Approved: 3-22-93
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 9, 1993 in Room 526-S of the Capitol.

All members were present except: Senator Lee, Excused

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Donna Bales, Executive Director, Association of Kansas Hospices, Wichita
Sandy Kuhlman, President, Association of Kansas Hospices and Director, Hospice Service, Phillipsburg
John G. Carney, President, Hospice Inc., Wichita
Greg L. Reser, Medical Facilities Certification Administrator, Kansas Department of Health and Environment
Patsy L. Johnson, R.N., M.N., Executive Administrator, Kansas State Board of Nursing
Canda Byrne, Advanced Registered Nurse Practitioner, Kansas State Nurses Association
Joseph P. Conroy, Kansas Association of Nurse Anesthetists, Emporia
Jane Anne Conroy, Kansas Alliance of Advanced Registered Nurse Practitioners, Emporia
Terri Roberts, Executive Director, Kansas State Nurses Association

Others attending: See attached list

Hearing on **SB 397** - Hospice licensure act.

Staff briefed the Committee on **SB 397** which would authorize the Secretary of the Kansas Department of Health and Environment to implement a licensure program for hospices. Appearing in support of the bill was Donna Bales, Association of Kansas Hospices, who gave the history of the hospice association which began in 1981 with 13 members and grew to 30 hospices in all but 8 counties in Kansas today. Ms. Bales stated the bill is a result of input from hospice and community leaders from throughout Kansas that reflects the highest level of hospice care and assures the uniformity and continuity of hospice patients and their families in Kansas. (Attachment 1) It was pointed out during Committee discussion that this type of licensure and certification could result in an adverse cost impact, and a concern about the quality of care patients are receiving.

Sandy Kuhlman, Association of Kansas Hospices, appeared before the Committee and submitted written testimony in support of hospice licensure. Ms. Kuhlman stated that licensure would insure that standards and principles of care are consistently applied in every setting and that quality care would be provided by every organization in the community that calls itself "hospice". (Attachment 2) In answer to a member's question, Ms. Kuhlman stated one of their concerns is comprehensive hospice care, and components such as nursing, social work and management could not be provided by untrained volunteers. She also indicated she was not aware of the state's credentialing process.

John G. Carney, Hospice Inc., appeared in support of the hospice bill and stated in 1992, a total of 675 patients received nearly 50,000 days of care from the hospice team of professionals and trained volunteers, and that nearly nine out of ten of those patients died in the patients' home or nursing home from cancer, AIDS, lung or heart disease, and that licensure would serve to recognize the viability of hospice on the health care continuum. (Attachment 3) In answer to a member's question in regard to what more could be done to improve the good work that hospices are now doing, Mr. Carney stated it was to specifically insure standards of quality.

Greg L. Reser, KDHE, provided informational testimony on **SB 397** and the role the department would have if the bill becomes law. Section 6 of the bill gives the Secretary of Health and Environment authority to adopt rules and regulations to carry out the provisions of this act, and the Secretary may fix, charge and collect license fees

and license renewal fees as may be necessary to cover the expenses incurred in administering the act. In regard to the fiscal impact of the bill, one administrative position and state funds for on site surveys would be required since licensure of hospices would reduce the federal portion of funding now received through Title XVIII (Medicare). (Attachment 4) There were no opponents that testified on **SB 397** .

Hearing on **HB 2072** - Licensure of nurses.

Patsy L. Johnson, KSBN, appeared in support of **HB 2072** and gave a summary of the changes that have been proposed in the bill. Many of the changes are from the review that was done by the Legislative Rules and Regulations Committee, -- limiting the number of times the licensure examination could be taken was a result of a change in testing on a national level. New language had been added in several different statutes to clarify what is in practice and has been interpreted to be legal. Ms. Johnson also submitted a balloon of the bill with additional proposed amendments in regard to the required continuing education hours for the advanced registered nurse practitioner's specialty and the proper proceedings against any person in violation of any of the provisions of the act. (Attachment 5)

Canda Byrne, KSNA, appeared in support of **HB 2072** with the exception of Section 7 as being unnecessary, and asked the Committee to delete the language on lines 9-26, shown on the balloon of the bill. Ms. Byrne stated the position of KSNA is that the CE requirement for ARNP's should be self-determined, and thirty hours of continuing education are already required to maintain licensure status. There is no such requirements dictating CE content for RN's, and therefore, they cannot support this policy for ARNP's. She further stated that disciplining ARNP's for incompetency has not been an issue for the Board of Nursing. (Attachment 6)

Joseph P. Conroy, KANA, appeared in opposition to Section 6 of **HB 2072** where KSA 65-1132 is amended to allow the Board of Nursing to establish requirements for programs of continuing education for advanced registered nurse practitioners. The Board may require certain categories of ARNP's to obtain a minimum number of continuing education hours in pharmacology. (Attachment 7)

Jane Conroy, KAANP, appeared in support of **HB 2072** and Section 6 of the bill. She stated KAANP is in total support of a minimum of six hours of pharmacology in the practitioner's specialty area for those advanced registered nurse practitioners writing prescriptions under protocol. (Attachment 8)

Hearing on **HB 2073** - Licensure of nurses and mental health technicians, discipline.

Patsy L. Johnson, KSBN, appeared in support of **HB 2073** in which the grounds for disciplinary action have been updated for all Board of Nursing licensees. The disciplinary section for registered nurse anesthetists has been moved into KSA 65-1120(a). Written testimony outlined different sections of the bill that were amended by the House. (Attachment 9)

Terri Roberts, KSNA, appeared in support of **HB 2073** especially public and private censorship for licensees who violate the Nurse Practice Act and changes on page 1 relating to redefining areas for discipline, including the addition of adding misdemeanor convictions involving illegal drug offenses and an expanded definition of "mentally incompetent." Ms. Roberts submitted a balloon of the bill with proposed changes - one change would recommend two additional RNs to the Board of Nursing. (Attachment 10)

The Chair appointed a subcommittee to review **HB 2072 and HB 2073** and report back to the Committee with Senator Hardenburger as Chair, and Senators Jones and Ramirez as members.

The meeting was adjourned at 11:00 A.M.

The next meeting is scheduled for March 10, 1993.

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 3-9-93

NAME	ADDRESS	COMPANY/ORGANIZATION
Jane Gilgun	LSOB Topeka	KSBN
Pat Johnson	" "	"
Mary Holloway	LSOB Topeka	KSBN
Kay Conway	Topeka	MHA
Kathy Faulkenberry	Topeka	MAC
Patricia David	Wichita	Kansas League for Nurs.
Carla Byrne	Topeka	KSNA
Joan M. Jenny	Topeka	KONE
Jane Conroy	Emporia	Ks Alliance Advanced Nurse Practitioners
Joseph P. Conroy	Emporia	Ks Assoc Nurse Anesth.
Amy Intfield	Manhattan	Intern
John S. Hamlish	Topeka	Ks. Hospice
Karen Wachter	Topeka	Topeka Hospice
John Carney	Wichita	Hospice Inc / Assoc of KS Hospices
Sandy Kuldman	Phillipsburg	Hospice Services + AKH
Donna Bales	Wichita	Assoc. of Ks. Hospices
Danielle Kee	Wichita	Wichita Hosp Assoc.
Tom Bell	Topeka	Ks. Hosp Assn.
Pat Johnson	Topeka	Bd of Nurs
Terri Roberts		
Linda Luberda	Lawrence	KS Home Care Assoc
Greg Lee	Topeka	KDHE
Barbara Riehm	Topeka	KAOM

GUEST LIST

COMMITTEE: SENATE PUBLIC HEALTH AND WELFARE DATE: 3-9-93

NAME	ADDRESS	COMPANY/ORGANIZATION
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
Lynda Dunn	Topeka	KDOA
Sharon Duffman	"	KCDC
Karen White	Topeka	SRS - Medical Services
Chip Wheelen	Topeka	Ks Medical Soc
Esther L. Decker	Wichita Ks	~~155~~ Friends of Hospice

TESTIMONY IN SUPPORT OF S.B. 397: HOSPICE LICENSURE.

MARCH 9, 1993

DONNA BALES
EXECUTIVE DIRECTOR, ASSOCIATION OF KANSAS HOSPICES
313 S. MARKET
WICHITA, KANSAS 67201-3395

I am Donna Bales, Executive Director of the Association of Kansas Hospices (AKH). I have served in this position since March, 1990. I come before this committee to testify in support of Senate Bill 397.

The Association of Kansas Hospices began in 1981 with 13 member hospices. Today over 30 hospices provide hospice care to all but 8 counties in Kansas. During the previous 12 months, hospice in Kansas has served over 3,000 patients and their families. Hospice in Kansas is recognized as the leader in comprehensive care of terminally ill patients, pain management and symptom control.

I have felt the benefits of hospice care. A year ago, I became the primary caregiver to my sister while she was a hospice patient. She had chosen to remain at home rather than spend her time in a hospital. We cared for her as a family. My two young children became important contributors to her care. With the help of the hospice team, the nurse, social worker, home health aides and volunteers, we were able to provide the care and love my sister needed and deserved. We had the security of knowing that we could call upon hospice 24 hours a day. We also knew that the care and support of hospice would not exhaust our family's financial resources.

But, in my position of Executive Director of AKH, I have also sometimes observed a lack of uniformity and continuity in hospice. An eighty year old woman was terminally ill with cancer. Her husband was in failing health, but was determined to care for his wife as best he could. They had chosen to remain in their own home and had asked for and were receiving hospice care. Their son, seeing his mother decline and his father's struggles, encouraged his parents to come and live with him, some 85 miles away. The couple's hospice social worker offered to help the them make the transition to their son's home and a new hospice. Their son had told his parents that hospice care would be available to them after

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their move. He had been told hospice care was available in his community. The social worker called me to find out how to contact the hospice in the son's area. We discovered that two organizations identified themselves as providers of hospice care in the son's area. While contacting both to get information and make the referral, we found that one would provide nothing more than a hospital bed. The other could probably get someone to come and visit a few times a month.

