Approved: March 30, 1999
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on March 22, 1999 in Room 423-S of the Capitol.

All members were present except: Representative Brenda Landwehr, Excused
Representative Dale Swenson, Excused

Committee staff present: Emalene Correll, Kansas Legislative Research
Norman Furse, Revisor of Statutes
June Evans, Secretary

Conferees appearing before the committee: Representative Becky Hutchins
Norma Fox
Pat Johnson, State Board of Nursing
Carolyn Middendorf, Kansas State Nurses Association

Others attending: See Attendance Sheet

The Chairperson opened the hearing on **SB 110 - Requirements for an exempt license for board of nursing licensees.**

Staff gave a briefing on the bill stating it amends two statutes in the Kansas Nurse Practice Act and one in the act under which mental health technicians are licensed and practice. Currently, in order to qualify for an exempt license, the nurse or mental health technician must not be regularly practicing and be a charitable health care provider as that term is defined in the Kansas Tort Claims Act. **SB 110** amends the requirements to provide that in order to qualify for an exempt license one must not be in regular practice and must either volunteer his or her services or meet the criteria to be a charitable health care provider under the Kansas Tort Claims Act.

The Health Care Reform Legislative Oversight Committee found the existing provisions of law created a "catch 22" in which only a nurse or mental health technician who was fully licensed could qualify as a charitable health care provider and thus be eligible for an exempt license which is intended to encourage persons who are retired from active practice to continue to provide charity care or to work less than regularly in certain, specified settings that serve the medically indigent. (See Attachment #1)

Representative Becky Hutchins testified in support of **SB 110**, stating in 1997 the Kansas Legislature passed a bill authorizing an exempt license for registered nurses to do volunteer work without having to acquire continuing education units for licensures. This piece of legislation would make available a valuable resource of retired nurses who are on inactive status.

One obstacle that may be preventing exempt licenses being issued may be due to the Board of Nursing's interpretation of the statute to require an applicant for an exempt license to be registered with the Secretary of Health and Environment as a charitable care provider. This interpretation places the applicant for an exempt license in a "catch 22" situation since he or she could not be registered as a charitable health care provider if not the holder of a valid license to practice. (See Attachment #2)

Norma J. Fox, R.N. (Inactive), testified in support of **SB 110**, stating she is retired and would like to volunteer at camp but needs an exempt license to do so. At the present to apply for an exempt license, one must become a charitable health care provider, but to become a charitable health care provider one must have an exempt or regular license. The areas in which a nurse could volunteer his or her services is also extremely limited. This language change would make it possible for retired nurses to volunteer their services much as physicians are already able to do. An amendment to make the effective date on publication in the Kansas Register is suggested enabling nurses to be able to volunteer this summer. (See Attachment #3)

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

support of **SB 110**. The Board of Nursing was originally opposed to the change because of the difficulty in defining the term "not regularly engaged in the practice of nursing." With the amendment that ties the exempt license to being a volunteer or charitable health care provider, the Board would support the change in law made in **SB 110.** The Board offers a suggestion to make the change subject to publication in the Kansas Register. July 1 would be too late for some nurses to volunteer for summer camps this year. (See Attachment #4)

Carolyn Middendorf, Legislative Chairperson for the Kansas State Nurses Association, testified as a proponent to **SB 110**, stating the amendments allow persons who do not practice nursing on a regular basis to obtain exempt licenses by the Board of Nursing; that is, they may be provided with a license without attaining the required continuing nursing education. In the past, nurses could obtain exempt licenses only if they practiced as a "charitable health care giver." (See Attachment #5)

Representative Morrison moved and Representative Geringer seconded to amend **SB 110** to change the effective date to publication in the Kansas Register. The motion carried.

Representative Haley moved and Representative Gilmore seconded to move **SB 110** out as amended. The motion carried.

The Chairperson stated there was a hearing on **HB 2538** - **Sale of nonprescription drugs and medicines through vending machines** last week and a balloon was requested which has been distributed. (See Attachment #6)

Representative Geringer moved and Representative Morrison seconded to move **HB 2538** out as amended.

Representative Bethell stated he had a problem with no more than one vending machine through which nonprescription drugs offered for sale or sold shall be located within 100 feet of another vending machine in which nonprescription drugs are offered for sale or sold.

Representative Bethell moved and Representative Long seconded a substitute motion to amend the balloon and delete the sentence, "No more than one vending machine through which nonprescritpion drugs offered for sale or sold shall be located within 100 feet of another vending machine in which nonprescritpion drugs are offered for sale or sold" and move out as amended.

Representative Geringer called a Question on the substitute motion eliminating the 100 feet and moving the bill out as amended. The motion carried.

