Approved: 2-20-03
Date

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 20, 2003, in Room 243-N of the Capitol.

All members were present except Representatives Landwehr and Long, who were excused.

Committee staff present:
Bill Wolff, Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:
Doug Billings, Nuclear Technologist, Lawrence
Kevin Robertson, Executive Director, Kansas Dental Association
Jerry Slaughter, Executive Director, Kansas Medical Society
Deborah Stern, Kansas Hospital Association
Larry Buening, Executive Director, Kansas Board of Healing Arts
Chip Wheelen, Executive Director, Kansas Association of Osteopathic Medicine
Rebecca Rice, Kansas Chiropractic Association
Jane O'Bryan, Member, Board of Adult Care Home Administrators
Margaret Farley, Member, Kansas Trial Lawyers Association
Phyllis Kelly, Executive Director, Kansas Adult Care Association
Debra Zehr, Vice President, Kansas Association of Homes and Services for the Aging
Nancy Pierce, Kansas Health Care Association
Joseph Kroll, Director, Bureau of Health Facilities, Kansas Department of Health and Environment

Others attending: See Guest List.

Doug Billings, Nuclear Medicine Technologist, Lawrence, reviewed various levels of nuclear and radiologic technology, saying that all levels require increasing levels of knowledge and expertise, noting that ignorance of radiation procedures puts the patient at risk for misdiagnosis and radiation overexposure. Answering a question regarding the bill increasing wages for employers, he cited studies in Ohio and Maryland showing that after passage of licensure, the average salaries increased only 2-3% over a period of 8 years. (Attachment 1)

Kevin Robertson, Executive Director, Kansas Dental Association, said the Association is neutral regarding licensure of radiologic technologists, since dental procedures are exempt from the bill. He suggested a change to make the dental exemptions more nearly accurate, since dental assistants are not licensed in Kansas. (Attachment 2)

Jerry Slaughter, Executive Director, Kansas Medical Society, also spoke as a neutral party regarding the bill. He said that, after meeting with radiological technologists, KMS recognizes the need to improve

health care; however, he expressed concern regarding smaller medical offices or rural hospitals who could not employ such a person, suggesting that the increased costs would create a severe hardship. KMS suggested two optional amendments to exempt smaller hospitals and medical offices. (Attachment 3)

Deborah Stern, Kansas Hospital Association, spoke in opposition to the bill because of the difficulty of designing a realistic scope of practice without negatively impacting the work-flow of smaller offices and rural hospitals. (Attachment 4) She suggested as options an interim study to add flexibility to the bill, create a minimal-training license, and expand the exemptions. She noted that under present statutes a hospital is legally liable for oversight of radiologic technologists, providing incentive for hospitals to provide adequate training for x-ray personnel.

Chip Wheelen, Executive Director, Kansas Association of Osteopathic Medicine, reviewed testimony of previous conferees, saying that the Committee had been led to believe that x-ray procedures are unregulated. Not so, he said. He cited existing KDHE regulations governing radiation procedures and equipment. Further, he noted that a physician can delegate personnel to do x-rays, something the bill prohibits. Further, he noted that Kansas statutes list the ways a license can be revoked, one of which is incompetence from improper supervision or delegation. He stated that the standards of accountability are already there; there is no need for licensure. He offered a draft amendment to broaden the scope of the bill. (Attachment 5)

Rebecca Rice, Executive Director, Kansas Chiropractor Association, said that after hearing the previous testimony, she could add objections in addition to her comments in Attachment 6; there are too many terms undefined, it is not clear what education is required, and the focus of the bill is ambiguous.

Larry Buening, Executive Director, Kansas Board of Healing Arts, said his board, which originally had oversight over medical doctors, osteopathic doctors and chiropractors, now oversees 13 health-care professions with over 1700 health-care professionals. (Attachment 7) He said this bill would add 1300 more individuals for oversight. He said his board of directors instructed him to oppose the bill because it creates problems of delegation, prohibiting a doctor from delegating unlicensed employees for radiologic services, and it limits access and availability of radiologic services in Kansas.

Committee members asked questions of conferees. Ms. Croucher said presently radiologic technologists receive an associate degree. Mr. Hein said the bill would not disable any present college programs.

The Chair closed the hearing on **HB 2274.**

Staff Bill Wolff provided a briefing on **HB 2171,** which he said involved standards of licensing for adult care home administrators, requiring such administrators to be of good character and properly trained; the bill also creates new fees. He explained that the bill lists three areas in which an administrator is subject to discipline.

Representative Bob Bethell as chair opened the hearing for **HB 2171.**

Jane O'Bryan, Member, Board of Adult Care Home Administrators, spoke in support of the bill, saying it establishes standards of character, training, and experience as eligibility criteria for licensing care home administrators. She noted the bill introduces an additional provision allowing the Board to deny, revoke, or suspend a license if the licensee has been disciplined by other licensing boards. (Attachment 8)

Margaret Farley, Member, Kansas Trial Lawyers Association, offered support for the bill. She said the bill will help improve the overall quality of care in adult care homes, noting that the work of care home administrators is a key to providing good care. (Attachment 9)

Phyllis Kelly, Executive Director, Kansas Adult Care Association, representing over 200 care home administrators in Kansas, also spoke in support of the bill. (Attachment 10)

The Chair closed the hearing on **HB 2171.**

Dr. Wolff briefed the Committee on **HB 2172,** saying that the bill creates an informal dispute resolution process for adult care home administrators as a way of challenging inspection reports, doing so by establishing an arbitration panel of a physician, another medical person, and a person appointed by KDHE. He said any penalty for a deficiency is postponed until the resolution process has been completed. Answering a question, Dr.Wolff said if the inspection process were transferred from KDHE to another agency, there is a transfer process in the new statute.

Representative Bethell opened the hearing for **HB 2172.**

Debra Zehr, Vice President, Kansas Association of Homes and Services for the Aging, said the bill addresses the concern of her members that the present review process is done by the agency that did the original survey. She said this bill would de-link that connection. (Attachment 11) Answering questions, Ms. Zehr said each care home is inspected annually; if deficiencies are severe, a re-inspection occurs within a week or two. She noted that most care homes are under federal guidelines, so a federal process is followed for IDR (Informal Dispute Resolution).

Nancy Pierce, Kansas Health Care Association, testified that her members had voiced similar concerns—that the present survey process is neither independent nor effective. (Attachment12)

Phyllis Kelly, Executive Director, Kansas Adult Care Association, also spoke in support of the bill. (Attachment 13)

Joseph Kroll, Director, Bureau of Health Facilities, Kansas Department of Health and Environment, stated that the intention of the present IDR was not to make the resolution team independent, but to allow the administrator to sit down with the inspection team and work out disputes. He said that statistics from his

office show that most disputes are resolved amicably. He said the KDHE follows the federal regulations for inspections, noting that the bill makes IDR more cumbersome and costly and that, since the federal agency will not pay for the process created by the bill, the costs will be all state dollars. (Attachment14) Answering questions, he said that, guided by federal standards, all violations are placed on a severity grid; most do not involve fines or banning new patients. He said state and federal law require public posting the results of inspections, but that these posting are not done until disputes are resolved. He said most federal and state inspectors are at least RNs; all have experience in administration, and all receive training.

Margaret Farley, Member, Kansas Trial Lawyers Association, spoke in opposition to the bill, saying the process for selecting panel members is vague and current procedures for resolving disputes are comprehensive and adequate. (Attachment 15) She noted that this bill would be costly to the state, adding a further level of bureaucracy without any benefit to administrators of care homes beyond what provisions for resolution they already have. She said if the bill passes, she would want to see the costs borne by care homes. The chair read a fiscal note from the Division of the Budget that the additional cost to the state would range from $264,000 to $338,000 annually.

The Chair closed the hearing on **HB 2172.**

The meeting was adjourned at 3:15 p.m. The next meeting is scheduled for Monday, February 24, at 1:30 p.m. Chairman Morrison announced that, if possible, all bills that had received a hearing would be worked.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: FEBRUARY 20 2003

NAME	REPRESENTING
Nancy Pierce	KHCA
Joseph Moore	KOHE
Shelly Keely	KACE
Christina Collins	KMS
Jerry Slaughter	KAPS
Carolyn Middendorf	Ks St Ds Assn
Doug Billings	KSRT- Nuclear Medicine
Linda Croucher	KSRT
Rebecca Fin	KCA
Chip Wheelen	Assn of Osteopathic Med.
LARRY BUENING	BD OF HEALING ARTS.
Ron Seeker	KS Society Rad. Techs
Rebecca Zeigler	Federico Consulting
M. Ewert	Self HV County Advsy Com Aging
Mary McAfee	HV Co. Agency
V. King	HV Co. Aging
Wayne Probasco	Ks Podiatric Med Assn
Doug Bowman	Ks Coordinating Council on Early Childhood
Aaron Dybvad	Rep. J. Williams (INTERN)
Mary Lou Allison	Central Plains AAA
Kathryn Hannemann	Harvey County Dept. on Aging
Loretta Hoekman	KAPA
Jane O'Bryan	BACHA

e-GOVERNMENT COMMITTEE
GUEST LIST
DATE: Feb. 20 - 2003

NAME	REPRESENTING
Joe Brown	Sg County Council on Aging *
Ron Hein	Ks Society of Radiologic Technologists
Dodie Wellshear Johnson	Patrick Hurley & Co (KAFP)

HB 2274 Testimony
House Health and Human Services Committee

Mr. Chairman and members of the committee, my name is Doug Billings. I am a Registered Radiologic Technologist and a Registered Nuclear Medicine Technologist. Thank you for the opportunity to speak to you today.

