Approved: Feb. 4, 2008
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairperson Brenda Landwehr at 1:30 P.M. on January 28, 2008 in Room 526-S of the Capitol.

All members were present.

Committee staff present:
Norman Furse, Revisor of Statutes Office
Dianne Rosell, Revisor of Statutes Office
Melissa Calderwood, Kansas Legislative Research Department
Cindy Lash, Kansas Legislative Research Department
Chris Haug, Committee Assistant

Conferees appearing before the committee:
Larry Buening, Executive Director Kansas State Board of Healing Arts

Others Attending:
See Attached List.

The minutes of the January 23rd meeting were reviewed. Representative Neighbor moved that the minutes be approved and Representative Storm seconded. The motion carried.

Representative Storm made a motion to introduce a bill on Cosmetology on Body Art, specifically adding regulations on Tanning and the number of hours required for the Aesthetician license. Vice Chairperson Mast seconded the motion. The motion carried.

Representative Hill made a motion for the Kansas Dental Board to change the licensor for Continuing Education requirement from 12 to 24 months. Representative Neighbor seconded the motion and the motion carried.

Representative Hill made another motion for the Kansas Dental Board for license reciprocity to Dentist and Hygienist. Representative Neighbor seconded the motion and the motion carried.

Larry Buening, Executive Director of the Kansas State Board of Healing Arts, made a presentation on a case currently going on in Sedgwick County. The presentation is attached as (Attachment 1).

Chairperson Landwehr asked about page 2 of the report. She wanted to know which committee reviewed? Mr. Buening stated it was the Osteopathic committee.

Representative Storm asked why in 2003, if there were complaints regarding 4 physicians, why did Schneider come to the top? Were the other 3 investigated? Mr. Buening said the complaint was with the Schneider Clinic. Investigation into this may have revealed the other complaints. He can provide feedback.

Chairperson Landwehr asked where were the complaints coming from? Mr. Buening said complaints come in on a complaint form. Letters come in as letters and petitions also come in.

Representative Neighbor asked, "how many repeated instances of neglect have to take place?" Mr. Buening stated that it depended on the severity of the situation. Once a review committee reviews, it goes to a disciplinary committee. They look at the totality and make a decision as to whether there are repeated instances and whether disciplinary action is required.

Representative Colyer asked a question about the process. He wondered if there was an emergency process where they can be suspended. Mr. Buening said there was. Representative Colyer asked what it takes to trigger the emergency process. Mr. Buening said it depended on the circumstances. The fact that there was a petition for malpractice may or may not have any indication of a violation of the Healing Arts Act. I think statistics have shown, over the years, that only 1 in 4 petitions for malpractice that have been filed against physicians have resulted in payout to the plaintiff in the case. Representative Colyer asked

who makes the decision whether this is an emergency procedure or a standard disciplinary case? Mr. Bruening said the disciplinary panel or the board members themselves. They try to prioritize the cases based on the allegations and the entire history before that. When the disciplinary panel authorizes a case they would also state whether it would be an emergency case or not.

Chairperson Landwehr wanted clarification of that statement by asking, "what does it take to declare a disciplinary action in an emergency case? Mr. Buening stated it would take a violation of the Healing Arts Act. There are sixty some grounds of disciplinary action, it would need to indicate an imminent danger to public health. Chairperson Landwehr wanted to know how many repeated violations on standard of care would it take? Mr. Buening stated it depends on the persons past history and types of cases, were they similar or not similar situations. Again, the board is provided with all of that information and they make that determination.

Representative Flaharty wondered how frequently complaints come? She wondered if you had been practicing for a long time whether it would be probable to have a complaint after a long period of time. Mr. Buening said it is not probable but it certainly was not unusual.

Representative Rhoades asked whether it was common to find have 8 or 9 complaints within a three year period, as in this case. Mr. Buening said it was not.

Representative Crum wondered why the Schneider case did not qualify for an emergency suspension of his license, with the grounds that you have spelled out here in this report. Mr. Buening said it wasn't until we received the complaint in March of 05 and August of 05 that we had our 2nd and 3rd instance. I don't know of a case in which there has been an eminent danger determined on standard of care issues based upon three instances. Representative Crum stated that when the information was brought in from the Federal people involved it seemed to stall your process a little bit because Federal agencies were involved also. At that point wouldn't that have raised a red flag that you needed to stop this physician from continuing to practice temporarily until it could be found out how much of a danger he was to the patients he served. Mr. Buening said that he thought that was a fair statement and in hindsight today, yes.

Representative Morrison asked, "who oversees the board?" Mr. Buening said the board was appointed by the governor. Who oversees your actions and your work. Mr. Buening said as far taking actions the legislative post audit does reviews and the court systems get involved any time there is an appeal of the action. Representative Morrison asked if an appeal had ever been overturned. Mr. Buening said there was a case where the district court did overturn the board action but I think eventually it was resolved. Rep. Morrison said we have an inspector general now who oversees the health policy and authority and its work. It looks for capricious behavior and oversees in that way. Do they come in and randomly review your records. Mr. Buening stated, "no".

Representative Neighbor's asked for a clarification of page 3. Should that be May 05 or 06? Mr. Buening clarified it should be May 06.

Chairperson Landwehr asked to go back to the differing of opinions between the Board of Healing Arts and the US Attorney. As long as the Board of Healing Arts has been in place, I'm surprised that if a state or federal agency asked to hold off on a case that I thought should proceed forward that something wasn't asked for, in writing. I'm surprised that you guys didn't do that. That was actually a request from the US Attorney's office. Mr. Buening did not have a response to that. Chair Landwehr asked if this was the first time this has ever popped up in the boards history. Kelly Stephens, Litigation Counselor for the Board got up and spoke. Kelly stated that they had worked extensively with the US Attorney's office on cases over the years. These cases are not frequent. They come up about once a year and then we work with them very closely. She said she thought they had developed a very good working relationship with them, over the years. Maybe, I was incorrect about that. We worked with them a few years ago on another case where they had a criminal indictment pending and we had a parallel investigation going on and the federal government worked to come to a resolution while their matter was pending as a condition of that individuals release, pending their trial that we were also involved with. We monitored that person's practice while they were on release from the federal government, so we've had a working relationships

from time to time. I think that case was Herbert Daniels, M.D. I can answer your question. I did not ask for the US Attorney's request to be in writing. In hindsight, yes I should have. But, I can very clearly state that she made that request to me, and there were 3 other individuals present. Assistant US Attorney, Connie Tredway was who asked us to hold off on our case until she was able to indict him.