Information regarding Newborn and Infant Hearing Loss: Detection and Intervention from the American Academy of Pediatrics was distributed. (See Attachment #7)

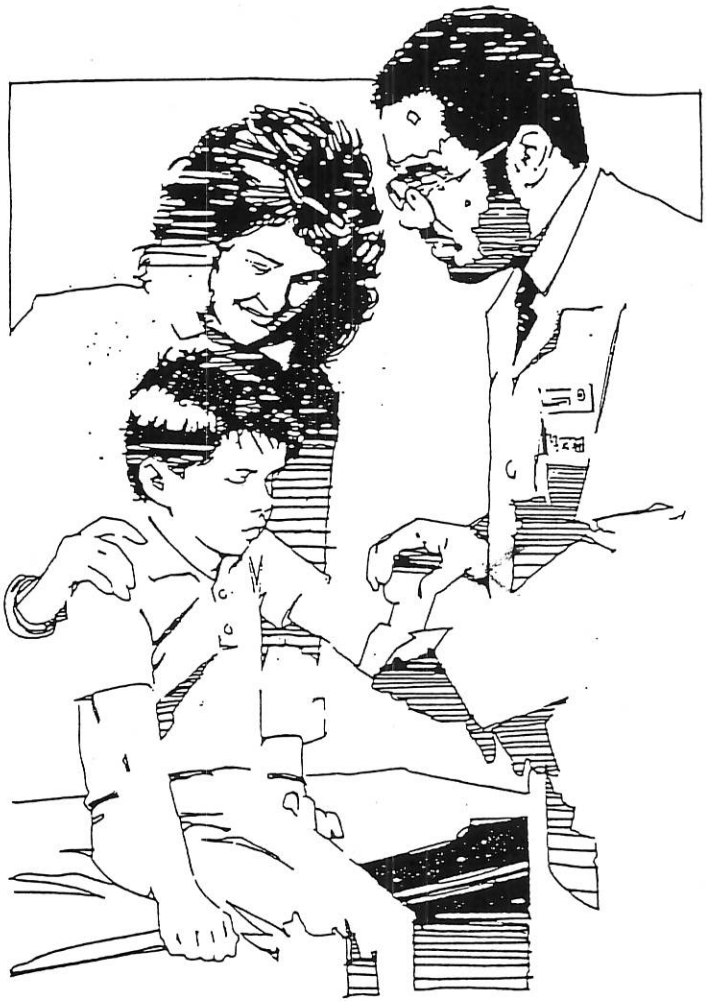
The meeting adjourned at 2:30 p.m. At this time there are not any more scheduled meetings, but if needed, a meeting will be called.

HEALTH AND HUMAN SERVICES

Date: March 22, 1999

Rogene Handlon	B of Cos.
Mary Lou Davis	" " "
Norma Fox	Registered Nurse - Inactive
Carolyn Middendorf	KSNA
Pat Johnson	KSBN
Larry Froelich	Ks Board of Pharmacy
Stacey Soldan	Hein + Weir Chtd.
Keith R Landis	Christian Science Committee on Publication for Kansas
Bob Alderson	Ks. Pharmacists Assoc.

Charitable Health Care Provider Program



Kansas Department of Health and Environment

Office of Local and Rural Health Systems

Landon Bldg., Room 665, 900 SW Jackson, Topeka, KS 66612-1290

(913) 296-1200

CHARITABLE HEALTH CARE PROVIDER PROGRAM

TABLE OF CONTENTS

PROGRAM DESCRIPTION

Program Intent

The Charitable Health Care Provider Program began in 1991 as a way to increase the provision of medical care to the medically indigent by providing liability coverage to health care professionals in exchange for their services. The Charitable Health Care Provider program allows health care providers who give care to the medically indigent and persons on Medicaid and MediKan to be indemnified for liability purposes under the state Tort Claims Fund. This means that charitable health care providers who are sued by a recipient of their care will be defended by the Attorney General's office and the Tort Claim Fund will be the payor of first resort even if there exists other insurance coverage.

Eligible Providers

The definition of Charitable Health Care Provider includes any person or facility defined as a health care provider in KSAs 40-3401 and 65-4921, including medical doctors, osteopaths, dentists, registered nurses, physician's assistants, pharmacists, optometrists, licensed practical nurses, chiropractors, podiatrists, physical therapists and assistants, occupational therapists and assistants, respiratory therapists, dental hygienists and mental health technicians. **Providers must have current Kansas licensure.**

Facilities defined as health care providers include medical care facilities licensed by the Kansas Department of Health and Environment, state certified HMOs, professional corporations of health care providers, non-profit corporations of health care providers, licensed psychiatric hospitals and mental health centers or clinics licensed by SRS, excluding state MR institutions and state psychiatric hospitals.

Eligible Recipients

Persons eligible to receive care from charitable health care providers include the medically indigent and persons receiving medical assistance under programs operated by the Secretary of Social and Rehabilitation Services (SRS). Medical indigency is defined in K.A.R. 28-53-3 as having no health insurance and being at or below 200% of the federal poverty line and entering the system through a point of entry. The medical assistance programs operated by SRS include Medicaid and MediKan.

Points of Entry

A Point of Entry into the Charitable Health Care Provider system is a participating local health department, a federally qualified health center or an indigent health care clinic. An indigent health care clinic is defined in K.S.A. 75-6102(h), as amended by Chapter 29 of the 1993 Session Laws, as an "outpatient medical care clinic operated on a not-for-profit basis which has a contractual agreement in effect with the Secretary of Health and Environment to provide health care services to medically indigent persons."

POINTS OF ENTRY

What is a Point of Entry

A Point of Entry **(POE)** into the Charitable Health Care Provider system is a participating local health department, a federally qualified health center or an indigent health care clinic. POEs perform intake of patients, refer eligible patients, maintain patient records and report on a quarterly basis. Some POEs function only in a clearinghouse capacity, verifying patients and referring them to the offices of charitable health care providers. Others are also clinical sites, where the charitable patient will actually see a doctor or nurse. POEs may have a sliding fee scale based on patient's income.

