Approved: 2-17-99
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on February 11, 1999 in Room 526-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee:
Carolyn Bloom, Kansas Physical Therapy Association
Tom Bell, Kansas Hospital Association
Kris Ochs, Grisell Memorial Hospital Administrator
Roger S. John, President & CEO, Great Plains Health Alliance
Harold E. Riehm, Executive Director, Kansas Assn. of Osteopathic Medicine
Qizhi Gao, President, Acupuncture Association of Kansas
Richard Morantz, Kansas Acupuncture Art
Charles Wheelen, Kansas Association o Osteopathic Medicine
Jim Crowl, Kansas Chiropractic Association
Meg Draper, Kansas Medical Society

Others attending: See attached list

Approval of Minutes

Senator Becker made a motion to approve the Committee minutes of February 1, 2, 3 and 4, 1999, seconded by Senator Langworthy. The motion carried.

Hearing on: SB 192 - Physical therapist evaluation of patients

Carolyn Bloom, Kansas Physical Therapy Association, testified before the Committee in support of **SB 192** and noted that the bill, if passed, would allow the Kansas Chapter to be in compliance with the American Physical Therapy Associations' Standards of Practice for Physical Therapy and Direction, Delegation and Supervision in Physical Therapy Services. The current clause to be deleted would allow a physical therapist assistant to initiate treatment in a hospital setting when the physical therapist is not immediately available. She pointed out that with the changes in health care reimbursement, there is no longer a shortage of available physical therapists, especially after Medicare's prospective payment system went into effect January 1, 1999, that physical and occupational therapists are being laid off in skilled nursing units with new graduates looking for jobs in the upcoming months. She felt that small and rural hospitals should be able to capitalize on these prospective employees to provide expedient care to patients as noted in her written testimony. (Attachment 1) During Committee discussion, Ms. Bloom noted there were 42 physical therapists who graduated from KU, 32 graduated from Wichita State University, and 120 physical therapist assistants graduated from community colleges this past year.

Tom Bell, Kansas Hospital Association, appeared before the Committee in opposition to **SB 192**. He also presented letters in opposition to the bill from various hospital administrators from western Kansas whose main concern was the shortage of physical therapists in rural areas, and that the bill would delay treatment for many patients in rural hospitals and create problems with patient follow-up eventually resulting in poor patient care. (Attachment 2) Also speaking in opposition to the bill were Kris Ochs, Grisell Memorial Hospital Administrator, (Attachment 3), Roger S. John, President & CEO, Great Plains Health Alliance, (Attachment 4), and Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine, (Attachment 5).

Hearing on: SB 144 - Licensing and acupuncture practitioners

Qizhi Gao, President of the Acupuncture Association of Kansas, testified before the Committee in support of **SB 144** which concerns regulation of the practice of acupuncture in the state. Currently there is

no licensing or regulation of acupuncture. The bill would establish a system of acupuncture licensing through the use of a national certifying board. It was noted that there are over 50 schools and colleges teaching traditional Chinese medicine in the U.S. These schools require over 2000 hours of didactic and clinical training prior to national certification as noted in his written testimony. (Attachment 6) Also testifying in support of the bill was Richard Morantz, Lawrence acupuncturist who provided a copy of the Missouri acupuncture statute along with his written testimony. (Attachment 7) During Committee discussion, the Chair called attention to the Credentialing Act which established a process to help the legislature determine whether a health occupation should be credentialed. A technical review is conducted during which time specific criteria established in statute and regulation are applied to gather critical information in order to evaluate the need for public protection from the unregulated practice of a given health care provider. The Chair suggested the two proponents of **SB 144** confer with Lesa Bray, Director of Health Occupations Credentialing, KDHE, and go through the required process until further action can be taken on the bill.

Speaking in opposition to the bill were Charles Wheelen, Kansas Association of Osteopathic Medicine, (Attachment 8); Jim Crowl, Kansas Chiropractic Association, (Attachment 9); and Meg Draper, Kansas Medical Society, (Attachment 10).

Action on SB 126 - Quality enhancement wage pass-through program

After Committee discussion on the bill, Senator Jones made a motion to strike the language on page 1, line 23, "hydration and nutrition aides" and that the Committee recommend **SB 126 as amended** favorably for passage, seconded by Senator Steineger. The motion carried.

Adjournment

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

The next meeting is scheduled for February 15, 1999.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-11-99

NAME	REPRESENTING
Peggy Johnson	Great Plains Health Alliance
Keith Hobbs	Beloit Memorial Hospital
Jan M. Pelton	Utica, KS
Tom Sipe	KS Hosp Assoc.
Angie Alexander	Bethel Nursing Student
Julie Aldrich	Bethel Nursing Student
Amin S. Amat	Washburn Univ.
Stacey Soldan	Hein + Weis Chtd
Meg Draper	KMS
Rick Gilliam	Health Midwest
Pernie Ann Brown	KAHP
Randall Hobbs	KS Acupuncture Association
QIZHI GAO	KS Acupuncture Associations
STAN BAILE	KANP
Bob Timberlake	KANP
Lynn Beyer	KANP
Dana Albrecht	Kansas Wesleyan Nursing Student
Hongxue Yao	KS Acupuncture Associates
Richard Morantz	KS Acupuncture Assn.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-11-99

NAME	REPRESENTING
Carolyn Micek	Kansas Acupuncture Assoc.
Anessa Ayesh	KSNA
Jessica Chaplin Amerian	KSNA
Tom Bell	Ks. Hosp. Assn.
Carolyn Agosto	KSNA
Brian Lindstrom	Eudora, KS
Denise Alexander	Children's Mercy Hospital / Webster University
Mary A. Warden	Bethel College Nursing Student
Don Gulick	KSNA
Tom Burgess	KHCA

February 11, 1999

Kansas Physical Therapy Association
1200 W. 10th Street
Topeka, KS 66601 785.233.5400

Carolyn Bloom, PT
1045 SW Gage Blvd.
Topeka, KS 66604 785.273.7700

Honorable Chairwoman Praeger and the Senators of the Health and Welfare Committee:

On behalf of the Kansas Physical Therapy Association, as Chief Delegate and Past President, I urge your support of S.B.192 to delete only one clause in the Kansas Statute Relating to Physical Therapy. This action will again allow the Kansas Chapter to be in compliance with the American Physical Therapy Association's Standards of Practice for Physical Therapy (HOD 06-96-3--42) and Direction, Delegation and Supervision in Physical Therapy Services, (HOD 06-96-16-31).

The current clause to be deleted allows a physical therapist assistant to initiate treatment in a hospital setting when the physical therapist is not immediately available. This was added in 1990 as compromise language to help cover the shortage of physical therapists in hospitals at that time. With the changes in health care reimbursement, there is no longer a shortage of available physical therapists, especially after Medicare's prospective payment system went into effect January 1, 1999. Now hospitals are the only site of physical therapy service where there is not a $1500/year shared cap for care.

Physical and occupational therapists are being laid off in skilled nursing units, home health settings, and rehabilitation facilities, with classes of new graduates looking for jobs in the upcoming months. Small and rural hospitals should be able to capitalize on these prospective employees to provide expedient care to patients.

In 1997 the American Physical Therapy Association contracted a Workforce Study by Vector Research, Inc. of Ann Arbor, Michigan. The outcomes included:
-By 1998 a balance between supply of and demand for physical therapists will be reached
-A surplus of physical therapists on the order of 20-30% will exist by 2005-2007

-There are available physical therapists in Kansas.
-The physical therapist is educated to perform the initial evaluation and establish the plan of treatment for the most efficient and cost effective care for the patient.
-Return Kansas law to minimum professional standards.

Thank you for your consideration and support of this bill.

Carolyn Bloom, PT

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 1

APTA
American Physical Therapy Association

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

November 24, 1998

Susan Grace, PT
President, Kansas Chapter
Route 1 Keystone Ranch
Burns, KS 66840-9801

Dear Susan:

At the recent November 1998 Board of Directors meeting, the APTA Executive Committee had the opportunity to discuss the identification of chapters whose state practice acts may not be in compliance with APTA's policies and standards of practice. Such situations frequently cause confusion for APTA members caught in the middle between contradictory standards.

As a result of the Executive Committee's discussion, the Kansas State Practice Act was identified as one which remains in conflict with the current Standards of Practice for Physical Therapy in relation to its statement on the utilization of the physical therapist assistant (K.S.A. 65-2914. Unlawful acts: misdemeanors, (c)). We realize that this conflict has been in existence since early 1990 when the language was first approved (Senate Bill No. 543). We are also aware of the opposition expressed by the Kansas Chapter at the time of its passage, as well as of the testimony provided by Carolyn Bloom, PT, on behalf of the Physical Therapy Examining Committee. In follow-up to the Executive Committee's discussion, I am writing to inquire as to the possibility of the chapter reigniting its efforts to revise the state practice act, and to offer the Association's assistance to collegially effect such a change. APTA continues to strongly oppose this type of legislation and would be willing to support the chapter in any renewed work toward its revision.

For your information, enclosed are copies of the current House of Delegates' policies, Standards of Practice for Physical Therapy (HOD 06-96-30-42) and Direction, Delegation and Supervision in Physical Therapy Services (HOD 06-96-16-31) which identify the Association's position on the provision of services and the utilization of the physical therapist assistant.

Please let us know what we can do as an Association to assist the Kansas Chapter in initiating further negotiations toward bringing your state practice act into compliance with APTA's policies and standards.

Sincerely,

Jan K Richardson

Jan K. Richardson, PT, PhD, OCS
President

cc: APTA Executive Committee
Francis J. Mallon, Esq., CEO
Jerome B. Connolly, PT, Senior Vice President, Health Policy

PRACTICE
H of D 6/98, Section I

Public laws and regulations and requirements of private organizations should make it clear that the term physical therapy should be applied only to services provided by licensed physical therapists. Selected aspects of treatment may be carried out by a trained physical therapist assistant or physical therapy aide, but only under conditions of continuing guidance and supervision by licensed physical therapists. Although some aspects of the work done by practitioners in other fields may be similar to physical therapy, they represent a limited part of basically different services. It is, therefore, misleading and may be illegal to represent services as physical therapy unless they are provided by individuals whose education and practice comply with the standards established for the public protection.