Chair Landwehr said she can understand the hindsight thing and building relationships of trust, but I also understand when you are dealing with legal matters everything needs to be in writing and that is why I'm surprised that the Board of Healing Arts was somewhat lax in that. Ms. Stephen's said to give you a little perspective, at the time that agreement was made, we were under an order to produce documents to opposing counsel regarding anything pertaining to the matter. A letter from the US Attorney's office could have been produced to the opposing counsel at that time. Again, their criminal investigation was on-going and I think there was a concern about compromising their case. Chair Landwehr said she could understand that. But she still couldn't understand why an agency wouldn't ask for something in writing. Ms. Stephen's agreed. At the exact same time this was happening we were trying to work up additional cases against Dr. Schneider to strengthen the case and we knew we would potentially have to request a stay to amend our petition. The agreement to stay the proceedings was based on our need to add the additional cases. At that time, unfortunately it got extended way beyond my comfort zone as well and that's were we are today. Chair Landwehr asked how many complaints, reports, etc. prior to this meeting with the US Attorney's office. Ms. Stephen's said she didn't deal with the investigative process. Once those cases are completed and they come to me for prosecution that is when I begin my work. My best recollection is that in April of 2006 we brought 10 investigation cases to the Osteopathic Review committee. The exact date was April 26. Our next disciplinary panel was scheduled for May 19, 2006. I'm going to try to explain it without getting into client-privileged information. We start looking for an expert once we get the case. The Osteopathic community in Kansas is actually very small and it's difficult to find someone who don't know each other or who have not worked with each other before. And it's also true for pain-management. It's a very small area of practice. We were also preparing the cases for the disciplinary panel and they reviewed those on May 19, 2006 and we filed our action on May 30, 2006.

Representative Otto asked if physician assistants operate under the board of healing arts? Mr. Buening said they are licensed by us and are regulated by us. Can it be possible for a physician's assistant to operate under a physician in jail. Mr. Buening said no, that is not possible. They cannot be available within 30 minutes.

Representative Colyer asked for clarification, in 2007 the Board of Healing Arts was relying on the Feds to indict and that is why there is was no action in 2007 by the board? Mr. Buening stated that was correct. Ms. Stephen's stated they had contact with the US Attorneys office. Rep. Colyer asked if there was ever a discussion with the Osteopathic board that they needed to have an emergency evaluation of his license. Ms. Stephen's stated that yes, those discussions took place.

Chairperson Landwehr reiterated that an emergency proceeding should have taken place by the Board of Healing Arts prior to December 2006. Mr. Buening said in hindsight, things would probably been done differently.

Representative Mast mentioned a physician in Western Kansas that had past instances of inappropriate sexual contact. Do people in the community have a way to be informed ahead of the time they are charged, when they are involved with misconduct? Mr. Buening said if the Board has taken any action against a physician, it is published on our own website the actual action. You can go back as far as 1998. Representative Mast wondered why this particular case in Western Kansas was marked confidential. Mr. Buening said if the records relate to drug and alcohol or psychiatric issues, then we would show these as non-disclose able. Representative Mast questioned whether he would go on a sexual predator list and Mr. Buening did not know. Representative Mast asked what the difference was between censor and limitations. Mr. Buening stated our statute is number **KSA 65-2836**. A censor is a finding that there was a violation of the Healing Arts Act and they are censored for that comment. It is a serious thing, it is reported to the federal data bank. A limitation limits the license of the individual to some respect. Such as prescribing certain substances. Suspension is a temporary thing that lasts for a certain amount of time and then comes off. A revocation is a much more permanent action. Although an individual can come

back after 3 years and seek reinstatement of that license. One other provision not in the statute that allows us to impose an administrative fine.

Representative Storm wanted to picture the procedures correctly, if a person is censored or have a limitation and want to appeal who do they appeal to? Mr. Buening said the appeals are with the district court. Representative Storm wondered if most of the time the Board of Healing Arts operated away from the court. Mr. Buening said, "yes".

Chairperson Landwehr adjourned the meeting at 2:35 p.m. The next meeting will be January 29, 2008.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE GUEST LIST

DATE: January 28, 2008

NAME	REPRESENTING
Tristan Mayer	Pinegar Smith
Michelle Robinson	Capitol Strategies
Brad Williams	KS. Osteopathic Medicine
Jody Schrock	KSWA

KANSAS

KATHLEEN SEBELIUS
GOVERNOR

STATE BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

MEMORANDUM

TO: **House Health and Human Services Committee**

FROM: Lawrence T. Buening, Jr.
Executive Director

RE: **Investigative Processes and Stephen Schneider, D.O.**

DATE: **January 28, 2008**

Good afternoon. I am the Executive Director of the Kansas State Board of Healing Arts and am providing this information on behalf of the Board.

To briefly provide some information on the Board, it was created in 1957 by combining the existing boards that regulated medical doctors, osteopathic doctors, and chiropractors. Currently, the Board is comprised of 15 members, each appointed by the Governor for four-year terms. Five members are medical doctors, three are osteopathic doctors, three are chiropractors, one is a podiatrist and three are appointed from the general public. The Board regulates the practice for approximately 21,500 persons engaged in 13 health care professions.

The Board performs its regulatory functions pursuant to statutes enacted by the Legislature and rules and regulations adopted by the Board to implement those statutes. The Healing Arts Act (K.S.A. 65-2801 *et seq.*) was enacted in 1957 to regulate the professions of medicine and surgery, osteopathic medicine and surgery and chiropractic. K.S.A. 65-2801 has remained unchanged since 1957 and provides that the regulation of the healing arts is required so that "the public shall be properly protected against unprofessional, improper, unauthorized and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice...".