Registering as a Point of Entry

Health Departments need to fill out a Point of Entry registration form (Form A) to become a point of entry. Health departments that have already registered in the past, do not need to do so again.

Indigent Health Care Clinics need to enter into a contractual agreement with the Secretary of Health and Environment (Form B). This includes indigent health care clinics that have previously registered with the Secretary of Health and Environment as a Point of Entry. An indigent health care clinic is defined as an "outpatient medical care clinic operated on a not-for-profit basis which has a contractual agreement in effect with the Secretary of Health and Environment to provide health care services to medically indigent persons."

Functions of a Point of Entry

A. **Intake** involves helping patients fill out the Eligibility Certification Form (Form C) and than verifying that the patient is eligible. This form asks for monthly income, number of persons supported by this income and health insurance coverage. A table is included for computing where the patient falls on the federal poverty level scale.

   Persons eligible to receive care from charitable health care providers include:

   1. **the medically indigent**, who are defined as having no health insurance and being at or below 200% of the federal poverty line and entering the system through a point of entry, and
   2. **persons receiving medical assistance** under programs operated by the Secretary of Social and Rehabilitation Services (SRS). These programs include **Medicaid** and **MediKan**.

The POE may bill SRS when Medicaid/MediKan patients are seen on site.

B. **Referral** involves setting up an appointment for the eligible patient with a registered charitable health care provider. This is only necessary if the patient is referred away from the POE.

POEs may use their own referral form or they may use the one provided (Form D). Referral forms are to be sent with the charitable patient for their visit to the charitable health care provider. The provider is asked to return a part of the form, to be retained in the POEs patient record.

A directory of charitable health care providers, listed by county, will be sent to each POE every six months. New providers within the last six months will be starred. POEs may contact charitable providers in other counties, however, charitable health care providers are not obligated to take patients, regardless of their county of origin.

IMPORTANT: POEs that employ outside health care providers to see charitable patients are asked to send a copy of the employment agreement or contract to the Department of Health and Environment. The address is:

Kansas Department of Health and Environment
Office of Local and Rural Health Systems
ATTN: Charitable Health Care Provider Program
Landon State Office Building, Room 665
900 SW Jackson
Topeka, Kansas 66612-1290

C. **Record** maintenance involves keeping a file on each charitable patient that includes the patient's completed Eligibility Certification Forms, copies of medical assistance cards where applicable and copies of referral forms.

D. **Reporting** involves filling out and submitting a Quarterly Report form (Form E). The report asks for numbers of visits on a quarterly basis. Quarterly reports are due January 15, April 15, July 15 and October 15.

PROVIDERS

Doctors, nurses and other health care providers, who are recognized by the state as Charitable health Care Providers, are considered employees of the state when rendering charitable care to eligible patients. This means they are covered by the Tort Claims Act for liability purposes in the event they are sued by a recipient of their charitable care. A complete list of eligible providers is on Page 1.

Health care providers must have current Kansas licensure in order to apply for Charitable Health Care Provider status. **Physicians** may have licenses with either an 'ACTIVE', 'EXEMPT', or 'FEDERAL ACTIVE' status. They may also participate with a 'LIMITED PERMIT'.

Providers receiving status as a Charitable Health Care Provider will have their names added to a registry that is periodically sent to Points of Entry (POEs).

Charitable Health Care Providers may see patients at three different sites:

A) at a **health department or indigent health care clinic,**

B) in a **private office**, and

C) at ***Operation Immunize*** **Sites.**

Where patients are seen has a bearing on several other functional elements of the program. A detailed explanation of each type follows:

Site A: **Private Office Location**

Charitable Health Care Providers giving care from their private office:

1. <u>May see medically indigent persons or persons receiving medical assistance under programs operated by the Secretary of Social and Rehabilitation Services (SRS).</u> Medical indigency is defined as having no health insurance and being at or below 200% of the federal poverty line and entering the system through a point of entry. ***SEE EXCEPTION*** Programs operated by the Secretary of Social and Rehabilitation Services (SRS) include **Medicaid** and **MediKan.**

   EXCEPTION Potential charitable patients do not legally have to go through a Point of Entry to be eligible for charitable services.

Please note different procedures to follow if you are seeing patients that have not been referred through a Point of Entry, under `Documentation'.

2. <u>May provide services either for free or for a fee paid by a health department or indigent health care clinic.</u>

   a) Providers who intend to give their care **gratuitously** will need to submit the Agreement to Provide Gratuitous Services (Form F) in order to receive Charitable Health Care Provider status.

   b) Providers who intend to give their care **for a fee** paid by a health department or indigent health care clinic will need to have a copy of their employment agreement or contract submitted to the Department of Health and Environment. Providers who have registered with the Secretary of Health and Environment in the **past** to provide their services gratuitously and who are **now** going to be paid for their services <u>must</u> have a contract for services with the health department or indigent clinic that will be paying them and that contract must be submitted to the Department of Health and Environment.

   c) Providers who intend to provide their care **gratuitously to Medicaid and MediKan recipients ONLY** will need to submit the Agreement to Provide Gratuitous Services (Form F) in order to receive Charitable Health Care Provider status. Please check the statement at the bottom of the form indicating your intention. This type of Charitable Health Care Provider will not be included on the registry of CHPs that is periodically sent to Points of Entry.

