

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Vice Chairperson Peggy Mast at 1:30 P.M. on March 18, 2008 in Room 526-S of the Capitol.

All members were present except:

Representative Landwehr, excused

Committee staff present:

Norman Furse, Revisor of Statutes Office

Cindy Lash, Legislative Research Department

Chris Haug, Committee Assistant

Conferees appearing before the committee:

Brenda Walker, Director Bureau of Disease Control and Prevention, KDHE

Kathy Damron, Representing Sanofi-Pasteur

Gianfranco Pezzino, M.D., M.P.H. Associate Director of Public Health Systems, Kansas Health Institute

Mark Stafford, General Counsel, State Board of Healing Arts

Dan Morin, Director Governmental Affairs, Kansas Medical Society

Others Attending:

See Attached List.

Vice Chairperson Mast opened the hearing on **SB529 - Educational awareness regarding meningococcal meningitis vaccine.**

Cindy Lash, Kansas Legislative Research Department gave a briefing on **SB529**. This bill provides educational awareness of the importance of the vaccination for Meningitis during grades 6 through 12. There will be no fiscal effect on the State, the school districts will provide the information.

Brenda Walker, Director Bureau of Disease Control and Prevention for KDHE spoke in favor of **SB529**. (Attachment 1) The KDHE feels this educational awareness will give the incentive for more students to receive the vaccination against meningitis and other infectious diseases. There was discussion about whether these immunizations are currently required. Ms. Walker said they are currently recommended, not required.

Kathy Damron, representing Sanofi-Pasteur, provided testimony in support of **SB529**. (Attachment 2) Her testimony provided the recommended immunization schedule for people aged 7-18 and listed the 10 different vaccines. She also provided testimony from Andy Marso, who suffered meningitis when he was a student at KU. There was discussion about how the education on meningitis would be dissimulated. Ms. Damron said the local health departments get the information out to the schools, so it would not be a cost driver to the schools.

Written Testimony in support of the bill was provided by Bob Williams, Executive Director KAOM. (Attachment 3)

Dan Morin, Kansas Medical Society provided written testimony in support of this bill. (Attachment 4)

The hearing on **SB529** was closed.

The hearing on **SB548 - School-based influenza vaccination pilot program** was opened.

Ms. Lash gave a briefing on this bill. This bill would require the department of environment to increase flu vaccination awareness and participation for young children 6 months to five years old when they are enrolled in day care facilities. KDHE would also have a responsibility for school aged children. They would conduct a study to see if it were feasible to conduct a school based vaccination pilot program. This would just be a feasibility study. They would be required to submit a report to the joint committee on health policy oversight prior to the 2009 session. SRS would have expenditures of \$17,400 for mailings and KDHE estimates \$20,000 for preparation of the report.

CONTINUATION SHEET

MINUTES OF THE House Health and Human Services Committee at 1:30 P.M. on March 18, 2008 in Room 526-S of the Capitol.

Proponents:

Brenda Walker, Director Bureau of Disease Control and Prevention, KDHE provided testimony in support of **SB 548**. ([Attachment 5](#)) Ms. Walker stated influenza affects 5-20% of the US population each year. Assessing the feasibility of the delivery of influenza immunizations in the school setting is an important first step.

Gianfranco Pezzino, M.D., M.P.H. Associate Director of Public Health Systems, Kansas Health Institute spoke in support of this bill. ([Attachment 6](#)) The focus on schools is important because of the high incident of transmission in our schools.

Written Testimony in support of **SB548**:

Bob Williams, Kansas Association of Osteopathic Medicine ([Attachment 7](#))

Dr. Ann Elliot, Student Services, School District 437 ([Attachment 8](#))

Dr. Ellen Losew, M.D., F.A.A.P. ([Attachment 9](#))

Dr. Daniel Reynolds, D.O. ([Attachment 10](#))

Allyn Bandell, MedImmune Way ([Attachment 11](#))

Dan Morin, Kansas Medical Society ([Attachment 12](#))

The hearing on **SB548** was closed.

The hearing on **Sub SB596- Board of Healing arts; cosmetic or aesthetic purpose included in the practice** was opened.

Ms. Lash gave a briefing on **Sub SB596**. This bill adds to the healing arts act, a definition of the term, "surgery". This bill clarifies surgical procedures are within the scope of the medicine and surgery profession even when performed solely for cosmetic or aesthetic purposes.

Proponents:

Mark Stafford, General Counsel, State Board of Healing Arts, spoke in favor of **Sub SB596**. ([Attachment 13](#)) Mr. Stafford stated the Board seeks clarification of the scope of surgery because surgical services are being used for cosmetic or aesthetic purposes. Some of these services are performed by physicians and some are not. This bill defines surgery in definite terms and clearly identifies that cosmetic or aesthetic surgery is the practice of medicine and surgery.

There was discussion as to whether a procedure such as Liposuction could be performed by anyone, in any setting, with the current law. Mr. Stafford said that it could. Rep. Patton felt the definition of surgery was too broad. Mr. Stafford said it was broad enough to cover the surgical processes we currently use or develop in the future. There was discussion about the ear stapling procedure. Mr. Stafford felt this fell under the surgical category. Further discussion occurred about persons rendering aid in an emergency situation. Mr. Stafford clarified page 2, line 20-21 allows for people to offer gratuitous service in an emergency. Mr. Stafford could not say whether the scarification process was a widespread problem in Kansas, but there are instances of it occurring in Kansas.

Dan Morin, Director Governmental Affairs, Kansas Medical Society gave testimony in support of this bill. ([Attachment 14](#)) The Kansas Medical Society has a real problem with the tongue splitting procedure. Performing the procedure is one thing, but responding to a problem from the procedure is another. When you are doing this type of procedure it is important to have someone who is licensed and trained to handle the consequences if something goes wrong.

Written testimony as neutral was provided by Terri Roberts, Kansas State Nurses Assoc. ([Attachment 15](#))

Written testimony in support of the bill was provided by Bob Williams, Kansas Association of Osteopathic Medicine. ([Attachment 16](#))

The hearing on **Sub SB596** was closed.

CONTINUATION SHEET

MINUTES OF THE House Health and Human Services Committee at 1:30 P.M. on March 18, 2008 in Room 526-S of the Capitol.

The meeting was adjourned at 2:15 P.M. The next meeting was scheduled for March 19, 2008.

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

DATE: March 18, 2008 _____

NAME	REPRESENTING
Terri Roberts	KSNA



Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

www.kdheks.gov

Division of Health

Testimony on SB 529

Presented to
House Health and Human Services Committee

By
Brenda E. Walker, Director
Bureau of Disease Control and Prevention

March 18, 2008

Chairperson Landwehr, and members of the committee, my name is Brenda Walker and I am the Director of the Bureau of Disease Control and Prevention for the Kansas Department of Health and Environment. Thank you for the opportunity to present testimony in support of Senate Bill 529, which relates to educational awareness of infectious disease vaccines in grades six through 12.

