Approved: April 29, 2010
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 p.m. on February 8, 2010, in Room 784 of the Docking State Office Building.

All members were present except:
Representative Owen Donohoe
Representative Jim Ward

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Kathie Sparks, Kansas Legislative Research Department
Debbie Bartuccio, Committee Assistant

Conferees appearing before the Committee:
Ron Hein, Kansas Association of Nurse Anesthetists (Attachment 1)
Jerry Slaughter, Executive Director, Kansas Medical Society (Attachment 7)
Greg Unruh, Anesthesiologist, Kansas University Medical Center (Attachment 8)
Representative Don Hill (Attachment 9)
Dr. Jason Eberhart-Phillips, State Health Officer and Director of Health, Kansas Department of Health and Environment (Attachment 10)
Debra Billingsley, Executive Secretary, Kansas State Board of Pharmacy (Attachment 11)
Pat Hubbell, Kansas Pharmacists Association (Attachments 12 and 13)
Sam Boyajian, Rph., (Attachment 14)
Bob Williams, Executive Director, Kansas Association of Osteopathic Medicine (Attachment 16)
Dan Morin, Kansas Medical Society (Attachment 18)
Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services (Attachment 19)
Marla Rhoden, Director, Health Occupations Credentialing, KDHE (Attachment 20)
Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board (Attachment 21)
Stuart Little, Ph.D., Kansas Association of Addiction Professionals (Attachment 22)
Barbara Burks and Win Smith, Kansas Association of Addiction Professionals (Attachment 23)
Myron Unruh, CEO, ValueOptions-Kansas (Attachment 24)
Terry Humphrey, Kansas Chapter, National Association of Social Workers (Attachment 25)
Janace Maynard, Licensed Specialist Clinical Social Worker (Attachment 26)

Others attending:
See attached list.

HB 2619 - Registered nurse anesthetists duties

Chairperson Landwehr opened the hearing on **HB 2619**.

Ron Hein, legislative counsel for the Kansas Association of Nurse Anesthetists (KANA) presented testimony in support of the bill. He explained the history of the bill and that this bill is designed to respond to an Attorney General's opinion which ruled that a practice which the CRNAs had been doing for years, could not legally be done pursuant to his reading of their scope of practice. They can perform certain functions, such as injecting medication by their scope of practice, but the AGA ruled that they could not order a nurse to give that same medication. If they are involved in a case, with someone under anesthesia, and the nurse comes in and indicates a prior case, in recovery, is vomiting, the CRNA can walk into the other room and can give the anti-nausea medication (although they can't leave their current patient), but they can NOT order the nurse to give the previous patient the anti-nausea drug. The inability of the CRNA to be able to conduct his or her practice with the assistance of other personnel, results in poor patient care. (Attachment 1)

Written testimony in support of the bill was provided by Brian K. Smith, CRNA, MS, Director of Anesthesia, St. Catherine Hospital, Garden City, Kansas. (Attachment 2)

Written testimony in support of the bill was provided by Nancy Whitson, CRNA, MS, Board Advisor and Past President, Kansas Association of Nurse Anesthetists. (Attachment 3)

Twelve letters of support were provided as written testimony from CRNAs and physicians. (Attachment 4)

Written testimony in support of the bill was provided by Rachel Edgerton, CRNA, President, Kansas Association of Nurse Anesthetists. (Attachment 5)

Written testimony in support of the bill was provided by Mary Blubaugh, MSN, RN, Executive Administrator, Kansas State Board of Nursing. (Attachment 6)

Jerry Slaughter, Executive Director, Kansas Medical Society, provided neutral testimony. He stated the groups most affected by legislative changes in this area of practice - the Kansas Association of Nurse Anesthetists, the Kansas Society of Anesthesiologists, the Board of Nursing, and KMS - have worked together closely over the years to address practice questions as they arise. The Kansas Medical Society is continuing to meet with the groups to discuss the issue and the approach contained in the bill, as well as other suggestions. They are optimistic the groups will be able to reach consensus in the very near future, and be able to report back to this committee with an agreed upon recommendation for amendments to existing law. (Attachment 7)

Chairperson Landwehr had encouraged the groups to work together to resolve issues and she expressed her appreciation to the groups for doing so on this bill.

Greg Unruh, Anesthesiologist at the Kansas University Medical Center, presented neutral testimony on the bill. He also indicated they are working to resolve issues with the language of the bill. (Attachment 8)

Chairperson Landwehr gave the committee members the opportunity to ask questions and when all were answered, the hearing on **HB 2619** closed.

HB 2448 - Pharmacists, administration of vaccine

Chairperson Landwehr opened the hearing on **HB 2448**.

Representative Don Hill provided testimony in support of the bill. He explained three years ago legislation very similar to this bill was introduced by Representative Kiegerl but the bill was not worked in committee and died at the end of the session. He then explained the following three things that have changed since the last time it was introduced:

First - due to what we have experienced in the last year with H1N1 flu, we know, as a state, we are deficient in our ability to provide immunizations in an emergency situation in Kansas.

Second - in the past 3 years the University of Kansas Pharmacy School has produced approximately an additional three hundred pharmacists - fully trained and experienced in immunization administration.

Third - the bill has changed. Instead of allowing unlimited ability for pharmacists to immunize any age patient, the bill maintains age restrictions, lowering the general age from 18 to 12 and lowers flu vaccinating specifically to age 6.

He believes the new bill presents a significant opportunity for health care in Kansas to be improved in terms of the critical component of access. (Attachment 9)

Dr. Jason Eberhart-Phillips, State Health Officer and Director of Health, Kansas Department of Health and Environment, provided testimony in support of the bill. (Attachment 10)

Debra Billingsley, Executive Secretary, Kansas State Board of Pharmacy, presented testimony in support of the bill. She stated the Board would ask that a friendly amendment be made to the language clarifying that an intern

or student must work under the direct supervision of an immunization-certified pharmacist if the student or intern is immunizing patients. (Attachment 11)

Pat Hubbell, a practicing pharmacist from Sigler Pharmacy in Lawrence, Kansas provided testimony in support of the bill. He is also a member of the Board of Trustees of the Kansas Pharmacists Association and was testifying as a representative of the Association. His testimony also included an article from the January 2010 National Association of Boards of Pharmacy newsletter. (Attachments 12 and 13)

Sam Boyajian, Rph, provided testimony in support of the bill. He is the former chairman of the Kansas Independent Pharmacy Service Corporation and a career long member of the Kansas Pharmacists Association. He believes the bill addresses not only a need but a requirement for our younger Kansans to get their valuable and necessary vaccines. It addresses the issue of access to healthcare more than anything. (Attachment 14)

Written testimony in support of the bill was provided by Ron Hein on behalf of the Kansas Association of Chain Drug Stores. (Attachment 15)

Bob Williams, Executive Director, Kansas Association of Osteopathic Medicine, provided testimony in opposition of the bill. He stated there has been a growing concern in this country regarding the vaccination of children. Only a physician is trained to determine if a child is a candidate for specific vaccination. He also discussed the disruption of the continuity of care for children. When a child is taken to a physician to receive a vaccine, it is an opportunity for the physician to evaluate the child's progress. An unintended consequence of the bill will be fewer children routinely seen by physicians. (Attachment 16)

Written testimony was provided in opposition to the bill by Dennis Cooley, MD, FAAP, President, Kansas Chapter American Academy of Pediatrics. He stated decisions that are made concerning the proper administration of immunizations can be confusing and difficult to make. These decisions require providers experienced in immunizations administration, usage and potential complications. (Attachment 17)

Dan Morin, Kansas Medical Society, provided testimony in opposition of the bill. He stated to maximize their effectiveness, immunizations for school-aged children should be coordinated through a "medical home" so that they may be provided on specific schedules and for specifically indicated reasons. (Attachment 18)

Chairperson Landwehr gave the committee members the opportunity to ask questions and when all were answered, the hearing on **HB 2448** closed.

HB 2577 - Addictions counselor licensure act

Chairperson Landwehr opened the hearing on **HB 2577**.

Ray Dalton, Deputy Secretary, SRS, provided testimony in support of the bill. Licensing of addiction counselors would align the profession with social workers, marriage and family therapists, psychologists and licensed professional counselors. Twenty-three states already professionally license addiction counselors. Licensure will provide a needed workforce development ladder in the field to ensure an adequate pool exists for the delivery of addictions counseling services and will support retention rates of the current workforce. (Attachment 19)

Marla Rhoden, Director, Health Occupations Credentialing, Kansas Department of Health and Environment, provided testimony in support of the bill. Passage of the bill serves to demonstrate the successful processing of an application for a change in the level of credentialing under the law. The department asks that the legislature act favorably on this bill as the applicant group has thoroughly demonstrated the need and rationale under the legislature's criteria for the licensing of addictions counselors. (Attachment 20)

Phyllis Gilmore, Executive Director, Behavioral Sciences Regulatory Board, provided testimony in support of the bill. The Board supports licensure of Addiction Counselors, as it would give increased regulatory oversight, including the opportunity for recourse by the consumer, which does not presently exist today. The BSRB is prepared to respond to the potential demand as it relates to the initial group of applicants for licensure as well as the ongoing licensure and regulatory processes. They believe this can be accomplished without any additional

Minutes of the House Health and Human Services Committee at 1:30 p.m. on February 8, 2010, in Room 784 of the Docking State Office Building.

full time staff. (Attachment 21)

Stuart Little, Ph.D., provided testimony in support of the bill on behalf of the Kansas Association of Addiction Professionals. (Attachment 22)

Barbara Burks and Win Smith, the Kansas Association of Addiction Professionals, provided joint testimony in support of the bill. (Attachment 23)

Myron Unruh, Executive CEO, ValueOptions-Kansas, provided testimony in support of the bill. He stated having the Behavioral Sciences Regulatory Board administer the licensing and regulation of substance abuse treatment providers would:

- enhance consistency in the practices of substance abuse treatment,
- increase the possibility of collaboration among health professions and offer the availability of different payer mixes to assist consumers in getting the help they need

(Attachment 24)

Terry Humphrey, Kansas Chapter, National Association of Social Workers, provided testimony in opposition of the bill. The following two concerns were discussed:

1) If this bill becomes law, it will expand addictions counselors scope of services to permit diagnosis and treatment which is currently prohibited. This new licensure will seriously lower professional standards and the quality of care for persons seeking mental health services for substance abuse. The provisions in the bill are unprecedented and far-reaching because it would permit bachelor trained persons to diagnose and treat individuals with a substance abuse disorder.

2) The bill proposes to add another professional member to the Behavioral Sciences Regulatory Board going from 11 members to 12. Adding a member to the BSRB will increase costs unnecessarily, at a time when certain fees are in the process of being doubled to meet BSRB's budget needs.

If the bill should advance, rather than adding another person to the board, the following no-cost solution was suggested. Currently, the BSRB has four public members. This is approximately two more public members than any other health care regulatory board. This presents an opportunity to 1) take one public position and reassign it to a clinical addictions counselor and 2) take the second public position and reassign it to a licensed specialist clinical social worker.

The testimony also included four visuals to illustrate the other regulatory boards number of public members and the current distribution and the projected distribution of licensees to professional representation on the BSRB board. (Attachment 25)

Janace Maynard, Licensed Specialist Clinical Social Worker, presented testimony in opposition to the bill. She commented she was deeply concerned regarding the broad scope of proposed licensure. From her professional experience reviewing the actual work of current AAPS certified individuals, they did not appear qualified to do diagnosis. Specifically, individuals with a bachelor degree or less did not appear to have the education/experience resulting in the clinical judgment, skill, and expertise necessary to diagnose. (Attachment 26)

Due to time constraints, Chairperson Landwehr asked Janace Maynard if she would be available to return at a future meeting for additional discussion on this topic and Janace confirmed she could do so.

The next meeting is scheduled for February 9, 2010.

The meeting was adjourned at 3:30 p.m.

HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2-8-10

NAME	REPRESENTING
Janet Simpson, Holbrook & Osborn	Ks Assn of Nurse Anesthetists
Catie Rech	KNASW
Les Sperling	KAAP
Tom Lohff	KAAP
Harold W. Casey	KAAP - wichita area
Winthrop B. Smith	"
	Ks Optometric Assoc.
Stuart Little	Ks Assoc. of Addiction Professionals
Mack Smith	Kansas State Board of Mortuary Arts
Chad Austin	KAHA
Sharon Weigel	KNASW
Mary Blubaugh	KSBN
Diane Gilkerson	KSBN
Sue Bowden	KDHE
Barbara Walker	KDHE BDCP
Michelle Butler	Cap. Strategies
Deb Billingsley	KBOP
Christina Meeds	KBOP

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HEIN LAW FIRM, CHARTERED

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Phone: (785) 273-1441
Fax: (785) 273-9243

Ronald R. Hein
Attorney-at-Law
Email: rhein@heinlaw.com

Testimony re: HB 2619
House Health and Human Services Committee
Presented by Ronald R. Hein
on behalf of
Kansas Association of Nurse Anesthetists
February 8, 2010

Madam Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Association of Nurse Anesthetists (KANA).

