Approved: May 10, 2002
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE.

The meeting was called to order by Chairperson Senator Susan Wagle at 1:30 p.m. on February 20, 2002 in Room 231-N of the Capitol.

All members were present except:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Lisa Montgomery, Revisor of Statutes
Ms. Margaret Cianciarulo, Administrative Assistant

Conferees appearing before the committee: Mr. Paul Silovsky, Legislative Chairman for KS Physical Therapist Association
Mr. Chukuka Enwemeka, Physical Therapist, PHD, FACMS
Ms. Alice Mounger, Consumer
Ms. Judy Hensley, Physical Therapist
Ms. Diane Gough, Consumer
Ms. Connie Kelley, Consumer
Ms. Mary Ann Palmer, Consumer
Ms. Rebecca Rice, Legislative Council for KS Chiropractic Association

Others attending: See attached guest list.

Hearing on SB583 - an act relating to physical therapy; concerning physical therapists

With the call to order, Chairperson Wagle announced that before the hearing, Ms. Emalene Correll, Kansas Legislative Research Department, would present a brief overview of the bill. The highlights of Ms. Correll's overview were: explaining the definition, raising the flag on therapeutic exercise, manual therapy, subsection d moved from current law, Sec. 2 amends the current act, line 12 on page 3 affecting small rural hospitals and adult care homes who may have been consulting physical therapists, making it a crime if misuse of the letters in PT, and broadens the scope of practice (but some other people do these things, so this does limit too PT's only).

As there were no questions of Ms. Correll, Chairperson Wagle recognized Mr. Paul Silovsky, Legislative Chairman for the Kansas Physical Therapist Association. Mr. Silovsky testified that the bill does two things in a clearly defined manner: 1) updates what the term and practice of physical therapy means today and a clarification of how physical therapy is currently practiced in the state of Kansas; and 2) makes it unlawful to use in connection with a person's name or business activity the term's physical therapy and physiotherapy or any other words or abbreviations indicating or implying that the physical therapy is provided or supplied, unless these services are provided by or under the direction of a physical therapist registered pursuant to this act.

Mr. Silovsky also pointed out that the bill does not do the following: 1) limit any other provider's scope of practice or delivery of their professional services, so long as they do not represent those services to the public as physical therapy without being provided by or under the direction of a physical therapist; 2) change the level of credentialing; and 3) change the status of physical therapists as dependent practitioners. A copy of his testimony and Mr. Bud Langston's written testimony is (Attachment 1) attached hereto and incorporated into the Minutes by reference. Mr. Langston is Chairman, Department of Physical Therapy.

Chairperson Wagle then recognized Mr. Chukuka Enwemeka, Physical Therapist, PHD, FACMS, who stated that the bill brings the practice of physical therapy in line with contemporary physical therapy education. He also provided an attachment, an excerpt from the Handbook for Accreditation of Physical Therapy Education, detailing the scope of physical therapy education including: screening, evaluation and diagnosis for physical therapy, in order to derive a prognosis and a plan of care. A copy of his testimony and attachment is (Attachment 2) attached hereto and incorporated into the Minutes by reference.

The next proponent to come before the Committee was Ms. Alice Mounger, a health care consumer, who supported the bill to protect the term "Physical Therapy" to describe the services provided only by a Physical Therapist or a Physical Therapist Assistant, under the direction and supervision of a Physical Therapist. A copy of her testimony is (Attachment 3) attached hereto and incorporated into the Minutes by reference.

Ms. Judy Hensley, physical therapist, was the next proponent, who began her testimony stating she represents the Kansas Physical Therapy Association as a specialist in the area of manual physical therapy and provided her qualification. She provided: the definition of manual therapy stating that the two words are also the CPT code used for charging these services; facts from literature supporting the use of manipulation dating back too 1928; a report regarding the safety of physical therapists; and information from the Rand Corporation to dispute the issue rose by the Kansas Chiropractors Association. A copy of her testimony and written testimony from Ms. Julie Hershey Downes is (Attachment 4) attached hereto and incorporated into the Minutes by reference.

Next to testify in support of the bill was Ms. Diane Gough, a consumer, who supported the bill stating it should pass in order to ease the advisability of physical therapy to the public. A copy of her testimony is (Attachment 5) attached hereto and incorporated into the Minutes by reference.

The next to testify is Ms. Connie Kelley, a consumer, who stated that the current laws are too laxed, leading to misrepresentations that confuse consumers regarding the specific qualifications of individual therapists. A copy of her testimony is (Attachment 6) attached hereto and incorporated into the Minutes by reference.

Ms. Mary Ann Palmer, a consumer, was next to testify. Ms. Palmer stated that she finds it rather confusing when she sees advertising by a massage therapist stating that they offer physical therapy as one of their services. A copy of her testimony is (Attachment 7) attached hereto and incorporated into the Minutes by reference.

Last to testify as a proponent, but providing no written testimony, was Ms. Pam Palmer, physical therapist, who stated this bill is not to limit scope of practice and that PT is not a generic term.

As there was no more proponent testimony, Chairperson Wagle recognized Ms. Rebecca Rice, Legislative Counsel for the Kansas Chiropractic Association, who stated that they would be addressing only those parts of the proposed legislation which appear to impact chiropractic care, in particular, the chiropractic scope of a practice statute. She proposed the following amendments with the understanding that other healthcare providers should also be included in these amendments, but KCA does not presume to speak for them. The amendment proposed to insert: 1) after manual therapy; therapeutic massage "but not adjustment of misplaced tissue or manipulation"; after medicine and surgery "and the practice of the chiropractic; after act "or is a licensed chiropractor"; and after act "or is a licensed chiropractor". A copy of her testimony is (Attachment 8) attached hereto and incorporated into the Minutes by reference.

As there was no further testimony, the hearing was open up for questions and/or comments. A healthy discussion involving Senators Brungardt, Wagle, Praeger, Salmans, Ms. Correll, Ms. Rice, and Mr. Silovsky covered issues from chiropractic exclusions, concerns over validity of subscribers, CPT's, not seeing conflict of putting a name to practice, consumer concerns, will it limit in rural areas for practices currently under way, to PT assistant in communication with PT. Ms. Rice did reiterate that KCA did not want to strike anything, they only wanted to include chiropractors.

Chairperson Wagle did ask that Ms. Rice and Mr. Steve Kearney, representing Kansas Physical Therapists Association work together on some language change. Mr. Kearney did state that the intent of KPTA was also not to limit.

Adjournment

Adjournment time was at 2:35 p.m.