Radiologic Technologist Training

A Registered Radiologic Technologist or Medical Diagnostic Radiographer is educated in the safe use of radiation emitting equipment to produce images of various parts of the body to assist in the diagnosis of disease processes. Radiographers must complete a formal educational program accredited by a mechanism acceptable to the American Registry of Radiologic Technologists to be eligible to take the national examination. The curricula of the program shall include at least the following areas of study. Medical Ethics and Law, Principles of Diagnostic Imaging, Imaging equipment, Radiographic Processing, Human Structure and Function, Medical Terminology, Principles of Radiographic Exposure, Radiographic Procedures, Principles of Radiation Protection, Radiographic Film Evaluation, Methods of Patient Care, Pathology, Quality Assurance, Radiation Physics, Radiobiology, Introduction to computer science and clinical education. In addition to the body of knowledge there are specific skills and abilities technologists must demonstrate proficiency in to be eligible for the national examination.

Radiation therapists are educated in the safe and effective use of a variety of therapeutic equipment, including high energy linear accelerators, radioactive isotopes, and particle generators. This equipment is used to administer ionizing radiation usually to cure or improve the quality of life of patients with malignant and non-malignant disease. The curricula for accredited therapy programs include most of the same areas of study of the radiologic technologist with additional emphasis on radiation oncology, oncologic pathology, radiobiology and clinical dosimetry.

Nuclear Medicine Technologists are also educated in the safe and effective use of equipment that detects ionizing radiation. Nuclear medicine involves the use of radioactive materials for diagnostic and therapeutic studies. Nuclear procedures are used to diagnose and treat a wide range of abnormalities or disease processes including
infections, tumors, infarctions and a wide variety of functional/physiological disorders. Nuclear medicine technologists calculate, prepare and administer radiopharmaceuticals to patients by intravenous, intramuscular, subcutaneous, and oral methods. Radionuclides are also utilized to treat specific diseases and cancers in the body. The curricula involves the same core as the radiologic technologist with an additional emphasis on nuclear and health physics, radionuclide chemistry, radiopharmacy, radionuclide therapy and instrumentation and statistics.

Attachment 1
HHS 2.20-03

The diagnostic and therapeutic areas of medicine are incredibly dynamic requiring continued education. Technologists and therapists learn their education does not stop with graduation or at the end of a training program, it will be a lifelong experience in learning. The critical thinking and problem solving skills develop through the education experience and continue to grow with the advanced educational opportunities available. Radiologic technologists are required to document a specific number of hours of continuing education. The choice is left to the discretion of the technologist, realizing they are an educated professional who is capable of making appropriate decisions pertaining to the areas of study most beneficial to their position.

Harm to Public by Radiotion Exposure

We have all heard considerable concern regarding the risks from radiation exposure. And yet, rarely do you hear anything about the exposure to man-made ionizing radiation resulting from medical procedures, which accounts for approximately ninety percent of the public's exposure to radiation. Virtually, every individual present today has had a x-ray examination performed in the last three years. How many of these examinations were performed by technologists that have been educated in the proper and safe use of radiation? Were you overexposed to radiation? Data published by the Federal government tells us that the number of U.S. citizens receiving x-ray examinations has risen from 130 million examinations in 1970 to approximately 350 million in 1996. This increase in x-ray usage is attributed to greater sophistication of diagnostic imaging equipment. Regardless how sophisticated or how simple the imaging equipment may be there is still a great potential for misuse and damage from radiation.

The production of radiation in the practice of medicine is an invaluable tool in the diagnosis and treatment of disease. Even so, the utilization of radiation in medicine is not without risks and an inherent potential of biological damage to healthy tissue. Any exposure to ionizing radiation, however small the dose, increases the risks of developing cancer, leukemia, cataracts, blood disorders and birth defects or mental retardation in developing fetuses. Any unnecessary exposure therefore produces a risk without benefit to the patient.

The increased risks associated with unnecessary or excessive exposure to radiation include somatic and genetic effects. The biological effects of ionizing radiation on generations yet unborn are termed genetic effects. The chromosome mutations on reproductive cells occur as a result of radiation-induced damage to the DNA of reproductive cells. The use of ionizing radiation does not create new mutations, but it does increase the incidence of known mutations. The number of mutations is proportional to the radiation dose received. Certified technologists practice radiation protection methods to minimize gonadal doses.

Radiographs that are not properly exposed are detrimental to a correct diagnosis. Improper radiographic exposure may cover up a disease process or fracture or may mimic a disease.

Studies of Trained Versus Untrained Radiologic Technologists

A study done in Texas by Dr. Karl Dockray looked at 25,000 cases taken by registered technologists and 20,997 cases taken by persons with mixed or no formal education. The non-certified had 2.8 times more radiographs that were too dark, 4 times more that were too light, 3.5 times more exhibited motion, 7 times more with production artifacts and 4.5 times more with missing anatomy. The poor quality examination leads to repeat examinations resulting in increased exposure and unnecessary delays in diagnosis and treatment. Certified technologists are taught radiograph evaluation criteria and the necessary adjustments required in the event a repeat film is necessary.

The National Evaluation of X-Ray Trends (NEXT) Program – FDA obtained data from states on physical factors related to patient radiation exposure from several common radiographs. The study showed that trained technologists delivered a significantly lower radiation dose to the patient than the untrained operators. A Canadian study also found that the dose delivered to the patient was significantly lower when administered by an educated technologist.

The South Carolina Department of Health and Environment Control did a study from January 1990 to March 1994 while inspecting x-ray equipment. The inspectors included an evaluation of radiographs in their inspections. They determined that ARRT operators performed fewer operator violations (patient over- and under-exposure and failure to restrict the beam to the area of study) than non-registered operators

Health Care Cost Issues

Some believe that licensure will increase wages. Salary information gathered from the Bureau of Labor Statistics and American Hospital Association surveys show the following: Ohio had licensure enacted in 1995. The average salary four years before in 1991 was $12.63. Over the next five years salaries increased 12% to an average in 1996—1997 of $14. 28. Over the next two years the salaries increased an additional 7% in 1998-99 to $15.34. Maryland enacted licensure in 1992. The average salary in Maryland in 1990 was $13.29. Over the next 6-7 years the salaries rose 20% to $16.42. An additional increase of 7% over the next two years ending in 1999 showed an average salary of $17.45. Over a nine year period average salaries increased a total of 27% in Maryland. The average 3% per year salary increase may be easily explained by cost-of-living adjustments and merit increases.

In 1997 the ASRT performed a salary study on registered technologists. The average salary for Kansas and the surrounding states are as follows: Kansas $15.74, Nebraska $15.74, Colorado $16.87, Missouri $16.38, Iowa $15.51 and Oklahoma $15.75. RT Image published average annual salary information in their January 13, 2003 issue. The findings for Kansas and the surrounding states are as follows: Kansas $33,520, Nebraska $32,840, Colorado $38,930, Missouri $35,740, Iowa $31,920 and Oklahoma $33,830. Of the states listed in both the studies, Nebraska and Iowa have full licensure. Colorado has limited licensure. The salaries in both studies demonstrate comparable salaries in Kansas and the surrounding states in the Midwest. It further demonstrates the salaries in Nebraska and Iowa with full licensure are actually at or below the salaries for registered technologists in Kansas.

Improperly Trained Radiation Technicians is a Statewide Concern.
Regretfully the improper utilization and production of excessive and unnecessary medical radiation exposure is a widespread practice throughout the state. A facility in the State of Kansas is under no obligation to require any credential or specific education of the person employed to operate the equipment.

Sadly, the patient is rarely in a position to judge the qualifications of the operator or the quality of the examination, let alone the radiation dosage they received. Properly calibrated equipment and well-educated radiologic technologists are primary elements in the safe delivery of this radiation. Lacking this education, the unqualified operator poses a serious threat to the safety of the patient.

In 1999 I contacted a number of small rural hospitals in western Kansas during the Technical Committee Review. Most of the facilities have lab technicians performing the x-ray examinations. Several of the lab technicians that I spoke to did not feel comfortable taking x-rays. One person I spoke to told me, "I would rather not be doing x-rays. I am to busy doing lab and there are thirty others here just as qualified as me to take x-rays." He also told me they had interviewed eight prospective lab directors but have been unsuccessful due to the x-ray part of the position. Another hospital I called had four lab technicians that also performed the x-ray examinations. The lead lab technician told me he preferred not to be taking x-rays since he really didn't know anything about it. He also told me he did not like to do fluoro (fluoroscopic x-rays) due to concerns with it. One facility I spoke to had three people who had been trained by their "boss". The person I spoke to felt they should know more about what they were doing. Each of the facilities I spoke with about pay felt a registered technologist would be paid about the same as the lab technicians. The pay range repeatedly quoted to me was in the ten to twelve dollar range. Properly qualified staffing in these facilities can be accomplished for the safety of the patients.

