Approved: 2-16-98
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 12, 1998 in Room 526-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee:
Sally Finney, Kansas Public Health Association
Nancy Bear, Tribal Council Chair, Kickapoo Tribe
Keith Landis, Christian Science Committee on Publication for Kansas
Bob McDaneld, Administrator, Kansas Board of Emergency Medical Services
Dennis M. Allin, M.D., KUMC, Emergency Services
Connie McAdam, President, Kansas EMS
Rex Prior, Emergency Care and Education Services, Ottawa
Carolyn Middendorf, Kansas State Nurses Association

Others attending: See attached list

Continued Hearing on SB 437 - Prevention of child lead poisoning

Sally Finney, Kansas Public Health Association, Inc., testified before the Committee in support of **SB 437** which was requested by the Kansas Department of Health and Environment to address childhood lead poisoning prevention, accreditation of training programs related to lead-based paint activities, and licensure and/or certification of individuals, business entities and public agencies who provide, engage in or conduct lead-based paint activities. Ms. Finney offered an amendment that would direct the Secretary of Health and Environment to develop a plan that would fund activities conducted by local health departments as shown in her written testimony. (Attachment 1)

Nancy Bear, Tribal Council Chair of the Kickapoo Tribe, addressed the Committee in support of **SB 437** and noted that lead exposure and lead poisoning are two dangerous and potentially lethal conditions that can cause chronic or acute illness. Ms. Bear stressed the need for passage of the bill as a measure to prevent lead poisoning in children as noted in her written testimony. (Attachment 2)

Keith Landis, Christian Science Committee on Publication for Kansas, expressed concern with language in the bill dealing with the definition of a health care provider, and suggested new language be added on page 3, line 16, that would read, "The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices, or a person who provides care and treatment by spiritual means in accord with the person's religious teachings...." Mr. Landis offered another amendment that would allow parents or guardians of a child of spiritual objections to state in writing that the child be exempt from screening or testing for lead poisoning as shown in his written testimony. (Attachment 3)

The Chair noted that the Secretary of Health and Environment will be bringing back information to the Committee on an acceptable lead prevention program for Kansas that would permit the state to enforce the program without EPA regulation, as well as allowing communities to apply for federal funding.

Hearing on SB 535 - Board of emergency medical services; powers and duties; regulation of attendants; instructor coordinators; training officers

Bob McDaneld, Administrator, Kansas Board of Emergency Medical Services, testified before the Committee in support of **SB 535** which would allow emergency medical services personnel to perform additional procedures under the direct supervision, via radio or telephone, of qualified medical staff. The additional procedures would allow for an emergency medical technician-intermediate to preform an endotracheal intubation and administering nebulized albuterol. It was pointed out that emergency medical technicians and first responders

would also be allowed to use an automatic external defibrillator. The bill also broadens the language which defines criminal conduct for which the board may take action to revoke or deny an application for certification or certification renewal. Mr. McDaneld also offered technical amendments as shown in his written testimony. (Attachment 4) Committee discussion related to training of EMS responders and types of ambulance services.

Dennis Allin, M.D., KUMC, Department of Emergency Services, submitted written testimony and expressed support for **SB 535** and addressed two issues in the bill that he felt were of utmost importance: (1) the provision to expand the type of criminal activity that can be considered during deliberations on an attendant's or instructor-coordinator's certificate, and (2) providing EMT and EMT-1 level providers the skills and equipment necessary to perform life-saving techniques such as endotracheal intubation and external defibrillation. (Attachment 5)

Connie McAdam, President, Kansas EMS, expressed support for the bill but expressed concern with how it would be determined whether an applicant had been convicted of a criminal offense. Another proposal offered by Ms. McAdam related to adding language in the bill that would protect EMS personnel from assault and interference while performing their duties. (Attachment 6)

Rex Prior, Emergency Care and Education Services, testified before the Committee and suggested that language be added in **SB 535** that would offer protection to the multiple qualified providers so that said individuals could use all of the training and abilities interchangeably with EMS certification as noted in his written testimony. (Attachment 7)

Carolyn Middendorf, Kansas State Nurses Association, addressed the Committee and requested clarification of the definition of professional nurse as being a "licensed" professional nurse as noted in her written testimony. (Attachment 8)

John Dudte, Paramedic instructor at Hutchinson Community College, testified before the Committee in support of the intent of **SB 535**, but suggested striking "endotracheal intubation" from page 8, line 11, because given current limitation in support, education and regulation, he noted that EMT-I intubation is medically, educationally an unsound practice without proper training as shown in his written testimony. (Attachment 9)

Written testimony was received from Meg Draper, KMS, who expressed concern regarding the wording and definition of a physician in the bill (Attachment 10), and Patsy Johnson, Kansas State Board of Nursing, who offered an amendment to change the definition of emergency medical care, (Attachment 11).

The Chair announced that because of the many concerns and amendments to the bill made by the various conferees, a subcommittee was appointed consisting of Senators Salmans and Steineger to bring back recommendations and present them to the full Committee before the bill is considered.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 16, 1998.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-12-98

NAME	REPRESENTING
LARRY BUENING.	BD OF HEALING ARTS.
Scott Kneer	K.S Pharmacists Assoc
Bob Courtney	Sumner County Commission
Thomas Riehm	KADM
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
Connie McAdam	Ks EMS Association
JON E. FRIESEN	HUTCHINSON COMM. COLLEGE
Andrea Chapman	MidAmerica Nazarene Uni. (KSNA)
Michelle David	MidAmerica Naz. Uni. (KSNA)
Lindsay McBee	Mid-America Nazarene Univ. (KSNA)
Lex H. Pryor	Emergency Care & Education Serv
John Dudte	Hutchinson Community College
Dan Jones	Hutchinson Commuity College
John Thomas	Kickapoo Tribe in Kansas
Nancy Beaver	Kickapoo Tribe in Kansas
Ronald R Hawker	Kickapoo Tribe in Kansas
Sean Hoskinson	KANS. Wichita State University
Doug Smith	KSSA
Bob McDaniel	Board of EM

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-12-98

NAME	REPRESENTING
Meg Draper	KMS
Dennis Allin m.d	Board of EMS
Pat Lehman	KS Fire Service Alliance

Kansas Public Health Association, Inc.
Affiliated with the American Public Health Association
701 SW Jackson Avenue, Suite 300
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Testimony on Senate Bill 437
Presented on February 12, 1998

Senator Praeger and members of the Senate Public Health and Welfare Committee, my name is Sally Finney. I am Executive Director of the Kansas Public Health Association. Thank you for the opportunity to appear before you this morning on behalf of Senate Bill 437.