The next meeting is scheduled for February 21, 2002.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

42 in att

GUEST LIST

DATE: Wednesday, Feb 20, 2002

NAME	REPRESENTING
Patricia Schack	KU School of Social Work
Sallie Chapin	KU School of Social Welfare
STEVE KEARNEY	KPTA
Chris Collins	KMS
Mark Stafford	Bd of Healing Arts
Shannon Segraves	KU School of Social Welfare
Shanna VanTuyl	KU school of Social Welfare
PHIL HURLEY	PAT HURLEY & Co.
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
[illegible]	KS PTA
Judy Hensley	KPTA
Chukuka Enwemeka	KPTA
Alice Mounger	KPTA
Glenn Linden	University of KS - Social Welfare
[illegible]	Conlee Consulting
Mark Dwyer	KS PHYSICAL THERAPY ASSOC. (KPTA)
Chip Wheeler	Osteopathic Association
Rebecca Z [illegible]	KS Chiropractic Assn.
Mary J Hughes	KU-MSW
Janie Ann Rower	KAHP
Stephanie Neal	KS Governmental Consulting

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

GUEST LIST

DATE: Wednesday, Feb 20, 2002

NAME	REPRESENTING
Connie L. Kelley	Public
Diane Gough	Public
Mary Ann Palmer	Consumers
Kris Baird	Kansas Physical Therapy Ass'n
Daryl Menke	Physical Therapist
Marla Rhoden	KDHE/HOC
Marsha Ryan	KDHE/HOC
Lesa Roberts	KDHE
Christina Whitehorn	University of Kansas (Social Welfare Student)
Natalie Peterson	KU School of Social Welfare
Stephanie Utzel	University of Kansas Social welfare student
Catherine Denning	University of Kansas Social Welfare student
Mel Childs	"
Ginny Ramsayer	"
Maureen Seferovich	"
Tom Brewer	Ks Athletic Trainers Society
Allison McLain	KU School of Social Welfare
Glenda M Fowler	" "
Rebecca Adams	KU school of social welfare

February 20,2002

Kansas Physical Therapy Association
Paul Silovsky PT
Legislative Committee Chair
216 SW 6th Street
Topeka, Kansas 66603

Chairman Wagle and members of the Public Health and Welfare Committee, thank you for the opportunity to appear before you and offer testimony in regard to SB 583. I represent the Kansas Physical Therapy Association as the Legislative Committee Chair and a Physical Therapist in private practice here in Topeka.

I urge your support of SB 583 as it relates to the current practice of physical therapy and the public's perception of who is qualified to deliver "physical therapy" services in the state of Kansas. I wish to outline for you the desired intent and result of this proposed legislation. **SB 583 does two things in a clearly defined manner**.

1. This bill updates what the term and practice of physical therapy means today. This bill is a clarification of how physical therapy is currently practiced in the state of Kansas.
2. This bill also makes it unlawful to use in connection with a person's name or business activity the terms physical therapy and physiotherapy or any other words or abbreviations indicating or implying that physical therapy is provided or supplied, unless these services are provide by or under the direction of a physical therapist registered pursuant to this act.

It is important to point out that this bill does not do the following;

1. Limit any other provider's scope of practice or delivery of their professional services, so long as they do not represent those services to the public as physical therapy without being provided by or under the direction of a physical therapist.
2. Change the level of credentialing for the profession of physical therapy.
3. Change the status of physical therapists as dependent practitioners.

You will hear testimony today from members of the public who strongly feel that when physical therapy is indicated by their physician as a prescribed mode of treatment, that they should be assured by law that physical therapy care is in fact provided by or under the direction of a physical therapist registered in the state of Kansas. Many members of the public and medical community are currently deceived by the perception that they are paying for and receiving physical therapy services, when in fact they have never even seen or never been evaluated and treated by a physical therapist.

You will also hear from a Physical Therapy educator as to the requirements for and the education provided by, the curriculum within Physical Therapy education today. This training and education clearly defines the practice of physical therapy and fully supports

Senate Public Health + Welfare Committee
Date: February 20, 2002
Attachment 1

the scope of practice as defined in this bill. Passage will assure the people of Kansas that only individuals who have successfully completed this comprehensive physical therapy education are providing physical therapy services.

You are likely to hear opposing testimony with regard to our proposed language describing what the "practice of physical therapy" means. Previously debated topics such as "manual therapy" and "diagnosis for physical therapy" will be of potential concern for our opponents. The proposed language in SB 583 reflects current practice patterns in Kansas, the Model Practice Act for Physical Therapy, and simply updates the physical therapy practice act to reflect how physical therapy is practiced today. This legislation in no way limits or redefines other professional's scope of practice.

Briefly stated a "diagnosis for physical therapy" is not a medical diagnosis nor are we attempting to portray this within our practice act. By education, and now by practical and legal necessity, physical therapists, prior to making patient management decisions, must come to a conclusion (a diagnosis for physical therapy) regarding the patient's specific condition for which they will be providing physical therapy intervention. Previously established diagnoses from other health practitioners are helpful and should always be considered but cannot provide the sole basis for decisions regarding physical therapy management. A diagnosis from another referral source, even the definitive diagnosis, does not rule out a physical therapist's responsibility to arrive at a diagnosis specific to the condition for which the therapist's treatment plan and intervention will be directed.

Quite simply, the practice of physical therapy is not physical therapy unless it is provided by or under the direction of a physical therapist. Physical therapy is not a generic term and should not be presented to the public as such (*Pennsylvania Supreme Court ruling, April 20,1999).* I urge passage of this bill for the protection of the people of Kansas.

I would be happy to address any questions at this time.

February 19, 2002

Madame Chairperson
and Members of the Senate Committee on Public Health and Welfare:

My name is Bud Langston and I am presenting testimony in support of Senate Bill #583.

Over the preceding 40+ years I have, as a consumer, had an opportunity to utilize therapeutic services related to symptoms resulting from a spinal cord injury. These therapies have involved orthopedics, neurosurgical procedures, chiropractic, physical therapy and occupational therapy. While all of these areas of medical expertise are directed toward curing and relieving maladies their specific applications are quite **separate and distinct**. I am a consumer out of need due to severe trauma and I would certainly know that I would not seek a Doctor of Chiropractic Medicine for neurosurgical procedures. I would make the appropriate choice of service providers through their titles.

