be appointed by the governor for terms of three years. Vacancies shall be filled by appointment by the governor for the unexpired term. The governor shall have the power to remove from office any member of the board for neglect of duty, incompetency, improper or unprofessional conduct, or when the certificate of a member has been revoked.

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uncomfortable loudness levels to determine the selection of the best fitting arrangement for maximum hearing aid benefit.

(6) Middle ear assessment by air conduction and bone conduction comparisons, ~~screening tympanometry or other technologically appropriate tests~~.

(b) A hearing assessment as described in subsection (a) shall be valid for six months.

(c) ~~Audiometric tests listed in subsection (a) that cannot be performed due to the mental or physical condition or disability of the client may be excluded, except that documentation shall be maintained by the dispenser for three years that supports the exclusion of the specific audiometric tests.~~

Any client who cannot complete the audiometric tests as listed in subsection A shall be referred to an audiologist or a person licensed to practice medicine, preferably a person who specializes in diseases of the ear, for evaluation and examination. Such person must present medical clearance prior to the purchase of a hearing aid.

(d) The board shall establish a list of otologic conditions detectable through a hearing assessment as set forth in subsection (a) for which prepurchase medical evaluation shall be required. Such list shall take into account the otologic conditions referred to as "red flags" in the U.S. food and drug administration 1977 regulations on hearing aid devices or subsequent otologic conditions to remain consistent with FDA regulations. When such otologic conditions are detected, a hearing aid shall not be fitted until medical clearance is obtained for the condition noted. If a consumer provides the required medical clearance and the condition noted, if treatable, is no longer observable, a hearing aid may be fitted.

(e) In addition, a consumer shall not be required to obtain medical clearance for the repurchase of a hearing aid once a medical evaluation and clearance has been obtained for certain otologic conditions that are permanent and will be reidentified at each hearing assessment. At a minimum, such conditions shall include the following:

(1) Visible congenital or traumatic deformity of the ear.

(2) Hearing loss as a secondary condition as established by the board.

significant

(3) Unilateral or asymmetric hearing loss, assuming no change in thresholds

or speech discrimination

(4) Audiometric air-bone gap equal to or greater than 15 decibels (dB) average at 500 Hertz (Hz), 1000 Hz and 2000 Hz.

(5) Bilateral hearing loss of greater than 90 dB.

Any person with a significant difference between bone conduction hearing and air conduction hearing must be informed of the possibility of a medically treatable condition.

(f) The board may inspect the premises of any licensee in order to determine the state of compliance with the provisions of this section, the applicable rules and regulations and may enter the premises of a licensee and inspect the records upon reasonable belief that a violation of this act is being or has been committed or that the licensee had failed or is failing to comply with the provisions of this act.

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(g) No hearing aid can be sold or distributed through the mail to the ultimate consumer unless the consumer provides to the mail order company a written hearing assessment as set forth in subsection (a).

Sec. 9. K.S.A. 74-5808 is hereby amended to read as follows: 74-5808. No person shall engage in the sale of or practice of dispensing and fitting hearing aids or display a sign or in any other way advertise or hold ~~himself~~ *oneself* out as a person who practices the dispensing and fitting of hearing aids unless ~~he~~ *the person* holds a current, unsuspended, unrevoked license issued by the board as provided in this act, or unless ~~he~~ *the person* holds a current, unsuspended, unrevoked certificate of endorsement pursuant to K.S.A. 74-5814 *and amendments thereto*. The license or certificate required by this section shall be kept conspicuously posted in ~~his~~ *the person's* office or place of business at all times.

Sec. 10. K.S.A. 74-5809 is hereby amended to read as follows: 74-5809. Any person who practices the fitting or dispensing of hearing aids shall deliver to each person supplied with a hearing aid, by ~~him or at his~~ *such person or by such person's* order or direction, a bill of sale which shall contain ~~his~~ *the typed or* printed name and ~~his~~ signature *of such person* and show the address of ~~his~~ *the* regular place of practice and the number of ~~his~~ *the person's* license, together with a description of the make and model of the hearing aid furnished and the amount charged therefor. The bill of sale shall also reveal the condition of the hearing device and whether it is new, used or rebuilt. *Records of hearing aid purchase and corresponding hearing assessment shall be maintained by the hearing aid specialist for at least three years* ~~except in the case of the death of the purchaser~~.