Lead poisoning is one of the most pressing environmental problems facing children in the United States. The U.S. Agency for Toxic Substances and Disease Registry reports that one of every six children in the United States has high levels of lead in their blood. In 1994, the National Conference of State Legislatures released a report, "Lead Poisoning Prevention: A Guide for Legislators." That document cites the following facts about lead poisoning:

- blood lead levels of less than 10 micrograms/deciliter may cause decreased IQ and impair hearing and growth (page 1);
- increasingly higher blood lead levels cause increasingly more severe complications ranging from a reduction in production of hemoglobin, the chemical that carries oxygen to cells, to nervous system damage. It may, in the most serious cases, cause kidney damage and death (page 1); and
- children are more likely to be exposed to lead from exposure to lead-based paint than through any other source (page 2).

The pages noted above are attached for your reference.

Children are at greatest risk from lead exposures because their bodies absorb three to 10 times more lead than do the bodies of adults. Children are also at greater risk because they are more likely to have hand-to-mouth contact. A child who touches a lead-bearing object, like such as a window sill painted with lead-based paint, who then sucks his or her fingers is then exposed to lead. A child who picks up an object that has been in contact with a lead-bearing surface also will be exposed.

Childhood lead poisoning can impact future generations, because the body can store lead in bone tissue, sometimes for as long as 20 years. It is then released during times of stress, such as the kind that pregnancy causes. This means that a young girl exposed to lead who becomes pregnant as an adult can expose her unborn children to lead. Lead poisoning threatens rural, urban, and suburban communities, and it is entirely preventable.

Senate Public Health and Welfare
Date:
Attachment No. 1

According to the Centers for Disease Control and Prevention, blood lead levels have declined since the 1970's with the implementation of regulatory and voluntary bans enacted on the use of lead in gasoline, household paint, food and drink cans, and plumbing systems. However, threats to our children still exist because unsuspecting homeowners lack the proper education to contain those threats.

Why support SB 437?

- This bill will not require homeowners to have inspections, risk assessments, or abatement.
- If they choose to have this work done, it will assure that it will be completed by a quality, properly-trained work force.
- SB 437 provides for the kind of state-based childhood lead poisoning prevention activities that would make this education available where it is needed most.
- The enactment of this act will also open the door for communities to apply for HUD grant funding for remediation of older homes of low income families.

There is an unmet need not addressed in SB 437 as it is currently written to which I would like to speak. Section 3, subsection 7 refers to involvement of local health departments in conducting screening and follow-up activities. However, there is no mention of how these agencies will fund such activities. At the present time, participation of local health departments through the state is inconsistent because many local agencies have been unable to find the resources to do so. Yet, as is reflected in this legislation, the expectation exists that they will play a role in conducting lead poisoning prevention activities. In order to address this issue, we propose an amendment to SB 437, the purpose of which is to direct the secretary of health and environment to develop a plan to support local health department programs. A copy of our proposed amendment is attached.

In conclusion, I would like to close by saying that the Kansas Public Health Association supports the passage of SB 437.

Thank you for your time.

LEAD POISONING PREVENTION: A GUIDE FOR LEGISLATORS

by Doug Farquhar
Senior Policy Specialist
State Issues and Policy Analysis Program

National Conference of State Legislatures
in cooperation with the
U.S. Environmental Protection Agency

National Conference of State Legislatures
William T. Pound, Executive Director
1560 Broadway, Suite 700
Denver, Colorado 80202-5140
303/830-2200

444 North Capitol Street, N.W., Suite 515
Washington, D.C. 20001
202/624-5400

August 1994

1-3

1. THE NATURE AND EXTENT OF LEAD POISONING

Lead is a highly toxic metal that exists in paints, dust, and soils in and around homes in the United States. If ingested by humans lead disturbs virtually every system in the body and provides no physiological benefit. The most comprehensive study of blood lead levels, the Third National Health and Nutrition Examination Survey (NHANES), estimates 1.7 million children have blood lead levels at least 10 µg/dL or above.[12]

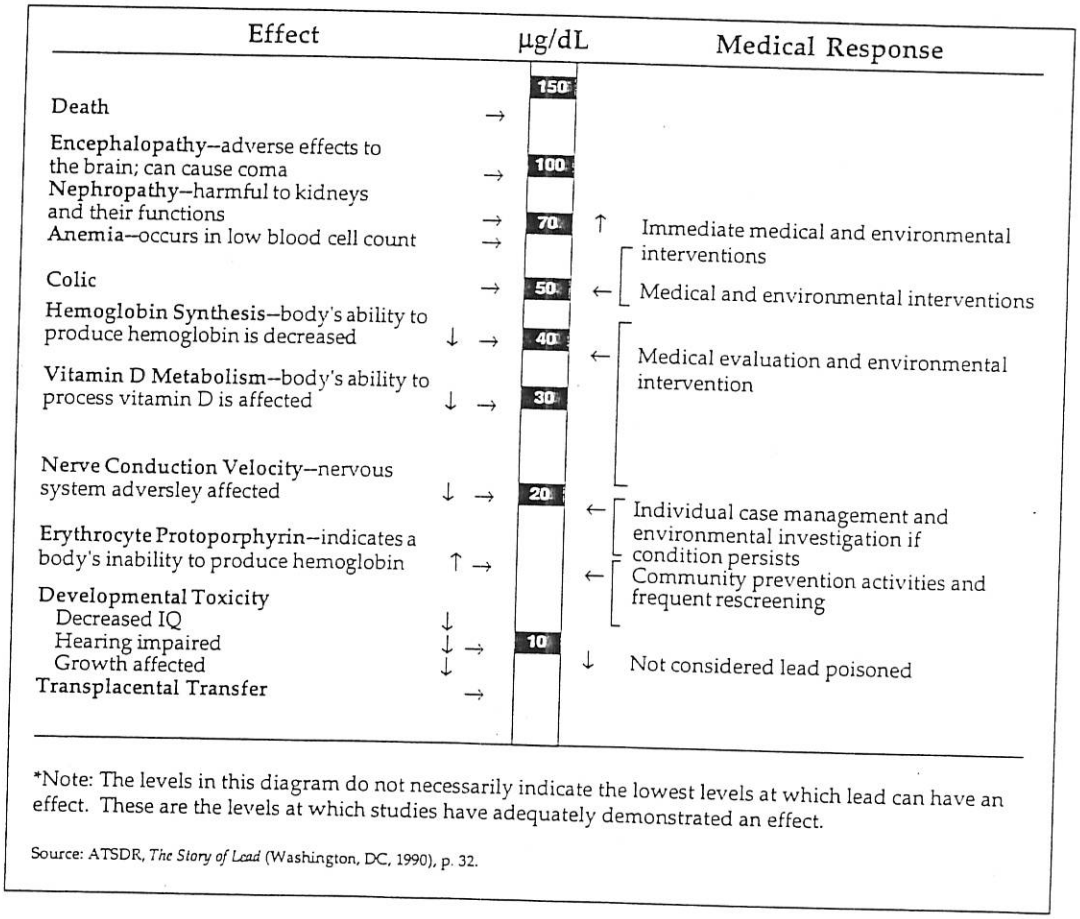
Characteristics of the Metal

Lead has unique properties that increase the severity of the problem. As an element, inorganic lead cannot be processed or destroyed, nor can its chemical structure be changed. Lead also accumulates in the environment. Once released from its natural state it remains indefinitely, continually posing a threat for which there are no natural defenses.[13]