This couple had elected hospice. They had regular visits from a nurse. A home health aide assisted the patient and her husband with hygiene and nutrition, as well as many daily living tasks. Their social worker assisted them as together, in their own way, they faced the process of dying. Pastoral and volunteer support had been readily available to the couple.

What was called hospice in their son's town had no resemblance to the comprehensive hospice care the couple had been receiving in their home.

In another case, a hospice nurse moved to a new community and called the local hospice offering her assistance as a volunteer.She was asked to visit a hospice patient. She found that the patient had many needs requiring immediate attention. She called the hospice office, but was denied the support and assistance her patient required. This nurse felt entirely alone in offering services to her patient. What she did for her dying patient was courageous. What was promoted as hospice was not hospice care.

In April, 1991, twenty-five hospice leaders from throughout Kansas met in Salina to envision and plan the future of hospice care in Kansas. For the next year, AKH members involved themselves in developing principles and standards for providing hospice. The membership gathered in regional meetings. Each hospice completed a self-assessment. Community input was gathered and integrated into the final version of AKH's standards and principles. In May, 1992, the membership of the Association of Kansas Hospices adopted "Principles and Standards of Hospice Care for the State of Kansas". (See Attachment, Monograph 2.) The Principles and Standards were designed and adopted to reflect the quality of care the majority of Kansas hospices were committed to provide to their patients and families. At the sametime, they represented voluntary guidelines for the development and maintenance of the highest level of hospice care.

During the development and adoption of AKH's Principles and Standards, it became evident that a majority of member hospices supported hospice licensure. In October, 1992, AKH

committed itself to determine the level of support throughout the state for hospice licensure. Twenty-two hospices enthusiastically supported licensure. Eighteen of these from rural areas, joined in support for licensure with hospices from Wichita, Topeka, Kansas City and Olathe. The following month, the membership committed itself to seeking licensure (see Attachment, Monograph 3) based on the Principles and Standards adopted the previous Spring.

Senate Bill 397 before you today, reflects the Principles and Standards for maintaining the highest level of hospice care. S.B. 397 assures the uniformity and continuity of hospice patients and their families throughout Kansas. S.B. 397 reflects AKH's commitment to cost effective care of terminally ill patients. Senate Bill 397 has broad and enthusiastic support among our membership, health care providers, patient families and community leaders who respect the important contributions of hospice.

On behalf of our patients and their families, I ask for your support of Senate Bill 397.

I wish to thank each of you for your kind attention.

TO: Kansas Senate

FROM: Sandy Kuhlman
President, Association of Kansas Hospices
Hospice Director, Hospice Services, Inc.
P.O. Box 116 1150 State Street
Phillipsburg, KS 67661

RE: Hospice Licensure Act
Senate Bill 397

Thank you for this opportunity to testify in support of Hospice licensure. I believe Senate Bill 397 must be enacted. This act would define comprehensive hospice care and insure minimum standards of quality hospice care! I will share from two different perspectives: 1) as President of the state association and 2) as the Director of a rural hospice in northwest Kansas.

The terminally ill and their families across Kansas are struggling to cope with loss and terminal illness. They need pain control, symptom management, and terminal care. They must be able to chose Hospice care based on "Informed Consent." Consumers need assurance and protection that:

1) hospice services are comprehensive and coordinated
2) hospice personnel must be prepared and trained
3) hospice care is continuous across all settings
4) hospice volunteer and bereavement components (key to hospice and not defined in other health care) are of a certain quality.

These families are vulnerable -- and need definitions and standards to consider when seeking hospice care. Terminally ill Kansans deserve at least this quality of care.

Several issues and impacts which I wish to address include:

1) the mission of hospice
2) consumer protection
3) the urgency of the issue
4) term protection.

The mission of Hospice Services (Phillipsburg) is to provide physical, spiritual, emotional, and social support to enable people to live with hope and dignity while coping with loss and terminal illness. For over a decade hospices existed in Kansas to offer care to the terminally ill and their families. Hospice programs have emerged to become an integral part of the health care system. It is urgent that hospice, like all health care, work to insure professional quality care to every patient!

Licensure insures that standards and principles of care are consistently applied in every setting and aids the public to be sure that quality care is provided by every organization in the community that calls itself "hospice." Hospices must be accountable to the communities they serve.

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Licensure will assist Hospice in securing its place in the health care system. Hospice is not yet a familiar term to the general public. In a recent Gallup Poll, nine out of ten Americans say they would prefer to be cared for and die either in their own home or a family member's home if they were facing a terminal illness. At the same time, the survey revealed some unfamiliarity with the term Hospice...(only) slightly over one-fifth of the people who had high interest in the described services did not opt for hospice when asked to choose "by name."

Hospices across Kansas met in April 1991 to plan for the future. The three goals set were: 1) To establish statewide standards and licensure of hospice services by 1996; 2) To offer wider hospice coverage across the state -- encompassing 80% of our geographic area by 1996; and 3) To better educate the public and professional communities of Kansas regarding hospice. The membership of the state association has significantly grown in number and quality of services offered. AKH has sponsored many educational events. Mailings and materials have become more in number -- in addition to other references becoming available through AKH. As hospices continue to increase in number and services offered, the issue of meeting is urgent and imperative to address now. Hospice must be accountable, especially during this period of development. The state association is committed to assist members in seeking to meet the requirements of licensure.

Families served by Hospice cherish the term and appreciate the services offered. This is documented by the positive evaluations/surveys received from families. We must protect the term and what it stands for. Hospice is coordinated, comprehensive care for the terminally ill and their families! The term should NOT be used for any other than that definition.

There is a separate issue related to reimbursement. Hospice is a "benefit" under Medicare, Medicaid, and certain commercial insurances if a hospice chooses to seek that certification. This is cost-effective -- and a significant benefit to patients (especially covering certain charges NOT covered otherwise).

This affirmation of hospice will continue to increase the support and enthusiasm of those involved in providing hospice care across Kansas. As more people are offered more services, the "spirit" of Hospice (of the Hospice Wave) gains momentum every day. WE are proud and excited about the care we offer.

I volunteer to be involved in the Hospice Advisory Council. Thank you for enacting licensure of hospices in Kansas -- and the impact that will have on the terminally ill in Kansas.

TESTIMONY BEFORE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
THE HOSPICE LICENSURE ACT - SENATE BILL NUMBER 397
STATE CAPITOL - TOPEKA, KANSAS
Tuesday, March 9, 1993

Presented by: JOHN G. CARNEY, President, Hospice Inc. (Wichita, KS)
Treasurer, Association of Kansas Hospices

Good morning. My name is John Carney, president of Hospice Incorporated, an organization serving the terminally ill in Wichita/Sedgwick County, Butler, Cowley, Harper, Kingman and Sumner counties in southcentral Kansas.

In 1992, a total of 675 patients received nearly 50,000 days of care from our team of professionals and trained volunteers, most often during the last 10 weeks of their lives. More than 95% of those patient days were provided in our patients' homes - their private residences or in the nursing homes where they lived. Nearly nine out of ten of those patients died in that home. Obviously, these patients were critically ill; dying of cancer, AIDS, lung and heart diseases. Many suffered from severe symptoms and pain. Our commitment to each was the same: to address their physical, emotional, and spiritual needs regardless of diagnosis.

Our work is terminal care. It requires intense levels of service during a critical time of family crisis. Caring for these families in a comprehensive manner, requires a variety of expertise coming together towards a common goal. It requires a team effort, and a recognition that **their** needs, and not our own, must be met.

For nearly a decade, we have refined our expertise in pain control and symptom management. Although the outcome of our care is rarely questioned, our focus remains to help the dying to live as fully as possible in the face of imminent death. Dying people do not have to suffer needlessly. People with a terminal illness still have important work to do. Life with dignity, even as it ends, is a hallmark of hospice care.

Bereavement care is an important part of hospice care as well. Life with hope and purpose is as important for caregivers and survivors after the patient's death as it is for the dying while facing it.

Hospice care was, at one time, an alternative to the healthcare delivery system in this country. That is no longer true. Hospice assumes a critical spot in the continuum of care, especially in this death denying culture as we all too often treat disease in futility and then certainly in wantonness.

Unfortunately, as an industry, we have begun only within the past few years to define clearly, the definition and scope of hospice care. Today, we as representatives of our field seek to complete that work by asking for your help in insuring that it continues for terminally ill Kansans. We seek your help in protecting the reason for our existence - to serve those who

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are dying and their caregivers - not only with sincerity but with integrity. Within our individual and collective missions, we have assumed the public trust of caring for one of society's most vulnerable populations.

We do not come before you to seek restriction. Rather, we come to protect that trust - our most treasured possession and the essence of who we are. Hospice does not belong to me, my nurses, social workers, or physicians who direct our care. It belongs to our communities and to the families we serve. That dispossession requires us to acknowledge the public benefit of our work and to recognize the public trust we hold.

In the proposed legislation, we have identified a number of unique elements of this comprehensive program that involves the public trust. Requiring volunteers to be an integral part of any hospice program, recognizes both their value and their necessity in appropriately demonstrating the community's humane response to the loss of life. The sensitive offering of pastoral care and spiritual support, and the provision of bereavement care for those who have lost a loved one, underscore again the elements of public trust. These hospice components help us recognize how we are all bound to each other as members of the human family, especially in the experience of losing a loved one. They speak to core values upon which this society is built.

This law is not about what we have to do just to call ourselves a hospice. It is not about just which regulations we have to follow to access benefits for those we serve. This law serves to focus our attention on the appropriate, compassionate, and humane treatment of those who are dying and those who care for them.

Current licensure requirements, under the provisions of home health, are not appropriate for hospice. Those regulations do not focus on the distinct needs of the terminally ill. Hospice care is provided in a variety of settings; home and inpatient - hospital and nursing home. In addition, our focus is not to restore health or rehabilitate, but rather to address the physical, spiritual, and emotional needs of dying patients. Skilled management of pain and other symptoms, as well as psychological and emotional support for the patients and families, is integral to quality hospice care.