It is our anticipation that this educational awareness will prompt more students to choose to receive vaccination against meningitis, and other infectious diseases, thus lowering the disease incidence in Kansas.

It is noteworthy to mention that the Board of Regents' meningitis policy (approved September 15, 2006) states: "Effective from the start of the 2006-07 academic year, all of the state universities shall have in place policies and procedures requiring that all incoming students residing in university housing be vaccinated for meningitis. Such policies shall include appropriate waiver procedures for those who refuse to take the vaccine."

Increasing the awareness of the importance of vaccines during grades six through 12 will result in higher rates of immunization against infectious diseases in the adolescent and young adult age groups. For these reasons the Department supports passage of SB 529 which provides for a description of the causes, symptoms and means of transmission; a list of sources for additional information; and related recommendations issued by the National Centers for Disease Control and Prevention (CDC), for parents and guardians of students in grades six through 12.

Thank you for the opportunity to appear before the committee today. I will now stand for questions.

BUREAU OF DISEASE CONTROL AND PREVENTION
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STF Health & Human Services Committee

Voice 785-296-5591 Fax 785-296-65

Date: 3-18-08

Attachment: (

**Kathy
Damron**

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Chairman Landwehr and members of the Committee:

Thank you for agreeing to hear Senate Bill 529, establishing important educational awareness efforts for vaccinations. I am representing Sanofi-Pasteur, a manufacturer of various vaccines.

We have been working with a number of meningitis advocacy organizations and with the Kansas Department of Health and Environment to increase awareness of meningitis immunizations in Kansas. Senate Bill 529 is a product of those discussions and is similar to legislation enacted in more than a dozen other states.

It is important to point out that this bill is NOT a mandate. No one is required to get immunized, but we do believe information is power and if we can get accurate information in the hands of parents our immunization rates will increase.

Attached to my testimony you will find a copy of testimony presented in the Senate Public Health Committee by Andy Marso. Andy suffered meningitis while a student at KU and today he bears the loss of fingers and toes, but his life was saved as a result of quick action and attention from a fellow student. Andy is a champion for this bill and he is an inspiration to all of us who see his bravery and determination displayed each day as a sports writer for the Olathe newspaper.

Thank you for your consideration of this measure.

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Four years I had two smooth, tan arms that each ended in five fingers. I had two intact feet that allowed me to run and play the sports I loved. ~~But all~~^{all} that was taken from me by bacterial meningitis one day in April of 2004. Within hours, a disease I had barely heard of left me fighting for survival and ultimately maimed for life.

It started as a simple shiver the night before. Soon after that first shiver I was bathed in cold sweats; nauseous and miserable. But all my symptoms that night were consistent with the flu, and the thought that I might have something more serious never crossed my mind. I prescribed for myself a good night's rest and left it at that.

I should have known by the next morning, though, that something was seriously wrong. ~~That's when~~ I woke up with my throat parched and could barely make it to the kitchen because my feet hurt so bad – a prickly, pins and needles feeling like I was walking on a cactus. That's also when I noticed an odd rash on my arms, thousands of little purple polka dots from my elbows to my fingertips. But I didn't know what that rash meant. All I knew was that it hurt to walk and I wanted to go back to bed.

I would have died in that bed at the University of Kansas if my friend Clay hadn't checked on me a few hours later and insisted I see a doctor. He and another friend carried me to his car and took me to the student health center. I still would not have survived that day except that the doctor on duty, Leah Luckerth, recognized that purple rash and immediately knew how serious it could be.

By 5 o'clock that night I had been Life-flighted to KU Med in critical condition. The infection was ravaging my bloodstream, ripping holes in my vessels and leaking the life out of me. My vital signs were off the charts and I had to be intubated because I couldn't breathe on my own. Doctors told my parents that they should expect me to be on dialysis the next day because my kidneys would have failed completely.

Meningococcal bacteria had made my blood toxic and I was in septic shock, a condition that carries a mortality rate of approximately 50 percent, regardless of medical treatment. My body had completely broken down in less than 24 hours.

I spent three weeks in a drug-induced coma with machines breathing for me, but thanks to the staff at KU Med and prayers from across the country, I survived. The tissue on my arms and legs, however, did not. When I left intensive care and entered the KU Med burn unit I had skin damage equal to third degree burns over 30 percent of my body.

To save my arms and legs I went through debridement, the standard treatment for severe

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burns, for the better part of three months. Every other day I was taken to a sauna-like room called "the tank," where wound techs and occasionally surgeons wet down my blackened limbs and then sliced away the dead tissue until I bled. For three months I watched pieces of my body float down the drain and gritted my teeth as the heavy pain medication I was on became less and less effective.

Some parts of my body couldn't be saved. My fingers and toes were so badly damaged that they had to be amputated. These procedures were done in the operating room under full anesthesia, but the aftermath was horrific, physically and emotionally. It doesn't look like anyone here knows what the post-surgical pain is like after an amputation and I'm not sure I can adequately describe it. Suffice it to say, it is intense, and I got to experience it multiple times.

All told, I spent four-and-a-half months straight in the hospital, a period of more than 130 consecutive days and nights. The next 13 months were consumed with rehabilitation, as my parents drove me back and forth to hospitals and clinics so I could learn to walk, shower, dress and do all the other things that I used to be able to do without thinking. In a very real sense I was 23-year-old trapped in a toddler's helpless body. Few scenarios could be more frustrating.

Four years after that first shiver I've managed to get most of my life back, but there are some things meningitis stole that I may never get back. I miss the feeling of running a two-on-one fast break in a game of pick-up basketball. I miss being able to hold a girl's hand as we walk down the street together, and I miss being able to go out in public without trying to hide my mangled hands as much as possible.

I have a new life, though, and it is a good life. One of my central missions ~~now~~ is promoting meningitis awareness so that someday, when a kid develops that same rash I had, he will know what it means and will get to a doctor in time to save his hands and feet. I also promote the current vaccine, Menactra, which has the power to prevent 80 percent of meningitis cases.

My dream is that someday researchers will develop a comprehensive vaccine and we can wipe meningococcal disease off the face of the earth. It is a little-known, little-publicized disease because it is rare, but those of us who have survived it know that few things are more frightening.

Meningitis kills. It maims. It causes brain damage, hearing loss, or organ failure. And it does its horrible work in a matter of hours, not months or years like other, more well-known diseases. Waiting until you get meningitis to get educated about it is not an option – by then it is often too late. Because of my ignorance I lost part of my limbs. If not for the quick action of friends and doctors I would have lost everything. What happened to me must not happen again.

