Approved: March 18, 2004
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 2:00 p.m. on March 17, 2004, in Room 526-S of the Capitol.

All members were present except:
Representative Brenda Landwehr- excused
Representative Joe McLeland - excused

Committee staff present:
Dr. William Wolff, Legislative Research Department
Renae Jefferies, Office of Revisor of Statutes
Gary Deeter, Secretary

Conferees appearing before the committee:
Lawrence Buening, Executive Director, Kansas Board of Healing Arts
Chris Collins, Director of Government Affairs, Kansas Medical Society
Elizabeth Phelps, Attorney, Osawatomie State Hospital
Dr. James Owens, psychiatrist, Larned Mental Health Correctional Facility
David Lake, Director, Board of Emergency Medical Services
Tuck Duncan, Attorney, American Medical Response
John Hayworth, Operations Director, American Medical Response

Others attending:
See Attached List.

The Minutes for the March 16 meeting were approved.

The Chair opened the hearing on **SB 426,** which creates an institutional license under the Board of Healing Arts.

Lawrence Buening, Executive Director, Kansas Board of Healing Arts, testified as a proponent. (Attachment 1) He said current statutes for obtaining an institutional license require that an individual be a graduate of a medical school and be employed by a Kansas institution, stating that the bill increases the requirements to receive a license, but once those requirements are met, the bill allows continuous renewal. He commented that the institutional license is not a new concept; a similar idea has been around since 1969, when it was introduced as a fellowship license, and has been modified periodically. He said presently there are 18 licensees, 15 of these in state institutions, noting that the bill protects institutions from unnecessary turnover.

Chris Collins, Director of Government Affairs, Kansas Medical Society, testified in support of the bill. (Attachment 2) She said that institutional licenses have been expanded the past few years, and normally the Kansas Medical Society opposed such expansion. However, to ensure that doctors currently practicing are able to continue their practice, the Society is supporting the bill, especially since most of

those licensed provide an important role in positions that are difficult to fill.

Elizabeth Phelps, Attorney, Osawatomie State Hospital, representing Kansas Social and Rehabilitative Services, spoke as a proponent. (Attachment 3) She said state institutions had 3100 admissions in FY 2003, and adhering to a two-year limit for institutional licenses is an unnecessary disqualifier for those who are otherwise doing their jobs well.

Dr. James Owens, psychiatrist, Larned Mental Health Correctional Facility, spoke in support of the bill. (Attachment 4) He said he received an institutional license in 2001 from the Board of Healing Arts and served various state facilities as a contract employee and is presently providing psychiatric services at Ellsworth and Larned. He commented that even though he received outstanding evaluations, the institutional license has expired, which will force him to resign because there is no provision for renewal.

The Chair closed the hearing on **SB 426** and opened the hearing on **HB 2832,** a bill addressing emergency medical services attendant temporary certification.

David Lake, Director, Board of Emergency Medical Services, explained the provisions of the bill. (Attachment 5) He said the bill amends the current statute regarding obtaining a Kansas EMT (emergency medical technician) certification, whether such certification is permanent or temporary, changing the length of time an applicant can apply to mirror the National Registry requirement of two years. He stated that the bill establishes criteria for a temporary license (valid for two years), eliminating the stipulation that an employer must request the temporary license; he noted that if an applicant is currently registered on the national registry or is licensed/certified in another state, the Board will grant a temporary license.

Tuck Duncan, Attorney, representing the American Medical Response, testified as an opponent. (Attachment 6) He said his company is the largest ambulance service in the United States and provides services in rural and urban areas of Kansas. He commented that the bill appears to be simple, but carries pitfalls for those coming from other states to work in Kansas by changing the educational requirements after the temporary license has expired. He quoted from the EMS Board's proposed rules and regulations, which will require that paramedics must have either an associate degree or have completed 15 college hours in designated areas. He said an EMT could have been practicing for years in another state, be listed on the national registry, but after the 2-year temporary license expired, would be considered unqualified to practice in Kansas unless he/she completed the educational requirements, noting that the national registry is presently recognized as sufficient for certification in 44 other states.

Mr. Duncan offered two proposals: The first was to kill the bill. The second was a suggested amendment to **K.S.A. 65-6129**, (1) (A) (2) adding after the end of section (2) the words *or is registered for the clarification of attendant certificate for which application is made by the National Registry of emergency medical technician.*

Answering questions, Mr. Duncan commented that one motive for the new regulations might be to increase attendance at certain schools. He suggested a better way would be to create levels of credentialing. He replied to another question that raising the standards would further exacerbate the EMT shortage, concluding that if an out-of-state person was listed on the national registry, he or she should be eligible for reciprocal credentialing.

John Hayworth, Operations Director, American Medical Response, also spoke as an opponent. (Attachment 7) He began by answering a member's question about the impact of the bill on rural areas, saying that ambulance services and fire departments are competing for personnel and that many fire departments who rely on volunteers will find it difficult to certify volunteer staff if the educational requirements are raised. He said that validation by the national registry should be sufficient.

The Chair closed the hearing on **HB 2832**.

Staff Bill Wolff reviewed **SB 529**, saying that the bill adds two groups who are authorized to approve the initiation of physical therapy treatment–licensed physician assistants and advanced registered nurse practitioners.

A motion was made to consider **SB 426** and to recommend it as favorable for passage. The motion was seconded and passed.