STANDARDS OF PRACTICE FOR PHYSICAL THERAPY HOD 06-96-16-31 (Program 32)
[Amended HOD 06-91-21-25; HOD 06-85-30-56; Initial HOD 06-80-04-04; HOD 06-80-03-03]

Preamble
The physical therapy profession is committed to providing an optimum level of service delivery and to striving for excellence in practice. The House of Delegates of the American Physical Therapy Association, as the formal body that represents the profession, attests to this commitment by adopting and promoting the following Standards of Practice for Physical Therapy. These Standards of Practice for Physical Therapy are the profession's statement of conditions and performances that are essential for provision of high-quality physical therapy. The Standards provide a foundation for assessment of physical therapy practice.

I. Legal/Ethical Considerations
   A. Legal Considerations
      The physical therapist complies with all the legal requirements of jurisdictions regulating the practice of physical therapy.

      The physical therapist assistant complies with all the legal requirements of jurisdictions regulating the work of the assistant.

   B. Ethical Considerations
      The physical therapist practices according to the *Code of Ethics* of the American Physical Therapy Association.

      The physical therapist assistant complies with the *Standards of Ethical Conduct for the Physical Therapist Assistant* of the American Physical Therapy Association.

II. Administration of the Physical Therapy Service
   A. Statement of Mission, Purposes, and Goals
      The physical therapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the individuals served, the physical therapy personnel affiliated with the service, and the community.

   B. Organizational Plan
      The physical therapy service has a written organizational plan.

   C. Policies and Procedures
      The physical therapy service has written policies and procedures that reflect the operation of the service and that are consistent with the mission, purposes, and goals of the service.

   D. Administration
      A physical therapist is responsible for the direction of the physical therapy service.

   E. Fiscal Management
      The director of the physical therapy service, in consultation with staff and appropriate administrative personnel, shall participate in planning for, and allocation of, resources.

      Fiscal planning and management of the service is based on sound accounting principles.

   F. Quality/Performance Improvement
      The physical therapy service has a written plan for continuous improvement of the performance of services provided.

G. Staffing
The physical therapy personnel affiliated with the physical therapy service have demonstrated competence and are sufficient to achieve the mission, purposes, and goals of the service.

H. Staff Development
The physical therapy service has a written plan that provides for appropriate and ongoing staff development.

I. Physical Setting
The physical setting is designed to provide a safe and accessible environment that facilitates fulfillment of the mission and achievement of the purposes and goals of the physical therapy service.

J. Interdisciplinary Collaboration
The physical therapy service collaborates with all appropriate disciplines.

III. Provision of Services

A. Informed Consent
The physical therapist has sole responsibility for providing information to the patient and for obtaining the patient's informed consent in accordance with jurisdictional law before initiating physical therapy.

B. Initial Examination and Evaluation
The physical therapist performs and documents an initial examination and evaluates the results to identify problems and determine the diagnosis prior to intervention.

C. Plan of Care
The physical therapist establishes and provides a plan of care for the individual based on the results of the examination and evaluation and on patient needs.

The physical therapist involves the patient, and appropriate others in the planning, implementation, and assessment of the intervention program.

The physical therapist, in consultation with appropriate disciplines, plans for discharge of the patient, taking into consideration goal achievement, and provides for appropriate follow-up or referral.

D. Intervention
The physical therapist provides, or delegates and supervises, the physical therapy intervention consistent with the results of the examination and evaluation and plan of care.

The physical therapist documents, on an ongoing basis, services provided, responses to services, and changes in status relative to the plan of care.

E. Reexamination and Reevaluation
The physical therapist reexamines and reevaluates the individual continually and modifies or discontinues the plan of care accordingly.

F. Discharge/Discontinuation of Treatment or Intervention
The physical therapist discharges the patient from physical therapy intervention when the goals or projected outcomes for the patient have been met.

The physical therapist discontinues treatment when the goals are achieved, the patient/client declines to continue care, the patient/client is unable to continue, or the physical therapist determines that intervention is no longer warranted.

IV. Education
The physical therapist is responsible for individual professional development. The physical therapist assistant is responsible for individual career development.

The physical therapist participates in the education of physical therapy students, physical therapist assistant students, and students in other health professions.

The physical therapist educates and provides consultation to consumers and the general public regarding the purposes and benefits of physical therapy.

The physical therapist educates and provides consultation to consumers and the general public regarding the roles of the physical therapist and the physical therapist assistant.

V. Research

The physical therapist applies research findings to practice and encourages, participates in, and promotes activities which establish the outcomes of physical therapist patient management.

The physical therapist supports collaborative and interdisciplinary research.

VI. Community Responsibility

The physical therapist demonstrates community responsibility by participating in community and community agency activities; educating the public; formulating public policy or providing pro bono physical therapy services.

PRACTICE
H of D 6/98, Section I

In performing the diagnostic process, physical therapists may need to obtain additional information (including diagnostic labels) from other health professionals. In addition, as the diagnostic process continues, physical therapists may identify findings that should be shared with other health professionals, including referral sources, to ensure optimal patient care. When the patient is referred with a previously established diagnosis, the physical therapist should determine that the clinical findings are consistent with that diagnosis. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience or expertise, the physical therapist should then refer the patient to an appropriate practitioner.

DIRECTION, DELEGATION AND SUPERVISION IN PHYSICAL THERAPY SERVICES

HOD 06-96-30-42 (Program 32) [Amended HOD 06-95-11-06; HOD 06-93-08-09; HOD 06-85-20-41; Initial HOD 06-84-16-72/HOD 06-78-22-61/HOD 06-77-19-37]

Physical therapists have a responsibility to deliver services in ways that protect the public safety and maximize the availability of the services. They do this through direct delivery of services in conjunction with responsible delegation of certain tasks to physical therapist assistants, physical therapy aides, and other supportive personnel.

Direction and supervision are essential in the provision of quality physical therapy services. The degree of direction and supervision necessary for assuring quality physical therapy services is dependent upon many factors, including the education, experience, and responsibilities of the parties involved, as well as the organizational structure in which the physical therapy services are provided. Supervision should be readily available to the individual being supervised.

The director of a physical therapy service is a physical therapist who has demonstrated qualifications based on education and experience in the field of physical therapy and accepted the inherent responsibilities. The director of a physical therapy service must: 1) establish guidelines and procedures that will delineate the functions and responsibilities of all levels of physical therapy personnel in the service and the supervisory relationships inherent to the functions of the service and the organization; 2) assure that the objectives of the service are efficiently and effectively achieved within the framework of the stated purpose of the organization and in accordance with safe physical therapy practice; and 3) interpret administrative policies, act as a liaison between line staff and administration, and foster the professional growth of the staff.

Written standards of practice and performance criteria should be available for all levels of physical therapy personnel in a physical therapy service. Regularly scheduled performance appraisals should be conducted by the supervisor based on these standards of practice and performance criteria.

Delegated responsibilities must be commensurate with the qualifications, including experience, education and training, of the individuals to whom the responsibilities are being assigned. When the physical therapist of record delegates patient care responsibilities to physical therapist assistants or other supportive personnel, that physical therapist holds responsibility for supervision of the physical therapy program. Regardless of the setting in which the service is given, the following responsibilities must be borne solely by the physical therapist:

1. Interpretation of referrals when available.
2. Initial evaluation, problem identification, and diagnosis for physical therapy.
3. Development or modification of a plan of care which is based on the initial evaluation and which includes the physical therapy treatment goals.
4. Determination of which tasks require the expertise and decision making capacity of the physical therapist, and must be personally rendered by the physical therapist, and which tasks may be delegated. Prior to delegating any procedure, the physical therapist should determine that the consequences of the procedure are predictable, the situation is stable, and the basic indicators are not ambiguous and do not require ongoing observation by the physical therapist.
5. Delegation and instruction of the services to be rendered by the physical therapist assistant or other supportive personnel, including, but not limited to, specific treatment program, precautions, special problems, or contraindicated procedures.
6. Timely review of treatment documentation, reevaluation of the patient and the patient's treatment goals, and revision of the plan of care when indicated.
7. Establishment of the discharge plan and documentation of discharge summary/status.

A. Definition and Utilization of the Physical Therapist Assistant

Definition

The physical therapist assistant is a technically educated health care provider who assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant associate degree program accredited by an agency recognized by the Secretary of the United States Department of Education or the Council on Postsecondary Accreditation.

Utilization

The physical therapist of record is the person who is directly responsible for the actions of the physical therapist assistant. The physical therapist assistant may perform physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist. Where permitted by law, the physical therapist assistant may also carry out routine operational functions, including supervision of the physical therapy aide and documentation of treatment progress. The ability of the physical therapist assistant to perform the selected and delegated tasks shall be assessed on an ongoing basis by the supervising physical therapist. The physical therapist assistant may modify a specific treatment procedure in accordance with changes in patient status within the scope of the established treatment plan.

The physical therapist assistant must work under the direction and supervision of the physical therapist in all practice settings. When the physical therapist and the physical therapist assistant are not within the same physical setting, the performance of the delegated functions by the physical therapist assistant must be consistent with safe and legal physical therapy practice and shall be predicated on the following factors: complexity and acuity of the patient's needs; proximity and accessibility to the physical therapist; supervision available in the event of emergencies or critical events; and type of setting in which the service is provided. When the physical therapist and the physical therapist assistant are not continuously within the same physical setting, greater emphasis in directing the physical therapist assistant must be placed upon oral and written reporting.

When supervising the physical therapist assistant in any off site setting, the following requirements must be observed:

1. A qualified physical therapist must be accessible by telecommunications to the physical therapist assistant at all times while the physical therapist assistant is treating patients.
2. The initial visit must be made by a qualified physical therapist for evaluation of the patient and establishment of a plan of care.
3. There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients, the frequency of which is determined by the needs of the patient and the needs of the physical therapist assistant.
4. In those situations in which a physical therapist assistant is involved in the care of a patient, a supervisory visit by the physical therapist will be made:
   a. Upon the physical therapist assistant's request for a reevaluation, when a change in treatment plan of care is needed, prior to any planned discharge, and in response to a change in the patient's medical status.
   b. At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient.
   c. A supervisory visit should include:
      1. An on-site re-assessment of the patient.
      2. On-site review of the plan of care with appropriate revision or termination.
      3. Assessment and recommendation for utilization of outside resources.