While many areas of medicine have protected terminology or terms, the term "physical therapy" is quite broadly used in the profession and could be misleading to the consumer. When an individual reads the term "Physical Therapy" the conclusion may be drawn that this is provided by a Physical Therapist. In all too many cases this is not true. The wording in Senate Bill #583 provides language that would aid consumers in receiving the appropriate care through the appropriate source. I support the language that provides physical therapy services are to be provided by appropriately trained and registered Physical Therapists only.

While this restricts, or protects the term "physical therapy", it does not restrict the application of other professionals in the medical field of applying their expertise and training. It only allows for clarification of services through clear terminology.

The language in Senate Bill #583 no way restricts the provision of services by other professionals, but does clarify the term "physical therapy" and who provides this service.

February 20, 2002

Kansas Physical Therapy Association
Chukuka S. Enwemeka, PT, PhD, FACSM
Professor & Chairman
Department of Physical Therapy & Rehabilitation Sciences
University of Kansas Medical Center
Kansas City, KS 66160

Chairman Wagle and members of the Public Health and Welfare Committee, I thank you for the opportunity to appear before you and to offer testimony concerning SB 583. I stand before you on behalf of the Kansas Physical Therapy Association as a Professor of Physical Therapy and Rehabilitation Sciences with more than twenty years of academic and clinical experiences.

I strongly urge you to support SB 583 as it brings the practice of physical therapy in line with contemporary physical therapy education. As detailed in the attached except from the Handbook for Accreditation in Physical Therapy Education, the scope of physical therapy education includes: screening, evaluation, diagnosis for physical therapy, in order to derive a prognosis and a plan of care.

Contemporary physical therapy education includes didactic course work, laboratory practica, and clinical experiences designed to prepare graduates to perform all the skills detailed in the attached document, including screening, evaluation and diagnosis for physical therapy. No physical therapy education program is accredited unless the curriculum is comprehensive and covers every topic detailed in the Accreditation Handbook.

Thanks again for the opportunity to appear before you. I would be most pleased to address any questions now.

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 2

2.7.3. The program has, or has access to, space for core faculty to fulfill their role as scholars.

Core faculty are expected to contribute to the scholarship of the profession and to be viable academicians. They therefore must have access to adequate space that is appropriate for their research or other scholarly needs. Space in which to conduct research activities approved by the program and institution is available to meet the needs of the core faculty.

2.8. Equipment and Materials

2.8.1. The program has, or has use of, equipment and materials necessary to meet the goals and objectives of the program.

Supplies and equipment are available and in good repair and safe operating condition for: laboratory experiences; teaching; research; and supportive activities, such as preparation of instructional materials, correspondence, administrative materials, and special projects. The program is responsible for assuring that these supplies and equipment are reflective of contemporary practice in physical therapy, are sufficient in amount, and are available when needed.

2.8.2. The program has, or has use of, equipment and materials for core faculty to fulfill their role as scholars.

Core faculty are expected to contribute to the scholarship of the profession and to the mission of the institution. They therefore must have adequate equipment and materials that are appropriate for their scholarly needs. In addition, technological support and equipment are adequate to meet the needs of the core faculty to conduct research and other scholarly activities approved by the program and institution.

SECTION 3: CURRICULUM DEVELOPMENT AND CONTENT

Preamble

A curriculum is a plan for learning, designed by the program faculty in consultation with practitioners and members of communities of interest, to achieve explicit educational goals and objectives for preparation of a physical therapist. In addition to preparing practitioners, one goal of physical therapy education is to build on the liberal education of the student by incorporating the concepts of responsible citizenship into the professional curriculum. The curriculum sets forth the knowledge, skills, attitudes, and values needed to achieve these goals.

The professional program is built on a foundation of liberal arts, and social and basic sciences. Course work within the professional curriculum includes a balance of foundational and clinical sciences; critical inquiry; clinical practice; and studies of society, health care delivery, and physical therapy practice. The educational philosophy and values of the institution, the program, and the individuals who teach in it and the knowledge of and beliefs about learning are central aspects of the curriculum.

The educational outcomes are entry-level and are based on practice expectations that are congruent with and reflect current physical therapy practice, emerging trends in health care delivery, and advances in physical therapy theory and technology.

3.1. Core faculty assume primary responsibility for curriculum development with input from all program faculty as well as from students enrolled in the program.

Curriculum development is the responsibility of the core faculty. The core faculty develop the curriculum using information about the contemporary practice of physical therapy; standards of practice; and, current literature, documents, publications and other resources related to the profession, physical therapy professional education, and educational theory. Input from program faculty, the clinical community, and students is utilized in this development process.

3.2. There is a formal curriculum plan.

The curricular plan developed by the faculty is documented and includes the components listed below.

3.2.1. The curriculum plan states the philosophy and the principles and values of the program and reflects the nature of professional education in physical therapy.

There is a formal statement of the philosophy, principles, and values on which the curriculum plan is based.

3.2.2. The curriculum plan includes the conceptual bases of the curriculum, the educational principles on which the curriculum is built, and statements of the expected student outcomes.

The conceptual bases of the curriculum are apparent in the description of the curriculum plan. The curriculum plan and expected student outcomes are formally presented and understood by all communities of interest including students.

3.2.3. The curriculum plan includes a series of organized, sequential and integrated learning experiences.

The curriculum design is a well-planned and organized approach to the accomplishment of the program's mission utilizing sound principles of education. The comprehensive curriculum plan is designed in such a manner that the performance of the expected student outcomes is facilitated. Throughout the curriculum, opportunities are provided for students to explore areas of interest or to pursue in greater depth topics in which they wish to become more proficient or knowledgeable.

The comprehensive curriculum plan includes the development of instructional courses or units (both required and elective; both academic and clinical) which will be used in the implementation of the curriculum design. The didactic content of the instructional courses or units and the learning experiences should be those which will facilitate the attainment of the expected student outcomes.

3.2.4. The curriculum plan includes instructional units with objectives stated in behavioral terms that are reflective of the depth and breadth of the content and of the level of student performance expected.

The objectives of the instructional courses, units, and learning experiences should be stated in terms of what the student will be able to do or demonstrate upon successful completion of each course, unit, or experience. There should be a variety of effective methods, reflecting specific course didactic and/or skill content, by which the students achievement of the objectives and competencies can be measured.

3.3. The curriculum encompasses a variety of instructional methods selected to maximize learning.

There is evidence of consideration of a variety of instructional methods. Methods employed are chosen based on the philosophy of the curriculum plan, the content, the needs of the learners, and the defined outcomes expected of the students.

3.4. Faculty use evaluation processes to determine whether students are competent and safe to progress through the curriculum, including the clinical education component.