The meeting was adjourned at 2:54 p.m. The next meeting is scheduled for Thursday, March 18, 2004.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: MARCH 17 2004

NAME	REPRESENTING
Dwight Young	The Center for Counseling - Great Bend
Walter Hill	High Plains MHC - Hays
Heather Grece	Bannon + Associates
John Hayworth	American Medical Response
Pat Lehman	KFSA
DAVID LAKE	KBEMS
BUD BURKE	KPTA
JAMES E. OWENS III, MD	INDIVIDUAL PROPONENT of SB-426
LARRY BUENING	BOHA
MARY FRIGHNY	KEMS
Lizz Phelps	SRS / Health Care Policy
R.E. "TUCK" DUNCAN	American medical response
Ron Seeber	Heinz Law Firm

KANSAS BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

MEMO

TO: House Committee on Health and Human Services

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: March 17, 2004

RE: **Senate Bill No. 426**

Thank you for the opportunity to appear before you on behalf of the State Board of Healing Arts. S.B. No. 426 amends the current statute pertaining to institutional licenses. Currently, the only qualifications for an institutional license are: (1) graduation from an accredited school of the healing arts or a school which has been in operation for not less than 15 years; and (2) employment as described in K.S.A. 65-2895. To be eligible for renewal, an institutional license holder must successfully complete the clinical practice examination required for a permanent license. The proposed amendments to K.S.A. 65-2895 provide that completion of two years of postgraduate training in the United States will be required for the initial issuance of an institutional license (page 1, lines 20 and 21). However, completion of an examination is deleted as being a requirement for renewal (page 2, lines 17-20). Additionally, the amendments would allow expanded practice by an institutional licensee if they have practiced within an SRS or DOC institution for at least three years. S.B. No. 426 had three conferees in the Senate Committee—all proponents. The bill passed the Senate 40-0.

The concept behind the institutional license has been around for 35 years. The 1969 Legislature created a new category of medical license called a fellowship license. This license was for individuals employed by the division of institutional management of the state board of social welfare or employed by any institution with the state department of penal institutions until they obtained a permanent license. There was no provision for renewal and the license remained valid as long as the holder met the employment qualifications. This law was included in the statute books as K.S.A. 65-2895.

K.S.A. 65-2895 has been amended seven times since it was originally enacted. In 1976, the permitted employers for a holder were changed to SRS and Department of Corrections. Further, language was added that no fellowship license would be valid for more than two years and the license was not renewable. In 1985, the fellowship license was changed to an institutional license. Also, it was made a requirement that an applicant pass an examination in basic and clinical science approved by the Board, but the license could be renewed if the holder successfully completed the examination required under K.S.A. 65-2873(a)(3). In 1988, the requirement that a new applicant for

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an institutional license pass a clinical science examination was deleted but the applicant still had to pass a basic science examination to qualify for the license. In 1997, the requirement that an applicant for a new license pass any examination was deleted. However, the requirement for successful completion of the examination required under K.S.A. 65-2873(a)(3) has been retained since 1988 and remains a requirement for renewal today.

In 2000, a new subsection (c) was added to K.S.A. 65-2895 that allowed an institutional license to be renewed once for two years if the holder was issued the institutional license prior to May 8, 1997, and had successfully completed two years of postgraduate training in the United States. The 2001 Legislature inserted a provision in the Board's appropriations bill directing the Board, notwithstanding the provisions of K.S.A. 65-2895, to renew for an additional two years all institutional licenses which expired during FY2002 and FY2003 and were valid on May 1, 2001. The 2002 and 2003 Legislatures had bills introduced that would have granted certain institutional license holders a permanent license (See 2002 S.B. No. 584 and 2003 S.B. No. 107). These, however, did not pass.

Currently, there are 18 individuals holding active and valid institutional licenses. Fifteen are employed within state institutions as follows:

Larned----------9
Osawatomie----------3
Rainbow----------2
Parsons----------1

Three institutional licensees qualify to provide mental health services in an employment setting outside a state institution. There is one each in Kiowa, Emporia, and Salina.

The purpose of the proposed amendments is to increase the requirements to be eligible for an institutional license, but to enable renewal of the license following issuance without having to meet additional qualifications. The circumstances vary insofar as the ineligibility of current institutional licensees to qualify for either a permanent license or for renewal of the institutional license. It appears that seven institutional licensees are eligible to renew their institutional license under the current statute so long as the have qualifying employment. The remaining 11 will not be able to renew their licenses. Since October 1999, the Board has issued five institutional licenses to individuals who were not eligible to renew and, therefore, their licenses have since been canceled. Four of these worked at Larned and one at KNI. Obviously, being unable to retain these institutional licensees for more than two years results in high turnover, particularly at SRS institutions.

The Board has been in contact with SRS and DOC to determine whether the need for an institutional license still exists. We have received responses from both Departments that institutional licensees do provide a benefit, particularly in those areas of the state where it is difficult to attract fully-licensed physicians. Based upon this factor and that it has been public policy in the state for 35 years to provide for a separate category of license for physicians working in state institutions, the Board is supportive of S.B. No. 426.

Again, thank you for the opportunity to appear before you. I would be happy to respond to any questions.