To meet its statutory responsibilities in the regulation of the healing arts, the Board has three programs: (1) Licensing and Renewal; (2) Investigation and Disciplinary; and (3) Enforcement and Litigation. The Licensing and Renewal Program goal is to ensure that only those meeting the required qualifications are issued licenses and are allowed to renew those licenses. The goal of the Investigation and Disciplinary Program is to promptly, aggressively and thoroughly investigate matters alleging incompetence,

Health + Human Svcs. Comm.
1-28-08
Attachment 1

235 SW TOPEKA BLVD., TOPEKA, KS 66603
Voice: 785-296-7413 Toll Free: 888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org

unprofessional conduct and other statutorily proscribed conduct and to submit completed investigations to review committees for fair and consistent recommendations. The Enforcement and Litigation Program is involved in restricting or otherwise affecting the license of those individuals who lack professional competence or have committed other violations of the Healing Arts Act.

Before providing information on the topic requested by Chairperson Landwehr, I would like to briefly describe the Board's investigative processes. During the summer of 2006, Legislative Division of Post Audit conducted a performance audit of the Board of Healing Arts, including reviewing issues related to complaint investigations. Attachment 1 constitutes pages 3 through 7 of the Performance Audit Report issued October 2006. The process for reviewing complaints, investigating them, and ordering corrective action is set forth in Figure OV-2 on page 5 of the Report.

Attachment 2 is the Disciplinary Procedure that can be accessed from on our website at www.ksbha.org.

Chairperson Landwehr has requested that I provide information to the Committee on a case that has received substantial coverage in Sedgwick County. This press and media coverage began when a Grand Jury indictment was filed in United States District Court on December 20, 2007 against Stephen J. Schneider and Linda K. Schneider, case no. 07-10234-WEB. The Indictment contains 34 counts alleging conspiracy, unlawful distribution and dispensing of controlled substances, health care fraud, illegal monetary transactions, and money laundering. Since the filing of the indictment, a plaintiff's attorney has been quoted on more than one occasion, an editorial appeared in the December 22, 2007 edition of The Wichita Eagle, and two legislators were cited in an article that appeared December 23, 3007. As a result, I have reviewed the information in the Board's possession regarding what information was provided to the Board and when it was provided.

In calendar year 2003, the Board received a police report concerning medication bottles found in the home of a decedent. An investigative case was opened six days following receipt of the report. The investigation revealed that bottles of pills from four practitioners were found in the decedent's home. The autopsy determined that death was due to toxic effects of cocaine. The osteopathic review committee determined that Dr. Schneider did not violate the healing arts act and the matter was closed.

In calendar year 2004, the Board office received three pieces of information. On February 11, 2004, a complaint was received and opened for investigation six days later. Following the conclusion of the investigation, a determination was made that there had been no deviation from the standard of care. A letter was received on March 23, 3004, and an investigation commenced. It was subsequently determined that the standard of care had been met. On November 11, 2004, a complaint was filed. Investigation revealed that the standard of care had not been met. This was the first finding that standard of care had not been met. Pursuant to K.S.A. 65-2837(a)(2), repeated instances of ordinary neglect are required for a violation of the healing arts act to have occurred.

The treatment provided to the patient relating to this complaint has been included in the disciplinary action now pending before the Board.

During the first nine months of 2005, six additional matters came to the Board's attention. Complaints received on March 17, March 25 and April 15, 2005 have all been determined to be within the standard of care. On February 4, 2005, a complaint was received and an investigation opened March 1, 2005. Licensee's conduct in the treatment of this patient was subsequently determined to have been below the standard of care and this matter has been included in the disciplinary action that was originally filed May 30, 2006. Treatment of the patient that was described in the complaint received August 2, 2005, was also determined to negligence and is included as one of the counts in the matter currently pending before the Board.

The sixth matter received during the first nine months of 2005 was a letter received from SRS on May 25, 2005 advising that licensee had been terminated from participation in the Kansas Medicaid program. On July 1, 2005, an appeal was taken by the licensee in case no. 05-CV-2566. As a result, a hearing was conducted July 6, 2005, in which a District Court Judge in Sedgwick County found that there was substantially likelihood of success on the part of the licensee on the appeal. Specifically, the Honorable Karl W. Friedel stated as follows: "From the standpoint of irreparable injury, I find that if this action is not stayed – the action on the part of the State is not stayed there will be irreparable injury not only to the doctor and the clinic, the staff of the clinic, but also to the patients by way of an interference with the doctor/patient relationship. And given the evidence that's provided of the compliance by the clinic with regard to the FirstGuard requirements of remedial action, I find no threat to the public health, no undue harm to the public or the prospect of harm." (Transcript of proceedings, Page 3, Lines 2-12). The Court ordered that the Kansas Division of Health Policy and Finance permit the licensee to continue to participate in the Kansas Medicaid program.

In September 2005, it became a matter of public knowledge that Federal authorities were conducting an investigation and had executed a search warrant on the Schneider clinic. From October 6, 2005 through the end of the year, the Board received one complaint and four initial reports from the Health Care Plan that malpractice suits had been filed---two of these pertained to Stephen Schneider, D.O. and two related to Schneider Medical Clinic, LLC. It should be noted that malpractice petitions are not generally investigated as statistics have shown that only about one in four result in payments or a determination that negligence had occurred by a practitioner.

During the first three months of 2006, the Board received reports from the Plan that four more suits had been filed or a written claim made against the licensee. Also, in addition to copies of Petitions or claims received from both the Fund and Plaintiff attorneys, the Board received two complaints on February 7 and February 17.

On May 31, 2006, the Board initiated a disciplinary proceeding. The treatment relating to six of the patients that were brought to the Board's attention during the first three months of 2006 are currently included in the disciplinary proceeding. In addition, the

disciplinary proceedings involve the treatment provided to patients relating to the complaints received on November 11, 2004 and February 4, 2005.