Kansans living in rural areas deserve the same level of health care as those who have access to urban medical centers. They shouldn't be expected to settle for

a lesser quality of care or put their health in the hands of unqualified health care providers just because they live in a rural environment. Several rural states are among the thirty-five
that have already enacted licensure laws. Those states include Arizona, Montana, Nebraska, and New Mexico. In those states, rural populations have not suffered from the
licensure laws. In fact licensure improves the quality of health care provided to the rural areas. The added costs due to misdiagnosis from poor quality x-ray procedures are significantly reduced. In malpractice lawsuits, standard of care becomes a very important issue. The accepted standard of care would be based on what the radiologic technologist has been taught. They are educated in the proper safe use of ionizing radiation to produce high quality diagnostic images and the potential damage from improper use of radiation. A recent study released in the April 27 issue of the Proceedings of the National Academy of Sciences reported that, "ionizing radiation's damaging effects may be more widespread in cells than previously believed". The study showed that low-level ionizing radiation increased DNA mutation rates threefold. Unnecessary radiation exposure is a serious concern. Concerns with exposure and misdiagnosis were addressed with the passage of the Mammography Quality Standards Act in 1992.

Mammography Quality Standards Act

The Mammography Quality Standards Act (MQSA) was passed to insure that only qualified technologists could perform mammograms. The MQSA also requires the proper calibration of equipment and film processors as well as continuing education requirements. These requirements are to insure the patient's safety and to provide a more accurate diagnosis of disease processes. Imaging and therapy standards should be a right for every Kansan not only those that fall under the Mammography Quality Standards Act. We should never overlook the consumer-patients rights. I would like to close with one thought for each of you to reflect on. If you would consider each of the consumer-patients as if they were a member of your own family or yourself, wouldn't you want to consider their health and safety first?

I want to give my sincere thanks to the Committee for giving me the opportunity to speak.

Doug Billings, B.A. R.T. (R), C.N.M.T
Past-President Kansas Society of Radiologic Technologists
Nuclear Medicine Technologist-Lawrence, Kansas
February 18, 2003

Revised

KANSAS DENTAL ASSOCIATION

Date: February 20, 2003

To: House Committee on Health and Human Services

From: Kevin J. Robertson, CAE
Executive Director

RE: HB 2274 – Licensure of Radiologic Technologists (Revised)

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 here today as a neutral party with regard to HB 2274. Since the earliest inception of this concept dating back several years, it has been clear that the intent of this and past legislation has not been to license dental personnel that are licensed by the Dental Board or are under supervision of a dentist. This is the case because dental x-rays expose a patient to very low doses of radiation. Information I gathered two years ago from the KDHE Bureau Air and Radiation indicated that a typical 15 milliamp dental radiograph machine creates very low exposure to the patient as the radiograph is confined to a limited area, the film is in close proximity to the machine, and the exposure is only .10 to .25 second. All things considered, exposure from a dental x-ray is only 2-5 MAS.

With that having been said, the language exempting dental offices in section 5(d) (page 3, line 3-5), needs some modification as dental assistants are not licensed and, therefore, their practice has no "provisions of law."

I would suggest something like the following

5(d) a licensed dentist, a licensed dental hygienist or an unlicensed person working under the supervision of a licensed dentist who has been trained by a licensed dentist on the proper use of dental radiographic equipment for the purpose of providing medical imaging for dental diagnostic purposes consistent with KSA 65-1422 et. seq. and amendments thereto.

There may be other language that would adequately exempt dental office personnel, and the KDA would be open to those suggestions.

Thank you for your time, I will be happy to answer any questions you may have at this time.

Attachment 2
HHS 2-20-03

HOUSE HEALTH & HUMAN SERVICES COMMITTEE
PUBLIC HEARING 2.18.03

Session of 2003

HOUSE BILL No. 2161

By Committee on Health and Human Services

2-3

AN ACT regarding dentists and dentistry; relating to dental hygienists; amending K.S.A. 65-1456 and repealing the existing section.

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

Section 1. K.S.A. 65-1456 is hereby amended to read as follows: 65-1456. (a) The board may suspend or revoke the license of any dentist who shall permit any dental hygienist operating under such dentist's supervision to perform any operation other than that permitted under the provisions of article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof, and may suspend or revoke the license of any hygienist found guilty of performing any operation other than those permitted under article 14 of chapter 65 of the Kansas Statutes Annotated, or acts amendatory thereof. No license of any dentist or dental hygienist shall be suspended or revoked in any administrative proceedings without first complying with the notice and hearing requirements of the Kansas administrative procedure act.

(b) The practice of dental hygiene shall include those educational, preventive, and therapeutic procedures which result in the removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci. Included among those educational, preventive and therapeutic procedures are the instruction of the patient as to daily personal care, protecting the teeth from dental caries, the scaling and polishing of the crown surfaces and the planing of the root surfaces, in addition to the curettage of those soft tissues lining the free gingiva to the depth of the gingival sulcus and such additional educational, preventive and therapeutic procedures as the board may establish by rules and regulations.

(c) Subject to such prohibitions, limitations and conditions as the board may prescribe by rules and regulations, any licensed dental hygienist may practice dental hygiene and may also perform such dental service as may be performed by a dental assistant under the provisions of K.S.A. 65-1423 and amendments thereto.

(d) Except as otherwise provided in this section, the practice of dental hygiene shall be performed under the direct or general supervision of a licensed dentist at the office of such licensed dentist. The board shall

designate by rules and regulations the procedures which may be performed by a dental hygienist under direct supervision and the procedures which may be performed under general supervision of a licensed dentist. As used in this section: (1) "Direct supervision" means that the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure and before dismissal of the patient evaluates the performance; and (2) "general supervision" means a Kansas licensed dentist may delegate verbally or by written authorization the performance of a service, task or procedure to a licensed dental hygienist under the supervision and responsibility of the dentist, if the dental hygienist is licensed to perform the function, and the supervising dentist examines the patient at the time the dental hygiene procedure is performed, or during the 12 calendar months preceding the performance of the procedure, except that the licensed hygienist shall not be permitted to diagnose a dental disease or ailment, prescribe any treatment or a regimen thereof, prescribe, order or dispense medication or perform any procedure which is irreversible or which involves the intentional cutting of the soft or hard tissue by any means. A dentist is not required to be on the premises at the time a hygienist performs a function delegated under part (2) of this subsection.

(e) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution, local health department or indigent health care clinic on a resident of a facility, client or patient thereof so long as:

(1) A licensed dentist has delegated the performance of the service, task or procedure;

(2) the dental hygienist is under the supervision and responsibility of the dentist;

(3) either the supervising dentist is personally present or the services, tasks and procedures are limited to the cleaning of teeth, education and preventive care;

(4) the supervising dentist examines the patient at the time the dental hygiene procedure is performed or has examined the patient during the 12 calendar months preceding performance of the procedure; and

~~(5) nothing in this subsection (e) shall be construed to prevent a dental hygienist from providing dental education *hygiene instruction or visual oral health care screenings* in a school or community based setting.~~

~~(f) The board may issue a permit to a licensed dental hygienist to provide dental screening under such terms and conditions as the board may reasonably establish in such permit. Such permit shall be subject to renewal at the time the license for dental hygiene is renewed.~~

~~(g)~~ *(f) The practice of dental hygiene may be performed at a public school or accredited non public school, as defined in K.S.A. 72-89b02, and*

delete lines 35-37

amendments thereto, head start program, state correctional institution, local health department or indigent health care clinic, as defined in K.S.A. 65-1466, and amendments thereto, on a student who meets the requirements of medicaid, healthwave or the federal free and reduced lunch program, an inmate, client or patient thereof so long as:

(1) The dental hygienist has received an "extended care permit" from the Kansas dental board specifying that the dental hygienist has performed 1,800 hours of dental hygiene care or has been an instructor at an accredited dental hygiene program for four semesters during the three years prior;

(2) the dental hygienist shows proof of professional liability insurance;

(3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit;

(4) the tasks and procedures are limited to: (A) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; (B) the application of fluoride; (C) dental hygiene instruction; (D) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities; and (E) other duties as may be delegated verbally or in writing by the sponsoring dentists consistent with this act;

(5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute a comprehensive dental diagnosis and care;

(6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in this subsection;

(7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in this subsection; and

(8) nothing in this subsection shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health screenings in a school or community based setting.