I am requesting that the State Board of Healing Arts be placed as a proponent for S.B. No. 426 which is scheduled for hearing on Wednesday, March 17. I am attaching a copy of the testimony in support of this bill. Thank you very much for your assistance.

Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts
785-296-3680

KANSAS MEDICAL SOCIETY

KMS

TO: House Health and Human Services Committee

FROM: Christina Collins
Director of Government Affairs

DATE: March 17, 2004

RE: SB 426

Chairman Morrison and Members of the Committee:

Thank you for the opportunity to testify today in support of SB 426.

SB 426 would extend a law within the Healing Arts Act to continue the concept of an institutional license to practice medicine. This applies only to a handful of physicians who currently practice solely within the state institutional setting.

According to prior testimony by the Board of Healing Arts, the concept of this discrete license category first developed in 1969 when the legislature created a fellowship license for persons who held a degree of doctor of medicine and who were employed by the division of institutional management of the state board of social welfare or employed by any institution within the state department of penal institutions. Practice privileges under a fellowship license were restricted to the period of employment and only within the institution to which the individual was assigned.

In 1976, the requirements were added that the individual had to be a graduate of an accredited medical school and had to successfully complete an examination by the education commission on foreign medical graduates. The license was restricted to two years and was not renewable. In 1985, the fellowship license was changed to an institutional license. Holders of this license were also required to pass an examination approved by the Board in basic and clinical sciences. The license could be renewed if the examination was passed – a requirement later eliminated by the legislature. In 1997, the

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license was expanded to allow licensees to provide mental health services within a community mental health center, a duly chartered educational institution, a hospital or a psychiatric hospital. In 2000, the license scope was further expanded to include the provision of mental health services pursuant to a written protocol with an individual with a full and unrestricted license to practice medicine and surgery. At the same time, the requirement for passage of the examination in basic and clinical sciences as a condition of renewal was waived if the individual had completed two years of post-graduate training in the U.S. In 2001 the legislature directed the Board to renew all institutional licenses which expire during 2002 and 2003 for two more years. This was done by a last-minute proviso to an appropriations bill.

The Kansas Medical Society remains opposed to the concept of granting a license to practice medicine and surgery to those who have not met the full academic and examination requirements set forth in the Healing Arts Act for all physicians. In years past, KMS has consistently opposed bills that would expand the scope of practice for those practicing under institutional licenses. For example, SB 584, introduced last year, would have granted institutional license-holders what amounted to an unrestricted license to practice medicine anywhere within the state without having met the academic and examination requirements that all other physicians must meet before being granted the privilege of practicing medicine.

However, in the present case, SB 426 simply creates a "grandfather clause" for those currently practicing in state institutions under these licenses. These practitioners may only continue to practice as they currently are within the state institutional setting, a venue where recruitment of new practitioners can be somewhat challenging. For this reason, the Kansas Medical Society urges the passage of SB 426. Thank you for the opportunity to testify today and I am pleased to stand for any questions the committee may have.

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

For additional information contact:

House Health and Human ServicesCommittee
March 17, 2004

Senate Bill 426 - Institutional Licenses

Division of Health Care Policy
Elizabeth Phelps, Attorney, Osawatomie
State Hospital
785.296.3773

ation contact:
Public and Governmental Services
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Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

House Health and Human Services Committee
March 17, 2004

Senate Bill 426 - Institutional Licenses

Chairperson Morrison and members of the committee, thank you for the opportunity to speak to you about Senate Bill 426. My name is Elizabeth Phelps, and I am the Attorney for Osawatomie State Hospital, a state mental health hospital managed by the Department of Social and Rehabilitation Services (SRS). On behalf of SRS, I offer support of this bill.

Since the inception of the institutional license option, SRS has made good use of it. Within its state hospitals, SRS currently employs 15 physicians who hold institutional licenses with the Kansas State Board of Healing Arts. Nine are employed at Larned State Hospital; three at Osawatomie State Hospital; two at Rainbow Mental Health Facility; and one at Parsons State Hospital and Training Center.

In providing patient care at these hospitals, often to Kansans at their most vulnerable and in situations of acute illness and crisis, we take very seriously our job of providing high quality patient care, in safe and effective treatment settings, and in ways that demonstrate fiscal responsibility. We support this bill because it does a good job of supporting those important public interests.

When physicians are employed at a state institution, their services are managed by an array of features, including:

- The significant qualifications included in this statute, being the medical education, post-graduate training and continuing medical education.

- An employment contract which requires both pre- and post-employment training, as well as ongoing solid performance outcomes.

- A service setting that supports each physician's work with on-site presence and supervision by a medical/clinical director holding a full medical license; colleagues with full medical licenses; and/or a limited scope of practice, primarily related to psychiatric/mental health services.

Particularly during times of economic difficulty, our state hospitals have limited success in funding salaries that can attract and retain fully licensed physicians. Certainly we do that when we can. The option of institutional licenses allows Kansans to take advantage of the safeguards inherent in our state hospital settings and employ

physicians who can fully meet the treatment needs of our patients.

The changes to the institutional license option contained within this bill strengthen its value:

- By removing the prior limitation of two years (in many instances subject to extension), we are allowed to continue in longer-term relationships with physicians in this status, thus making good use of the training and experience acquired in our state hospitals and returning that investment into enhanced patient care. Because of such reasons as cultural or language barriers, or the passage of time between formal education and testing, the two year limit previously existing can, and has, served as an automatic disqualifier of an otherwise capable physician, well trained to meet the needs of our patients.