There may be questions about the length of time it has taken for the Board's disciplinary proceeding to come to a hearing. Since the filing of the disciplinary proceeding, the Board has continued to receive additional complaints and information on malpractice suits filed. Investigations are still ongoing and peer review is being conducted. A Board member was appointed as the Presiding Officer in June 2006. A prehearing conference was then scheduled for July 31, 2006. In August 2006, a substitute Presiding Officer from the Office of Administrative Hearings was designated to hear the case. The Board's attorney filed a 44-page First Amended Petition on September 1, 2006. A second prehearing conference was scheduled for September 25, 2006, resulting in a prehearing order scheduled the matter for hearing on March 26, 2007. On January 26, 2007, an Agreed Order of Stay was entered. This was agreed to as a result of repeated discussions with Federal authorities indicating a Federal indictment would be forthcoming and that the possibility of a resolution involving the Federal investigation and the licensee's license to practice in Kansas. A third prehearing conference was scheduled for November 13, 2007, on which date a 56-page Second Amended Petition was filed. On December 27, 2007, a Motion for Emergency Suspension was filed which was heard by the Presiding Officer on January 15, 2008. The Presiding Officer has taken the Motion under advisement and he informed the parties that he would rule as soon as possible.

The Board was aware of an investigation being conducted by Federal authorities prior to the service of the first search warrant in September 2005. Contact with Federal authorities has been continuous. However, it was not until December 2006 and January 2007, that discussions with Federal authorities revealed just how extensive the Federal investigation was. According to the December 21, 2007 issue of The Wichita Eagle the indictment filed December 20, 2007, followed four years of investigation. An Associated Press story appearing January 17, 2008, cites one of the defense attorneys as saying the government has 200 boxes of evidence. A Kansas City Star article posted December 20, 2007 cited United States Attorney Eric Melgren as follows: "Melgren called the case one of the most complicated investigations his office has ever done, and his office worked as quickly as possible, given the circumstances." Just how extensive was the Federal case was not totally made aware to the Board until the filing of the indictment.

The Board itself is very aware of the concerns of practitioners who are involved in pain management. The abuse and addiction potential of narcotic painkillers and fears of federal and state scrutiny and prosecution discourage many primary-care doctors from treating chronic pain patients. Patients with pain are difficult patients for any doctor to treat.

One past case if of particular note. In July 1994, a licensee was arrested on murder and attempted murder charges. A settlement proposal was provided to the licensee's attorney February 7, 1995, and signed by the licensee on February 18, 1995, and accepted by the Board at its meeting April 29, 1995. The settlement resulted in the licensee surrendering his license to practice in Kansas. Eight months later the licensee was convicted of

murder and attempted murder. Subsequently, the appellate courts set aside the convictions. The doctor's license was then reinstated on October 17, 1998. However, the 2000 Legislature determined that $66,666 should be paid to the doctor by the healing arts fee fund, the Attorney General's fund and the State General Fund.

In October 1998, the Board adopted Guidelines for the Use of Controlled Substances for the Treatment of Pain. This was followed up in June 2002 by the adoption of a Joint Policy with the Nursing and Pharmacy Boards. Copies of these policies are included as Attachments 3 and 4. Excerpts from the Joint Guidelines include:

> "Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment."
>
> "Prior to the filing of any allegations, the results of the investigation will be Evaluated by the health care provider's peers who are familiar with the policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board."

In 2006, the Legislature amended the healing arts act as follows:

> "(23) Prescribing, dispensing, administering~~,~~ *or* distributing a prescription drug or substance, including a controlled substance, in an ~~excessive,~~ improper or inappropriate manner ~~or quantity~~, *or for other than a valid medical purpose*, or not in the course of the licensee's professional practice."

This amendment was included with the bill that adopted the Pain Patient's Quality of Care Act. (2006 Senate Substitute for House Bill No. 2649) and, in combination, resulted in the state of Kansas receiving the highest grade for balanced pain policies in the nation by the Pain & Policy Studies Group of the University of Wisconsin Comprehensive Cancer Center. (See Attachment 5).

Cases involving potential overprescribing are extremely difficult and time consuming. Not only must the patient prescription records be obtained, but the investigation must be reviewed by a committee of the practitioner's peers, the Board's Disciplinary Panel and, if proceedings are authorized, an expert who will testify at the hearing. This case was further complicated by a number of factors: patients received prescriptions from a number of prescribers, many of the victims had obtained illegal drugs, and there are more than 40 pharmacies in the vicinity surrounding the Schneider Clinic that could reasonably be used by patients to fill prescriptions. Subpoenas for pharmacy records produce results in different formats. For instance, some pharmacies may provide prescription information based on the date the prescriptions were filled; others may provide information based on the drug prescribed, etc.

A centralized database of prescriptions that could produce results in a centralized format would be extremely beneficial. The 2007 Legislature enacted S.B. No. 302 and thereby

created a controlled substances monitoring task force. The report of the controlled substance monitoring task force was presented to President of the Senate and Speaker of the House on January 16, 2008. The Board would urge adoption the draft bill enacting the prescription monitoring program act that has been recommended by the task force.

Thank you for your time and I would be happy to respond to any questions.

ATTACHMENT 1

PERFORMANCE AUDIT REPORT

Board of Healing Arts: Reviewing Issues Related to Complaint Investigations, Background Investigations, and Composition of the Board

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
October 2006

The Board's mission is to protect the public by ensuring that practitioners in the 14 health care professions it regulates meet and maintain certain qualifications. The Board tries to protect the public from incompetent practice, unprofessional conduct, and other proscribed behavior by these individuals.

The 15-Member Board Licenses 14 Health Care Professions

The Board has regulated some of these professions for years, but others are newer. For example, radiologic technologists weren't required to be regulated until July 1, 2005. ***Figure OV-1*** shows the professions the Board regulates and the number of licensees in each. The Board has no oversight or regulatory authority over clinics, hospitals, or other health-care facilities, although it has standards for offices at which surgical procedures are performed.