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

Vaccine ▼	Age ▶	7–10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis ¹	see footnote 1		Tdap		Tdap	
Human Papillomavirus ²	see footnote 2		HPV (3 doses)		HPV Series	
Meningococcal ³	MPSV4		MCV4		MCV4 ⁴ MCV4	
Pneumococcal ⁴			PPV			
Influenza ⁵			Influenza (Yearly)			
Hepatitis A ⁶			HepA Series			
Hepatitis B ⁷			HepB Series			
Inactivated Poliovirus ⁸			IPV Series			
Measles, Mumps, Rubella ⁹			MMR Series			
Varicella ¹⁰			Varicella Series			

 Range of recommended ages

 Catch-up immunization

 Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components

of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DaP vaccination series.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. (Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥ 2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). (Minimum age: 2 years)

- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged < 9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥ 4 weeks for TIV and ≥ 6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). (Minimum age: birth)

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥ 4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥ 4 weeks between the doses.

10. Varicella vaccine. (Minimum age: 12 months)

- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged < 13 years at least 3 months apart. Do not repeat the second dose, if administered ≥ 28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥ 13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip/>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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TESTIMONY

House Health and Human Services Committee
SB 529
Tuesday, March 18, 2008

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the Social Services Budget Committee regarding SB 529.

SB 529 would create an educational awareness program regarding infectious diseases for school age children six through twelve years of age. The Kansas Association of Osteopathic Medicine is in support of SB 529. Infectious diseases can quickly spread in "closed" environments such as schools. An educational program will go a long way to creating awareness among student populations regarding the prevention of disease.

We encourage the Committee to support SB 529.

Thank you.

Health & Human Services Committee

Date: 3-18-08

Attachment: 3



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To: House Committee on Health and Human Services

From: Dan Morin
Director of Government Affairs

Date: March 18, 2008

Subject: SB 529; An act concerning vaccinations; relating to educational awareness of infectious disease vaccines.

The Kansas Medical Society appreciates the opportunity to comment on SB 529, which would require that if a local board of education provides information on vaccinations to parents of students in grades six through 12, the board must also provide information about each infectious disease and each disease's vaccines.

One of the major historical public health advancements has been the development of vaccines that prevent people from getting certain diseases. The highly effective U.S. childhood immunization program has led to elimination of smallpox, greater than 99 percent reductions in diphtheria, measles, polio and rubella, and to a greater than 90 percent reduction in mumps, tetanus and pertussis. Achieving and maintaining high immunization rates is critical for disease prevention.

Adolescent vaccines are grouped into three categories. The three newest vaccines for adolescents are recommended for first-time administration during adolescence. "Catch-up" vaccines, which have been available for a longer time, are for administration to adolescents who were not immunized or were under immunized as infants and toddlers. There are also three vaccines recommended for use in certain high-risk adolescent subpopulations. Together, these vaccines protect adolescents from 14 infectious diseases.

One particular vaccine of note guards against meningococcal disease. Even when treated quickly and appropriately, meningococcal disease kills about 10 to 14 percent of people infected, and 11 to 19 percent of survivors suffer serious long-term effects such as hearing loss, brain damage and digit or limb amputation. About 70 percent of cases of meningococcal disease in U.S. adolescents are caused by strains included in the vaccine.

Not only do vaccines save lives and prevent disease, they also save society many millions of dollars in health related costs. Vaccinations continue to be the best overall prevention strategy and the most effective way to prevent transmittable disease. The Kansas Medical Society is encouraged by the public policy included in SB 529.

Health & Human Services Committee

Date: 3-18-08

Attachment: 4



Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

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Division of Health

Testimony of SB 548

Presented to
House Health and Human Services Committee

By
Brenda E. Walker, Director
Bureau of Disease Control and Prevention

March 18, 2008

Chairperson Landwehr, and members of the committee, I am Brenda Walker, Director of the Bureau of Disease Control and Prevention for the Kansas Department of Health and Environment (KDHE). Thank you for this opportunity to present testimony in support of Senate Bill 548.

Senate Bill 548 relates to KDHE conducting a school-based influenza vaccination pilot program; providing for a study. KDHE would conduct such study of the feasibility of establishing a school-based influenza vaccination pilot program. The study will include examination of costs, benefits, barriers and solutions for implementation. Findings and recommendations of the study would be reported to the Joint Committee on Health Policy Oversight before the 2009 legislature convenes.

- The impact of influenza illness on the United States is significant, with annual estimates of
 - 31.3 million influenza cases
 - 11.3 million outpatient visits
 - 226,000 hospitalizations
 - 36,000 deaths
 - \$11 billion in economic costs associated with healthcare and lost time from work and school
- Influenza affects 5-20% of the US population each year.
- Over 8 million children and adolescents 2-18 years of age have at least one medical condition placing them at high risk for complications of the flu.

Health & Human Services Committee

Date: 3-18-08

BUREAU OF DISEASE CONTROL AND PREVENTION
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 21

Attachment: 5

- Children are the major pathway for the spread of influenza infection to others.
- Approximately 75% of the US population is adults, but more than half of the cases of influenza infection occur in individuals under 19 years of age

Childhood and adolescent immunization may represent an important step in protecting the rest of the population from illness, hospitalization and death. A recent study demonstrated that if an 80% influenza immunization rate is achieved for children under the age of 19 years in the US population, over 32,000 deaths and 100,000 hospitalizations could be prevented in the elderly population. (See attachment 1)

- A Japanese study demonstrated that mandatory influenza immunization of school children 7-15 years of age decreased deaths attributed to pneumonia and influenza for the general population. In 1957 Japan experienced a severe epidemic of the Asian flu in which approximately 8,000 people died from flu-related causes. This was the largest influenza-related death toll ever recorded in Japan. Consequently, Japan began immunizing school children against influenza in 1962 and made immunization mandatory in 1977. During the years the immunization program was in effect (from about 1977-1987), an estimated 37,000-49,000 lives/year were saved. In 1987, however, legislation was relaxed, and by 1994, the program was discontinued entirely. When the program was terminated, the increase in deaths accelerated. The increase in influenza-related deaths after termination of the program lends further support for the importance of vaccinating school-aged children against influenza. (See Attachment 2)
- The benefit of the activity proposed in the pilot looks beyond the illness and death of those being immunized. Immunizing this target population has public health value for the entire population.
- Immunizing children against influenza has greater far-reaching effects than simply preventing disease in the vaccinated group: it has the potential to substantially reduce the burden of disease for thousands of other people by providing herd immunity.
- Increasing the number of childhood influenza immunizations makes solid medical and economic sense.
- Assessing the feasibility of the delivery of influenza immunizations in the school setting is an important first step.