- By including the two-year post-graduate training requirement, we are assured of this as a minimum standard for future holders of institutional licenses, and we are in no way limited from including additional training requirements – above and beyond this – in employment contracts with these physicians when appropriate.

This option is functional and effective in meeting the needs of patients in our state hospitals. And Kansas is not alone in making use of institutional licenses for physicians in limited settings where other safeguards are present and needs are high. According to information from the Federation of State Medical Boards, there are at least ten other states which issue institutional licenses. This option, as governed by Senate Bill 426, is effective for Kansans.

We encourage you to favorably consider this bill, and thank you for your consideration. This concludes my testimony, and I would be happy to stand for any questions.

March 16, 2004

House of Representatives
Health and Human Services Committee
Capitol, 300 SW 10th Avenue
Topeka, KS 6612-1590

Re: SB-426

Dear Mr. Chairman Morrison and Distinguished Members of the Health and Human Services Committee,

My name is James E. Owens III, M.D. I am writing to you in advocacy of SB-426. I am a graduate of the University of Illinois (BS), Eastern Illinois University (MA), and Southern Illinois University School of Medicine (MD). I completed my Psychiatry Post-Graduate Residency Training at the University of South Florida and I completed a Forensic Psychiatry Fellowship at the University of Florida. On December 04, 2001, I was granted the privilege of Institutional Licensure by the Kansas Board of Healing Arts. I was in the employ of Prison Health Services, a corporation contracted to provide medical and psychiatric services by the Kansas Department of Corrections. My employ continued uninterrupted under Correct Care Solutions who subsequently held and currently holds the contract with the Kansas Department of Corrections. During my employ, I provided psychiatric services to inmates at Larned Correctional Mental Health Facility-Central Unit (LCMHF-C). As you may be aware, this 150-bed maximum-security prison is dedicated to the care and treatment of severely mentally ill incarcerated persons. Shortly after I began my duties at LCMHF-C, I was asked to provide psychiatric coverage for an average of 50 additional patients at the West Unit of LCMHF, a minimum-security prison, and approximately 95 patients at Ellsworth Correctional Facility (ECF), a medium-security prison. The West Unit is located across the street from the Central Unit, which allows for inmates to be transported to the Central Unit for their psychiatric appointments. My early months of service at ECF required me to drive to Ellsworth one day every two weeks following the completion of that day's responsibilities at LCMHF. Ultimately, telepsychiatry was implemented which eliminated my travel, but required weekly service due to a growing population of inmates requiring services. Additionally, I provided on-call service for all KDOC facilities and some county jails. On-call service was shared with four other psychiatrists on weekly rotations. I was the sole psychiatric provider at each of my assigned facilities. My responsibilities at each of the facilities and on-call were limited solely to the provision of psychiatric services. All non-psychiatric medical services at each of these facilities are provided by another physician.

Since the beginning of my employment in 2001, I performed my duties ethically and responsibly with diligence and dedication. My professional record prior to and since I began working in Kansas is untainted. My performance evaluations have been "superior." My Regional Medical Director and immediate supervisor, psychiatrists and medical colleagues also employed by CCS, as well as the respective wardens of LCMHF and ECF supported my continued service. However, on December 04, 2003, my institutional license expired and, under the Kansas Statute No. 65-2895 as it is currently written, could not be renewed without passage of the United States Medical Licensure Examination.

By my advocacy for SB-426, I am in no way minimizing the importance and necessity of successfully completing the United States Medical Licensure Examination, nor am I trying to

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circumvent the examination. On the contrary, please note that I have every intention of ultimate success on this three-part examination. Rather, it is my contention that the scope of this examination is far broader than what is required for my day-to-day practice and broader still than the contractual privileges and limitations designated in my job description as well as the boundaries defined by the statute. I would add that a relatively small percentage of this examination is dedicated to psychiatry. It would appear that it was considered in the conception and subsequent amendments of the institutional license statute that a trained psychiatrist could be qualified to practice psychiatry in the absence of passage of the USMLE for it would certainly be to the detriment of the state to allow unqualified psychiatrists to treat patients in its correctional facilities and hospitals for two years. It would further appear that the institutional license was designed to be reciprocally beneficial in that it allowed the State of Kansas to provide quality psychiatric care for an underserved population while providing employment opportunities for physicians as they prepared for the examinations required for permanent licensure. While two years may appear to be an adequate period of time for passage of the examination, I ask you to consider not only that the first two parts of the USMLE are eight hours each and the third part is 16 hours, but that the detail and volume of information is extensive as it encompasses all of the basic sciences as well as all specialties of medicine.

In conclusion, I ask that you move to approve SB-426 amending Kansas Statue No. 65-2895 thereby allowing renewal of the institutional license beyond the initial two-year period in the absence of examination completion pending the approval of the superintendent or supervising body of the institution for which the individual is employed.

I hope to appear before you to offer my personal testimony in the hearing on this matter scheduled for March 17, 2004. If for any reason I am not present, please do not hesitate to contact me.

Thank you for your time and consideration.