Figure OV-1
Professions Regulated by the Board of Healing Arts, and Number of Licensees, Fiscal Year 2006

Profession	Number of Licensees	Profession	Number of Licensees
Medical Doctor	9,424	Osteopathic Doctor	899
Radiologic Technologist	2,559	Physician Assistant	683
Physical Therapist	1,798	Occupational Therapist Assistant	308
Respiratory Therapist	1,510	Athletic Trainer	286
Occupational Therapist	1,150	Podiatric Doctor	134
Chiropractic Doctor	1,041	Naturopathic Doctor	17
Physical Therapist Assistant	1,012	Contact Lens Distributors	4
Total			**20,825**

Source: Board of Healing Arts

The Board's members are appointed by the Governor, and include three public members and 12 doctors—5 medical, 3 osteopathic, 3 chiropractic, and 1 podiatric. The Board was created in 1957 when the Healing Arts Act was passed, and its composition has changed gradually, with the latest change in 1986. Advisory councils represent the professions that don't have a Board seat, and advise the Board on topics relevant to their areas.

Board Staff Are Responsible for Licensing Professionals And Responding to Complaints

The agency is divided into four sections: administration, licensure, legal, and information technology. Nearly all the agency's 32 staff are assigned to either the licensure or legal sections.

- Licensure. Seven analysts and three administrative staff issue new and renewal licenses to applicants who meet requirements. Licenses are valid for one year.

- Legal. The 18 staff in this section includes eight investigators (representing 7.5 FTE), a complaint coordinator, five attorneys, two legal assistants, and other administrative staff. Among other things, they handle all complaint investigations, present options for Board action against practitioners who have violated the Act (which can range from fines to a license revocation), and handle all legal prosecutions.

  Board staff indicated that investigators' caseloads range from 33 to 84 open cases. Each investigator was assigned an average of 43 new

cases last year. Five investigators live in the Topeka area, while the other three live and work from their homes to cover the Kansas City area, the Emporia/Wichita area, and southeast Kansas. All but one of the investigators have a law enforcement background.

- Administration and Information Technology. The agency has five administrative positions and two information technology positions.

More information about the Board can be found in the At-A-Glance box on page eight.

The Board Has Established a Complaint-Handling System With Multiple Levels of Review

The Board's complaint-handling process is shown in ***Figure OV-2*** at right, and is described briefly below.

The Board of Healing Arts considers all "adverse information" it receives about a licensed professional to be a complaint. During fiscal year 2006, the agency received nearly 2,600 pieces of information that it labeled as complaints. ***Figure OV-3*** shows the sources of these complaints, and numbers of each:

Figure OV-3
Sources and Number of Complaints Received
Fiscal Year 2006

Complaint Source	# of Complaints Received
Malpractice petitions received from Health Care Stabilization Fund	668
General public/patients filing a complaint form, calling or e-mailing	580
National reports from organizations that track disciplinary actions	300
Hospitals submitting an adverse findings report	79
Other, such as information self-reported by a doctor on the license application	960
Total	**2,587**

Source: Kansas Board of Healing Arts complaint database.

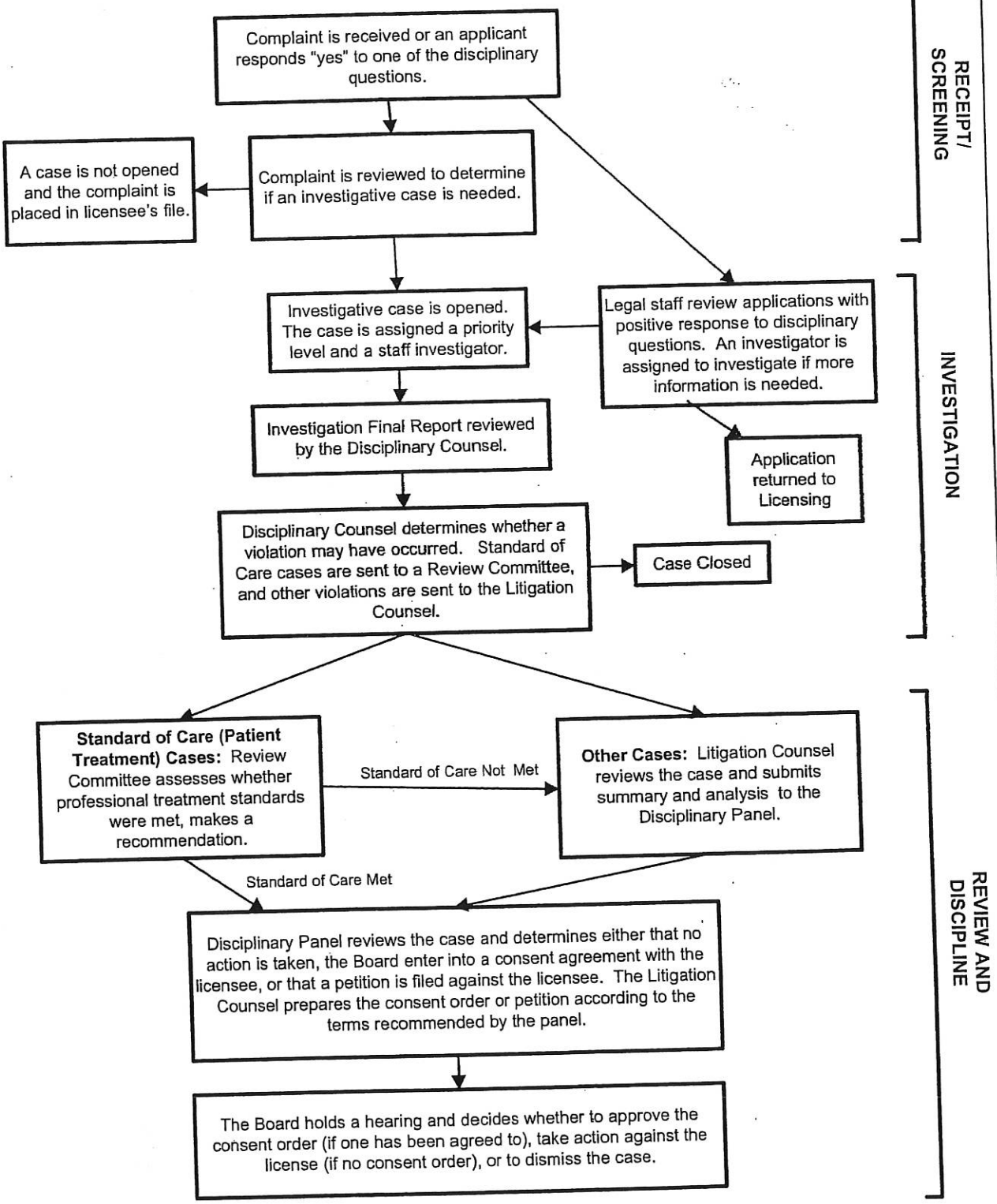
Agency policy is for staff to review complaints within two weeks of receipt to assess whether the Board has jurisdiction, and whether an investigation should occur.