The program faculty utilize a variety of effective methods to assess student competence, safety, and readiness to progress through the curriculum. Evaluation of student performance occurs regularly. At a minimum, performance evaluation must occur at the end of each term of the curriculum and include assessment of performance in both academic and clinical course work. Student progression is based on demonstrated competencies. Students receive regular formal feedback about their performance.

3.5. Clinical experiences selected by the program reflect a variety of practice settings and provide the students with professional role modeling, and access to patients representative of those commonly seen in practice.

Clinical experiences required of students are planned based on student progression in the curriculum and are based on the type of supervision required, the variety of experiences needed, and the complexity of clinical problem solving to be accomplished. In planning clinical education programs, the collective experiences provided allow opportunities in patient care and teaching, as well as opportunities for students to learn through observation of and participation in administrative activities, quality assurance activities, clinical research, and supervision of physical therapist assistants and other supportive personnel.

3.6. The clinical experiences selected by the program ensure that the type and amount of clinical supervision are appropriate for the student's experience, ability and point of progression in the program, and that appropriate guidance and feedback are provided to the student.

The program provides a formally designed program of clinical education coordinated with all course work in the program. This is communicated to the clinical education faculty to facilitate their planning of appropriate clinical experiences for students and to ensure that the clinical education faculty appreciate the level of supervision needed by individual students at various phases throughout the curriculum. The program establishes policies and procedures with the clinical education faculty which assure that students receive planned guidance and formal and regular assessment of their clinical performance.

3.7. Physical therapy education is built on a balance of course work in social sciences, humanities, and natural sciences, that is appropriate in depth and breadth, to develop the ability in students to think independently, to weigh values, to understand fundamental theory, and to develop skills for clinical practice, including critical thinking and communication.

Prerequisite course work for the professional program assures that the student has acquired a comprehensive background in the liberal arts and sciences. This includes study in social sciences, humanities and natural sciences which results in a broadly educated student. Students enter the professional program with skills which include being able to think independently, demonstrate problem solving techniques for solving complex and simple problems, weigh values and set priorities, understand fundamental theory, exhibit responsible social behavior, demonstrate professional collegiality and good citizenship, and effectively communicate both orally and in writing as expected of all students. These attributes are typically exemplified by students who have a baccalaureate degree.

3.8. The curriculum incorporates a combination of didactic, clinical, and research learning experiences that are reflective of contemporary physical therapy practice, and includes:

3.8.1. instruction in the foundational sciences, including laboratory or other practical experiences involving quantitative and qualitative observations;

Learning experiences are designed to 1) provide basic knowledge in the sciences related to normal and abnormal human structure, function, and response to injury and disease; 2) enhance the students' ability to make quantitative and qualitative observations; and, 3) facilitate understanding of the clinical sciences.

3.8.2. instruction in the clinical sciences, including laboratory or other practical experiences;

Theory and practical learning experiences are designed to 1) build on the foundational sciences, 2) develop the knowledge necessary to generate a diagnosis, prognosis and plan of care; and 3) develop the knowledge necessary for understanding, presenting rationale for, and applying intervention strategies.

3.8.3. learning experiences designed to achieve educational outcomes required for initial practice of the profession of physical therapy. Graduates of the program are prepared, in the following areas, to:

Communication

3.8.3.1. Expressively and receptively communicate with all individuals when engaged in physical therapy practice, research, and education, including patients, clients, families, care givers, practitioners, consumers, payers, and policy makers.

Individual and Cultural Differences

3.8.3.2. Incorporate an understanding of the implications of individual and cultural differences when engaged in physical therapy practice, research, and education.

Professional Behavior

3.8.3.3. Demonstrate professional behaviors in all interactions with patients, clients, families, care givers, other health care providers, students, other consumers, and payers.

3.8.3.4. Adhere to legal practice standards, including all federal, state, jurisdiction, and institutional regulations related to patient or client care, and to fiscal management.

3.8.3.5. Practice ethical decision making that is consistent with applicable professional codes of ethics, including the APTA's Code of Ethics.

3.8.3.6. Participate in peer assessment activities.

3.8.3.7. Participate in clinical education activities.

Critical Inquiry and Clinical Decision-making

3.8.3.8. Participate in the design and implementation of decision-making guidelines.

3.8.3.9. Demonstrate clinical decision-making skills, including clinical reasoning, clinical judgment, and reflective practice.

3.8.3.10. Evaluate published studies related to physical therapy practice, research, and education.

3.8.3.11. Secure and critically evaluate information related to new and established techniques and technology, legislation, policy, and environments related to patient or client care.

3.8.3.12. Participate in scholarly activities to contribute to the body of physical therapy knowledge (e.g., case reports, collaborative research).

Education

3.8.3.13. Educate others using a variety of teaching methods that are commensurate with the needs and unique characteristics of the learner.

Professional Development

3.8.3.14. Formulate and implement a plan for personal and professional career development based on self-assessment and feedback from others.

Screening

3.8.3.15. Determine the need for further examination or consultation by a physical therapist or for referral to another health care professional.

Examination

3.8.3.16. Independently examine and re-examine a patient or client by obtaining a pertinent history from the patient or client and from other relevant sources, by performing relevant systems review, and by selecting appropriate age-related tests and measures. Tests and measures (listed alphabetically) include, but are not limited to, the following:

a) aerobic capacity and endurance
b) anthropometric characteristics
c) arousal, mentation, and cognition
d) assistive and adaptive devices
e) community and work (job, school or play) reintegration
f) cranial nerve integrity
g) environmental, home, and work barriers
h) ergonomics and body mechanics
i) gait, assisted locomotion, and balance
j) integumentary integrity
k) joint integrity and mobility
l) motor function
m) muscle performance (including strength, power, and endurance)
n) neuromotor development and sensory integration
o) orthotic, protective, and supportive devices
p) pain
q) posture
r) prosthetic requirements
s) range of motion (including muscle length)
t) reflex integrity
u) self care and home management (including activities of daily living and instrumental activities of daily living)
v) sensory integrity (including proprioception and kinesthesia)
w) ventilation, respiration, and circulation

Evaluation

3.8.3.17. Synthesize examination data to complete the physical therapy evaluation.

Diagnosis

3.8.3.18. Engage in the diagnostic process in an efficient manner consistent with the policies and procedures of the practice setting.

3.8.3.19. Engage in the diagnostic process to establish differential diagnoses for patients across the lifespan based on evaluation of results of examinations and medical and psychosocial information.

3.8.3.20. Take responsibility for communication or discussion of diagnoses or clinical impressions with other practitioners.