(g) The practice of dental hygiene may be performed at an adult care home, hospital long-term care unit, state institution or at the home of a homebound person who qualifies for the federal home and community based service (HCBS) waiver on a resident of a facility, client or patient thereof so long as:

(1) The dental hygienist has received an "extended care permit II" from the Kansas dental board specifying that the dental hygienist has: (A)

performed 1,800 hours of dental hygiene care or has been an instructor at an accredited dental hygiene program for four semesters during the three years prior; and (B) completed six hours of training on the care of special needs patients or other training as may be accepted by the board;

(2) the dental hygienist shows proof of professional liability insurance;

(3) the dental hygienist is sponsored by a dentist licensed in the state of Kansas, including a signed agreement stating that the dentist shall monitor the dental hygienist's activities, except such dentist shall not monitor more than five dental hygienists with an extended care permit II;

(4) the tasks and procedures are limited to: (A) removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci; (B) the application of fluoride; (C) dental hygiene instruction; (D) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities; and (E) other duties as may be delegated verbally or in writing by the sponsoring dentist consistent with this act;

(5) the dental hygienist advises the patient and legal guardian that the services are preventive in nature and do not constitute comprehensive dental diagnosis and care;

(6) the dental hygienist provides a copy of the findings and the report of treatment to the sponsoring dentist and any other dental or medical supervisor at a participating organization found in this subsection;

(7) any payment to the dental hygienist for dental hygiene services is received from the sponsoring dentist or the participating organization found in this subsection;

(8) the dental hygienist completes a minimum of six hours of education in the area of special needs care within the board's continuing dental education requirements for relicensure; and

(9) nothing in this subsection shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health screenings in a school or community based setting.

(h) In addition to the duties specifically mentioned in subsection (b) of K.S.A. 65-1456, and amendments thereto, any duly licensed dental hygienist may:

(1) Give fluoride treatments as a prophylactic measure, as defined by the United States public health service and as recommended for use in dentistry;

(2) remove overhanging restoration margins and periodontal surgery materials by hand scaling instruments; and

(3) administer local block and infiltration anaesthesia and nitrous oxide. (A) The administration of local anaesthesia shall be performed under

the direct supervision of a licensed dentist. (B) Each dental hygienist who administers local anaesthesia shall have completed courses of instruction in local anaesthesia and nitrous oxide which have been approved by the board.

~~(h)~~ *(i)* (1) The courses of instruction required in subsection ~~(g)~~ *(h)*(3)(B) ~~of K.S.A. 65-1456, and amendments thereto,~~ shall provide a minimum of 12 hours of instruction at a teaching institution accredited by the American dental association.

(2) The courses of instruction shall include courses which provide both didactic and clinical instruction in: (A) Theory of pain control; (B) anatomy; (C) medical history; (D) pharmacology; and (E) emergencies and complications.

(3) Certification in cardiac pulmonary resuscitation shall be required in all cases.

Sec. 2. K.S.A. 65-1456 is hereby repealed.

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

add new subsection (j)

The board is authorized to issue to a qualified dental hygienist an extended care permit or extended care permit II as provided in subsection (f) and (g) of this section.

add new subsection (k)

Nothing in this section shall be construed to prevent a dental hygienist from providing dental hygiene instruction or visual oral health care screenings in a school or community based setting.

KANSAS MEDICAL SOCIETY

KMS

To: House Health and Human Services Committee

From: Jerry Slaughter
Executive Director

Date: February 18, 2003

Subject: HB 2274; concerning licensure of radiologic technologists

The Kansas Medical Society appreciates the opportunity to appear today on HB 2274, which would create a licensing act for radiologic technologists. While we do not oppose the regulation and credentialing of radiologic technologists generally, we do have some problems with the bill as it is currently written.

Specifically, enactment of this bill will make it illegal for anyone other than a licensed radiologic technologist to operate an x-ray machine for diagnostic or therapeutic purposes. The only exceptions to that requirement are for licensees of the healing arts board (physicians, chiropractors, podiatrists) when they personally provide the service, students, health care providers in the armed services, and dentists, dental hygienists and dental assistants. In other words, any physician who provides x-ray services in his or her medical office would have to employ a licensed radiologic technologist to operate the x-ray unit. Particularly in rural areas, this requirement is problematic.

First, there is not an overabundance of radiologic technologists available. Many physician offices would find it difficult to find a licensed individual. Second, in many small physician practices it is necessary to have employees cross-trained to provide a wide range of services such as basic diagnostic laboratory and x-ray services, as well as other patient care services, all under the direction and supervision of a physician. Requiring every office in which x-rays are provided to employ a licensed radiologic technologist would be costly, impractical, and probably not possible, particularly in rural areas. By imposing this requirement on small physician practices, the legislature would make it more difficult for those practices to provide a full range of services, which would not be to the benefit of patients.

The legislation does contain a "grandfather" clause (section 10, page 6), but it would only apply to persons who are currently working for physicians, and would not help in the case of an individual who went to work for a physician after the effective date of the act.

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We cannot support this bill as it is written, but would offer the following suggestions to make it more workable. Either (1) exempt physician offices and persons working under the direction and supervision of physicians entirely, as is the case with dentists; or (2) exempt persons working under physician direction for diagnostic x-ray services only. Option 1 is a broader exception, while option 2 is narrower and would still require licensure if the person performed services which involved the injection of contrast media or radioactive substances, or used radiation for therapeutic purposes. We could support either option. We have attached a balloon amendment of both options.

We would urge you to adopt one of the two options suggested on our attachment. Thank you for the opportunity go offer these comments.

To: House Health and Human Services Committee
From: Kansas Hospital Association
Thomas L. Bell, Executive Vice President
Re: House Bill 2274

Thank you for the opportunity to comment regarding the provisions of HB 2274. This bill would provide for the licensure of radiologic technologists in the state of Kansas. As a result of the passage of this legislation a distinct scope of practice would be created for this group of health care workers. At the same time, other workers who might perform a task that is included in the scope of practice set out in the legislation would be penalized unless they were licensed. Legislation such as HB 2274, which grants credentialing status to a particular group, must be given careful review as it can affect the quality of health care provided to the public, increase the cost of health care, increase costs to employers and limit the ability of certain workers to provide health care in Kansas.

Health care providers in Kansas and across the nation are having more and more difficulty recruiting and retaining qualified health care personnel. Recently, the Kansas Hospital Association conducted a member survey that identified workforce shortages as one of the most critical problems facing hospitals in Kansas. Both statistical and anecdotal evidence of a long-term shortage of health care personnel continues to build. Hospitals are reporting immediate difficulty filling positions such as staff nurses, radiologic technologists, sonographers, nurse anesthetists, pharmacists, paraprofessionals and entry-level workers. The map following our testimony shows the most current regional vacancy rates for radiologic technologists in Kansas.

The factors contributing to health care workforce shortages are complex. Clearly, the demand for health care services continues to increase with the explosion of new technology and aging of the population. The over 85 age group is the fastest expanding segment of the Kansas population. Persons in this age group require more health care services, and the demand for health care workers is projected to increase accordingly. In addition, the health care workforce is aging. The supply of health care workers also is projected to decline because fewer young people are choosing a health occupation as a career. Furthermore, the labor market is extremely competitive, and workers may opt for higher paying jobs in other sectors of the economy.

It is against this uncertain background that HB 2274 must be judged. In short, the committee must decide whether legislation such as this does anything to help resolve the current workforce shortages. Many of our small rural hospitals must cross train their personnel to perform diagnostic radiological procedures. This is done in order to assure adequate on call staff in a way that is financially feasible. The training of these staff members may be done on site, at the hospital or through the secondary and tertiary hospitals willing to assist. Small rural hospitals have had to utilize on the job training to provide adequate coverage for their radiology departments. Current Kansas hospital

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regulations, which are enforced by the Kansas Department of Health and Environment, require that the personnel working in a hospital radiology department must be qualified for the type of service performed. In addition, current federal regulations state that in hospitals only personnel designated by the medical staff may use the radiologic equipment and administer procedures. Because of this, HB 2274 as written could create a regulatory barrier to the delivery of these types of services in some parts of the state.