Hospice providers seek uniform standards and practices to be applied throughout the state. In January 1992, the Association of Kansas Hospices (AKH) adopted a set of **principles and standards** which this legislation will codify. Nearly 3/4 of the states have adopted hospice licensure requirements. As part of healthcare's regulated system of care delivery, hospices need to protect those we serve and preserve the integrity of our programs by requiring minimum standards.

As a member of the National Hospice Organization board of directors, and recently having been elected to serve on its Executive Committee as secretary of the corporation, I can testify as to the position that Kansas holds among hospices nationwide. We have done our homework well, and the work is now paying off. Donna Bales, our state director has

assumed a role of leadership among the Council of States especially in its work of addressing the needs of rural areas that are unserved or underserved. The state's commitment to assisting small rural programs is being looked at as a model among at least five other states at this time.

Our reason for being here today is not keep any terminally ill from receiving the care they need regardless of where they live. On the contrary, our reason for being here is to do all we can to see that those who need our care receive it and receive it well - with all that the public trust imposes upon us. We want every terminally ill Kansan who seeks hospice care to receive what we can all identify as true hospice care.

Licensure will serve to recognize the viability of hospice on the healthcare continuum. It will call all of us to like standards of quality and help insure the integrity of what we claim to do. Finally, it will serve to speak for those who cannot speak for themselves. Dying persons need to be assured that we will serve their interest and the public trust. For ultimately, it is in our best interest to uphold their dignity and to serve them with the skill and compassion that they are entitled to receive and so richly deserve.

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, Secretary Reply to:

TESTIMONY PRESENTED TO

THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Senate Bill 397

Introduction

Thank you for the opportunity to provide testimony on Senate Bill 397. This bill proposes that the Secretary of the Kansas Department of Health and Environment would be authorized to implement a licensure program for hospices.

Background

Hospice services are generally available to terminally ill patients and their families. KDHE currently conducts onsite inspections of 17 hospices which are Medicare certified. Also, since hospices may meet the statutory definition of being a home health agency, KDHE also conducts home health licensure surveys at hospice organizations providing home health agency services "for a fee" (K.S.A. 65-5101 (b)). In 1991, of 220 licensed home health agencies, 21 were identified as providing hospice services. Of these, 12 were Medicare certified.

Program Impact

The provisions of SB 397 would have significant impact upon KDHE. Section 5 (b) requires any hospice organization, operational as of January 1, 1993, to petition the Secretary for a provisional license in order to fulfill the requirements for hospice licensure. By January 1, 1996, the organization must demonstrate complete compliance with the Act. Section 5 (d) requires organizations seeking licensure to file a written application and fee with the Secretary. The forms and fee are to be established by rules and regulations.

Section 6 of SB 397 gives the Secretary authority to adopt rules and regulations to "carry out the provisions of this act." The Secretary may "fix, charge, and collect license fees and license renewal fees as may be necessary to cover the expenses incurred in administering the act."

As mentioned, KDHE currently licenses home health agencies. By definition, Medicare

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Attachment #4

certified hospices are recognized as licensed home health agencies. Therefore, there may be some advantage to developing hospice specific regulations by amending the current home health agency law (K.S.A. 65-5101 - 5116), rather than implementing an entirely new statute as proposed by SB 397. It should also be noted that no other provider group is licensed by KDHE based upon Medicare only certification. Private accreditation, such as the Joint Commission on Accreditation of Healthcare Organizations has been recognized for licensure of hospitals.

A hospice advisory council within the department is also established in Section 7. The council is to "advise and make recommendations to the secretary relating to the rules and regulations adopted and the implementation and administration of this act."

KDHE preliminarily estimates that approximately 30 organizations may eventually seek licensure. Although Section 5 contemplates that a hospice certified under Medicare can be licensed "after proof confirming the hospice is certified," additional administrative responsibilities will be placed upon KDHE.

The administrative requirements of staffing a hospice advisory council, developing rules and regulations for non-certified hospices, and implementing a new licensure program would undoubtedly rest with the Bureau of Adult and Child Care. The Hospital and Medical Program within BACC is responsible for licensure and Medicare certification of hospitals, ambulatory surgical centers and home health agencies. It is also responsible for Medicare certification of 13 other provider groups (excluding adult care homes) and administration of the statutorily defined Risk Management Program. The Hospital and Medical Program continues to expand its number of regulated providers without additional administrative staff. In 1985, the home health agency licensure program was added to the unit without staff increases. Today, approximately 225 home health agencies are licensed by BACC.

Recommendation

There is a fiscal impact to the implementation of SB 397. One administrative position and state funds for onsite surveys are required since licensure of hospices would reduce the federal portion of funding now received through Title XVIII (Medicare).

Although KDHE takes no formal position on SB 397, we believe the Committee needs to be informed of these issues and the impact this bill will have on agency resources.

Presented by: Greg L. Reser, Medical Facilities Certification Administrator
Hospital and Medical Programs
Bureau of Adult and Child Care
Kansas Department of Health and Environment
March 9, 1993

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-3068

TO: The Honorable Senator Sandy Praeger, Chairperson and Members of the Public Health & Welfare Committee

FROM: Patsy L. Johnson, R.N., M.N.
Executive Administrator
Board of Nursing

DATE: February 8, 1993

RE: HB 2072

HB 2072 has been prepared to change the length of temporary permits and to set maximum fees that may be charged by the Board of Nursing. Other changes in the bill clarify or eliminate sections in advanced registered nurse practitioner, registered nurse anesthetist or licensed mental health technician statutes.

In Sections 1 and 2 as amended, (Page 3, lines 10-12 and page 4, lines 23-25) there are two changes affecting registered professional and licensed practical nurses. The Board is requesting extension of the temporary permit from 60 to 90 days. A second temporary permit for 30 days would allow a total of 120 days. The temporary permit is issued most often for the nurse endorsing into Kansas. With the temporary permit, the nurse can go to work while awaiting verification of licensure from where the individual took the licensure exam. They present the Board evidence of current licensure in the other state with the endorsement application. Verification from other states is now taking three to four months. When the temporary permit expires, the nurse cannot work. Many telephone calls are often made to get information. Getting verification from the other state is dependent up their workload and is beyond our control. Expanding the length of the temporary permit would allow time for most verifications

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Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Diane Glynn, R.N., J.D.
Practice Specialist
296-3783

Patricia McKillip, R.N., M.N.
Education Specialist
296-3782

to be returned to the Board office. The change would be positive for the licensee and also the Board staff.

The second change in sections 1 and 2 (Page 2, lines 39-43 and page 3, line 1 and page 4, lines 9-14) is stimulated by a change in the licensure examination process. In the spring of 1994, computer adapted testing will begin for professional and practical applicants. Rather than the paper and pencil exam offered twice per year, all applicants will take the examination on a computer. It may be taken any time as scheduling permits. It is conceivable that the examination could be taken eight times in one year. Since the examination is to establish minimum competency, the Board felt that after failing the exam four times, the individual should get additional education or assistance. The problem could be lack of knowledge or just test anxiety. Limiting the number of times an individual could retake the examination could be positive for the applicant. Rather than just repeatedly taking the examination and failing, the applicant could get needed help and not waste time and money. The main issue is that if an applicant is not able to pass an examination after several attempts it is likely to be a lack of knowledge. The limitation protects the consumer from incompetent practice.

Although the licensure examination will not be given by computer to the mental health technicians, the same requirement is added in Section 9, (Page 10, lines 22-26) for this category of licensee. The Board is considering offering the examination an additional time (three per year) for the mental health technician.

K.S.A. 65-1117 in Section 3 is primarily an update. Inactive license is delineated in more detail (Page 5, line 3-5). Definition for continuing nursing education has been added (Page 5, lines 13-16) to replace outdated language (lines 10-13). The definition of continuing nursing education is very broad. The Board wants to specifically note that continuing nursing education is above and beyond what is attained at the basic level of preparation of the licensee.

Reinstatement is currently referred as an untimely renewal and is not clear in subsection (b), so that has been modified. New subsection (c) specifies that licensees have to notify the Board of changes in name or address. Change of address continues to be a big problem. Service of notice during legal processes is covered because the Kansas Administrative Procedures Act requires service at the last known address. The bigger problem is sending out renewal applications and getting them to the right address. There have been a growing number of nurses practicing without a license claiming that the application did not get there. While it is the licensees' own responsibility, the addition would clearly state to nurses in black and white that the address must be updated.

The provisions in the two previous paragraphs have been added for the licensed mental health technicians in K.S.A. 65-4205, Section 10, (Page 10-12).

Board fees are listed in Section 4 (starting Page 5, line 39). The maximum amounts the Board may charge for renewal and reinstatement have been raised by $20 each (page 6, lines 2-3). The Appropriations Committee has carefully reviewed the fee fund balance the last two years. With the revenues remaining stable and a gradual increase in expenditures, the fee fund balance has been decreasing. The Board also has tentative approval for two new positions for FY 1994 which will increase expenditures. It is imperative that increases in staff occur over the next few years due to the increasing workload and need for increased efficiency. Dependent upon the minimum level allowed for the fee fund balance, fees will have to be raised in the next couple of years. Attachments A and B show comparisons of revenues and expenditures over the years and the fee fund balances.

Based on the recent review of statutes, rules and regulations for the Rule and Regulation Committee, a new fee is requested for verification of licenses to other states (Page 6, line 25). The staff spends a good deal of time in checking applications for the verifications. There are 1,500 verifications per year at $25 per person or $37,500.

In Section 5 (Page 6, line 33), the biennial renewal fee of accreditation of schools of nursing is changed to an annual fee. Budgeting for both the schools and the Board would be easier if an annual fee is paid rather than biennial. Currently $300 is being charged every two years.