3. <u>May not bill SRS for services provided to Medicaid/MediKan recipients.</u>

4. Documentation

   a) **If patients are referred through a Point of Entry,** the Point of Entry is responsible for certifying eligibility, maintaining records and submitting quarterly reports. Patients referred through a Point of Entry will have a referral form. You are asked to complete and return it to the Point of Entry.

   b) **If you chose to gratuitously provide services to patients who have not been referred to you through a Point of Entry,**

for your own protection, confirm those persons' eligibility by using an Eligibility Certification form (Form C) or by copying their medical assistance card. Retain these in their patient record. Additionally, you are asked to provide a quarterly accounting of these patients using the Quarterly Report form (Form E).

Site B: **Health Department or Indigent Health Care Clinic**

Charitable Health Care Providers giving care from these sites:

1. May see medically indigent persons or persons receiving medical assistance under programs operated by the Secretary of Social and Rehabilitation Services (SRS). Medical indigency is defined as having no health insurance and being at or below 200% of the federal poverty line and entering the system through a point of entry. Programs operated by the Secretary of Social and Rehabilitation Services (SRS) include **Medicaid** and **MediKan.**

2. May provide services either for free or for a fee paid by the health department or indigent health care clinic.

   a) Providers who intend to give their care **gratuitously** will need to submit the Agreement to Provide Gratuitous Services (Form F) in order to receive Charitable Health Care Provider status.

   b) Providers who intend to give their care **for a fee** paid by the health department or indigent health care clinic will need to have the site submit a copy of their employment agreement or contract to the Department of Health and Environment. Providers who have registered with the Secretary of Health and Environment in the **past** to provide their services gratuitously and who are **now** going to be paid for their services must have a contract for services with the health department or indigent clinic that will be paying them and that contract must be submitted to the Department of Health and Environment.

3. May not bill SRS for services provided to Medicaid/MediKan recipients.

4. Documentation of patient eligibility, record maintenance and quarterly reporting is handled by the site.

Site C: *Operation Immunize* Sites

Charitable Health Care Providers giving care from these sites:

1. May see all patients presenting at pre-arranged *Operation Immunize* sites, during scheduled *Operation Immunize* weekends.

2. May only give care gratuitously.

3. Will need to apply for Charitable Health Care Provider status on special form. This form is not included in this booklet but is made widely available before the upcoming *Operation Immunize* weekends.

4. Documentation is handled by staff at the *Operation Immunize* site.

CHARITABLE HEALTH CARE PROVIDER PROGRAM

Detailed Explanation of Provider Type

Location of Visit	Provider Will See:	Agreement Required	Form Requirements	Other Action at Time of Visit
A. PRIVATE OFFICE	1. Medically indigent and Medicaid/Medikan	1. Provider gives care gratuitously or is paid by clinic or health department. May not bill SRS for services	1. If gratuitous, submit Form F. If paid, submit coy of professional contract for services with health department or clinic.	If patient is referred through point of entry, fill out and return referral form. If patient is not referred through point of entry, confirm eligibility using Form C or by copying medical assistance card. Maintain patient record and submit quarterly report (Form E).
	2. Medicaid/Kan only	2. Provider not paid. Provider may not bill SRS for services.	2. Submit Form F. Check box indicating Medicaid/Medikan only.	Confirm eligibility by copying medical assistance card. Maintain patient record and submit quarterly report (Form E).
B. HEALTH DEPARTMENT OR INDIGENT HEALTH CARE CLINIC	Medically Indigent and Medicaid/Medikan	Provider gives care gratuitously or is paid by clinic or health department. Health department or clinic may bill SRS for services where applicable	If gratuitous, submit Form F. If paid, submit copy of professional contract for services with health department or clinic.	Documentation is handled by clinic or health department.
C. OPERATION IMMUNIZE SITES	Operation Immunize participants	Provider is not paid. Provider may not bill for services. Only covers professional services during Operation Immunize weekends.	Use specific Operation Immunization application. Submit form to Secretary of Health & Environment. Other documentation may be required.	

Address for submittal to KDHE:

Kansas Department of Health and Environment
Charitable Health Care Provider Program
900 SW Jackson, LSOB, Room 665
Topeka, KS 66612-1290
(913) 296-1200

All forms are available from the above address

STATE OF KANSAS

BECKY HUTCHINS
REPRESENTATIVE, FIFTIETH DISTRICT
JACKSON AND SHAWNEE COUNTIES
700 WYOMING
HOLTON, KANSAS 66436
(785) 364-2612

ROOM 427-S
STATE CAPITOL
TOPEKA, KANSAS 66612-1504
(785) 296-7698

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE CHAIR: TOURISM
MEMBER: ENVIRONMENT
FEDERAL AND STATE AFFAIRS

March 22, 1999

To: Chairman Boston and Members of the House Health and Human Services Committee

Subject: Senate Bill 110

Thank you for this opportunity to come before you today in support of SB 110.

This issue first was brought to my attention by a constituent of mine, Norma Fox. Ms. Fox is a retired registered nurse who had acted as Camp Nurse at White Memorial Camp for the Developmentally Disabled Adult Camp in 1995, 1996 and 1997.