B. Definition and Utilization of the Physical Therapy Aide

Definition

The physical therapy aide is a non-licensed worker who is specifically trained under the direction of a physical therapist. The physical therapy aide performs designated routine tasks related to the operation of a physical therapy service delegated by the physical therapist or, in accordance with the law, by a physical therapist assistant.

Utilization

The physical therapist of record is the person who is directly responsible for the actions of the physical therapy aide. The physical therapy aide provides supportive services in the physical therapy service, which may include patient related or non-patient related duties. When providing direct physical therapy services to patients, the physical therapy aide may function only with the continuous on-site supervision of the physical therapist or, where allowable by law and/or regulation, the physical therapist assistant. Continuous on-site supervision requires the presence of the physical therapist or physical therapist assistant in the immediate area, and the involvement of the physical therapist or physical therapist assistant in appropriate aspects of each treatment session in which a component of treatment is delegated to a physical therapy aide.

The physical therapy aide may assist patients in preparation for treatment and, as necessary, during treatment and at the conclusion of treatment, and may assemble and disassemble equipment and accessories, in accordance with the training of the physical therapy aide. The extent to which the physical therapy aide participates in operational activities, including maintenance and transportation and in patient-related activities, will be dependent upon the discretion of the physical therapist and the applicable state and federal regulations.

Students who are enrolled in physical therapist professional education programs or physical therapist assistant education programs and who are employed in a physical therapy clinical setting where such employment is not a part of the formal educational curriculum will be classified as physical therapy aides. Where their employment is part of the formal educational curriculum this policy will not apply. The physical therapist student who is a graduate of an approved physical therapist assistant program is exempt from this restriction and may be classified as a physical therapist assistant.

C. Other Support Personnel

When other personnel (e.g., exercise physiologists, athletic trainers, massage therapists), work within the setting of a physical therapy service they should be employed under their appropriate title. Any involvement in patient care activities should be within the limits of their education, in accord with applicable laws and regulations, and at the discretion of the physical therapist. However, if they function as an extension of the physical therapist's license, their title and all provided services must be in accordance with state and federal laws and regulations. In all situations when the physical therapist delegates activities to other support personnel, the physical therapist must recognize the legal responsibility and liability for such delegation.

GOALS TO IMPROVE THE STATUS OF WOMEN IN PHYSICAL THERAPY HOD 06-92-23-51 (Program 33)

Progress in achieving the following Goals in the Plan to Improve the Status of Women in Physical Therapy shall be reported annually to the House of Delegates:

GOAL 1: Increase awareness of the issues of inequity for women.

GOAL 2: Recognize barriers and promote mechanisms to eliminate or reduce these barriers to professional growth and career development.

GOAL 3: Promote physical therapy as a lifelong profession.

GOAL 4: Provide for the systematic evaluation of the status of women and Association action concerning women's issues.

PHILOSOPHICAL STATEMENT ON PHYSICAL THERAPY (POSITION) HOD 06-83-03-05 (Program 32)

Physical therapy is a health profession whose primary purpose is the promotion of optimal human health and function through the application of scientific principles to prevent, identify, assess, correct, or alleviate acute or prolonged movement dysfunction.

HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

February 9, 1999

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: **SENATE BILL 192**

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 192. We are opposed to this legislation because we think it will have an adverse impact on access to health care in rural Kansas.

In 1990, the language deleted by Senate Bill 192 was introduced by the Kansas Physical Therapy Association. The purpose was to allow the initiation of needed physical therapy when the physical therapist was not available. We think the passage of this amendment in 1990 made sense. In many rural hospitals in Kansas, there is not a physical therapist on duty at all times. These hospitals are forced to contract with a consulting physical therapist who provides services to more than one facility. There are two major reasons for this situation. First, there are not enough physical therapists to cover every hospital in rural Kansas. Second, not every hospital in Kansas can afford full-time coverage by a physical therapist.

The current law acts to maintain access to physical therapy services in all areas of Kansas. The situation facing hospitals today is much the same as it was in 1990. Physical therapists are still not available in some areas of the state, and the cost of physical therapists has increased. This situation will only get worse with the reductions in the Medicare program approved by Congress.

Current law simply provides that a patient will not have to wait for physical therapy services when the physical therapist is not available. Importantly, it does not remove the physical therapist from the equation. It is only when the physical therapist is comfortable that treatment can be initiated that the phone consultation will be allowed. Even then, the physical therapist must still see the patient as soon as possible.

We think the repeal of current law by passing Senate Bill 192 would threaten access to physical therapy services in certain situations. We urge you to oppose it.

TLB:cdc

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 2

Healing Through Caring
GOVE COUNTY MEDICAL CENTER

February 8, 1999

Kansas Physical Therapy Association
1200 W. 10th Street
Topeka, Kansas 66601-2428
(781)233-5400

To: Honorary Chairwoman Praeger and the Senators of the Health and Welfare committee

In response to the request of Carolyn Bloom, PT, regarding K.S.A. 65-2914 of the Kansas Statute Relating to Physical Therapy, we request this change not be implemented. Being a small rural hospital, we currently utilize contract Physical Thereapists secondary to a shortage of Physical Therapists in rural areas. If this change were allowed to go into effect, we feel it would create problems with patient follow-up eventually resulting in poor patient care. Rural hospitals may be 30-60 miles apart with a Physical Therapist covering several facilities. If implemented, this would delay treatment of patients up to several days, and in our opinion, would be considered patient descrimination in the rural setting.

Therefore, we request no change be made in the current K.S.A. 65-2914 regarding the clause that was added in 1990.

Respectfully,

Paul Davis
Administrator

Elizabeth Ashbaugh, CPTA
Elizabeth Ashbaugh, CPTA

Sondra Kitch PT
Sondra Kitch, PT

Becky Brooks CPTA
Becky Brooks, CPTA

Shirlee Kalt, CPTA

P.O. Box 129 ‡ 520 West 5th ‡ Quinter, Kansas 67752 ‡ Phone 913.754.3341 ‡ FAX 913.754.3329

PRH
PLAINVILLE RURAL HOSPITAL DISTRICT #1
xxx South Colorado - P.O. Box 389 - Plainville, Kansas 67663-0389 - USA
Phone 785-434-4550 - Fax 785-434-2434

February 16, 1999

Kansas Physical Therapy Association
1200 W. 10th Street
Topeka, KS 66601-2428

The Honorable Chairwoman Praeger and the Senators of the Health and Welfare Committee:

In response to the request by Carolyn Bloom, PT regarding K.S.A. 65-2914 of the Kansas Statute relating to Physical Therapy, we request this change not be implemented. Being a small rural hospital, we currently utilize contract Physical Therapists due to a shortage of Physical Therapists in this area. If this change were allowed to go into effect, we feel it would create problems with patient follow-up care eventually resulting in poor patient care. Rural hospitals can be 30 to 60 miles apart with a Physical Therapist covering several facilities. If this change is implemented, it would delay treatment of patients for up to several days, and in our opinion, would be considered patient discrimination in the rural setting.

Respectfully,

Richard Bergling
Administrator
Plainville Rural Hospital District #1

Mitchell County Hospital

An Affiliate Of Great Plains Health Alliance

FAX TRANSMISSION COVER SHEET

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TO: Tom Bell, Senior V.P., Kansas Hospital Association
FROM: John M. Osse, Administrator J. Osse **FAX NO. (785) 738-9503**
DATE: February 10, 1999
SUBJECT: Legislation - Physical Therapy Assistants
Total Pages Including This Sheet: 1 **FAX NO. (785) 233-6955**

____ Urgent ____ Per Our Conversation __X__ FYI ____ Call Me

____ By Your Request ____ For Your Approval

The passage of Senate Bill 192 would have a detrimental impact on rural hospitals. The current practice of allowing physical therapy assistants to begin therapy in the hospital setting after phone consultation with the physical therapist when the physical therapist was not readily available has worked very well. It has allowed the physical therapist to extend appropriate treatment without compromising quality of care by allowing the physical therapy assistant to provide therapy within their scope of practice. Even though the market for physical therapists may have improved, it has not improved enough to benefit most rural hospitals. We have not seen any compromise regarding the quality of care regarding physical therapy patients under the current system. I submit that the passage of Senate Bill 192 would only add to the burden of physical therapists and unnecessarily delay treatments to patients by physical therapy assistants who are qualified to do so.

400 West Eighth / P.O. Box 399 / Beloit, Kansas 67420-0399 / Telephone (785) 738-2266 / Fax (785) 738-9503

2-4

SMITH COUNTY MEMORIAL HOSPITAL
AND LONG TERM CARE
P.O. Box 349
Smith Center, Kansas 66967
(785) 282-6845

An Affiliate Of
GPHA
Great Plains Health Alliance

February 8, 1999

Honorable Chairwomen Praeger and Senators of the Health and Welfare Committee:

I am writing this letter to you to address the issue raised by the Kansas Physical Therapy Association regarding how a Physical Therapist may treat patients in the hospital setting. The argument raised to delete the option allowing the Physical Therapist to initiate treatment by telephone contact with the Physical Therapy Assistant is that there seems to not be a shortage of available Physical Therapists at this time. This may seem to be the case in the urban areas in the state of Kansas. However, I am quite sure that this overabundance of Physical Therapists does not exist in the rural areas of the state. Currently, when our Physical Therapist is away on vacation or for continuing medical education we must contact a Physical Therapist sixty miles away to cover our institution. At these times it would not seem prudent to have a Physical Therapist drive two hours to spend fifteen minutes evaluating a patient for Physical Therapy when this can be done over the phone when communicating to a Physical Therapy Assistant. Also, our Physical Therapist currently works with the educational system in our area and commutes distances sometimes up to 70 miles away from our community to see children with physical therapy needs. Without the ability to communicate with the Physical Therapy Assistants while she is providing physical therapy services to the children in our area she would not be able to provide Physical Therapy services on-site at the same time.