Section 6 is additional clean up of the K.S.A. 65-1132 for advanced registered nurse practitioners (A.R.N.P.). Although researched and supported by the Attorney General's office that A.R.N.P.'s are required to have continuing education for certificate renewal, some licensees have been confused in reading the act. New language has been added to spell this out very specifically (Page 7, lines 9-15). An amendment was added which allows the Board to require some categories of A.R.N.P.'s to obtain pharmacology content as part of the continuing nursing education hours, but then restricts the Board from requiring content in the area of specialty for the A.R.N.P. The Board offers a balloon (next page) to the bill which would require 50 percent of the continuing nursing education hours to be in the specialty area including any pharmacology hours which might be needed. A further refinement would be to require only those A.R.N.P.'s who are transmitting prescription orders per physician protocol to obtain pharmacology hours. Those A.R.N.P.'s, including nurse anesthetists, who do not transmit prescription orders would not have to get pharmacology hours.

The Board of Nursing has consistently maintained its position on A.R.N.P.'s and continuing education needs, but we currently have some other data that supports the position. The Board is just completing a survey of clinical nurse specialists, nurse clinicians/practitioners, and midwives. Of the total 383 A.R.N.P.'s in these categories, there have been 184 responses or 49 percent return as of now. I want to share the results we have currently gotten. (Attachment C) There was 72 percent of both the clinical nurse specialists and nurse clinicians/practitioners who believed pharmacology was needed by A.R.N.P.'s to maintain competency. Only 38 percent of those individuals are even transmitting written prescriptions. Sixty-nine percent were having no difficulty getting the pharmacology courses.

of this act, whether initial or renewal, shall expire every two years. The expiration date shall be established by rules and regulations of the board. The board shall mail an application for renewal of a certificate of qualification to every advanced registered nurse practitioner at least 60 days prior to the expiration date of such person's license. Every person who desires to renew such certificate of qualification shall file with the board, on or before the date of expiration of such certificate of qualification, a renewal application together with the prescribed biennial renewal fee. *The board shall require every licensee with an active certification as an advanced registered nurse practitioner to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the board. The board shall adopt rules and regulations to establish the requirements for such program of continuing education.* The continuing education requirements established by the board under this section shall not be in addition to continuing education requirements established for the renewal of a license under K.S.A. 65-1117 and amendments thereto. Out of the total hours of continuing education established by the board under K.S.A. 65-1117 and amendments thereto, the board may require ~~certain categories of licensees with an active certification as advanced registered nurse practitioners to obtain a minimum number of continuing education hours in pharmacology, as established by rules and regulations of the board, but the board shall not require that the remaining number of required continuing education hours be in the area of specialty of the advanced registered nurse practitioner.~~ Upon receipt of such application and payment of any applicable fee, and upon being satisfied that the applicant for renewal of a certificate of qualification meets the requirements established by the board under K.S.A. 65-1130 *and amendments thereto* in effect at the time of initial qualification of the applicant, the board shall verify the accuracy of the application and grant a renewal certificate of qualification.

(b) Any person who fails to secure a renewal certificate of qualification prior to the expiration of the certificate of qualification may secure a ~~renewal~~ *reinstatement* of such lapsed certificate of qualification by making application therefor on a form provided by the board, upon furnishing proof that the applicant is competent and qualified to act as an advanced registered nurse practitioner and upon satisfying all of the requirements for ~~renewal set forth in subsection (a),~~ *reinstatement* including payment to the board of a reinstatement fee as established by the board.

~~(c) Any person who on June 20, 1982, held a certificate of~~

Substitute for lines marked out

that up to fifty percent of the required continuing education hours be in the advanced registered nurse practitioner's specialty and may require those advanced registered nurse practitioners who are transmitting prescription orders pursuant to written protocols as authorized by a physician to obtain a certain number of the specialty continuing education hours in pharmacology, as established by rules and regulations of the board.

Advanced registered nurse practitioners are educated to make independent decisions which may greatly impact patients. Pharmacology is an integral component of most nurses' practice, but takes on greater significance when the A.R.N.P. is assessing patients and then writing prescriptions based on findings. The Board believes that continuing education is crucial to nurses when the practice is changing at the pace it is. An A.R.N.P. practices in a specialty. If A.R.N.P's get CNE in their area of specialty as Kansas State Nurses Association argues, then meeting a 50 percent or 15 contact hour requirement every two years will not be any problem. Getting six hours in pharmacology for those transmitting prescriptions seems reasonable. At least 125 A.R.N.P's also agree pharmacology is important. The whole argument over this issue is like which came first, the chicken or the egg. If A.R.N.P's get CNE in their specialty areas and in pharmacology as needed, then do we need a regulation for it? Would they get CNE in those areas if there was no regulation? For consistency and continued upgrading of knowledge and skills, the Board feels regulation is needed. I would also like to note that registered nurse anesthetists are required by the American Association of Nurse Anesthetists to get 40 hours of continuing education in anesthesia every two years. The nurse anesthetists do not transmit written prescriptions so neither the specialty or pharmacology requirement should have no impact of them. The Board hopes you will consider the suggested amendment to the bill.

In subsection (b), reinstatement language has been clarified as it was with registered nurse language in section 4. Subsection (c) was deleted since it was used as a grandfather clause when the statute was implemented for A.R.N.P.'s.

In Section 7, K.S.A. 65-1152 speaks to accreditation of schools of nurse anesthesia, subsection (a) (2) (Page 8, lines 23-25). There is no statute as to the accreditation process. New subsection (b) was added to cover the issue (Page 8, lines 31-33).

Similar to Section 6, the changes in Section 8 update the registered nurse anesthetist language in K.S.A. 65-1155. Language is deleted that covers the process when registered nurse anesthetists were first authorized (Page 9, line 15-23). This is not needed now. The time

requirement for the Board office to send out authorization renewal notice has been changed from 90 to 60 days. It will be consistent with the registered nurse notice which is 60 days (Page 9, line 25). Subsection (b) updates the reinstatement language addressed in other sections of this bill.

In K.S.A. 65-4205, Section 9, outdated language referring to the initiation of the licensed mental health technician (L.M.H.T.) has been removed (Page 10, lines 33-39). Subsection (a) has been rewritten to update the renewal process for L.M.H.T.'s. The inactive license provision has been added (Page 11, lines 2-7). There has also been clarification of reinstatement in subsection (b).

New Section 11 (Page 12) sets out the requirements and duties for a disciplinary counsel. The Board originally requested funding to obtain disciplinary counsel for the agency rather than to continue to use counsel from the Attorney General's litigation division. The amendment in the bill directs the Attorney General to appoint an assistant on a full time basis to the agency with the Board's approval. This amendment is acceptable to the Board except for the description of duties. The job description in the bill calls for an attorney to legal advisor and to represent the Board in litigation. The Board proposes a slight change in language which was submitted to us by Camille Nohe, Assistant Attorney General, who currently represents the Board as administrative council. (Next page) The agency currently needs a disciplinary attorney and the new language describes the disciplinary function.

The rationale for requesting a full time attorney is the current workload of the disciplinary division. Now the Assistant Attorney General not only represents the Board of Nursing but other clients as well, sometimes several agencies. Only about 75 percent of the attorney's time is appropriated to the Board of Nursing. Although not specifically hired as an attorney for the Board, Diane Glynn, the Board's Practice Specialist is currently writing the stipulation agreements following disciplinary proceedings. She writes 50-60 stipulations per year and is doing this to keep up with the workload. As compared to the Board of Healing Arts which has

~~sole judge of the adequacy of the evidence so presented~~ *and of satisfying all the requirements for reinstatement.*

(c) Each licensee shall notify the board in writing of a change in name or address within 30 days of the change. Failure to so notify the board shall not constitute a defense in an action relating to failure to renew a license, nor shall it constitute a defense in any other proceeding.

~~New Sec. 12–11. The board shall appoint a disciplinary counsel, with the duties set out in this act. The disciplinary counsel shall be an attorney admitted to practice law in Kansas. The disciplinary counsel shall have the power and the duty to investigate or cause to be investigated all matters involving professional incompetency, unprofessional conduct or any other matter which may result in disciplinary action against a licensee pursuant to the Kansas nurse practice act or the mental health technician's licensure act and amendments thereto. In the performance of these duties, the disciplinary counsel may apply to any court having power to issue subpoenas for an order to require by subpoena the attendance of any person or by subpoena *duces tecum* the production of any records for the purpose of the production of any information pertinent to an investigation. Subject to approval by the board the executive administrator shall employ clerical and other staff necessary to carry out the duties of the disciplinary counsel. The board may adopt rules and regulations necessary to allow the disciplinary counsel to properly perform the function of such position under this act. This section is made specifically supplemental to the Kansas nurse practice act.~~

New Sec. 11. (a) The attorney general shall appoint, with the approval of the board of nursing, an assistant attorney general who shall be the attorney for the board of nursing. The attorney shall receive an annual salary fixed by the attorney general with the approval of the board of nursing. The salary shall be paid from moneys appropriated to the board of nursing in the board of nursing fee fund.

(b) The assistant attorney general appointed under subsection (a) shall ~~be the legal advisor for the board of nursing, shall represent the board of nursing in any litigation that may arise in the discharge of the duties of the board of nursing~~ and shall perform such other duties of a legal nature as may be directed by the board of nursing.

Sec. ~~13~~ 12. K.S.A. ~~65-1114,~~ 65-1115, 65-1116, 65-1117, 65-1118, 65-1118a, 65-1132, 65-1152, 65-1155, 65-1156, 65-1157, 65-1160, 65-4203 and 65-4205 are hereby repealed.

