

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE.

The meeting was called to order by Chairperson Jim Morrison at 1:32 p.m. on February 18, 2003, in Room 243-N of the Capitol.

All members were present except Representatives Landwehr and Holland, both of whom were excused.

Committee staff present:

Bill Wolff, Legislative Research Department  
Renaë Jefferies, Revisor of Statutes' Office  
Gary Deeter, Committee Secretary

Conferees appearing before the committee:

Rod Bates, Kansas X-Ray School, Oakley  
Judy Eyerly, Deputy Director, Kansas Association for the Medically Underserved  
Janette Delinger, President, Kansas Dental Health Association  
Kevin Robertson, Executive Director, Kansas Dental Association  
Deborah Zehr, Kansas Association for Homes and Services for the Aging (written testimony)  
Maggie Smet, Wichita Dental Hygienists Association  
Marla Rhoden, Director, Health Occupations Credentialing, Bureau of Health Facilities, Kansas Department of Health and Environment  
Ron Hein, Kansas Society for Radiologic Technologists  
Dr. James Owen, Diagnostic Radiologist, Kansas Radiological Society  
Randy Stucky, President, Kansas Society of Radiologic Technologists  
Wayne Probasco, Executive Secretary, Kansas Podiatric Medical Association  
Priti Lakhani, Podiatrist, Topeka

Others attending: See Guest List.

Serving as chair, Representative Judy Showalter opened the hearing on **HB 2161**.

Janette Delinger, President, Kansas Dental Hygienist Association, gave background on **HB 2161**, saying it was patterned after Missouri legislation. (Attachment 1) She noted that 14 other states have similar statutes which allow dental hygienists less restrictive supervision. She observed that the bill will allow dental hygienists to work with Medicaid and HealthWave children, many of whom have never seen a dentist. Answering questions, Ms. Delinger said most dental hygienists' work under this bill will be compensated, and that the sponsoring organization will usually bill Medicaid for their services. In working with children, she assured members that services will not be done without parental consent.

Kevin Robertson, Executive Director, Kansas Dental Association, said the KDA enthusiastically supports the bill, noting that KDA worked for 12 months with KDHA to develop this legislation. (Attachment 2) He commented that a hygienist cannot bill Medicaid or a patient directly; payment must be received through another source, noting also that when a dental hygienist provides indigent care, he/she must notify the patient or legal guardian what care is being received and what is not being done. The dental hygienist

## CONTINUATION SHEET

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE on February 18, 2003, in Room 243-N of the Capitol.

must also provide the sponsoring dentist and the institution the services that have been provided. A committee member wondered if schools where dental care has been received will ask school nurses to handle the paperwork. Answering another question, Mr. Robertson said the bill goes further that the current definition of "general supervision," allowing a hygienist to see a patient irrespective of whether he/she had been seen by a dentist within the past year, thus offering care than would otherwise not be provided.

Judy Eyerly, Deputy Director, Kansas Association for the Medically Underserved, commended KDA and KDHA for making dental care available to a wider range of Kansas citizens. ((Attachment 3)

Maggie Smet, Wichita Dental Hygienists Association, Newton, reported on the Health Ministries of Harvey County, which serves the indigent population from Harvey and surrounding counties. (Attachment 4) She said that, since not every dentist accepts HealthWave or Medicaid, the bill would enhance dental service to the underserved. Answering questions, Ms. Smet said after determining dental needs, the hygienist would encourage parents to take a child to a dentist. Ron Gaches noted that the hygienist would also provide information to the sponsoring dentist or another supervisor, as the bill requires; since most have never seen a dentist, he did not see problem of dentists competing for the patient.

The hearing was closed for **HB 2161**.

With Representative Peggy Long as chair, the hearing was opened for **HB 2274**.

Rodney Bates, Oakley, spoke in support of the bill. (Attachment 5) As an administrator of an x-ray training school approved by the Kansas Board of Regents, he questioned if licensure might be too stringent for small rural hospitals, but he acknowledged that the public needed more protection than under current regulations. He noted that 32 of the 50 states have established at least some form of regulation. He noted that some technicians have limited education and very little training in operating radiologic equipment. He suggested as an adjunct to licensure a form of attestation or affidavit of competence.

Wayne Probasco, Executive Secretary, Kansas Podiatric Medical Association, introduced Priti Lakhani, a local Podiatrist. She reported that, for her, employing a radiologic technologist would be cost-prohibitive and that sending a patient to the hospital for needed x-rays would cost the patient additional time and money. She said she delegates 400 x-rays annually to her nurse, using only 5 views. She suggested that podiatrists, like dentists, could be excepted from statutory strictures. Answering a question, staff Bill Wolff noted that podiatrists, as licensed practitioners, were excluded from the bill; however, delegated persons were not exempt.

Marla Rhoden, Director, Health Occupations Credentialing, Bureau of Health Facilities, Kansas Department of Health and Environment (KDHE), testified that the radiologic technologists had successfully completed the credentialing process, meeting all 10 criteria. (Attachment 6) Further, she

## CONTINUATION SHEET

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE on February 18, 2003, in Room 243-N of the Capitol.

said the Secretary of KDHE has concurred with the credentialing committee's recommendation.

Ron Hein, representing the Kansas Society for Radiologic Technologists, stated that Kansas is one of 11 states that does not license radiologic technologists. (Attachment 7) He said that during the summer he had contacted various groups to apprise them of the contents of the bill in order to ward off turf battles, often adjusting the legislative wording to address their concerns. He noted that the paucity of radiologic personnel in small hospitals and rural areas could be addressed in various ways: through a liberal grandfather provision, through an attestation of competency, or through a scaled-down licensure as a first step. He said the intent was to upgrade the quality of education and practice for the public.

Dr. James Owen, Diagnostic Radiologist, Kansas Radiologic Society, reviewed the history of licensure for radiologic technologists, saying the need has been recognized for 25 years, noting that most other states have comparable legislation already in place. (Attachment 8) He said the proposed legislation focuses on who can take x-rays; currently anyone can do so. He warned that the results include inadequate diagnosis or wrong treatment, further unnecessary diagnostic procedures, overexposure to radiation, and ultimately increases costs for health-care. He said he opposes exempting small practices or rural areas, since those are the ones who may offer less protection for patients. By showing comparative radiographs, he illustrated that a bad radiograph may be worse than none at all. Representative Reitz expressed a desire to expedite the bill.

Randy Stucky, President, Kansas Society of Radiologic Technologists, assured the Committee that the Society wants to work with other groups to address their reservations, with the goal of providing better health care. He said at the very least there should be minimal uniform training for all those operating radiologic equipment. (Attachment 9)

Additional written testimony is provided in Attachment 10.

Chairman Morrison announced that the hearing for **HB 2274** would continue on Thursday, February 20, and that a hearing would also be held for **HB 2171** and **HB 2172**.

The meeting was adjourned at 2:37 p.m. The next meeting is scheduled for Wednesday, February 19, 2003.

**HOUSE HEALTH AND HUMAN SERVICES COMMITTEE  
GUEST LIST**

DATE: FEBRUARY 18 2003

NAME	REPRESENTING
Rod GACHES	KIDHA
Janette Debingert	KIDHA
KEVIN ROBERTSON	As Dental Assn
James Owen MD	K.R.S.
Binda Croucher	KSRT
Doug Billings	KSRT - Nuclear Medicine
Robby Stucky	KSRT
Becky Dudge	KSRT / Radiation Therapy
Viccie Burgess	Burgess & Assoc.
Maggie Smet	Health Ministries of Harvey Co., WAHA
Lisa Ross	KIDHA
<del>JERRY SAUKHTER</del>	KMS
David Ross MD	KMS
Jerol	KGP
Janelle Garrison RN	SRS
Mike Hammond	Assoc. of Counties
Ryan Schlink	KPhA
Gail Jordan	CCG
Rodney Bates	St. Louis School



**HOUSE HEALTH AND HUMAN SERVICES COMMITTEE  
GUEST LIST**

DATE: 12/18/03

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NAME	REPRESENTING
Marla Rhoden	KDHE/HOC
Jenni Freed	KS Dental Bd.
Walter Probaseo	KS Podiatry Assoc
Priti Lakhani	KS Podiatric Med Assoc.
Matthew Galliano	KS Podiatric Med Assoc.
Judy Eyerly	KS Assn. for Medically Underserved
LARRY BUENIAS	BD OF HEALING ARTS
Rebecca Zepick	Federico Consulting
Melissa Ruggiero	" " "

**Testimony Before House Health and Human Services Committee  
Regarding HB 2161 Access to Dental Health Care  
Presented by Janette Delinger, President  
Kansas Dental Hygienists Association  
Tuesday, February 18, 2003**

Thank you Chairman Morrison and Members of the Health and Human Services Committee. The Kansas Dental Hygienists Association (KDHA) urges your support for legislation allowing licensed Dental Hygienist to receive an "extended care permit" to perform preventive procedures to the underserved while being sponsored by a licensed Kansas Dentist authorized under KSA65-1456.

