Approved: March 5, 2001
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 8, 2001 in Room 210 Memorial Hall

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Joan Golden, Chair, Vision 21st Century Initiative
Mary Blubaugh, MSN, RN, Executive Administrator, Kansas State Board of Nursing
Terri Roberts, J.D., R.N., Executive Director, Kansas State Nurses Association
Dr. Bill Wolff, Kansas Legislative Research Department

Others attending: See Attached Sheet

The Chairperson stated there would be a briefing on the Governor's Vision, 21st Century Task Force: Meeting the Challenge of Serving Special Care Kansans.

Joan Golden, Chair, Vision 21st Century Initiative, briefed the committee on the report given to the Governor on December 1, 2000, stating the Task Force recommends a collaborative care or one stop care for Kansans with special needs.

The objective is to create an integrated long-term system of care that improves access, choice, quality of care, quality of life and contains cost.

The guiding principles should insure the Collaborative or One-Stop program is: flexible and inclusive, promotes self-determination and consumer directed independence, easy to access, cost effective, outcomes based, with an emphasis on the quality of care and the quality of life (Attachment 1).

The Chairperson opened the hearing on **HB 2313 - Board of Nursing Regulatory Changes.**

Dr. Bill Wolff, Kansas Legislative Research Department, gave a briefing on **HB 2313** stating these were technical changes. "Accredited" is changed to "approved" throughout the bill.

Mary Blubaugh, Executive Administrator, Kansas State Board of Nursing, testified in support of **HB 2313** stating throughout the bill when there is reference to accreditation of schools or programs of nursing or mental health technicians, that language is changed to approval. The term approval is defined as "official or formal consent, confirmation or sanction". Approval refers to mandatory and legal recognition of a program to begin or to continue to operate by meeting essential standards (Attachment 2).

Terri Roberts, Executive Director, Kansas State Nurses Association, testified in support of **HB 2313**, stating that KSNA supports the updates and changes recommended by the Board of Nursing to the nurse practice act (Attachment 3).

The Chairperson closed the hearing on **HB 2313**.

Representative Long moved and Representative Wells seconded to approve the minutes of January 29, 30, 31 and February 1. The motion carried.

Dr. Bill Wolff, Kansas Legislative Research Department gave a briefing on credentialing (Attachments 4

& 5).

The meeting adjourned at 2:40 p.m. and the next meeting will be February 12.

HEALTH AND HUMAN SERVICES

DATE February 8, 2001

NAME	REPRESENTING
Janette Pucci	KSBN
Diane M Olson	KSBN
Mary Blubaugh	KSBN
JANE CONROY	KSBN BDM
Diane Okeson	KSBN BDM
KAREN Gilpin	KSBN BDM

VISION 21ST CENTURY

Presented to

Governor Bill Graves

December 1, 2000

Lt. Governor Gary Sherrer, Chairman

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VISION 21ST CENTURY INITIATIVE

Meeting the Challenges of Serving Special Care Kansans

Chair Joan Golden	Lawrence	Sr. VP, Firstar Bank
Vice Chair Kenneth Havner	Hays	Attorney, Havner & Brin; Former Member of the Board of Regents
Sherman Jones	Kansas City	Kansas State Senator
Patricia Lightner	Overland Park	Kansas State Representative
Clay Thompson	Salina	Realtor, Coldwell Banker Dean Whitter
Deborah Haltom	Overland Park	Director of Special Education, Shawnee Mission School District
E. LaVerne Epp	Lawrence	Secretary & General Council, Retirement Management Company
David Provorse	Topeka	Professor of Psychology, Washburn University
Jack Dalton	Dodge City	Attorney, retired

MEETING THE CHALLENGES OF SERVING SPECIAL CARE KANSANS

SUMMARY OF ISSUES

Kansas has long provided care for state residents with special needs. Historically that care has been provided primarily through institutional setting – nursing homes and large state hospitals. In the 1990s the state pursued a policy of shifting the focus of care from institutional settings to community settings. Two state hospitals were closed and significant amounts of money were shifted to support community programs.