KANA supports HB 2619. Previously, another bill, HB 2536 had gotten introduced, and I would like to explain how that bill came about.

Prior to the KANA Board finalizing the bill language, several of us had met with KMS in October, and presented them a proposed bill draft. We met again with KMS in January, at which time KMS responded to our original proposal with their proposed compromise. Several of those provisions appeared good to those of us at the meeting, and we indicated that to the KMS, but also indicated we would have to take it back to the KANA Board for approval.

We subsequently requested a bill draft from this committee, conceptually, and presented to the revisor the KMS proposal. Subsequent to that, KANA heard from their lawyer, and from the State Board of Nursing, and were advised of problems with the KMS proposed draft. By the time we tried to get the bill revised through the Revisor's office, the bill had already gotten thrown into the House hopper.

Therefore, KANA requested a second bill introduction, which is HB 2619.

This bill is designed to respond to an Attorney General's opinion which ruled that a practice which the CRNAs had been doing for years, could not legally be done pursuant to his reading of their scope of practice. They can perform certain functions, such as injecting medication by their scope of practice, but the AGA ruled that they could not order a nurse to give that same medication. If they are involved in a case, with someone under anesthesia, and the nurse comes in and indicates a prior case, in recovery, is vomiting, the CRNA can walk into the other room and can give the anti-nausea medication (although they can't leave their current patient), but they can NOT order the nurse to give the previous patient the anti-nausea drug. This inability of the CRNA to be

able to conduct his or her practice with the assistance of other personnel, results in poor patient care.

We urge the committee to pass HB 2619.

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

Brian K. Smith, CRNA, MS
Director Of Anesthesia,
St. Catherine Hospital, Garden City, KS, 67846
February 4, 2010

To: Health and Human Services Committee
Re: HB 2619

Dear Committee Members;

My name is Brian Smith and I am Director of Anesthesia services at St. Catherine hospital in Garden City, Kansas. St. Catherine is a 132 bed regional health care center, and the primary care facility for a large part of southwest Kansas.

Over 5000 surgeries and nearly 1000 obstetrical deliveries are performed each year at St. Catherine, with nearly all of the deliveries receiving labor analgesia normally consisting of a labor epidural. Our hospital also provides a much needed pain management service consisting mainly of epidural steroid injections given under fluoroscopy. Providing this service allows our patients to avoid an arduous and painful 7 hour round trip to the nearest pain management clinic.

All of the anesthesia services provided by St. Catherine are performed by a group of 9 CRNA's. Our surgeons and OB/GYNs have consistently rated our anesthesia services as excellent, and have expressed no desire to have our scope of practice limited in any way. Quite the contrary, we have developed a collegial relationship based on mutual trust. Anesthesia is, after all, our specialty. We are not surgeons and the surgeons are not anesthetists.

The legal and risk management departments at St. Catherine have long interpreted our nurse practice act to include several implicit rights that are not explicitly mentioned. These include, but are not limited to, ordering whatever testing we feel is necessary to carry out our anesthesia plan of care. We have also ordered whatever medications we deem necessary to insure patient

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comfort and well-being. Further, the nursing staff at St. Catherine has followed our orders without question. In other words, after the surgeon or other physician writes for the initial anesthesia consult, it has been our practice that the anesthetist is fully responsible for the patients peri-operative care, including post operative pain management.

Kansas statute states that no practitioner covered under the Health Care Stabilization Fund can be held vicariously liable for the actions of another covered under the fund, and CRNA's are the only advanced practice nurses covered under the fund. Since that statute was put into place, it has been understood in our practice that the anesthetist, the CRNA, is 100% liable for the anesthetic outcome, and therefore, it has been an absolute necessity that our scope of practice include the aforementioned ordering capabilities.

Unfortunately, the recent AG opinion concerning our scope of practice act has raised several concerns that need to be addressed immediately. Without a change in the nurse practice act to reflect our current practice, several negative consequences may develop. Unless we have the explicit right to order tests and medications, surgical delays and patient discomfort, as important as they are, may be the least important of the negative consequences. For instance, a short delay in treating severe post-operative hypertension while waiting for a response from an internist or surgeon might develop into a stroke or heart attack. This is a common post-operative complication that needs immediate attention and in our practice is generally taken care of by the attending CRNA. This example is not an exaggeration as we are asked to take care of severe health concerns every day, both in and out of the surgical suite. If our current law is not reformed, patient care and surgical outcomes will surely suffer. In short, we need the law to reflect our area of expertise.

It has been suggested that HB 2619 expands CRNA scope of practice, but I don't believe this to be true. HB 2619 is nothing more than an attempt to bring our statues up to date with our current state of practice. From speaking with other practitioners around the state, I also believe that our anesthesia practices at St.

Catherine to be very similar to the practices at the 85% of the hospitals in Kansas in which CRNA's are the sole anesthesia providers. If we have been working outside of our scope of practice, then so have the majority of CRNA's in Kansas, and I just don't believe that to be true.

In conclusion, HB 2619 is an effective solution that accurately reflects our current practice. I urge the committee to approve HB 2619 and to move the bill forward to the full House for a vote. I would like to thank the committee for its thoughtful consideration of this matter.

Sincerely,

Brian K. Smith, CRNA, MS
Director of Anesthesia
St. Catherine Hospital

Nancy A. Whitson, CRNA, MS
Board Advisor and Past President,
Kansas Association of Nurse Anesthetists

Independent Practice, Topeka, Kansas

To: The Kansas House Health and Human Services Committee –

I would like to thank you for hearing my testimony and for considering HB 2619 which addresses Certified Registered Nurse Anesthetist practice in Kansas.

My name is Nancy Whitson. I am a lifetime resident of Kansas, and have been a practicing nurse in the state since 1993, and a Certified Registered Nurse Anesthetist since 2002. As a CRNA, I have practiced in six different hospitals across the state, as an employee of the hospital, and as an employee of an Anesthesiology group and also as a traveling self employed anesthetist. My current assignment is a long-term contract with an anesthesia group in Dodge City, Kansas called Anesthesia Critical Care Nursing. In my experiences, I have worked in hospital settings ranging from our state capital to small towns in Western Kansas.

For the past several years I have served on the Board of the Kansas Association of Nurse Anesthetists. In 2007, a survey of Kansas Hospitals, administered by the Kansas Department of Health and Environment, raised questions about the scope of practice of CRNA's in Kansas. These questions were investigated by the Kansas Department of Nursing. In their opinion, released in the Fall of 2007, old statutes defining the scope of practice by CRNA's did not match the actual practice of CRNA's in hospitals in the state of Kansas. The release of this opinion was the beginning of a three year long odyssey for me and the other members of the Kansas Association of Nurse Anesthetists. We tried to obtain clarity from an Attorney Generals' opinion, but unfortunately, this left us even more confused. The Kansas Medical Society then attempted to clean up their so-called delegation language (how CRNA's work through Doctors) and it was hoped that this would be our solution. Ultimately, though, confusion still exists among the powers –that- be in our state about the statutory scope of practice for CRNA's.

Much of what we've been doing on a lobbying and legislative basis for the past two years is a matter of record, and is familiar to many of the distinguished members of the Health and Human Services Committee. The short version of it is this: we have been trying to rectify three things: one, the statutory definition of Nurse Anesthesia practice in Kansas; two, the actual practice of Nurse Anesthesia in the state; and three, the needs of the citizens of Kansas relating to the delivery of services by Nurse Anesthetists. As we have worked on this issue, we have encountered opinions of various medical and legislative groups which have differing takes on the matter. After much deliberation ourselves, we feel that HB 2619 is an acceptable solution.

At the hospital where I currently practice, a place where only CRNA's perform anesthetic and analgesic care, they seem be totally unaware of any delegation language in state statutes and want anesthetist's to write and sign orders as they have been practicing for the more than 20 years. The hospital is not requiring that delegation language be used on any charts. Technically, this is illegal and it could wind up getting a nurse or an anesthetist in litigation and cause them to lose their license since they are not following the law. The hospital seems to be following some unwritten rule but not the law. If a mishap would occur over an order I wrote, I would face legal issues, have my license in jeopardy, and my malpractice insurance could choose to not cover since technically I was practicing out of my statutes. This is why it is vital to clean up our statutes and bring them up to date with the way we practice here in Kansas. We have been safely working and practicing this way since 1986 when our statutes were first written. The surgeons and family physicians whom we work closely with have come to rely on our ability to provide safe anesthesia to their patients.

Essentially, just as in any surgical facility, a surgeon expects to have a patient safely and competently prepared for the procedure. For this to happen, orders must be written, procedures given, and patient well being must be seen to. In over 80% of our state's facilities, these responsibilities rest with Certified Registered Nurse Anesthetists. Kansas should be proud of the outstanding health care we have in our state. We would like to keep practicing as we have been to provide the highest quality of health care to Kansans.

Thank you for your consideration.

Respectfully submitted, Nancy A. Whitson, CRNA, MS

February 4, 2009

To whom it may concern,

I am writing you with regards to HB2619 and the impact that last year's attorney general opinion has made on my practice. This has created a grey area and confusing charting for me and my staff. The pre-operative nurses and the post operative nurses who have been receiving orders from my CRNA's since 1996 without complication are now required to call me for orders rather than being able to take them from the CRNA that has been taking care of the patient throughout the surgery and in tune with the patients needs. At times this delay has caused needless discomfort for my patients. The other area that this has affected me is in the pre-operative arena where the CRNA's orders the tests that are needed to deliver a safe anesthetic. Often times these tests take a good period of time to obtain and can have the potential to delay surgical start times thereby decreasing the numbers of your constituents that I am able to provide care for. I don't have to emphasize the growing demand on rural surgeons and how important it is to provide them the access to health care they so desperately need. The other alternative is to not follow the law and have false documentation placed on the chart and encourage an atmosphere of dishonesty in a profession where strong ethics are paramount.

The impact of this change has the potential to adversely affect thousands of rural Kansans who depend on the safe quality care afforded to them by the CRNA's that live in their communities. We must address this issue by passing HB 2619. This bill was introduced by the Kansas Association of Nurse Anesthetstists and will allow CRNA's to practice as they have been since 1996 without complications. RN's will once again be able to accept orders from CRNA's so that patients can be cared for in a safe, timely fashion and will eliminate the confusion created last year.

I thank you for your consideration in this matter and trust that you will indeed pass HB2619 so that your constituents will continue to receive the quality anesthesia care they have been afforded since 1996.

Feel free to contact me with any questions.

Sincerely,

Nathan Strandmark D.O. (Family Physician)
Coolidge City, KS

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 4-1

February 4, 2009

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Sincerely,

BTachitt CRNA, MSNA.

BRIAN TACHITT CRNA, MSNA.
Holcomb, KS.

February 4, 2009

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Feel free to contact me with any questions.

Sincerely,

Kyle Nevills CRNA, MSNA

Kyle Nevills CRNA, MSNA
Garden City, Kansas.

4-8

February 4, 2009

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The impact of this change has the potential to adversely affect thousands of rural Kansans who depend on the safe quality care afforded to them by the CRNA's that live in their communities. We must address this issue by passing HB 2619. This bill was introduced by the Kansas Association of Nurse Anesthetstists and will allow CRNA's to practice as they have been since 1996 without complications. RN's will once again be able to accept orders from CRNA's so that patients can be cared for in a safe, timely fashion and will eliminate the confusion created last year.

I thank you for your consideration in this matter and trust that you will indeed pass HB2619 so that your constituents will continue to receive the quality anesthesia care they have been afforded since 1996.

Feel free to contact me with any questions.