Passage of this bill will allow licensed Dental Hygienists in Kansas the opportunity to access those that have been unable to get dental services elsewhere. The fact that the patient does not have to be a "patient of record" of any dentist makes it easier to access those children who may have never been to a dental office. Being able to work in the specified areas noted within the bill will allow dental hygienist's not only the ability to perform preventive services such as dental prophylaxis and fluorides, but also to educate those children on how to prevent dental problems, thereby saving the state thousands of dollars in the future.

KDHA has worked closely with the Kansas Dental Association on the concepts and language contained within this bill. Leaders from both associations have met at least five times over the last year to collaborate on the many components of the bill. We are very excited about the opportunity this proposal provides dental hygienists to be able to participate more actively in serving those in need. Your support for the access to care bill (HB 21 61) will assist us in broadening access to dental health across the state of Kansas.

KDHA is the professional association of Kansas Registered Dental Hygienists. With members from all regions of the state, KDHA is a proactive voice for access to dental health.

*Attachment 1  
HHS 2-18-03*

## KANSAS DENTAL ASSOCIATION

Date: February 18, 2003

To: House Committee on Health and Human Services

From: Kevin J. Robertson, CAE  
Executive Director

**RE: Testimony in SUPPORT of HB 2161**

Chairman Morrison and members of the committee I am Kevin Robertson, executive director of the Kansas Dental Association representing 1,168, or some 80% of the state's licensed dentists.

I am pleased to be here today supporting HB 2161. This bill is the culmination of some 12 months, a handful of meetings (one facilitated), numerous emails, and other communications between representatives of the KDA and Kansas Dental Hygienists' Association (KDHA). HB 2161 amends the dental practice act to create a permit system by which qualified dental hygienists could practice in settings with a level of dental supervision less than currently exists.

The KDA agrees with the KDHA that dental hygienists can be an important player in helping meet the preventative dental needs of many Kansans outside the dental office setting. .

There are significant populations of Kansans who - for a variety of reasons - have difficulty accessing dental services: Medicaid eligible children and adults, nursing home residents, and homebound persons are a few. HB 2161 allows a dental hygienist, working under a sponsoring dentist to provide care in settings to help meet the preventative needs of these Kansans. The dental hygienist would inform the patient's legal guardian that the procedures being performed do not constitute a comprehensive dental diagnosis. The dental hygienist would provide a copy of the treatment findings to the sponsoring dentist and the medical advisor of the facility to ensure proper follow-up care is provided tot he patient if necessary.

Make no mistake, the KDA's support to HB 2161 was an arduous process that required a significant paradigm shift on behalf of many in the KDA leadership. The provisions are a delicate balance that not all dentists across Kansas support – and I dare say not all dental hygienists support. The association does, however, solidly support it. We would ask that you keep that in mind as you work HB 2161 – working with the both the KDA and KDHA should concerns on the bill arise.

The KDA has reviewed the technical amendments discussed by Dr. Bill Wolfe and KDHA, and does support of them.

Thank you for your time today, I am happy to answer any questions you may have at this time. I urge you to support HB 2161 with a favorable recommendation.

*Attachment 2*  
*AHS 2-18-03*



Kansas Association  
for the  
Medically Underserved  
*The State Primary Care Association*

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112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 [www.ink.org/public/kamu](http://www.ink.org/public/kamu)

February 18, 2003

Committee on Health and Human Services  
Representative Jim Morrison, Chair

Testimony in support of HB 2161

Chairperson Morrison, Committee, my name is Judy Eyerly and I am with The Kansas Association for the Medically Underserved (KAMU). We wholeheartedly support HB 2161 to allow Dental Hygienists to use their knowledge and skills in public health settings, schools and indigent health care clinics. The need for dental care is tremendous in the State of Kansas and bringing hygienists into these settings begins an educational process and helps create a new mindset. We are for the first time saying that everyone needs to have access to a minimum level of dental care. We as a State are placing a priority on the health and psychological benefits of being able to smile with pride.

As an association of clinics that have a primary mission to serve individuals who face many barriers to health care – especially dental – this bill will serve as an impetus to increase or find new resources for providing dental care. Many clinics will be able to increase Dental Hygiene services as a result of this bill.

I am a board member of a small not for profit dental clinic in Lawrence and there are many hygienists who have expressed interest in donating their services to the clinic. This bill will allow us to take advantage of those generous offers and increase the number of patients in our system and more effectively utilize the time of the paid and volunteer dentists in the clinic.

I want to applaud this committee and the Kansas Dental Association for the care and attention brought to this issue. This is a tremendous step in providing a greater number of individuals with access into the dental system.

*Attachment 3*

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*Kansas Health Centers - A Good Investment* *AHS 2-18-03*

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Jin. Morrison

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**From:** Maggie Smet [ms2thbrsh@hotmail.com]  
**Sent:** Monday, February 17, 2003 1:41 PM  
**To:** GaryD@house.state.ks.us; Jmorrison@lnk.org  
**Subject:** Testimony HB 2161 for 2-18-03

TESTIMONY from Maggie Smet (Registered Dental Hygienist, Newton Ks.) Concerning HB 2161 Hearing Feb. 18, 2003

Thank you for the opportunity to tell you about the wonderful facility I volunteer time at each month. It is the Health Ministries Clinic of Harvey County. It serves anyone needing medical or dental care from the following counties: Harvey, Marion, McPherson and Butler. These individuals have no medical or dental insurance and their income is 200% below the poverty level.

It is funded through the United Methodist Health Ministries fund, United Way and grants written by it's director Nancy Martin, RN.

All medical and dental care is donated through volunteers who are licensed in their field like myself a Registered Dental Hygienist.

As the laws stands currently, I can treat those persons who have had an exam by a dentist in the previous 12 months. However, Currently 1 dentist volunteers at the site and he can not keep up with the volume of persons asking and needing to be seen for dental problems and routine examinations. The current wait is 6 - 12 months to see a Hygienist for a dental cleaning.

We have before us a golden opportunity to aid so many more persons who could be treated. HB2161 will relax the stipulation of a patient (in specific situations) being required to see the dentist FIRST. I could provide a dental cleaning, fluoride treatment, oral hygiene instruction and stress the need for further evaluation by the dentist. This would help reach those persons waiting.

Not every private dental practice accepts medicare/medicade or Healthwave reimbursement. In passing HB2161, Please imagine all the people we could help...Every kids who attends Head Start, those who receive care from health departments, Indigent clinics like Health Ministries of HV.Co, any person in a nursing home and long term care, the home bound and state institutions. These Kansans could be seen by a dental professional and have their needs evaluated and a portion of their needs met!

The dentists and dental hygienists of Kansas have worked together to make this Access to Care a reality and we ask for your help to. Please pass HB2161.

Thank You. Maggie Smet, RDH

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## TESTIMONY IN SUPPORT OF HOUSE BILL 2161

To: Representative Jim Morrison, Chair, and Members,  
House Health and Human Services Committee

From: Debra Zehr, Vice President

Date: February 18, 2003

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Thank you, Chairman Morrison, and Members of the Committee, for this opportunity to offer support for House Bill 2161. The Kansas Association of Homes and Services for the Aging representing over 160 not-for-profit long-term health care, housing, and community service providers throughout the state.

Providing good dental care is one of the biggest challenges facing nursing home caregivers. Residents' lifelong oral care practices, compounded by debilitating conditions like stroke and Alzheimer's, and high turnover among nurse aides all conspire to make good oral care very difficult. Currently, most residents must still travel to their dentist's office to receive dental care. Nursing home residents and staff need all the help they can get in this area.

The provisions embodied in House Bill 2161 will assist in the provision of good dental care to a high risk population.

We ask for your support of House Bill 2622.

Thank you. I would be happy to answer any questions.

February 17, 2003

Members of the Health & Human Services Committee

Thank you for allowing me to appear today.

My name is Rodney M. Bates. I live in Oakley, Kansas.

I support the bill as proposed with a minor change. I am not sure licensure is absolutely required for the safety of the public, but apparently this is the only way to ensure persons working in the x-ray field have any knowledge of the dangers of the radiation producing instruments which they are operating.

I am a Registered X-ray Technologist, retired status, operating a school specifically for those persons who are working in the field of Medical X-ray who have not had formal training in the x-ray field. Our school has been in operation since October of 2001, and is approved by the Kansas Board of Regents as a proprietary school. I began this school with the belief there should be some alternative for education for persons working in x-ray who cannot attend a course which requires them to be absent from their jobs for extended periods of time.

Prior to starting this school I was the Administrator of Logan County Hospital for over 32 years. During that time I employed and trained a number of persons to work in X-ray who had no formal training. During that time I also testified before the committee of the Department of Health which was to determine if there was evidence of the need for licensure of x-ray personnel. Because of the wording of the bill which was proposed at that time I was opposed to licensure. I am still not convinced that "licensure" is needed, however I do believe there needs to be some evidence of knowledge by those persons working in the x-ray field for the protection of the public.