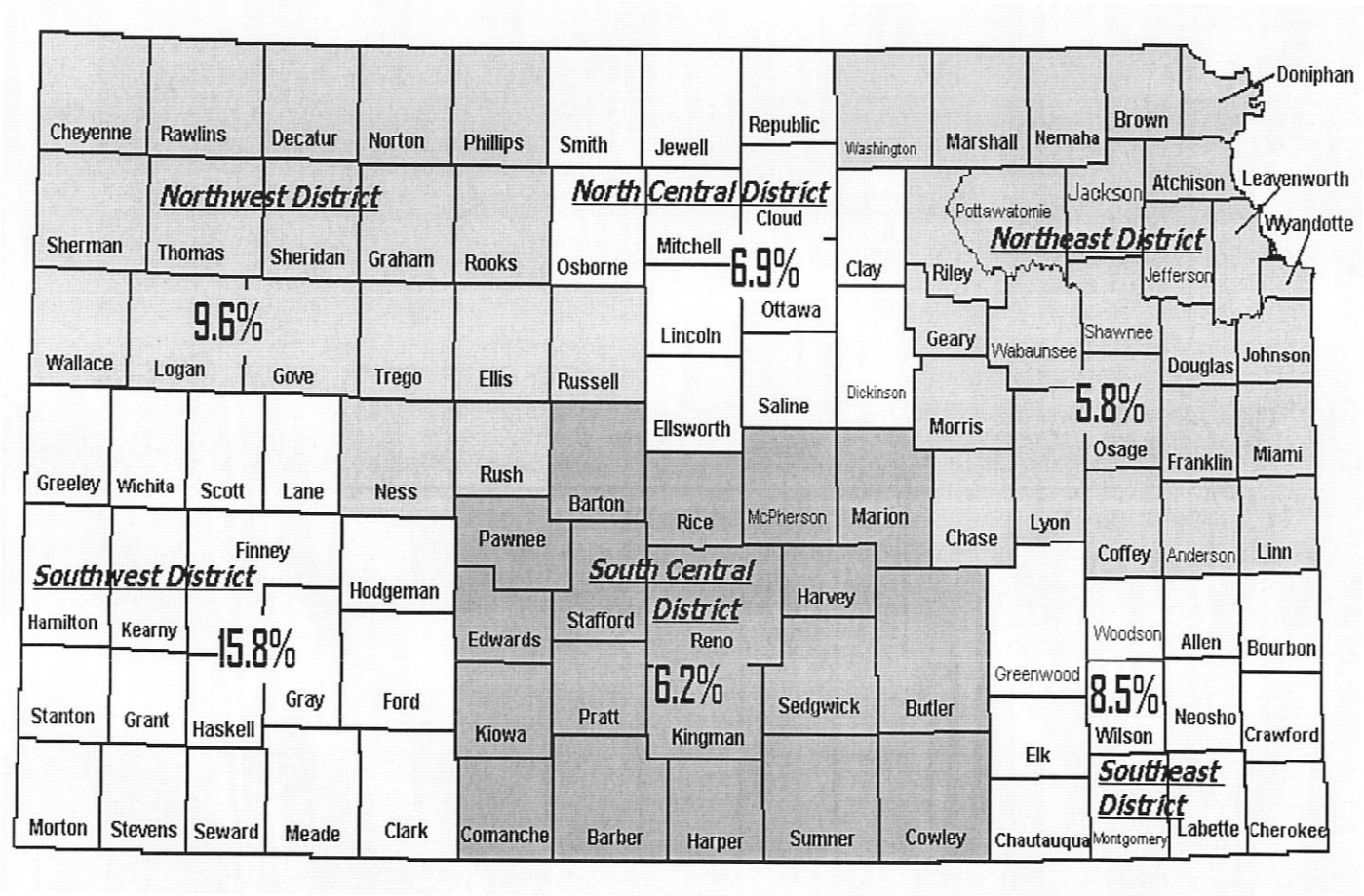
With regard to HB 2274 specifically, there are several areas that need to be examined. First, the committee must remember that it has the less regulatory tools of the credentialing law available to it, including certification or registration. Second, the committee could expand the exemptions for diagnostic radiology in the current bill. An exception for dentists' offices is already in the bill. The Nebraska law provides an exception to some of the requirements for employees in rural hospitals. Third, HB 2274 does not do an adequate job of recognizing that other health care providers may be impacted by the creation of an exclusive scope of practice. For, example the Kansas law that licenses respiratory therapists makes the following statement:

> *Nothing in this act is intended to limit, preclude or otherwise interfere with the practices of other health care providers formally trained and licensed, registered, credentialed or certified by appropriate agencies of the state of Kansas. The practice of respiratory therapy shall not be construed to include the following individuals:*
> *(1) Persons rendering assistance in the case of an emergency.*
> *(2) Members of any church practicing their religious tenets.*
> *(3) Persons whose services are performed pursuant to the delegation of and under the supervision of a respiratory therapist who is licensed under this act.*
> *(4) Health care providers in the United States armed forces, public health services, federal facilities and coast guard or other military service when acting in the line of duty in this state.*
> *(5) Licensees under the healing arts act, and practicing their professions, when licensed and practicing in accordance with the provisions of law or persons performing services pursuant to the delegation of a licensed physician under subsection (g) of K.S.A. 65-2872 and amendments thereto.*
> *(6) Dentists practicing their professions, when licensed and practicing in accordance with the provisions of law.*
> *(7) Nurses practicing their professions, when licensed and practicing in accordance with the provisions of law or persons performing services pursuant to the delegation of a licensed nurse under subsection (m) of K.S.A. 65-1124 and amendments thereto.*
> *(8) Health care providers who have been formally trained and are practicing in accordance with the training or have received specific training in one or more functions included in this act pursuant to established educational protocols or both.*
> *(9) Students while in actual attendance in an accredited health care occupational educational program and under the supervision of a qualified instructor.*

(10) Self-care by a patient or gratuitous care by a friend or family member who does not represent or hold oneself out to the public to be a respiratory therapist. (11) Monitoring, installation or delivery of medical devices, gases and equipment and the maintenance thereof by a nonlicensed person for the express purpose of self-care by a patient or gratuitous care by a friend or family member.

HB 2274, as written, would act as a barrier to the delivery of health care in numerous small communities in Kansas. Thank you for your consideration of our comments.

Radiologic Technologist (ARRT certified)
2002 Vacancy Rates in Kansas



Source:
The Health Alliance of MidAmerica
2002 Compensation Levels Survey Report

Kansas Association of Osteopathic Medicine

1260 SW Topeka Boulevard
Topeka, Kansas 66612

Phone (785) 234 5563
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Testimony on House Bill 2274
House Health and Human Services Committee
By Charles L. Wheelen
February 18, 2003

Thank you for the opportunity to express our opposition to HB2274. This bill would interfere with the ability of osteopathic physicians to utilize essential diagnostic equipment.

Last summer we were contacted by a representative of the Kansas Society of Radiology Technologists who invited our comments on a draft bill similar to HB2274. My response to Mr. Hein said in part,

> Many physicians, particularly in rural areas, do not have convenient access to imaging centers or hospital radiology departments. Instead, they invest in x-ray equipment for use in their own office because x-ray imaging is an extremely valuable diagnostic tool. The equipment is often operated by a nurse or other employee under direction of the physician. It would not be feasible to employ a licensed radiologic technologist to occasionally operate the diagnostic imaging equipment.

My letter went on to say that any proposed legislation should,

> include an exemption section clearly stating that licensed practitioners are exempt from the act. Furthermore, it would be extremely important to include language in the same section that would exempt persons performing medical imaging or radiation therapy under direction of a licensed practitioner.

House Bill 2274, as introduced, does include an exemption section but does not exempt persons performing medical imaging or radiation therapy under direction of a physician or other licensed practitioner. For that reason, we request that section five of the bill be amended (page two, line 37) as follows:

> Sec. 5. The following shall be exempt from the provisions of this act and the requirement of a license pursuant to this act:
>
> (a) a licensed practitioner <u>or a person performing radiologic technology under the direction of a licensed practitioner</u>;
>
> (b) a resident physician or a student enrolled in and attending a school while under the direct supervision of a licensed practitioner, radiographer, radiation therapist or nuclear medicine technologist; and
>
> (c) health care providers in the United States armed forces, public health services, federal facilities and other military service when acting in the line of duty in this state;
>
> (d) dentists, dental hygienists and dental assistants practicing their professions, when licensed and practicing in accordance with the provisions

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Kansas Association of Osteopathic Medicine

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of law.

Thank you for your attention to our concerns and for considering our request for an amendment.

TESTIMONY PRESENTED

TO

THE HOUSE HEALTH AND HUMAN RESOURCES COMMITTEE

on HB 2274

February 18, 2003

by: Rebecca Rice, Legislative Counsel
Kansas Chiropractic Association

Mr. Chairman and members of the committee, my name is Rebecca Rice and I appear before you today on behalf of the Kansas Chiropractic Association to express opposition to HB 2274.

As I attempted to put into words the KCA opposition to this legislation, only adjectives came to mind: *breathtaking* being the most common. However, others include: *amazing; bold; remarkable*; *unbelievable; catastrophic; incredible*. But I couldn't work these words into sentences so that coherent testimony could be prepared. I was left with simple exclamations: *Truly amazing. Remarkably bold. Incredibly unbelievable.*

But *breathtaking* remains the most descriptive because I am left speechless. The havoc this legislation would wreak for so many licensed practitioners, their office staff and their patients is indescribable. But, I am making an assumption. That the "grandfather" language is extremely restrictive. However, I am uncertain because the "grandfather" language is unclear - at least, it is to me.

The assumptions imbedded in the mandatory policies of this legislation would be offensive if practitioners weren't willing to acknowledge the motives for the legislation and the apparent ignorance of how licensed practitioners supervise their office personnel who perform X-rays. The legislation assumes patients are placed in danger by Kansas licensed practitioners when X-rays are performed. That assumption is false.

If the radiology technologists were to seek a thorough, many-sided credentialing review, (such may or may not be obtainable through the statutory process) several criteria appear impossible to meet, including:

- **Criterion III** - performed under the direction of other health care personnel is not adequate to protect the public;
- **Criterion IV** - the effect of licensure on health care costs would be minimal;
- **Criterion VI** - the effect on health care personnel providing these services would be minimal;
- **Criterion IX** - the effect on the scope of practice of other health care personnel, whether or not credentialed.

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A short list of our questions regarding this legislation include the undefined educational requirements and the undefined phrase in Section 10 *engaged in the practice of* and *successfully completed secondary schooling.*

Thank you, Mr. Chairman and members of the committee.