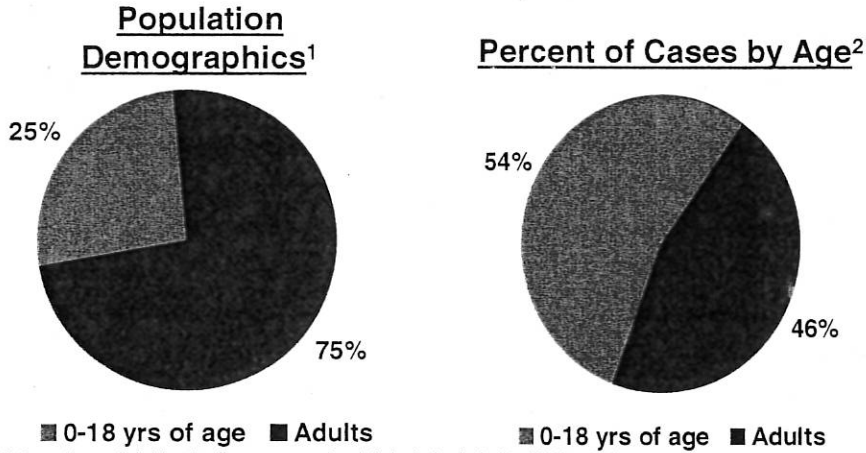
It is for these reasons that the KDHE supports this bill.

Thank you for the opportunity to appear before the committee today. I will now stand for questions.

Attachments to SB 548

Chart 1

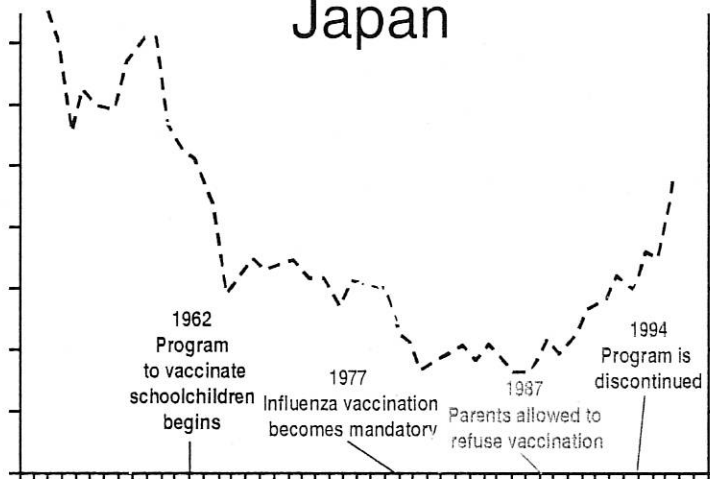
Those under 19 years of age are nearly 3.5 times more likely to contract influenza than adults



1. US Census Bureau. Available at: http://www.census.gov/population/projections/nation/detail/d2001_10.pdf. Accessed April 2004. 2. Adapted from Weycker D, et al. *Vaccine*. 2005;23:1284.

Chart 2

A Mass Vaccination Program in Japan



Adapted with permission from Reichert TA, et al. *N Engl J Med*. 2001;344:889-896.

Slide courtesy of W. Paul Glezen, MD
National Campaign for Influenza Prevention



KANSAS HEALTH INSTITUTE

For additional information contact:

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School-based influenza vaccination pilot program

SB 548

March 18, 2008

House Health and Human Services Committee

Gianfranco Pezzino, M.D., M.P.H.
Associate Director of Public Health Systems
Kansas Health Institute

Information for policymakers. Health for Kansans.

The Kansas Health Institute is an independent, non-profit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

Health & Human Services Committee

Date: 3-18-08

Attachment: 6

My name is Dr. Gianfranco Pezzino. I am a board-certified public health physician with experience working at the federal, state and local levels. Currently I am the Associate Director of Public Health Systems at the Kansas Health Institute, and also the Health Officer for Shawnee County in Topeka.

I want to congratulate this committee for its attempt to address through SB 548 the important public health issue of how to most effectively vaccinate Kansas children against influenza.

Children play a special role in the epidemiology of influenza for two reasons. First, children who contract influenza can develop complications which in some cases can be fatal. Second, there is a growing body of evidence showing that children represent a reservoir for the community-wide outbreaks of influenza that we experience every year.

Children get infected early during the influenza season and can transmit the infection to others for up to 6 days before they become sick, compared to the average 1–2 days for adults. Because children spend a lot of their time in close contact with other individuals in their families or in schools and day care settings, they have the potential to infect many people.

Transmission of influenza in schools plays a major role in propagating influenza outbreaks. Cases among students often rise rapidly after holiday recess. In addition, studies have shown that school absenteeism often increases just before an increase in absenteeism in other work places, suggesting that students may become infected first and pass the virus on to their parents.

Does vaccinating children make a difference? Recent studies and the experience in other countries certainly suggest that this is the case. A study conducted in 11 sites across our country in 2004–2005 involving more than 15,000 school children showed that vaccination against influenza reduced disease both in the children who received the vaccine and, most interestingly, in their families, confirming the importance of children in the chain of transmission of this disease. In Japan, where vaccination of school children against influenza was widespread for some years, a substantial reduction in influenza deaths was reported among the elderly. Unfortunately, when the Japanese government decided to discontinue the vaccination of children, the number of deaths in the community increased again.

So it appears that vaccinating school-aged children against influenza can be an important preventive measure to reduce disease and deaths from this infection. Does it make sense to vaccinate the children in the school setting? There are several arguments in favor of this approach. Schools are an environment where disease is transmitted. In a school-based immunization program, administration costs are lower and vaccination can be achieved with minimal time commitment from parents, which in turn can increase vaccination coverage and reduce the indirect cost of the program. An analysis published in the journal *Health Affairs* in January showed that school-based vaccination could be a cost-effective option for preventing influenza among children and their families, and that the cost of the program would be less than the direct and indirect flu-related costs. According to the researchers, school-based immunization of 47 percent of students could save an estimated \$171.96 per student-household over the course of a flu season, and the saving could be higher if more children could be vaccinated.

School-based campaigns also represent excellent opportunities to test the readiness of our public health system to respond to an influenza pandemic or to other public health emergencies that would require the vaccination of many people in a short period of time.

Based on this body of evidence, the CDC is updating its current recommendations for influenza vaccination (putting more emphasis on the importance of vaccinating school children), and at least one state (New Jersey) is requiring flu shots for pre-school children.

Implementing broad vaccination campaigns in schools may present logistical and procedural challenges. In some communities, the use of volunteers can play an important role, while in others public health and school staff may be able and willing to take the full charge for the program. Some administrative and billing requirements and procedures from insurance payers also may conflict with the attempt to deliver vaccines in schools in the quickest and most cost-effective way. It is important that these issues be studied further and that communities be given sufficient flexibility to implement the best program most suitable for their needs.

As a final comment, I want to notice that there are two types of vaccine available for children. Both have an excellent record of safety and efficacy. The two vaccines have different indications and contra-indications. Once again, it is important to give local and state public health officials

flexibility in deciding which vaccine to use given that circumstances may be different from community to community.

Thank you for your attention. I will be glad to answer any questions that you may have.



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TESTIMONY

House Health and Human Services Committee
SB 548
Tuesday, March 18, 2008

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the Social Services Budget Committee regarding SB 548.