At the present time the majority of hospitals in Western Kansas are employing personnel within their x-ray departments who have little or no formal training in x-ray. I am speaking of the small, rural hospitals, those who find it very difficult to employ Registered Radiological Technologists. This is not limited to Western Kansas however, a number of hospitals in Central and Eastern Kansas also use these personnel. Most of these facilities would like to employ more Registered Technologists, however, there are not enough graduates from approved schools within the state of Kansas to fill all the opportunities in the state. HB 2274 however, does allow for these hospitals to continue to use these present personnel under a grandfathering clause, so there would not be an immediate impact upon the hospital's abilities to continue to operate. To my knowledge there has not been a formal study of the clinics and other facilities who operate x-ray machines as to their use of non-registered personnel, however I am cognizant of a number who have no Registered Technologists on their staff. Again, this bill would not immediately impact their ability to continue to operate.

A number of states surrounding Kansas have instituted laws similar to this legislation. In fact, by 1999, 32 of the 50 states had passed similar laws. All I am aware of have established a "limited practice" category for personnel who have had some formal training, however are not registered by the American Registry of Radiological Technologists. I am assuming this would also be the case in Kansas, as I have already indicated, the present schools cannot prepare the number of Registered Technologists sufficient to meet the needs of the state. If this bill is passed, I will be applying to the Council for recognition of my graduates to be included in a category to be approved to practice in the field of x-ray.

Attachment 5  
HHS 2-18-03

I believe it is time for the State of Kansas to provide for some protection for the public with regard to the practice of performing x-rays on humans. Although there is no evidence that education of personnel will provide adequate protection to the public, certainly the lack of any evidence of education gives no protection! There are a number of persons now performing x-rays on patients who have absolutely no knowledge of how the machine which they are using works, what causes the image to appear on the film, nor how much radiation to which they are subjecting the patient! Many have little knowledge about safety procedures which should be implemented. Those who support this legislation feel there is a need to ensure the people performing x-ray procedures have an understanding about these and many more important aspects of x-ray examinations.

There would be some who would use the increased cost of this training to be a detriment to the public. I believe that our school and similar training programs could be used and our graduates can attest that it would not place an unusual financial burden on any hospital or clinic.

There are those who question why we even need to ensure that only qualified personnel are operating x-ray machines. To those I would answer, I believe those who are entrusted to care for the health of the public should carefully examine their reasons for opposing an increase in the quality of care of their patients.

I would suggest that section 10 (b) of the bill might be strengthened by placing a minimum time which a person "engaged" prior to the effective date of the act could be waived from the requirements by affidavits from administrators and physicians. I don't believe a person who would begin work on December 31, 2003, never before having experience in the x-ray field should be qualified to receive such a waiver.

This concludes my remarks. I would be most happy to answer any questions from the committee.

Again, thank you for this opportunity.

Rodney Bates  
Kansas X-ray School  
202 Center Ave.  
Oakley, Ks. 67748



# K A N S A S

RODERICK L. BREMBY, SECRETARY      KATHLEEN SEBELIUS, GOVERNOR  
DEPARTMENT OF HEALTH AND ENVIRONMENT

## House Bill No. 2274

to the  
House Committee on Health and Human Services

by  
Marla Rhoden, Director, Health Occupations Credentialing  
February 18, 2003

Chairperson Morrison, I am pleased to appear before the House Committee on Health and Human Services to discuss House Bill 2274. The Kansas Department of Health and Environment bears responsibility for the administration of the Kansas Health Occupations Credentialing Act, K.S.A. 65-5001 *et seq.*, the purpose of which is to review the public's need for a new health occupation to be credentialed in Kansas according to statutory criteria. Several health occupations have sought to become credentialed without the benefit to the legislature of this standardized review. This is a disservice to you, the legislature, in making fully informed decisions. Standardized and comparative data are not always brought to your attention which may be significant to your interest in public health and safety.

In April of 1997, the Kansas Society of Radiologic Technologists provided a letter of intent and then in October of 1998 submitted a formal application according to the Kansas Health Occupations Credentialing Act. A technical review committee was convened and in October of 1999 the technical review committee found that the applicant group met all ten criteria outlined in the statute. House Bill 2274 is virtually identical to 2002 HB 2964. The provisions of this bill are consistent with the technical review. The only difference is that there has been additional work outlining the composition of a radiologic technology council and the fee structure.

Attachment 6  
HHS 2-18-03

Passage of this bill serves to demonstrate the successful processing of an application for credentialing under the law. The department asks that the legislature act favorably on this bill as the applicant group has thoroughly demonstrated the need and rationale under the legislature's criteria for the licensing of radiologic technologists. Failure to support this legislation could further diminish the effectiveness of this important tool, the Kansas Health Occupations Credentialing Act, by ignoring an opportunity to demonstrate its purpose and success.

Thank you again for the opportunity to comment on House Bill No. 2274. I would gladly respond to any questions you may have.

DIVISION OF HEALTH  
Bureau of Health Facilities, Health Occupations Credentialing  
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1365  
Voice 785-296-1240 Fax 785-296-1266 <http://www.kdhe.state.ks.us>

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**Testimony re: HB 2274  
House Health and Human Services Committee  
Presented by Ronald R. Hein  
on behalf of  
Kansas Society of Radiologic Technologists  
February 18, 2002**

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Society of Radiologic Technologists. The KSRT is the professional association for radiologic technologists in Kansas.

Since the KSRT requested that this Committee introduce HB 2274, we are obviously in support of the bill and strongly urge its passage.

HB 2274 provides for licensure for radiologic technologists practicing in Kansas. This act, like other healthcare licensure acts, provides for title protection as well as a protected scope of practice. Kansas is one of only 11 states that do not have some form of licensure for radiologic technologists. Of the 39 states which have some form of licensure, 32 of those states have a comprehensive licensure statute, although it is referred to as certification in some other states. [See Attachment A.]

I would like to give you a history of how this licensure bill is coming before you.

First of all, K.S.A.65-5001, *et.seq.* provides that all healthcare groups seeking to be credentialed in the State of Kansas shall make application to the Department of Health and Environment pursuant to the Health Occupations Credentialing Act. That process provides for an extensive review by a technical committee composed of representatives from numerous healthcare groups and the public to review the application utilizing statutory criteria for determining whether or not to recommend credentialing of the applicant group. The criteria outlined by the statute are as follows:

1. The unregulated practice of the occupation or profession can harm or endanger the health, safety or welfare of the public and the potential for such harm is recognizable and not remote;
2. the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing

Attachment 7  
HHS 2-18-03

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- occupational professional ability;
3. if the practice of the profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing health care services, such arrangement is not adequate to protect the public from persons performing non-credentialed functions and procedures;
4. the public is not effectively protected from harm by certification of members of the occupation or profession or by means other than credentialing;
5. the effect of credentialing of the occupation or profession on the cost of health care to the public is minimal;
6. the effect of credentialing or profession on the availability of health care personnel providing services provided by such occupation or profession is minimal;
7. the scope of practice of the occupation or profession is identifiable;
8. the effect of credentialing of the occupation or profession on the scope of practice of other health care personnel, whether or not credentialed under state law, is minimal; and
9. nationally recognized standards of education or training exist for the practice of the occupation or profession and are identifiable.

After reviewing the application and conducting hearings, the technical committee made the findings that all the statutory criteria were met by the radiologic technologists, and the technical committee recommended credentialing at the level of licensure.

The credentialing statute provides that that recommendation then be submitted to the Kansas Department of Health and Environment, which will approve or reject the recommendation, or approve the recommendation but at a different level of credentialing than was recommended by the technical committee. In this instance, the Secretary of KDHE reviewed the application and the findings of the technical committee, and recommended to the legislature that radiologic technologists be approved for credentialing at the level of licensure. His recommendation also concluded that all the statutory criteria had been met. [See Attachment B.]

Last year, I requested the introduction of a licensure bill at the end of the legislative session with the intent not to have the bill heard or worked by the legislature, but solely for the purposes of getting a printed bill that could be utilized to communicate with other healthcare providers over the interim. At that time, I began talking to the other health care groups about this bill.

Last summer, I wrote letters to the following healthcare groups seeking their feedback on this legislation:

Kansas Board of Healing Arts  
Kansas Association of Osteopathic Medicine  
Kansas Dental Assistants Association



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Kansas Dental Association  
Kansas Dental Hygienists Association  
Kansas Hospital Association  
Kansas Medical Society  
Kansas State Nurses Association

As word got out about our seeking input on the proposed legislation, I eventually heard from other groups, including the following:

Kansas Academy of Physician Assistants  
Kansas Podiatric Medicine Association

We received feedback from a number of these groups. As a result of input from these groups, we made numerous modifications to the bill draft prior to its introduction. As a result of some of the last minute changes being made in response to groups and our working with the Revisor of Statutes, there are still some changes that did not get incorporated properly. When the Committee works the bill, we will provide a balloon amendment which makes some technical changes to the bill draft but which does not, in our opinion, significantly alter the substantive provisions of the bill itself.

Not going into detail, I also want to tell you that as a result of objections raised by the Kansas Medical Society, the Kansas Hospital Association, and others, we have incorporated a liberal grandfather clause providing for the waiver of examination and the two year training program for (1) persons who have operated radiologic technology equipment for two of the three years prior to the effective date of this act, (2) persons whose application includes an affidavit from a hospital administrator, a radiologist, and a licensed practitioner attesting to the applicant's competency, and (3) persons who already meet the requirements of this act by virtue of holding a current certificate from the American Registry of Radiologic Technologists or other comparable boards which meet standards at least as stringent as those established by the board.