(line 33, page 6 should be changed from wave to waive)*

KANSAS STATE BOARD OF HEALING ARTS

MEMO

TO: House Committee on Health and Human Services

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 17, 2003

RE: **H.B. No. 2274**

Thank you for the opportunity to appear before you and provide information on H.B. No. 2274. This bill would require radiologic technologists to be licensed by January 1, 2004. The licensing and regulatory agency is designated as the Kansas State Board of Healing Arts. The 15-member Board met on Saturday, February 15, 2003, and had the opportunity to review H.B. No. 2274 and provided directions to me regarding its position on this bill.

As this is my first appearance before this Committee this year, I want to briefly describe the State Board of Healing Arts. The Board was created in 1957 by the combination of the then existing Medical, Osteopathic and Chiropractic Boards. Over the years, additional professions have been added to the Board so that as of January 16, 2003, the Board regulated more than 17,000 individuals in 11 health care professions. Attached is a statistical listing of the number of individuals regulated in each profession. In addition, the Board has issued postgraduate permits to 574 individuals who are engaged in a postgraduate training program in Kansas. Effective January 1, 2003, pursuant to legislation passed during the 2002 Legislative Session, the Board began the regulation of naturopathic doctors and persons and entities that dispense contact lenses through the mail. At its meeting last Saturday, the Board authorized the issuance of the first registration to a naturopathic doctor.

The Board is comprised of 15 members—five medical doctors, three osteopathic doctors, three chiropractors, one podiatrist and three members from the general public. The other professions regulated by the Board have advisory councils that provide advice and assistance to the Board. The composition of each advisory council differs by profession. The smallest is the contact lens advisory council that consists of three members. The largest is the respiratory therapy care council consisting of seven members.

The Kansas State Board of Healing Arts is opposed to the enactment of H.B. No. 2274 in its present form for two major policy reasons: (1) the effect the bill would have on the ability of healing arts practitioners to delegate professional services and (2) the impact the bill would have on the availability and accessibility to radiologic services.

The Legislature, courts and the Board have long recognized the ability of practitioners of the healing arts to delegate services to other non-credentialed individuals. Without this ability to delegate, the delivery of health care services would be drastically altered. This delegation ability has been referred to as the "Captain of the Ship Doctrine". Specifically, K.S.A. 65-2872(g) states that the practice of the healing arts shall not be construed to include persons "whose professional services are performed under the supervision or by order of or referral from a practitioner who is licensed under this act". This delegation authority is recognized is all of the statutes that create a license or registration for a particular health care profession. Under the optometry law, K.S.A. 65-1508 states that nothing in that act is to "be construed to prevent persons who are licensed to practice medicine and surgery in this state from performing the acts or services authorized for optometrists under the optometry law or *from delegating the performance of screening procedures for visual acuities, color vision, visual fields and intraocular pressure to assistants....*"(Italics supplied). Under the nursing statutes, K.S.A. 65-1125(h) states that the nursing law does not prohibit "auxiliary patient care services performed...*under the direction of a person licensed to practice medicine and surgery...*"(Italics supplied).

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In the past few years, professions regulated by the Board have changed their credentialing status from registration to licensure. Respiratory therapists, occupational therapists, and physician assistants were all originally registered by the Board but are now licensed. Only respiratory therapists, however, received a scope of practice protection as was described by Dr. Wolff yesterday. However, the respiratory therapy law provides at K.S.A. 65-5514(b)(5) that the practice of respiratory therapy is not to be construed to include " ...persons performing services *pursuant to the delegation of a licensed physician under subsection (g) of K.S.A. 65-2872*" (Italics supplied).

Section 5 of H.B. No. 2274 contains the only exemptions to the licensure requirements for radiologic technologists. None of these four exemptions would allow for a licensed practitioner; as that term is defined in the bill, to delegate services falling within the definition of radiologic technology to someone who is not licensed in one of the three categories of radiologic technologists. This inability to delegate the performance of these services to someone not licensed would dramatically affect the manner in which medicine and surgery, chiropractic and podiatry are currently practiced in clinics throughout the state. The final findings of the technical committee that reviewed the application to license radiologic technologists stated that persons not current registered by the American Registry of Radiologic Technologists who currently perform radiographic examinations included "LPNs, laboratory technicians, medical assistants, R.N.s, office personnel, physician assistants, physicians and chiropractors". (P. 15 of Final Findings and Conclusions of the Technical Committee on the Review of the Application to License Radiologic Technologists, October 13, 1999). Should H.B. No. 2274 be enacted in its present form, all but physicians and chiropractors would be prohibited from performing radiographic procedures.

The other major policy reason the Kansas State Board of Healing Arts opposes H.B. No. 2274 is the likely impact licensure of radiographic technologists would have on the access and availability of this type of health care service. Testimony during the meetings of the technical committee indicated that there are 2532 radiologic technologists registered by the American Registry of Radiologic Technologists in the state of Kansas. This number represents 75% of the persons performing radiologic technology procedures in the state. It was also estimated that 844 individuals who are currently performing radiographic examinations and are not currently credentialed by a national organization would be negatively impacted. In 1998, the Kansas Society of Radiologic Technologists conducted a survey of facilities owning radiographic equipment in eleven Kansas counties. 146 facilities responded. 67 indicated that they hired registered radiologic technologists and 81 indicated that non-radiologic technologists performed the radiographic examinations. In its final findings, the technical committee quoted the following from the application:

> "The 146 facilities responding represent approximately 12% of the facilities which own radiographic equipment. Of those 146 facilities, approximately 55% indicated the use of non-radiologic technologists to perform radiographic examinations. If this percentage holds true throughout the other counties, then approximately 660 facilities utilize persons other than radiologic technologists to operate ionizing radiation equipment." (Application, p. 35)" (P. 15, of Final Findings and Conclusions of the Technical Committee on the Review of the Application to License Radiologic Technologists, October 13, 1999).

In 1999, of the 2505 technologists registered in Kansas, 156 indicated they were unemployed and not seeking employment and 190 indicated they were employed but not in radiologic technology. (P. 9 of Final Findings). There are five diagnostic radiology programs in Kansas. There programs graduate approximately 130 students each year. (P. 6 of Final Findings). However, there was also information that 124 students were enrolled in the existing Kansas programs in 1999 (P. 16 of Final Findings). The Kansas State Board of Healing Arts is very concerned that even with the "grandparent" provisions of Section 10 that H.B. No. 2274 would have a detrimental effect on the ability of hospitals and clinics to attract licensed radiographic technologists. One Board member from Lawrence described the difficulty his clinic had in hiring a new technologist. Therefore, the concerns about the scarcity of available, qualified technologists is not limited to just rural areas.

In addition to the above policy issues, the Board wishes this Committee to also consider the following items:

Section 3 (page 2, lines 8 through 26). Subsections (a) through (e) contain specific prohibitions unless a person is licensed under the act. However, unlike Section 4 that makes it a class B misdemeanor to violate that section, there is no penalty for a person who violates the provisions of Section 3. Therefore, while Section 4 contains a criminal

penalty for a person to hold oneself out as a licensed radiologic technologist, there is no penalty for an unlicensed person to practice this profession.

Section 4(d). It is our understanding that dental assistants are not licensed in the state of Kansas. Even though this subsection would indicate that dental assistants are exempt from the law, it would not appear that this is the case since they are not "licensed and practicing in accordance with the provisions of law".

Section 6. The Board would ask that the composition of the radiologic technology council be decreased in size. Since it is the Board that has final authority, as explained by Dr. Wolff yesterday, the costs associated with 9 members seems excessive. This would be a larger council than currently exists for physical therapists, occupational therapists, respiratory therapists, physician assistants or athletic trainers.

Section 6(e) (page 3, at lines 31 and 32). The Board sees no reasons to limit the first meeting of the council to organization purposes only. The Board must be ready to license these professions by January 1, 2004. Having just gone through the process of registering naturopaths and contact lens dispensers, the Board will find it very difficult to have everything in place to commence the licensure process in a six-month time frame from the date the bill becomes effective. Every meeting of the council should be utilized to prepare recommended rules and regulations and forms.

Section (b)(a)(A) through (C) (page 5, lines 14 through 20. While the bill indicates it is providing for the regulation and licensing of radiologic technologists, there is no license for a radiologic technologist. Rather, this section calls for the licensure of three specific areas of radiologic technology—radiographer, radiation therapist and nuclear medicine technologist. Therefore, instead of creating one new profession, there are actually three new professions to be licensed under this bill.

Section 9(e) (page 5, line 33). The word "wave" should be changed to "waive".

Section 11. (page 5, beginning at line 34). The Board believes that the statutory fee maximums established by this section should be at least equal to the maximums established for licensed respiratory therapists under K.S.A. 65-5509.

Section 12(b) (page 7, lines 36 through 39). In section 12(a), the Board is authorized to limit a license in addition to taking the other actions described in this section. Therefore, ", limitation" should be inserted after the word "suspension" in line 36.

In conclusion, the Kansas State Board of Healing Arts is opposed to H.B. No. 2274 and urges this Committee to not recommend the bill favorably for passage by the entire House. I would be happy to respond to any questions.