Sincerely,

N. Perkins, M.D.
Director of Emergency Services
St Catherine Hospital
Garden City, Ks

February 4, 2009

To whom it may concern,

I am writing you with regards to HB2619 and the impact that last year's attorney general opinion has made on my practice. This has created a grey area and confusing charting for me and my staff. The pre-operative nurses and the post operative nurses who have been receiving orders from my CRNA's since 1996 without complication are now required to call me for orders rather than being able to take them from the CRNA that has been taking care of the patient throughout the surgery and in tune with the patients needs. At times this delay has caused needless discomfort for my patients. The other area that this has affected me is in the pre-operative arena where the CRNA's orders the tests that are needed to deliver a safe anesthetic. Often times these tests take a good period of time to obtain and can have the potential to delay surgical start times thereby decreasing the numbers of your constituents that I am able to provide care for. I don't have to emphasize the growing demand on rural surgeons and how important it is to provide them the access to health care they so desperately need. The other alternative is to not follow the law and have false documentation placed on the chart and encourage an atmosphere of dishonesty in a profession where strong ethics are paramount.

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Sincerely,

G. Garcia MD. Orthopaedic Surgeon
1809 Van Dyke
Garden City
KS
67846

February 4, 2009

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Feel free to contact me with any questions.

Sincerely,

JP Atwood MD

Ron Catanese MD

Garden City, KS

February 4, 2009

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Feel free to contact me with any questions.

Sincerely,

Kyle Nevills CRNA, MSNA

Kyle Nevills CRNA, MSNA
Garden City, Kansas.

8
4-8

February 8, 2010

Representative Brenda Landwehr
Chair, House Health and Human Services
Topeka, Kansas 66612

Chairman Landwehr,

My name is Rachel Edgerton. I am a Certified Registered Nurse Anesthetist (CRNA) from Kansas City, Kansas, and President of the Kansas Association of Nurse Anesthetists (KANA). I am here today in support of H.B. 2619.

This bill is brought before you because of actions that developed in 2007 as a result of an interpretation of KSA 65-1158 by staff of the Kansas State Board of Nursing (KSBN). That interpretation said that CRNAs could never order medications or lab work pursuant to the anesthesia plan of care. Based upon that interpretation, the Kansas Department of Health and Environment (KDHE) began issuing deficiencies to rural hospitals during their surveys for Medicare accreditation. One such hospital was in Hiawatha, Kansas.

Subsequently, the KSBN requested that KDHE put any on hold any further action based upon this interpretation while the KSBN, the Kansas medical Society (KMS) and the Kansas Hospital Association (KHA) met to try and resolve the situation. Eventually, the Attorney General's Office was asked for a formal opinion that was delivered on January 26, 2009. The opinion said: 1) CRNAs cannot write orders and 2) physician delegation statutes under the Healing Arts Act were ambiguous and the conclusions of several AG opinions on delegation were withdrawn due to conflicts in the interpretations.

At the end of the 2009 session, the Legislature passed HB 2010, that removed the conflict in the physician delegation statutes, but the bill had no effect on our statutes nor did it "solve" our problems with "ordering". It only fixed the flaw in the physician delegation statutes.

There still exist three problems unresolved by now requiring the physician to specifically delegate "ordering" to the CRNA for each case performed by the CRNA, in addition to the original order by the physician for anesthesia care, required since 1996.

1) **Logistics**: Trying to get the delegations order on every chart before the CRNA gives any orders to a nurse, and making sure it is worded correctly creates confusion and is an impediment to efficient and safe patient care. If you ask ten physicians how they satisfy this new requirement for delegation, you would get ten different answers. The most common answer from physician in the larger medical centers is "I just make sure that their (CRNA) orders are all co-signed by me". This does not satisfy the regulatory requirement for delegation. If there is no delegation order on the chart prior to the CRNA giving an order to the nurse, then the CRNA and the nurse have both violated the law. It doesn't matter if or when the order is co-signed.

2) **Liability**: If the CRNA gives an order to a nurse without the proper delegation on the chart, who becomes liable for any complication after that time?

Is the physician, who did not write the delegation order, now liable for all of the post-anesthesia care in the recovery room?

If the surgeon refuses to write a delegation order, can the CRNA abdicate all responsibility for that patient as soon as they get to recovery room?

If the CRNA gives an order to a nurse without the proper delegation order, does our malpractice insurance become null and void because the CRNA is practicing outside their scope of practice?

3) **Licensure**: Without the proper delegation order on the chart prior to any order being given, the CRNA and RN who accepted that order are subject to discipline and possible loss of their license at the KSBN.

We thought that in 1996, the order by the physician for anesthesia or analgesia care included all the components of anesthesia care, not just pieces of it. Anesthesia care does not exist in a vacuum. It requires the support of all of the staff in the Operating Room, Recovery Room, Obstetrics or the Emergency Room. Anesthesia care is not just drugs we can give ourselves.

The three concerns listed above all have a direct impact on patient care and patient safety. The change in our authorizing statute, KSA 65-1158, contained in this bill will allow us to practice as we have since 1996. This is not a request for an expansion of the scope of practice. H.B. 2619 would clarify that the statute says CRNAs not only develop the anesthesia plan of care with the physician or dentist, but have the authority to order others to provide medications or tests necessary for the anesthesia plan of care.

We feel this issue is important to our patients and we hope it is important to you as well.

Respectfully,

Rachel Edgerton, CRNA
President, Kansas Association of Nurse Anesthetists

Health and Human Services Committee
March 8, 2007

Written Testimony in Support of HB 2619

Mary Blubaugh MSN, RN
Executive Administrator

Good Afternoon Chair Landwehr and Members of the Health and Human Services Committee. I am providing written testimony on behalf of the Kansas State Board of Nursing to provide support of HB 2619 which will allow Registered Nurse Anesthetists, upon the order of a physician, to select, order, or administer appropriate medications necessary for the anesthesia plan of care.

The Kansas Association of Nurse Anesthetists has worked closely with the Kansas State Board of Nursing during their process of developing language to included ordering medications during the anesthesia plan of care. At the December 2009 Board of Nursing meeting, the language was reviewed by the Advanced Practice Committee and the full Board of Nursing. On December 21, the Board of Nursing voted to support the language change to include ordering of medications for the anesthesia plan of care.

Thank you for the opportunity to provide written testimony and the Kansas State Board of Nursing supports HB 2619 and we request that the committee passes it out favorably.

KANSAS MEDICAL SOCIETY
Established 1859

To: House Health and Human Services Committee

From: Jerry Slaughter
Executive Director

Date: February 8, 2010

Subject: HB 2619; Concerning registered nurse anesthetists

The Kansas Medical Society appreciates the opportunity to appear today as you consider HB 2619, concerning the duties and authority of registered nurse anesthetists. This issue was partially addressed last session in HB 2010, which attempted to clarify a matter that arose regarding the ability of physicians to delegate certain acts to registered nurse anesthetists (RNAs) and others. The question was the subject of an attorney general's opinion (Opinion 2009-4; January 26, 2009) in which the AG ruled that RNAs were not authorized under current law to order pre- and post-operative medications and diagnostic tests, unless authorized to do so pursuant to a physician order, which is a requirement of their licensing statute. A related issue was whether RNs and LPNs could lawfully carry out orders issued by RNAs. The legislation from last year did not limit, nor expand, the scope of practice for RNAs. It merely attempted to clarify and preserve the working arrangement that has been in the law since it was last amended in 1996. However, there remains concern in some areas of the state that the issue needs to be specifically addressed in the RNA statute in order to remove any confusion or questions about interpretation of RNA duties.

As the Committee is aware, the statutes governing RNAs are quite specific to their unique advanced nursing practice, because the selection and administration of anesthetics is at one of the intersections of specialized advanced nursing practice and the practice of medicine. The groups most affected by legislative changes in this area of practice - the Kansas Association of Nurse Anesthetists, and the Kansas Society of Anesthesiologists, the Board of Nursing, and KMS – have worked together closely over the years to address practice questions as they arise. We are continuing to meet with the groups to discuss the issue and the approach contained in HB 2619, as well as other suggestions. We are optimistic that the groups will be able to reach consensus in the very near future, and be able to report back to this committee with an agreed upon recommendation for amendments to existing law.

Thank you for the opportunity to offer these comments.

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 7-1

Kansas Society of Anesthesiologist

Remarks Concerning House Bill No. 2619

House Health and Human Services Committee

February 8, 2010

Chairman Landwehr and Members of the House Committee:

My name is Greg Unruh and I am an Anesthesiologist licensed to practice the Healing Arts in Kansas. I graduated from Southwestern College in Winfield and the Kansas University School of Medicine and practice anesthesiology at Kansas University Hospital. I serve as Associate Professor and Director of Residency Education for the Hospital. Currently, I also serve as Legislative Chair for the Kansas Society of Anesthesiologists.

The Kansas Society of Anesthesiologists was organized to raise and maintain the standards of the medical practice of anesthesiology and improve the care of the patient in Kansas. We are a component Society of the American Society of Anesthesiologists (ASA). The ASA serves as an important voice in American Medicine and the foremost advocate for all patients who require anesthesia or relief from pain.

The Kansas Society of Anesthesiologists appreciates this opportunity to provide testimony here today. Along with the Kansas Medical Society, the leadership of our society has been working continuously over the last year with the Kansas Association of Nurse Anesthetists, the Kansas Hospital Association, and the State Board of Nursing, to find legislative language that may correct perceived administrative problems with the practice of nurse anesthesia.

We hope new language will allow nurse anesthetists to practice safely and effectively within their Scope of Practice as delineated in K.S.A. 65-1158, utilizing their skills and abilities to provide optimum and safe patient care while maintaining the role of the operating physician in delivering that care. Although we have been able to resolve some issues, we have not come to complete consensus.

The Kansas Society of Anesthesiologists (KSA) recognizes the role of nurse anesthetists in Kansas as valuable providers of anesthesia care. Under their scope of practice as delineated in statute, nurse anesthetists practice in an interdependent role as a member of a physician or dentist directed health care team. KSA has previously presented testimony to this committee that this relationship as part of the health care team is important to maintain.

KSA recognizes that nurse anesthetists in Kansas practice in two types of practice settings. The majority practice under the medical direction of an anesthesiologist and they do not have the need to issue orders for medical tests or medications to other nursing personnel in the peri-operative setting. The directing anesthesiologists perform that function.

In the other practice settings, nurse anesthetists provide anesthesia care to their patients by a direct order of a physician or dentist. It is in this setting that their ability to issue orders for medical tests or medications to other personnel is in question under the current nurse anesthetist scope of practice.

KSA recognize that under the statute as written, nurse anesthetists in Kansas may have administrative difficulties performing usual and routine functions of patient care in the peri-anesthetic period. KSA is committed to assisting the nurse anesthetists in finding legislative relief from these perceived administrative difficulties.

KSA is not supportive of changes to K.S.A. 65-1158 that enable an expanded scope of practice for nurse anesthetists. In particular, KSA opposes any movement of nurse anesthetists into the practice of critical care or chronic pain management.

The leadership of the Kansas Society of Anesthesiologists remains committed to finding legislative language that allows nurse anesthetists in Kansas to continue to deliver safe, effective, legal and efficient anesthesia care for Kansas patients within the structure of a physician or dentist directed health care team.

Thank you for allowing our Society to appear here today.

STATE OF KANSAS

DON HILL
REPRESENTATIVE, 60TH DISTRICT
1720 LUTHER
EMPORIA, KANSAS 66801

STATE CAPITOL
300 SW 10TH AVENUE
TOPEKA, KANSAS 66612
785-296-7636
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: AGING AND LONG TERM CARE, VICE CHAIR
ECONOMIC DEVELOPMENT AND TOURISM
EDUCATION
FEDERAL AND STATE AFFAIRS
JOINT HEALTH POLICY
AUTHORITY OVERSIGHT

Testimony in Support of HB 2448

Good afternoon Chairman Landwehr and members of the committee. Thank you for the opportunity to provide brief testimony in support of HB2448. Three years ago legislation very similar to HB2448 was introduced by Rep Kiegerl and some of you will recall a hearing on that legislation was conducted in this committee. The testimony as I vividly recall was exceptionally well reasoned and well presented by both proponents and opponents. The bill was not worked in committee and as a result died at the end of that session.

The matter now returns and I would like to share with the committee what has changed in the past three years to make it worthy of a new hearing and I hope a vote to advance the measure.

What has not changed – Kansas immunization rates remain well below what we would all hope and strive for.

What has changed –

First - due to what we have experienced in the last year with H1N1 flu we know we as a state are deficient our ability to provide immunizations in an emergency situation in Kansas.

Second – in the past 3 years the University of Kansas Pharmacy School has produced an additional approximately three hundred pharmacists - fully trained, qualified and experienced in immunization administration. Comprehensive

immunization training has not been part of the accepted accredited pharmacy curricula for more than 10 years.