We have also made a proposal to the Kansas Medical Society, also articulated to the Kansas Hospital Association and the Kansas Podiatric Medical Association to deal with those persons who wish to be hired after the effective date of the act in individual practitioner's offices or in certain small hospitals. We would consider language providing a limited license for those facilities only which will permit another mechanism to insure that no area or office is unable to perform services because of lack of a licensed professional. These overtures were directly intended to insure that licensure is obtained, so that competent people could continue to practice, and yet to permit a mechanism for the state to insure a minimum level of competency. Licensing these individuals would permit a mechanism for revoking licenses of non-competent individuals and would require licensees to have continuing education, which would have the effect of continuing to upgrade the educational standards of these individuals.

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I might also note that 32 other states require licensure of radiologic technologists throughout the state, including physician's offices, with only a small number of states providing for a mechanism for hardship exceptions or limited licenses.

Despite our best overtures to reach an agreement with the other involved groups, as of the date of this hearing, we have not received a positive response to the proposals we have laid on the table. We anticipate that there will be objections to the licensure bill on many of these grounds, and we want you to know that we have stood willing to address all of those objections with alternatives that we believe to be extremely reasonable.

We urge your support for HB 2274.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

**Attachment A**  
**U.S. States with Licensure/Certification Laws or Regulations**  
**And Year of Implementation**

Arizona-1977	Nebraska-1987
Arkansas - 1999	New Jersey-1968
California-1969	New Mexico-1983
Connecticut-1993	New York-1965
Delaware-1989	Ohio-1995
Florida-1979	Oregon-1979
Hawaii-1974	Rhode Island-1994
Illinois-1990	South Carolina – 1999
Indiana-1982	Texas-1987
Iowa-1987	Utah-1989
Kentucky-1978	Vermont-1984
Louisiana-1984	Virginia-1997
Maine-1984	Washington-1991
Maryland-1992	West Virginia-1977
Massachusetts-1987	Wyoming-1985
Mississippi-1996	
Montana-1977	

**States with Partial Licensure Laws and or Other Forms of Regulation**

Colorado—Laws for mammography and limited (non-ARRT registered) licensure only.

Michigan—Laws for mammography only.

Nevada—Laws for mammography only.

Pennsylvania—Technologists who have not passed the ARRT or other board-approved examination must pass a state examination in order to perform patient examinations in physician, osteopathic physician, podiatrist, chiropractic or dentist offices.

Minnesota\_ Operator of any x-ray equipment for human use must be either a registered radiologic technologist through the ARRT, a licensed person from another state (which are then given an x-ray operator equivalent standing) or have passed one of Minnesota's state approved exams.

Tennessee\_ Licenses radiologic technologists or limited scope personnel working in the offices of medical doctors, chiropractors, osteopathic physicians and podiatrists only.

Wisconsin\_ State requires that anyone performing radiation therapy or computed tomography be registered by the ARRT and that anyone performing hybrid CT/PET examinations be registered by either the ARRT or the NMTCB.

**States without Licensure Laws or with Legislative Proposals Being Considered**

Alabama  
Alaska  
District of Columbia

Missouri

Georgia  
Idaho  
Kansas

2/11/03

7-5

New Hampshire  
North Carolina  
North Dakota  
Oklahoma  
South Dakota



**Attachment B**  
**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT**  
**FINAL REPORT TO THE LEGISLATURE**  
**FROM THE SECRETARY ON THE APPLICATION**  
**OF KANSAS SOCIETY OF RADIOLOGIC TECHNOLOGISTS**  
**FOR LICENSURE**

November 1, 1999

The Kansas Society of Radiologic Technologists submitted a credentialing application requesting licensure for radiologic technologists. The application has been reviewed in accordance with the Kansas Health Occupations Credentialing Act by a technical review committee and the Secretary of Health and Environment. The technical committee conducted four fact-finding meetings, including a public hearing, to investigate the issues. According to K.S.A. 65-5005, within 120 days of receiving the technical committee's report the Secretary is to issue a final report to the Legislature. The technical committee's report was submitted to the Secretary on October 15, 1999. (Attached is the technical committee's report.) This is the final report of the Secretary to the Legislature.

The statutes state that the Secretary is not bound by the recommendations of the technical committee, nor is the Legislature bound by the Secretary's recommendations.

K. S .A. 65-5005 requires that all of the criteria are to be found met and a need for credentialing established prior to the technical committee or Secretary making a recommendation that the application be approved. The technical committee concluded that all criteria were met. The technical committee determined that there was sufficient need shown for licensing of radiologic technologists in order to protect the public from the documented harm, therefore, the technical committee recommends that the application be approved.

In summary, the technical committee findings and conclusions are:

The unlicensed practice of the occupation can harm the public and the potential for harm is recognizable and not remote. Criterion I is met.

The practice of the occupation requires an identifiable body of knowledge acquired through a formal period of advanced study that can be obtained in Kansas; and the public needs, and does benefit, from assurances of initial and continued education. Criterion II is met.

From the information provided, it appears that over half of radiologic technology services are performed under the direction of other health care personnel or inpatient facilities providing health care services. Evidence was provided which indicates that this arrangement is not adequate to protect the public from harm. Therefore, Criterion III is met.

Criterion IV is recognized as asking for documentation on why registration and

certification or other, less regulatory means, are not effective in protecting the public from harm. Evidence was provided which indicates that registration/certification of radiologic technologists at the

national level with no requirements at the state level has not been adequate to protect the public from harm. Thus, Criterion IV is found to be met.

Licensing the occupation appears to have minimal impact on the cost of health care since it does not appear to limit the availability of radiologic technology services. Criterion V is met.

Licensing the occupation appears to have minimal impact on the availability of health care personnel providing services. Thus, Criterion VI is met.

The scope of practice of the occupation is identifiable. Criterion VII is met.

From the information provided, it appears that licensure of radiologic technologists would have minimal effect on the scope of practice of other health care personnel. Therefore, Criterion VIII is met.

Nationally recognized standards of education for providing radiologic technology services exist and are identifiable. Criterion IX is met.

With the first nine criteria having been found to be met, credentialing of the profession to protect the public from the documented harm is appropriate. Licensure was determined to be the least regulatory means of ensuring that the public is protected from the documented harm.

**The Secretary of Health and Environment's Findings, Conclusions and Recommendations Are:**

After consideration of the technical committee's report and the evidence and testimony presented to the committee, I concur with the technical committee's findings and conclusions. I find that the first nine criteria have been met.

I concur that sufficient evidence was presented to warrant credentialing of radiologic technologists in order to protect the public, and that licensure of radiologic technologists is the appropriate level of credentialing to ensure protection from the documented harm.

I recommend that legislative action be taken on the credentialing application.

(Signed)  
Clyde D. Grabber, Secretary

10/22/99  
Date

House Health and Human Services Committee  
Testimony on House Bill 2274  
By Dr. James Owen, Topeka, KS  
Kansas Radiological Society

I am Dr. James Owen. I am a diagnostic radiologist –a member of the medical specialty that deals with x-rays and other forms of diagnostic imaging. I am a Fellow of the American College of Radiology, past President of the Kansas Radiological Society and the Councilor representing the state of Kansas to the Council of the American College of Radiology. I am speaking today representing the KRS, which has previously gone on record in support of legislation to set minimum standards governing the quality of x-ray exams in Kansas. Similar legislation already exists in thirty-seven other states. Both the KRS and the ACR have a long history of support for quality standards in patient care.. The ACR, for example, spearheaded the Mammography Quality Standards Act, which has become the premier example of how standards can be used to improve quality of care. I should preface my remarks by saying that, in general, I am opposed to excessive government regulation and intervention. That should only take place when absolutely necessary to safeguard the public. I believe that the performance of x-ray exams is such a case.

I would like to provide a little background information. There are three components to an x-ray procedure: 1) the equipment, 2) the generation of the x-ray itself and its recording on film, and 3) its professional interpretation. Equipment, by statute, is supposed to be monitored by the KDHE and is not addressed by this bill. The professional interpretation is rendered by a physician. Again, by statute, any licensed physician can provide that interpretation and they are under the regulation of the Board of Healing Arts. The actual generation of the exam is the one area with no oversight whatsoever and no standards. Consequently, it is subject to the highest variability.

Is this a problem? We believe that it is a substantial problem. First of all, the quality of x-ray images is perhaps the single most variable “product” in healthcare in Kansas. That is largely a reflection of the training, knowledge and capabilities of the person generating the images. Most patients presume that the person taking their x-ray knows what he or she is doing. In a great many cases, nothing could be further from the truth. They also presume that their doctor oversees the quality. Again, with the exception of radiologists, most physicians receive no training in x-ray image assessment, and not only are unable to give guidance to the radiographer, they are often unable to determine if the x-ray is even acceptable to interpret.