SB 548 would instruct the Department of Health and Environment to conduct a study regarding establishing a school-based influenza vaccination pilot program. Many of us baby boomers remember the days when polio vaccines and tuberculosis tests were administered in schools. Such vaccinations and tests all but wiped out these diseases. Schools are a "closed" environment creating an ideal setting for the spread of diseases. These days, with both parents working, it is difficult to pull children out of school to take them to the doctor or clinic for vaccinations. Conducting vaccinations in schools would reach the maximum number children in an efficient, cost effective manner.

We encourage the Committee to support SB 548.

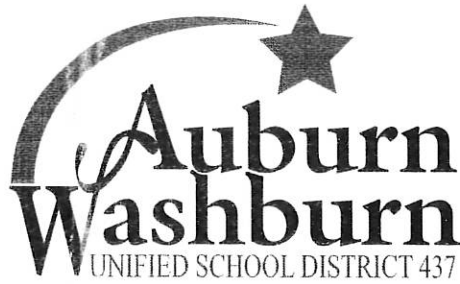
Thank you.

Health & Human Services Committee

Date: 3-18-08

Attachment: 7

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Dr. Brenda S. [redacted] ch
Superintendent
Steve Johnston
Associate Superintendent
Dr. Ann L. Elliott
Director of Student Services
Dr. Dennis R. Johnson
Director of Support Services
Keith A. Love, CPA
Director of Business Services
Bruce Petersen
Director of Human Resources

March 18, 2008

For the past two years the Auburn-Washburn School District has conducted a flu clinic for our students. The purpose of the clinics was to provide immunization for students to reduce the negative impact of flu especially as it relates to attendance. The goal was to immunize as many students as possible with a minimum loss of class time.

The clinics were held at each of the district's nine school locations with a make-up day for students who couldn't attend on the designated date. Each year the district immunized approximately 500 students. Two types of immunizations were given. Most students received the quick, painless nasal inhalant mist. Students who were unable to take the mist, for a variety of medical reasons, were given a traditional injection.

The district worked with a local pediatrician who provided oversight during the clinics. The doctor was a patron of the district and volunteered his services. Nursing assistance was provided the first year by students at the Washburn University School of Nursing. The students were not available on the second year due to a last minute schedule change for the clinic. The change was caused by a shortage of vaccine. The district hired outside nursing services instead.

Families were notified in advance of the immunizations and had to sign up to have their children receive the vaccine. Students were charged \$20 each to cover the cost of the vaccine. The Auburn-Washburn Board of Education did not want cost to be a deterrent. The first year a third party grant funded the vaccine for students who had already qualified for free and reduced priced meals. The second year the district planned to use Medicaid funds but were not able to navigate the paperwork to make this happen. In the end the district provided the vaccine for Medicaid qualified students.

While we felt that it was a benefit to our students, the district does not plan to hold the flu clinic again. We learned that we are not set up to act as a medical clinic. The obstacles include acquiring the vaccine at the right time and at the right quantities, coordinating nursing services, and coordinating payment options through insurance and Medicaid.

We would love to work with a medical provider to host a clinic in our district but don't feel that we have the necessary resources to conduct our own.

Sincerely,

Dr. Ann Elliott
Director of Student Services

Health & Human Services Committee

Washburn Rural High School • Washburn Rural Alternative High School • Ta
Washburn Rural Middle School • Aurora Elementary • Indian Hills Element
Pauline South Intermediate • Pauline Central Primary • Wagon

Date: 3-18-08

Attachment: 8

March 13, 2007

Dear Representative Brenda Landwehr:

As a rural Kansas pediatrician, I would like to voice my support for SB548. Influenza is an important disease and needs to be more widely discussed in our state in order to increase education and prevention.

Many people realize that widespread vaccination has greatly diminished the spread of what were once deadly childhood illnesses. Diphtheria, polio, even meningitis from Haemophilus bacteria are now rarely encountered. Unfortunately, the public, and even many healthcare workers, do not realize that influenza is even more deadly than these now rare illnesses. We commonly hear of deaths from pertussis (whooping cough), which may kill a few hundred children per year. The public does not realize that influenza is actually the most deadly of ALL the vaccine preventable illnesses- causing over 36,000 deaths in the United States alone each year. Even more costly, approximately 200,000 hospitalizations and over 15 million infections are attributed to influenza in the U.S. each year!

How is influenza spread? It is spread through respiratory secretions, coughing, sneezing, runny nose, etc. Who are the largest culprits in this action? I'm a pediatrician- let me tell you- it's kids!! We laugh about how easily children spread germs, but it is true! Children are the most important vector in spreading influenza. Children also produce more viral particles and are capable of shedding more virus than an adult. If one stops to think about the many people a typical school-age child comes into contact with it can be sobering to think of the "shed and spread" capabilities: other children in school, teachers, day-care providers, siblings, parents, grandparents, other family members, etc. The best way to stop the spread is to prevent the illness!

It is widely known that influenza vaccination is effective in preventing the spread of illness. Routine vaccination of school-age children has been shown in many studies throughout the world to be effective in preventing influenza infection across society as a whole! School vaccine programs are effective and an excellent opportunity to vaccinate otherwise healthy children who may not have an opportunity to visit with a doctor or clinic. High risk children, and adults, should be encouraged to continue vaccination as well.

Thank you for your concern for the health of the children of Kansas. Increased education and disease prevention statewide is exciting for those of us "in the trenches." Please consider SB548 to help improve the health of the children we serve.

Sincerely,

Ellen Losew, M.D., F.A.A.P.
The Medical Center
1100 N. Main
Hutchinson, Ks. 67501

Health & Human Services Committee

Date: 3-18-08

Attachment: 9

Senate Bill No. 548

To whom it may concern:

Immunizations arguably have done more for a child health and well being than any other invention in health care. Influenza due to its very nature is an aggressive virus that mutates rapidly and thus must be accounted for every year. Through Senate Bill No. 548 parents would have access to information about this dangerous virus and the importance of annual immunization. I have participated in school-based influenza vaccine programs here in Topeka, Kansas. With the help of the Auburn-Washburn school district 437, we have for the last two years made flu vaccines available to school age children. Children could get a flu vaccine, without having to leave school or have parents miss work time to bring them to a clinic. Parents continually expressed their appreciation to not have to miss work to have this service provided. We truly need to move forward with this across all school districts in Kansas.

A study needs to be conducted to examine all parts of a school-based influenza vaccination program. I am confident that Kansas can be a front-runner in fight against influenza. I know that a school-based program can work, more children can be vaccinated, and Kansas can be the state to do it. Thank you for your time and consideration in this important endeavor.

Sincerely,

Dr. Daniel Reynolds D.O.

Health & Human Services Committee

Date: 3-18-08

Attachment: 10

MedImmune, Inc Statement to Kansas State Legislature Bill 548

This document summarizes MedImmune's comments to the Kansas Legislature on Bill 548 March 18, 2008. It is provided to the Kansas Legislature in support of its efforts to increase education on influenza vaccination in children 6 months to 5 years of age as well as to evaluate feasibility of school-based influenza vaccination in all school-aged children.