Substitute for lines marked out

institute in the name of the state or board the proper proceedings against any person regarding whom a complaint has been made charging him or her with the violation of any of the provisions of this act

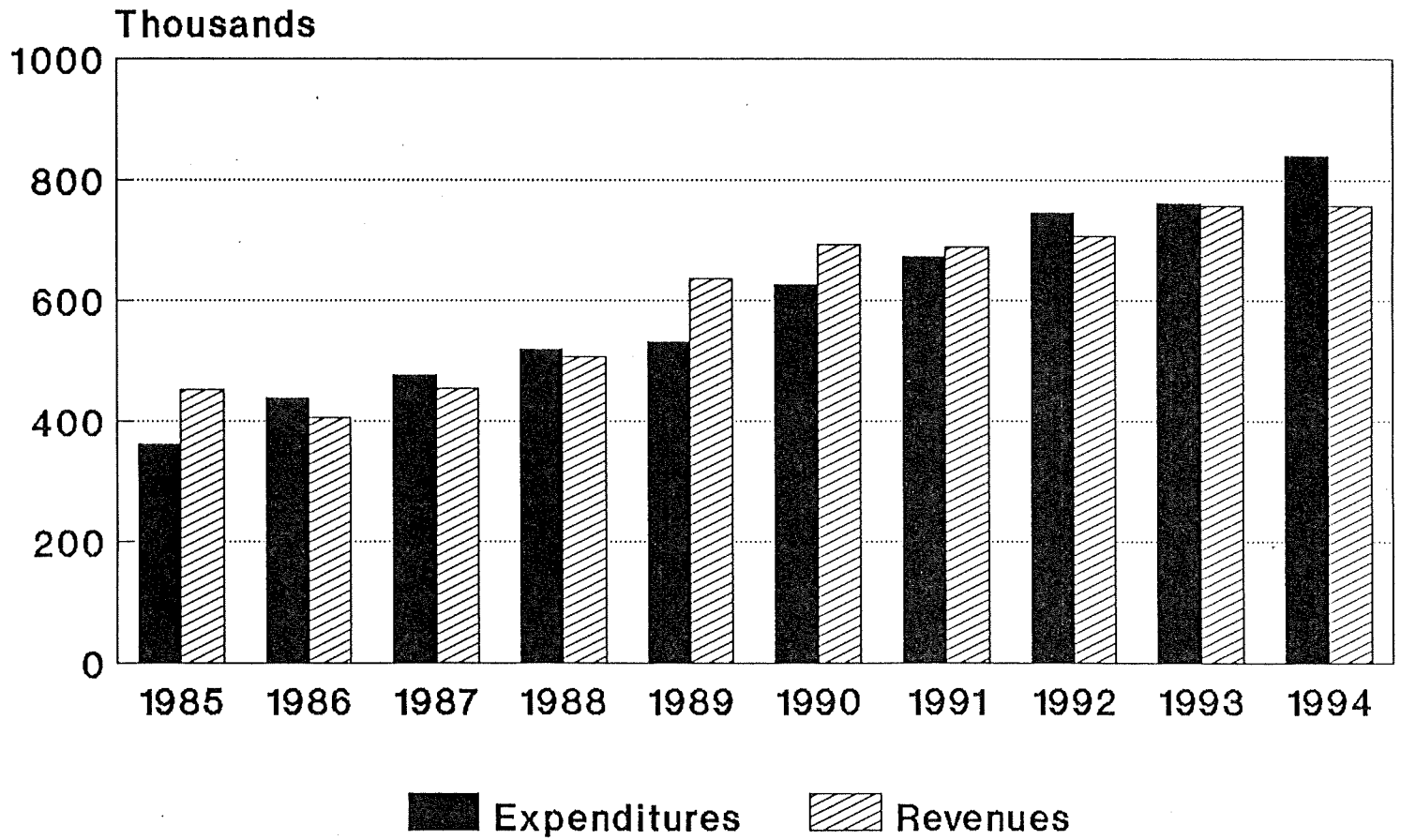
its own disciplinary attorneys (two), the Board of Nursing has a similar caseload. (Attachment D) It is felt that there is sufficient workload to utilize a full time attorney. There are 33 cases at the Attorney General's office now with another 15 to go. (Attachment E) We cannot effectively protect the public without processing these cases as expeditiously as possible. This has been a continuing concern.

In summary, many changes have been proposed in this bill. Many of the changes are from the review that was done for the Legislative Rule and Regulation Committee. Limiting the number of times the licensure examination can be taken is a result of a change in testing on a national level. New language has been added in several different statutes to clarify what is in practice and has been interpreted to be legal. The Board has studied the budget closely as to the fee fund balance. The agency's future monetary needs are being anticipated.

The Board hopes that you will approve HB 2072 with the additional amendments we have suggested.

Thank you. I will be glad to answer questions.

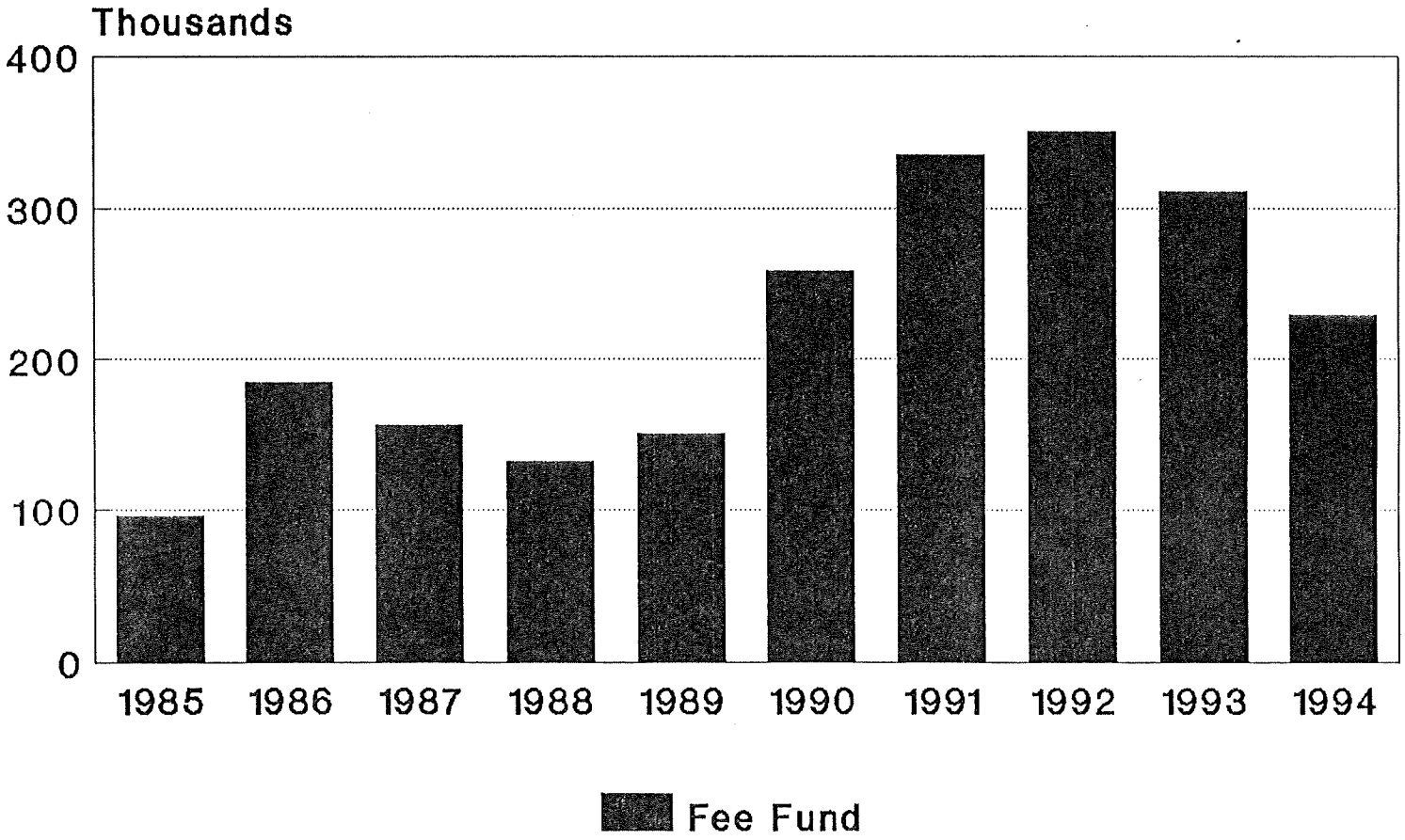
Board of Nursing
Expenditures/Revenues



Attachment A

3-10

Board of Nursing
Fee Fund Balance



Attachment B

5/11

KANSAS STATE BOARD OF NURSING

ARNP SURVEY

	NP/C			CNS		
	Yes	No	No Answer	Yes	No	No Answer
1. Are you transmitting in writing prescription orders?	52	65		17	50	
2. Is continuing education on pharmacology necessary to maintain ARNP competency?	84	30	3	41	18	8
3. Have you had any difficulty in renewing your ARNP certification because you could not obtain six hours of continuing education in pharmacology?	23	80	14	CNS's were not asked to answer this question.		

Summary

Of the 117 NC/P's who answered question one, 45 percent are transmitting written prescriptions. There is 26 percent of the 67 CNS's transmitting prescriptions.

Of the NC/P's and CNS's surveyed, 72 percent of both categories felt pharmacology was necessary to maintain competency.

There were 69 percent of the NC/P's who had no difficulty obtaining the required six hours of pharmacology for re-certification with 20 percent having difficulty.

3/3/93

COMPARISON OF CASES FROM BOARD OF NURSING AND BOARD OF HEALING ARTS

	FY 89		FY 90		FY 91		FY 92	
	HA	Nsg	*HA*	Nsg	*HA*	Nsg	*HA*	Nsg
Cases	*302*	147	*244*	302	*313*	426	252	525
Investigations	*537*	?	*541*	1562	*956*	1610	944	1652
ACTIONS								
Denial for Cause	*5*	1	*3*	2	*17*	6	7	1
Emergency Proceeding	*15*	0	*3*	0	*1*	1	1	3
Stipulation	*30*	3+	*11*	31	*18*	53	10	18
Fine or Censure	*18*	NA	*11*	NA	*6*	NA	1	2
Informal Reprimand	*0*	NA	*0*	NA	*5*	NA	1	NA
Revocation/Suspension/ Limitation	*8*	15	*3*	26	*8*	16	6	17
Affidavit	*10*	NA	*8*	NA	*0*	NA	0	NA
Litigation	*0*	0	*0*	1	*6*	0	10	1
Total Actions	*92*	19+	*44*	60	*66*	77	61	42

Attachment D

5-6

KANSAS STATE BOARD OF NURSING

Current case load
Attorney General's office

At AG's office pending Oldest transferred December 1991	33
Called for hearing Being promised for AG's office	15
Stipulations that are outstanding Used to be done by AG, now by Board staff Oldest from July 1992	16
BACKLOGGED	**64**

Estimate it takes between 4 hours to maximum of 300 hours per case (probably have 3 - 4 cases per year that takes 300 hours).