Third – the bill has changed. In positive and constructive dialogue with opponents of the legislation considered three years ago and recognizing important concerns on their part – this bill, instead of allowing unlimited ability of pharmacists to immunize any age patient, maintains age restrictions – lowering the general age from 18 to 12 and lowers flu vaccinating specifically to age 6.

I believe HB2448 presents a significant opportunity for health care in Kansas to be improved in terms of the critical component of access. I urge action and favorable consideration.

Thank you!

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT
Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on House Bill 2448
Related to Pharmacists, Administration of Vaccine

Presented to
House Health and Human Services Committee

By
Dr. Jason Eberhart-Phillips
State Health Officer and Director of Health
Kansas Department of Health and Environment

February 8, 2010

Chairwoman Landwehr and members of the committee, I am Jason Eberhart-Phillips, State Health Officer and the Director of Health for the Kansas Department of Health and Environment. Thank you for the opportunity to speak in favor of House Bill 2448.

The intent of this bill is to amend K.S.A. 65-1635a by expanding the capacity for provision of immunizations by pharmacists, pharmacy students and interns by reducing the age of recipients of pharmacy provided vaccines. The existing statute limits the age of persons receiving the vaccine to 18 years or older.

In 1996, the Department of Health and Human Services (HHS) asked the American Pharmacists Association to recommend that all pharmacists take a role in immunization advocacy by educating their clients about the importance of vaccines; hosting vaccine clinics at pharmacies; and administering vaccines.

Currently all 50 states give pharmacists the authority to immunize patients. Many of these states report that pharmacists actively administer immunizations. Adult vaccines that may be administered by pharmacists include Tetanus, diphtheria, pertussis (Td/Tdap); Human papillomavirus (HPV); Varicella (chickenpox); Zoster; Measles, Mumps, Rubella (MMR); Pneumococcal; Hepatitis A; Hepatitis B; Meningococcal and Influenza..

OFFICE OF THE DIRECTOR OF HEALTH
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 300, TOPEKA, KS 66612-1368
Voice 785-296-1086 Fax 785-296-1562

The national Advisory Committee on Immunization Practices (ACIP) recommends annual vaccination of children 6 months through 18 years of age. Expanding the age group eligible for influenza vaccination by pharmacists to 6 years and older will increase access to vaccination services for a large number of patients in a vulnerable population requiring annual vaccination for flu. Pharmacists have proven to be a valuable and effective partner in the Pandemic H1N1 Influenza A effort to vaccinate individuals 18 years of age and older. Allowing pharmacists to vaccinate individuals 6 years and older would help relieve the burden on the vaccine administration delivery system during a pandemic situation.

Before 2005, vaccines were administered to adolescents to "Catch up" children with vaccinations not received at a younger age. However, since 2005, new vaccines specifically for older children have been licensed and recommended in the United States. Allowing pharmacists to provide immunizations to adolescents 12 years of age and older will help increase access to vaccination services by a population whose immunization rates are well below the 90% target rate for all adolescent vaccines. Adolescents do not frequently seek preventive health-care services, some do not have health insurance, and some visit multiple health-care providers and nontraditional providers who vary in vaccination practices. Pharmacies could be a resource for the immunization needs for the adolescent population. Individuals without health insurance could qualify for free vaccine through the Vaccines for Children (VFC) program. This legislation would enable the enrollment of pharmacists as providers for the VFC program.

Kansas has made great strides in improving immunization rates of preschool age children. This legislation would provide a strategy for improving influenza vaccination rates of school age children and immunization rates for vaccines needed by adolescents.

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

KANSAS

BOARD OF PHARMACY
DEBRA L. BILLINGSLEY, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

Testimony concerning HB 2448: Administration of Vaccine
Committee on Health and Human Services
Presented by Debra Billingsley
On Behalf of
The Kansas State Board of Pharmacy
February 8, 2010

Madam Chairperson, Members of the Committee:

My name is Debra Billingsley, and I am the Executive Secretary of the Kansas State Board of Pharmacy. Our Board is created by statute and is comprised of seven members, each of whom is appointed by the Governor. Of the seven, six are licensed pharmacists and one is a member of the general public. They are charged with protecting the health, safety and welfare of the citizens of Kansas and to educate and promote the understanding of pharmacy practices in Kansas.

Pharmacists, pharmacy students, and interns (hereinafter referred to as "pharmacist(s)") who have been certified to immunize are currently permitted by statute to immunize patients eighteen years of age or older. The pharmacist must have a written protocol with a duly Kansas licensed medical doctor or doctor of osteopathic medicine which establishes procedures and record keeping and reporting requirements. The protocol must be updated every two years.

The change that is being made in this bill is that the age of the patient is being lowered to age six for influenza vaccination and age twelve for any vaccination. The Board of Pharmacy recommends passage of this bill because we feel that licensed pharmacists certified to administer immunizations and functioning under an immunization protocol with a physician provide a safe mechanism for vaccinating their patients. The pharmacists that would be immunizing patients must have a current CPR certificate , and have been trained in vaccination storage, protocols, injection techniques, emergency procedures and record keeping.

The Board also supports the bill because it advances the health and welfare of the citizens of Kansas. This past year the Board of Pharmacy worked with KDHE on a mass vaccination campaign for the 2009 H1N1 influenza vaccine. It required the coordination and collaboration of multiple partners to fully vaccinate the population of Kansas. Pharmacists were in a unique position to reach mass numbers of people and they were trained, experienced, and currently administering vaccines. Pharmacists serve as trusted members of the community and already provide immunization education. Pharmacists

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provide an additional provider venue to address the needs of the healthy patient population, reducing the burden on traditional practice sites and emergency rooms. The age limitations that are being requested will require children younger than 12 to continue seeing their pediatrician for their immunizations. The amendment will not hinder the well baby relationship but will increase immunization rates in Kansas.

The Board would ask that a friendly amendment be made to the language clarifying that an intern or student must work under the direct supervision of a immunization-certified pharmacist if the student or intern is immunizing patients. This is clarifying language only.

Thank you for permitting me to testify and I will yield to any questions from the committee.

KPhA
Kansas Pharmacists Association

Health and Human Services Committee
Testimony by the
Kansas Pharmacists Association
Submitted by Pat Hubbell, RPh
Member, KPhA Board of Trustees
February 8, 2010

Chairperson Landwehr and Members of the Committee:

My name is Pat Hubbell, and I am a practicing pharmacist from Sigler Pharmacy located in Lawrence, Kansas. I am also a member of the Board of Trustees of the Kansas Pharmacists Association and am here before you today as are representative of the Association. Thank you for allowing the Kansas Pharmacists Association to provide testimony today in support of House Bill 2448 which would allow pharmacists to provide flu vaccines to persons age 6 and above and to provide all other vaccinations to individuals 12 years of age and older. I will provide you some brief information on why pharmacists should be legally authorized to administer these vaccinations.

Pharmacists and pharmacy interns in Kansas have had the authority to administer vaccines to individuals age 18 and above for the past 10 years. These skilled individuals must have in place a protocol with a licensed M. D. or D.O. before immunizations are provided. Pharmacists and pharmacy interns that administer these vaccinations must also be fully trained in providing the vaccinations as well as receiving training in cardiopulmonary resuscitation, vaccinations storage, injection techniques, record-keeping, emergency procedures, and protocols.

I am sure that you will agree that the medical professionals and citizens of Kansas have great confidence in the ability of pharmacists and pharmacy interns to administer vaccinations. They will also agree that providing vaccinations against serious diseases is critical to effective health care. What is most important is that individuals *actually receive* vaccines. During the recent H1N1 influenza outbreak, pharmacists throughout Kansas were asked by county health departments and schools to assist in the administration of the H1N1 vaccine. Unfortunately, while fully trained and able to assist, many pharmacists were prevented from helping because the population of individuals was below the age of 18. In the likely event such an outbreak occurs in the future, we would like to be there to help.

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 12-1

Study after study has shown that pharmacists are possibly the most accessible and highly trusted healthcare professionals in the United States. A recent Gallup poll found that most consumers visit their community pharmacy at least once per month, and in some settings, such as supermarkets, several times per month. The accessibility of pharmacists is particularly key for people without medical insurance, people without a primary care physician, and Medicare Part D. beneficiaries. Additionally, nearly every American lives within 5 miles of a community retail pharmacy, and in rural areas pharmacies are still among the closest health care access point.

In closing, I would like to bring to your attention the latest issue of the National Association of Boards of Pharmacy newsletter, which I have provided with my written testimony. It provides you a good overview of the efforts and actions that other states had to undertake in reaction to the H1N1 outbreak. I believe that *action* by the Kansas Legislature today will help prevent having to *react* during the next health emergency in the future.

Thank you very much for permitting me to provide testimony today. If I can clarify aspects of this written testimony or answer any other questions for you, please feel free to let me know.

Pat Hubbell, RPh
Sigler Pharmacy
Lawrence, Kansas
Kansas Pharmacists Association Board Member

newsletter

National Association of Boards of Pharmacy®

January 2010 / Volume 39 Number 1

aid to government
the profession
the public
1904 to 2010

Upcoming Events

January 26-27, 2010
Committee on Law Enforcement/Legislation Meeting
Rosemont, IL

January 25 - February 5, 2010
PCOA Administrations

April 13, 2010
Committee on Constitution and Bylaws Meeting

April 19, 2010
FPGEE Administration

May 22-25, 2010
NABP 106th Annual Meeting
Hyatt Regency
Orange County
Anaheim, CA

Pharmacists' H1N1 Vaccination Roles Expand Patient Care

With no change in the phase 6 pandemic alert set by the World Health Organization in June for the H1N1 influenza virus, governments and health care organizations continue to be concerned about rapid spread of the virus. Federal and state health agencies stepped up their prevention efforts beginning in June and including the fall distribution of over 65 million doses of H1N1 vaccine. This large influx of vaccines increased the need for additional vaccine providers, and pharmacists are a natural fit. By early October, Centers for Disease Control and Prevention (CDC) had documented cases of 2009 H1N1 influenza in 37 states, with death and hospitalization rates due to influenza higher than normal for that time of year; these statistics verified the need for careful H1N1 vaccination and treatment planning, including pharmacy planning.

President Obama's declaration of a national emergency on October 25, 2009, made it easier for state governments to implement efficient state and local vaccination and treatment programs. Pharmacists in all states were authorized to administer at least some vaccines to certain age groups, and to address the impending 2009 H1N1 influenza situation, several state boards of pharmacy and health departments authorized emergency rules, adopted new statutes, or permanently updated existing statutes to expand the authority of pharmacists administering influenza vaccines. Along with state health departments and boards of pharmacy, CDC encouraged pharmacists to assist in administering the 2009 H1N1 vaccine, as well as educate patients about the need for vaccination and the proper use of antiviral medications.

State Pharmacist Vaccination Policies Expand

Persons aged six months to 24 years were found to be among those most vulnerable to the 2009 H1N1 influenza virus and, thus, early on, CDC placed them on the list of persons recom-

(continued on page 2)

In This Issue . . .

The NABP Newsletter (ISSN 8756-4483) is published 10 times a year by the National Association of Boards of Pharmacy (NABP) to educate, to inform, and to communicate the objectives and programs of the Association and its 66 member boards of pharmacy to the profession and the public. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of NABP or any board unless expressly so stated. The subscription rate is $35 per year.

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Carmen A. Catizone
Executive Director/ Secretary

Larissa Doucette
Communications Manager

Pharmacists' Roles

(continued from page 1)

mended to receive the initial administrations of the H1N1 vaccine. In response, boards of pharmacy in some states offered pharmacists the opportunity to vaccinate more people in this age group by modifying statutes or passing emergency statutes.

- In September 2009, Texas amended the Texas Pharmacy Act to allow pharmacists to administer the H1N1 influenza vaccination to patients over seven years of age; to become an influenza vaccinator, pharmacists in Texas must obtain required training and a written protocol from a physician.
- In Minnesota, the 2009 legislature clarified that pharmacists may administer influenza vaccines to all eligible patients 10 years of age or older through December 31, 2009, and after that date they remain authorized to administer influenza vaccines if they enroll in the Vaccines for Children program.
- The North Carolina Board of Pharmacy, as the result of discussions with the state health director and medical boards, passed an emergency amendment to the pharmacist vaccination rule in October 2009. This amendment authorizes pharmacists in North Carolina to administer seasonal and H1N1 influenza vaccines to patients age 14 and older through July 2010. The emergency rule was directly related to the need for pediatric patients to receive the H1N1 vaccination and the need for pharmacists to aid in this vaccination effort.
- In June 2009, Maine became the 50th state to pass legislation allowing pharmacists to administer certain vaccinations. Maine law authorizes pharmacists to administer influenza vaccines to patients at least nine years old without a prescription, while certain other vaccines require a prescription. Thus, pharmacists in Maine were positioned appropriately to help protect many young people from 2009 H1N1 influenza.