Prognosis

3.8.3.21. Determine patient or client prognoses based on evaluation of results of examinations and medical and psychosocial information.

Plan of Care

3.8.3.22 Collaborate with patients, clients, family members, payers, other professionals, and individuals to determine a realistic and acceptable plan of care.

3.8.3.23. Establish goals and functional outcomes that specify expected time duration.

3.8.3.24. Define achievable patient or client outcomes within available resources.

3.8.3.25. Deliver and manage a plan of care that complies with administrative policies and procedures of the practice environment.

3.8.3.26. Monitor and adjust the plan of care in response to patient or client status.

Intervention

3.8.3.27. Practice in a safe setting and manner to minimize risk to the patient, client, physical therapist, and others.

3.8.3.28. Provide direct physical therapy intervention, including delegation to support personnel when appropriate, to achieve patient or client outcomes based on the examination and on the impairment, functional limitations, and disability. Interventions (listed alphabetically) include, but are not limited to:

a) airway clearance techniques
b) debridement and wound care
c) electrotherapeutic modalities
d) functional training in community and work (job, school or play) reintegration (including instrumental activities of daily living, work hardening, and work conditioning)
e) functional training in self care and home management (including activities of daily living and instrumental activities of daily living)
f) manual therapy techniques
g) patient-related instruction
h) physical agents and mechanical modalities
i) prescription, application, and as appropriate fabrication of adaptive, assistive, orthotic, protective and supportive devices and equipment
j) therapeutic exercise (including aerobic conditioning)

3.8.3.29. Provide patient-related instruction to achieve patient outcomes based on impairment, functional limitations, disability and patient satisfaction.

3.8.3.30. Complete thorough, accurate, analytically sound, concise, timely, and legible documentation that follows guidelines and specific documentation formats required by the practice setting.

3.8.3.31. Take appropriate action in an emergency in any practice setting.

Outcomes Measurement and Evaluation

3.8.3.32. Implement an evaluation of individual or collective outcomes of patients or clients.

Prevention and Wellness

3.8.3.33. Identify and assess the health needs of individuals, groups, and communities, including screening, prevention, and wellness programs that are appropriate to physical therapy.

3.8.3.34. Promote optimal health by providing information on wellness, disease, impairment, functional limitations, disability, and health risks related to age, gender, culture, and lifestyle.

Management in Various Care Delivery Systems

3.8.3.35. Provide primary care to patients with neuromusculoskeletal disorders within the scope of physical therapy practice through collaboration with other members of primary care teams based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.

3.8.3.36. Provide care to patients referred by other practitioners, independently or in collaboration with other team members, based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.

3.8.3.37. Provide care to patients, in collaboration with other practitioners, in settings supportive of comprehensive and complex services based on patient or client goals and expected functional outcomes and on knowledge of one's own and other's capabilities.

3.8.3.38. Assume responsibility for the management of care based on the patient's or client's goals and expected functional outcomes and on knowledge of one's own and other's capabilities.

3.8.3.39. Manage human and material resources and services to provide high-quality, efficient physical therapy services based on the plan of care.

3.8.3.40. Interact with patients, clients, family members, other health care providers, and community-based organizations for the purpose of coordinating activities to facilitate efficient and effective patient or client care.

Administration

3.8.3.41. Delegate physical-therapy-related services to appropriate human resources.

3.8.3.42. Supervise and manage support personnel to whom tasks have been delegated.

3.8.3.43. Participate in management planning as required by the practice setting.

3.8.3.44. Participate in budgeting, billing, and reimbursement activities as required by the practice setting.

3.8.3.45. Participate in the implementation of an established marketing plan and related public relations activities as required by the practice setting.

Consultation

3.8.3.46. Provide consultation to individuals, businesses, schools, government agencies, or other organizations.

Social Responsibility

3.8.3.47. Become involved in professional organizations and activities through membership and service.

3.8.3.48. Display professional behaviors as evidenced by the use of time and effort to meet patient or client needs or by providing *pro bono* services.

3.8.3.49. Demonstrate social responsibility, citizenship, and advocacy, including participation in community and human service organizations and activities.

The curriculum includes content and learning experiences designed to prepare students to exhibit the above practice expectations upon graduation from the program. The expected student outcomes include those sets of knowledge and skills which the graduates are prepared to demonstrate upon successful completion of the required academic and clinical portions of the education program. The practice expectations are drawn from the Normative Model of Physical Therapist Professional Education (1996) and the Guide to Physical Therapist Practice, Volume I (1995, and early drafts of the 1997 revision).

In determining the specific content to be included, the program faculty utilize information about the contemporary practice of physical therapy; standards of practice; and current literature, documents, publications and other resources related to the profession, health care delivery, physical therapy professional education, and educational theory. The Commission recognizes that the documents referenced above are subject to periodic review and revision. In view of the changing nature of health care delivery and of the profession, the Commission expects that the program faculty will keep abreast of any and all changes in professional physical therapy practice as reflected in future revisions of these documents and will make appropriate adjustments in curricular content and expectations, whether or not these criteria have been formally revised.

The program faculty evaluate students in a variety of ways during the academic and clinical education aspects of the program to ascertain each student's preparation for physical therapy practice.

3.9. The first professional degree for physical therapists is awarded at the postbaccalaureate level at the completion of the physical therapy program.

The institution is responsible for naming the degree at the post baccalaureate level that is awarded after the completion of the education program. A program located in an institution which is not a degree granting institution must demonstrate that it has an agreement with one or more accredited institutions which will grant the first degree, at the postbaccalaureate level, to the student upon completion of the physical therapy program.

SECTION 4: PROGRAM ASSESSMENT

Preamble

Physical therapy education programs are accountable for an ongoing process of assessment of educational outcomes and for continuous improvement in all aspects of the program.

In judging compliance with the following evaluative criteria, the Commission on Accreditation in Physical Therapy Education and the on-site review team will seek evidence that the program is involved in an on-going effort to determine the effectiveness of the program. The information collected about the performance of program graduates related to the practice expectations of the curriculum as well as evidence that supports the relevance of the program philosophy and the attainment of the program's mission, goals and objectives is obtained through ongoing outcome assessment efforts and used to support future changes in all aspects of the program. The ongoing process of assessment includes collection of information on a regular basis with input from multiple sources and using a variety of methods to gather data.

Although the curriculum must include learning experiences that lead to the attainment of the educational outcomes in Section 3.8.3., the Commission recognizes that the complexity and variety of physical therapy practice is such that program graduates may engage in those activities to varying degrees. The Commission expects that the program will determine the extent to which this variety in graduate practice warrants changes in the program, particularly in light of the need to prepare graduates for practice in any setting or location.