Investigative Cases Pending

1/01/90	-	06/30/90	1
7/01/90	-	12/31/90	4
1/01/91	-	06/30/91	18
7/01/91	-	12/31/91	46
1/01/92	-	06/30/92	44
7/01/92	-	12/31/92	85
1/01/93	-	current	90
TOTAL			**288**

Currently have 2 full time investigators. Practice Specialist would help with investigations but currently not doing so because has to write stipulations.

KSNA

the voice of Nursing in Kansas

For Further Information Contact:
Terri Roberts J.D., R.N.
Executive Director
Kansas State Nurses Association
700 SW Jackson, Suite 601
Topeka, Kansas 66603-3731
(913) 233-8638

HB 2072 Board of Nursing; Licensure, Qualification and Authorization

Chairperson Praeger and Members of the Senate Public Health and Welfare Committee. I am Canda Byrne, MSN, ARNP, CS. I am an Advanced Registered Nurse Practitioner and here representing the Kansas State Nurses Association and the Advanced Practice Conference. We would like to lend our support HB 2072 with the exception of Section 7. In Section 7, lines 3-26, the new language to be added reads:

> The board shall require every licensee with an active certification as an advanced registered nurse practitioner to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the board. The board shall adopt rules and regulations to establish the requirements for such program of continuing education. The continuing education requirements established by the board under this section shall not be in addition to continuing education requirements established for the renewal of a license under K.S.A. 65-1117 and amendments thereto. Out of the total hours of continuing education established by the board under K.S.A. 65-1117 and amendments thereto, the board may require certain categories of licensees with an active certification as advanced registered nurse practitioners to obtain a minimum number of continuing education hours in pharmacology, as established by rules and regulations by the board, but the board shall not require that the remaining number of required continuing education hours be in the area of specialty of the advanced registered nurse practitioner.

We cannot support the adoption of this new language and ask that this Committee delete the proposed language in Section 7, lines 3-26.

In discussion with ARNP's around the state we found most are certified by a national organization that has continuing education requirements for re-certification above and beyond the hours required by the Kansas State Board of Nursing. None of these require specific content except as it relates to the practice area. The American College of Nurse Midwives which tests and certifies nurse midwives had a past practice of

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attachment #6
3-9-93

mandating content for re-certification. However, because of specialization this mandate was dropped. Nurses have reported that the six hours of pharmacology continuing education now required by KSBN are available but the level is not satisfactory and does not meet their educational/practice needs.

It is our contention that ARNP's who hold a voluntary certification do so because of their professionalism and dedication to their practice. They are therefore able to assess their educational need and acquire the education they need to fulfill these needs. The new statutory language is unnecessary. Our position is that the CE requirement for ARNP's should be self-determined. Thirty hours of continuing education are already required to maintain our licensure status. There is no such requirements dictating our CE content for R.N.'s and we cannot support this policy for ARNP's. We are confident that the ARNP's are obtaining CE relevant to their practice as part of these 30 hours. Disciplining ARNP's for incompetency has not been an issue for the Board of Nursing.

I appreciate the opportunity to express our concerns on HB 2072. Thank you.

of this act, whether initial or renewal, shall expire every two years. The expiration date shall be established by rules and regulations of the board. The board shall mail an application for renewal of a certificate of qualification to every advanced registered nurse practitioner at least 60 days prior to the expiration date of such person's license. Every person who desires to renew such certificate of qualification shall file with the board, on or before the date of expiration of such certificate of qualification, a renewal application together with the prescribed biennial renewal fee. ~~*The board shall require every licensee with an active certification as an advanced registered nurse practitioner to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the board. The board shall adopt rules and regulations to establish the requirements for such program of continuing education.* The continuing education requirements established by the board under this section shall not be in addition to continuing education requirements established for the renewal of a license under K.S.A. 65-1117 and amendments thereto. Out of the total hours of continuing education established by the board under K.S.A. 65-1117 and amendments thereto, the board may require certain categories of licensees with an active certification as advanced registered nurse practitioners to obtain a minimum number of continuing education hours in pharmacology, as established by rules and regulations of the board, but the board shall not require that the remaining number of required continuing education hours be in the area of specialty of the advanced registered nurse practitioner.~~ Upon receipt of such application and payment of any applicable fee, and upon being satisfied that the applicant for renewal of a certificate of qualification meets the requirements established by the board under K.S.A. 65-1130 *and amendments thereto* in effect at the time of initial qualification of the applicant, the board shall verify the accuracy of the application and grant a renewal certificate of qualification.

(b) Any person who fails to secure a renewal certificate of qualification prior to the expiration of the certificate of qualification may secure a ~~renewal~~ *reinstatement* of such lapsed certificate of qualification by making application therefor on a form provided by the board, upon furnishing proof that the applicant is competent and qualified to act as an advanced registered nurse practitioner and upon satisfying all of the requirements for ~~renewal set forth in subsection (a),~~ *reinstatement* including payment to the board of a reinstatement fee as established by the board.

~~(c) Any person who on June 20, 1982, held a certificate of~~

DELETE

Kansas State Nurses Association (KSNA)
Kansas Association of Nurse Anesthetists (KANA)

Balloon Recommendations for HB 2072
March 9, 1993

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

Members of the Senate Public Health and Welfare Committee, thank you for allowing me time to address this hearing.

I am Joseph P. Conroy, a Certified Registered Nurse Anesthettist from Emporia, Kansas, representing the Kansas Association of Nurse Anesthetists.

I am here today to oppose H.B. 2072, Sec 6, where K.S.A. 65-1132 is amended such that the Board of Nursing shall establish requirements for programs of continuing education for advanced registered nurse practitioners. The Board may require certain categories of ARNP's to obtain a minimum number of continuing education hours in pharmacology.

All of the Registered Nurse Anesthetists in Kansas are re-certified bi-annually by the American Association of Nurse Anesthetist's Council of Recertification. We are required to have at least 40 hours of continuing education in anesthesia. Over half of our lectures deal with pharmacology, but are not necessarily listed that way on the agendas. We feel the requirement for pharmacology to be an unworkable and time-consuming process, as a requirement for renewal of certification as an ARNP.

The largest group of advanced practice nurses in the state of Kansas are CRNA's. The Board has accepted the accreditation of our schools by our American Association of Nurse Anesthetist. Perhaps, especially considering the fact that there are no advanced practice nurses specializing in anesthesia on the Board of Nursing, that the Board continue to allow our national association to set standards for continuing education in the practice of nurse anesthesia.

Thank you for your time.

Joseph P. Conroy

Joseph P. Conroy B.A., C.R.N.A., A.R.N.P.
2614 Apple Drive Emporia Kansas 66801
(316)-342-0856

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Attachment # 7
3-9-93

kaanp

Kansas Alliance of Advanced Nurse Practitioners

Members of the Senate Public Health and Welfare Committee, thank you for allowing me time to address this hearing.

My name is Jane Conroy. I am an Advanced Registered Nurse Practitioner/ Family Nurse Clinician from Emporia, Kansas. I am representing the Kansas Alliance of Advanced Registered Nurse Practitioners.

I am here today in support of H.B. 2072, Sec 6, where K.S.A. 65-1132 is amended to allow the Board of Nursing to establish requirements for programs of continuing education for advanced registered nurse practitioners. The Board may require no more than fifty percent of the total number of contact hours in the area of specialty of the advanced registered nurse practitioner and may require certain categories of ARNP's to obtain a minimum number of continuing education hours in pharmacology.

The Kansas Alliance of Advanced Nurse Practitioners is in total support of a minimum of six hours of pharmacology in the practitioner's specialty area for those advanced registered nurse practitioners writing prescriptions under protocol. This would help to ensure that the ARNP was current in the latest pharmacology updates.

The majority of nurse clinician/practitioners practicing in the State of Kansas do so in a rural area. To require them to have fifty percent of their contact hours in their area of specialty could cause an undue hardship. This would involve extensive travel and expense as there are limited programs of continuing education for ARNP's in those rural areas.

We feel that it would be more appropriate to leave the type of continuing education to the discretion of the individual advanced practice provider.

Thank you for your time.

Jane Anne Conroy

Jane Anne Conroy R.N., M.S., F.N.C., A.R.N.P.

2614 Apple Drive

Emporia, Kansas 66801

(316) 342-0856 Home (316) 342-4864 Work

Senate PH&W
Attachment #8
3-9-93

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-3068

To: The Honorable Senator Sandy Praeger, Chairperson
and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, R.N., M.N.
Executive Administrator
Kansas State Board of Nursing

Date: February 8, 1993

Re: HB 2073

Thank you for allowing me to testify to HB 2073 for the Board of Nursing. The grounds for disciplinary action have been updated for all Board of Nursing licensees in HB 2073. The disciplinary section for registered nurse anesthetists has been moved into K.S.A. 65-1120 (a) (Page 1, lines 19 and 22). This was a suggestion from Norman Furse last year when the statute changes were first introduced. All nurses will be covered in this part of the statute and grounds for discipline will be uniform.

K.S.A. 65-1120 for professional and practical nurses and K.S.A. 65-4209 (Section 5, Pages 5-7) for licensed mental health technicians have been revised so that both statutes are similar in language. Several amendments were made to HB 2073 and the Board is supportive of these changes.

The first change in K.S.A. 65-1120 was that "misdemeanor" (Page 1, line 27) be added. This was amended to allow the Board to take disciplinary action if an individual has been guilty of a misdemeanor involving drugs. Since most drug convictions are misdemeanors and not felonies, this addresses the concern the Board had with drug addiction and rehabilitation.