Much of the non-institutional care is provided through Home and Community Based Service (HCBS) programs. These programs provide a variety of services that allow people to live in their own home or community. The services are not generally medical, but rather provide assistance to children and adults with various kinds of disabilities to accomplish routine daily living activities. 60 percent of HCBS program costs are paid for with federal Medicaid funds and 40 percent with state funds. The three main HCBS programs in Kansas serve the developmentally disabled, the frail elderly and the physically disabled.

Since the initiation of HCBS programs in Kansas the demand for these services and the program costs have skyrocketed. In Fiscal Year 1997 HCBS spending totaled $120 million, but by Fiscal Year 2000 total costs were approximately $275 million.

CHARGE TO THE TASK FORCE

The task force should review the current HCBS programs and gain an understanding of why demand and costs have escalated.

Are the right alternatives to institutional care being offered and are those alternatives cost effective? Are the people who need services the most getting services? What are the overhead costs of providing services?

Can the state afford the escalating costs, keeping in mind that the increases may come at a cost to other programs? Can some services be combined, restructured or eliminated so that existing resources can serve more people?

The task force should answer these questions and formulate a policy that can guide the state in serving special care Kansans. The committee should submit its report by December 1, 2000.

INTRODUCTION

When evaluating the spiraling cost of funding of the basic needs of persons encompassed within the population of *Special Care* Kansans, it is imperative to consider these factors:

1. Our society is living longer
2. Persons identified within the *Special Care* population are living longer.

A majority of persons with disabilities live with their families. The person receiving the care is outliving the caregiver.

The mean age of death of a person with developmental disabilities has grown from 19 years in the 1930s to 66 years in the 1990s.

The increasing number of persons constituting the *Special Care* population is growing at such a rate that the numbers of persons "in need" have expanded beyond a level manageable by the state and federal government. More numbers of persons require a greater demand upon a finite source of funds.

To meet this challenge, we recognize that to adequately meet the needs of this *Special Care* population," it will require the commitment of families and private sources within the community to meet the needs of persons eligible for such funds.

With this in mind, the Task Force recommends: **Collaborative Care or One Stop Care for Kansans with Special Needs**

The objective is to create an integrated long-term system of care that improves access, choice, quality of care, quality of life and contains cost.

The guiding principles should insure the Collaborative or One-Stop program is:

- flexible and inclusive;
- promotes self-determination and consumer directed independence
- easy to access
- cost effective
- outcomes based, with an emphasis on the quality of care and the quality of life.

RECOMMENDATION: ONE STOP COORDINATION OF CARE

A. Create (or utilize existing entities) a central agency to administer all services for Special Care Kansans.

Rationale for part A:

These can be regional based on population needs and could follow the mental health or CDDO models. Members would be appointed by the county governments to oversee the collaboration among the various state and local agencies to create One Stop for assessment/coordination. This new entity would broker or contract services with area providers. (This removes conflict of interest with case management). The current level of HCBS funding

would flow through this new entity for local distribution. New funding opportunities should be explored through insurance reform. For example: annuitize life insurance policies or develop a model for long term health insurance. New ways to incent public and private partnerships should be studied to encourage shared costs in the future.

B. Eligibility would be based on the individual's need and their ability to pay.

Rationale for part B:

Each of the HCBS waivers has different criteria when evaluating the impairment or disability. Each Special Care Kansan should be evaluated equally. If they need assistance in their home, for example, the amount of time and level of care would be tiered according to need. Loopholes that preclude assistance from families that have the ability to pay for the care, which is needed by their family member, should be closed.

C. The Task Force encourages the utilization of existing technology to enhance or deliver service and/or knowledge to outlying areas of our state.

Rationale for part C:

This will provide equitable access to appropriate services throughout the state. Currently, there is technology in place that allows diagnosis to be made at the KU Med Center for a clinic in western Kansas. Or interactive classroom discussions can be broadcast to other parts of the state. Models for recruitment, training and retention of the workforce and volunteers should be created. Finding and retaining personnel is one of the major concerns among all the service providers.

D. Improve the state's HCBS' database to provide demographic information, improve future predictability of impact to the system, and measure outcomes.

Rationale for part D:

This will insure the proper allocation of funds for the consumer and assist the state government in the budgeting process. Through outcomes measurement, the quality of care by the providers and the quality of life for consumers can be monitored.