Having this option available to the Physical Therapist we have on staff makes it possible to provide patient care in many cases where that would not be possible. At our hospital we have never had concerns regarding treatment initiated by telephone contact. Certified Physical Therapy Assistants work with the Physical Therapists on a daily basis and through communication are able to provide quality physical therapy services until an on-site evaluation can be completed. It is our hope that the Physical Therapists and the Physical Therapy Assistants are allowed to continue to work together to provide Physical Therapy services. Without the ability to initiate patient care after the telephone contact this would jeopardize the timeliness of Physical Therapy services in our community.

Sincerely,

John Terrill
Administrator
Smith County Memorial Hospital

LOGAN COUNTY HOSPITAL

211 Cherry - (913) 672-3211
Oakley, Kansas 67748

February 9, 1999

Honorable Chairwoman Praeger
and Senators of the Health and Welfare Committee

Subj: Kansas Physical Therapy Association request regarding KSA 65-2914

Dear Senator Praeger and Committee Members:

As a small, rural hospital in Kansas, we wish to register our objection to the request of the Kansas Physical Therapy Association request to change the ability of Registered Physical Therapy Assistants to begin a program of care with telephone approval of a Registered Physical Therapist.

This language was requested a few years ago because of the lack of Registered Physical Therapists available in all areas of the state. It has worked well, with no reports that we are aware of which states that it does not. It has been a workable solution to a very difficult problem of availability of Registered Therapists

At this time this hospital does not have a great problem with the availability of a Registered Therapist, however, she is in house 3 days per week, at least, and lives close enough that she can travel in to see patients on an emergency basis to begin a program if needed, but if we should lose this therapist, the whole situation becomes different. Not another therapist would be located close enough to allow them to provide this service. The current law would then allow patients to begin a treatment program on a schedule which is needed by their condition - not at the whim of a traveling therapist! We have been through the trials of attempting to entice a therapist to provide service which is needed to provide adequate care for patients - in spite of what the association might say, there is NOT sufficient access to Registered Therapists to ensure adequate coverage!

We wish to request no change be made in the current K.S.A. 65-2914 regarding the clause added in 1990 which allows initial care to begin.

Sincerely,

Rodney Bates, Administrator

Graham County Hospital

February 8, 1999

Kansas Physical Therapy Association
1200 W. 10th Street
Topeka, Kansas 66601-2428
781 233-5400

To: Honorary Chairwoman Praeger and the Senators of the Health and Welfare Committee:

In response to the request of Carolyn Bloom, PT, regarding K.S. A. 65-2914 of the Kansas Statute Relating to Physical Therapy, we request this change not be implemented. Being a small rural hospital, we currently utilize contract Physical Therapists secondary to a shortage of Physical Therapists in rural areas. If this change were allowed to go into effect, we feel it would create problems with patient follow-up care eventually resulting in poor patient care. Rural hospitals may be 30 - 60 miles apart with a Physical Therapist covering several facilities. If implemented, this would delay treatment of patients up to several days, and in our opinion, would be considered patient discrimination in the rural setting.

Therefore, we request no change be made in the current K.S.A. 65-2914 regarding the clause that was added in 1990.

Respectfully,

Fred J. Meis,
Administrator, CEO

Carolyn Long, CPTA
Department Head

Sondra Kitch, PT

304 W. Prout Street • P.O. Box 339 • Hill City, Kansas 67642-0339 • (785) 421-2121
FAX (785) 421-2034

GRISELL MEMORIAL HOSPITAL

Hospital District No. 1

An Affiliate of Great Plains Health Alliance

February 9, 1999

To: Senate Public Health and Welfare Committee
From: Kris Ochs, Grisell Memorial Hospital Administrator
RE: Senate Bill 192

I appreciate the opportunity to comment regarding the provisions of Senate Bill 192.

In the past ten years that I have been the administrator of Grisell Memorial Hospital, we have had several different consulting Physical Therapists from surrounding areas, such as Hays, Great Bend, and Dodge City. Small rural hospitals have networked together to contract Registered Physical Therapists to cover our Certified Physical Therapy Assistants in the local hospitals. By doing this we have been able to provide the service at an affordable cost for each facility. With the low volume of physical therapy patients, it is impossible for us to hire full time therapists at the fair market rate.

When our local patrons go to larger facilities for surgery and more acute treatment, many times, because of the swingbed program, they can come back "home" for their rehab needs, where they are close to family, friends and local healthcare personnel, which a lot of times speeds their recovery.

I oppose Senate Bill 192 because it would delay treatment for our patients, possibly making them not be able to come home for their therapy, and secondly it would increase the costs of rural hospitals to offer the Physical Therapy service, or worse, eliminate it entirely.

210 S. Vermont ★ P.O. Box 268 ★ Ransom, Kansas 67572
Phone 785-731-2231 ★ Fax 785-731-2895

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 3

GRISELL MEMORIAL HOSPITAL

Hospital District No. 1

An Affiliate of Great Plains Health Alliance

We at Grisell had the fortunate opportunity in 1996 to hire a Registered Physical Therapist that was originally a local gal. As I have said earlier, we could not have afforded to hire her full time because of our low volume and the costs, so we networked with WaKeeney and Hill City hospitals, Hill City Nursing Home, and Hays Medical Center Home Health to share her services.

Thank you for your time.

Keil Dahs, adm

210 S. Vermont ★ P.O. Box 268 ★ Ransom, Kansas 67572
Phone 785-731-2231 ★ Fax 785-731-2895

GRISELL MEMORIAL HOSPITAL

Hospital District No. 1

An Affiliate of Great Plains Health Alliance

February 10, 1999

To: Honorary Chairwoman Praeger and Senators of Health and Welfare Committee
From: Lynette Nichol-Withington, PT/ATC-R
RE: Senate Bill 192

I am writing this letter to oppose the request to change the wording of Bill K.S.A. 65-2914. This is on behalf of the small rural hospitals who, because of financial costs and patient volume, ban together to contract physical therapists to provide services to compliment Certified Physical Therapy Assistants.

I am a member of the Kansas Physical Therapy Association and the American Physical Therapy Association but do not feel that these organizations always allow for the needs of the small rural hospitals.

Patients from small communities are presently served by a combined effort of Physical Therapists and Physical Therapist Assistants which allows them to return to their home town environment. This not only lessens the burden on family members, but also provides friends with the opportunity to visit the patient more readily. These factors, as well as receiving treatment from home town health care providers, help expediate the patient's recovery.

Physical Therapy Assistants in rural communities are also able to provide high quality care to patients in a different capacity then their urban counterparts. CPTA's in rural hospitals are very autonomous and often do the managerial work of a P.T. department as well as providing the excellent patient care. The Physical Therapist in these settings have close relationships with the Physical Therapy Assistants for which they provide supervision. Their level of competency and ability to provide quality care is of the utmost concern to the Physical Therapist. The CPTA's, which I personally supervise, are excellent regarding both.

210 S. Vermont ★ P.O. Box 268 ★ Ransom, Kansas 67572
Phone 785-731-2231 ★ Fax 785-731-2895

If it is unacceptable to maintain the present wording, I would like to propose a compromise to the request to change the present bill, perhaps adding the statement ... "except for those hospitals who contract physical therapists who are not immediately available upon the premises daily. Such facilities shall require Physical Therapy Assistants to contact Physical Therapists for a documented plan of care. The Physical Therapy Assistant may then initiate treatment as directed by the Physical Therapist. The Physical Therapist shall then evaluate the patient as soon as possible".

The need still exists in rural communities to allow such language so as the patient may receive the immediate care they deserve. I can personally attest to this need since I cover three hospitals in a sixty mile radius. I am connected to all these communities through being raised here and by way of family.

Thank you for giving your attention to this matter and for considering the requirements necessary in a small hospital to provide quality care to their patients.

Sincerely,

Lynette Nichol-Withington, PT/ATC-R

Great Plains Health Alliance

P.O. Box 366
Phillipsburg, Kansas 67661
(913) 543-2111

250 N. Rock Road, Suite 160
Wichita, Kansas 67206
(316) 685-1523

February 9, 1999

TO: Senate Public Health and Welfare Committee

FROM: Roger S. John, President & CEO

RE: Senate Bill 192

Thank you for the opportunity to submit this testimony in opposition to Senate Bill 192. Great Plains Health Alliance is an organization which operates twenty six small rural hospitals, 24 of them in Kansas and two in Nebraska. All of these hospitals have less than fifty beds and are located all over Kansas, but primarily in western Kansas. All of our hospitals provide some level of physical therapy services, most of which are provided through part-time registered physical therapists (RPT) and certified physical therapy assistants (CPTA).

Currently, KSA 65-2914 allows a CPTA to initiate treatment on a patient after calling a registered physical therapist, discussing the assistant's evaluation and deciding on a course of therapy. The registered physical therapist would then evaluate the patient personally at the therapist's next visit.

SB 192 would mandate a registered physical therapist see the patient before any treatment is initiated. This would not present a problem if every hospital had access to a registered physical therapist daily. However, most of our hospitals and other rural hospitals in Kansas have access to a registered physical therapist only on a part time basis, typically two to three times a week. By statute, a registered physical therapist may work with up to four certified physical therapy assistants; so could possibly serve up to four hospitals.

We are concerned that if the CPTA cannot initiate treatment upon consultation with the registered physical therapist, then there could be delays in treatment of those patients who need it. For example, a hospital whose registered physical therapist comes on Tuesdays and Thursdays. Under SB 192, if a patient presented on Thursday after the registered physical therapist left, the patient may not receive treatment until Tuesday, a delay of four days. This represents a four day stay for the patient who has not received the therapy he/she needs.

Under current statutes, physical therapy could be initiated immediately by a certified physical therapy assistant upon consultation with the registered physical therapist over the phone. The registered physical therapist always has the option to decide against treatment until the therapist can evaluate the patient personally.

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Kansas has been fortunate to have a good educational program for certified physical therapy assistants; and none of our hospitals have experienced quality of care problems because certified physical therapy assistants initiated treatment, according to current statutes. KSA 65-2914 works for rural healthcare as it is written; and we would ask the members of this Committee to oppose any change to it that would limit the flexibility or delay the care of patients who need treatment the most.