Allyn Bandell, Pharm.D.
Director, Medical Science
Infectious Disease
MedImmune, Inc
One MedImmune Way
Medical Affairs
Gaithersburg MD 20878

For additional questions please contact:
Karen Lancaster
Public Relations
301 398 5864

Acknowledgement and support of the bill:

Committee Chair, House Health and Human Services Committee; Representative Brenda Landwehr, I am unable to be there in person but submit this testimony to you. Thank you for your consideration.

- The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Influenza Practices (ACIP) underscored the importance of childhood influenza vaccination with changes in influenza vaccination recommendations.
- Last month the ACIP expanded recommendations for routine seasonal influenza vaccination to include all children up to the age of 18 years as soon as feasible, but no later than the 2009-2010 influenza season.
- The previous ACIP recommendations included the vaccination of children between the ages of 6 months and 59 months of age (or 5 years of age), their household contacts, and out-of-home caregivers.
- All eligible children six months up to 17 years of age can receive annual influenza immunization through the federal Vaccines for Children (VFC) program
- All individuals who wish to be protected against influenza are encouraged to be vaccinated.
- Still, there is work to be done. According to the statistics from the CDC, in 2006:
 - Of high risk school aged children only 36.6% are vaccinated against flu. Estimates suggest that vaccination rates of healthy children, whether they are household contacts or not are even lower.
 - Only 20.6 percent of 6-23 months olds were fully vaccinated during the 2005/06 season and in 2006/07 seasons < 30% of children 6-23 months and < 20% of children 24-59 months were fully vaccinated.

With Kansas State Bill 548, it is clear that the legislature has identified education on influenza vaccination in young children as a critical issue for the health of children in

Health & Human Services Committee

Date: 3-18-08

Attachment: 11

Kansas. Vaccination of school-aged children against influenza is gaining support in the medical community because of the need to help protect this age group, which has the highest influenza attack rate. The flu is most prevalent in school-age children, as the virus travels easily from person to person and because children in this age group spend a large part of their day in close contact with other children. School-age children are twice as likely to get influenza than adults, including the elderly. During a widespread outbreak, the rate of flu infections can exceed 30 percent in school-age children. School-age children respond well to influenza vaccine, and by supporting education as well as a pilot program to vaccinate children against influenza in an organized setting, Kansas is among the more progressive states in the movement towards vaccination of all children against influenza.

About vaccines in schools:

MedImmune lauded the expansion of ACIP recommendations to include all school-age children to receive influenza vaccinations. As children are often the primary spreaders of influenza in the home and in the community, effective vaccination programs directed at immunizing school-age children will not only offer protection to those children, but may offer protection to their siblings and parents at home. Research has shown statistically significant reductions in influenza like illness (ILI), child doctors' office visits, medication use and work/school absenteeism among households whose children attended schools/daycares with influenza vaccination programs, compared to those whose children attended schools/daycares without these programs.

Ideally, all healthy and high-risk school-age children would be vaccinated against influenza in their medical home. However, this is not being adequately accomplished and/or is not an option for many children without a medical home. For such children, school-based vaccination could provide an efficient mechanism for access to vaccination. Finally, establishment of a school-based infrastructure for routine seasonal influenza vaccination would enhance the nation's pandemic preparedness by providing a familiar and accessible place and a practiced protocol for vaccination against pandemic influenza.



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To: House Committee on Health and Human Services

From: Dan Morin
Director of Government Affairs

Date: March 17, 2008

Subject: SB 548; AN ACT relating to the department of health and environment; a school based influenza vaccination pilot program; providing for a study.

The Kansas Medical Society appreciates the opportunity to comment on SB 548, which would allow the Department of Health and Environment to provide influenza information for day care facilities and study the feasibility of a school based influenza vaccination pilot program.

Influenza vaccination is the most effective method for preventing influenza virus infection and its potentially severe complications. Influenza vaccine reduces the likelihood of becoming ill with influenza or transmitting influenza to others. People recommended for vaccination based on their risk of complications from influenza include children aged 6 months until their 5th birthday. While infants younger than 6 months are a high-risk group, they cannot be vaccinated, so vaccinating people around them (like family members, caregivers and any other close contacts) is recommended. Health officials urge people to get flu shots before it's too late. It takes about two weeks for the vaccine to become fully protective.

Two hundred thousand people are hospitalized with the flu every year and approximately 35,000 Americans die each year from the flu. Not only do flu vaccines keep people healthy, they save the lives of our most vulnerable residents. The Kansas Medical Society is encouraged by the public policy included in SB 548.

Health & Human Services Committee

Date: 3-18-08

Attachment: 12



KATHLEEN SEBELIUS
GOVERNOR

STATE BOARD OF HEALING ARTS

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

March 14, 2008

The Hon. Brenda Landwehr, Chairperson
House Committee on Health and Human Services
Kansas State Capitol
Room 161-W
Topeka, KS 66612

Re: Substitute for Senate Bill No. 596

Dear Representative Landwehr:

Thank you for the opportunity to appear on behalf of the State Board of Healing Arts before the House Committee on Health and Human Services in support of Substitute for Senate Bill No. 596. That bill would define the term "surgery" and clarify that surgical procedures are within the scope of the medicine and surgery profession even when performed solely for cosmetic or aesthetic purposes. The Senate unanimously passed this bill.

The current definition of the healing arts and of the practice of medicine and surgery, appearing at K.S.A. 65-2802 and 65-2869, respectively, describe professional services performed for the treatment or correction of diseases, injuries and deformities. In addition, there has been controversy in the past over what constitutes surgery. Senate Bill 596 would define surgery in definite terms and would clearly identify that cosmetic or aesthetic surgery is the practice of medicine and surgery, which is a branch of the healing arts. This definition is not intended to encompass acupuncture or manipulation, which are currently understood not to be surgery procedures.

The Board seeks clarification of the scope of surgery because surgical services are being used for cosmetic or aesthetic purposes, some of which are performed by physicians, and some of which are not. The purpose for seeking the service should not be the factor that determines whether licensure is required. Examples of surgeries that might or might not be for treating or correcting diseases, injuries or deformities include face lifts, breast augmentations or reductions, or liposuction. No serious argument has been advanced that these surgeries should be outside of the regulatory scheme. Other surgical procedures are performed that pose dangers to patients. I have attached pictures of a woman who is receiving a treatment called "scarification." Also attached is a picture of the end result of tongue splitting. Other procedures include implanting of materials and devices under the skin.

BOARD MEMBERS: BETTY McBRIDE, Public Member, PRESIDENT, Columbus - VINTON K. ARNETT, D.C., VICE PRESIDENT, Hays - MICHAEL J. BEEZLEY, M.D., Lenexa
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ROGER D. WARREN, M.D., Hanover - NANCY J. WELSH, M.D., Topeka - RONALD N. WH

Health & Human Services Committee

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Date: 3-18-08

Attachment: 13

State Board of Healing Arts
Senate Bill No. 596
March 14, 2008
Page 2

Section 3 of Senate Bill 596 also provides that non-surgical services performed by electrologists, licensed permanent color technicians and tattoo artists, or body piercers regulated by the Board of Cosmetology and acting within the scope of their licenses are not required to be licensed by the Healing Arts Board. Section 3 also includes non-substantive clean up recommended by the Revisor of Statutes.