Before the industrial age, exposure to lead was rare. Industrialization, however, released massive amounts of lead into the environment. Lead was used extensively in paints and gasoline, emitted from smelters and factories, used in pipes and plumbing for water systems, as well as other consumer and industrial applications. Large amounts of lead remain in old paint and drinking water

Figure 1

Lead Levels in Blood That Cause Certain Effects in Children*



*Note: The levels in this diagram do not necessarily indicate the lowest levels at which lead can have an effect. These are the levels at which studies have adequately demonstrated an effect.

Source: ATSDR, *The Story of Lead* (Washington, DC, 1990), p. 32.

systems. Dust and soil contain the residues from all these major sources, and natural forces widely disperse dust contaminated by lead. No socioeconomic group, geographic area, or racial or ethnic population is free from lead.

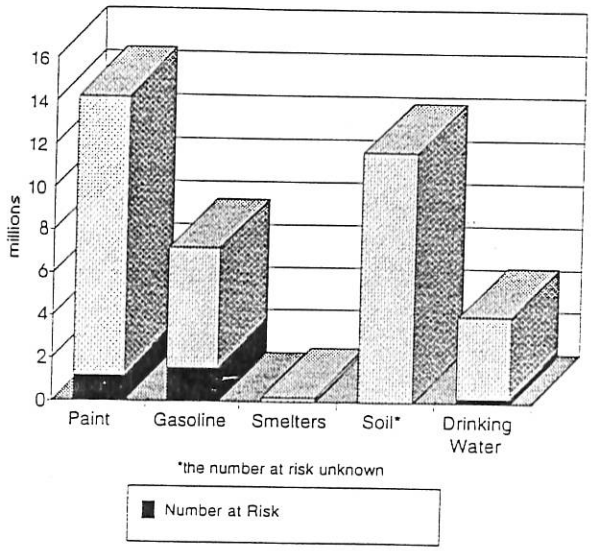
Effects on Children and Pregnant Women

When absorbed into the body, lead usually affects the central nervous system most severely (see figure 1). It is, therefore, particularly harmful even at low-levels to the developing brain and nervous system of young children, infants and fetuses.[14] Children and infants are more likely than adults to be poisoned by lead because they have more hand-to-mouth activities and thereby ingest more lead-contaminated dusts and paints. Their bodies also are more likely to absorb the lead once ingested.[15]

Lead affects pregnant women by causing premature deliveries and lower birthweight and, in extreme cases, causing miscarriages and stillbirth. Research has indicated that low levels of lead in the blood harm a fetus' central nervous system, and the Centers for Disease Control and Prevention (CDC) believes it may have an adverse effect.[16]

Lead poisoning is measured by blood lead content: the number of micrograms of lead in a deciliter of blood (µg/dL). A microgram per deciliter is equivalent to four grains of salt placed in a swimming pool. Extreme levels in children, above 80 µg/dL, can cause comas, convulsions, and death if not treated. Lower levels, between 25 µg/dL and 60 µg/dL, cause adverse effects on the central nervous system, the kidneys, and blood-forming organs. At levels nearing 10 µg/dL, lead decreases intelligence and impairs neurobehavioral development. Other effects linked to low blood lead levels include decreased height, impaired hearing, and an inability to stand upright.[17]

Figure 2
Number of Children Exposed to Lead via Various Media



Source: Agency for Toxic Substances and Disease Control (1988)

Sources and Reduction of Exposure

The three major sources of lead are lead-based paint, lead particles in dust and soils (mostly contaminated by lead in paints and gasoline), and lead in drinking water. Lead from smelters and other stationary sources, municipal waste and sewage sludge incinerators, and consumer products also contribute to lead into the environment (see figure 2).[19]

Lead-based paint. Lead in household paints is the most frequent cause of lead poisoning.[20] Although the sale and use of lead-based paint was banned in 1978,[21] 4.9 million tons of lead were used in paints, and more than 57 million homes have lead-based paint.[22] Nearly 10 million of these homes are occupied by families with children under seven, and almost four million of these homes have chipping and peeling paint that poses an immediate risk to children.[23] Many children from upper- and middle-income families are being exposed to lead paint and dust from home

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Sec. 3. The secretary is authorized and directed to:

(a) Develop and implement a childhood lead poisoning prevention program and adopt rules and regulations, standards and procedures relative to lead poisoning prevention as necessary to protect the health of the children of Kansas. To fulfill the provisions of this paragraph, the secretary shall:

(1) Investigate the extent of childhood lead poisoning in Kansas;

(2) develop a data management system designed to collect and analyze information regarding childhood lead poisoning;

(3) develop and conduct programs to educate health care providers regarding the magnitude and severity of and the necessary responses to lead poisoning in Kansas;

(4) issue recommendations for the methods and intervals for blood lead screening and testing of children, taking into account recommendations by the CDC;

(5) develop and issue health advisories urging health care providers to conduct blood lead screening of children;

(6) encourage health care providers to ensure that parents and guardians of children are advised of the availability and advisability of screening and testing for lead poisoning;

(7) develop a program to assist local health departments in identification and follow-up of cases of elevated blood lead levels in children and other high-risk individuals; and

(8) in consultation with appropriate federal, state, and local agencies, develop a comprehensive public education program regarding environmental lead exposures and lead poisoning by:

(A) Identifying appropriate target groups that are in a position to prevent lead poisoning or reduce the number of children who are exposed to lead;

(B) assessing the information needed for each of the target groups and determining the best means of educating the members of each target group; and

(C) disseminating the information to the target groups and determining the best means of educating the members of each target group.