Attachment 8  
AHS 2-18-03

What problems does this create? There are primarily three: 1) generation of x-rays that are technically inadequate to render a diagnosis, 2) unnecessary radiation exposure to the patient and 3) cost. Poor quality radiographs can make it difficult, if not impossible, to make a diagnosis even in the best of hands. The likelihood of missing a lung cancer on a chest x-ray, for example, goes way up as the quality of the x-ray goes down. My practice, based here in Topeka, interprets x-rays for some forty different locations across northeast and east central Kansas. We have, over the years, been asked by numerous other sites to provide professional interpretations for their exams, and, after an initial assessment, have declined to do so because the films were of such poor quality as to render them, in our opinion, uninterpretable. Those exams are still being performed; they're just not being read by us. This is also not an urban vs. rural issue – we see just as many poor quality images generated around Topeka, Wichita and Kansas City as in rural areas of the state.

Not only does this create problems in initial diagnosis, it also leads to unnecessary additional exams such as the technically inadequate chest x-ray that leads to an unnecessary CAT scan to prove that there is nothing wrong, or the person admitted to the hospital who, as a first step, has to have his basic x-rays repeated so we know where to start in his evaluation. There is, therefore, also a financial cost to this, with which the state, as the administrator of Medicaid, should be fiscally concerned.

Regarding unnecessary radiation exposure, this has two sources. First, patients get excess radiation when the radiographer fails to collimate, or limit, the exposure to just the area in question, and fails to use the proper technique. Second, it occurs when films have to be repeated because they were badly exposed. This happens to all techs occasionally, for a variety of reasons, but it is a bigger problem when the person with his finger on the button has no training. I am aware, for example, of an instance in Topeka in which a child had his face radiated twelve times before the untrained radiographer finally quit trying to get a satisfactory exam of his sinuses. This, to me, is unacceptable.

Who takes x-rays now? This is a picture of extremes. On the one hand are radiologic technologists (R.T.s) – persons who have completed two years of classroom and practical training followed by a national board examination. At the opposite extreme could be, quite literally, ANYONE else. In one practice near Topeka of which we are aware, the x-rays were taken by a girl whose last job was scooping ice cream at Dairy Queen. Her training consisted of being told to “press the button”. She had no idea of how to vary the exposure, let alone correct a problem. It turned out her films were coming out black because she didn't know

the chemicals in the processor needed to be changed monthly (she had never changed them) and that the temperature of the developer was critical (she had no thermometer). Her solution to try to get an x-ray was to just crank up the voltage. It is this sort of situation that we wish to correct.

What do radiographers really need to know? Many people mistakenly believe that it truly is a "push the button" business. The attached list shows some of the parameters of which the radiographer needs to be aware and deal with on every x-ray he or she takes. The process is easiest at the largest hospitals and offices where they can afford more modern and semi-automated equipment. Ironically, that is also where the best-trained radiographers are.

It is our opinion that this is a problem worthy of correction, and one which can be addressed fairly easily by requiring a minimum amount of training and accountability such as this proposed legislation provides.

Obviously, I have not heard testimony from opponents of this legislation. Nevertheless, I would like to briefly address aspects of this bill which I might expect opponents to question.

- 1) This is unnecessary regulation and intrusion into a physician's or hospital's practice of medicine.

As I indicated, I too am opposed to unnecessary regulation. Hopefully, you see why I believe that this is truly needed. Personally, I find it incredible that one has to be licensed to cut hair in Kansas, but not to expose someone to radiation or determine whether or not they have a life-threatening condition.

- 2) There aren't enough RTs to replace people not qualified.

It is true there is a shortage of RTs right now. Ideally, everyone taking x-rays would be an RT, but that is simply not practical at the moment. There are however alternatives, both in the short run and long term. In the short term, you could elect to grandfather in those people currently engaged in radiography with the stipulation that they become certified within, say, two or three years, and that any new radiographers be certified. In the long term, there are alternatives to full RT registration. The ARRT has for example a track that permits limited licensure following a minimal education program. This could be used for those facilities that for whatever reason are unable to attract or support an RT. Finally, I believe in a free market economy. If there is a demand for trained technologists, more people will seek training.



3) This will negatively impact small rural hospitals and practices.

The same approach described above would address this concern. Limited licensure would permit existing radiographers to acquire the minimum training needed to be marginally safe with little effort or cost. Thirty-seven other states, including rural states, already require radiographer licensure. Clearly they have made it a priority and found a way to make it work. That number should also make it clear that we are in a distinct minority in our failure to safeguard patients through proper training. One should also consider that it might be possible that bad radiography is worse than none at all.

4) Cost.

The state would not have to incur any cost of developing and administering exams, since there is already a nationally recognized process through the ARRT. Costs of record-keeping should be borne by those being certified, similar to other groups. The program would be under the Board of Healing Arts, so the infrastructure is already in place.

5) Dentists are exempted.

Frankly, it doesn't matter to me whether or not they are exempt, and I doubt it would matter to them. This legislation was designed to address a need. Dental radiography is limited to a single standardized exam, with limited exposure options using a machine that can be used for nothing else, and dental hygienists all receive appropriate radiographic education in their training programs. My personal perception is that there is not a problem with them.

6) This interferes with physician autonomy and we know what's appropriate.

As I indicated earlier, most physicians have no training in radiographic quality assessment. In addition, every other aspect of their practice has oversight. Furthermore, there are worse things than state regulation. Previously, states failed to adequately monitor clinical laboratory work in physician's offices. The result was CLIA – federal legislation that essentially shut down most office laboratory work completely amid a mountain of



regulatory requirements. Personally, I would prefer to see regulation be done at the local level.

7) This is an attempt to shift all of the x-ray interpretations to radiologists.

As I indicated, this legislation says nothing about who interprets the studies, and the BOHA places no restrictions on individual practitioners. A large percentage of x-rays in Kansas are interpreted by nonradiologists and we as radiologists have no desire to alter that. In addition, there is a shortage of radiologists, just as there is a shortage of technologists, and we couldn't handle the increased workload if we had to.

Hopefully, I have made it clear that there is a quality problem in Kansas related to radiographers and that citizens are being harmed as a result. Our role as physicians is to be advocates for our patients. That should also be the goal of the state regulatory environment. The desire of the Kansas Radiological Society is to do what we can to improve patient care and ensure safe, diagnostic studies for the people of Kansas. We strongly believe this legislation, with modifications as you feel necessary, would foster that goal.

Thank you for your attention and consideration.

## Attachment

Technologist actions when performing a radiographic examination.

### Patient assessment

- confirms patient identification and verifies procedure requested
- verifies patient's pregnancy status when appropriate
- determines if patient has been appropriately prepared for the procedure
- assesses factors that may contraindicate the procedure, such as medication, insufficient preparation or artifacts
- assesses factors that may necessitate a change from the routine procedure

### Analyze assessment information and develop an action plan

- determine need for accessory equipment
- selects appropriate shielding devices
- selects appropriate immobilization devices
- determines appropriate contrast agent
- review chart & request to determine optimal imaging procedure for suspected pathology
- selects appropriate amount of radiation (dependent on patient size, pathology, film, screen, etc.)
- selects appropriate energy of radiation (dependent on energy that is necessary to penetrate the part and dependent on contrast level appropriate for examination)
- select time of exposure (short to control motion or long to allow motion to blur ribs and pleural markings)
- select appropriate film and screen (detail screen to demonstrate bony anatomy, fast screen for abdomen, etc.,)
- select appropriate SID (source to image distance), 40-44 inches for most examinations performed on the table or 72" for chest, lateral C-spine, etc.
- select appropriate focal spot, small vs large
- select appropriate settings that will not harm the x-ray tube
- determine if grid should be utilized
- utilize appropriate phase of respiration - inhalation, exhalation, quiet breathing
- utilize infection control methods
- utilize appropriate body mechanics and patient transfer methods
- determine necessity of filter to compensate for variances in thickness of part to be demonstrated
- restrict the beam to appropriate anatomy
- utilize methods to protect the patient, the operator and any other individuals assisting with exam
- align the tube with the film and the grid
- process film

### Patient education

- verifies that patient has consented to procedure

- provides accurate explanations and instructions at appropriate time and level the patient can understand
- addresses patient questions and concerns regarding procedure when appropriate
- refers questions about diagnosis, treatment or prognosis to the patient's physician

#### Implementation

- implements an action plan that falls within established protocols and guidelines
- elicits cooperation of the patient
- modifies action plan according to changes in the situation
- administers first aid or provides life support in emergency situations
- assesses and monitors the patient's physical and mental state
- monitors for patient reactions to contrast agent
- uses appropriate radiation safety devices

#### Evaluation

- determines if radiograph is of diagnostic quality
  - proper density (too light or too dark)
  - proper contrast (black/white or greys)
  - evaluates detail & distortion
  - determine if there are any artifacts (metal, dirt in cassette, etc.)
  - proper grid alignment
  - necessary anatomy demonstrated
  - correct markers (R/L, time, etc.)
  - correct identification (patient, facility, etc.)
- determines cause of non-diagnostic radiograph
  - due to technique factors (mAs, kVp)
  - due to improper positioning
  - due to pathology
  - due to processing (chemicals, roller marks, etc.)
  - due to artifacts (on the patient, in the cassette, etc)
  - determine if film and screen match, if mAs/kVp are appropriate for film/screen combination
- determines how to improve the radiograph
  - if a change in mAs is necessary - how much
  - changes in patient position
  - adjust technical factors to demonstrate pathology
  - find and remove any artifacts
  - if using automatic exposure control, is it necessary to change the positioning or the density control
- equipment evaluation
  - evaluate if beam restriction device is accurate
  - maintain cleanliness of screens and cassettes
  - test shielding devices to determine if any breaches in lead

**HB 2274**

**House Health and Human Services Committee**

**On behalf of Kansas Society of Radiologic Technologists**

**February 18, 2003**

Mr. Chairman and members of the committee, my name is Randy Stucky and I represent the Kansas Society of Radiologic Technologists, a professional organization founded for the express purpose of enhancing, through education, the proper and safe delivery of medical imaging and therapy services. With me today are registered radiologic technologists and members of the KSRT. We welcome the opportunity to appear before you today and commend the Kansas legislature for its attention to this very important subject.