Thank you.

Roger S. John
President & CEO
Great Plains Health Alliance
Phillipsburg, Kansas

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director
1260 SW Topeka Blvd
Topeka, KS 66614

(785) 234-5563
(785) 234-5564 fax
e-mail: kansasdo@aol.com

February 11, 1999

To: Chairperson Praeger and Member, Senate Public Health Committee

From: Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Subject: Opposition to SB 192

Thank you for this opportunity to express our reservations about the deleted language proposed SB 192.

Several years ago, KAOM raised the concerns that eventually led to compromise language in KSA 65-2914. It is this language that now would be deleted were SB 192 to pass.

KAOM's initial concern dealt with instances in rural hospitals in which a physician ordered physical therapy when there was no physical therapist present. In some cases it could be hours or days before a physical therapist could visit the patient, creating a delay in patient care.

Often, in these circumstances, a physician therapy assistant was present and could commence therapy under the physician's direction. The law, however, provided that therapy could not begin until the PT saw the patient.

The compromise language set up a procedure by which the PT Assistant could commence therapy after phone contact with a supervising PT, with required PT evaluation as soon as possible or practical.

Apparently the reasons for the change (deletion of compromise language) are that this provision is inconsistent with national PT directives, and that there is now a sufficient number of PTs practicing in rural areas that the potential for treatment delays no longer exists.

We question whether national standards or directives should dictate State policy and whether or not there still may be a problem of distribution of PTs and physical therapy services, even though numbers may suggest no shortage, if indeed the latter is the case.

We think the language should remain. If there is a sufficient supply of physical therapists to preclude delay, then the use of a PT Assistant would be inoperative anyway. If not, then we think therapy could begin immediately, or sooner, with adequate protection of quality of care.

Quality of patient care is and always should be the primary concern. We think the existing language addresses that matter, with adequate patient safeguards.

I will be pleased to respond to questions.

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Date: 2-11-99
Attachment No. 5

tioners and establish limitations and restrictions on such ~~expanded~~ role. The board shall adopt a definition of ~~expanded~~ *the* role under this subsection (c)(3) which is consistent with the education ~~, training~~ and qualifications required to obtain a certificate of qualification as an advanced registered nurse practitioner, which protects the public from persons performing functions and procedures as advanced registered nurse practitioners for which they lack adequate education ~~, training~~ and qualifications and which authorizes advanced registered nurse practitioners to perform acts generally recognized by the profession of nursing as capable of being performed, in a manner consistent with the public health and safety, by persons with postbasic education in nursing. In defining such ~~expanded~~ role the board shall consider: (A) The ~~training and~~ education required for a certificate of qualification as an advanced registered nurse practitioner; (B) the type of nursing practice and preparation in specialized practitioner skills involved in each category of advanced registered nurse practitioner established by the board; (C) the scope of practice of nursing specialties and limitations thereon prescribed by national organizations which certify nursing specialties; and (D) acts recognized by the nursing profession as appropriate to be performed by persons with postbasic education ~~and training~~ in nursing.

(d)An advanced registered nurse practitioner may ~~not~~ prescribe drugs ~~but may transmit prescription orders~~ pursuant to a written protocol as authorized by a responsible physician. Each written protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the advanced registered nurse practitioner is authorized to ~~transmit prescription orders~~ *prescribe* and shall specify all drugs which may be ~~transmitted~~ *prescribed* by the advanced registered nurse practitioner. *The advanced registered nurse practitioner may not dispense drugs, but may request, receive and sign for professional samples and may distribute professional samples to patients. In order to prescribe controlled substances, the advanced registered nurse practitioner shall (1) register with the federal drug enforcement administration; and (2) notify the board of the name and address of the responsible physician or physicians.* In no case shall the scope of authority of the advanced registered nurse practitioner exceed the normal and customary practice of the responsible physician. An advanced registered nurse practitioner certified in the category of registered nurse anesthetist while functioning as a registered nurse anesthetist under K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, shall be subject to the provisions of K.S.A. 65-1151 to 65-1164, inclusive, and amendments thereto, with respect to ~~medications~~ *drugs* and anesthetic agents and shall not be subject to the provisions of this subsection. For the purposes of this subsection, ``responsible physician" means a person licensed to practice medicine and surgery *in Kan-*

KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE

PROPOSED AMENDMENT TO HB 2168

pursuant to a written protocol as authorized by a responsible physician.

5-8

KANSAS COLLEGE OF CHINESE MEDICINE

堪萨斯中医学院

Testimony - Bill #144

Kansas Acupuncture Act of 1999

Good morning Madame Chair and distinguished Senators.

My name is Qizhi Gao. I am president of the Acupuncture Association of Kansas and the Kansas College of Chinese Medicine in Wichita. We, the Acupuncture Association of Kansas, are seeking your vote in passing legislation for the licensing of acupuncturists.

The practice of *Traditional Chinese Medicine (TCM)*, or *Acupuncture* as it is known in the West, has a long and dynamic history which began to take form nearly 5000 years ago. TCM incorporates a variety of interrelated and highly effective modalities into a medical system which takes each individual into account as a whole entity, rather than simply treating "diseases".

Worldwide medical research agencies such as the World Health Organization and more recently, the U.S. National Institutes for Health, continue to publish positive findings for acupuncture and its related disciplines in treating a broad range of medical conditions. Public and scientific acceptance of acupuncture is growing at a rapid rate in the United States. In 1993 the Food and Drug Administration reported 9-12 million patient visits for acupuncture. These patients spent over five hundred million health care dollars.

There are over 50 schools and colleges teaching traditional Chinese medicine in the U.S. These schools require over 2000 hours of didactic and clinical training prior to national certification. Currently, thirty-eight states have licensing or certification for acupuncturists, including the nearby states of Texas, Iowa, Arkansas, Colorado and Missouri.

As the popularity of acupuncture increases there is a risk of fraud and injury from individuals who practice acupuncture with little or no training. Passage of Bill #144 will ensure Kansas consumers have access to health care professionals who are trained and have passed the stringent requirements of a nationally recognized certification and accreditation organization.

For this purpose we ask for your support in passing Bill #144.

Thank you for your time.

9235 East Harry . Building. 100 . Suite 1A . Wichita KS, 67207

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 6

February 11, 1999
Senate Bill 144, Kansas Acupuncture Act
Senate Committee on Public Health and Welfare

Good morning Senators and Madam Chair. Thank you for this opportunity to address you today. I would like to outline for you the purpose and means of this legislation. As practitioners of acupuncture and other Oriental healing arts, we want to establish a procedure and criteria for the licensing of acupuncturists which will insure the safety of the people of Kansas.

In order to keep down the cost of this licensing procedure, we are proposing a method employed by a number of other states. We propose that the establishment of eligibility standards and examination procedures be delegated to other organizations which have been established to perform this function. We have borrowed language from the Missouri bill (which you will find attached to my statement) which states that in order to qualify for a license in Kansas an individual must be either actively certified as a Diplomat in Acupuncture by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM) or actively licensed in another state which has eligibility and examination requirements that are at least equivalent to those of the NCCAOM.

We propose in this legislation that the Board of Healing Arts carry out the provisions of this act assisted and advised by an Acupuncture Review Committee, similar to those for other professions regulated by the Board of Healing Arts. Other provisions of the act also defer to current Board of Healing Arts practices for such matters as renewal, fees and prohibited activities.

I would especially like to point out two features of our proposal which may be of specific interest. This legislation does not seek to alter the scope of practice of any other licensed professionals, nor does it require direct third-party reimbursements to persons licensed under this article.

We are not lawyers and are unfamiliar with legislative process and language, so I ask for your understanding if the legislation we have written is clumsy or unclear. We have patterned our language on current Kansas statute and acupuncture bills from other states, notably Missouri and North Carolina.

We are anxious to work with you and your staff to make of our draft a bill which can be considered by your committee and proceed to the floor of the senate. We are here to answer any questions you may have. I want to thank you in advance for your consideration.

Richard Morantz
1103 Massachusetts
Lawrence, Kansas 66044
785-841-1587
email: rmorantz@juno.com

attachment: Missouri Acupuncture Statute

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 7

MISSOURI ACUPUNCTURE STATUTE

SIGNED, JULY 10, 1998

Section 15. For the purposes of sections 15 to 23 of this act, the following terms mean:

(1) "Acupuncture", the use of needles inserted into the body by piercing of the skin and related modalities, for the assessment, evaluation, prevention, treatment or correction of any abnormal physiology or pain by means of controlling and regulating the flow and balance of energy in the body so as to restore the body to its proper functioning and state of health;

(2) "Acupuncturist", any person licensed as provided in sections 15 to 23 of this act, to practice acupuncture as defined in subdivision (1) of this section;

(3) "Auricular detox technician", a person trained solely in, and who performs only, auricular detox treatment. An auricular detox technician shall practice under the supervision of a licensed acupuncturist or a physician licensed pursuant to sections 334.010 to 334.265, RSMo, or a chiropractor licensed pursuant to chapter 331, RSMo. Such treatment shall take place in a hospital, clinic or treatment facility which provides comprehensive substance abuse services, including counseling, and maintains all licenses and certifications necessary and applicable;

(4) "Auricular detox treatment", a very limited procedure consisting of acupuncture needles inserted into specified points in the outer ear of a person undergoing treatment for drug or alcohol abuse or both drug and alcohol abuse;

(5) "Board", the state board of chiropractic examiners established in chapter 331, RSMo;

(6) "Committee", the Missouri acupuncture advisory committee;

(7) "Department", the Missouri department of economic development;

(8) "Director", the director of the division of professional registration;

(9) "Division", the division of professional registration of the department of economic development;

(10) "License", the document of authorization issued by the division for a person to engage in the practice of acupuncture.

Section 16. 1. There is hereby created the "Missouri Acupuncturist Advisory Committee", to be composed of five members to be appointed by the governor with the advice and consent of the senate. The governor shall appoint committee members who are citizens of the United States and registered voters in the state of Missouri, from a list provided by the director of the department of economic development.