In 1997 the Kansas Legislature passed a bill authorizing an exempt license for registered nurses to do volunteer work without having to acquire continuing education units for licensures. This piece of legislation would make available a valuable resource of retired nurses who are on inactive status.

Ms. Fox planned to act as camp nurse in 1998 but was unable to get her exempt license after repeated attempts with the Kansas State Board of Nursing.

This past summer the Health Care Reform Legislative Oversight Committee reviewed the letter I received from Ms. Fox. At the August 31 meeting, Ms. Johnson, executive director of the Board of Nursing, stated that no exempt licenses had been issued since passage of the 1997 bill.

One obstacle that may be preventing exempt licenses being issued may be due to the Board of Nursing's interpretation of the statute to require an applicant for an exempt license to be registered with the Secretary of Health and Environment as a charitable care provider. This interpretation places the applicant for an exempt license in a "catch 22" situation since he or she could not be registered as a charitable health care provider if not the holder of a valid license to practice. I do not feel the Board's interpretation of the statute reflects the intent of the Legislature. However, the Board's interpretation may reflect the literal reading of the statute. Under current qualifications for an exempt license set out in the Nurse Practice Act, my constituent, Ms. Fox, would not qualify unless the persons attending the camp qualified as medically indigent or are receiving assistance under Medicaid or MediKan.

HHS
3-22-99
Atch #2

Following the October meeting, the Health Care Reform Oversight Committee requested a bill (SB 110) amending the Kansas Nurse Practice Act.

As amended in the Senate, SB 110 would change the requirements to provide that in order to qualify for an exempt license, one must not be in regular practice and must either volunteer his or her services or meet the criteria to be a charitable health care provider under the Kansas Tort Claims Act.

I feel that passage of SB 110 would address this so called "catch 22" situation and enable Ms. Fox and others to qualify for an exempt license.

Thank you.

Becky Hutchins

Becky Hutchins
Representative 50th District

Chairman Gary Boston
Members of the House Health and Human Services Committee

Date: March 22, 1999

Re: SB 110

Thank you for allowing me to testify on SB 110.

First a little history to explain my interest in this bill. A week or so before I had planned to work one week as a counselor for developmentally disabled adults at White Memorial Camp, United Church of Christ Camp in Council Grove, the nurse who had volunteered to be the camp nurse that week was inducted into the army. I had converted my license to inactive status, but my active license was still in force for another month. The camp would be canceled if I was unable to take over as camp nurse. Though it was not in my area of expertise, which was Operating Room Nursing, I prepared the best I could, by spending a day at the Kansas Neurological Institute. Then I acquired my 30 hours of continuing education [though unable to find any offerings that related to work with developmentally disabled] and re-activated my license, serving again as camp nurse for one week in 1996 and again in 1997.

The difficulty in acquiring nurses for the camp, is what spurred my interest in the exempt license. When I was working full time at nursing, I very much needed my vacation to be just that, a vacation, a complete rest of my mind and body from nursing. I am not surprised that it is difficult to find volunteer nurses. Yet there is an untapped reservoir of retired nurses out there, who surely would wish to fill some of these needs.

At present to apply for an exempt license, one must become a charitable health care provider, but to become a charitable health care provider one must have an exempt or regular license. The areas in which a nurse could volunteer his or her services is also extremely limited. This language change would make it possible for retired nurses such as myself to volunteer our services much as physicians are already able to do.

If the proposed change is adopted, then the Board of Nursing has done it's job by making available the exempt license. The requirement to become a charitable provider for some agencies then is the responsibility of the nurse. There are apparently some volunteer positions in some charitable care agencies that receive remuneration. The additional wording clarifies the use of the exempt license for unpaid, volunteer work of the nurse's choosing.

There was a concern that a nurse in many situations would not be covered under the Kansas Tort Claims Act. When I was working, it was always considered wise to check on your employer's coverage and perhaps carry your own malpractice insurance, or make the decision to go without coverage. Malpractice insurance for nurses is usually not very expensive. It is not the Board of Nursing's responsibility to protect nurses from malpractice claims.

After the original bill authorizing the exempt license was passed in 1997, and I was finally able to get an application form in the fall of 1998, I received the form, along with a letter telling me I did not qualify. Though probably 99% of the developmentally disabled adults at the camp were from group homes and carried medical cards, the camp did not meet the qualification of being for the indigent. I felt frustrated as I had a service to give, but was prevented from giving it. The camp then had to pay $1000 per week for agency nurses, from a very limited budget.

I support the bill as amended. I would request that one additional amendment be made to the bill making it effective on publication in the Kansas Registry. This would allow time for nurses to acquire the exempt license before June so that White Memorial Camp and other groups could meet their staffing needs for the summer.

Thank You

Norma J. Fox, R.N. [Inactive Status]
5949 NW 35th St.
Topeka, KS 66618
Phone: 286-3343
email: lairfox@aol.com

I am available for questions.

HHS
3-22-99
Atch #3

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551 S
Topeka, Kansas 66612-1230
785-296-4929
FAX 785-296-3929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
785-296-5752
ksbn0@ink.org

To: The Honorable Garry Boston, Chairperson
And Members of the Health and Human Services Committee

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

Date: March 22, 1999

Re: SB 110

Thank you for allowing me to testify on SB 110 or the Board of Nursing.