We understand that section 11 of House Bill 2721 would amend the professional title of "permanent color technicians" to "cosmetic tattoo artists." If that bill becomes law, a conforming amendment to K.S.A. 65-2872(a)(18), as enacted by Senate Bill 596, Sec. 3 would be necessary in the future. At the present time, however, this bill does not conflict with the current law or with House Bill 2721.

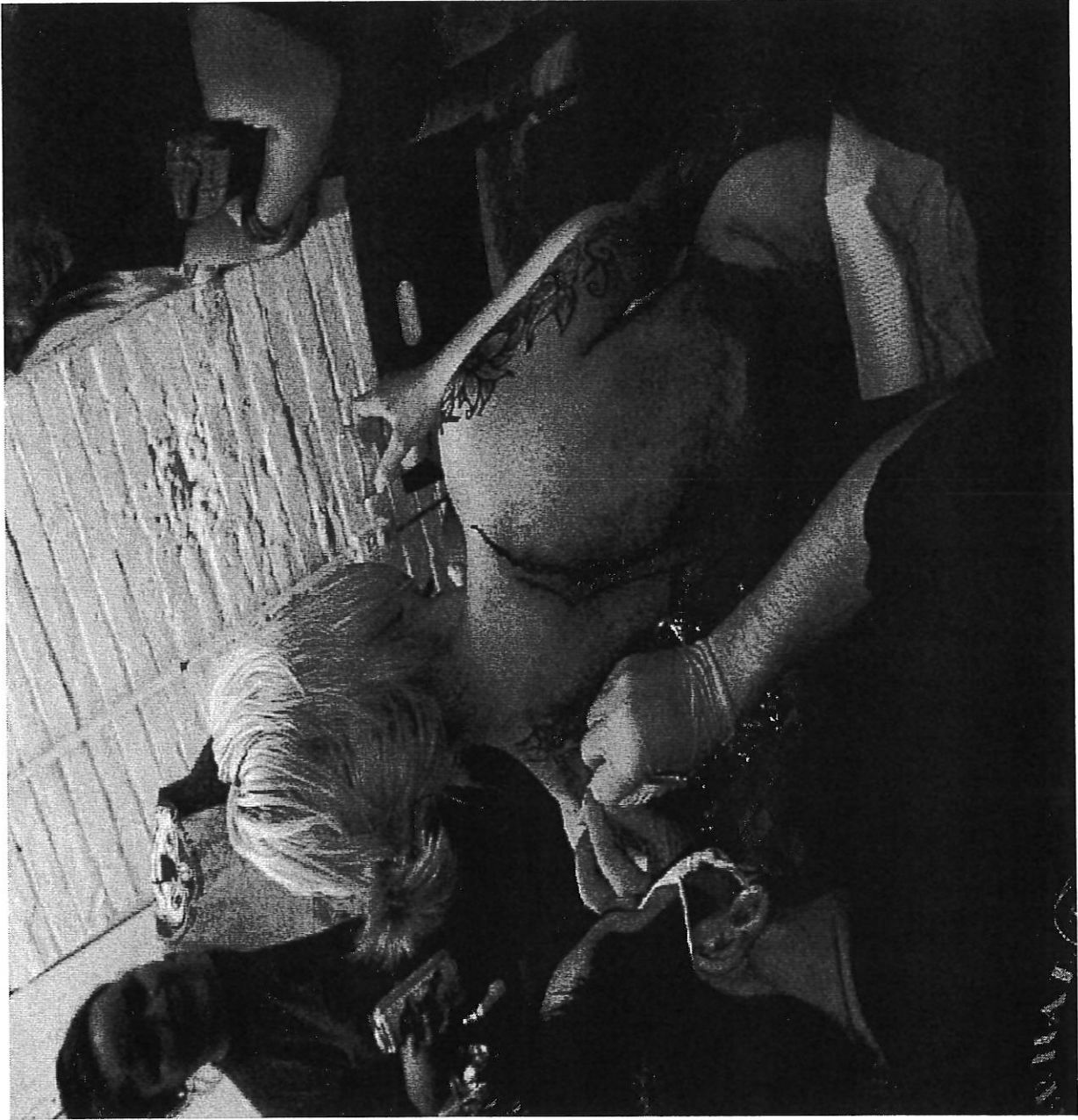
The Board urges the Committee to act favorably on Senate Bill 596. Once again, thank you for the opportunity to appear before the Committee.

Respectfully,

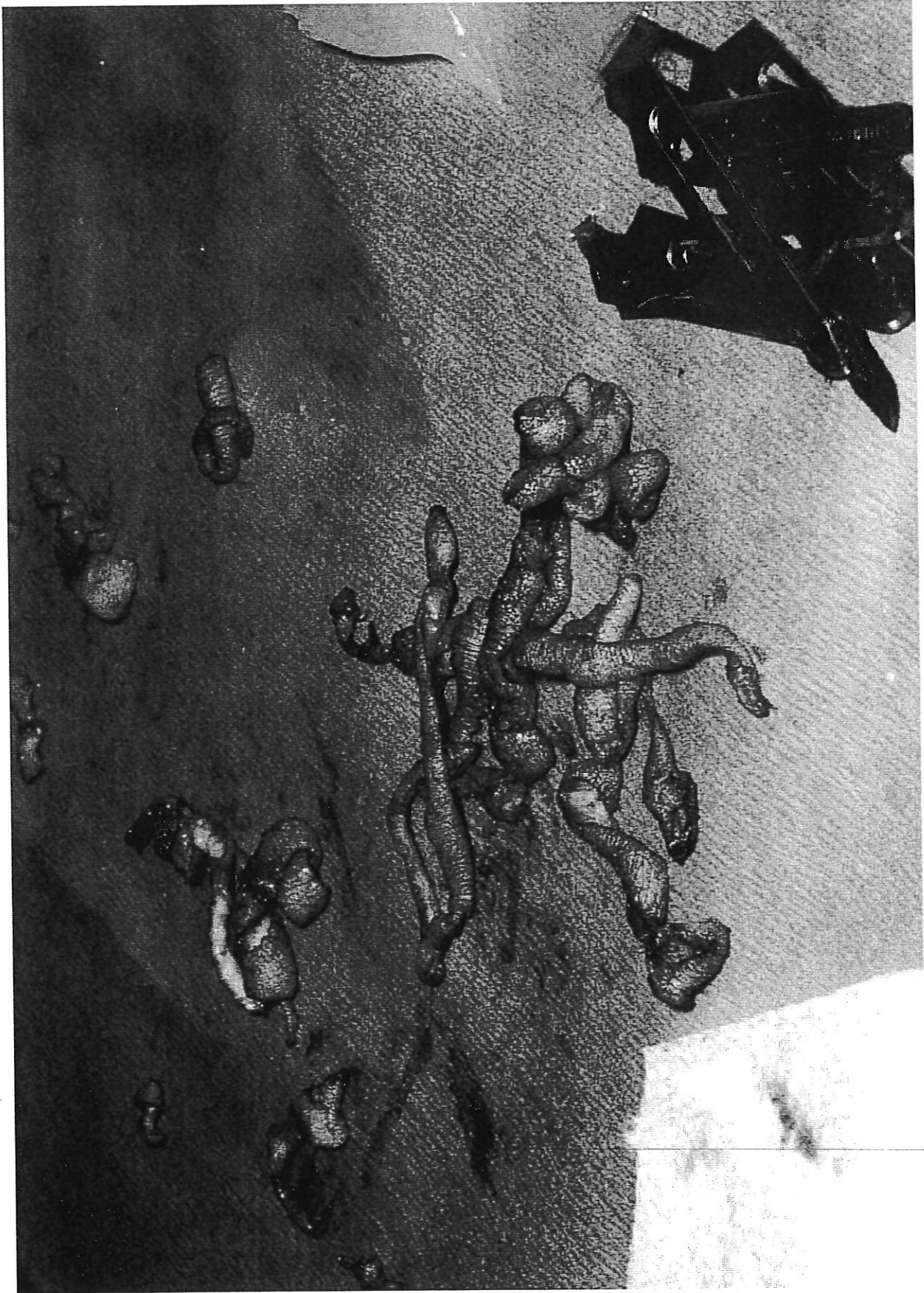
A handwritten signature in black ink, appearing to read "Mark W. Stafford". The signature is fluid and cursive, with the first name being the most prominent.