2. The acupuncturist advisory committee shall:

(1) Assist the division in the review and issuance of all licenses;

(2) Advise the board on all matters pertaining to the licensing of acupuncturists;

(3) Review all complaints and/or investigations wherein there is a possible violation of sections 15 to 23 of this act or regulations promulgated pursuant thereto and make recommendations to the board on complaints the committee determines to warrant further

action;

(4) Follow the provisions of the board's administrative practice procedures in conducting all official duties.

3. The acupuncturist advisory committee shall:

(1) Be comprised of three licensed acupuncturists except for initial appointees who hold no other professional license in the state;

(2) One member shall be a physician duly licensed by the Missouri state board for chiropractic examiners; and

(3) One member shall be a general public member.

4. Except for the initial appointees, members shall hold office for terms of six years. The board shall designate one member for a term expiring in 1999, one member for a term expiring in 2000, one member for a term expiring in 2001, one member for a term expiring in 2002, and one member for a term expiring in 2003. In the event of death, resignation, or removal of any member, the vacancy of the unexpired term shall be filled by the board in the same manner as the other appointments.

Section 17. 1. The division shall upon recommendation of the committee license applicants who meet the qualifications for acupuncturists, who file for licensure, and who pay all fees required for this licensure.

2. The division shall:

(1) Prescribe application forms to be furnished to all persons seeking licensure pursuant to sections 15 to 23 of this act;

(2) Prescribe the form and design of the license to be issued pursuant to sections 15 to 23 of this act;

(3) Set the fee for licensure and renewal thereof;

3. The board shall:

(1) Maintain a record of all board and committee proceedings regarding sections 15 to 23 of this act and of all acupuncturists licensed in this state;

(2) Annually prepare a roster of the names and addresses of all acupuncturists licensed in this state, copies of which shall be made available upon request to any person paying the fee therefor;

(3) Set the fee for the roster at an amount sufficient to cover the actual cost of publishing and distributing the roster;

(4) Adopt an official seal;

(5) Inform licensees of any changes in policy, rules or regulations.

4. The board may with the approval of the advisory committee:

(1) Issue subpoenas to compel witnesses to testify or produce evidence in

proceedings to deny, suspend or revoke licensure;

(2) Promulgate rules pursuant to chapter 536, RSMo, in order to carry out the provisions of sections 15 to 23 of this act including, but not limited to, regulations establishing:

(a) Standards for the practice of acupuncture;

(b) Standards for ethical conduct in the practice of acupuncture;

(c) Standards for continuing professional education;

(d) Standards for the training and practice of auricular detox technicians, including specific enumeration of points which may be used.

5. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is promulgated to administer and enforce sections 15 to 23 of this act, shall become effective only if the agency has fully complied with all of the requirements of chapter 536, RSMo, including but not limited to, section 536.028, RSMo, if applicable, after the effective date of this act. If the provisions of section 536.028, RSMo, apply, the provisions of this section are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028 to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void, except that nothing in this act shall affect the validity of any rule adopted and promulgated prior to the effective date of this act.

Section 18. 1. Nothing in sections 15 to 23 of this act shall be construed to apply to physicians and surgeons licensed pursuant to sections 334.010 to 334.265, RSMo, or chiropractors licensed pursuant to chapter 331, RSMo; except that, if such physician or surgeon or chiropractor, with or without a current certification in meridian therapy, uses the title, licensed acupuncturist, then the provisions of sections 15 to 23 of this act shall apply.

2. No license to practice acupuncture shall be required for any person who is an auricular detox technician, provided that such person performs only auricular detox treatments as defined in section 15 of this act, under the supervision of a licensed acupuncturist or a physician licensed pursuant to sections 334.010 to 334.265, RSMo, or a chiropractor licensed pursuant to chapter 331, RSMo, and in accordance with regulations promulgated pursuant to sections 15 to 23 of this act by the division. An auricular detox technician may not insert acupuncture needles in any other points of the ear or body or use the title, licensed acupuncturist.

Section 19. 1. It is unlawful for any person to practice acupuncture in this state, unless such person:

(1) Possesses a valid license issued by the division pursuant to sections 15 to 23 of this act; or

(2) Is engaged in a supervised course of study that has been authorized by the committee approved by the board, and is designated and identified by a title that clearly indicates status as a trainee, and is under the supervision of a licensed acupuncturist.

2. A person may be licensed to practice acupuncture in this state if the applicant:

(1) Is twenty-one years of age or older and meets one of the following requirements:

(a) Is actively certified as a Diplomate in Acupuncture by the National Commission for the Certification of Acupuncture and Oriental Medicine; or

(b) Is actively licensed, certified or registered in a state or jurisdiction of the United States which has eligibility and examination requirements that are at least equivalent to those of the National Commission for the Certification of Acupuncture and Oriental Medicine, as determined by the committee and approved by the board; and

(2) Submits to the committee an application on a form provided by the division; and

(3) Pays the fee specified by the division.

3. The division shall issue a certificate of licensure to each individual who satisfies the requirements of subsection 2 of this section, certifying that the holder is authorized to practice acupuncture in this state. The holder shall have in his or her possession at all times while practicing acupuncture, the license issued pursuant to sections 15 to 23 of this act.

Section 20. 1. Licenses issued pursuant to sections 15 to 23 of this act shall expire on July first of each odd-numbered year. Renewal applications shall be submitted to the division along with a renewal fee, to be determined by the division.

2. A license to practice acupuncture which is not renewed on or before the date of its expiration becomes invalid. Such license may be restored by complying with the provisions of section 21 of this act.

Section 21. Any acupuncturist who fails to renew such acupuncturist's license on or before the date of its expiration may restore such license as follows:

(1) If the application for renewal is submitted to the division not more than two years after the expiration of the applicant's last license, by payment of the fee specified by the division and by providing all documentation required by the division by rule; or

(2) If the application for renewal is submitted to the division more than two years after the expiration of the applicant's last license, by payment of the fee specified by the division, and by reapplying as provided in subdivisions (1) and (2) of subsection 2 of section 19 of this act.

Section 22. Subject to rules promulgated pursuant to sections 15 to 23 of this act, the board with recommendation of the committee may:

(1) Make investigations or conduct hearings to determine whether a violation of sections 15 to 23 of this act or any rule promulgated pursuant to sections 15 to 23 of this act has occurred;

(2) Reprimand an acupuncturist or deny, limit, suspend or revoke a license pursuant to the provisions of sections 15 to 23 of this act, if it finds that an acupuncturist has committed any of the following:

(a) Made a material misstatement in an application for license or renewal;

(b) While engaged in the practice of acupuncture, evidenced a lack of knowledge or ability to apply professional skills;

(c) Has been convicted of an offense which occurred during, or as a result of, the practice of acupuncture;

(d) Advertised in a manner which is false, deceptive or misleading;

(e) Practiced acupuncture while the individual's ability to practice was impaired by alcohol or other drugs.

Section 23. 1. Any person who violates any provision of sections 15 to 23 of this act is guilty of a class B misdemeanor.

2. All fees or other compensation received for services which are rendered in violation of sections 15 to 23 of this act shall be refunded.

3. The board on behalf of the committee may sue in its own name in any court in this state to enforce the provisions of sections 15 to 23 of this act. The board may investigate any alleged violations of sections 15 to 23 of this act referred to it by the committee, may institute actions for penalties provided in this section and shall enforce generally the provisions of sections 15 to 23 of this act.

4. Upon application by the board, the attorney general may, on behalf of the board, request that a court of competent jurisdiction grant an injunction, restraining order or other order as may be appropriate to enjoin a person from:

(1) Offering to engage or engaging in the performance of any acts or practices for which a certificate of registration or authority, permit or license is required upon a showing that such acts of practices were performed or offered to be performed without a certificate of registration or authority, permit or license; or

(2) Engaging in any practice or business authorized by a certificate of registration or authority, permit or license, issued pursuant to sections 15 to 23 of this act upon a showing that the holder presents a substantial probability of serious harm to the health, safety or welfare of any resident of this state or client or patient of the licensee.

5. Any action brought pursuant to this section may be in addition to, or in lieu of, any penalty provided by sections 15 to 23 of this act and may be brought concurrently with other actions to enforce the provisions of sections 15 to 23 of this act.

Kansas Association of Osteopathic Medicine

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Testimony
to the
Senate Public Health and Welfare Committee
February 11, 1999
by Charles Wheelen

Thank you for the opportunity to express our opposition to SB144. To the best of our knowledge there has not been any kind of application submitted for state credentialing of acupuncturists. This means that SB144 does not comply with the requirements of K.S.A. 65-5002 and therefore we oppose the bill.

We recognize, however, that the Legislature can suspend or waive the provisions of K.S.A. 65-5002 any time it wishes. This section of law is only effective if the Legislature enforces it. With that in mind we have reviewed SB144 and discovered a significant flaw. The first exception listed under section 3(a) does not define "other health care professionals." For that reason we have drafted an amendment which would restrict the practice of acupuncture to: (1) those licensed under the provisions of SB144, (2) those licensed to practice medicine and surgery, (3) those licensed to practice chiropractic, and (4) students training under direct supervision. A copy is attached.

Thank you for considering our position. We respectfully request that you recommend SB144 not be passed. But if you should choose to recommend favorably, we ask you to first incorporate our draft amendment.

Senate Public Health & Welfare
Date: 2-11-99
Attachment No. 8

Kansas Association of Osteopathic Medicine

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Session of 1999

SENATE BILL No. 144

By Committee on Public Health and Welfare

1-26

AN ACT concerning acupuncture; providing for the licensure of certain persons to practice acupuncture; establishing an acupuncture review committee; providing for administration by the state board of healing arts; authorizing the fixing and collecting of fees; providing penalties for violations.

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

Section 1. The purpose of this act is to promote the health, safety and welfare of the people of Kansas by establishing an orderly system of acupuncture licensing and to provide a valid, effective means of establishing licensing requirements without undue financial burden to the people of Kansas, through use of a national certifying board which has been established to certify the competency of acupuncturists and an acupuncture review committee overseen by the board of healing arts.

Sec. 2. As used in this act, unless the context requires otherwise:

(a) "Acupuncture" means a form of health care developed from traditional and modern Oriental medical concepts that employs Oriental medical evaluation and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance and restoration of health and the prevention of disease.