The Board of Nursing was originally opposed to the change in SB 110 because of the difficulty in defining the term "not regularly engaged in the practice of nursing." With the amendment that ties the exempt license to being a volunteer or charitable health care provider, then the Board will support the change in law made in SB 110.

The Board offers a suggestion to make the change subject to publication in the Kansas Register. A number of nurses volunteer during the summer months for different types of camps. To have the change in the law effective July 1 may be too late for some of them to get exempt licenses.

Thank you. I am available for questions.

Janette Pucci, R.N., M.S.N.
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ksbn1@ink.org

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KANSAS STATE NURSES ASSOCIATION

700 SW Jackson, Suite 601
Topeka, Kansas 66603-3758

785/233-8638 * FAX 785/233-5222
www.nursingworld.org/snas/ks
the Voice of Nursing in Kansas

Debbie Folkerts, A.R.N.P.--C.
President

Terri Roberts, J.D., R.N.
Executive Director

March 22, 1999

S.B. 110: Exempt Licenses Issued by the Board of Nursing

Representative Boston and the members of the House Committee on Health and Human Services, my name is Carolyn Middendorf and I am the Legislative Chairperson for the **Kansas State Nurses Association.**

The **Kansas State Nurses Association** supports SB 110 as it has been amended. The bill contains specific portions regarding exempt licenses in the Nurse Practice Act that apply to licenses professional nurses, licensed practical nurses, advanced registered nurse practitioners, and licensed mental health technicians. The proposed amendments allow persons who do not practice nursing on a regular basis to obtain exempt licenses by the Board of Nursing; that is, they may be provided with a license without attaining the required continuing nursing education. In the past, nurses could obtain exempt licenses only if they practiced as a "charitable health care giver," as defined by K.S.A. 75-6102.

Not all population groups who benefit from volunteer nursing come under the definition provided above. These opportunities are most often the result of a special interest of the nurse and they occur infrequently. The proposed changes in the statutes provide a way for nurses, often older nurses who have left regular employment, to assist with health care in a special way. **KSNA** supports the proposed language changes that allow exempt licenses to be obtained by nurses who wish to volunteer their services to provide nursing care in this limited manner.

Thank you for allowing me to speak in support of SB 110 as it has been amended, and KSNA requests your support of this legislation.

HHS
3.22-99
Atch #5

HHS 3-22-99 Att #2

Session of 1999

HOUSE BILL No. 2538

By Committee on Federal and State Affairs

2-25

AN ACT concerning the sale of medicines and drugs through vending machines; amending K.S.A. 65-650 and repealing the existing section.

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

Section 1. K.S.A. 65-650 is hereby amended to read as follows: 65-650. *(a)* Any person, firm or corporation who ~~shall offer for sale or sell or distribute~~ *offers for sale, sells or distributes* any *prescription* medicine, *prescription-only* drug or poison through or by means of any vending machine or other mechanical device, or who ~~shall use~~ *uses* any vending machine in or for the sale or distribution of any *prescription* medicine, *prescription-only* drug or poison, shall be ~~deemed~~ guilty of a *class C nonperson* misdemeanor and upon conviction shall be fined not less than ~~twenty-five dollars ($25)~~ $25 nor more than ~~five hundred dollars ($500)~~ *$500*.

(b) No nonprescription drugs shall be sold through a vending machine in anything other than the manufacturer's original tamper-evident and expiration-dated packet. Any vending machine in which nonprescription drugs are offered for sale or sold shall be located ~~in a climate controlled area, and the drugs~~ offered for sale or sold in such vending machine shall not be older than the manufacturer's expiration date. A violation of this subsection is a class C nonperson misdemeanor and upon conviction the violator shall be fined not less than $25 nor more than $500.

Sec. 2. K.S.A. 65-650 is hereby repealed.

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

,controlled substance, drug intended for human use by hypodermic injection

offered for sale or

No more than 12 different nonprescription drugs products shall be offered for sale or sold through any one vending machine.

so that the drugs stored in such vending machine are stored in accordance with drug manufacturer's requirements. No more than one vending machine through which nonprescription drugs offered for sale or sold shall be located within 100 feet of another vending machine in which nonprescription drugs are offered for sale or sold. Drugs

Each vending machine through which nonprescription drugs are offered for sale or sold shall have an obvious and legible statement on the machine that identifies the owner of the medicine, a toll-free telephone number at which the consumer may contact the owner of the machine, a statement advising the consumer to check the expiration date of the product before using the product and the telephone number of the state board of pharmacy. As used in this subsection, "nonprescription drug" does not include any prescription medicine, prescription-only drug, controlled substance, drug intended for human use by hypodermic injection or poison.

AMERICAN ACADEMY OF PEDIATRICS

Task Force on Newborn and Infant Hearing

Newborn and Infant Hearing Loss: Detection and Intervention

ABSTRACT. This statement endorses the implementation of universal newborn hearing screening. In addition, the statement reviews the primary objectives, important components, and recommended screening parameters that characterize an effective universal newborn hearing screening program.

ABBREVIATIONS. UNHSP, universal newborn hearing screening program; EOAE, evoked otoacoustic emissions; ABR, auditory brainstem response; CDC, Centers for Disease Control and Prevention.