KSBHA - Statistics

STATISTICS
County Breakdown
Licensee / Registrant Statistics
Updated February 12, 2003

LICENSEESActiveExemptFederalInactiveMilitaryTOTAL
Medical Doctors

5,5989102071,7252138,653
Osteopathic Doctors

540481915011 768
Chiropractic Doctors

7274321695946
Podiatric Doctors

11452141 136
Physician Assistants

470018161505
Respiratory Therapists

1,45100001,451
Total Licensees8,9001,0062482,07423112,459

REGISTRANTSActiveExemptFederalInactiveMilitaryTOTAL
Physical Therapists

1,64300001,643
Physical Therapist Assistants

9700000970
Occupational Therapists

1,19800001,198
Occupational Therapy Assistants

3180000318
Athletic Trainers

2230090232
Total Registrants4,35200904,361

Kansas State Board of Healing Arts
235 S. Topeka Boulevard - Topeka, KS 66603-3068
Phone: (785) 296-7413 - Fax: (785) 296-0852

K A N S A S
RODERICK L. BREMBY, SECRETARY KATHLEEN SEBELIUS, GOVERNOR
DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on House Bill No. 2171
to the
House Committee on Health and Human Services

Presented by
Jane O'Bryan, Member, Board of Adult Care Home Administrators
February 20, 2003

Chairperson Morrison and members of the committee, I am pleased to have the opportunity to discuss the proposed amendments to the Kansas Adult Care Home Administrators licensing law.

The 2001 legislature shifted enforcement and general counsel of the Board to the Office of the Kansas Attorney General. The bill before you is the result of recommended changes approved by the Board at the advice of its General Counsel. These changes are primarily technical, but include an additional provision that would allow the Board to deny, revoke, or suspend a license if the licensee has been disciplined by other specified licensing boards.

House Bill 2171 amends K.S.A. 65-3503 to clarify the Board's authority to assess fees for license replacements and duplicate licenses. At K.S.A. 65-3504, the added language clarifies the Board's authority to establish standards of character, training, and experience as eligibility criteria for admission to examination for licensure. K.S.A. 65-3506 is amended so that the Board's final orders will be issued in accordance with the Kansas Administrative Procedure Act (KAPA).

Attachment 8
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The proposed amendment to the introductory paragraph in K.S.A. 65-3508 clarifies that the Board may deny licensure to an applicant who has violated the provisions of this section, and clarifies how the Board uses KAPA procedures. Proposed new section (i) established the Board's authority to discipline a licensee or applicant for misrepresentation or omission of a material fact in an application or communication to the Board. Proposed new sections (j) and (k) would allow the Board to deny, revoke, or suspend the license of an applicant or licensee who has been disciplined by the adult care administrator licensing board of another state, or by the health care, mental health care, or social worker licensing board of this state or another state. These changes would align the Board's authority and statutory language with that of other similar state licensing laws.

The Board respectfully requests an additional change to correct a technical error, that the statute cite at K.S.A. 65-3508(h) be changed from K.S.A. 65-3504 to 65-3502.

Thank you again for the opportunity to appear before this committee on behalf of the Board, and we ask that House Bill 2171 be favorably passed by this committee. I will gladly respond to any questions the committee may have on this topic.

DIVISION OF HEALTH
Bureau of Health Facilities, Health Occupations Credentialing
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1365
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Testimony on HB 2171 re: Board of Adult Care Home Administrators

Honorable Chairman Morrison
and Health and Human Services Committee Members

The Kansas Trial Lawyers Association strongly favors this bill which strengthens the enforcement authority of BACHA by providing stronger minimum professional requirements for candidates for licensure as adult care home administrators. Nursing facilities often struggle in public opinion due to far too many documented cases of substandard care. Professional management is key to improving the overall quality of care in nursing homes. The Board of Adult Care Home Administrators seeks through this bill to strengthen the standards for admission to licensure, i.e., the requirement that a candidate for the licensure exam must first meet the "board established standards of good character, training and experience". The bill also strengthens BACHA's ability to take disciplinary action, including denial of license, in circumstances of material misrepresentation to the board or adverse disciplinary actions in other states. Finally, the bill assures that final orders be issued in accordance with the Kansas administrative procedure act.

The work of nursing home administrators is critically important to the health and safety of Kansans who live in nursing homes. BACHA is key to the ongoing development of professionalism in an industry that seeks to assure the public that it is working to provide quality care for the frail elderly and disabled consumers it serves, whose care is largely paid for by public dollars. We applaud this bill which will serve to enhance and assure the professionalism of Kansas adult care home administrators, and to further support their important work.

KTLA strongly supports this bill.

In the interest of full disclosure, I am also a member of the board of Kansas Advocates for Better Care, a nonprofit organization which advocates for the rights of nursing home residents. Deanne Bacco, our executive director is out of town this week, but I wish to call to the Committee's attention her testimony, previously submitted on February 6, 2003. As you will note, Kansas Advocates also strongly favors this bill.

Respectfully submitted,

Margaret Farley
Member, Kansas Trial Lawyer's Association

Thursday, February 20, 2003

Testimony before the House Health and Human Services Committee on HB 2171- an Act concerning adult care home administrators; relating to licensure; amending K.S.A. 65-3503, 65-3504, 65-3508 and repealing the existing sections.

Mr. Chairman, Members of the Committee:

I am Phyllis Kelly, Executive Director of the Kansas Adult Care Executives Association (KACE). Our association represents over 200 adult care home executives in nursing homes and assisted living facilities throughout Kansas. I appear before you today in support of HB 2171.

The KACE Board of Directors and the KACE Legislative Committee have reviewed the proposed changes to the Adult Care Licensure Act and concur with these changes. We have conferred with staff from the Attorney General's Office and members of the Board of Adult Care Home Administrators, both of whom are supportive of the recommended changes.

We urge your support of HB 2171.

Testimony on HB 2171 re: Board of Adult Care Home Administrators

Honorable Chairman Morrison
and Health and Human Services Committee Members

The Kansas Trial Lawyers Association strongly favors this bill which strengthens the enforcement authority of BACHA by providing stronger minimum professional requirements for candidates for licensure as adult care home administrators. Nursing facilities often struggle in public opinion due to far too many documented cases of substandard care. Professional management is key to improving the overall quality of care in nursing homes. The Board of Adult Care Home Administrators seeks through this bill to strengthen the standards for admission to licensure, i.e., the requirement that a candidate for the licensure exam must first meet the "board established standards of good character, training and experience". The bill also strengthens BACHA's ability to take disciplinary action, including denial of license, in circumstances of material misrepresentation to the board or adverse disciplinary actions in other states. Finally, the bill assures that final orders be issued in accordance with the Kansas administrative procedure act.

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Respectfully submitted,

Margaret Farley
Member, Kansas Trial Lawyer's Association

Attachment 9
HHS 2-20-03

Thursday, February 20, 2003

Testimony before the House Health and Human Services Committee on HB 2171- an Act concerning adult care home administrators; relating to licensure; amending K.S.A. 65-3503, 65-3504, 65-3508 and repealing the existing sections.

Mr. Chairman, Members of the Committee:

I am Phyllis Kelly, Executive Director of the Kansas Adult Care Executives Association (KACE). Our association represents over 200 adult care home executives in nursing homes and assisted living facilities throughout Kansas. I appear before you today in support of HB 2171.

The KACE Board of Directors and the KACE Legislative Committee have reviewed the proposed changes to the Adult Care Licensure Act and concur with these changes. We have conferred with staff from the Attorney General's Office and members of the Board of Adult Care Home Administrators, both of whom are supportive of the recommended changes.

We urge your support of HB 2171.

Attachment 10
HHS 2-20-03

Testimony in Support of House Bill 2172

To: Representative Bob Bethell and Members,
House Health and Human Services Committee
From: Debra Zehr, Vice President
Date: February 20, 2003

Thank you, Mr. Chairman and Members of the Committee for this opportunity to offer support for House Bill 2172. The Kansas Association of Homes and Services for the Aging represents over 160 not-for-profit long-term health care, housing, and community service providers throughout the state.

House Bill 2172 would address a concern shared by many of our members. It calls for formation of a three-member independent review panel for processing of state adult care home inspection results with which an administrator disagrees.

Under the current system, KDHE staff members, who are themselves responsible for oversight and administration of the survey process, are the ones who conduct the review of disputed deficiencies. We believe it makes sense to have this informal dispute resolution process handled in a way that is as independent and objective as possible. This bill would mark a constructive step toward that end.

Thank you for your favorable consideration of House Bill 2172. I would be happy to answer questions.

Attachment 11
HHS 2-20-03

February 19, 2003

Testimony

Before the
House Health and Human Services Committee
(HB 2172-Adult Care Home Dispute Resolution)

By
Nancy Pierce
KANSAS HEALTH CARE ASSOCIATION

Chairperson Morrison and Members of the Committee, thank you for the opportunity to testify before you today on the Adult Care Home Dispute Resolution bill.

My name is Nancy Pierce, a representative of the Kansas Health Care Association and I will speak in support of HB 2172. The Kansas Health Care Association represents more than 200 long-term-care facilities including nursing facilities, assisted living facilities and long-term-care units of hospitals across the state of Kansas.

Many of our members have voiced concerns that the current IDR process is not an independent, effective, or heavily utilized process. For these reasons, our Association supports establishing an independent review panel outside KDHE to review any disputed survey deficiencies.