90% of public exposure to man-made ionizing radiation results from medical procedures, primarily diagnostic x-ray examinations. The **FDA Bureau of Radiologic Health** has estimated that 30% of exposures to man-made radiation are unnecessary, and 5% to 10% of the unnecessary exposures may be attributed to repeated x-ray examinations. If only 0.5% of the exams performed in 1996, which was 350 million, were improperly performed, the consequences would be more than 4100 non diagnostic medical images every day of the year.

Regretfully the improper utilization and production of excessive and unnecessary medical radiation exposure is a widespread practice throughout our state. Over utilization, as well as improper utilization, of radiation in the practice of medicine is a genuine and ever-increasing health hazard to the public and most importantly to those we hold close to us, that it must be dealt with now. A physician using x-ray equipment in his practice is under no obligation to ascertain or require any credential or specific education of the person he or she employs to operate the equipment. Literally, anyone off of the street can be hired this morning and be operating this potentially dangerous equipment this afternoon. Radiation is not detected by the senses of sight, hearing, touch, smell or taste. Without sufficient knowledge of its application, the operator has the potential to produce biological damage not only to the patient, but to himself or herself as well.

Since the enactment of **Public Law 90-602, the Electronic Products Legislation of 1968**, significant steps have been taken to protect public health through the regulation of electronic products such as x-ray and other medical imaging equipment. However, like your car, the operator determines the use and abuse of this equipment. No one would permit his or her car, with all of its safety features, to be driven by someone who has never been taught to drive. And yet, we allow untrained operators to expose our family and friends to radiation that can affect future generations.

*Attachment 9*  
*HHS 2-18-03*

On the Federal level, the U.S. Congress passed a bill in 1981, the **Consumer-Patient Radiation Health and Safety Act**, calling for minimum educational standards for operators of x-ray equipment. The passage of this bill mandated states to establish minimum standards for operators of ionizing radiation equipment. Unfortunately, compliance with this bill is voluntary and there are no penalties for not following this Federal recommendation. One other movement on the Federal level was the approval of the **Mammography Quality Standard Act** of 1992. MQSA established a uniform standard for a radiologic procedure and set minimum qualifications for those who perform it and interpret it. I think all of us can understand the importance of the MQSA. I am confident that everyone here has been touched by the effects of breast cancer in some way.

There are 35 states that have developed minimum standards or adopted regulatory processes for radiologic technologists. One of the 35 states, California, submitted a report to their legislature after 10 years of requiring licensure for radiologic technologists. I have heard that licensure will only raise the cost of healthcare. The report from California showed that for the 10-year period, overall medical fees increased 92.7% throughout the state, while fees for radiology services only increased 59.2%. Certification has not caused increases in the costs of radiology services, but rather has helped to reduce increasing costs of health care through knowledgeable radiologic technologists; competent in reducing not only radiation exposure to the consumer-patient, but also in reducing waste of medical supplies, technologist and patient time and the wear and tear of radiologic equipment from improper use.

During President Jimmy Carter's administration, he formed the **Department of Health and Human Services task force** to investigate the effects of low-level radiation. Among the many recommendations of this report, minimum educational standards for the operators of x-ray machines were recognized as one of the foremost methods of reducing radiation exposure. This report also showed that:

- A patient undergoing the same x-ray examination may receive 100 times more radiation in one hospital or clinic as in another.
- Over 90% of the radiation the general public receives is from exposure to medical x-rays, while less than 10% is from naturally occurring radiation, nuclear fallout, nuclear accidents or nuclear power plants.
- Over 40% of personnel administering ionizing radiation for medical purposes have not received any formal education in radiologic technology.
- 80% of the medical radiation the consumer-patient receives is administered in facilities other than a hospital.

- One patient receives more radiation from an x-ray examination of the abdomen than the entire exposed public received from the Three Mile Island incident.

In 1979, President Carter signed **Executive Order 10831**, which approved a number of recommendations for the guidance of Federal agencies. Recommendation number eight (8) stated:

“Operation of medical or dental x-ray equipment should be (performed) by individuals who have demonstrated proficiency to produce diagnostic quality radiographs with the minimum of exposure required; such proficiency should be assessed through national performance-oriented evaluation procedures or by didactic training and practical experience identical to, equivalent to, or greater than training programs and examination requirements of recognized credentialing organizations”

There are 2600 registered technologists practicing in Kansas that have demonstrated their competency through education and voluntary certification through the American Registry of Radiologic Technologists (ARRT) and other certification bodies. There is no way of knowing how many people with minimal training and no certification are operating x-ray, radiation therapy and other medical imaging equipment in Kansas and administering potentially harmful ionizing radiation to family and friends without having demonstrated scientific knowledge, technical understanding, clinical competency or professional responsibility for the practice of proper radiological procedures.

From its inception, the Kansas Society of Radiologic Technologists has recognized that formal education coupled with moral obligation is a controlling factor in the competence of the individual and in the reduction of unnecessary radiation to both the patient and the practitioner. As educated radiologic technologists, we strive to eliminate unnecessary radiation, and optimize that which is needed to produce a diagnostic image. We have voluntarily submitted to examination and have met the educational standards prescribed by the profession.

The Kansas Society of Radiologic Technologists does not believe there is an alternative to uniform standards. We remain firm in our opinion that without uniform standards for qualifications of persons who perform medical imaging and radiation therapy procedures, the public, specifically family and friends will remain unprotected and at the mercy of untrained



personnel. Because of the unique nature and inherent danger of radiation, the KSRT believes that every patient undergoing a medical imaging examination has the right to have that examination performed properly and with minimal risk by a qualified practitioner.

A voluntary credentialing process for medical radiologic technologists through the American Registry of Radiologic Technologists (ARRT) has existed for over 75 years. Other nationally recognized credentialing agencies are the Nuclear Medicine Technology Certification Board (NMTCB) and Cardiovascular Credentialing International (CCI). But these credentials are voluntary and are not a condition for practice in Kansas. Consequently, the voluntary credentialing programs cannot effectively impact the radiation health and safety of the citizens of Kansas, since non-credentialed personnel can still administer medical radiation examinations.

The number of persons taking the ARRT examination has increased over the last three (3) years. In the field of Diagnostic Radiography: 2001 showed a 10.7% increase, 2002 a 13.7% increase. In the field of Radiation Therapy: 2001 showed a 34.9% increase, 2002 a 27.4% increase. The field of Nuclear Medicine: 2001 showed a 20.4% increase, 2002 a 29% increase. The number of people taking the examination in 2002 in Kansas was 109 radiographers, 37 radiation therapists, and 5 nuclear medicine. Given that there are a limited number of accredited schools for radiography, the numbers are on a rise. In a report sent to us in 2000, of the ARRT technologists who answered these items when renewing their registry: 63% worked in a hospital, 11.4% worked in private offices, and 19.5% worked in clinics. Therefore approximately 31% worked in a clinic or office. Why would a technologist want to work in a clinic or office in which they spend time performing other duties outside of radiology, because of the hours and the no call situation. Most clinics/offices have ours from 8 am to 5 pm, approx.. No holidays to work, evenings or weekends. Granted, there aren't enough graduating students to possibly fill every office in the state. I have been told by three of the five schools in the state of Kansas that they have taken more students this last year than ever before. A hospital in the area that was having trouble recruiting an ARRT technologist, decided to financially help an individual to complete a formal program. They recruited a student from their area who intends to reside in that area for many years. In return for the financial assistance, the student agrees to practice at that facility for a specified length of time. Their first student has graduated, a second will this summer, and another will the following summer. This was not a quick fix, however, it is giving them a good supply of technologists. Another hospital in that area has financially helped several students graduate from a program. Many hospitals are offering some type of assistance either up front or as tuition reimbursement upon hiring. These are only a couple of examples of how communities have solved the issue of finding properly educated registered

technologists. Ultimately, with time, licensure will benefit the doctor's offices/clinics and hospitals, and our family and friends. And provide those in the rural areas, with quality radiological health care and properly educated technologists.