Standing Orders

Some state health departments and boards of pharmacy made the vaccination process more efficient by authorizing pharmacists to administer the 2009 H1N1 vaccine to eligible patients under a "standing order" prescription process. In Louisiana, State Health Officer Jimmy Guidry allowed Louisiana Board of Pharmacy-certified pharmacists to administer the H1N1 influenza vaccine as long as they followed the established government protocol. This emergency order and protocol was extended on October 23, 2009, and remains effective through June 1, 2010.

Following the protocol detailed in a new collaborative drug therapy agreement (CDTA), pharmacists in Washington State will be authorized to prescribe antiviral medications if the local health officer determines this action necessary to respond to an influenza outbreak. The development of the CDTA was supported by CDC pandemic preparedness funds. If the protocol is put into effect, pharmacists will be authorized to evaluate patients using local public health guidelines to determine whether antivirals should be dispensed.

Various pharmacist associations, CDC, and the Association of State and Territorial Health Officials promoted the inclusion of pharmacies in states' 2009 H1N1 influenza immunization programs. At least 30 states included pharmacists in preregistration screening to become an H1N1 vaccine administrator according to a state-by-state list compiled jointly by the National Alliance of State Pharmacy Associations and Rx Response. As more vaccines were released and the demand for administering the vaccine grew, pharmacists were given an opportunity to increase patient access to the vaccine, thereby expanding their role in patient care.

States Take Action to Promote Efficiency

On October 29, 2009, New York Governor David Paterson issued an executive order declaring a state disaster emergency, an ac-

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Pharmacists' Roles

(continued from page 2)

tion that allowed additional personnel and flexibility to local governments implementing the statewide 2009 H1N1 influenza vaccination campaign. Under the state's existing law, only physicians, certified nurse practitioners, and nurses were authorized to administer vaccinations. Pharmacists and other health care professionals who chose to assist in the vaccine administration were required to complete training and worked under the direction of state and county health departments. The executive order authorized additional health care professionals, including pharmacists, to administer the 2009 H1N1 vaccine. Approximately 10 million New Yorkers fell into CDC's 2009 H1N1 vaccination priority groups, and the additional authorized vaccinators helped to meet the state's vaccination goals.

Other state boards of pharmacy also recently updated policies to increase efficiency in procedures enabling pharmacists to administer vaccines. In September 2009, the New Hampshire Board of Pharmacy adopted a new statute providing clear guidelines for regulating pharmacists' administration of influenza vaccines; by adopting clear guidelines for regulation, the Board aims to make vaccinations more easily accessible and to provide immunity to a larger patient population.

Specifically in response to the approaching influenza season and the threat posed by the H1N1 pandemic, the District of Columbia adopted an emergency rule aimed to eliminate the requirement for multiple protocols, thus, increasing the number of pharmacies participating in the vaccination efforts. Effective August 18 through December 18, 2009, the rule permitted District of Columbia Board of Pharmacy certified-pharmacists to administer immunizations and vaccinations, including the H1N1 vaccine, to people 18 years of age and older pursuant to one written protocol and standing order with one DC-licensed physician.

H1N1 Training for Pharmacists

All states require appropriate training for pharmacists wishing to administer vaccines, and in 2009 several states created additional pharmacist training specific to the 2009 H1N1 influenza pandemic. In October 2009, the state of Maryland provided a free course, "Influenza Pandemic Training for Pharmacists," through the University of Maryland School of Pharmacy, in conjunction with Montgomery County Department of Health and Human Services, Public Health Services, and the Public Health Emergency Preparedness and Response Program. The Massachusetts Department of Public Health offered free training for vaccine administrators, including pharmacists, throughout October. Training included information on initial target groups to receive H1N1 vaccine, screening, and immunization administration for children and adults.

Helping Pharmacists to Educate the Public

Just as state boards, health departments, and universities provided H1N1-related training to pharmacists, pharmacists were encouraged to become even more active in their role to educate the public.

Pharmacists in California, through the coordinated efforts of Federal Emergency Management Agency (FEMA) and the California Pharmacists Association (CPhA), were called upon to provide H1N1 information to patients as well as participate in the administration of vaccines, as their part in the Ready America campaign. The Ready America campaign urges the public to prepare emergency kits and make plans to cope with emergency disasters, and a CPhA press release notes that California "[p]harmacists and pharmacies [were] uniquely positioned at the center of the H1N1 crisis" expected in the fall, and that pharmacists were "swiftly preparing to participate in state-wide vaccination and dissemination of information."

Studies confirm the efficacy of pharmacists' educational efforts. For example, a study published in the *International Journal of Pharmacy Practice* by Grabenstein and colleagues in 1993 concluded that unvaccinated people encouraged by pharmacist mailings were 74% more likely to get vaccinated. Another study published in *Pharmacotherapy* in 2001, analyzed the results of 655 patients at high risk for influenza who were mailed educational materials and discovered that vaccination rates increased by 24% from the previous year when no mailings were sent.

The pharmacist's role as educator was lauded in an October 2009 CDC press release covering the 2009 Get Smart About Antibiotics Week. CDC stressed that pharmacists can help emphasize to patients that influenza viruses do not respond to antibiotic treatments, helping promote correct treatment of viral infections, as well as helping to curb the rate of antibiotic resistance. In the press release, CDC medical director for the Get Smart program emphasizes the important role of pharmacies in the promotion of appropriate antibiotic use, citing the pharmacists' knowledge and ability to have a positive influence on public health. CDC's ample information and updates for pharmacists, as well as its Web site and educational materials for

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Pharmacists' Roles

(continued from page 12)

the public, continue to assist pharmacists in these efforts.

Additionally, boards of pharmacy in Missouri, Nebraska, New Jersey, Maryland, and other states assist pharmacists by providing educational materials and external links on their board of pharmacy Web sites.

Pharmacists' Opportunity to Expand Patient Care

The opportunity for pharmacists to assist in the 2009 H1N1 vaccination campaign is one example of pharmacists beginning to realize the future vision of pharmacy practice that emphasizes patient care outlined in the Joint Commission of Pharmacy Practitioners Future Vision statement. In late September 2009, CDC declared, "The current [H1N1 influenza] situation will likely impact the nation's pharmacies as a greater number of people than usual seek to fill prescriptions for influenza antiviral drugs or antibiotics to treat secondary infections, in addition to seeking advice on over-the-counter flu medications." As the end of flu season approaches, pharmacists are expected to see continued opportunities for increasing patient care. State boards of pharmacy and health department efforts to update vaccination policies and provide training and educational materials assist pharmacists in fulfilling their roles as vaccinator and patient educator, spurring the patient care movement forward.

Practice of Timing

(continued from page 11)

number of prescriptions per day, and to prioritize their dispensing. For example, prescriptions for patients who wait in the pharmacy, or for patients who need medications more urgently than others, can be automatically prioritized.

Since workflow systems prioritize prescriptions for waiting customers over those with designated pick-up times, which are often arranged by phone, use of these systems may be helping pharmacy operators to meet customer expectations. According to Boehringer Ingelheim's 2008 Pharmacy Satisfaction Digest, of 34,454 patients surveyed by Wilson Health Information, LLC, 40% consider wait times very important, and 44% consider wait times important. 30% were highly satisfied and 56% were satisfied with pharmacy service in this area. The computer workflow system may be one tool that helped to generate these positive survey results. In fact, the same report also reveals that 63% of patients surveyed valued as very important the ability to call ahead in order to have prescriptions ready, and another 28% ranked this area as important. Further, in the same survey patients identified accurate and error-free prescription dispensing as one of their top concerns. The report indicates that 56% were highly satisfied and 41% were satisfied that their prescriptions were filled without errors.

In addition, workflow systems may assist pharmacies in meeting customer expectations regarding communication. Boehringer Ingelheim's 2006 "10 Steps to Customer Satisfaction," also based on a Wilson Health Information survey, highlights communication as step two, and suggests that communication about wait times is a primary customer concern. While the pharmacy's ability to fill prescriptions on time is critical for customer satisfaction, one pharmacist surveyed emphasized that most patients do not mind waiting longer for a prescription, but they do want to know how much extra time is needed and why. Since computer timer systems alert pharmacists if the promised dispensing time is exceeded, some advocates may perceive timers as a tool to let the pharmacist know when and what information to communicate to the customer.

Some pharmacies do not use timers, but do have a standard fill time in the interest of customer service and efficiency. Kaiser Permanente pharmacies, for example, have a standard of filling new prescriptions within 15 minutes, and expect that 80% of prescriptions meet that standard. The guideline can be used as a benchmark to alert Kaiser Permanente management of the need for improvements. For example, a pharmacy improvement team can work with management and staff to make recommendations for increasing efficiency, such as hiring more staff.

NABP will continue to monitor the issue and interested parties may submit relevant comments or information electronically to the NABP Executive Office at exec-office@nabp.net.

Testimony In Support of HB 2448
Reducing the Age Limit on Pharmacists' Immunizations
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

Respectfully Submitted:
Sam H. Boyajian RPh

February 8, 2009

Hello, my name is Sam Boyajian. I am the former chairman of Kansas Independent Pharmacy Service Corporation, and a career long member of Kansas Pharmacists Association. Thank you for letting me take the opportunity to stand in support of HB 2448. I believe this bill addresses not only a need but a requirement for our younger Kansans to get their valuable and necessary vaccines. Among other reasons I will cite, this is an issue of access to healthcare more than anything.

Pharmacist have had the legal ability to give vaccines for over 10 years now and have proven their worth in delivering adult vaccines yet our younger patients are having a more difficult time in getting their vaccines. As Dr. Cooley, well respected Topeka pediatrician, very astutely noted in the July 7, 2008 KMI, many doctors are not involved in vaccinating because of initial up front costs and low reimbursements. As of a year and a half ago, Kansas ranked in the bottom 7 states in the number of private physicians that offer vaccines. All this contributes to a lack of access for these valuable services, and an area where pharmacists can contribute greatly. Pharmacists are the most accessible healthcare professionals in our communities, and indeed, sometimes the only healthcare professional for miles. Lack of adequate vaccination venues, or difficulty getting into see the physician, results in lower immunization rates. Kansas, and KDHE, in particular, needs to be applauded at the improvements to early childhood vaccine rates in the 19-35 month range. The Immunize Kansas Kids program has been a great success. Pharmacists can help in achieving similar success with our older children. Kansas currently ranks 32nd in overall state rankings for vaccination rates. While I cannot say that this bill alone would place us in the top 5, it stands to reason with more vaccinators available, higher rates can be achieved.

On a personal level, I have had to turn away countless young patients whose parents were trying to get their child vaccinated, whether it is the 7 year old for the flu shot or the 17 year old graduating senior needing to get their meningococcal vaccine before going off to college. Often times these patients were referred to me by their physician, because they were either too overloaded with work and could not see the patient, or they did not carry the vaccine. I

have been asked to help administer the tetanus/diphtheria/pertussis and the H1N1 vaccine by my school district's nursing staff, because they were facing a huge daunting task of giving all their children these vaccines. I had to decline, when I would have been happy to help them get this done. Doctors and nurses are stretched so thin that they often times cannot administer these vaccines, yet we have pharmacists all over the state, ready willing and able to help, but can't. I am also registered as a volunteer with the Medical Reserve Corp. There were times when I had the opportunity to volunteer at H1N1 clinics but had to excuse myself because their main target at the time was children. Should we realize another resurgence in the spring of H1N1, or another Greensburg occurs, or another 9/11, public health groups will be scrambling for every possible volunteer to help. Some may say, an exception could be made on the age restriction at that time. This is true, however, no matter how well qualified, educated, and prepared pharmacists are, experience would prove invaluable at that time.

It is important to note that this bill in no way alters the presently accepted and proven procedures under which we currently practice. Pharmacists would still practice under the direction and strict protocol of their physician, they will continue to inform the patient's physician whenever a vaccine is given, and they of course would be bound, as any healthcare provider, to the strict rules of immunization practices, including stringent record keeping.

In conclusion, I believe it should be the goal of Kansas to be a national leader on the immunization front in keeping our children healthy. I strongly believe this is an important step towards that goal. I respectfully ask that you support HB 2448. Thank you.

I stand for questions.

Sam H. Boyajian RPh

Gardner, Ks

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Written Testimony re: HB 2448, Administration of Vaccines
House Health and Human Services Committee
Presented by Ronald R. Hein
on behalf of
Kansas Association of Chain Drugs Stores
February 8, 2010

Madam Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Association of Chain Drugs Stores (KACDS).