(b) "Board" means the state board of healing arts.

(c) "Committee" means the acupuncture review committee.

(d) "NCCAOM" means the national certification commission for acupuncture and Oriental medicine.

(e) "Practice of acupuncture" means the insertion of acupuncture needles into specific areas of the human body based upon Oriental medical theory as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include the warming, massage or electrical stimulation of these specific areas, the recommendation of dietary guidelines and therapeutic exercise based on traditional Oriental medical theory.

Sec. 3. (a) It is unlawful to practice acupuncture without a license pursuant to this act. This restriction does not apply to the following:

(1) ~~Other health care professionals practicing within the scope of their registration or license~~. A person licensed to practice the healing arts pursuant to K.S.A. 65-2803 and amendments thereto.

Kansas
Chiropractic
Association

TESTIMONY OF JAMES CROWL
LEGAL COUNSEL FOR THE
KANSAS CHIROPRACTIC ASSOCIATION
FEBRUARY 11, 1999

Chairperson Praeger and Members of the Committee. My name is Jim Crowl and I represent the Kansas Chiropractic Association. The KCA appreciates the opportunity to offer testimony in regard to SB 144.

Currently, acupuncture may be performed in Kansas by persons licensed by the Kansas State Board of healing Arts to practice the healing arts (medicine, osteopathy or chiropractic.) Each of these "licensees" is a doctor who is trained and authorized to examine, diagnose and treat the human living body.

On the other hand, most "registrants" of the healing Arts Board are not permitted to examine and diagnose the human living body. Furthermore, none are permitted to treat a patient without authorization from a "licensee." As you can see, "registrants" assist in a specialized part of a particular healing art with statutes placing their care under the direct supervision of a licensee.

Essentially, the two tier system is based on the higher education level, qualifications, and authority of licensees. In a final analysis, that is the separating factor and basis for having "licensure" for doctors and "registration" for mid-level practitioners.

SB 144 would dramatically change all that by doing two things. First it would allow non-doctor acupuncturists to perform acupuncture without any input from persons licensed to practice the healing arts. The Kansas Chiropractic Association opposes SB 144 on that basis. We do not feel it is in the public's interest to allow acupuncture treatment unless and until a proper examination and diagnosis has first been made by a qualified and licensed doctor.

The second major problem with SB 144 is that it extends "licensure" to acupuncturists. Not only is that contrary to all other statutes regarding mid-level practitioners, it would extend far greater privileges to acupuncturists than we think the Legislature intends.

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To illustrate the problem, I have attached 110 Kansas statutes which refer to persons "licensed by the Board of Healing Arts" or to persons "licensed to practice the healing arts." If SB 144 is passed in it's present form, all these statutes would then apply to acupuncturists. I doubt that was the intent of the bill's authors, and I doubt it would be the Legislature's intent.

If the Legislature feels that some type of legislative practice authorization for acupuncturists is absolutely necessary, the Kansas Chiropractic Association urges that the bill be amended to make acupuncturists "registrants" of the Kansas Board of Healing Arts and subject to the same type of treatment protocols required of all other mid-level practitioners.

I will be happy to answer any questions at the appropriate time.

The following Kansas statutes refer to a "licensee of the healing arts board," a person "licensed to practice the healing arts," or a person "licensed by the board of healing arts."

Statute # 7-121b
Chapter 7.--ATTORNEYS AT LAW
Article 1.--GENERAL PROVISIONS
Attorney fees in damage actions for acts or omissions of health care providers; approval; definitions.

Statute # 8-1,125
Chapter 8.--AUTOMOBILES AND OTHER VEHICLES
Article 1.--GENERAL PROVISIONS
License plates, placards and individual identification cards for persons with disability; penalty.

Statute # 8-1,130
Chapter 8.--AUTOMOBILES AND OTHER VEHICLES
Article 1.--GENERAL PROVISIONS
Falsely obtaining accessible parking identification; penalties.

Statute # 12-736
Chapter 12.--CITIES AND MUNICIPALITIES
Article 7.--PLANNING AND ZONING
Group homes, exclusion of, prohibited; conditions; definitions.

Statute # 12-5101
Chapter 12.--CITIES AND MUNICIPALITIES
Article 51.--REGULATION OF PROFESSIONAL BOXING AND WRESTLING MATCHES
Definitions.

Statute # 21-3721
Chapter 21.--CRIMES AND PUNISHMENTS
Article 37.--CRIMES AGAINST PROPERTY
Criminal trespass.

Statute # 22a-226
Chapter 22a.--DISTRICT OFFICERS AND EMPLOYEES
Article 2.--DISTRICT CORONERS
District coroner; qualifications; nomination; appointment; term; compensation; vacancies; oath; deputy coroners.

Article 14.--REPORTING ABUSE, NEGLECT OR EXPLOITATION OF CERTAIN PERSONS
Same; reporting abuse, neglect or exploitation or need of protective services; personsrequired to report; contents of report; posting notice of requirements of act; penalty for failure to report.

Statute # 39-1431
Chapter 39.--MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE
Article 14.--REPORTING ABUSE, NEGLECT OR EXPLOITATION OF CERTAIN PERSONS
Same; reporting abuse, neglect or exploitation or need of protective services; personsrequired to report; contents of report; penalty for failure to report.

Statute # 39-1501
Chapter 39.--MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE
Article 15.--ADULT FAMILY HOMES
Adult family homes; definitions.

Statute # 40-2,100
Chapter 40.--INSURANCE
Article 2.--GENERAL PROVISIONS
Insurance coverage to include reimbursement or indemnity for services performed by optometrist, dentist or podiatrist.

Statute # 40-2,101
Chapter 40.--INSURANCE
Article 2.--GENERAL PROVISIONS
No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act.

Statute # 40-2,111
Chapter 40.--INSURANCE
Article 2.--GENERAL PROVISIONS
Definitions.

Statute # 40-1126
Chapter 40.--INSURANCE
Article 11.--GENERAL PROVISIONS RELATIVE TO CASUALTY, SURETY AND FIDELITY COMPANIES
Reports by insurers of health care providers of any actions to state board of healing arts.

Statute # 40-12a01
Chapter 40.--INSURANCE

Article 12a.--MUTUAL INSURANCE COMPANIES ORGANIZED TO PROVIDE HEALTH CARE PROVIDER LIABILITY INSURANCE
Definitions.

Statute # 40-19c03
Chapter 40.--INSURANCE
Article 19c.--NONPROFIT MEDICAL AND HOSPITAL SERVICE CORPORATIONS
Organization; purposes; board of directors.

Statute # 40-2230
Chapter 40.--INSURANCE
Article 22.--UNIFORM POLICY PROVISIONS
Same; when reimbursement or indemnification required; deductibles, coinsurance and other limitations permissible.

Statute # 40-3103
Chapter 40.--INSURANCE
Article 31.--KANSAS AUTOMOBILE INJURY REPARATIONS ACT
Definitions.

(k) "Medical benefits" means and includes allowances for all reasonable expenses, up to a limit of not less than $4,500, for necessary health care rendered by practitioners licensed by the board of healing arts or licensed psychologists, surgical, x-ray and dental services, including prosthetic devices and necessary ambulance, hospital and nursing services; and such term also includes allowances for services recognized and permitted under the laws of this state for an injured person who relies upon spiritual means through prayer alone for healing in accordance with such person's religious beliefs.

Statute # 40-3202
Chapter 40.--INSURANCE
Article 32.--HEALTH MAINTENANCE ORGANIZATIONS
Definitions.

Statute # 40-3401
Chapter 40.--INSURANCE
Article 34.--HEALTH CARE PROVIDER INSURANCE
Definitions.

Statute # 40-3403
Chapter 40.--INSURANCE
Article 34.--HEALTH CARE PROVIDER INSURANCE

Health care stabilization fund, establishment and administration; board of governors, membership, organization, meetings, executive director and staff and general powers andduties; duties of commissioner of insurance; liability of fund; payments from fund; qualification of health care provider for coverage under fund, termination; liability of provider for acts of other providers; university of Kansas medical center privatepractice foundation reserve fund, establishment, transfers from; provider coverage options, election; eligibility of psychiatric hospitals and certain inactive providers for coverage; termination of fund liability for optometrists and pharmacists,purchase of coverage from fund for periods of prior compliance.

Statute # 40-3409
Chapter 40.--INSURANCE
Article 34.--HEALTH CARE PROVIDER INSURANCE
Service upon board of governors required in action filed in state for injury or death arising out of act or omission of health care provider; time for filing; effect of failure tomake service; notification of board of governors required in action filed outside of state; copy of petition involving certain health care providers forwarded to state board of healing arts; defense of action; costs; submission of certain information toboard of healing arts.

Statute # 40-3414
Chapter 40.--INSURANCE
Article 34.--HEALTH CARE PROVIDER INSURANCE
Qualification of health care provider or system as self-insurer; cancellation of certificate of self-insurance, grounds; payment of surcharge; Kansas soldiers' home, personsengaged in residency training and persons engaged in a postgraduate training program as self-insurers; health maintenance organizations and related groups; private practice foundations and faculty of university of Kansas Medical center.

Statute # 48-1601
Chapter 48.--MILITIA, DEFENSE AND PUBLIC SAFETY
Article 16.--NUCLEAR ENERGY DEVELOPMENT AND RADIATION CONTROL
Declaration of policy; construction of act.

Statute # 59-2946
Chapter 59.--PROBATE CODE
Article 29.--CARE AND TREATMENT FOR MENTALLY ILL PERSONS
Definitions.

Statute # 60-427
Chapter 60.--PROCEDURE, CIVIL
Article 4.--RULES OF EVIDENCE
Physician-patient privilege.

Statute # 60-513d
Chapter 60.--PROCEDURE, CIVIL

Article 5.--LIMITATIONS OF ACTIONS
"Health care provider" defined.

Statute # 60-2609
Chapter 60.--PROCEDURE, CIVIL
Article 26.--GENERAL PROVISIONS
Judgments in damage actions for acts or omissions of health care providers; installment or periodic payment of damages; contents and modification of judgment; "health care provider"defined.