E. The State should increase Public Awareness with a public relations and marketing campaign

Rationale for part E:

This will increase private funding and public support of area providers. Individual planning for long term care will take on new importance. This could be achieved through a five-year plan.

CONCLUSION

The House Social Services Budget Committee requested the Kansas Department on Aging (KDOA) and the Department of Social and Rehabilitation Services (SRS) to convene several meetings of stakeholders. The purpose was to make recommendations on the definitions

of "needs" vs. "wants" of consumers, served by the Home and Community Based Services waiver, to the Committee prior to the veto session in late April 2000.

The KDOA meeting identified these top five priorities:

1. Availability of attendant care services
2. Increased hours of case management services
3. Operation of the Waiver in a "risk sharing fashion" in order to allow services to be provided for consumers, even when the state cannot provide all such needed services
4. Flexible, available funding for a variety of services
5. Incentives that encourage provider availability in rural and urban areas.

The findings of the SRS meetings reported:

1. Needs and Wants are individually defined for each consumer and family
2. Flexibility is necessary
3. Consumer "choice" and consumer-driven "plans of care" are central to disability service delivery
4. Better tools to help define needs should be identified, tested and put into practice.
5. Paid family supports should be realistic
6. The current level of services should not be reduced

Therefore, "One Stop Coordination of Care" proposed in this recommendation to address the needs of *Special Care* Kansans, is a collaboration between multiple provider organizations to form a single, integrated service delivery system. The model utilizes a community-up design strategy, building an integrated service delivery system around the target population through the provider structure that exists within the defined service area. It allows the flexibility necessary to accommodate changing community needs, recognizing that one size does not fit all.

Each "One Stop Care" entity will be distinct in its organization, adjusting the collaboration as necessary to meet the changing needs of *Special Care* Kansans. Participating organizations could be: an Area Agency on Aging, Skilled and Basic-care Nursing Facilities, Local Health Departments, Home Health agencies, Community Mental Health services programs, assisted living residences, Community Developmental Disability Organizations, Centers for Independent Living, and others as deemed appropriate.

It is anticipated that the model will maximize the inclusion of individuals with disabilities and the elderly in all aspects of community living. Because it is community based, it is intended to be particularly consumer driven and community supported in its design, implementation and ongoing quality improvement. An expected outcome is that consumers will have extensive opportunities to be woven into the total fabric of the community--including its social, recreational, spiritual, vocational and other contributory areas of life, in addition to health care services and supports.

Since this plan is community based, it provides maximum opportunity to be constructed in a way that reflects and is sensitive to local cultural, economic and demographic profiles. It offers the opportunity for providers who have historically served these individuals and their families, with commitment and understanding, to help shape the new environment through responsible system administration and management. This will require new ways of thinking and doing business for these entities. But, it offers a leadership role for those willing and capable of

collaborating to create and align themselves differently with "**One Stop Coordination of Care" for *Special Care* Kansans.**

Federal and private resources could be used to implement this recommendation as a "phased in" or pilot process.

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To: Representative Gary Boston, Chair
Representative Jim Morrison, Vice-Chair
Members of the Health and Human Services Committee

From: Mary Blubaugh MSN, RN
Executive Administrator
Kansas State Board of Nursing

Date: February 8, 2001

Re: House Bill 2313

Good afternoon Representative Boston, Representative Morrison, and members of the Health and Human Services Committee. Thank you for the opportunity to appear before you today. My name is Mary Blubaugh and I am the Executive Administrator of the Kansas State Board of Nursing. I am here on behalf of the Board Members to offer testimony for the support of House Bill 2313.

Though out this bill, when there is reference to accreditation of schools or programs of nursing or mental health technician, that language is changed to approval. The term approval is defined as "official or formal consent, confirmation or sanction". Approval refers to mandatory and legal recognition of a program to begin or to continue to operate by meeting essential standards.

The term accreditation is defined as "recognition of an institution of learning as maintaining prescribed standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice. National Council of State Board of Nursing defines accreditation (see attachment A) as "the official authorization or status granted by an agency other then a state board of nursing. Accreditation is generally considered a voluntary process that focuses on program excellence and is conducted by peers.