KACDS supports HB 2448.

Under current law pharmacists, pharmacy students and interns who are certified to immunize are currently permitted by statute to immunize patients eighteen years or older. The change being made in this bill is to lower the age of the patient to six for influenza vaccination and twelve for any vaccination. The pharmacists who would be giving the immunizations must have a current CPR certificate, and have been trained in vaccination storage, protocols, injection techniques, emergency procedures and record keeping.

KACDS further supports the amendment being offered by Board of Pharmacy which we understand is a clarification that if a student or intern is immunizing, they must be supervised by a pharmacist who is also certified to immunize.

Thank you very much for permitting me to submit this written testimony.

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 15-1

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
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TESTIMONY

House Health and Human Services Committee
February 8, 2010
HB 2448

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the committee regarding HB 2448.

The Kansas Association of Osteopathic Medicine (KAOM) is opposed to HB 2448.
Approximately eight years ago the Kansas Pharmacists Association was successful in amending K.S.A. 65-1635a to allow pharmacists to administer vaccines. At that time the KAOM as well as the Kansas State Nurses Association did not oppose the legislation because the Kansas Pharmacists Association agreed to limit the administration of vaccines to individuals 18 years and older. HB 2448 removes that prohibition and permits pharmacists to administer influenza vaccine to children as young as 6 years of age and any vaccine to individuals 12 years of age and older.

As was illustrated by the H1N1 flu epidemic, much concern was expressed regarding short and long term side effects as a result of vaccinating children with the H1N1 vaccine. KAOM members received numerous phone calls from concerned parents requesting information and advice regarding the H1N1 vaccine. And it isn't just the H1N1 vaccine. There has been a growing concern in this country regarding the vaccination of children. Only a physician is trained to determine if a child is a candidate for specific vaccinations.

Additionally, HB 2448 will disrupt the continuity of care for children. When a child is taken to a physician to receive a vaccine, it is an opportunity for the physician to evaluate the child's progress. Many KAOM members have stated the only time they see children is when they are go to the physician's office to receive a vaccination. An unintended consequence of HB 2448 will be fewer children routinely seen by physicians. That is not a good trend to be encouraging.

KAOM respectfully requests the Committee oppose HB 2448.

Thank you.

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 16-1

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Kansas Chapter

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TESTIMONY ON HB 2448

House Committee on Health and Human Services

February 8, 2010

The Kansas Chapter of the American Academy of Pediatrics represents over 90% of the practicing pediatricians in the state. The KAAP is providing testimony against the passage of HB 2448.

Immunizations are one of the best methods of preventative care that we can provide. Providing these immunizations, however, is not as straightforward as may seem from the schedules. Decisions that are made concerning the proper administration of immunizations can be confusing and difficult to make. These decisions require providers experienced in immunizations administration, usage and potential complications. They are best administered by providers functioning in the medical home who will be able to manage complications should these arise. In a medical home children can receive information, counseling, and follow up care in regards to immunizations. If a child is unable to receive immunizations from a health care provider the state of Kansas has an extensive public health system with clinics in each county that can provide these immunizations. Many of these clinics also can provide follow up care should it be needed.

Is there a need to have immunizations given by pharmacists during pandemics? We would argue that school vaccine clinics are the better way to administer vaccines to large numbers of children during these situations. Many communities successfully used such clinics during the recent H1N1 pandemic. Will having pharmacists provide immunizations to children improve our immunization rates? Certainly in previous years Kansas's immunization rates were some of the lowest in the country. But the most recent data shows Kansas is well above the national averages. This improvement was accomplished in a very short time thanks in large part from the efforts by KDHE and coalitions of interested parties including physicians and health departments. This improvement didn't require adding pharmacist to the list of vaccine providers.

In summary there doesn't appear to be any convincing reason to allow pharmacist to administer immunization to children and adolescents. We owe it to our children to provide the optimum health care we can and one of the ways to do this is to insure that immunization are given in the best setting possible. Thank you.

Submitted by

Dennis M Cooley MD, FAAP
President
Kansas Chapter American Academy of Pediatrics

HEALTH AND HUMAN SERVICES
DATE: 2-8-10
ATTACHMENT: 17-1

KANSAS MEDICAL SOCIETY
Established 1859

To: House Committee on Health & Human Services

From: Dan Morin
Director of Government Affairs

Date: February 8, 2010

Subject: HB 2448—Pharmacists administration of vaccine

The Kansas Medical Society appreciates the opportunity to appear today to comment on HB 2448 which would allow pharmacists, and pharmacy students under certain circumstances, in the State to deliver all vaccinations to children 12 years of age and older and influenza vaccinations only to those 6 years of age and older pursuant to a vaccination protocol with a physician. Current law allows vaccination delivery by a pharmacist for individuals 18 years of age and older pursuant to a vaccination protocol.

First, immunizations are obviously one of the most cost effective and vital health care services available to children in Kansas. But to maximize their effectiveness, immunizations for school-aged children should be coordinated through a "medical home" so that they may be provided on specific schedules and for specifically indicated reasons. The Kansas Legislature included the concept of the medical home in statute during the 2008 session. The goal of Senate Bill 81 was "to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner." Expanding the providers who are allowed to administer the childhood immunizations runs counter to that goal, because rather than creating a closely controlled and organized health plan, a disorganized and poorly coordinated result can occur. Immunizations for schoolchildren should be accessed through the medical home concept of care where proper care coordination, documentation and integration with other health care services can be assured.

The desire of pharmacists to increase the responsibilities of their profession is laudable and they are valuable members of the health care delivery team, however, their vaccination duties should focus on the pressing public policy challenges of our adult population. State law requires immunization as a condition of attending school or day care; however, no such institutional mandate exists for adults, apart from those in the military or certain colleges. According to a recent report published by the Infectious Diseases Society of America, the Robert Wood Johnson Foundation, and the Trust for America's Health, one third of adults aged 65 years and older have not been vaccinated against pneumonia and 30.5% have not been vaccinated against the seasonal influenza. The pneumococcal vaccination rate is 66.9% nationwide for seniors although the Centers for Disease Control and Prevention has a set goal of 90%. The nationwide immunization

rate for seniors against seasonal influenza is 69.5% while for 18-64 aged adults it's a paltry 36.1% according to the study.

The numbers are even more alarming for other immunizations:

- Human papillomavirus vaccine for eligible adult women (ages 18 - 64 years): 10%
- Shingles vaccine for patients aged 60 years and older: less than 2%
- Tetanus, diphtheria, and whooping cough vaccine for eligible adults (ages 18 - 64 years): 2.1%

In addition, the recent H1NI outbreak showed how difficult it is to maximize and efficiently immunize adults in a timely manner. Pharmacists can already enhance those efforts under current law. H1N1 immunization programs by Kansas school districts were outstanding and provided a preferred, and ideal, central location for vaccinating our children.

Thank you for the time and opportunity to comment on HB 2448. The Kansas Medical Society respectfully requests the committee not move the bill favorably.

KANSAS

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

House Health and Human Services Committee
February 8, 2010

HB 2577 – Licensure of Addiction Counselors

Disability & Behavioral Health Services
Ray Dalton, Deputy Secretary

For Additional Information Contact:
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KANSAS
DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

HB 2577 – Licensure of Addiction Counselors

House Health and Human Services
February 8, 2010

SRS supports HB 2577, which would make addictions counseling a licensed profession regulated by the Behavioral Sciences Regulatory Board (BSRB). Licensing of addiction counselors would align the profession with social workers, marriage and family therapists, psychologists and licensed professional counselors. Twenty-three states already professionally license addiction counselors.

The practice of addictions counseling was first developed by people in long term recovery who wanted to provide support and guidance to others seeking recovery from substance use disorders. In 1993, legislation was passed which formally recognized addictions counseling as a profession and minimum standards were established for counselors working in licensed alcohol and drug treatment facilities.

In Kansas, the minimum requirement to practice addictions counseling is an associate's degree with 27 credit hours in substance use disorders. Successful passage of this bill would elevate the minimum requirement of an addiction counselor to a bachelor's degree with a corresponding increase in the number of hours required in substance use disorder coursework, including coursework in the diagnosis of substance use disorders. This would allow addiction counselors to not only treat, but also diagnose clients that may be in need of services.

The ability to provide a diagnosis is required for many private and public funds that reimburse for treatment of substance use disorders. As the Wellstone-Domenici Mental Health Parity and Addictions Equity Act is implemented across private and public health plans, the demand for licensed addiction counselors will become paramount. Consumers of alcohol and drug services deserve the protection that only licensure provides through legally enforceable standards of conduct.

Licensing of other professions in Kansas occurred as the result of the increased need for higher quality professional services. Licensure for the addictions counseling profession is needed now to ensure that the highest quality of care possible is provided to Kansans needing substance use disorder services.

Licensure will provide a needed workforce development ladder in the field to ensure an adequate pool exists for the delivery of addictions counseling services and will support retention rates of the current workforce.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on House Bill 2577
Licensure of Addictions Counselors

Presented to
House Health and Human Services Committee

By
Marla Rhoden, Director, Health Occupations Credentialing
Kansas Department of Health and Environment

February 8, 2010

Chairwoman Landwehr and members of the committee, I am Marla Rhoden, Director of Health Occupations Credentialing for the Kansas Department of Health and Environment. Thank you for the opportunity to appear before the committee in support of House Bill 2577.

The Kansas Department of Health and Environment is responsible for the administration of the Kansas Health Occupations Credentialing Act, (HOCA) K.S.A. 65-5001 *et seq.*, the purpose of which is to review the public's need for a new health occupation to be credentialed in Kansas or for a change in the level of credentialing according to statutory criteria.

In 1991, addictions counselors, who were then referred to as alcohol and drug abuse counselors, sought a credentialing review in accordance with the HOCA. In 1992 legislation was passed establishing the level of credentialing at registration. In 2009 the group once again applied for a credentialing review to change the level of credentialing from registration to licensure. The technical review was completed in 2009, with the technical committee recommending licensure. Secretary Bremby concurred with that recommendation in his report to the Legislature. The provisions of this bill are consistent with the technical review.

Passage of this bill serves to demonstrate the successful processing of an application for a change in the level of credentialing under the law. The department asks that the legislature act favorably on this bill as the applicant group has thoroughly demonstrated the need and rationale under the legislature's criteria for the licensing of addictions counselors. I will now stand for questions.

BUREAU OF CHILD CARE AND HEALTH FACILITIES
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HOUSE TESTIMONY
HEALTH AND HUMAN SERVICES COMMITTEE
February 8, 2010

HB 2577

Madam Chair and Committee Members:

Thank you for the opportunity to testify today in support of HB 2577. I am Phyllis Gilmore the Executive Director of the Kansas Behavioral Sciences Regulatory Board (BSRB).

The BSRB is the licensing board for most of the state's mental health professionals; the licensed psychologists, the master level psychologists, the clinical psychotherapists, the bachelor, master and clinical level social workers, the master and clinical level professional counselors, and the master and clinical level marriage and family therapists. Additionally, some of the drug and alcohol counselors are registered with the board, although most of them are certified with SRS at the present time.

This bill would create tiered licensure for addiction counselors. The Board supports licensure of Addiction Counselors, as it would give increased regulatory oversight, including the opportunity for recourse by the consumer, which does not presently exist.

The BSRB is prepared to respond to the potential demand as it relates to the initial group of applicants for licensure as well as the ongoing licensure and regulatory processes. We believe this can be accomplished without any additional full time staff.

Thank you. I will be happy to stand for questions.

House Health and Human Services Committee
Testimony on House Bill 2577

February 8, 2010

Dear Chairwoman Landwehr and Members of the Committee

I am appearing today on behalf of the Kansas Association of Addiction Professionals. I will be followed by Barbara Burks and Win Smith who will discuss our support for House Bill 2577 in greater detail. You have their testimony.

House Bill 2577 asks this Committee to make several public policy decisions:

- Unify the substance abuse treatment system in Kansas
- Protect consumers and ensure appropriate oversight of the substance abuse treatment side of the public health system
- Ensure oversight of state and federal funds
- Do not create more government or increase costs to the state—will place addiction counselors under the Behavioral Sciences Regulatory Board
- House Bill 2577 is modeled after the exact same legislation used for marriage and family therapists, counselors, and social workers. We are not asking the Legislature to reinvent the wheel. House Bill 2577 uses the same structure and organization to transition or "grandfather" in the current field as was used for others in BSRB
- The main public policy choice you must make: We believe the public interest is best served in this bill by allowing licensed addiction counselors to offer a clinical diagnosis on the narrow range of "substance use disorders" as defined by the Diagnostic and Statistical Manual

Thank you for your time and I would be happy to answer questions at the appropriate time.