Statute # 60-2801
Chapter 60.--PROCEDURE, CIVIL
Article 28.--SETTLEMENTS, RELEASES OR STATEMENTS
Settlement or release of liability; limitations; disavowal of agreement.

Statute # 60-2802
Chapter 60.--PROCEDURE, CIVIL
Article 28.--SETTLEMENTS, RELEASES OR STATEMENTS
Same; applicability of act.

Statute # 60-3412
Chapter 60.--PROCEDURE, CIVIL
Article 34.--PROFESSIONAL LIABILITY ACTIONS
Expert witnesses, qualifications.

Statute # 65-118
Chapter 65.--PUBLIC HEALTH
Article 1.--SECRETARY OF HEALTH AND ENVIRONMENT, ACTIVITIES
Reporting to local health authority as to infectious or contagious diseases; persons reporting; immunity from liability; confidentiality of information;disclosure.

Statute # 65-431
Chapter 65.--PUBLIC HEALTH
Article 4.--HOSPITALS AND OTHER FACILITIES
Rules and regulations; selection of professional staff; hospital compliance through combined operation.

Statute # 65-5a01
Chapter 65.--PUBLIC HEALTH
Article 5a.--CHILDREN WITH SPECIAL HEALTH CARE NEEDS
Definitions.

Statute # 65-669
Chapter 65.--PUBLIC HEALTH
Article 6.--FOOD, DRUGS AND COSMETICS
Same; drugs or devices deemed misbranded, when.

Statute # 65-6b01
Chapter 65.--PUBLIC HEALTH
Article 6b.--AMYGDALIN (LAETRILE)
Amygdalin (laetrile); definitions.

Statute # 65-1501a
Chapter 65.--PUBLIC HEALTH
Article 15.--REGULATION OF OPTOMETRISTS
Definitions.

Statute # 65-1940
Chapter 65.--PUBLIC HEALTH
Article 19.--LICENSURE OF ENTITIES BY STATE BOARD OF COSMETOLOGY
Licensure of tattooing and body piercing; definitions.

Statute # 65-2003
Chapter 65.--PUBLIC HEALTH
Article 20.--REGULATION OF PODIATRISTS
Examination for license to practice podiatry; licensure qualifications; license by endorsement; recognized school of podiatry, criteria.

Statute # 65-2006
Chapter 65.--PUBLIC HEALTH
Article 20.--REGULATION OF PODIATRISTS
Suspension, revocation or limitation of licenses and permits; grounds; consent to submit to mental or physical examination implied; professional incompetency and unprofessionalconduct defined; hearing procedure.

Statute # 65-2008
Chapter 65.--PUBLIC HEALTH
Article 20.--REGULATION OF PODIATRISTS
Exceptions to operation of act.

Statute # 65-2015
Chapter 65.--PUBLIC HEALTH
Article 20.--REGULATION OF PODIATRISTS
Civil fine for violation of podiatry act.

Statute # 65-2016
Chapter 65.--PUBLIC HEALTH
Article 20.--REGULATION OF PODIATRISTS
Review committee; establishment and appointment; qualifications; expenses.

Statute # 65-2801
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Purpose.

Statute # 65-2802
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Definitions.

Statute # 65-2803
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
License prerequisite to practice of the healing arts; exceptions; penalty.

Statute # 65-2809
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Expiration date of licenses; continuing education requirements; evidence licensee maintaining professional liability insurance; notice of expiration; fees; cancellation of license;reinstatement, when; exempt licensees; inactive license; federally active license.

Statute # 65-2811a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Special permits; issuance; conditions and qualifications; limitations on practice; expiration of permit.

Statute # 65-2812
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
State board of healing arts; membership; appointment.

Statute # 65-2813
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
State board of healing arts; qualifications of members.

Statute # 65-2833
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Endorsement licenses; requirements.

Statute # 65-2835
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Certificate of standing; application; fee.

Statute # 65-2836
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS

Revocation, suspension, limitation or denial of licenses; censure of licensee; grounds; consent to submit to mental or physical examination or drug screen, or any combination thereof,implied.

Statute # 65-2837
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Professional incompetency, unprofessional conduct, false advertisement and advertisement, license and licensee defined.

Statute # 65-2837a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Restrictions on prescribing, ordering, dispensing, administering, selling, supplying or giving certain amphetamine or sympathomimetic amine controlled substances; unprofessionalconduct.

Statute # 65-2839a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Investigations and proceedings conducted by board; access to evidence; subpoenas; access to criminal history; confidentiality of information.

Statute # 65-2840a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Disciplinary counsel; appointment; qualifications; duties; application for subpoenas; staff; rules and regulations.

Statute # 65-2846
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Costs of proceedings; assessment of costs incurred.

Statute # 65-2852
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Fees; collection by board.

Statute # 65-2857
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Injunction and quo warranto for unlawful practice of the healing arts.

Statute # 65-2863a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Administrative fines.

Statute # 65-2864
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Enforcement of act; investigations; evidence.

Statute # 65-2867
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Certain acts prohibited; exceptions; penalty.

Statute # 65-2872
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Persons not engaged in the practice of the healing arts.

Statute # 65-2873
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
License to practice healing arts by examination; prerequisites; postgraduate study; use of title and degree.

Statute # 65-2891
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Emergency care or assistance at scene of an emergency or accident by certain persons; liability; standards of care applicable; health care provider defined.

Statute # 65-2892a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Examination and treatment of minors for drug abuse, misuse or addiction; liability.

Statute # 65-2895
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Institutional license; qualifications; rights and restrictions; term of license.

Statute # 65-2897a
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS
Same; definitions.

Statute # 65-2898
Chapter 65.--PUBLIC HEALTH
Article 28.--HEALING ARTS

KMS

KANSAS MEDICAL SOCIETY

February 11, 1999

TO: Senate Public Health and Welfare Committee

FROM: Meg Draper
Director of Government Affairs

SUBJ: SB 144: Acupuncture

The Kansas Medical Society appreciates the opportunity today to testify on SB 144. This bill relates to the practice of acupuncture and would allow acupuncturists to receive a license in Kansas if they meet certain criteria. KMS does not support the bill as currently drafted.

SB 144 would make it illegal for individuals to practice acupuncture unless they are licensed pursuant to this law. The purpose of licensing a health care provider group is to ensure that the public is protected. Only licensed individuals may practice within a provider's designated scope of practice. However, this bill creates a rather broad scope of practice for acupuncturists, permitting them to use "adjunctive therapies and diagnostic techniques for the promotion, maintenance and restoration of health and the prevention of disease." This implies that acupuncturists could perform a wide variety of treatments on patients, even treatments beyond what acupuncturists are trained to do. Additionally, the bill establishes no minimum level of education, clinical training or competency for this group. All that is required is certification as a diplomate in acupuncture by a national certification commission, licensure in a comparable state, or five years of practice in Kansas. The American Academy of Medical Acupuncture is an organization of physician acupuncturists. These physicians receive a minimum of 200 hours of training in acupuncture. We are unclear as to the level of education or training that non-physician acupuncturists receive and believe that minimum education requirements should be codified to help ensure competence and to protect the public.

KMS also suggests that the legislature wait to grant licensure to acupuncturists until they have completed the credentialing process through the Kansas Department of Health and Environment. Kansas law requires all health care provider groups seeking to be credentialed or requesting a change in their level of credentialing to file an application with KDHE, which reviews the application and makes a recommendation as to whether the change is warranted. The legislature may use the recommendations in determining whether to grant licensure to acupuncturists.

Studies have shown that acupuncturists, along with other alternative care providers, may provide beneficial care for certain conditions. Many states recognize these types of providers through some level of certification, and it is not our opinion that acupuncturists should not be able to practice their profession in the state. However, as the number of alternative health groups seeking recognition in Kansas grows - this committee has already held hearings on another alternative group, naturopaths - KMS believes that the legislature should study the education and training of alternative providers as a whole before acting on this legislation.

Thank you very much for considering our comments.

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Senate Public Health and Welfare
Date: 2-11-99
Attachment No. 10

Classification of Complementary and Alternative Medical Practices

NIH Office of Alternative Medicine Clearinghouse

March 1997

This classification of complementary and alternative medical health care practices was developed by the ad hoc Advisory Panel to the Office of Alternative Medicine (OAM), National Institutes of Health (NIH).

It was further refined by the Workshop on Alternative Medicine as described in the report *Alternative Medicine: Expanding Medical Horizons*, published December 1994 (Government Printing Office).

This classification was designed to facilitate the grant review process and should not be considered definitive.

Alternative Systems of Medical Practice

Acupuncture
Anthroposophically Extended Medicine
Ayurveda
Community-Based Health Care Practices
Environmental Medicine
Homeopathic Medicine
Latin American Rural Practices
Native American Practices
Natural Products
Naturopathic Medicine
Past Life Therapy
Shamanism
Tibetan Medicine
Traditional Oriental Medicine

Bioelectromagnetic Applications

Blue Light Treatment and Artificial Lighting
Electroacupuncture
Electromagnetic Fields
Electrostimulation
and Neuromagnetic Stimulation Devices
Magnetoresonance Spectroscopy

Diet, Nutrition, Lifestyle Changes

Changes in Lifestyle
Diet
Gerson Therapy
Macrobiotics
Megavitamins
Nutritional Supplements

Herbal Medicine

Echinacea (Purple Coneflower)
Ginger Rhizome
Ginkgo Biloba Extract
Ginseng Root
Wild Chrysanthemum Flower
Witch Hazel
Yellowdock

Manual Healing

Acupressure
Alexander Technique
Aromatherapy
Biofield Therapeutics
Chiropractic Medicine
Feldenkrais Method
Massage Therapy
Osteopathy
Reflexology
Rolfing
Therapeutic Touch
Trager Method
Zone Therapy

Mind/Body Control

Art Therapy
Biofeedback
Counseling
Dance Therapy
Guided Imagery
Humor Therapy
Hypnotherapy
Meditation
Music Therapy
Prayer Therapies
Psychotherapy
Relaxation Techniques
Support Groups
Yoga

Pharmacological and Biological Treatments

Anti-Oxidizing Agents
Cell Treatment
Chelation Therapy
Metabolic Therapy
Oxidizing Agents (Ozone, Hydrogen Peroxide)