Sincerely,

James E. Owens III, M.D.
1019 Williams #2
Great Bend, KS 67530
(620)792-4520
Analyz1@hotmail.com

March 16, 2004

House of Representatives
Health and Human Services Committee
Capitol, 300 SW 10th Avenue
Topeka, KS 6612-1590

Re: SB-426

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Since the beginning of my employment in 2001, I performed my duties ethically and responsibly with diligence and dedication. My professional record prior to and since I began working in Kansas is untainted. My performance evaluations have been "superior." My Regional Medical Director and immediate supervisor, psychiatrists and medical colleagues also employed by CCS, as well as the respective wardens of LCMHF and ECF supported my continued service. However, on December 04, 2003, my institutional license expired and, under the Kansas Statute No. 65-2895 as it is currently written, could not be renewed without passage of the United States Medical Licensure Examination.

By my advocacy for SB-426, I am in no way minimizing the importance and necessity of successfully completing the United States Medical Licensure Examination, nor am I trying to

circumvent the examination. On the contrary, please note that I have every intention of ultimate success on this three-part examination. Rather, it is my contention that the scope of this examination is far broader than what is required for my day-to-day practice and broader still than the contractual privileges and limitations designated in my job description as well as the boundaries defined by the statute. I would add that a relatively small percentage of this examination is dedicated to psychiatry. It would appear that it was considered in the conception and subsequent amendments of the institutional license statute that a trained psychiatrist could be qualified to practice psychiatry in the absence of passage of the USMLE for it would certainly be to the detriment of the state to allow unqualified psychiatrists to treat patients in its correctional facilities and hospitals for two years. It would further appear that the institutional license was designed to be reciprocally beneficial in that it allowed the State of Kansas to provide quality psychiatric care for an underserved population while providing employment opportunities for physicians as they prepared for the examinations required for permanent licensure. While two years may appear to be an adequate period of time for passage of the examination, I ask you to consider not only that the first two parts of the USMLE are eight hours each and the third part is 16 hours, but that the detail and volume of information is extensive as it encompasses all of the basic sciences as well as all specialties of medicine.

In conclusion, I ask that you move to approve SB-426 amending Kansas Statue No. 65-2895 thereby allowing renewal of the institutional license beyond the initial two-year period in the absence of examination completion pending the approval of the superintendent or supervising body of the institution for which the individual is employed.

I hope to appear before you to offer my personal testimony in the hearing on this matter scheduled for March 17, 2004. If for any reason I am not present, please do not hesitate to contact me.

Thank you for your time and consideration.

Sincerely,

James E. Owens III, M.D.
1019 Williams #2
Great Bend, KS 67530
(620)792-4520
Analyz1@hotmail.com

M E M O R A N D U M

DATE: March 17, 2004

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

FROM: David Lake - Board of Emergency Medical Services

RE: HB 2832

Mr. Chairman and members of the committee, Thank You for the opportunity to provide this testimony in support of HB2832. The Board of EMS considers this legislation to be very user-friendly in that it amends the current statute 65-6129 with regard to gaining Kansas EMS attendant certification, whether permanent or temporary. The portions of the current statute for which we are proposing amendment are the following:

In section 1; (1)(A), (line 19) the Board proposes changing the length of time an applicant can make application to the board for certification from one year to two years from the date of the final class. The purpose for this change is to mirror the length of time allowed by the National Registry for eligibility to take the registry exam. This is the examination we are currently utilizing for initial certification at the First Responder, EMT, and MICT levels.

In section 1; (b) (line 34) the Board proposes to remove the requirement of an EMT certificate on the applicant for a Mobile Intensive Care Technician certificate. The National Registry requires

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a current EMT certificate of anyone taking their registry examination which we use for State certification.

The "strike-through" in line 38 merely cleans up the language that was added two years ago. It established the base-line date for two-year attendant certification.

On page two, section 1; (2)(d) lines 3 though 18 is the current language that establishes the criteria for issuing a temporary certification to anyone who is not qualified under paragraph (1) or (2) of subsection (a). Lines 19 through 32 is the change proposed for your consideration. The difference in the language is two-fold; *first*, it increases the length of time a temporary certificate is valid from a maximum of one year to a maximum of two years. *Second,* it eliminates the need for the application to be requested by an employer. If the applicant is currently registered by the national registry or certified/licensed in another jurisdiction at the level of certification for which the application has been made, upon payment of the appropriate fee the Board can issue the applicant a temporary Kansas certification. This is especially important to agencies such as fire departments who wish to hire certified attendants but are not the operator of an ambulance service.

Also on page two, section 1; (e)(A) simply cleans up the language with regard to what we identified two years ago as a "graduate certification", also temporary in nature. It does not change the requirements for gaining this "graduate" certification.

I appreciate the opportunity to provide this testimony and will be glad to respond to any questions or comments you may have with regard to this proposed legislation or our agency.

To: House Health and Human Services Committee
From: *R.E. "Tuck" Duncan*
American Medical Response
RE: HB 2832 March 15, 2004

HB 2832 would amend the process by which the Board of Emergency Medical Services issues temporary certifications. Under current law, the Board may issue a temporary certificate at the request of an attendant's employer, if that attendant has met the minimum requirements prescribed by the Board. This bill would allow individuals to apply for a temporary certificate as long as they are on the National Registry of Emergency Medical Technicians or have a comparable license or certification from another state. The bill would also extend the expiration date of a temporary certificate from one to two years. The Board of Emergency Medical Services indicates that this change would not have a fiscal effect on the agency.