Mark W. Stafford
General Counsel





13-4





13-6







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To: House Committee on Health and Human Services

From: Dan Morin
Director of Government Affairs

Date: March 17, 2008

Subject: Sub for SB 596; concerning the performance of aesthetic or cosmetic procedures;
and definition of surgery

The Kansas Medical Society appreciates the opportunity to appear in support of SB 596, which amends the Healing Arts Act to clarify that the performance of surgical procedures for purely aesthetic or cosmetic purposes constitutes the practice of medicine and. The bill also adds a definition of "surgery" to the Healing Arts Act (page 1, lines 36-43). Finally, the bill adds licensed electrologists, tattoo artists, and body piercers to the list of individuals that are exempt from licensure under the Act when licensed and practicing their profession pursuant to law (page 4, lines 1-6).

The principal effect of the bill would be to make it clear that certain "body modification" surgical procedures that are purely aesthetic or cosmetic, and not medically necessary, such as tongue-splitting (which is the central bifurcation of the tongue, so as to achieve a "forked tongue" appearance) may only be done by licensed physicians. Such a procedure carries with it significant risk of complications, such as substantial tongue hemorrhage, abscess formation, tetanus and nerve damage. Scarification (cutting of the skin for cosmetic purposes where lines are cut with surgical blades and scars are formed to produce "body art") would also be covered under the bill. This legislation would make it clear that such procedures would constitute the practice of medicine and surgery, and thereby be subject to the Act (page 2, lines 7-8).

We believe the legislation is necessary and would be very helpful to the Board for enforcement purposes. The definition contained in Sub for SB 596 is consistent with the definition of surgery, which appears in the Board's regulations governing office-based surgical procedures.

We would urge the Committee to recommend the bill favorably for passage. Thank you for considering our comments.

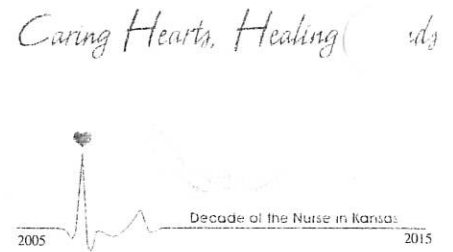
Health & Human Services Committee

Date: 3-18-08

Attachment: 14



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SUSAN BUMSTED, M.N., R.N.
PRESIDENT

THE VOICE AND VISION OF NURSING IN KANSAS

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR

For More Information Contact:
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troberts@ksna.net
March 18, 2008

Testimony

SUBSTITUTE FOR S.B. 596 AN ACT RELATING TO THE BOARD OF HEALING ARTS; CONCERNING COSMETIC OR AESTHETIC PURPOSE INCLUDED IN THE PRACTICE

-NEUTRAL-

Chairperson Landwehr and Members of the House Health and Services Committee Committee, the Kansas State Nurses Association has no formal position on Substitute for S.B.596 regarding adding a new definition surgery in the Healing Arts Act. This bill adds the following new definition of surgery on page 1, line 36.

"Surgery" shall mean the use of any device, procedure or method to sever, remove, destroy or structurally alter body tissue or implant any device, object or tissue into the body of human beings for any purpose, including preserving health, diagnosing or treating disease, repairing injury, reducing closed or open fractures, correcting deformity or defects, prolonging life or relieving suffering, or for an aesthetic, reconstructive or cosmetic purpose. Surgery shall not be construed to mean manipulation for adjustment of misplaced tissue or acupuncture.

Many registered nurses in carrying out their daily responsibilities perform a task which falls within this new definition/description of "Surgery." We would want to ensure that Registered Nurses (RN), including Advanced Registered Nurse Practitioners (ARNP's) in all settings would be in compliance with state law while they are carrying out these tasks essential to their work.

Some examples of common tasks that meet this definition include but are not limited to:

- inserting intravenous catheters
- PICC line insertions
- NG tube insertions
- foley catheter insertions
- wound care and burn debridement
- staple removal
- toenail clipping or removal

In K.S.A. 65-2872, there is an exception for registered nurses (LPN's, RN's, ARNP's) to perform what otherwise constitutes the Healing Arts Act when they are practicing their licensed profession pursuant to the Kansas Nurse Practice Act (page 3, line 16, number (13)). This is part of the exception clause to the Healing Arts Act, which lists those that "are not practicing the healing arts". As long as licensed nurses continue to be able to perform these tasks upon the approval of this new language in Substitute S.B. 596 this will not impede our current functioning. Thank You



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TESTIMONY

House Health and Human Services Committee
SB 596
Tuesday, March 18, 2008

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the Social Services Budget Committee regarding SB 596.

SB 596 clarifies surgical procedures which are the practice of medicine and surgery. Specifically, SB 596 identifies certain "body modifications" as surgical procedures and may only be done by a licensed physician. SB 596 also adds a definition of surgery to the Healing Arts Act. During discussions of SB 596 in the Senate Public Health and Welfare Committee, the Kansas Medical Society offered an amendment to the definition of surgery in the bill which was ultimately adopted. KAOM supports the amended definition of surgery in SB 596.

KAOM supports SB 596 and encourages the Committee to favorably pass SB 596.

Thank you.

Health & Human Services Committee

Date: 3-18-08

Attachment: 16