The amendments to 65-1115, 65-1116, and 65-4203 provides a clear list of the qualifications an applicant for professional nurse, practical nurse, and mental health technician must meet to be issued a license. This language basically clarifies that the applicant will pass a written test and deletes the language that the examination may be supplemented by an oral or practical examination. These amendments also list and clarify the requirements for an applicant who does not take or is unsuccessful in passing the examination within 24 months of graduation. In both cases the applicant must petition the board for permission to sit for the examination and the board may require the

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applicant to submit and complete a plan of study. This provision assists the applicant to pass the examination.

65-1119 and 65-1133 will allow the board of nursing to extend the approval of schools of nursing and educational program for advance registered nurse practitioners for a period not to exceed 10 years after granting the approval. Deleted from these regulations is the statement "from time to time, as deemed necessary by the board, it shall cause to be made a resurvey of accredited schools and written reports of such resurveys submitted to the board. The replacement for this statement is "the board shall resurvey approved schools on a periodic basis as determined by rules and regulations. Additions to these statutes goes one step further to allow the board of nursing to accept nationally accredited schools of nursing, and if these schools files evidence of accreditation the board may grant approval not to exceed 10 years. If the schools of nursing hold approval based on national accreditation they are also responsible to comply with all other requirements as determined by rule and regulation. Allowing the Board to review and accept school accreditation by a nationally recognized nursing accreditation agency will reduce the duplication of the same process for the nursing schools for approval and renewal of their approval. The Board supports the change in the number of years of approval from 5 to 10 years as several accreditation agencies give the accreditation for 10 years.

With the passage of HB 2169 in the 2000 session, the requirement for one year clinical experience prior to being admitted to an Intravenous Fluid Therapy course was deleted except for (c) (2) in KSA 65-1136.

In summary, HB 2313 contains a number of changes that clarifies or updates current statutory language. The Board has responded to the needs of the nursing community while considering the safety issues of the public. I ask that the committee pass HB 2313 out favorably.

Thank you and I will stand for questions at this time.

Position Paper Related to Use of Terms *Approval* and *Accreditation*

The right to practice a profession or discipline is protected by the U.S. Constitution. The Constitution also states that a state may regulate a profession or occupation that affects general welfare. Nursing is a profession that makes an impact on general welfare and is, therefore, subject to regulation by the state. Language in state nurse practice acts and rules and regulations, however, has not been consistent in differentiating between mandated, legal processes and voluntary, quality-assurance processes, as related to the regulation of nursing education programs. A review of the nurse practice acts and rules and regulations of the 61 Member Boards of the National Council of State Boards of Nursing (NCSBN) indicates that most state boards of nursing use the term *approval* to describe oversight of nursing education programs. Some boards use the term *accreditation*, and a few boards use both terms interchangeably. The purpose of this position paper is to differentiate between the terms *approval* and *accreditation* as they describe a state regulatory body's role and responsibility in nursing education programs.

The term *approval* is defined as "official or formal consent, confirmation or sanction" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *approval* is defined as "official recognition of nursing education programs which meet standards established by the board of nursing" (NCSBN, 1994, p. 2). Implied in approval is permission to carry out an act, in this case, the operation of a nursing education program. In the regulatory arena, approval refers to mandatory and legal recognition of a nursing program to begin and/or continue to operate. Graduation from an approved program is necessary for a student to be eligible to take the NCLEX® examination for registered nurses or licensed practical/vocational nurses.

Approval also requires compliance with essential educational standards to protect both the students who are enrolled in the program and the public who will receive nursing care from the graduates of the program. Participation by regulatory bodies in the approval process is congruent with their legal responsibility.

The term *accreditation* is defined as "recognition of an institution of learning as maintaining prescribed standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *accreditation* is defined as "the official authorization or status granted by an agency other than a state board of nursing" (NCSBN, 1994, p. 2). Inherent in the accreditation process is evaluation by peers (Bogue & Saunders, 1992).

Whereas approval is a mandatory process related to permission for an education program to begin and continue operating by meeting essential educational standards, accreditation is generally considered a voluntary process that focuses on program excellence. In addition, approval processes (initial and continuing) are generally carried out by governmental agencies while accreditation is conducted by peers.

Both approval and accreditation are important components in the successful operation of nursing education programs designed to protect the public and provide appropriate educational experiences for future nurses. Thus, it is important that boards of nursing review their state Nurse Practice Acts and Rules and Regulations to ensure that terminology is consistent with the inherent differences between the terms *approval* and *accreditation*.