(7) develop a program to assist local health departments in identification and follow-up of cases of elevated blood lead levels in children and other high-risk individuals; ~~and~~

(8) develop a plan to fund activities conducted by local health departments pursuant to this act; and

~~(8)~~ *(9)* in consultation with appropriate federal, state, and local agencies, develop a comprehensive public education program regarding environmental lead exposures and lead poisoning by:

KICKAPOO TRIBE IN KANSAS

P.O. Box 271 • Horton, KS 66439-0271

Office: 913-486-2131 • Fax: 913/486-2801

TESTIMONY PRESENTED TO

THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Thursday, February 12, 1998

by

Ms. Nancy Bear
Tribal Council Chairperson
Kickapoo Tribe in Kansas
Registered Nurse - State of Kansas

SENATE BILL 437

Madam Chair, members of the committee and guests. Thank you for the opportunity of appearing here today to address you on a very important issue. I am here as a representative of the Kickapoo Tribe in Kansas, a sovereign Indian Nation within this state.

Lead exposure and lead poisoning are two dangerous and potentially lethal conditions that we simply cannot ignore. Exposure to high concentrations of lead can cause either chronic or acute illness. The presence of lead in the body from inhalation, ingestion or absorption can cause irreparable damage to a persons blood system, digestive system, central nervous system, reproductive system and/or the kidneys.

I learned a long time ago that prevention is the best medicine. We Americans have taken the necessary measures since about 1978 to eliminate all paint and construction items that contain lead. A larger percentage of the homes in this country were constructed prior to 1978 and many of these homes pose a health hazard, because of the presence of lead, to all household members, especially children because they are more susceptible.

Next to prevention, early detection and treatment are the most medically effective and cost effective remedies that exist. Believe me, it is much more cost effective to test for the

Senate Public Health & Welfare
Date: 2-12-98
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KICKAPOO TRIBE
IN KANSAS

P.O. Box 271 • Horton, KS 66439-0271
Office: 913-486-2131 • Fax: 913/486-2801

presence of lead and to treat the symptoms than it is to pay the medical and other related costs of kidney dialysis, serious brain and reproductive disorders, and birth defects. And what about the cost of loosing a child or loved one to lead poisoning?

The Kickapoo Tribe wishes to support and work with the State of Kansas and the Environmental Protection Agency in safeguarding one of our most important assets, our children. Our Tribe is working to establish a Lead Program on the reservation. We are currently in the educational and assessment phases. Next will be blood testing and treatment. Insuring our future means insuring the health and welfare of our people and protecting the environment we live in.

Senate Bill 437 contains provisions for these items that I just mentioned; education, environmental assessments, testing and treatment. Thank you for allowing my co-workers and myself to be here offering support of Senate Bill 437.

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

To: Senate Committee on Public Health and Welfare

Re: SB 437

It is requested that the following amendments be made to SB 437:

On **page 3, line 15** after the word "devices" add a comma "," and delete the "or";

On **page 3, line 16** after the word "services" delete the period "." and add", or a person who provides care and treatment by spiritual means in accord with the person's religious teachings.". Page 3, lines 13-16 will read as follows:

> "The term does not include a person who provides health care solely through the sale or dispensing of drugs or medical devices ~~or~~, *or a person who provides care and treatment by spiritual means in accord with the person's religious teachings,*" or a person rendering emergency medical services."

On **page 5, line 23** after "CDC" add: "except that no child shall be screened or tested if the child's parent or guardian objects in writing that such screening or testing is contrary to the religious beliefs and practices of the parent or guardian."

Your consideration of this request is appreciated. Thank you.

Keith R. Landis
Committee on Publication
for Kansas

Senate Public Health & Welfare
Date: 2-12-98
Attachment No. 3

STATE OF KANSAS
BOARD OF EMERGENCY MEDICAL SERVICES

109 S.W. 6TH STREET, TOPEKA, KS 66603-3826
OFFICE (913) 296-7296 FAX (913) 296-6212 TDD (913) 296-6237

Bob McDaneld
Administrator

Bill Graves
Governor

DATE: February 12, 1998

TO: Senate Public Health and Welfare Committee

FROM: Bob McDaneld

SUBJECT: Testimony in support of SB 535

The Board of Emergency Medical Services is the state agency which regulates out-of-hospital emergency medical care. Agency responsibilities include the licensing of ambulance services and vehicles and the training, examination and certification of ambulance attendants and instructors. The board also provides an emergency radio communications system in 51 counties and supports the emergency medical services portion of the Kansas Department of Transportation's 800 Mhz communications system.

SB 535 is the board's legislative package. It was introduced in this committee at the request of the board by Sen. Chris Steineger, who sits on the board and serves on its administration committee.

SB 535 has five primary objectives. First, the bill authorizes Emergency Medical Technician-Intermediates to administer nebulized albuterol (used in the emergency treatment of asthma) and insert endotracheal tubes (used to establish an airway in a non-breathing patient) when these skills have been approved by the local component medical society.

Second, the bill gives the board clear authority to regulate emergency medical services training providers, primarily educational institutions. Currently, approval for a training program is issued to an individual instructor, even though that instructor is usually employed by an educational institution.

Third, the bill adds use of an automated external defibrillator as an authorized activity for first responders and emergency medical technicians, replacing current language. Training on automated external defibrillators has been included in all first responder and emergency medical technician courses since January 1, 1997.

Fourth, the bill clarifies the definition of a number of terms used in the emergency medical services statutes, including all levels of attendant certification and the definitions of physician, registered nurse and medical protocols. Authorized activities at two certification levels are also clarified.

(Continued on next page.)

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Fifth, the bill broadens the language which defines criminal conduct for which the board may take action to revoke or deny an application for certification or certification renewal. The board's legal counsel has recommended this change to ensure that appropriate action can be taken when warranted by an applicant's criminal history.

This is the first time since 1994 the board has requested statutory changes. Almost two years of committee work and board discussion went into development of the bill. In addition, the board requested review of proposed legislation by emergency medical services and allied health organizations prior to requesting introduction of SB 535. Many of the concerns of these organizations were addressed in the bill as printed or have been addressed in the balloon language which is attached to this testimony. The board requests that this committee act favorably on SB 535.

RM/st
att.

C Board Members

sician, ~~physician's assistant~~ or professional nurse authorized by a physician. These protocols shall be developed and approved by a county medical society or, if there is no county medical society, the medical staff of a hospital to which the ambulance service primarily transports patients.

(o) "Mobile intensive care technician" means ~~any~~ *a* person who ~~has successfully completed a course of training, approved by the board, in emergency medical care, and who holds a valid mobile intensive care technician certificate under~~ *holds a mobile intensive care technician certificate issued pursuant to* this act.

