Approved: March 3, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:00 p.m. on February 16, 2011, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Melissa Calderwood, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Kevin Robertson, Executive Director, Kansas Dental Association
Dr. Cindi Sherwood, DDS, Independence
Katherine Weno, KDHE
Tanya Dorf Brunner, Oral Health Kansas
Dr. Brett Rouff, DDS, Newton
Dr. Betty Wright, Kansas Dental Board
Sandra Wilkes, Kansas Association of Oriental Medicine
Sue Britt
Dr. Richard Yennie, Acupuncturist, chiropractor
Dr. Dominador T. Perido, jr., Surgeon, Family Practice
Dan Morin, Kansas Medical Society

Others attending:
See attached list.

The Chair opened the hearing on **SB 132—Dental care; increasing availability and access to dental care.** Staff explanation stated that this bill would create the Kansas Comprehensive Oral Health Initiative Act. Under the Act, the Kansas Health Policy Authority (KHPA) would be required to include dental coverage for all Medicaid beneficiaries. It would also establish the Kansas Dentistry Bridging Loan program, located within and administered by the KDHE. It would provide loans of $10,000 to students who commit to locating their practices in rural Kansas. Finally, students who receive the Kansas in-state tuition rate as part of an agreement with the Kansas Board of Regents would be required to provide dental services in Kansas for a minimum of four years after graduation.

Kevin Robertson, Executive Director of the Kansas Dental Association, believes that all Kansans deserve access to quality oral health care and to a dentist to provide for their comprehensive oral health needs. This legislation is a comprehensive approach to improving dental care to Kansans through increasing the supply of dentists available and by using the existing infrastructure to allow dental hygienists to deliver more care without a dentist being present. It expands dental Medicaid to include all eligible adults, reinstituting funding for the Donated Dental Services program for disabled and elderly Kansans that was cut in FY 2010 (Attachment #1).

Dr. Brett Roufs, DDS, Newton, re-emphasized the comments made by Mr. Robertson and added that another issue with the Medicaid system is the difference in reimbursements that Federal clinics receive versus private practice providers (Attachment #2).

Dr. Cindi Sherwood, DDS, Independence added her support of the Donated Dental Services program, dental education in Kansas and the need to keep graduates in the state, and the possibility of increasing the number of dental school seats open to Kansas residents (Attachment #3).

Also speaking in support of **SB 132**, Dr. Katherine Weno, DDS, Kansas Department of Health and Environment, echoed her support of this bill in her capacity as Director for the Bureau of Oral Health (Attachment #4).

Also in favor was Tanya Dorf-Brunner, Oral Health Kansas, stating that this bill addresses the payment source and provider access issues (Attachment #5).

The minutes of the Public Health and Welfare Committee at 1:00 p.m. on February 16, 2011, in Room 546-S of the Capitol.

Betty Wright, Executive Director, Kansas Dental Board, stated the duties of the Board were to protect the public through licensure and regulation of the dental profession and that this legislation creates a higher level of extended care permit dental hygienist called a Level III (Attachment #6).

Dr. David Hamel, DDS, (Attachment #7), Cathy Harding, Kansas Association of the Medically Underserved (Attachment #8), and Ron Gaches representing the Kansas Dental Hygientists' Association (Attachment #9) all presented written testimony in support of **SB 132**.

Debra Billingsley, Kansas Board of Pharmacy, presented written neutral testimony on this legislation (Attachment #10)

There being no further conferees, the hearing on **SB 132** was closed.

The Chair opened the hearing on **SB 195—Relating to the licensure of acupuncturists**. Staff explained that this legislation would require the Board of Healing Arts to license acupuncturists, outlines the requirements for licensure as an acupuncturist, and sets the limit on the amount of each fee related to the licensure. It also establishes an Acupuncture and Oriental Medicine Council to assist the Board, detailing the membership of the Council and specifying the Council's responsibilities.

Sandy Wilkes, Vice President of the Kansas Association of Oriental Medicine, stated that this legislation was needed to protect the public from unsafe or ineffective practices by unqualified practitioners; to provide a basis for the public to make informed decisions on the level and type of training of practitioners; to maintain the national level of quality, effectiveness and safety in the practice; and to protect the public's freedom to trained and qualified specialists (Attachment #11).

Sue Britt shared her experience with an acupuncturist (Attachment #12).

Dr. Richard Yennie, Acupuncturist and Chiropractor, states that Kansas should pass an Acupuncture and Oriental Medicine Practice Act and acupuncturists should be recognized and licensed in Kansas (Attachment #13).

Also speaking in favor of **SB 195** , Dominador Perido stated that with passage of this legislation another avenue in pain management would be opened (Attachment #14).