The salient addition to current law that is proposed is as follows:
The board may issue one temporary certificate to a person who:

(A) Does not meet the requirement in section (a)(2) of completion of a program of instruction in another state that is equivalent to a program approved by the board for the class of attendant's certificate applied for;

(B) currently is registered by the national registry of emergency medical technicians or currently is certified or licensed in another jurisdiction at the level of certification for which application has been made; and

(C) pays to the board a temporary certificate fee not to exceed the amount of the application fee for the classification of attendant's certificate for which application has been made.

(2) A temporary certificate shall expire at such time as final action on the application for attendant certification or two years from the date of issuance of the temporary certificate, whichever occurs first.

On the surface this bill appears merely technical, however, we suggest that the bill represents a piece of a larger effort by the Board, an effort that should be rejected by the Legislature. The Board has for nearly a decade recognized persons who are currently registered by the national registry of emergency medical technicians as being eligible for reciprocal certification. It has been proposed that this practice be discontinued. This would be very damaging to the ability of ambulance services hiring EMICTs (paramedics). There is a shortage of paramedics. We need the ability to hire from our-of-

Attachment 6
HHS 3-17-04

state persons who have national registration. We recently conducted a survey of ALS (advance life support) services and learned that several of same had vacancies for EMICTs.

We propose that the Legislature reject the proposal set forth by the Board of EMS to extend the temporary certification period to two years which would facilitate the Board requiring our-of-state attendants to acquire an associate's degree prior to permanent certification and that the Legislature adopt an amendment that makes it clear that registration on the national registry is sufficient for reciprocity.

WHAT IS THE NATIONAL REGISTRY ?? From its web-site: http://www.nremt.org

The history of the National Registry of Emergency Medical Technicians began in 1969 with the recommendation by President Lyndon Johnson's Committee on Highway Traffic Safety that there be a national certification agency to establish uniform standards for training and examination of personnel active in the delivery of emergency ambulance service. This resulted in the appointment of a Task Force by the American Medical Association's Commission on EMS to study the feasibility of a National Registry for EMTs. Heading the Task Force was Oscar P. Hampton, Jr., M.D., recognized for his pioneering work with the American College of Surgeons, Committee on Trauma. Other physician members were A.E. Doktorsky, I.E. Hendryson, Maurice Schnitker, and J.D. Farrington.

These physicians, plus representatives of organizations actively involved in emergency medical service, attended the first meeting of the Task Force on January 21, 1970. The organizations invited to participate were the Ambulance Association of America, International Association of Fire Chiefs, International Rescue and First Aid Association, National Ambulance and Medical Services Association, National Forest Service, National Funeral Directors Association, National Park Service, National Safety Council, National Ski Patrol, American Heart Association, and International Association of Chiefs of Police. In his introductory remarks, Dr. Hampton stated, "A Registry of Emergency Medical Technicians-Ambulance would not only upgrade the quality of emergency care, but also the pay and status of certified personnel engaged in its provision." Organization and composition of the Registry's governing board were considered. As the minutes of the first meeting note, "It was the consensus of the representatives of the organizations in attendance that the majority of the members of the board should represent the organizations who provide emergency ambulance services". It was agreed that physicians should be chosen on the basis of their activity in the field of EMS, rather than as a representative appointed by a medical organization. This approach has proven highly beneficial with illustrious and involved physician directors contributing untold hours and a wealth of experience to the development of Registry policies and procedures.

From the beginning there was awareness of the importance of a balanced Board, fully representative of the agencies involved in emergency ambulance service, but carefully structured to guard against domination by those individuals seeking certification. Because of this approach, the National Registry has maintained the integrity of the certification process and avoided the problem described by Dr. Thomas Piemme, Chairman, National Commission for Health Certifying Agencies: "Some so-called certifying bodies lack independence and are dominated by the professionals they are supposed to judge".

The Task Force met a total of three times to draft bylaws, determine the composition of the Board, discuss funding, and tackle a myriad of other concerns inherent in the birth of the new certifying agency. At 2:15 PM, June 4, 1970, the Task Force was dissolved. It was immediately reconvened as the first meeting of the Board of Directors of the National Registry of Emergency Medical Technicians- an independent, not-for-profit, non-governmental, free standing agency. Seven organizational members and four physicians comprised the Board. It was decided that when 2,000 EMT-A's had been registered, the Directors representing the member organizations would elect one EMT-A from each of the proprietary, governmental, and volunteer categories of ambulance service. The Board of Directors

would then be composed of fourteen members. At the first meeting, the following Directors were elected: Roddy A. Brandes, Ambulance Association of America; Chief Curtis Volkamer, International Association of Fire Chiefs; David B. Hill, Jr., National Ambulance and Medical Services Association; David Wooten, National Sheriffs Association; Joseph L. McCracken, National Funeral Directors Association; George B. Johnson, International Rescue & First Aid Association; Norman Darwick, International Association of Chiefs of Police. In the intervening years, the private ambulance associations merged into the American Ambulance Association, and a representative from the National Association of Emergency Medical Technicians joined the Registry's Board. The original four physician directors were Oscar P. Hampton, Jr., J.D. Farrington, I.E. Hendryson, and A.I. Doktorsky.