4.1. Assessment is part of a systematic and formal approach to continuous improvement. There is an ongoing process of assessment to determine the effectiveness of the program that includes, but is not limited to, the following (listed alphabetically):

The program is engaged in collecting information on a regular and ongoing basis. The collection of information uses multiple approaches to assessment and includes data from a variety of sources. Such sources should include but not be limited to: program graduates, their coworkers and/or employers, the students enrolled in the program, and clinical education faculty who supervise the students during all aspects of their clinical education experiences.. Program faculty, administrators, support staff, graduates and students are involved in the regular assessment about whether institution and program policies, procedures and resources facilitate or hinder the attainment of the program mission and goals.

4.1.1. adjunct and supportive faculty

The performance of adjunct and supportive faculty is assessed at the completion of their teaching assignments. The assessment includes review of teaching effectiveness and may include review of other aspects of performance related to other responsibilities as appropriate. This evaluation is expected to be used to determine appropriate faculty development activities, and to be considered when determining whether to continue using these faculty members.

4.1.2. admissions criteria and prerequisites

The faculty regularly assess the appropriateness of both the admissions criteria and the admissions process to determine the adequacy of each for selecting students who are able to successfully complete the program and whose performance as graduates reflect the mission of the program as well as the practice expectations. The program faculty regularly review the prerequisites for the program to determine if the required background is appropriate in depth and breadth to prepare students for physical therapy professional education.

4.1.3. clinical education faculty

02-20-02

Alice Mounger
2213 SW 29th Terr. Apt. 34
Topeka, KS 66614
785-267-6454

Chairwoman Wagle and members of the Senate Public Health and Welfare Committee:

I thank you for allowing me to speak today on support of Senate Bill #583 to protect the term "Physical Therapy" to describe the services provided only by a Physical Therapist or a Physical Therapist Assistant, under the direct supervision of a Physical Therapist.

As a health care consumer in Kansas, I would assume any facility with the word Physical Therapy over the door, or any facility listed in the yellow pages in the phone book under the heading Physical Therapy, would provide services of a Physical Therapist. I was surprised to find that this is not the case in Kansas. Physicians give prescriptions for Physical Therapy care to the patients, and we determine where we would like to receive therapy. We may use location, advertisements that we hear on the radio, or phone book listings; therefore, consumers need to be protected with this bill.

As I understand, there is currently no regulation for anyone who may say he/she is performing Physical Therapy, but in fact may have no education or training in that field. This could harm patients or would certainly not provide them with the needed care of a skilled Physical Therapist. I urge you to pass Senate Bill 583. I am pleased to answer questions at this time.

Sincerely,
Alice Mounger

Alice Mounger

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 3

February 18, 2002

Judy Hensley, PT, MHS, OCS, MTC
7825 Rene
Lenexa, KS 66216

Madam Chairman Wagle and Members of the Kansas Public Health and Welfare Committee:

I would like to provide written testimony before you in support of Senate Bill 583. I represent the Kansas Physical Therapy Association today as a specialist in the area of manual physical therapy. I have been a physical therapist for 23 years. I presently work at Shawnee Mission Medical Center where I specialize in treating patients with back pain. I have received a certification in manual therapy from the University of St. Augustine and I am certified by the American Physical Therapy Association (APTA) as an orthopedic specialist. I also teach part-time at Rockhurst University, in areas of musculoskeletal and manual therapy.

Senate Bill 583 allows for the specific practice of manual physical therapy. I perform manual therapy with each patient I treat. In the July, 1999 Guide to Physical Therapy Practice from the APTA manual therapy techniques are defined as, "a broad group of skilled hand movements, including, but not limited to mobilization and manipulation, used by the physical therapist to mobilize or manipulate soft tissues and joints for the purpose of modulating pain; increasing range of motion; reducing or eliminating soft tissue swelling, inflammation, or restriction; inducing relaxation; improving contractile and non-contractile tissue extensibility; and improving pulmonary function. These interventions involve a variety of techniques, such as the application of graded forces".[1] Manual therapy is also the CPT code used for charging these services.

When similar legislation in the past has been presented there have been points of concern regarding the definition of manipulation versus mobilization, physical therapists' history of performing manual skills, the physical therapist's education, and the risk of harm for patients. I would like to further clarify these issues.

Manual therapy as stated previously, includes mobilization and manipulation. The American Academy of Orthopedic Manual Physical Therapists (AAOMPT) and the Orthopedic Section of the APTA recognize the terms manipulation and mobilization as interchangeable and synonymous. In fact, these terms were not even differentiated by the physicians who were founders of orthopedic medicine. John Mennell, M.D., James Cyriax, M.D. and Dr. Greenman, D.O. all defined manipulation as a manual procedure involving passive movement at a joint.[2,3,4] Dorland's Medical Dictionary defines manipulation as the forceful passive movement of a joint beyond its active limit of motion, *in physical therapy*.

The literature supports the use of manipulation by physical therapists dating back to 1928. In fact, physical therapists were originally trained by physicians to perform manipulation and now perform more clinical research in manipulation than any other profession. The RAND publication (which was produced with the support from the National Institutes of Health, the Consortium for Chiropractic Research, and the Foundation for Chiropractic Education and Research), and the Agency for Health Care Policy and Research, found physical therapists performed manipulation in twice the clinical trials as chiropractors and four times the number involving osteopaths.[5,6] Physical therapy manipulation intervention evaluates and promotes normal joint movement and /or pain control to the spine and extremities, while a chiropractor's manipulation focuses on treating spinal subluxation and all causes of disease through spinal adjustments (based on principles that are physiologically implausible to physical therapists).[7,8]

Senate Public Health + Welfare Committee
Date: February 20, 2002
Attachment 4

Nineteen states specifically address manipulation, manual therapy, or mobilization as part of the physical therapist's practice and an additional 29 states, including Kansas, allow manipulation by not specifically addressing it. Two states prohibit physical therapist's from performing manipulation, thus depriving patients of a physical therapist's comprehensive care.

The Normative Model of Physical Therapist Professional Education which determines course content necessary for physical therapy curriculum includes manipulation as a course content and a skill acquisition. Likewise the APTA's Guide to Physical Therapist Practice includes manipulation as a treatment intervention. A study by Setcliff in 1998 found that 100% of accredited physical therapy schools include manipulation techniques.[9] Once decided by the clinician that manipulation is an indicated intervention the safety of the technique applied, the psychomotor domain, is dependent on the clinicians' training and competency for the applied technique, the clinical practice or lab experiences. The skill level is best evaluated on a scientific standard with students reaching at least 85% competency in patient instruction, positioning and technical performance, such as used at Rockhurst University.