(p) "Municipality" means any city, county, township, fire district or ambulance service district.

(q) "Nonemergency transportation" means the care and transport of a sick or injured person under a foreseen combination of circumstances calling for continuing care of such person. As used in this subsection,transportation includes performance of the authorized level of services of the attendant whether within or outside the vehicle as part of such transportation services.

(r) "Operator" means a person or municipality who has a permit to operate an ambulance service in the state of Kansas.

(s) "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.

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

~~(u) "Training officer I" means any person who has completed successfully a course of training, approved by the board, to conduct continuing education programs for attendants.~~

~~(v) "Training officer II" means any person who has: (1) Completed successfully a course of training, approved by the board, to conduct continuing education programs for attendants; and (2) completed successfully a supplemental course of training, approved by the board, to conduct initial training programs for first responders.~~

(u) "Physician's assistant" means a person who is registered in accordance with the provisions of K.S.A. 65-2896a, and amendments thereto.

(v) "Professional nurse" means a professional nurse as defined by K.S.A. 65-1113, and amendments thereto.

(w) "Provider of training" means a corporation, partnership, ~~community college~~, ambulance service, fire department, hospital or municipality that conducts training programs that include, but are not limited to, initial courses of instruction and continuing education for attendants, instructor-coordinators or training officers.

(x) "Training officer" means a person who is certified pursuant to this

----- delete ", physician's assistant"

----- replace "community college" with "accredited post-secondary education institution"

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uing education as prescribed by the board.

Sec. 5. K.S.A. 1997 Supp. 65-6119 is hereby amended to read as follows: 65-6119. Notwithstanding any other provision of law, mobile intensive care technicians may ~~perform any of the following~~:

(a) ~~May~~ Perform all the authorized activities ~~of an emergency medical technician as described~~ *identified* in K.S.A. 65-6121, and amendments thereto~~.~~*;*

(b) perform cardiopulmonary resuscitation and defibrillation ~~in a pulseless, nonbreathing patient.~~*;*

(c) when voice contact or a telemetered electrocardiogram is monitored by a ~~person licensed to practice medicine and surgery or a licensed professional nurse where authorized by a person licensed to practice medicine and surgery,~~ *physician or professional nurse where authorized by a physician* and direct communication is maintained, and upon order of such person ~~or such nurse do any of the following~~ *may*:

~~(1) Perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions.;~~

~~(2) perform gastric suction by intubation.;~~

~~(3) perform endotracheal intubation.;~~

~~(4) administer parenteral injections of any of the following classes of drugs:~~

~~(A) Antiarrhythmic agents.;~~

~~(B) vagolytic agents.;~~

~~(C) chronotropic agents.;~~

~~(D) analgesic agents.;~~

~~(E) alkalinizing agents.; or~~

~~(F) vasopressor agents.;~~

(5) administer such ~~other~~ medications or procedures as may be deemed necessary by ~~such an ordering person.~~ *a person identified in subsection (c);*

(d) perform, during an emergency, those activities specified in subsection (c) before contacting ~~the person licensed to practice medicine and surgery or authorized licensed professional nurse~~ *a person identified in subsection (c)* when specifically authorized to perform such activities by medical protocols~~.~~*; and*

(e) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.

Sec. 6. K.S.A. 1997 Supp. 65-6120 is hereby amended to read as follows: 65-6120. Notwithstanding any other provision of law to the contrary, an emergency medical technician-intermediate *may*:

(a) ~~May~~ Perform any of the activities ~~described~~ *identified* by K.S.A.

-----delete lines 16 through 28

----- delete "other"

65-6121, and amendments thereto~~, which an emergency medical technician may perform~~;

(b) when approved by medical protocols and where voice contact by radio or telephone is monitored by a ~~person licensed to practice medicine and surgery or a licensed professional~~ *physician or professional* nurse, where authorized by a ~~person licensed to practice medicine and surgery~~ *physician*, and direct communication is maintained, upon order of such person ~~or such nurse~~ may perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions, *endotracheal intubation and administration of nebulized albuterol*;

(c) perform, during an emergency, those activities specified in subsection (b) before contacting the ~~person licensed to practice medicine and surgery or authorized licensed professional nurse~~ *persons identified in subsection (b)* when specifically authorized to perform such activities by medical protocols; or

(d) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.

Sec. 7. K.S.A. 1997 Supp. 65-6121 is hereby amended to read as follows: 65-6121. Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following *activities*:

(a) Patient assessment and vital signs;

(b) airway maintenance ~~to include~~ *including the* use of:

(1) Oropharyngeal and nasopharyngeal airways;

(2) esophageal obturator airways with or without gastric suction device;~~ and~~

(3) oxygen demand valves.

(c) Oxygen therapy;

(d) oropharyngeal suctioning;

(e) cardiopulmonary resuscitation procedures;

(f) control accessible bleeding;

(g) ~~application of~~ *apply* pneumatic anti-shock garment;

(h) ~~management of~~ *manage* outpatient medical emergencies;

(i) ~~extrication of patients and lifting and moving techniques~~ *extricate patients and utilize lifting and moving techniques*;

(j) ~~management of~~ *manage* musculoskeletal and soft tissue injuries ~~to include~~ *including* dressing and bandaging wounds or the splinting of fractures, dislocations, sprains or strains;

(k) use of backboards to immobilize the spine;

(l) administer syrup of ipecac, activated charcoal and glucose;

----- delete "and" Add new (3) "multi-lumen airway; and"
----- change (3) to (4)

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The University of Kansas Medical Center

Department of Emergency Services

Administrative Offices

SENATE BILL No. 535

Testimony Submitted By Dennis M. Allin M.D., FACEP

February 12, 1998

It is indeed a pleasure to present testimony on this bill, which is the result of hours of labor performed by technicians, service directors, educators, nurses, and physicians. This Board of Emergency Medical Services sponsored project featured a breadth of input and depth of debate that is unprecedented in the history of Kansas Emergency Medical Services. I would like to focus on two issues included in this bill that will fundamentally effect the public welfare and safety.

The first is the provision to expand the types of criminal activity that can be considered during deliberations on an attendant's or instructor-coordinator's certificate. As the chairman of the investigations committee of the Board of Emegency Medical Services, charged with reviewing theses cases, I have been involved with several of these deliberations in which the attendant had an extensive record of criminal activity, the nature of which made us very uncomfortable allowing him to serve within the state EMS system. Unfortunately, these crimes, for various reasons, were not eventually classified as felonies. Under the current statute, we have very little recourse to act when the crime is not a felony. The Board of Emergency Medical Services has been entrusted with the safety of the public where this certification is concerned and as experts in our field, need to be granted the latitude necessary to perform this important function.