Significant hearing loss is one of the most common major abnormalities present at birth and, if undetected, will impede speech, language, and cognitive development.[1–7] Significant bilateral hearing loss is present in ~1 to 3 per 1000 newborn infants in the well-baby nursery population, and in ~2 to 4 per 100 infants in the intensive care unit population. Currently, the average age of detection of significant hearing loss is ~14 months. The American Academy of Pediatrics supports the statement of the Joint Committee on Infant Hearing (1994), which endorses the goal of universal detection of hearing loss in infants before 3 months of age, with appropriate intervention no later than 6 months of age.[8] Universal detection of infant hearing loss requires universal screening of all infants. Screening by high-risk registry alone (eg, family history of deafness) can only identify ~50% of newborns with significant congenital hearing loss.[9,10] Reliance on physician observation and/or parental recognition has not been successful in the past in detecting significant hearing loss in the first year of life.

To justify universal screening, at least five criteria must be met:

1. An easy-to-use test that possesses a high degree of sensitivity and specificity to minimize referral for additional assessment is available.
2. The condition being screened for is otherwise not detectable by clinical parameters.
3. Interventions are available to correct the conditions detected by screening.
4. Early screening, detection, and intervention result in improved outcome.
5. The screening program is documented to be in an acceptable cost-effective range.[11,12]

Although additional studies are necessary, review of both published and unpublished data indicates that all five of these criteria currently are achievable by effective universal newborn hearing screening programs (UNHSP).[5,13,15–28] Therefore, this statement endorses the implementation of universal newborn hearing screening. In addition, this statement reviews the primary objectives, important components, and recommended screening parameters that characterize an effective UNHSP.

The Academy recognizes that there are five essential elements to an effective UNHSP: initial screening, tracking and follow-up, identification, intervention, and evaluation.[13,14] The child's physician and parents, working in partnership, make up the child's medical home and play an important role in each of these elements of a UNHSP.[29]

SCREENING[11,13,14]

The following are guidelines for the screening element of a UNHSP:

- Universal screening has as its goal that 100% of the target population, consisting of all newborns, will be tested using physiologic measures in both ears. A minimum of 95% of newborns must be screened successfully for it to be considered effective.[16,19,21]
- The methodology should detect, at a minimum, all infants with significant bilateral hearing impairment, ie, those with hearing loss ≥35-decibel in the better ear.[1,16,19]
- The methodology used in screening should have a false-positive rate, ie, the proportion of infants without hearing loss who are labeled incorrectly by the screening process as having significant hearing loss, of ≤3%. The referral rate for formal audiologic testing after screening should not exceed 4%.[16,17,19–21]
- The methodology used in screening ideally should have a false-negative rate, ie, the proportion of infants with significant hearing loss missed by the screening program, of zero.[21,23]
- Until a specific screening method(s) is proved to be superior, the Academy defers recommendation as to a preferred method. Currently, acceptable methodologies for physiologic screening include evoked otoacoustic emissions (EOAE) and auditory brainstem response (ABR), either alone or in combination. Both methodologies are noninvasive, quick (<5 minutes), and easy to perform, although each assesses hearing differently. EOAE

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

measures sound waves generated in the inner ear (cochlea) in response to clicks or tone bursts emitted and recorded via miniature microphones placed in the external ear canals of the infant. Although EOAE screening is even quicker and easier to perform than ABR, EOAE may be affected by debris or fluid in the external and middle ear, resulting in referral rates of 5% to 20% when screening is performed during the first 24 hours after birth. ABR measures the electroencephalographic waves generated in response to clicks via three electrodes pasted to the infant's scalp. ABR screening requires the infant to be in a quiet state, but it is not affected by middle or external ear debris. Referral rates <3% may be achieved when screening is performed during the first 24 to 48 hours after birth. Referral rates <4% are generally achievable with EOAE combined with automated ABR in a two-step screening system or with automated ABR alone.[16,17,19–21] In a two-step system using EOAE as the first step, referral rates of 5% to 20% for repeat screening with ABR or EOAE may be expected. The second screening may be performed before discharge or on an outpatient basis within 1 month of age. Screening should be conducted before discharge from the hospital whenever possible.

- Each birthing hospital should establish a UNHSP with a designated medical (physician) director and sufficient staff to perform the following:

1. Develop the screening protocol and select the screening method(s).
2. Provide appropriate training and monitoring of the performance of staff responsible for performing hearing screening.
3. Provide the parents or guardians information concerning the screening procedure, costs, potential risks of hearing loss, and the benefits of early detection and intervention.
4. Establish a system that ensures confidentiality and allows the parents or guardians the opportunity to decline hearing screening. In most institutions, general hospital consent obtained at time of admission is considered to be inclusive of routine care, such as newborn hearing screening.
5. Ensure that all individuals performing hearing screening are trained properly in the performance of the tests, the risks including psychological stress for the parents, infection control practices, and the general care and handling of infants in hospital settings according to established hospital policies and procedures.[30]
6. Establish clear guidelines for responsibility of documenting the results of the screening procedure.
7. Develop mechanisms for communicating results of screening in a sensitive and timely manner to the parents and the child's physician(s). If repeat screening is necessary after discharge from the hospital, ensure that appropriate follow-up is provided.
8. Work with local, state, and national monitoring systems to identify all cases of significant hearing loss occurring in infants designated initially as free of hearing impairment by the UNHSP (false-negatives).
9. Secure funding for the program. Funding through third-party reimbursement is essential to cover the costs of the UNHSP, including the initial screen(s), as well as of diagnostic and intervention services. The cost of complete screening in statewide programs ranges from ~$7 to $26 per infant screened.[13] Additional studies (some of which are ongoing) are necessary to quantify costs of tracking, diagnostic, and intervention services.[26–28]
10. Collect critical performance data to ensure that each UNHSP meets the criteria specified in this statement. These data should be reported in a regular and timely manner to a statewide central monitoring program.