Another benefit to licensure would be the 'policing', if you will, of those that are licensed. Currently, if there is a question to ones ability to perform radiologic examinations, they can easily quit one job and get hired at another place, regardless of the their ability.

We commend the Kansas legislature for its interest and timely concern with respect to the potential health hazards of medical diagnostic x-rays resulting from the lack of proper safeguards and qualifications of persons operating ionizing radiation equipment. We believe that this legislative area demands prompt and effective action. We urge the Kansas legislature to continue its effort to seek a sound legislative solution to this problem which we believe is essential to protect the rights of our family and friends to properly performed radiologic examinations and from the potential hazards of excessive and unnecessary medical imaging examinations and radiation therapy procedures. Thank you.

Randy Stucky  
President  
Kansas Society of Radiologic Technologists

Testimony Re: House Bill 2274  
Presented by Linda Croucher  
Kansas Society of Radiologic Technologists

Feb 18, 2003

Mr. Chairman, Member of the Committee:

I am writing this in support of HB 2274 which proposes to assure persons performing radiologic technology procedures (diagnostic radiology, radiation therapy, and nuclear medicine) have been properly educated. I am a radiologic technologist certified in radiography and teaching in the diagnostic radiography program at Washburn University.

Two benefits of this bill include decreasing the radiation dose to patients and decreasing misdiagnoses. Certified radiologic technologists are taught various techniques to minimize the amount of radiation utilized to create a radiograph. It has been known for many years that radiation can cause detrimental effects to the person exposed and to future generations. Radiation effects are cumulative and those effects might not be demonstrated for many years.

They are also taught parameters of a diagnostic radiograph in order to determine if a repeat is necessary. The technologist must determine if it is too dark, too light, contains motion, does not demonstrate all required anatomy, etc. Films that are too light might mimic pathology while one that is too dark could obstruct pathology. Obviously if the anatomy is not demonstrated on the radiograph, a diagnosis cannot be accurately made. A component of this is also understanding how to correct the problem.

In addition, I would like to share with you some of the examples of less than optimal radiographs performed by non-certified persons that were included in testimony to the Kansas Department of Health & Environment.

- 1) Patient had chest x-ray in office, told he might have cancer, sent to hospital for CT scan. At the hospital it was determined that the x-rays were not quality and the x-rays were repeated. It was then determined that the exam was normal and the CT scan was canceled. Problem: undo stress to patient, unnecessary exposure, additional cost of chest x-ray's, & possibility of additional unnecessary cost and exposure of CT scan.
- 2) Young child had x-rays of the skull. Two projections were taken with no beam restriction. The parent's hands were in the image. The films were non-diagnostic and the radiologist asked that the procedure be repeated. Other areas than the skull were exposed in addition to the parent's hands. Because

the x-rays were non-diagnostic, this radiation exposure was unnecessary. The eyes and thyroid are considered critical organs. Additionally, the cost of the examination was increased.

- 3) Skull x-rays ordered on a motor vehicle accident patient. The non-certified person tried 20 times to get one projection. Again radiation exposure was increased and treatment was delayed while waiting for radiographs.
- 4) A hip x-ray was repeated 9 times trying to get a diagnostic radiograph. Again there is unnecessary radiation dose. The gonads and blood forming organs are also considered critical organs.
- 5) A young female had her lumbar spine exposed 8 times trying to get a diagnostic radiograph. In addition, the beam was not restricted to the spine thus including the gonads.

In addition, following KDHE findings, I was shown flexion/extension cervical spine radiographs taken by a non-certified person. A certified technologist would perform 2 projections (flexion & extension in the lateral position) on 10" X 12" film. This particular examination consisted of an AP flexion, AP extension, lateral flexion, and lateral extension on 14" X 17" film with no beam restriction. The AP projections do not give any diagnostic information and were unnecessary.

I believe that all persons in Kansas deserve quality radiographic examinations. Please consider support of this bill. Thank you.

Linda Croucher, RT(R), MS  
4450 NW 51st Ct.  
Topeka, KS 66618

BOARD  
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February 12, 2003

Testimony RE; House Committee

On behalf of:  
Kansas Society of Radiologic Technologist 2003

Mr. Chairman, Members of the Committee:

I am a Board Certified Orthopedic Surgeon who has been in practice in Topeka, Kansas for 23 years. I am writing this letter at the request of the Kansas Society of Radiologic Technologist with the purpose of stressing the importance of properly done radiographs. The x-rays of which I deal are exclusively confined to the skeletal system and it is very important to have these films taken with proper technique. An improperly taken x-ray misses many pathologic abnormalities. The films can be taken improperly by either the technique of setting the exposure of the machine or more commonly by improperly positioning the patient. Films taken improperly are actually worse than no x-rays at all because the patient and his primary care physician think that the x-rays are normal when in fact the disease process has been missed because the x-ray was not taken properly. We see many examples of this in our daily practice when the patients are referred to us and x-rays sent with them when they are taken in private offices of a variety of practitioners who do not employ properly trained x-ray personnel.

I would, therefore, stress to you the importances of having properly trained people take x-rays on our Kansas patients.. Money spent for an improperly obtained x-ray is wasted and potentially dangerous to the patient.

Sincerely,



Kenneth Gimple, M.D.

KG/mt

**HB 2274**  
**House Health and Human Services Committee**  
**February 18, 2003**

Mr. Chairman, Members of the Committee:

I am writing this letter of testimony for HB #2274 because I feel that the citizens of Kansas deserve quality health care and unfortunately they often are not receiving quality radiographic examinations. I work as a registered radiologic technologist where I have had the opportunity to view many films from hospitals and physicians offices.

It is appalling how many patients are exposed to radiation by unqualified people who don't have the necessary education to realize that continually repeating a film until it "looks" right is unacceptable. These same unqualified people use the largest film size available for the majority of exams. Following is an example of poor quality imaging including incorrect film size, artifact, no collimation, and improper technical factors.

A 2 view cervical spine series was performed on an adult. Both the AP and Lateral views were exposed on 14"x17" films with no collimation. The patient was still wearing their glasses and earrings. The earrings were artifact in the spinous process of C1 and the vertebral body of C2. The patient is also wearing a hospital gown with metal snaps at the shoulders. A metal snap is seen in the zygapophyseal joint of C6-C7. C1 through C6 are seen in the Lateral projection and the top of C7 vertebral body is seen. The bottom of C7 and the junction of C7-T1 are not seen because the film is under penetrated. The correct size of film should have been 8"x10" or 9"x9" or 10"x12". The entire cervical spine must be demonstrated in both views without the presence of artifact since the artifact could hide potentially life-threatening fractures. In this particular series of films there were numerous locations where a fracture could have been hidden.

This is just one example of the poor quality health care that patients are receiving. Radiologic technologists receive education to train them on the proper imaging criteria of the human body. They are also required to document continuing education so they can remain current on information pertaining to delivering quality care for their patients. I feel it is imperative for all persons performing radiologic examinations to document continuing education. I support HB #2274 because I feel that the people of Kansas deserve the best health care and this bill will insure that they receive quality radiologic examinations.

Sincerely,

Denise Orth RT (R)(M)  
Hays, Kansas



Kansas Society of Radiologic Technologists

10-5

Testimony on HB 2274  
House Committee on Health and Human Services  
Kansas Society of Radiologic Technologists  
18 February 2003

Mr. Chairman, Members of the Committee:

I appreciate the opportunity to address you today regarding the bill HB 2274.

As a Radiographer, I have had the opportunity to witness events in the Radiology Suite that can not come close to meeting acceptable standards of film quality and radiation exposure. I would like to present two such incidences.

1. A small baby is radiographed on a 14 by 17 inch film. The examination was to be that of a chest radiograph and, as such, should have been on an 8 by 10 or at most, a 10 by 12 inch film. The collimators (shutters if you will) were left fully open thus irradiating the entire body of the child. This is inconsistent with acceptable standards of minimum exposure. When I asked the person why, the response was, "So I don't miss anything." This person had been educated(?) on the job in a physician office.
2. A young female of about 35 years of age was taken into the radiography suite for a five-film cervical spine (neck) examination. Two hours later, the young woman was released from Radiology with only two of the five films of diagnostic quality. The total number of times this person was exposed to radiation is not known. This person attended an eight-week military training session. He is noted for saying, "It ain't rocket science. Just push the button."

My concern with this bill is to provide educated individuals to irradiate the unsuspecting public. The bill allows for a "grandfather clause" but mandates continuing education. I don't see any harm in getting these people educated one way or another. Currently, that is not happening.

In conclusion, I find it absurd that the barber who cuts my hair must be licensed while anyone off of the street can expose an unaware public to unknown quantities of radiation.

Thank you for your kind attention.

Keith E. Burgess, R.T.  
3915 E. 95<sup>th</sup> Ave.  
Hutchinson, Ks. 67502

**Kansas Academy of Physician Assistants**  
**Legislative Testimony**  
**House Health and Human Services Committee**  
**House Bill No. 2274**

February 18, 2003

Chairman Morrison and Members of the House Health and Human Services Committee:

Thank you for the opportunity to present the written remarks of the Kansas Academy of Physician Assistants on House Bill No. 2274, a measure concerning the regulation and licensure of Radiologic Technologists.