The Board has established guidelines regarding which complaints will be investigated. The standard is, "If everything the complaint alleges is assumed to be true, when considering the licensees' entire history with the Board, are there grounds for discipline?" Typical allegations that will be assigned for investigation include:

- self-reported issues on an application for licensure (these are sent to the legal department for investigation and review) See ***Appendix C*** for more information

1-9

Figure OV-2
Board of Healing Arts' Process for Reviewing Complaints, Investigating Them, and Ordering Corrective Action



Source: LPA analysis of Board process.

- a complaint that is the third allegation of substandard patient care, which constitutes a "pattern" of misconduct as defined by the Board
- any allegation of gross negligence, which is defined as wanton or willful misconduct
- a single allegation of unprofessional conduct, such as sexual misconduct with a patient, chemical impairment, surrender of license in another state, or felony conviction

An administrative assistant reads all incoming complaints. If any are "emergencies," they are flagged and priority review. The rest are passed to the attorney responsible for reviewing and screening complaints and assigning them to investigators, as needed.

In fiscal year 2006, about 350 new cases were assigned to investigators for further review and potential disciplinary action.

Complaints that are assigned for investigation are given a priority level. The Board has four priority levels as defined in ***Figure OV-4*** below:

Figure OV-4
Priority Level Descriptions

Level	Description
4	**Emergency:** likelihood of posing an imminent threat of harm to the patient or other person if the behavior continues, and is a violation of law; practicing without a license; felony or misdemeanor that requires immediate investigation to preserve evidence
3	**Priority:** serious violation of the Healing Arts Act that is likely to result in harm to a patient or other person; felony or misdemeanor that requires timely investigation
2	**Important:** a violation of the Healing Arts Act that could result in harm to a patient or other person; violation of a registration requirement or other law; adverse action has been taken by another authority
1	**Other:** Other cases

Source: Kansas Board of Healing Arts

Complaints that don't lead to an investigation are maintained in the licensees' file for possible consideration in the future. Future complaints may be combined with the current complaint to establish a pattern of misconduct that would be the basis for opening an investigation.

The Board has set guidelines for how long different segments of a case should take. We reviewed these guidelines and estimate the Board's total time line for resolving complaints to be about 20 months from the time the complaint was received to the time the case was closed by Board or staff action. ***Figure OV-5*** shows a case progression time line for non-emergency complaints.

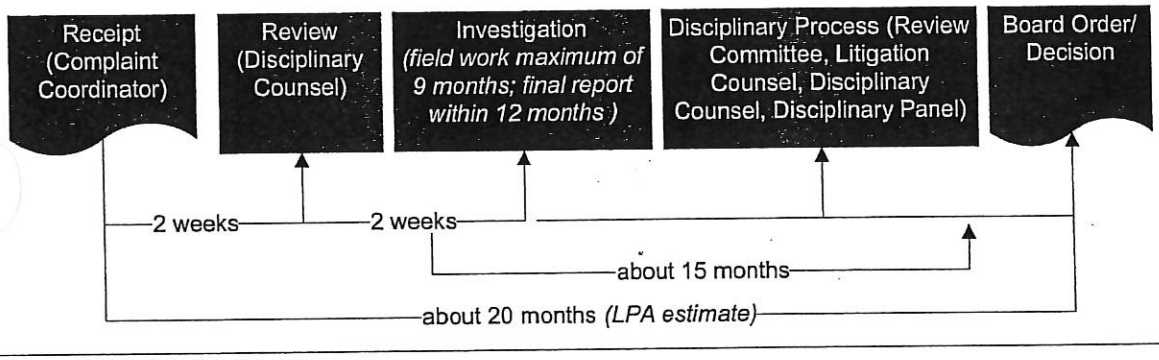
The Board has a multi-step process for cases needing disciplinary action. These are described on the next page.

1-11

- **Review Committee**: The Board has separate peer review committees for each licensed profession. Committee members are volunteers, not Board members. These committees review the entire investigation file for cases involving improper care or treatment of a patient, and determine if an acceptable level of patient care was met.

- **Disciplinary Panel**: This panel, made up of 4-5 Board members, reviews patient care cases and all other cases. The Disciplinary Panel can either recommend the case be closed without further action, or recommend disciplinary action.

Figure OV-5
Complaint Time Line



Source: KSBHA time line for new cases.

Board actions include suspending, limiting or revoking a license, requiring licensees to be supervised, requiring licensees to enter counseling or treatment programs and be monitored for 1-5 years, or publicly censuring or fining a licensee.

Board staff track and monitor the results of disciplinary orders, and rely on third party oversight as well. Staff have set up a system to track who was under monitoring status, fines assessed and payments received, and the like. Staff also rely on hospitals to report on doctors who practice in their facilities, and other doctors to report on their peers.

DISCIPLINARY PROCEDURE

Complaint Form

The Kansas State Board of Healing Arts is comprised of 15 members appointed by the Governor, 12 licensees, and three members from the general public. The Board licenses or registers 13 health care professions and out-of-state contact lens distributors. The mission of the Board is to protect the public by requiring those professionals to meet and maintain certain qualifications and standards of conduct.

Who does the Board regulate?