Roddy A. Brandes was elected the Board's first Chairman. Rocco V. Morando served as a member of the Board's first examination committee and was selected the following year as NREMT's founding Executive Director.

Interest free, start-up loans were made to the Registry by the American Medical Association, Employers Insurance of Wausau, and the Ambulance Association of America.

The National Registry continued to grow during the 80's. Its Board of Directors reviewed the issues related to registration and subsequent certification gained in more and more states. Policies and procedures had to have some flexibility yet continue to require and endorse the underlying goal of the founders of NREMT: to protect the public through a national registration process designed around standards that assure quality patient care.

In 1989 the National Registry amended its by-laws to include the National Association of State Emergency Medical Services Directors. The International Association of Chiefs of Police were removed from the Board of Directors.

In the early 90's the NREMT continued to grow, conduct self evaluations, keep contact with the needs of state offices and the nation. The NREMT became involved in national projects that were requested by the states, such as the EMS Education and Practice Blueprint. Standard methods to respond to the Americans with Disabilities Act, application reviewing for felony convictions, and transitioning of EMT-Basics over new educational materials, entered into the Registry's activities list. Seeking increased validation of written examinations the NREMT conducted a Practice Analysis for EMT-Basics and Paramedics. Growth continued, staff were added, the work space for the staff was remodeled and a new computer system was purchased. The NREMT continued to respond to the needs of the national EMS community.

In 1995 the NREMT Board of Directors approved the first major revision of the by-laws. Five physician members were to be selected, one from NAEMSP, one from ACEP and three at-large members. State government was represented by three members of NASEMSD and one member from the NCSEMSTC. Organizations continued representation from the AAA, IAFC, NAEMT, and IRECA. Two NREMTs at-large were maintained on the Board. The by-laws established terms of office, set apart officers as separate board members, and established January 1, 1997 as the date in which the new Board of Directors would take office.

The NREMT continued to evolve in the latter 90's reaching greater acceptance as demonstrated by the use of the NREMT process as part of the EMT licensure process in 43 states by the end of 2001. The Registry began in 1999 the important Longitudinal EMT Attribute Demographic Study (LEADS) project. An analysis of the practice of EMTs was also completed in 1999 that would later form the basis for all NREMT test plans. Enhancements were continued on the computer system and the Registry kept contributing to the national EMS community.

As EMS adapts to the changing health care environment, the NREMT will listen to the EMS community and change areas of registration accordingly.

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The NREMT provides a wide variety of products and services. They include: a registry

for nationally certified EMTs, valid and reliable tests for entry-level EMS responders, nationally consistent re-registration requirements for First Responders and EMTs, information from testing and registration databases, educational tools including self-assessments, technical assistance to states and organizations, a newsletter, and sale items which identify the registration status of NREMTs.

Understanding the current mission, values, customers, products and services, assets and barriers allowed the Board to identify its strategic directions. Recognition that EMS is an evolving discipline, that technology is under constant revision, and that staffing and resources are limited, the Board identified four major directions for 2001, modified them in 2002 and re-modified them, added additional strategic directions for 2003 and 2004. Other strategic directions for consideration over a five-year period were also reviewed.

The Board recognized that the National Registry of EMTs is the National EMS Certification Agency as described in the *EMS Education Agenda for the Future: A Systems Approach. Efforts.* The evidence presented to support this recognition by the Board include:

- NREMT's 33-year history, not-for-profit status and organization stability
- Use by 44 states and certification of over 1 million EMTs
- Its investment of over $50M supporting EMS
- NREMT's certification processes, staff, facility and information technology
- Its accreditation by the National Commission for Certifying Agencies and adherence to APA standards
- The NREMT's Board Membership, Strategic Planning process and governance of inclusiveness
- Its strong industry relationships and role as an EMS community leader
- NREMT's advocacy and participation in these areas: ADA, the EMS Blueprint and EMS Education Agenda for the Future, the National Standard Curriculum, the LEADS study, Committee on Accreditation and participation with state and Federal partners
- Its high customer satisfaction ratings with states and EMTs

The Registry in 2003 processed the following:

Total Examinations Scored	109,933
First Responder Examinations	7,052
Basic Examinations	82,640
Intermediate/85 Examinations	5,395
Intermediate/99 Examinations	916

Please find attached my testiomony for the hearing Wednesday, St. Pat's Day, @ 1:30 p.m. on HB 2832.

Thank you for your attention to and consideration of this matter.

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Paramedic Examinations		13,930
Reregistrations	42,915	
First Responders		1,061
Basic		22,396
Intermediate/85		2,725
Intermediate/99		58
Paramedic		16,675
Telephone Calls Received	113,667	
Administration		27,427
Examination Department		20,402
Certification Department		50,524
Reregistration Department		15,314

An organization capable of handling that many transactions deserves our respect and recognition.

Therefore, Kansas should, because of the professionalism of the Registry, and its capabilities, recognize same for reciprocity purposes for EMT and EMICT certification.