As background, there are more than 500 Physician Assistants (PAs) licensed by the Kansas Board of Healing Arts. In Kansas, the Kansas Academy of Physician Assistants promotes the PA profession and coordinates continuing medical education programs. Our membership includes 325+ licensed PAs and 78 student members.

A Physician Assistant serves an integral part in the practice of medicine by providing needed health care services across this state. Physician Assistants are educated in the medical school model and, participate in the care of patients, by provide medical and surgical care with physician supervision.

The boundaries of a physician Assistant's scope of practice are determined by four parameters:

- The PA's education and experience
- State law and regulatory approach
- Individual facility policy regarding practice privileges
- The Responsible Physician's delegation of healthcare decisions

Because a supervising physician delegates responsibilities to the physician assistant, the PA's role can be very flexible to fit the needs of the practice.

As a part of their comprehensive responsibilities PAs can conduct physical exams, diagnose and treat illnesses, order and interpret test, prescribe medications, counsel on preventive healthcare and assist in surgery.

Physician Assistants provide valuable support to the physicians they work with and to the communities they serve. PAs are like an extra pair of eyes and hands, giving the physician more hours in the week and the ability to concentrate on difficult patient cases. In many of our communities, Physician Assistants are the providers of daily primary care medical services. Without the use of Physician Assistant, the accessibility to medical care in rural areas can be limited.

There is language in HB 2274 that causes us concern in how it may negatively affect rural hospitals and clinics. Currently there are PAs, who are non-radiologic technologists, taking films at the direction of a physician, or under a written protocol. Would a PA now be required to complete the licensing process? Is a PA required to complete a course of study prior to performing radiological procedures delegated by a physician? What is the cost of this process and what will the impact to patient services be?

KAPA supports patient safety, but we would have a hard time supporting the exclusivity issue, unless there is some data proving that a restriction on who may take x-rays will make it safer. In addition, the economics of a small rural hospital's perspective would be a real financial challenge.

We ask that you carefully take into account the potential impact on patient services as you consider this legislation.

Thank you for your time today.

Douglas E. Smith  
Executive Director  
Kansas Academy of Physician Assistants

**From:** Jay Plank <jjayplank@yahoo.com>  
**To:** <morrison@house.state.ks.us>  
**Date:** Thu, Feb 13, 2003 11:06 AM  
**Subject:** HB2274

Dear Rep. Morrison:

I am commenting in regard to HB2274, which would license radiologic technicians. I am not automatically opposed to the licensure of these people, but must ask what public benefit will come with the implementation of this bill that is presently lacking. I can only guess that the rationale behind this move is (ostensibly) the safety of the patient. My pragmatic side is guessing that the radiologic technicians (or a lobbying group on their behalf) is pushing this bill to limit the persons who can perform such procedures in order to create an artificial need for certain persons and inflate salaries when that need cannot be filled adequately by licensed people.

If the safety of the patient is a concern, do you have documentation regarding specific incidents or statistics that show a safety hazard with the present system? If there is any other legitimate reason for the bill, would you share it with me?

Thanks, Jay Plank Logan County Hospital Oakley, KS

jjayplank@yahoo.com

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Do you Yahoo!?  
Yahoo! Shopping - Send Flowers for Valentine's Day

Jin. Morrison

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**From:** rjohn@gpha.hpmin.com  
**Sent:** Friday, February 14, 2003 9:43 AM  
**To:** morrison@house.state.ks.us  
**Cc:** longp@house.state.ks.us; phelps@house.state.ks.us; svaty@house.state.ks.us; williamsj@house.state.ks.us  
**Subject:** HB 2274 - Opposition

Dear Representative Morrison,

I am writing in opposition to HB 2274, which would license radiologic technologists in the state of Kansas. There are many radiologic technicians throughout western Kansas, in the rural hospitals who are not registered, yet are able to perform very well. Many of these technicians have been trained under the supervision of a radiologist and someone else within the hospital who has performed x-ray procedures to the satisfaction of the radiologist. To require licensing of radiologic technologists who perform diagnostic x-ray procedures would increase the cost of manpower to our rural hospitals, since any backup or on call technologists must also be licensed. Certainly, in the short term, grandfathering may reduce the need for hospitals to hire licensed technologists immediately, in the long term they would still be faced with this problem. Great Plains Health Alliance, Inc. leases or manages 25 rural hospitals in Kansas and Nebraska. Many of these hospitals utilize technicians which have been trained through on the job training to take diagnostic x-rays and they perform very well, with no quality problems. To require licensure, would not improve the quality of the radiographs, it would increase costs, and in the long run, would create another shortage of qualified manpower with which rural hospitals would have to struggle. Unlike urban Kansas, our rural communities just do not have the labor pool from which to draw these licensed individuals. I urge your opposition to HB 2274. Thank you.

Roger John  
President and CEO  
Great Plains Health Alliance, Inc.  
P.O. Box 366  
Phillipsburg, KS 67661



**Priti Lakhani, D.P.M., P.A.**

Board Certified American Board of Medical Specialists in Podiatry.  
Primary Care in Podiatric Surgery  
631 SW Home Suite 410  
Topeka, KS 66606  
Office (785) 357-0352  
Fax (785) 357-0356

February 20, 2003

Committee on Health and Human Services

RE: HOUSE BILL #2274

Ladies and Gentlemen,

I have been asked by the Kansas Podiatric Medical Association to address our concerns regarding the above referenced bill. To see this from the patient's perspective, there would be increases in cost, time and inconvenience. If this bill passes and a patient presents to my office with a possible fracture, I am left with one of two options. I can send the patient to the hospital, where they would register in the radiology department, await a technologist, obtain an x-ray, have the radiologist read it, generate a report, sign out the x-ray and report and return to our office. This is a 2-hour proposition. The other scenario is that I am able to obtain the x-ray in my office, taken by my nurse, who has been trained by me, read it and make a diagnosis. If I were to hire an x-ray technologist, it would drive up the already high cost of health care and it would be nearly impossible for me to absorb this cost. Furthermore, access to radiology technologists in western Kansas is limited.

Moreover, it is interesting to me that dentists have been excluded from this bill. I can only assume that this is because the views they use are basic and repetitive. The same argument can be made for podiatric x-rays.

I implore you to consider the effects of this bill on not just podiatrists, but also on the patients we serve. Thank you for your time.

Respectfully Yours,



Priti Lakhani, D.P.M.

# KANSAS

DIVISION OF THE BUDGET  
DUANE A. GOOSSEN, DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

February 18, 2003

The Honorable Jim Morrison, Chairperson  
House Committee on Health and Human Services  
Statehouse, Room 171-W  
Topeka, Kansas 66612

Dear Representative Morrison:

SUBJECT: Fiscal Note for HB 2274 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2274 is respectfully submitted to your committee.

HB 2274 would create the Radiologic Technologists Practice Act. Radiologic technologists use radioactive substances to emit ionizing radiation on humans for diagnostic purposes. The bill would authorize the Board of Healing Arts to license radiologic technologists with the assistance of the Radiologic Technology Council. The Council would advise the Board regarding examination and licensing fees, rules and regulations, subjects of education and examinations, and continuing education requirements. The three classes of radiation technologists are radiographers, radiation therapists, and nuclear medicine technologists. The bill would also establish limits on various fees similar to those imposed on other licensed professions.

Estimated State Fiscal Effect				
	FY 2003 SGF	FY 2003 All Funds	FY 2004 SGF	FY 2004 All Funds
Revenue	--	--	--	\$136,750
Expenditure	--	--	--	\$108,538
FTE Pos.	--	--	--	2.0

12  
10-14

The Honorable Jim Morrison, Chairperson  
February 18, 2003  
Page 2—2274fn

The Board of Healing Arts indicates that HB 2274 would increase its fee revenues and expenditures. The agency does not receive appropriations from the State General Fund. The bill would add three professions to the 13 that it currently regulates. The agency estimates that the number of individuals regulated would increase from 17,500 to 20,200. Based on the increased number of individuals who would be regulated, the agency estimates that its fee fund revenue would increase by \$136,750 in FY 2004. By statute, the agency is required to transfer 20.0 percent of its fee revenue, as agency earnings, to the State General Fund each year. The maximum is \$200,000. Although HB 2274 would increase the agency's fee revenue, this additional revenue would not be transferred to the State General Fund since the agency meets the \$200,000 maximum with the current fee revenues it generates.

To implement HB 2274, the agency estimates that its operating costs would increase by \$108,538 in FY 2004. The agency indicates that it would also need 2.0 additional FTE positions, a Special Investigator II and an Administrative Assistant. The operating costs also would include processing applications, renewal and reinstatements of licenses, and travel and subsistence of the Council, for a total fiscal effect of \$108,538. Any fiscal effect resulting from enactment of HB 2274 is not accounted for in *The FY 2004 Governor's Budget Report*.

Sincerely,



Duane A. Goossen  
Director of the Budget

cc: David Dallam, KDHE  
Betty Johnson, Healing Arts