- Medical Doctors
- Osteopathic Doctors
- Chiropractic Doctors
- Podiatric Doctors
- Physicians' Assistants
- Physical Therapists
- Physical Therapist Assistants
- Occupational Therapists
- Occupational Therapy Assistants
- Respiratory Therapists
- Athletic Trainers
- Naturopathic Doctors
- Contact Lens Distributors
- Radiologic Technologists (effective July 1, 2005)

The Board does not have disciplinary jurisdiction over other health care professions, hospitals, and other health care facilities. When a complaint is received by the Kansas State Board of Healing Arts, staff for the Board makes an initial determination: the complaint must pertain to the practice of the healing arts, and must allege facts constituting a violation of the laws administered by the Board. These two requirements are necessary to open a case for investigation. Sometimes the complaint contains insufficient information and more information may be requested of the complainant.

Examples of Prohibited Conduct

- Commission of acts of gross negligence or multiple acts of ordinary negligence.
- Conviction of a felony or Class A misdemeanor.
- Fraudulent or false advertisements.
- Fraudulent billing.
- Prescribing or distributing drugs for other than lawful purposes.
- The inability to practice the healing arts with reasonable skill and safety to patients by reason of illness, alcoholism, excessive use of drugs, or any mental or physical condition.
- Sexual abuse, misconduct or exploitation related to that person's practice.
- Referring a patient to a health care entity for services, if the licensee/registrant has a significant investment interest in the entity, (10% ownerships or more) unless the person regulated by the Board informs the patient of the interest in writing, and that the patient may obtain such services elsewhere.
- Other acts as proscribed by law .

Once a case is opened, it is investigated by an investigator. This usually involves getting

medical records from the licensee/registrant and any health care facilities that is involved. It may also involve interviewing witnesses, visiting facilities, obtaining drug profiles, and getting information from law enforcement or other regulatory agencies, in this state or elsewhere. Board investigations are time consuming and may take several months, depending on the seriousness and complexity of the allegations.

Board investigations are required by law to be confidential, pursuant to K.S.A. 65-2898a. Therefore, there are limits to what information may be released, even to the person making the complaint. The Board has broad authority to obtain information even though the information may otherwise be confidential as a privileged communication. However, other information may be available only with the patient's specific consent.

Once a complaint is investigated, it undergoes a review process. If the issues involves competency, the case may be reviewed by a panel of peers to determine whether the standard of care has been met.

If the issue involves unprofessional conduct (sexual misconduct, false advertising, etc.), the case is reviewed by a staff attorney to determine whether there is sufficient evidence of a violation of the statues and regulations. If there is evidence of a violation, the case is reviewed by a panel of the Board to determine what action, if any, to take. At that time, a petition may be filed against the licensee/registrant. The purpose of the petition is to seek public disciplinary action against the licensee/registrant.

The petition may be heard by a Hearing Officer who will provide an initial determination to the Board about the case. The licensee/registrant or the Board's attorney may then ask the Board to review the case. Either before or after the hearing, the attorneys representing the Board and the licensee/registrant may negotiate an agreement to resolve the case, for submission to the Board for approval. The Board has legal authority to revoke, suspend, or limit licenses/registrations, impose fines, reprimand, require monitoring, or additional education or other remedial measures.

The Board does not represent individuals, nor obtain compensation on behalf of individuals. Each person is free to seek legal representation if they believe it is necessary.

Board investigations and reviews are not subject to discovery by private litigants.

If you have questions regarding the functions of the Board, call (785) 296-7413.

Kansas State Board of Healing Arts
235 S. Topeka Boulevard - Topeka, KS 66603-3068
Phone: (785) 296-7413 - Toll Free: 1-888-886-7205 - Fax: (785) 296-0852

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas State Board of Healing Arts recognizes that principles of quality medical practice dictate that the people of the State of Kansas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with these guidelines. If such prescribing meets these criteria, the Board will support physicians whose use of controlled substances has been questioned by another regulatory or enforcement agency.

Allegations of improper prescribing of controlled substances for pain will be evaluated on a case- by-case basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such

deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning and recognizing that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. **Evaluation of the Patient**
   The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. **Treatment Plan**
   The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. **Informed Consent and Agreement for Treatment**
   The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

   - urine/serum medication levels screening when requested;
   - number and frequency of all prescription refills; and
   - reasons for which drug therapy may be discontinued (i.e., violation of agreement).

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4. **Periodic Review**
   At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. **Consultation**
   The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. **Medical Records**
   The physician should comply with and meet the requirements of K.A.R. 100-24-1 in the maintenance of an adequate record for each patient.

7. **Compliance With Controlled Substances Laws and Regulations**
   To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:
"Acute pain" is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

"Addiction" is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

"Analgesic tolerance" is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

"Chronic pain" is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

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"Pain" is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

"Physical dependence" on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

"Pseudoaddiction" is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

"Substance abuse" is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

"Tolerance" is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPROVED by the Kansas State Board of Healing Arts this 17th day of October, 1998.

Lawrence T. Buening, Jr.
Executive Director

Kansas State Board of Healing Arts
235 S. Topeka Boulevard - Topeka, KS 66603-3068
Phone: (785) 296-7413 - Toll Free: 1-888-886-7205 - Fax: (785) 296-0852

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ATTACHMENT 4

Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Kansas Legislature created the Board of Healing Arts, the Board of Nursing, and the Board of Pharmacy to protect the public health, safety and welfare. Protection of the public necessitates reasonable regulation of health care providers who order, administer, or dispense drugs. The boards adopt this statement to help assure health care providers and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain. Guidelines by individual boards are appropriate to address issues related to particular professions.

The appropriate application of current knowledge and treatment modalities improves the quality of life for those patients who suffer from pain, and reduces the morbidity and costs associated with pain that is inappropriately treated. All health care providers who treat patients in pain, whether acute or chronic, and whether as a result of terminal illness or non-life-threatening injury or disease, should become knowledgeable about effective methods of pain treatment. The management of pain should include the use of both pharmacologic and non-pharmacologic modalities.

Inappropriate treatment of pain is a serious problem in the United States. Inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and ineffective treatment. All persons who are experiencing pain should expect the appropriate assessment and management of pain while retaining the right to refuse treatment. A person's report of pain is the optimal standard upon which all pain management interventions are based. The goal of pain management is to reduce the individual's pain to the lowest level possible, while simultaneously increasing the individual's level of functioning to the greatest extent possible. The exact nature of these goals is determined jointly by the patient and the health care provider.