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House Health and Human Services Committee
Testimony in Support of House Bill 2577

February 8, 2010

Presented by

The Kansas Association of Addiction Professionals (KAAP)
Barbara Burks
Win Smith

Background

- 1970 - Alcohol Treatment Act was passed by the U.S. Congress and the first federal funding became available to states for programs to treat alcoholism
- 1970s First treatment programs established and self regulated
- 1992 – Kansas Legislature passed a registration law
- 1993 – SRS created its own standards for personnel working in alcohol/drug treatment programs (current SRS credential)
- Current system -- mix of three (registration, certification, credentialed)
- 2009 – KAAP submitted Kansas Department of Health and Environment (KDHE) application for addiction counselor licensure
  - Kansas Act on Credentialing requires KDHE Technical Review Committee hearings and final approval by KDHE Secretary

Who Are Addiction Counselors?

- Approx. 1500 credentialed alcohol/drug counselors
- Average age - 49
- 59% are female
- 80% have a bachelors degree
- 80% have worked 5 years or more in the field
- 60% have worked 10 years or more in the field

Kansas Addiction Workforce Survey, 2006

What Do Addiction Counselors Do?

- Screening and assessment
- Referral
- Treatment planning
- Counseling – individual, group, family
- Education
- Documentation
- Discharge planning

Where Do Addiction Counselors Practice?

- Social service agencies
  - Licensed substance abuse programs – residential & outpatient
  - Community mental health centers
  - Regional assessment centers (RADACs)
  - Prevention/education programs
  - Kansas Alcohol and Drug Safety Action Programs (ADSAP)
  - Social and Rehabilitation Services (SRS)
- Criminal justice settings
  - Prisons, detention facilities
  - Outpatient corrections programs
- Healthcare settings
  - Hospitals – inpatient & outpatient programs

Why is Addiction Counseling Unique?

- Recovery Focus
  - Historically, many addiction counselors entered the field as a result of their own personal recovery.
  - Today addiction counseling combines experiential knowledge, professional education and training, and evidence-based practices
- Specialized education and training
  - National standards - Substance Abuse and Mental Health Services Administration has developed national standards that identify the core competencies for addiction counselors
  - Psychopharmacology education is unique to addiction field
    - Education about drugs of abuse and drug interactions
    - Education about neurological, physiological, and psychological impact of drugs

Why Is Addiction Counseling Important?

- Prevalence of alcohol and drug abuse
- "Approximately 10% of Kansans (200,581 adults and 24,574 adolescents) are in need of addiction treatment."

  Kansas Comprehensive Substance Abuse Treatment Needs Assessment, DataCorp, 2006
- Unmet treatment needs of Kansans
- Vulnerability of our client population
  - Often intoxicated at the point of admission
  - Frequently disadvantaged--indigent, unemployed, homeless
  - Medically compromised
  - Recovery complicated by co-occurring mental health issues
  - Stigmatized

Why is House Bill 2577 Needed?

- Licensure would provide:
  - Improved consumer protection and confidence
  - Advancement of the field – parity with other behavioral health professionals
  - Attraction and retention of a professional workforce

Benefits of Licensure

- Improved Consumer Protection
  - Currently, consumers have minimal protection. SRS does not have staffing or mechanisms in place to investigate consumer complaints against individual counselors
  - Oversight by the Behavioral Sciences Regulatory Board would provide increased counselor accountability & investigation of consumer complaints
  - Licensing would define clear expectations for addiction counselor education/training, competency, and scope of practice

Benefits of Licensure

- Licensure would replace all existing credentials and set education, training, competency testing, supervision standards for all counselors
- HB 2577 uses the same structure and process as used for marriage and family therapists, social workers, and counselors
- HB 2577 would use existing regulatory agencies--Behavioral Sciences Regulatory Board

Current Credentialing

	KAAP	BSRB	SRS/APPS
Credential Estab.	1978	1993	1994
Title	Certified Alcoholism and Drug Counselor	Registered Alcohol and Other Drug Counselor	None* *("...eligible to practice alcohol and other drug counseling in a licensed alcohol and drug abuse treatment program in the State of Kansas.")*
Credential Designation	CADC I, II, or III	RAODAC	None*
Number	304	59	approx. 1500
Consumer Protection	Limited to KAAP credentialed counselors	Limited to registered counselors	None

Benefits of Licensure

- Current workforce "swept in"
  - Same as implemented for marriage and family therapists, social workers, and counselors
- Attraction and retention of a professional workforce
  - Opportunity for addiction counselors to have parity with other behavioral health professionals
- Other professions not affected – our scope of practice limited to diagnosis and treatment of substance use disorders
- Other BRSB professions are not impacted. Continue practice as currently allowed

Other States - Licensing

- All states regulate addiction counseling
- 23 states have enacted licensure
  - All use the same SAMHSA core competency framework used for the Kansas addiction counseling program curriculum
  - All have given licensed addiction counselors the authority to diagnose substance use disorders
  - All have given licensed addiction counselor the authority to provide all modalities of treatment and to supervise other addiction counselors, trainees, and students

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House Bill 2577 Proposal

- Modeled after licensure bills for marriage and family therapists, professional counselors and social workers
- Two levels of licensed addiction counselors
  - Licensed Addiction Counselor (LAC)
  - Licensed Clinical Addiction Counselor (LCAC)
- Both levels would have the authority to diagnose and treat substance use disorders only
- Only LCAC (second level) would be able to practice independently (without an SRS program license)

New Licensed Addiction Counselor (LAC)

1. Baccalaureate degree in a social services field
   (including completion of required addiction coursework supporting diagnosis and treatment of substance use disorders)
2. Passing score on national addiction counselor exam
3. Evidence of meriting public trust
4. Application/fees

* Option for BSRB-licensed master level professionals to test out to obtain addiction counselor license (LAC)

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New Licensed Clinical Addiction Counselors (LCAC)

1. Masters or doctorate degree in a social services field (including completion of required addiction coursework supporting diagnosis and treatment of substance use disorders)
2. Post-graduate supervised professional experience
3. Passing score on national addiction counselor exam
4. Evidence of meriting public trust
5. Application/fees

LAC "Grandfathering"

- Licensed Addiction Counselor (LAC)
  1. AAPS or KAAP credential
  - Proof of competency
    - Documentation of professional A&D work experience

      OR

    - Documentation of passing score on national addiction counselor examination

      AND

    - Documentation of completion required continuing education units in diagnosis of substance use disorders
  1. Application/fees

LCAC "Grandfathering"

- Licensed Clinical Addiction Counselor (LCAC)
  1. AAPS or KAAP credential
  2. BSRB license at clinical level
  - Proof of competency
    - Documentation of professional alcohol and drug work experience

      OR
    - Documentation of passing score on national addiction counselor examination

      AND
    - Documentation of completion required continuing education units in diagnosis of substance use disorders
  1. Application/fee

Conclusion

- Questions?

VALUEOPTIONS
KANSAS

Testimony to the House Committee on Health and Human Services
From
Myron Unruh, Executive CEO-ValueOptions – Kansas
In Support of Behavioral Sciences Review Board Licensing for Kansas
Substance Abuse Treatment Providers
Monday, February 8, 2010 at 1:30 p.m.

Hello. My name is Myron Unruh. I am the Executive Director for Value Options – Kansas, the company that manages the substance abuse contract for the State of Kansas through Kansas Social and Rehabilitation Services. On behalf of ValueOptions – Kansas, I am here to express support for the Kansas Association of Addiction Professionals in their pursuit of Addiction Counselor Licensure.

The 2006 Kansas Comprehensive Needs Assessment estimated that approximately 10% of Kansans are in need of substance abuse treatment, including over 200,000 adults and over 24,000 adolescents. These numbers offer a clear indication of the necessity for the ultimate quality and professionalism possible among substance abuse treatment providers.

Substance abuse treatment is now being recognized on the national level as having parity with other healing professions. Professional licensure is the next logical step towards true equality in high quality client treatment, protection and confidence.

In Kansas, licensing and regulation will be supported by Substance Abuse and Mental Health Administration (SAMHSA) standards as well as ten Kansas institutions of higher education that provide training in those standards. Kansas also offers the Kansas Addiction Educators Alliance which practices peer review to ensure quality and consistency in curriculum, and adherence to national competency requirements in all educational institutions providing substance abuse treatment education.

Though raising substance abuse treatment providers to the same professional level as other providers in the behavioral sciences field is compelling enough reason to consider having them licensed with the BSRB, there is another, more systemic reason for doing so.

Since 1993, the Department of Social and Rehabilitation Services has credentialed addiction counselors working within licensed treatment facilities. This credentialing process focuses on assuring that individuals providing treatment services have minimum educational requirements needed to work in the field. Professional licensing is needed to ensure that these individuals can be held accountable to provide quality, professional services.

In short, having the Behavioral Sciences Regulatory Board administer the licensing and regulation of substance abuse treatment providers would:

- enhance consistency in the practice of substance abuse treatment,
- increase the possibility of collaboration among health professions and offer the availability of different payer mixes to assist consumers in getting the help they need

ValueOptions – Kansas urges the state to consider offering Addiction Counselor Licensure to Kansas substance abuse treatment professionals.

Myron Unruh
CEO
ValueOptions-Kansas
Phone (785) 338-9051 Fax (785) 338-9020

Kansas Chapter
National Association of Social Workers
...the power of social work...

February 8, 2010
House Health and Human Services
HB 2577 Opposition to Addictions Counselors Licensure Legislation

Good afternoon. I am Terry Humphrey representing the Kansas Chapter, National Association of Social Workers. I appreciate the opportunity to speak with you today and discuss KNASW's opposition to HB 2577.

To begin, I want to let you know that social workers are the largest group of mental health professionals in the state. Over 6,000 social workers are providing mental health services in most Kansas communities. Social workers provide services in child welfare, aging, juvenile justice, schools, community programs, substance abuse treatment and many other fields of practice.

KNASW opposes HB 2577 in its present form. We have discussed our concerns with the advocates of the bill and proposed amendments to fix the bill. Regrettably, at this time they have not embraced our solutions.

Concern One:
If HB 2577 becomes law, you will expand addictions counselors scope of services to permit diagnosis and treatment which is currently prohibited. This new licensure will seriously lower professional standards and the quality of care for persons seeking mental health services for substance abuse. The provisions in HB 2577 are unprecedented and far-reaching because it would permit bachelor trained persons to diagnose and treat individuals with a substance abuse disorder.

Consider the following points as sound reasons for saying no to this request:

1. No other mental health care provider is permitted to diagnose and treat clients with a bachelor degree education. The training and skills at this level are simply inadequate.
2. The bill grandfathers licensure to about 1500 addiction counselors. These counselors have an Addictions and Preventions Services certificate (AAPS) issued by SRS, some will not have a bachelor's level of education.
3. Diagnosis and treatment is serious business. This authority, in the wrong hands, could lead to an incorrect diagnosis and a permanent scar on an individual's health care record.
4. The bill purports to limit addiction counselors to the diagnosis and treatment of only substance abuse disorders. However, this ignores the fact that in about half of the cases, there is an underlying mental condition such as depression, mood, or anxiety disorders that need attention.
5. Historically, the standard of care for diagnosis and treatment decisions rests with highly educated and trained masters or doctoral clinicians and physicians for the purpose of protecting the public.
6. If you permit individuals with a bachelor degree or less to diagnose and treat, you will have opened the flood gates for similarly educated health care workers to demand the same authority.

Concern Two:
HB 2577 proposes to add another professional member to the Behavioral Sciences Regulatory Board (BSRB) going from 11 members to 12. Adding a member to the BSRB will increase costs unnecessarily, at a time when certain fees are in the process of being doubled to meet BSRB's budget needs.

If this bill should advance, rather than adding another person to the board, please consider a no-cost solution. Currently, the BSRB has four public members. This is approximately two more public members then any other health care regulatory board.
This fact presents an opportunity:

- Take one public position and reassign it to a clinical addictions counselor.
- Take the second public position and reassign it to a licensed specialist clinical social worker.

Currently the BSRB has only two social workers serving on an eleven member board. Yet, social workers comprise 70% of the mental health care licensees. Having three social workers on the board will better support the duties of the board. Right now the board does not have a position specifically designated to be a Licensed Specialist Clinical Social Worker (LSCSW) which is the highest level of education, skill, and licensure within the profession. These reassignments will create a win-win at no additional cost.