The second issue is so important to me personally that it is one of the reasons I sought an appointment to the Board of Emergency Medical Services. As a practitioner of Emergency Medicine for the last 11 years and the Chairman of Emergency Medicine at the University of Kansas, I have witnessed too many times the devestation resulting from inadequate management of a patient's airway or a delay in delivering life-saving shocks to a patient's heart. This was not the fault of the individual technicians involved. We simply did not give providers at the EMT and EMT-I level the skills and equipment necessary to perform these functions. Senate Bill 535 will allow attendents at the EMT-I level to perform endotracheal intubation, the best and most definitive type of airway management, and will make training in the AED standard in EMT programs thus significantly expanding the use of this device in Kansas. Currently less than 80% of the citizens of Kansas have access to paramedic level care on a 24 hour a day basis and thus rely totally on technicians at the EMT and EMT-I level to provide these life-saving procedures. Even in areas of Kansas covered by paramedic services, some have 7to 9 minute response times for advanced life-support and have first response by EMT and EMT-I level care that arrives minutes earlier. A difference of 1 or 2 minutes in the management of a non-breathing patient or a patient whose heart has stopped in ventricular fibrillation can be a death sentence. It is clear that EMT and EMT-I level technicians can successfully perform these procedures and equally clear that not one more Kansan should die because these services were not available.

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KANSAS EMERGENCY MEDICAL SERVICES ASSOCIATION

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TO: **Senate Committee on Public Health and Welfare**

FROM: **Connie McAdam, President**

RE: **SB 535**

DATE: **February 12, 1998**

The Kansas Emergency Medical Services Association (KEMSA) is the professional organization that represents EMT's, paramedics, EMS Administrators and EMS Educators throughout the state of Kansas.

KEMSA has reviewed SB 535 and in general supports the changes that will occur following passage of the bill. The improvements in the EMT-Intermediate level of care and clarification in parts of the EMS law are all good steps for EMS to take in Kansas. We have also published a summary of the changes in our newsletter, the "Kansas EMS Chronicle", which was mailed to all 10,000 certified attendants in the state in effort to get as much feedback as possible about the proposed changes.

We recognize that maintaining high standards for EMS attendants and educators is critical because many of the patients we care for are incapacitated and certainly vulnerable. KEMSA is supportive of increasing the standards to which EMS providers are held. We believe the Board of EMS should be able to consider a wider range of criminal offenses when determining whether to issue state certification and would also like to look at ways to assist local EMS directors in doing the same. We would like to address the issue of how to determine if any applicant has been convicted of an offense. Currently this is a voluntary statement on the application for initial certification or renewal. Some criminals would certainly be dishonest when completing this application and thus we have very limited protection from these persons entering the EMS field. KEMSA feels this issue needs to be addressed in depth and plans to charge a committee of our members to begin working with the Board of EMS to resolve the problem. The Administrator's Society is particularly interested in being involved with this process.

KEMSA has reviewed Sec 14, K.S.A. 65-6133 (a)(5) of the proposed SB 535. While it does not contain the nonspecific language regarding misdemeanor convictions that many of our members were initially concerned about, we feel the language proposed by the Board of EMS is still too vague. Our request to this committee is that the language be left unchanged until KEMSA and the Board of EMS can research the solution to this problem together.

KEMSA would also like to request that the Senate Public Health committee consider adding language to SB 535 that will help protect EMS personnel from assault and interference while they perform their duties. EMS attendants respond to over 200,000 calls for assistance each year and the incidence of assault against them is growing. If an EMS attendant and Firefighter are both assaulted on the same call, the penalty for assaulting the firefighter is worse than for the EMT or Paramedic. Paramedics I work with have been kicked, hit, shoved and even stabbed while responding to a 911 call for help.

We would like to amend a current Kansas law (21-3416) which provides protection for firefighters to include EMS personnel. Attached is the proposed change for that statute.

We appreciate your consideration of these changes of SB 535

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PROPOSED ASSAULT BILL LANGUAGE:

21-3416 Unlawful interference with a firefighter *or EMS provider*
Unlawful interference with a firefighter is knowingly and intentionally interfering with, molesting or assaulting, as defined in K.S.A. 21-3408 and amendments thereto, any firefighter while engaged in the performance of such firefighter's duties, or knowingly and intentionally obstructing , interfering with or impeding the efforts of any firefighter to reach the location of a fire.

Unlawful interference with an EMS provider is knowingly and intentionally interfering with, molesting or assaulting, as defined in K.S.A. 21-3408 and amendments thereto, any EMS provider while engaged in emergency care of ill or injured persons; or knowingly and intentionally obstructing, interfering with or impeding efforts of EMS providers to reach the location of medical or trauma emergency.

Unlawful interference with a firefighter *or EMS provider* is a Class B person misdemeanor.

REX H PRIOR

EMT-I/SAED, EMCI, CNA/CMA, RA, SAT, BCLS-IT/AF. Telephone (785) 229-2780 or (785) 835-6430

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1998 KANSAS LEGISLATIVE SESSION

Senate Bill No. 535

Act concerning the Emergency Medical Services Board; Relating to the powers and duties thereof; relating to attendants and the regulation thereof.

Senate Committee on Public Health and Welfare

Thursday, February 12, 1998

SENATOR SANDY PRAEGER, Chairperson,
SENATOR LARRY SALMANS, Vice Chairperson,
COMMITTEE MEMBERS

Madam Chairman and members of the committee, My name is Rex Prior and I serve as an EMS and Allied Healthcare Provider, Co-Owner/ Director for Emergency Care & Education Services, The Director for the now forming Ks Chapter of the Save a Life Foundation, Director of a National Safety Council First Aid Institute Training Center and as a Co-Director of an American Heart Association Training Center. I appear before you today on the behalf of the States EMS Providers in opposition to a section of **SB 535**.

Current Issues: My testimony today is in relation to page 15, lines 9-12. of Sec 14 KSA 65-6133, Subsection 2. Subsection number two deals with a providers certification abilities and limits them to perform only functions that are authorized within the level at witch the provider is currently certified by the states emergency medical services agency. As a multiply qualified healthcare provider I feel it necessary to point out that in the state their are 371 EMS providers currently registered with the board that are qualified in other areas of healthcare that the board knows of and requires registration for. These numbers were supplied by the board.