References

1. American Heritage Dictionary. (1993). Houghton Mifflin Co.: Boston.
2. Bogue, E.G. & Saunders, R.L. (1992). The evidence for quality: Strengthening the tests for academic and administrative effectiveness. San Francisco: Jossey-Bass Publications.
3. National Council of State Boards of Nursing. (1994). Model Administrative Rules. Chicago: NCSBN.

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February 8, 2001

H.B. 2313 NURSE PRACTICE ACT CHANGES

Representative Gary Boston and members of the House Health and Human Services Committee, my name is Terri Roberts J.D., R.N. and I am the Executive Director of the KANSAS STATE NURSES ASSOCIATION (KSNA), the professional organization for registered nurses.

KSNA supports the updates and changes recommended by the Board of Nursing to the nurse practice act.

- The changes proposed in KSA 65-1115 (RN), 65-1116 (LPN) *License sections* more accurately reflect the process that the agency goes through in determining the appropriateness of the qualifications of applicants for licensure.

- On page 8 of the bill there is new language proposed in KSA 65-1119 (g) (and again on page 11 new (d) for ARNP programs) that will permit the Board to recognize national accreditation of schools of nursing in lieu of Board of Nursing program review, and this should reduce the duplication that programs now experience when participating in the BON approval/renewal process. The time frame for approval is being expanded from 5 years to 10 years, and this too will reduce the agency's workload, while still ensuring quality programs for nursing preparation.

- We are very proud of the fact that all of the RN programs in Kansas have been accredited by either the National League for Nursing (NLN) or the Commission on Collegiate Nursing Education (CCNE). We are one of the few states where 100% of our RN programs have received voluntary recognition by one of the two nationally recognized nursing education accrediting agencies.

Thank you for considering these proposed changes. On behalf of the nursing profession, we respectfully ask for your support.

Thank you

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65-5001

Chapter 65.--PUBLIC HEALTH
Article 50.--CREDENTIALING

65-5001. Credentialing health care personnel; definitions. As used in this act unless the context requires otherwise, the following words and phrases shall have the meanings respectively ascribed to them herein:

(a) "Credentialing" or "credentialed" means the formal recognition of professional or technical competence through the process of registration, licensure or other statutory regulation.

(b) "Certification" means the process by which a nongovernmental agency or association or the federal government grants recognition to an individual who has met certain predetermined qualifications specified by the nongovernmental agency or association or the federal government.

(c) "Registration" means the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

(d) "Licensure" means a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful.

(e) "Health care personnel" means those persons whose principal functions, customarily performed for remuneration, are to render services, directly or indirectly, to individuals for the purpose of:

(1) Preventing physical, mental or emotional illness;

(2) detecting, diagnosing and treating illness;

(3) facilitating recovery from illness; or

(4) providing rehabilitative or continuing care following illness; and who are qualified by training, education or experience to do so.

(f) "Provider of health care" means an individual:

(1) Who is a direct provider of health care (including but not limited to a person licensed to practice medicine and surgery, licensed dentist, registered professional nurse, licensed practical nurse, licensed podiatrist, or physician's assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including medical care facilities, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

(2) who holds a fiduciary position with, or has a fiduciary interest in, any entity described in subsection (f)(3)(B) or subsection (f)(3)(D) other than an entity described in either such subsection which is also an entity described in section 501(c)(3) of the internal revenue code of 1954, as amended and supplemented, and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals or the production of drugs or articles described in subsection (f)(3)(C);

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(3) who receives, either directly or through a spouse, more than 1/5 of such person's gross annual income from any one or combination of the following:

(A) Fees or other compensation for research into or instruction in the provision of health care;

(B) entities engaged in the provision of health care or in such research or instruction;

(C) producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care; or

(D) entities engaged in producing drugs or such other articles;

(4) who is a member of the immediate family of an individual described in subsection (f)(1), (f)(2) or (f)(3); or