In previous testimony by the Kansas Chiropractors Association (KCA) a question has been raised as to the number of hours of training in manual skills a physical therapist receives. Specifying how many hours one spends in training for manipulation does not assure competence or a mastery of the task. Issues of manipulation practice and safety can not be validly challenged, compared, rated or standardized interprofessionally in the absence of interprofessional cross competency. Under the Kansas Physical Therapy Act, in the section on unprofessional conduct (K.S.A. 65-2912), it states that any physical therapist shall be guilty of unprofessional conduct if he or she fails to refer patients to other health care providers if symptoms are present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the scope of knowledge of the registered physical therapist. All practitioners, whether a physical therapist, chiropractor, osteopath, or physician, understand both ethically and professionally, that there must be a limitation on practice based on their field of knowledge, particular expertise and range of ability and training.

Another issue raised by the KCA is the patient's risk of harm by physical therapists providing manual therapy. In a study of 177 published cases of injuries reported in 116 articles between 1925 and 1997, Richard DiFabio, found physical therapists were involved in less than 2% of the cases, and no deaths were attributed to manipulation by physical therapists, much less than for the chiropractors.[10] In a follow-up of DiFabio's study, Terrett "corrected" the identity of the practitioner if it was reported to be a chiropractor, but the report contained inaccurate descriptions of the practitioner. In 50 of the 78 corrected studies that resulted in significant disability and/or death, he identified the practitioner as a chiropractor. Three out of the 78 were attributed to physical therapists, two of those occurring in South Africa and New Zealand.[11]

In a previous testimony regarding physical therapists and manipulation, the KCA referenced a quote from Dr. Shekelle, who was part of the collaboration of doctors of medicine and chiropractic from the Rand Corporation, that chiropractors administer 94% of the manipulations and then used this to extrapolate a higher risk of injury for physical therapists on the number of patients they treat. Dr. Shekelle, , responded in an e-mail to a Washington physical therapist in February, 2000, that "there is no credible data to support a conclusion that any provider is more or less safe than any other provider in the delivery of spinal manipulation". [12]

The safety of physical therapists delivering manipulation can also be seen by a report from Maginnis and Associates (one of the nation's largest physical therapy liability insurers), who have had no specific losses attributed to "manipulation or high velocity thrust". A memorandum written in May of 1996 from Judith Cipriano, the Director of Property and Casualty Product Development stated that they were "not able to find a single claim with this

allegation". This was again confirmed March 22, 2001 by Michael J. Loughran, senior vice president of the Health Providers Service Organization, a leading liability insurer of physical therapists, who stated that, "direct access is not a risk factor that we specifically screen for in our program because it has not negatively impacted our claims". Since direct access is practiced in 34 states, this would include states practicing manual therapy, mobilization and/or manipulation.[13] In contrast, 1997, Jagbandhansingh indicates that between 1991 and 1995, the National Chiropractic Mutual Insurance Company paid over 73 million dollars for 1,403 losses at an average of $52,000 per case.[14]

In summary, manual physical therapy is an inclusive term encompassing mobilization, manipulation and all manual skills. According to Karl C. Kranz, DC, of the Dept. of Research and Statistics, American Chiropractic Association, "manipulation and mobilization have existed in physical therapy to some degree from the beginning". The rationale and practice of physical therapy manipulation is very different from chiropractic manipulation and physical therapists are well trained to provide these techniques in a safe and ethical manner. Manual therapy is part of the practice of physical therapy and I would like to ask your support for Senate Bill 583 to specifically add manual therapy into our practice act.

Respectfully submitted,

Judy Hensley PT, MHS, OCS, MTC

Judy Hensley, PT, MHS, OCS, MTC

References

1. Appendix 1-3 Guide to Physical Therapist Practice, American Physical Therapy Association, 1999. www.apta.org/res_cat. [Publication order no. P-139] ISBN 1-887759-16-6.
2. Mennell, John M., M.D. *Back Pain*, pg. 29, Little, Brown and Company, 1960
3. Cyriax, James, M.D., *Textbook of Orthopaedic Medicine*, Vol. 1 Bailliere Tindal, 6th edition, 1975, page 701
4. Greenman, PE D.O. In Korr: *The Neuroloical Mechanisms in Manipulative Therapy*. Plenum Press, London. pg. 83, 1978.
5. Shekelle PG, Adams AH, Chassin MR, et al. *The Appropriateness of Spinal Manipulation for Low-Back Pain: Project Overview and Lieterature Review*. Santa Monica, Calif: RAND; 1991. RAND publication R-4025/1-CCR/FCER.
6. Bigos S, Bowyer O, Braen G, et al. *Acute Low Back Problems in Adults: Clinical Practice Guideline No. 14.* Rockville, Md; Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services; December 1994. AHCPR Publication No. 95-0642.
7. Homola S. *Is the Chiropractic Subluxation Theroy a Threat to Public Health?* Scientific Review of Alt Med 5(1):45-53,2001.
8. Leboeuf-YdeC. *How Real is Subluxation? A Research Prospective*. J. Manipulative Physiol Ther. 1998;21(7):492-494.
9. Mobilization and Manipulation in Physical Therapy Curricula, Thesis, Master of Science in Physical Therapy, Southwest Texas State University, San Marcos, Texas
10. DiFabio RP. Manipulation of the Cervical Spine: Risks and Benefits. *Physical Therapy*. 1999;79(1):50-65.
11. Terrett, A.G. *Vertebrobasilar stroke following manipulation.* National Chiropractic Mutual Insurance Company; 1996.1-80.
12. E-mail to FliFshir@aolcom sent February 2, 2000
13. Moore J. Direct Access Under Medicare Part B: The Time is Now! *PT Magazine*. February, 2002. 30-32.
14. Jagbandhansingh, MP. Most common causes of chiropractic malpractice lawsuits. *Journal of Manipulative and Physiological Therapeutics*;1997;20(1):60-63.

February 20, 2002

Public Health & Welfare Committee
Senate Bill #583

To Whom It May Concern:

I am writing to you today to tell you how Physical Therapy has changed my life.