Of the healthcare qualifications held by other individuals, the board does not ask for or recognize all the possible credentials in healthcare that exist in Kansas. You may ask why this issue is relevant to this section of language that is now up for change. The issue comes in to question every time a EMS provider uses a skill or procedure from the persons other medical qualifications under the proper authority and direction of a state licensed physician in order to better benefit a patient, Especially when in a rural or remote area.

At the current time if an EMS Provider who is qualified in another area uses those skills and abilities they are at risk for the revocation of their EMS Certification from the Board of Emergency Medical Services, Often when this issue is present in a case one of two things will happen. The board may choose to drop the issue or they

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can go after the providers EMS Certification for suspension or Revocation at their own choosing.

To my personal knowledge their have been several cases involving this issue, Their are such cases pending at this time were the attendants are facing the loss of their certification as an emergency services provider as a result of them using such skills and abilities while under the direction of a physician. Myself as a multiply qualified provider would like to see some type of protection offered to the multiply qualified providers so that said individual may use all of their training and abilities interchangeably with the EMS certification, Especially if their is a Licensed state physician who is overseeing the actions of the provider and ensuring that a high standard of patient care and safety is being maintained.

I respectfully request that this issue be addressed in this bill, A provider should be informed if they are or are not protected before they engage in activities of this nature when authorized by a physician to perform to their complete levels of training, registration, certification and/or licensure. Clarification of this issue in the law will lead to a clear understanding in this area and will insure that fair and equal treatment to the provider or providers will be rendered in the future by the Board of Emergency Medical Services. On behalf of all EMS providers that are multiply skilled in healthcare areas we thank you for your time and attention in this matter. I will be glad to answer any questions the committee may have.

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President

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For More Information Contact
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February 12, 1998

S.B. 535 Emergency Medical Services

Senator Praeger and members of the Senate Public Health and Welfare Committee, my name is Carolyn Middendorf M.N., R.N. and I am the legislative chairperson for the KANSAS STATE NURSES ASSOCIATION. We have had an opportunity to review the changes proposed in S.B. 535 and wish to make one recommendation for change in the definition section where Registered Nurses are referenced. We recognize that for ease of construction the new proposed language throughout the bill will use the term "professional nurse" as the reference for R.N.'s. However, to make the intent clear and more easily understood we recommend adding the word "registered" to the definition of "professional nurse".

On Page 6, line 35, add "registered" after the word "a".

The term "registered professional nurse" is the term used consistently in the Kansas Nurse Practice Act (K.S.A. 65-1113, et al). We have provided a balloon for this change.

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We would like to add that in our discussions with the Board of Nursing on this bill we took note of the new definition being proposed for "Emergency Medical Services" that adds Physicians Assistants, but deletes all the specific categories of emergency personnel. The new definition uses the simple term "attendant" to refer to apparently all classes of such emergency personnel. The term "attendant" is a term that is used in other health care settings to describe types of care providers, such as "personal care attendants" that work for and with the physically handicapped. We question the wisdom of deleting the specific categories of emergency personnel (EMT's, EMICT', etc.) in favor of a more generic term like attendant, that may be misused or misinterpreted. We also note that the new definition may unintentially expand the scope of practice for "attendants" to non-emergency settings. The proposed definition may be clarified by adding language to insure that the "care" provided is "authorized emergency care". Another way to write that section of the definition would read:

> f)"Emergency medical service" means the effective and coordinated delivery of such care as may be required by an emergency, which includes the **performance of authorized emergency** care **while transporting** individuals by ambulance services . . . . . .

Thank you.

sician, physician's assistant or professional nurse authorized by a physician. These protocols shall be developed and approved by a county medical society or, if there is no county medical society, the medical staff of a hospital to which the ambulance service primarily transports patients.

(o) "Mobile intensive care technician" means ~~any~~ *a* person who ~~has successfully completed a course of training, approved by the board, in emergency medical care, and who holds a valid mobile intensive care technician certificate under~~ *holds a mobile intensive care technician certificate issued pursuant to* this act.

(p) "Municipality" means any city, county, township, fire district or ambulance service district.

(q) "Nonemergency transportation" means the care and transport of a sick or injured person under a foreseen combination of circumstances calling for continuing care of such person. As used in this subsection, transportation includes performance of the authorized level of services of the attendant whether within or outside the vehicle as part of such transportation services.

(r) "Operator" means a person or municipality who has a permit to operate an ambulance service in the state of Kansas.

(s) "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.

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

~~(u) "Training officer I" means any person who has completed successfully a course of training, approved by the board, to conduct continuing education programs for attendants.~~

~~(v) "Training officer II" means any person who has: (1) Completed successfully a course of training, approved by the board, to conduct continuing education programs for attendants; and (2) completed successfully a supplemental course of training, approved by the board, to conduct initial training programs for first responders.~~

(u) "Physician's assistant" means a person who is registered in accordance with the provisions of K.S.A. 65-2896a, and amendments thereto.

(v) "Professional nurse" means a professional nurse as defined by K.S.A. 65-1113, and amendments thereto.

(w) "Provider of training" means a corporation, partnership, community college, ambulance service, fire department, hospital or municipality that conducts training programs that include, but are not limited to, initial courses of instruction and continuing education for attendants, instructor-coordinators or training officers.

(x) "Training officer" means a person who is certified pursuant to this act to teach initial courses of instruction for first responders and contin-

Kansas State Nurses Association
Proposed Amendments to S.B. 535
February 10, 1998

licensed

registered

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Introduction

John Dudte, B.S., MICT I/C

Hutchinson Community College faculty, tenured - Paramedic Instructor 1991 - present

City of Newton, paramedic 1988 - 1997

Reno County Fire District #8, paramedic

City of Haven EMS, paramedic

Former Vice President Kansas EMS Association

Support for SB535

With language, amendments of Kansas EMS Association

Without amendment to Sec.14 K.S.A. 65-6133

Strike "endotracheal intubation" from authorized practice of EMT- I (Sec. 6 K.S.A.1997 Supp. 65-6120 (b)) page 8, line 11

Risk of EMT-I intubation without adequate training ✓

Misplacement is lethal

Misplacement is likely without adequate training

Training is extensive

Paramedic as follows

20 hours didactic

30 - 50 hours mannequin lab practice

80 hours clinical (physician directed, live patients)

320 - 700 hours field internship opportunity

Specialized courses for children, trauma patients (32 hours)

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Support of medical community mixed, ambiguous

Kansas Society of Anesthesiologists

Kansas Medical Society

Kansas EMS Association

National Standard Curriculum under development for EMT-I

Issue not yet resolved

Alternatives - Pharyngeotracheal Lumen Airway (PtL)

Viable

"PTL is the alternative of choice in our surgery suites" Dr. Dennis Allen, KU Medical Center during Board of EMS Education and Examination Committee discussion of EMT airway management, 05Feb98