The Legislative Post Audit of December 2001-Kansas Nursing Home Inspections supports my previous statement. Legislative Post Audit conducted a survey of more than 325 nursing home administrators about the survey process. More than 60% responded with some of the more typical comments they received:

- Administrators believe it is hard for the Regional Manager to be totally unbiased when the findings of their inspection staff are being questioned.
- Nursing Facilities are afraid of retribution from KDHE.
- Administrators feel the current process is not independent.

Legislative Post Audit goes on to report that only 6% of the total number of deficiencies cited during the audits 8-month time frame were appealed initiating the IDR process. Figures released by KDHE for the time period 1-1-01 through 6-30-02, states there were 186 IDR's initiated which involved 470 deficiencies. The total number of deficiencies cited during this time frame was 4091. This represents only 11.5% of the total number of deficiencies. Our Association feels that a third party independent review would be better utilized by our members.

Our Association supports HB 2172 with one exception. We would like to see the independent review process be done by the Department of Administration.

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

Attachment 12
HHS 2-20-03

Thursday, February 20, 2003

Testimony before the House Health and Human Services Committee on HB 2172- An Act concerning adult care homes; relating to informal dispute resolution; providing for an independent review panel.

Mr. Chairman, Members of the Committee:

I am Phyllis Kelly, Executive Director of the Kansas Adult Care Executives Association (KACE). Our association represents over 200 adult care home executives in nursing homes and assisted living facilities throughout Kansas. I appear before you today in support of HB 2172.

The KACE Board of Directors and the KACE Legislative Committee have reviewed the components of HB 2172. Both of these entities believe that the proposed legislation will strengthen the intent, credibility, and fairness of the adult care home informal dispute process. Key to the proposed legislation is the use of an independent review panel. As stated in HB 2172-

- The panel will be conducted in a timely fashion so as not to delay any correction of deficiencies not overturned by the panel;
- Only one request for an informal dispute resolution per inspection may be requested by the administrator; and
- All other deficiencies not in dispute must be corrected in the required timelines prescribed by the regulatory agency.

Other state regulatory agencies use an independent review panel when compliance issues are disputed. Oftentimes, federal law requires an independent entity to be used. The use of an independent panel does not mean that the process automatically becomes more formal or that there will be more conflict. In fact, it usually has the opposite effect.

By using an independent review panel, the regulatory agency cannot be accused of any bias if decisions of the regulators are not reversed. Informal dispute resolution conducted by an independent review panel gives the inspection process more credibility and less controversy.

We urge your support of HB 2172.

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K A N S A S
RODERICK L. BREMBY, SECRETARY KATHLEEN SEBELIUS, GOVERNOR
DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on HB 2172
to
Health and Human Services
Presented by Joseph F. Kroll, Director
Bureau of Health Facilities
February 20, 2003

Chairperson Morrison and members of the committee, I am pleased to appear before you today to discuss HB 2172.

House Bill 2172 would require the Secretary of the Kansas Department of Health and Environment to compose a three-person panel to hear disputes from adult care home administrators regarding deficiencies they received during inspections conducted by survey staff.

The Kansas Department of Health and Environment has long recognized the importance of providing an informal opportunity to dispute deficiencies, having implemented such a program in 1991. The Centers for Medicare and Medicaid Services followed with the Federal requirement in 1995. The existing KDHE process provides not one, but two opportunities for administrators to dispute deficiencies. The first is conducted by the bureau's regional managers and a second can be requested of bureau management staff. The administrator may present their information face-to- face to the regional manager if they choose.

In calendar year 2002, KDHE received 118 requests for dispute resolution involving 276 deficiencies. Of these 276 deficiencies, 51 or 18% were either deleted or amended in scope and severity. More importantly, 103 of these deficiencies were at G or level higher which triggers Federal enforcement action. Of these 103, 26 were either deleted or reduced in scope and severity for a 25% revision rate. We believe this revision rate demonstrates that KDHE is responsive to facility argument and the existing process is fair and impartial.

The informal dispute resolution process is viewed by KDHE as not only important to facilities, but to our own internal quality improvement activities. We also think it is important to point out that a legislative post-audit concluded in late 2001, found that our survey process is fair and reasonable and auditors agreed with our citation of G level deficiencies 98% of the time.

A pilot project in Iowa where an independent panel conducted dispute resolution resulted in only a 17% favorable ruling for facilities, less than when the Iowa survey agency conducted the process. Similar results could be expected in Kansas.

The Centers for Medicare and Medicaid Services have advised KDHE that an independent entity conducting IDR must "adhere to time frames, regulations, interpretations and guidelines established by CMS". CMS remains the final arbitrator of the validity of deficiencies and because virtually all deficiencies in question are Federal, the likelihood of outcomes any different from the existing KDHE process is remote, making the expense of this bill

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unnecessary.

Finally, this bill is cumbersome, expensive to implement and contains procedural and administrative flaws. For example, Section 1, line 15 refers to the 14th day of reinspection pursuant to K.S.A. 39-946. The statute references only those deficiencies a correction order has been issued pursuant to K.S.A. 39-945. Another problem is found in Section 1(d), line 39 and 40, which provides for correction of a deficiency in dispute to be suspended. This is contrary to Federal law and places residents in jeopardy. For example, if the deficiency relates to resident abuse, the facility could suspend corrective action simply by requesting dispute resolution leaving the cause of the abuse uncorrected until the issue is resolved. Federal law does not allow delay to occur.

Appointing a panel of three persons, including a physician for each request, is impractical. Even if the bill is interpreted to mean a panel of permanent members, the cost of contracting with a physician and two other qualified persons is significant. KDHE spends an average of six hours reviewing each IDR request. It should be expected that persons not as familiar with regulations, interpretations, administrative law decisions and court verdicts will take longer. The hourly rate the members will cost coupled with travel requirements and the cost of staff to develop and implement regulations as required by the bill all results in considerable cost to the state. Because the process is not required by CMS and exceeds federal requirements, state general funds would be the sole source of payment for this program.

Because of the reasons cited in this testimony, KDHE respectfully requests that HB 2172 not be favorably acted upon.

I thank you for the opportunity to appear before this Committee and will gladly stand for questions the committee may have on this topic.

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Testimony on HB 2172 re: Informal Dispute Resolution of Adult Care Home Survey Findings

February 20, 2003

Honorable Chairman Morrison
and Health and Human Services Committee Members

The Kansas Trial Lawyers Association strongly opposes this bill. Key provisions of HB 2172 provide for:

a) a third party review panel of surveyor findings before all administrative appeals have been exhausted;

b) suspension of efforts to correct disputed deficiencies pending the outcome of the "independent" panel's findings;

c) suspension of any civil penalty imposed as a result of the deficiency until the panel resolves the "dispute".

The panel is to be composed of three members, with member qualifications so vague that the practical problems with such a panel become self-evident. Indeed, the authors of the bill exclude KDHE employees, but would apparently permit adult care home administrators or employees or owners to serve on the panel.

Currently nursing facilities have several steps for informal dispute resolution and submission of exculpatory evidence during the survey and following it. We currently spend tax dollars on such informal dispute resolution. And we spend tax dollars on permitting for administrative appeals if the adult care home is not satisfied with the informal dispute resolution. If administrative appeals fail, the home can appeal to a district court. In this time of stark budgetary shortfalls, we cannot see why the state would invest money it does not have in such a redundant and unnecessary process.

Adult care homes have all of the appeal processes noted above, but consumers in the care homes have absolutely no appeal rights whatsoever, not even informal dispute resolution, if they disagree with surveyor findings. KDHE is chronically underfunded for surveyors. So much so that KDHE often permits adult care homes to investigate complaints against themselves, even those that involve abuse and neglect. If excess money is available to support this bill perhaps it would be better spent providing for a dispute resolution process for residents, or for more funding for the critical survey work of KDHE.

In addition, if such an independent panel is offered to the adult care home industry as an end run around well-established administrative procedures, it can be expected that many other industries will hop on board that train.

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KTLA strongly opposes this bill, and we believe that it should not pass in any form. However, if the Committee votes to advance this bill, we would offer the following amendments:

1) Civil penalties should be paid into trust pending the outcome of the panel's review;
2) Correction of disputed deficiencies should not be suspended--the very safety and welfare of residents is at stake; it is far better to err on the side of correcting a cited deficiency;
3) The panel should consist of consumers, such as a representative of AARP or similar such organization, or consumer advocates, such as a regional Ombudsman; the medical doctor should be a board licensed geriatrician with no ties to the industry;
4) The adult care home requesting the appeal should bear the burden of all of the costs of the panel.

We urge the Committee to reject this bill, or, failing that, to amend it as noted above.

In the interest of full disclosure, I am also a member of the board of Kansas Advocates for Better Care, a nonprofit organization which advocates for the rights of nursing home residents. Deanne Bacco, our executive director is out of town this week, but I wish to call to the Committee's attention Ms. Bacco's testimony, previously submitted on February 14, 2003. As you will note, Kansas Advocates also strongly opposes this bill.

Respectfully submitted,

Margaret Farley
Member, Kansas Trial Lawyer's Association