To assist you in your decisions, I have attached four visuals to illustrate the other regulatory boards number of public members and the current distribution and the projected distribution of licensees to professional representation on the BSRB board.

A final comment is that KNASW is well aware of the great need for substance abuse treatment. Persons in the substance abuse field work in and collaborate with the criminal justice systems, prevention and education programs, assessment centers, licensed drug treatment facilities and Kansas Alcohol and Drug Safety Action Programs. We commend the people who do the work.

In closing, on behalf of KNASW, I respectfully request that you oppose HB 2577 unless the attached amendments are adopted to correct the deficiencies in the bill. Thank you

SOLUTIONS for HB 2577

KNASW proposes language to address our concerns. We would be happy to work with the reviser's office to transfer them into the appropriate format for the committee.

On New Section 2 (page 1)

Modify lines 21—23 to read:

[This language is the current definition in KSA 65-6601]

"Addiction counseling" means the utilization of special skills to assist persons with alcoholism or other drug addictions, and to assist such persons families and friends, to achieve resolution of alcoholism or other drug addiction through the exploration of the disease and its ramifications, the examination of attitudes and feelings, the consideration of alternative solutions and decision making, as these relate specifically to the alcoholism or other addiction. Evaluation and assessment, treatment plan development, case management, crisis intervention, referral, recordkeeping and clinical consultation specifically related to the alcoholism or other addiction are within the scope of addictions counseling."

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Modify lines 24-31 to read:

[The modification deletes "diagnosis and treatment" from the definition of this level of licensure]

"Licensed Addiction Counselor" means a person who engages in the practice of addictions counseling limited to substance abuse disorders and who is licensed under this act, except that on and after July 1, 2011, such person shall engage in the practice of addiction counseling only in state-licensed or certified alcohol and other drug treatment program under the direction of a person licensed by the behavioral sciences regulatory board at the clinical or doctoral level or a person licensed to practice medicine and surgery."

On Section 16 (page 12)

Modify line 31—change the "12" back to "11"

Modify lines 33—34 to read:

"...three members of the board shall be licensed to engage in the practice of social work with at least one of the three a licensed specialist clinical social worker..."

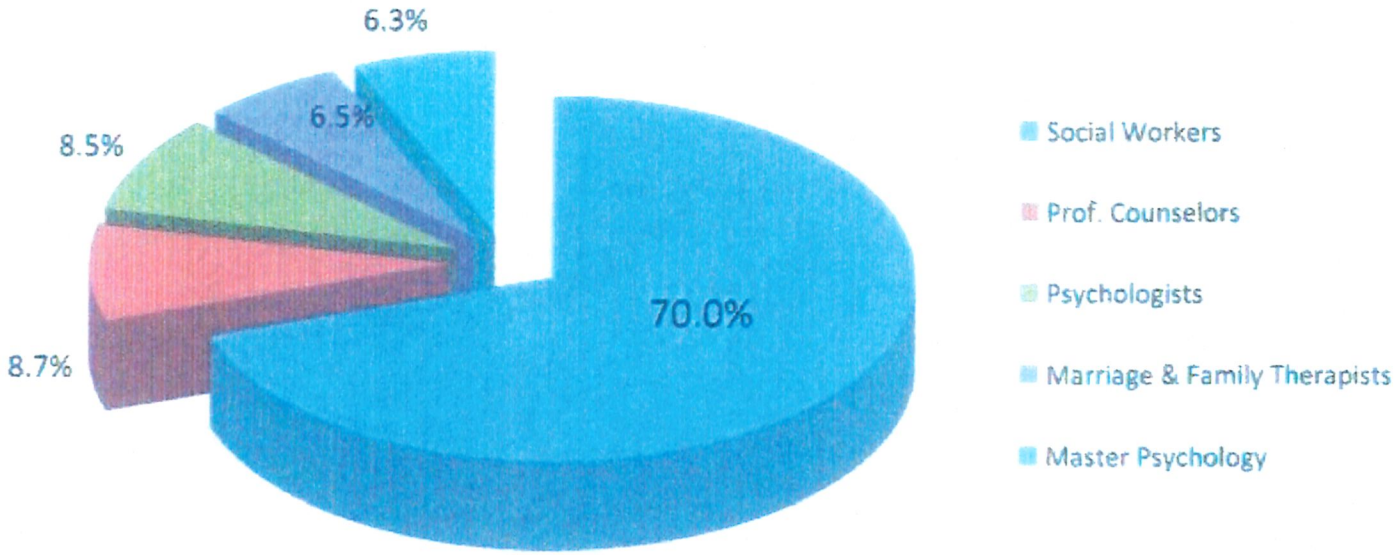
Modify lines 38—40 to read:

"...one member of the board shall be a licensed clinical addiction counselor: and two members of the board shall be from and represent the general public."

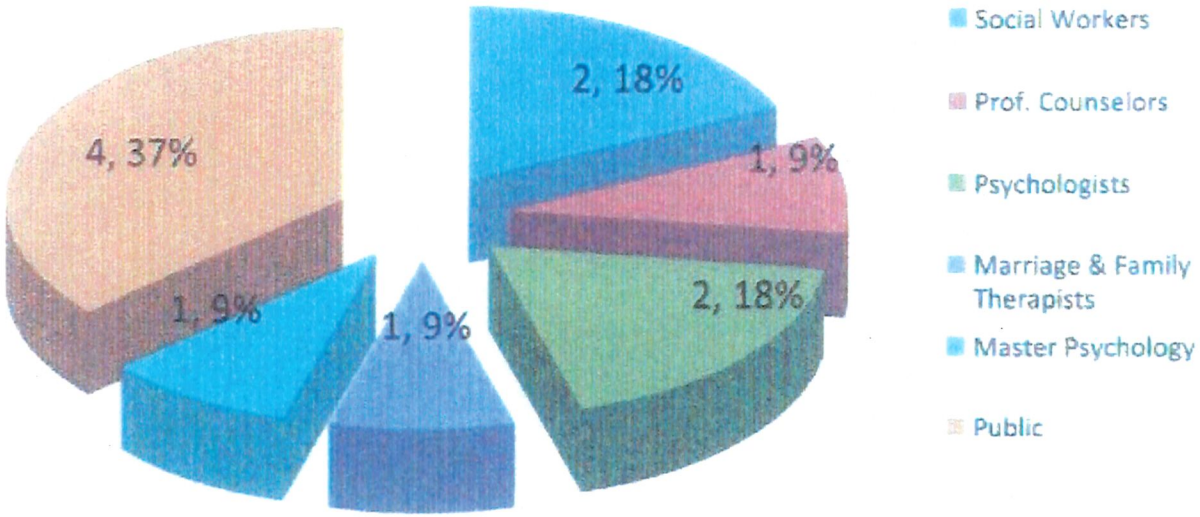
Kansas Regulatory Boards Professional and Public Member Distribution

Board	Number of Professional Members	Number of Public Members	Total Number of Members
Board of Pharmacy	6	1	7
Board of Healing Arts	13	2	15
Board of Examiners in Optometry	5	1	6
Board of Nursing	8	3	11
Dental Board	8	1	9
Board of Mortuary Arts	3	2	5
Board of Accountancy	6	1	7
Board of Cosmetology	5	2	7
Board of Technical Professionals	11	2	13
Board of Veterinary Examiners	7	1	8
Behavior Sciences and Regulatory Board	7	4	11

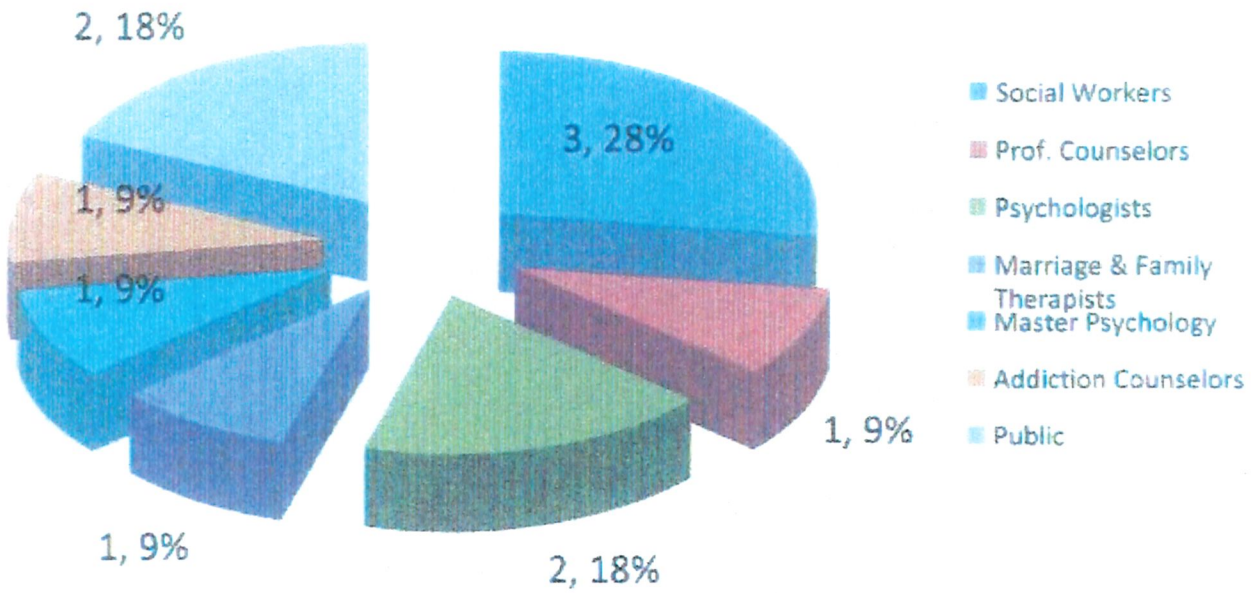
Kansas Chapter
National Association of Social Workers
Current Number of Licensees by Profession
Percent to Total



Kansas Chapter
National Association of Social Workers
Current BSRB Board Members By Profession and and Public Number on Board
Percent to Total



Kansas Chapter
National Association of Social Workers
Adding a Licensed Specialist Clinical Social Worker to the BSRB
Number of Professional Members to Percent of Representation



February 8, 2010

House Health and Human Services
Opposing HOUSE BILL 2577 Addictions Counselor Licensure

Good afternoon. My name is Janace Maynard. Thank you for allowing me to speak and address you on HB 2577. I am a Licensed Specialist Clinical Social Worker, receiving that license in 1996. I also have been AAPS certified since 1991. I chose my social work career to be in mental health and substance abuse and I have been in that area of practice since 1990. I completed a 6 month internship through Mercy Alcohol & Drug Recovery Program after obtaining a Bachelor of Science with a Major of Social Work from Iowa State University. I obtained a Master of Social Work from the University of Kansas, on the clinical tract which included a course on psychopathology. I served a one year internship at the Menninger Community Service Office, which included a weekly course on diagnostic criteria and weekly case presentations on diagnoses and treatment. I received two years of clinical supervision while employed at Wyandot Mental Health & Johnson County Mental Health Center and I continue to obtain 6 hrs of continuing education every 2 years regarding diagnosis & treatment. Most recently I worked as an independent contractor / consultant providing clinical oversight of AAPS certified individuals specifically regarding diagnosing substance abuse disorders.

I am here to urge you not to support this bill. I am deeply concerned regarding the broad scope of proposed licensure. From my professional experience reviewing the actual work of current AAPS certified individuals, they did not appear qualified to diagnosis. Specifically, individuals with a bachelor degree or less did not appear to have the education / experience resulting in the clinical judgment, skill, and expertise necessary to diagnosis. The following are some of the problems I encountered. Any specific examples are either a generic composite or have been altered to protect client confidentiality.

Problems encountered

- Incorrect identification of primary substance abuse diagnosis
- Incorrect classification of substances
- Lack of documentation of criteria in support of diagnosis
- Erroneous criteria

Ramifications of inaccurate diagnosis

- Inaccurate treatment plan
- Effect on client
- Medical record
- Potential future implications, i.e. employment, military service, life / medical insurance

Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM)

- What the book says – "who should and should not " utilize the DSM
- Sectioning off an integrated / interactive manual based on differential diagnosing – difficulty of "carving out" substance abuse disorders from the rest of the manual
- Difficulty addressing co morbidity / dual-diagnosis – the chicken vs. the egg dilemma and tendency to "over" diagnosis

Thank you for your time and again, I urge you to not support House Bill 2577. I will be happy to respond to questions.