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Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Diane Glynn, R.N., J.D.
Practice Specialist
296-3783

Patricia McKillip, R.N., M.N.
Education Specialist
296-3782

Amended sections (a) (4) and (5) allow action when a person is abusing drugs or alcohol or is judged to need a guardian or conservator usually someone who is mentally unstable.

A new action "public censure" was added to both statutes as another method that can be utilized following hearing. Many other states, 17 out of 30 which were reviewed, have a public censure policy. (Attachment A) While used infrequently, public censure allows for notice to consumers. An example of this would be the nurse who works home health and steals from a patient: Such actions would be printed in the Board's newsletter but could also be printed in the licensee's local newspaper. The House Committee added private censure to the bill as well, which the Board approves.

In Section 2 (Page 3, lines 41-43, page 4, line 1) it will be a violation of the Kansas Nurse Practice Act if a person or organization represents itself as a provider of continuing nursing education and is not approved by the Board. The Board has had nurses telephone concerned about the continuing nursing education they have attended. When they go to renew their licenses, they find the continuing nursing education has not been approved through the Board and the provider has represented that it has. Currently we can only advise the licensees to ask for their money back.

The Board supports the amendments that makes a violation of the Nurse Practice Act Class B misdemeanor with subsequent violations a Class A misdemeanor (Page 4, lines 3-5).

Section 3 (Page 4, lines 6-43) clarifies that the registered nurse anesthetist statutes are read as part of the Kansas Nurse Practice act. This follows with the new language found in 65-1120 which combines all groups into the discipline section.

K.S.A. 65-1162, Section 4 has been revised to parallel the disciplinary language in K.S.A. 65-1122 (section 2). Section 6 (Page 5 and 6) provides the same provisions for the licensed mental health technician.

New section 7 (Page 7, lines 37-43, page 8, and page 9, lines 1-16) was proposed to increase subpoena power for investigations. While referenced under K.S.A. 65-1120, there are no particulars in the act to define how the subpoena power shall be implemented. While never challenged in court, the Board has experienced an increase of attorneys, for facilities and individuals, questioning the Board's subpoena power. An increasing amount of staff time is wasted in arguing these points because the language is unclear. The Board's subpoena power for formal action is not questioned because Kansas Administrative Procedures Act clearly defines that power. It is a consensus of administrative law attorneys that the Kansas Administrative Procedures Act subpoena power speaks only to formal actions, not pending investigations. Without the ability to collect evidence, there is no discipline or regulation of licensees. Since K.S.A. 74-1106 (d) also spoke to subpoena power of the Board, it was suggested to amend this section and add investigations. The Board supports this change.

New section 8 (Page 13, lines 2-22) addresses investigative records. This new statute would specifically close the investigation file so that all records would remain confidential except in the specified situations as stated in the bill. This provides protection to consumers whose patient records have been obtained to use as evidence. It also protects the licensee who was accused unjustly and cleared through investigation. It does not effect a potential civil action because Chapter 60, discovery rules are the appropriate avenues in those cases. It also follows with the risk management language which make peer records privileged and confidential. This encourages better self policing of the profession.

In summary, the Board revised most of these statutes last year. Statutes from all categories of licensees are addressed so each will be parallel to the other. New provisions have been added to allow access to evidence and to make it confidential.

Thank you. I will be glad to answer any questions.

Attachment A

Nurse Practice Acts Reviewed	Censure	Otherwise Discipline*	Reprima
Arizona	Y		
Alabama		Y	
Delaware	Y		Y
Connecticut	Y		Y
Florida			Y
Georgia	Y		
Idaho	–	–	–
Illinois		Y	
Indiana	Y		Y
Iowa			Y
Louisiana (RN)		Y	
(LPN)			Y
Kentucky	–	–	–
Massachusetts	–	–	–
Maine	Y		Y
Michigan			Y
Missouri	–	–	–
Minnesota	Y		Y
Maryland	–	–	–
Pennsylvania	–	–	–
New Mexico			Y
North Carolina		Y	
Nevada	–	–	–
Nebraska	Y	Y	Y
New York	Y		Y
South Carolina		Y	Y
Texas	reprimand not confidential		Y
Utah	–	–	–
West Virginia		Y	
Wisconsin			Y
Wyoming	–	–	–
30	10	7	15

*Appears to be openended. Leaves room for censure. (Some language indicates factors to use in decision ie; public protection, relation of act to practice, etc.)

**Most states spoke to reprimand in form of conference or letter and some maintianed those as private and confidential, not related to public.

KSNA

the voice of Nursing in Kansas

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HB2073 Board of Nursing Licensure, Discipline

Chairperson Praeger and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of the Kansas State Nurses Association. The Kansas State Nurses Association supports many of the changes proposed in HB 2073 and has three recommendations for changes to the bill.

The ones we are particularly pleased about include the addition of **"public and private censorship"** for licensees who violate the Nurse Practice Act. This appropriately expands the list of actions that the Board may use to discipline licensees. The current three "revoke, limit or suspend" are very limiting. Expanding the list of disciplinary action the Board may take against a licensee affords the licensee a greater range, and the Board more appropriate latitude when issuing final orders for disciplining licensees.

We support the changes on page 1 related to redefining areas for discipline, including the addition of adding **misdemeanor convictions involving illegal drug offenses** and an **expanded** definition of **"mentally incompetent".**

In reviewing the Section 2 (Page 3, Line 41) change to add another violation of the Nurse Practice Act for CE providers falsely advertising we recommend adding the following language to clarify the possible infraction:

> (g) represent that a provider of continuing education is approved **by the board** for educating either professional nurses or practical nurses, unless the provider of continuing nursing education has been approved by the board and the approval is in full force.
>
> [See Balloon]

We support the changes in **classifications** in Nurse Practice Act **offenses** in the amended version of this bill also.

Senate PH&W
Attachment 10
3-9-93

We support the **increase in subpoena** power authorized for investigations that is added by Section 7. We do, however, have a very significant change to propose to this section which includes the composition and configuration of the eleven member Board of Nursing appointed by the Governor.

In 1992, the KSNA and five other nursing organizations introduced a bill that would change the composition of the Board of Nursing. The current composition is 5 RN's, 2 LPN's, 2 LMHT's and 2 Public Members. The bill as proposed in 1992 reduced the two LMHT's to 1 and the two public members to 1, with the two positions being converted to RN positions. Instead, the Senate Governmental Organization Committee amended the bill to add 2 RN's and 1 public member. This bill passed the Senate, and had a hearing in the House Governmental Organization Committee, but never made it out of Committee. The six organizations supporting this endeavor have continued in their support and when the House Public Health & Welfare Committee amended HB 2073 to amend KSA 74-1106 (on page 9) Section 7 beginning on line 17, we again discussed this initiative. The groups felt that the changes in practice area concerns, particularly in advanced practice were significant to ask this committee to once again consider adding 2 Registered Nurses to the Board of Nursing composition. We propose the 2 RN's be for practice nurses with one specifically identified for an ARNP or a RNA. Attached is the balloon with the language that we propose.

The fact sheet attached on yellow gives you detailed information comparing the number of licensees and schools regulated by the board. In the last six years alone there has been a 16% increase in the RN population from 21,850 to 25,500 RN licensees and four new schools preparing RN's. This increase in licensees/programs has increased the workload of the board related to reviewing programs annually and in the number of licensees needing disciplinary action.

The **workload of the Board** has been restructured over the past five years so that the Committees of the Board are assigned respective responsibilities and then are to make formal recommendations to the full Board for action. There are 9 committees. Five of these committees are chaired by Registered Nurses and at least one of the five R.N.'s on the Board is currently on each committee except the Mental Health Technician Exam Committee. Two committees that require a great deal of time are the education committee, responsible for reviewing the more than 50 school programs preparing ARNP's, RN's, LPN's and LMHT's and the ARNP committee which is responsible for reviewing all applications for ARNP status and new program approvals. In addition to RN Board members serving on these committees, the Board has appointed **non-board members** to serve as voting members of the **committees of the board.** The following **non-board** members serve on KSBN Committees at this time:

ARNP Committee 2 board members, **3 non-board members.**
Education Committee 3 board members, **2 non-board members.**
Practice Committee 4 board members, **2 non-board members.**
CE Committee 4 board members, **2 non-board members.**
LMHT Exam Committee, 2 Board members, **2 non-board members.**

All of the **non-board** members appointed to these committees are Registered Nurses. We believe that this is very demonstrative of the need for change in the Boards composition.

Additional rationale for the RN's to be added will be provided by representatives from the Kansas Organization of Nurse Executives, The Kansas League for Nursing, the Kansas Hospital Association and the Kansas Association of Nurse Anesthetists. The Kansas Association of Colleges of Nursing, Kansas Association of Nursing Students, and the Kansas School Nurse Organization supported this endeavor last year also.

We like the amended **New Section 8 (a)** language that reflects that the complaints or reports received apply only to licensees of the Board of Nursing relevant to discipline related matters.

The last change we recommend is on New Section 8 (3) on page 13, line 17.

". . . (3) to the person who is the subject of the information, but the board **may require disclosure in such a manner as to prevent identification of any other person who is the subject or source of the information**" . . .

We feel that the use of the word **may** allows the Board of Nursing too much discretionary power in determining when and whether there will be a release of information to the person named.

As a state public regulating agency, the Board of Nursing is administratively regulated by the Kansas Administrative Procedure Act (KAPA). For agencies under KAPA, all civil discovery techniques are authorized. K.S.A. 77-517(b) and 77-522(a).

KAPA authorizes the issuance of protective orders over confidential information (K.S.A. 45-221) and is recognized as appropriate by the Kansas courts (Wulfkuhle v. Kan. Dept. of Revenue, 234 Kan 241, 671 P.2d. 547 (1983)), this policy has been applied to trade secrets, financial matters, and legally recognized privileged relationships.