TRACKING AND FOLLOW-UP[13–15,26–28]

The following are guidelines for the tracking and follow-up elements of a UNHSP:

- Universal screening has as its goal that there will be 100% follow-up of all infants referred for formal audiologic assessment and for all infants not screened initially in the birthing hospital whose parents did not refuse screening. A minimum of 95% successful follow-up is required for a UNHSP to be considered an effective screening program.
- State departments of health, in coordination with programs mandated by Part C of the Individuals with Disabilities Education Act, should:

1. Establish and maintain a central monitoring system for all hearing screening programs within the state. Critical performance data, including number of infants born; the proportion of all infants screened; the referral rate; the follow-up rate; the false-positive rate; and the false-negative rate should be collected in a timely manner.
2. Establish and maintain a tracking program that monitors all referrals and misses. Monitoring should ensure that children with significant hearing loss are not missed, ie, all children designated as free of hearing loss by the UNHSP, but who are later detected to have significant hearing loss, are identified by the statewide tracking program.
3. Develop mechanisms for communicating results of follow-up activities with the parents/guardians and the child's physician(s), audiologist, and speech language therapist.[29]
4. Ensure that hearing screening is performed on all out-of-hospital births.
5. Report the screening performance parameters of individual hospital-based UNHSPs within the state in a timely manner.
6. Report critical performance data of each UNHSP (without personal identifiers) to a national Early Hearing Detection and Intervention monitoring program established by the Centers for Disease Control and Prevention (CDC).

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IDENTIFICATION AND INTERVENTION[13–15,26–28]

The following are guidelines for the identification and intervention element of a UNHSP:

- Universal screening has as its goal that 100% of infants with significant congenital hearing loss shall be identified by 3 months of age and shall have appropriate and necessary intervention initiated by 6 months of age.[5–7]
- Appropriate and necessary care for the infant with significant hearing loss should be directed and coordinated by the child's physician within the medical home, with support from appropriate ancillary services.[29]
- A regionalized approach to identification and intervention for infants with significant hearing loss is essential, ensuring access for all children with significant hearing loss to appropriate expert services. It is recognized that professionals with demonstrated competency to provide expert services in the identification and intervention of significant hearing loss in young infants are not available in every hospital or community. The child's physician, within the medical home, working with the state department of health must ensure that every infant with significant hearing loss is referred to the appropriate professional(s) within the regionalized system.
- It is anticipated that there will be increased demand for qualified personnel to provide age-appropriate identification and intervention services for young infants with significant hearing loss. As a result, there will be a need for the training and education of additional expert care providers.

EVALUATION[13–15,26–28]

The following are guidelines for the evaluation element of a UNHSP:

- The UNHSPs should be evaluated on an ongoing and regular basis by the state monitoring system for performance with regard to parameters enumerated in "Screening" above.
- Tracking and follow-up should be evaluated on an ongoing and regular basis by the state monitoring system, as well as through a national monitoring system to be established by the CDC.
- Intervention services should be evaluated on an ongoing and regular basis by the state department of health to ensure that sufficient expert services are available for children identified with significant hearing loss, that the services are accessible to the children in need, and that outcomes from interventions provided are effective.

OTHER RECOMMENDATIONS AND ISSUES

The following are additional recommendations of the Academy for developing a UNHSP:

- The Academy recommends that each American Academy of Pediatrics chapter assume a leadership role in state-based efforts to promote optimal implementation of UNHSPs. Effective statewide programs require broad-based suppo. and collaboration. Collaboration should include (but not be limited to) appropriate professional organizations, parent advocacy groups, deaf and hard-of-hearing adults, physicians, audiologists, speech and language therapists, nurses, administrators, payers, legislators, and state departments of health and special education.
- The Academy shall identify, develop, and disseminate educational materials regarding effective hearing screening programs.[13]
- To promote additional research and the development of the needed infrastructure to provide universal newborn hearing screening, the Academy recommends the following:

1. The National Institutes of Health support ongoing research to improve the efficacy of screening, identification, and intervention.
2. The Health Resources and Services Administration promote the development of a state-based early hearing loss identification and intervention network.
3. The CDC establish and maintain a national monitoring and evaluation program for early hearing loss identification and intervention.

- Physicians should provide recommended hearing screening, not only during early infancy but also through early childhood for those children at risk for hearing loss (eg, history of trauma, meningitis) and for those demonstrating clinical signs of possible hearing loss.[9,14] Although most hearing loss in children is congenital (ie, present at birth), a significant portion of hearing loss is acquired after birth.[2–4] Regardless of the age of onset, all children with hearing loss require prompt identification and intervention by appropriate professionals with pediatric training and expertise.

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