Thank you for your kind attention to and consideration of these matters.

health @ house.state.ks.us

65-6129

Chapter 65.--PUBLIC HEALTH
Article 61.--EMERGENCYMEDICAL SERVICES

65-6129. Attendant's certificate; application; forms; requirements; temporary certificates; authorized activities of applicants for certification; disposition of fees; renewal of certificate; continuing education. (a) Application for an attendant's certificate shall be made to the board upon forms provided by the administrator. The board may grant an attendant's certificate if the applicant meets the following requirements:

(1) (A) Has made application within one year from the date of the last class of a course of instruction approved by the board for the classification of attendant's certificate for which application has been made; and

(B) has completed successfully such course of instruction, passed an examination prescribed by the board and paid a fee prescribed by the board; or

(2) has completed successfully a course of instruction or training accredited by the commission on accreditation of allied health education programs, a program of instruction or training offered by the armed forces of the United States or a program of instruction completed in another state that is equivalent to a program approved by the board for the class of attendant's certificate applied for, passed an examination prescribed by the board and paid a fee prescribed by the board. or is registered for the classification of attendant's certificate for which application is made by the National Registry of emergency medical technicians.

(b) The board shall not grant an initial emergency medical technician-intermediate certificate, an initial emergency medical technician-defibrillator certificate or an initial mobile intensive care technician certificate unless the applicant for such an initial certificate is certified as an emergency medical technician.

(c) On and after January 1, 2001, an attendant's certificate shall expire on the date prescribed by the board. An attendant's certificate may be renewed for a period of two years upon payment of a fee as prescribed by rule and regulation of the board and upon presentation of satisfactory proof that the attendant has successfully completed continuing education as prescribed by the board. The board may prorate to the nearest whole month the fee fixed under this subsection as necessary to implement the provisions of this subsection.

(d) (1) The emergency medical services board may issue a temporary certificate to any person who has not qualified for an attendant's certificate under paragraph (1) or (2) of subsection (a) when:

(A) The operator for whom such person serves as an attendant requests a temporary certificate for that person; and

(B) such person meets or exceeds certain minimum requirements prescribed by the board by rules and regulations.

(2) A temporary certificate shall be effective for one year from the date of its issuance or until the person has qualified as an attendant under paragraph (1) or (2) of subsection (a), whichever comes first. A temporary certificate shall not be renewed and shall be valid only while an attendant works for the operator requesting the temporary certificate. A person holding a temporary certificate as an emergency medical technician shall not be eligible to apply for certification as an emergency medical technician-intermediate, emergency medical

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technician-defibrillator or a mobile intensive care technician.

(e) (1) Upon request by an operator to the board and upon approval by the board of such request, an applicant for certification may perform activities that are within the authorized activities of the certification level applied for, provided that the applicant:

(A) Has successfully completed the appropriate course of instruction for the level applied for;

(B) serves with the ambulance service identified in this subsection (e); and

(C) is practicing under the direct supervision of a physician, physician assistant, professional nurse or an attendant who is at or above the certification level for which the applicant has applied.

(2) The authority to perform activities under this subsection (e) shall terminate 120 days from the date of the last class or until the results of the first examination are received by the board, whichever comes first. Such authority to practice shall not be renewed and shall be valid only while the applicant serves with the ambulance service identified in this subsection (e).

(f) All fees received pursuant to the provisions of this section shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the state general fund.

(g) If a person who was previously certified as an attendant applies for an attendant's certificate within two years of the date of the certificate's expiration, the board may grant a certificate without the person completing a course of instruction or passing an examination if the person has completed continuing education requirements and has paid a fee prescribed by rules and regulations.

History: L. 1988, ch. 261, § 29; L. 1990, ch. 236, § 1; L. 1991, ch. 203, § 7; L. 1993, ch. 71, § 5; L. 1998, ch. 133, § 11; L. 2000, ch. 117, § 2; L. 2001, ch. 5, § 267; L. 2002, ch. 203, § 1; July 1.

AMERICAN MEDICAL RESPONSE

John Hayworth
Communities:
Operations Director
Kansas Division
1993,

Serving the Following Kansas

Shawnee County Since 1983; Johnson County Since 1985; Osage County Since

Wabaunsee County since 2001

To: House Health and Human Services Committee

From: John Hayworth

RE: HB 2832 March 15, 2004

Upon reading HB 2832 that changes temporary certification from 1 to 2 years and does not require the individual to be affiliated with a particular provider. It could be assume it would not have a significant impact on the provider or attendants. If passed in the present form it will allow regulatory changes, already approved, in the reciprocity process followed by the Board of EMS for many years. This could have a significant impact on both providers and attendants. Although the Board uses the National Registry of EMT's exam for validation of our educational process, standard used in 44 other states. The Board will no longer recognize those Nationally Registered if educated outside of Kansas unless they have or obtain additional general education defined by the Board.

Increased educational standards are an assumed improvement of Kansas EMS. There is no national data available to support that assumption. The educational process, associates degree, currently required for Kansas EMICT (paramedic) is a standard that has been tried in other states and failed because they were no longer able to staff ambulances. To add to our new educational requirements, with admitted fewer students, and at the same time create barriers to national recruiting, when most services have openings, appears unwise. It is difficult to understand why The Board supports SB 351, which asks the state to fund individuals to attend initial courses of certification. The purpose SB 351 is to address a shortage in EMS providers, and at the same time HB 2832 would discourage Nationally Registered providers, who validated their education with the same test our students take, from moving to Kansas.

As one of the many employers who have openings for care givers I ask that the legislature not do anything that may contribute to our struggle to provide service to those in time of need.

I ask the committee to amend HB 2832 to recognize Nationally Registered attendants.

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Attachment 7
HHS 3-17-04