Safe

Misplacement extremely unlikely

Widely accepted

Current EMT, EMT-I practice

Risk significantly lower

Currently part of curriculum, practice

Medically, educationally accepted and supported

Dilution of paramedic education experience

Clinical training sites currently crowded

Medical students

9-2

Physician assistant students

Registered nurse anesthetist students

Paramedic students

Clinical intubation opportunities decreasing

Changes in surgical practices

Field internship sites currently crowded

First Responder

EMT

EMT-I

EMT Paramedic

Ambulance service trainees

Public observers

Lack of regulatory support for appropriate education, clinical standards

Considerable pressure to minimize standards

Considerable pressure to avoid significantly lengthening EMT-I program

Limited medical community involvement

Unclear BEMS, staff position for medically sound, educationally viable process

For the Patients sake, consider -

Who should perform advance airway skills

What should the training, education expectations be

What level of care would you want in your home

Conslusion

Given current limitations in support, education, and regulation

EMT-I intubation is medically, educationally unsound practice

Without proper training, practice is likely lethal

Appropriate alternatives currently available to EMT-I

EMT-I intubation is unwarranted, dangerous, and impractical

Strike "endotracheal intubation" from (Sec. 6 K.S.A. 1997 Supp. 65-6120 (b)) page 8, line 11

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KMS

KANSAS MEDICAL SOCIETY

February 12, 1998

TO: Senate Public Health and Welfare Committee

FROM: Meg Draper
Director of Government Affairs

SUBJ: SB 535: Board of Emergency Medical Services

The Kansas Medical Society appreciates the opportunity to appear today on SB 535, which makes several changes to the Board of Emergency Medical Services statutes. While we are appearing today as a neutral conferee, we would like to take this opportunity to share our concerns with one of the provisions of the bill.

Section 4 of the bill amends several definitions in the EMS laws. Among those amendments is a change in the definition of "physician". The bill would define a physician as a person licensed in any state to practice medicine and surgery. Current law defines a physician as someone holding a Kansas license. We understand the Board of EMS' intent with this change, to accommodate those situations currently occurring in border areas of our state, but have concerns about the way the definition is currently worded. Conceivably, the new language could allow a physician in not just a contiguous state, but any state, to be a medical director of a Kansas EMS service. This would run counter to the policy the legislature has adopted in other areas, like telemedicine, where the general rule is that physicians located outside the state must have a Kansas license in order to treat Kansas patients.

We have spoken with the Board of EMS, which has agreed to delete the proposed change to this definition. KMS is more than willing to discuss this issue in coming months in an attempt to come up with language that is acceptable to all parties involved.

Thank you very much for the opportunity to testify.

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Kansas State Board of Nursing

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

To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

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

Date: February 12, 1998

Re: SB 535

Thank you for allowing me to testify on SB 535 on behalf of the Board of Nursing.

The Board recognizes and appreciates the services provided by emergency medical service (EMS) personnel in the care of individuals in emergency situations. These services are provided at the scene of the emergency and throughout the ambulance transport. Once the person in need of care reaches a health care facility, the emergency medical attendants turn over the care to nursing personnel.

The Board of Nursing supports a revision of the definition of emergency medical service that clearly indicates performance of authorized emergency care in conjunction with ambulance services outside health care facilities. See attached balloon. Nurses provide nursing care inside health care facilities. Emergency medical attendants are not educated or licensed as nurses. They are only certified to perform certain emergency procedures and administer certain medications in emergency situations in conjunction with ambulance transport. The Board of Nursing considers emergency medical attendants as unlicensed assistive personnel if employed to work inside health care facilities. There have been reports that emergency medical attendants

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Senate Public Health and Welfare
Date: 2-12-98
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sometimes work independently of a nurse or physician performing procedures that are not appropriate for an unlicensed assistant. Physicians may delegate medical procedures and nurses may delegate certain nursing procedures, but those procedures cannot be performed independently of delegation and supervision of licensed staff.

The revised language clearly sets the scope of practice for the EMS attendant in the field where there are not licensed health care personnel.

As a friendly note, attendant is used for many types of individuals not associated with health care. There may be an attendant in rest rooms. Possibly another title would be more appropriate.

The Board hopes you will consider the proposed change in the definition of emergency medical care.

Thank you.

~~(l)~~ ~~certify instructor-coordinators;~~

~~(m)~~ ~~authorize, pursuant to rules and regulations, training officers to conduct continuing education programs for attendants and courses in the initial training of first responders; and~~

~~(n)~~ *(j)* appoint a medical consultant for the board. Such person shall be a person licensed to practice medicine and surgery and shall be active in the field of emergency medical services; *and*

(k) approve providers of training by prescribing standards and requirements by rules and regulations and withdraw or modify such approval in accordance with the Kansas administrative procedures act and the rules and regulations of the board.

Sec. 4. K.S.A. 1997 Supp. 65-6112 is hereby amended to read as follows: 65-6112. As used in this act:

(a) "Administrator" means the administrator of the emergency medical services board.

(b) "Ambulance" means any privately or publicly owned motor vehicle, airplane or helicopter designed, constructed, prepared and equipped for use in transporting and providing emergency care for individuals who are ill or injured.

(c) "Ambulance service" means any organization operated for the purpose of transporting sick or injured persons to or from a place where medical care is furnished, whether or not such persons may be in need of emergency or medical care in transit.

(d) "Attendant" means a first responder ~~or an~~, emergency medical technician, ~~an~~ emergency medical technician-intermediate, ~~an~~ emergency medical technician-defibrillator or a mobile intensive care technician ~~whose primary function is ministering to the needs of persons requiring emergency medical services~~ *certified pursuant to this act*.

(e) "Board" means the emergency medical services board established pursuant to K.S.A. 65-6102, and amendments thereto.

(f) "Emergency medical service" means the effective and coordinated delivery of such care as may be required by an emergency~~, including services provided by first responders,~~ *which includes the* care ~~and transportation of~~ individuals by ambulance services~~, and the performance of authorized emergency care by a person licensed to practice medicine and surgery, a licensed professional physician, professional nurse, a registered physician's assistant, emergency medical technician, emergency medical technician-intermediate, emergency medical technician-defibrillator or a mobile intensive care technician or attendant~~.

performance of authorized emergency

while transporting

(g) "Emergency medical technician" means ~~any~~ *a* person who ~~has successfully completed a course of training, approved by the board, in preliminary emergency medical care and who holds a valid emergency medical technician certificate under~~ *holds an emergency medical tech-*

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