While the agency has the privilege of deleting the information requested, when a licensee is attempting to defend potential revocation or suspension of their license based on a complaint filed, the ability to investigate the complaint is severely limited if knowledge of the person complaining is deleted. When the respondent has notice of a hearing at

least ten days prior to the hearing, investigation to establish a defense becomes crippled when there can be no access to an unknown complainant. Access of a person to records bearing that person's name is allowed under K.S.A. 85-105.

A protective order is issued after a balancing of interests analysis is made:

balancing the litigants interest in obtaining the requested information with the resisting parties interest as well as the public interest in maintaining the confidentiality of the materials. Wesley Med Center V Clark, 234 Kan. 13, 669 P.2d. 209 (1983).

While the State's desire to protect the public be encouragement of submitting complaints by assuring confidentiality of the complainant, the licensee's interest in protecting their license from untoward and unsubstantiated attacks under the guise of confidentiality leads to a discretionary power by the board as to which complaint they will release the name of and which they do not. Kansas has substantial regulations giving immunity from civil liability for filing complaints, reports or provides information to an investigation, as long as the information provided was made in good faith, not false, or based on false information. K.S.A. 65-4926. The Board of Healing Arts state on their complaint form that a copy of the complaint may be released to the respondent during the investigation of the complaint. This policy balances the state's interest to protect the public by encouraging complaints, but also allows fairness to the professional licensee.

Also, Kansas public policy of promoting public disclosure and public access of documents is established under the Kansas Open Records Act (KORA). The public record has been broadly defined to mean "any form . . . of recorded information. . . .maintained or. . . . possessed by the agency." K.S.A. 45-217(c).

With these interests in mind, we would like to see the proposed amendment of new Section 8 (3) to read, **"to the person who is the subject of the information."**

Kansas State Nurses Association (KSNA)

Balloon Recommendations
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to the statutes relating to procedure in the district court. All costs accrued ~~at the instance of~~ *by* the board, when it is the successful party, and which the attorney general certifies cannot be collected from the applicant or licensee shall be paid ~~out of any available moneys in~~ *from* the board of nursing fee fund.

(e) *Professional incompetency defined.* As used in this section, "professional incompetency" means:

(1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

(2) repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board; or

(3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

Sec. 2. K.S.A. 65-1122 is hereby amended to read as follows: 65-1122. It ~~shall be a misdemeanor~~ *is a violation of law* for any person, firm, corporation or association to:

(a) Sell or fraudulently obtain or furnish any nursing diploma, license, record or certificate of qualification or aid or abet therein;

(b) practice professional nursing, practical nursing or practice as an advanced registered nurse practitioner, unless duly licensed or certified to do so;

(c) use in connection with such person's name any designation implying that such person is a licensed professional nurse, a licensed practical nurse or an advanced registered nurse practitioner unless duly licensed or certified so to practice under the provisions of ~~this~~ *the Kansas nurse practice* act, and such license or certificate is then in full force;

(d) practice professional nursing, practical nursing or as an advanced registered nurse practitioner during the time a license or certificate issued under the provisions of ~~this~~ *the Kansas nurse practice* act shall have expired or shall have been suspended or revoked;

(e) represent that a school for nursing is accredited for educating either professional nurses or practical nurses, unless such school has been duly accredited by the board and such accreditation is then in full force; ~~or~~

(f) violate any provisions of the Kansas nurse practice act or ~~any rule and regulation~~ *rules and regulations* adopted pursuant to that act~~.~~; *or*

(g) represent that a provider of continuing nursing education is approved for educating either professional nurses or practical nurses, unless the provider of continuing nursing education has been ap-

by the board

~~ports or any statements relating to diagnostic findings on treatment of patients, information from which a patient or a patient's family might be identified, peer review or risk management records or information received and records kept by the board as a result of the investigation procedure outlined in this section are confidential and shall not be disclosed.~~

~~(d) Nothing in this section or any other provision of law making communications between a physician and the physician's patient privileged communication shall apply to investigations or proceedings conducted pursuant to this section. The board and its employees agents and representatives shall keep in confidence the names of any patients whose records are reviewed during the course of investigations and proceedings pursuant to this section.~~

~~(e) This section shall be part of and suplemental to the Kansas nurse practice act.~~

Sec. 7. K.S.A. 74-1106 is hereby amended to read as follows: 74-1106. (a) *Appointment, term of office.* (1) The governor shall appoint a board consisting of ~~11~~ 13 members of which ~~five~~ seven shall be registered professional nurses, two shall be licensed practical nurses, two shall be licensed mental health technicians and two shall be members of the general public, which shall constitute a board of nursing, with the duties, power and authority set forth in this act. The members of the board of nursing holding office on the effective date of this amendment shall continue as members until the expiration of their respective terms.

(2) Upon the expiration of the term of any registered professional nurse, the Kansas state nurses association shall submit to the governor a list of registered professional nurses containing names of not less than three times the number of persons to be appointed, and appointments shall be made after consideration of such list for terms of four years and until a successor is appointed and qualified.

(3) On the effective date of this act, the Kansas federation of licensed practical nurses shall submit to the governor a list of licensed practical nurses containing names of not less than three times the number of persons to be appointed, and appointments shall be made after consideration of such list, with the first appointment being for a term of four years and the second appointment being for a term of two years. Upon the expiration of the term of any licensed practical nurse, a successor of like qualifications shall be appointed in the same manner as the original appointment for a term of four years and until a successor is appointed and qualified.

Kansas State Nurses Association (KSNA)
Kansas Organization of Nurse Executives (KONE)
Kansas Hospital Association (KHA)
Kansas Association of Nurse Anesthetists (KANA)

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(4) Upon the expiration of the term of any mental health technician, the Kansas association of human services technologies shall submit to the governor a list of persons licensed as mental health technicians containing names of not less than three times the number of persons to be appointed, and appointments shall be made after consideration of such list for terms of four years and until a successor is appointed and qualified.

(5) Each member of the general public shall be appointed for a term of four years and successors shall be appointed for a like term.

(6) Whenever a vacancy occurs on the board of nursing, it shall be filled by appointment for the remainder of the unexpired term in the same manner as the preceding appointment. No person shall serve more than two consecutive terms as a member of the board of nursing and appointment for the remainder of an unexpired term shall constitute a full term of service on such board.

(b) *Qualifications of members.* Each member of the board shall be a citizen of the United States and a resident of the state of Kansas. Registered professional nurse members shall possess a license to practice as a professional nurse in this state with at least five years' experience in nursing as such and shall be actively engaged in nursing at the time of appointment and reappointment. The licensed practical nurse members shall be graduated from an accredited practical nurse program, hold a diploma from an accredited high school or have otherwise obtained the equivalent of a high school education and be licensed to practice practical nursing in the state with at least five years' experience in practical nursing and shall be actively engaged in practical nursing at the time of appointment. Upon the expiration of the terms of the registered professional nurse members holding office on the effective date of this act, the governor shall appoint successors so that the registered professional nurse membership of the board shall consist of ~~three~~ four members who are engaged in nursing service [and two members] , one member certified as an ARNP or RNA, who are engaged in nursing education. The registered professional nurse members of the board holding office on the effective date of this act shall continue as members until the expiration of their respective terms. The licensed mental health technician members shall be high school graduates or shall have obtained the equivalent of a high school education and shall be licensed to practice as licensed mental health technicians in the state with at least five years' experience at the time of appointment. The consumer members shall represent the interests of the general public. Each member of the board shall take and subscribe the oath prescribed by

Kansas State Nurses Association (KSNA)
Kansas Organization of Nurse Executives (KONE)
Kansas Hospital Association (KHA)
Kansas Association of Nurse Anesthetists (KANA)

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vided in K.S.A. 75-3223, and amendments thereto.

New Sec. 8. (a) Any complaint or report, record or other information relating to the investigation of a complaint about a person licensed by the board which is received, obtained or maintained by the board is confidential and shall not be disclosed by the board or its employees in a manner which identified or enables identification of the person who is the subject or source of such information except:

(1) In a disciplinary proceeding conducted by the board pursuant to law or in an appeal of the order of the board entered in such proceeding, or to any party to such proceeding or appeal or such party's attorney;

(2) to the proper licensing or disciplinary authority of another jurisdiction, if any disciplinary action authorized by K.S.A. 65-1120 and amendments thereto has at any time been taken against the licensee or the board has at any time denied a license certificate or authorization to the person; or

(3) to the person who is the subject of the information, ~~but the board may required require disclosure in such a manner as to prevent identification of any other person who is the subject or source of the information.~~ DELETE

(b) This section shall be part of and supplemental to the Kansas nurse practice act.

Sec. 9. K.S.A. 65-1120, 65-1122, 65-1134, 65-1162, 65-4209 ~~and~~, 65-4214 and 74-1106 are hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

FACT SHEET
HB 2073 Changing the Board of Nursing Composition

The current number of Kansas Licensees is as follows:

R.N.'s 25, 538 L.P.N.'s 7,950 L.M.H.T.'s 1,126

Current KSBN	Ratio of Licensees per Board Member	KSNA Proposal	Change in Ratio Kansas RN's
R.N. 5	1:5100	7*	1:3650
L.P.N. 2	1:3975	2	1:3975
L.M.H.T. 2	1:560	2	1:560
Public 2		2	
TOTAL 11		13	

Schools/Programs

YEAR	RN	LPN	LMHT
1980	26	15	9
1990	30	17	5
Change	4	2	-4
Percent Change	15%	13%	44%
	Increase	**Increase**	**Decrease**

KSBN Licensees Population by Type

YEAR	RN	LPN	LMHT
1984	21,853	7,372	1,652
1992	25,538	7,950	1,126
Change	3,685	578	526
Percent Change	16%	8%	32%
	Increase	**Increase**	**Decrease**

Current Public Members appointed to Other Boards

	Public Members	Total Board Members
Board of Veterinarian Medicine	1	5
Board of Pharmacy	1	6
Board of Dentistry	1	5
Board of Nursing	2	11
Board of Behavioral Sciences	3	7
Board of Healing Arts	3	15

(2 Public Members were added in 1986)