About six years ago, I injured my neck in a car wreck. I was in pain and went to someone who included a number of different types of treatment in his practice, including "physical therapy." I will not go into what happened here at length, but I ended up getting badly injured by what this person did to me in my mid-back area. I went to an orthopedic doctor after this injury for quite a while, but I didn't have an injury that could be operated on. My pain was at such an intolerable level that I basically gave up all activities and stayed at home except to go to work. It was all I could do to get by at my job – I could barely sit and every second was spent in pain.

This kind of unimaginable pain went on for almost three years, and everything I had worked so hard for – a college degree, a great job, great friends and family – didn't matter anymore. The pain was overriding all joy in my life, and I couldn't help but think how my life had literally been ruined. I was number one in Topeka in doubles tennis my senior year in high school, played varsity softball in college, and now I couldn't sit, lie down, or do anything without pain.

Eventually, I told my doctor that I was going to have to quit my job. I couldn't stand the pain anymore, but losing my job I knew would be devastating, both emotionally and financially. I was single, had pretty much isolated myself because I was in too much pain to go out and do things (this would have been a surprise to those I worked with since I had a very "public" type of job) and my medical bills were piling up.

During these years, I will tell you I was so desperate that I sought numerous sources of treatments – some which helped temporarily (e.g., massage therapy, acupuncture), some from practitioners claiming they did physical therapy, and things I can't even remember the name of, quite frankly. Nothing helped long-term. It seemed hopeless and then a friend of mine told me about manual physical therapy. I told my doctor I wanted to go, and he sent me to a registered Manual Physical Therapist.

I'll never forget what the therapist said when he looked at my back: "She's not moving." My back was so locked up and muscles so tightly bound that my mid- and low back wasn't moving. I ended up going to another manual therapist, Sue, that was closer to me, and after a few visits, she told me she was going to sell her practice to stay home

with her children. I cried because I felt I was starting to see some progress for the first time in years.

I ended up going to a manual Physical Therapist that Sue referred me to, who also teaches at Rockhurst College. I had instability in my back from the injury, and all sorts of muscle problems and imbalances that had been ineffectively treated by others claiming to do "physical therapy." She diagnosed my problem, gave me exercises and worked with me closely.

I worked hard, did the exercises, and my life changed. It wasn't easy – I had, and still do, have to do exercises regularly. But after three years of searching, I found out that Physical Therapy was by far the best method of treatment –and that's saying a lot because I have spent tens of thousands of dollars of my own money (this is no exaggeration) visiting many different types of practitioners.

I work as a group manager for a major telecommunications company in Kansas City, and my job is to promote philantrophy and volunteerism. I plan to spend my time volunteering to tell people how a registered Physical Therapist restored my life, enabled me to continue my career, contribute to the community (I raised nearly $5 million for United Way through my job) get married and celebrate living again. I will always be indebted to those practicing licensed Physical Therapy and believe the general public has a right to know that when they are going someone practicing "physical therapy," they are going to a registered Physical Therapist.

Sincerely,

Julie Hershey Downes
13462 222nd Street
Linwood, KS 66052
1-913-723-3646 (H)
1-913-624-3431 (W)

February 20, 2002

To Whom It May Concern:

This is to inform that I, Diane L. Gough, think that the bill reforming physical therapy issues is a good one and should be passed in order to ease the availability of physical therapy to the public.

Diane L. Gough

Diane L. Gough
1128 Terradyne
Andover, KS
316.733.5024

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 5

Connie L. Kelley
1717 N. Governeour
Wichita, KS 67206

February 20, 2002

Kansas Senators:

I am in favor of Senate Bill 583 and strongly believe it should be passed.

I believe the current laws governing the representation of therapists' credentials are too lax and, therefore, lead to misrepresentations that confuse consumers regarding the specific qualifications of individual therapists. Therapists who have not completed the educational/training qualifications to be a licensed physical therapist should not be allowed in any way to represent themselves as such.

Senate Bill 583 will put an end to this confusion, and as a consumer of the services involved, I want this bill passed.

Respectfully,

Connie L. Kelley

Connie L. Kelley

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 6

Mary Ann Palmer
620 Renee
Andover, KS 67002

I have had physical therapy administrated by a registered physical therapist. As a consumer, I find it rather confusing when I see advertising by a massage therapist stating that they offer physical therapy as one of their services. Is the person administering this service actually a qualified therapist and what type of treatment is being given?

This bill needs to be passed into a law that protects both the consumer as well as the physical therapy profession.

Mary Ann Palmer

Mary Ann Palmer

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 7

Senate Public Health and Welfare Committee

February 20, 2002
Re: Senate Bill 583

By: Kansas Chiropractic Association
Rebecca Rice, Legislative Counsel

Madam chairman and committee members, I am Rebecca Rice and appear before you as legislative counsel for the Kansas Chiropractic Association. KCA has appeared in opposition to legislation regarding physical therapy in the past and the association doesn't want to leave the impression that it's members are automatically opposed to legislation regarding physical therapy. Therefore, rather than address the policy issues raised by this legislation, the KCA is addressing only those parts of the proposed legislation which appear to impact chiropractic care, in particular.

As a point of reference, I have reproduced below the chiropractic scope of practice statute.

> **65-2871. Persons deemed engaged in practice of chiropractic. For the purpose of this act the following persons shall be deemed to be engaged in the practice of chiropractic:** (a) Persons who examine, analyze and diagnose the human living body, and its diseases by the use of any physical, thermal or manual method and use the X-ray diagnosis and analysis taught in any accredited chiropractic school or college and (b) persons who adjust any misplaced tissue of any kind or nature, manipulate or treat the human body by manual, mechanical, electrical or natural methods or by the use of physical means, physiotherapy (including light, heat, water or exercise), or by the use of foods, food concentrates, or food extract, or who apply first aid and hygiene, but chiropractors are expressly prohibited from prescribing or administering to any person medicine or drugs in materia medica, or from performing any surgery, as hereinabove stated, or from practicing obstetrics.
>
> History: L. 1957, ch. 343, ' 71; L. 1976, ch. 273, ' 32; Feb. 13.

We propose the following amendments with the understanding that other healthcare providers should also be included in these amendments but we do not presume to speak for them. We do not object to such inclusion:

Page 2, line 10: insert after *manual therapy; therapeutic massage* "but not adjustment of misplaced tissue or manipulation"

Page 2, line 23: insert after *medicine and surgery* "and the practice of chiropractic"

Page 3 line 23: insert after *act* "or is a licensed chiropractor"

Page 3, line 26: insert after *act* "or is a licensed chiropractor"

Thank you for allowing us to express our concerns regarding this legislation and request these amendments.

Senate Public Health & Welfare Committee
Date: February 20, 2002
Attachment 8