Prescribing, administering or dispensing controlled substances, including opioid analgesics, to treat pain is considered a legitimate medical purpose if based upon sound clinical grounds. Health care providers authorized by law to prescribe, administer or dispense drugs, including controlled substances, should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

A board is under a duty to make an inquiry when it receives information contending that a health care provider treated pain inappropriately. Proper investigation is necessary in order to obtain relevant information. A health care provider should not construe any request for information as a presumption of misconduct. Prior to the filing of any allegations, the results of the investigation will be evaluated by the health care provider's peers who are familiar with this policy statement. Health care providers who competently treat pain should not fear disciplinary action from their licensing board.

The following guidelines are not intended to define complete or best practice, but rather to communicate what the boards consider to be within the boundaries of professional practice. This policy statement is not intended to interfere with any healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of the healthcare provider's profession.

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Section II: Principles

The boards approve the following principles when evaluating the use of controlled substances for pain control:

1. **Assessment of the Patient**
   Pain should be assessed and reassessed as clinically indicated. Interdisciplinary communications regarding a patient's report of pain should include adoption of a standardized scale for assessing pain.

2. **Treatment Plan**
   The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the drug therapy plan should be adjusted to the individual medical needs of each patient. The nurse's skill is best utilized when an order for drug administration uses dosage and frequency parameters that allow the nurse to adjust (titrate) medication dosage. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. If, in a healthcare provider's sound professional judgement, pain should not be treated as requested by the patient, the healthcare provider should inform the patient of the basis for the treatment decisions and document the substance of this communication.

3. **Informed Consent**
   The physician retains the ultimate responsibility for obtaining informed consent to treatment from the patient. All health care providers share the role of effectively communicating with the patient so that the patient is apprised of the risks and benefits of using controlled substances to treat pain.

4. **Agreement for Treatment of High-Risk Patients**
   If the patient is determined to be at high risk for medication abuse or to have a history of substance abuse, the health care provider should consider requiring a written agreement by the patient outlining patient responsibilities, including:

   - Submitting to screening of urine/serum medication levels when requested;
   - Limiting prescription refills only to a specified number and frequency;
   - Requesting or receiving prescription orders from only one health care provider;
   - Using only one pharmacy for filling prescriptions; and
   - Acknowledging reasons for which the drug therapy may be discontinued (i.e., violation of agreement).

5. **Periodic Review**
   At reasonable intervals based on the individual circumstances of the patient, the course of treatment and any new information about the etiology of the pain should be evaluated. Communication among health care providers is essential to review of the

medical plan of care. The health care providers involved with the management of pain should evaluate progress toward meeting treatment objectives in light of improvement in patient's pain intensity and improved physical or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved despite medication adjustments, the health care provider's should reevaluate the appropriateness of continued treatment.

6. **Consultation**
   The health care provider should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement poses a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

7. **Medical Records**
   The medical record should document the nature and intensity of the pain and contain pertinent information concerning the patient's health history, including treatment for pain or other underlying or coexisting conditions. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

8. **Compliance With Controlled Substances Laws and Regulations**
   To prescribe, dispense or administer controlled substances within this state, the health care provider must be licensed according to the laws of this state and comply with applicable federal and state laws.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to as "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction. Addiction must be distinguished from pseudoaddiciton, which is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic pain is a pain state which is persistent beyond the usual course of an acute disease or

a reasonable time for an injury to heal, or that is associated with a chronic pathologic process that causes continuous pain or pain that recurs at intervals for months or years.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

APPROVALS

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Healing Arts, on the 1st day of June, 2002.

Lance E. Malmstrom, D.C.
President

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Nursing, on the 17th day of July, 2002.

Karen Gilpin, R.N.
President.

The foregoing Joint Policy Statement was approved, upon a motion duly made, seconded and adopted by a majority of the Kansas Board of Pharmacy, on the 10th day of June, 2002.

Max Heidrick, RPh
President

Kansas State Board of Healing Arts
235 S. Topeka Boulevard - Topeka, KS 66603-3068
Phone: (785) 296-7413 - Toll Free: 1-888-886-7205 - Fax: (785) 296-0852

ATTACHMENT 5

American Cancer Society | LIVESTRONG LANCE ARMSTRONG FOUNDATION | Susan G. Komen for the Cure | Pain & Policy Studies Group

2007 Pain and Policy Report Card and Evaluation Guide

Grade Changes from 2006 to 2007

Arizona

Changed from B to B+ by replacing a previous medical board policy with the Federation of State Medical Board's "Model Guideline for the Use of Controlled Substances for the Treatment of Pain."

California

Changed from C to B by repealing numerous restrictive or ambiguous provisions from laws.

Colorado

Changed from C+ to B by adopting a law that clarifies for practitioners that there is an important distinction between manslaughter and prescribing controlled substances for palliative care; this language identifies a clinical misperception that is pervasive in end-of-life care and attempts to lessen its impact on patient treatment and the professionals who provide it.

Connecticut

Changed from C+ to B by adopting a law that establishes a prescription monitoring program to prevent the improper or illegal use of controlled substances while not interfering with their legitimate medical use; to achieve this objective, the law also establishes a prescription drug monitoring working group that requires that prescription monitoring program information be reviewed by a working group member who is a pain management specialist.

Kansas

Changed from B+ to A by repealing its single remaining restrictive provision from the Medical Practice Act.

Massachusetts

Changed from B to B+ by adopting a law that establishes a palliative care program to ensure that pain and symptom management is an essential part of care for pediatric patients.

New Hampshire

Changed from C+ to B by adopting a law that establishes pain assessment as an essential part of patient care in residential healthcare facilities.

Wisconsin

Changed from B to A by adopting a medical board policy statement based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain."

Report Card Highlights

California and Wisconsin had the greatest grade improvement.

- California's grade improved because of the repeal of numerous restrictions in law.
- Wisconsin's grade improved because the medical board adopted a positive pain management policy.

Kansas and Wisconsin now join Michigan and Virginia as having the most balanced policies in the nation.

Ct in 2000