Sec. 11. K.S.A. 74-5810 is hereby amended to read as follows: 74-5810. This act shall not apply to a person while ~~he is~~ engaged in the practice of fitting hearing aids if ~~his~~ *such* practice is part of the academic curriculum of an accredited institution of higher education or part of a program conducted by a public, charitable institution or nonprofit organization, which is primarily supported by voluntary contributions: ~~Provided. This~~. *Such an* organization ~~does~~ *shall* not sell hearing aids or accessories ~~thereto~~, unless persons making such a sale are licensed under this act

This act shall not be construed to prevent or limit any person who is a practitioner of the healing arts licensed by the state board of healing arts in treatment of any kind or in fitting hearing aids to the human ear.

Sec. 12. K.S.A. 74-5810a is hereby amended to read as follows: 74-5810a. (a) The Kansas board of examiners in fitting and dispensing of hearing aids is hereby authorized to adopt rules and regulations fixing the amount of fees for the following items and to charge and collect the amounts so fixed subject to the following limitations:

License application — not more than ..... ~~$50~~ *$100*

Temporary ~~license~~ *permit* — not more than	~~25~~ *75*
Temporary ~~license~~ *permit* renewal — not more than	~~100~~ *200*
Certificate of registration or endorsement — not more than	~~50~~ *175*
Certificate of registration or endorsement renewal — not more than	~~50~~ *175*
Certificate of registration or endorsement late renewal — not more than	~~100~~ *150*
Certificate of registration or endorsement extended late renewal — not more than	~~200~~ *300*
Duplicate certificate of registration or endorsement — not more than	25
Examination, written — not more than	~~100~~ *75*
Examination, practical — not more than	150
Sponsor's application — not more than	*75*
Verification of training program completion — not more than	*100*

(b) Whenever the board shall determine that the total amount of revenue derived from the fees collected pursuant to this section is insufficient to carry out the purposes for which such fees are collected, the board may amend such rules and regulations to increase the amount of the fee, except that the amount of the fee for any item shall not exceed the maximum amount authorized by this section. Whenever the amount of fees collected pursuant to this section provides revenue in excess of the amount necessary to carry out the purposes for which such fees are collected, ~~it shall be the duty of~~ the board ~~to~~ *shall* decrease the amount of the fee for one or more of the items listed in this subsection by amending the rules and regulations which fix such fees. *Fees collected by the board are nonrefundable.*

~~(c) Until the effective date of any rules and regulations adopted by the board in accordance with the provisions of subsection (b) which fix the amount of the fee for any item specified in subsection (a), the board shall charge a fee for such item in an amount equal to the maximum amount authorized for such item by subsection (a).~~

Sec. 13. K.S.A. 74-5811 is hereby amended to read as follows: 74-5811. An applicant for a license shall pay the license application fee provided for in K.S.A. 74-5810a and amendments thereto and shall show to the satisfaction of the board that such applicant:

~~(a) Is a resident of this state;~~

~~(b)~~ *(a)* Is ~~18~~ *21* years of age or older;

~~(c)~~ *(b)* has an education equivalent to a four-year course in an accredited high school ~~or has continuously engaged in the practice of fitting and dispensing hearing aids during the three years preceding the effective date of this act; and~~ *On and after July 1, 2001, the applicant shall have graduated from an accredited college or university with an associate degree, bachelor's degree, or equivalent, or an approved higher or professional education program as determined by the board; and*

or approved

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(d) ~~is free of contagious or infectious disease~~ *has not had a hearing aid dispenser license denied, revoked or suspended in any state within the past three years and that any current hearing aid licenses held in any state are in good standing and not subject to ongoing proceedings.*

Sec. 14. K.S.A. 74-5812 is hereby amended to read as follows: 74-5812. (a) An applicant for a license who is notified by the board that such applicant has fulfilled the requirements of K.S.A. 74-5811 *and amendments thereto* shall appear at a time, place and before such persons as the board may designate, *and shall present a current driver's license or other government issued photo identification,* to be examined by written and practical tests in order to demonstrate that such applicant is qualified to practice the fitting of hearing aids:

(b) An applicant who fulfills the requirements of K.S.A. 74-5811 *and amendments thereto* and ~~who has not previously applied to take the examination provided under this section may apply to the board for a temporary license~~ *who also establishes to the board that the applicant holds: (1) A current, valid certification from the national board for certification in hearing instrument sciences; (2)* ~~*a current, valid certificate of clinical competence award by the American speech language hearing association*~~*;* [(3)] *graduated from an accredited curriculum in hearing instrument sciences; or* [(4)] *a valid, current license as a hearing aid specialist or its equivalent from another state and has been actively practicing in such capacity for at least 12 of the last 15 months, shall be immediately eligible to take the licensure examination. Any applicant who fulfills the requirements of K.S.A. 74-5811 and amendments thereto, but who cannot establish that the requirements set forth in subsection (b) of K.S.A. 74-5812 and amendments thereto have been met must apply for and obtain a temporary permit and must complete a training program as set forth by the board as a condition of eligibility to take the licensure examination. The training program shall include a minimum number of hours of course work, observation, practical experience and a procedure for verifying the completion of the course work, the observation and the practical experience.*

a current, valid audiology license in the state

(3) a valid Kansas temporary license in audiology or is participating in a clinical fellowship year in the state;

(4)

(5)

~~(c) Upon receiving an application provided under subsection (b) of this section, accompanied by the temporary license fee provided for in K.S.A. 74-5810a, the board may issue a temporary license which shall entitle the applicant to practice the fitting and dispensing of hearing aids for a period ending thirty (30) days after the conclusion of the next examination given after the date of issue.~~

~~(d)~~ *(c)* No temporary ~~license~~ *permit* shall be issued by the board under this section unless the applicant shows to the satisfaction of the board that such applicant is or will be ~~employed by a supervised and trained person~~ *trained and supervised by a person* who holds a valid license or

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Session of 1996

SENATE BILL No. 577

By Committee on Judiciary

2-1

AN ACT concerning hospital liens; amending K.S.A. 65-406 and repealing the existing section.

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

Section 1. K.S.A. 65-406 is hereby amended to read as follows: 65-406. Every hospital in the state of Kansas, which shall furnish *furnishes* emergency, medical or other service to any patient injured by reason of an accident not covered by the workmen's *workers* compensation act, shall, if such injured party shall assert or maintain *asserts or maintains* a claim against another for damages on account of such injuries, *shall* have a lien not to exceed five thousand dollars ($5,000) upon that part going or belonging to such patient of any recovery or sum had or collected or to be collected by such patient, or by his *such patient's* heirs, personal representatives or next of kin in the case of his *such patient's* death, whether by judgment or by settlement or compromise. *Such lien shall be* to the amount of the reasonable and necessary charges of such hospital for the treatment, care and maintenance of such patient in such hospital up to the date of payment of such damages: *Provided, however,* That this. *Such* lien shall not in any way prejudice or interfere with any lien or contract which may be made by such patient or his *such patient's* heirs or personal representatives with any attorney or attorneys for handling the claim on behalf of such patient, his *such patient's* heirs or personal representatives: *Provided further,* That the. *Such* lien herein set forth shall not be applied or considered valid against anyone coming under the workmen's *workers* compensation act in this state.

Sec. 2. K.S.A. 65-406 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

(a)

physician or

physician or

by such physician or

(b) "Physician" means a person licensed to practice medicine and surgery under the healing arts act.

Senate Public Health & Welfare
Date: 2-23-96
Attachment No. 13

Session of 1996

SENATE BILL No. 500

By Committee on Public Health and Welfare

1-22

AN ACT concerning the health care data governing board; amending K.S.A. 1995 Supp. 65-6803 and repealing the existing section.

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

Section 1. K.S.A. 1995 Supp. 65-6803 is hereby amended to read as follows: 65-6803. (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 *Kansas health* 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.

(d) ~~(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.

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

new language added

, advisory panel

(c) The chairperson of the Health Care Data Governing Board will appoint an advisory panel of 5 - 7 persons to serve as a resource to the full board. This panel will provide technical and professional expertise and will be available to serve on the task forces appointed by the board.

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

Sec. 2. K.S.A. 1995 Supp. 65-6803 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the Kansas register.

14-2

STATE OF KANSAS

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SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE HEALTH CARE DECISIONS FOR THE 90's
MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
CORPORATION FOR CHANGE
KANSAS HEALTHY KIDS CORPORATION
JOINT COMMITTEE ON CHILDREN AND FAMILIES

January 30, 1996

Senate Public Health and Welfare Committee
Senator Sandy Praeger, Chair

Amendment to: SB 500 -- Membership of Health Care Data Governing Board

On page 1, line 23, after the word "institute", insert language "one member representing the health services research community from the three regents research universities who shall share the seat on a rotating basis, appointed by the ~~chief academic officers~~ Board of Regents)," KU - K-State - Wichita State

Senate Public Health and Welfare
Date: 2-23-96
Attachment No. 15