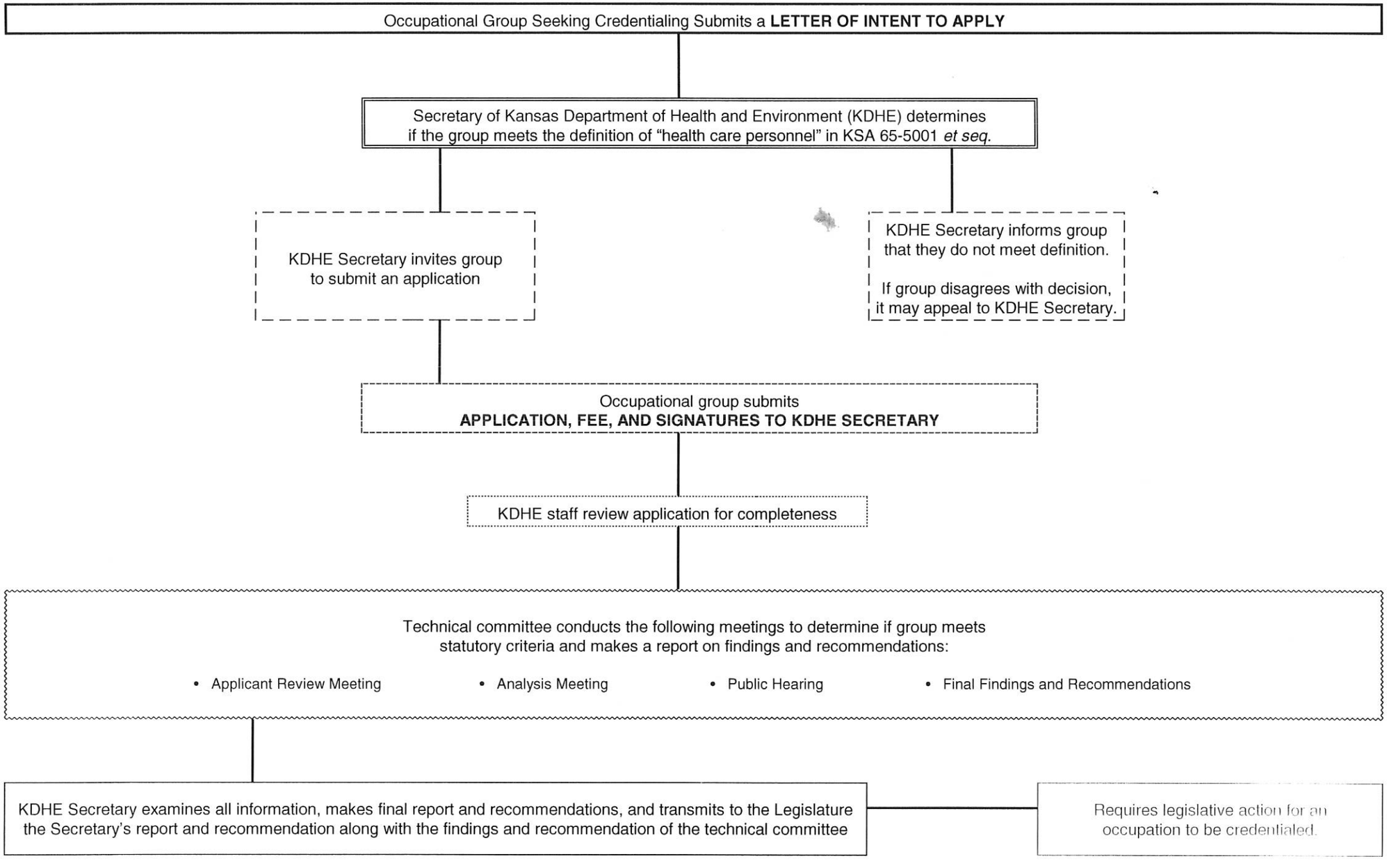
(5) who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits. An individual shall not be considered a provider of health care solely because the individual is a member of the governing board of an entity described in subsection (f)(3)(B) or subsection (f)(3)(D).

(g) "Consumer of health care" means an individual who is not a provider of health care.

(h) "Secretary" means the secretary of health and environment.

History: L. 1980, ch. 181, § 1; L. 1986, ch. 246, § 1; L. 1987, ch. 232, § 2; L. 1988, ch. 246, § 22; July 1.

CREDENTIALING REVIEW PROGRAM



SOURCE: Kansas Department of Health and Environment