Written testimony in favor of this legislation was introduced from Michael J. Schroeder, American Acupuncture Council (Attachment #15) and Anne Hodgdon (Attachment #16).

Written testimony in opposition to the bill was introduced from Joseph Kroll, Kansas Department of Health and Environment (Attachment #17).

Dan Morin, Kansas Medical Society, presented testimony Attachment #18) in dispute of that presented by the proponents of this legislation regarding licensure as set forth in the Credentialing Act through the Kansas Department of Health and Environment. He referenced two documents, both dated February 11, 1999 addressing this issue, one from the Kansas Medical Society (Attachment #19) which said that KMS believes that the legislature should study the education and training of alternative providers as a whole before acting on the proposed legislation, and the other from Lesa Bray, Director, Health Occupations Credentialing, Bureau of Health Facility Regulation, KDHE, stating the department believes any decision to license persons to practice acupuncture must follow the process set forth in the Credentialing Act (Attachment #20).

There being no further conferees, the hearing on **SB 195** was closed.

The Chair called for final action on **SB 33—school sports head injury prevention**. A balloon was introduced with language that clarified licensed health care provider by definition to read "person licensed to practice medicine or surgery". Motion by Senator Reitz, seconded by Senator Kelly. Senator Pilcher-Cook requested clarification on the motion. Motion was restated to amend the bill as a substitute bill for **SB 33**, eliminating all other previously adopted amendments. Motion carried.

The minutes of the Public Health and Welfare Committee at 1:00 p.m. on February 16, 2011, in Room 546-S of the Capitol.

The next meeting is scheduled for February 17, 2011. The meeting adjourned at 2:30 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

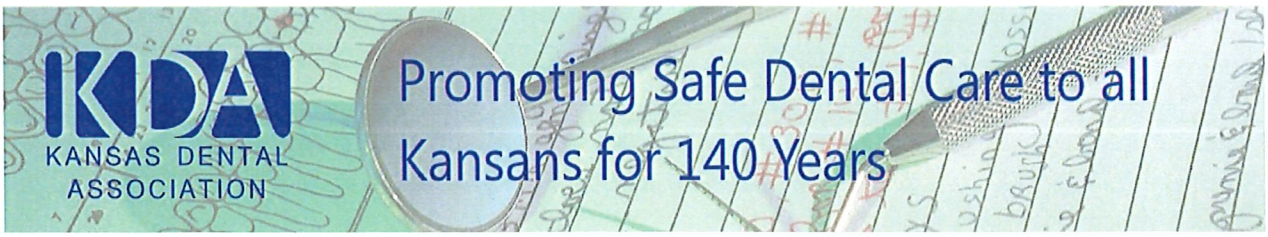
DATE: Wednesday, February 16, 2011

NAME	REPRESENTING
Tom Fiesher	Ks. Optometric Assoc.
Melissa Graham	Ks Dental Board
Billy Wright	Ks Dental Board
Kathy Damron	Strat. Comm of KS
Cindi Sherwood	KDA
Brett Banks	KDA
[illegible]	Bright & Company
[illegible]	KAMR
Bill Brady	KDA
Kathleen Sebelius/Lippert	KSBHA
Peter Kimble	KNPA
Patty Sampson	KDOA
Steve Shurn	KDHE
Jake Hein	Hein Law Firm
Paje Rauthier	Hein Law Firm
Nancy Jewett	the Superior Co.
[illegible]	KHA
Mark Peindo	KAOM

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: WEDNESDAY, FEBRUARY 16, 2011

NAME	REPRESENTING
DOMINADOR PERIDO	KAOM
Sandy Mackey	KAOM
Justin Bieber	KU MedCenter
Leigh Keck	Capitol Strategies



Date: February 16, 2011

To: Senate Committee on Public Health and Welfare

From: Kevin J. Robertson, CAE
Executive Director

RE: SB 132 – Comprehensive Oral Health Initiative

Chairman Schmidt and members of the committee I am Kevin Robertson, executive director of the Kansas Dental Association representing 1,250, or some 77% of the state's licensed dentists. Thanks for the opportunity to discuss with you the Kansas Dental Associations' thoughts on improving oral health for all Kansans.

The Kansas Dental Association (KDA) believes that all Kansans deserve access to quality oral health care and to a dentist to provide for their comprehensive oral health needs. As such, the KDA has worked with members of the dental team to enhance and increase the care they can provide to patients under various levels or dental supervision.

SB 132 is a comprehensive approach to improving dental care to Kansans. The KDA Comprehensive Oral Health Initiative seeks to safely and responsibly improve the delivery of oral healthcare throughout the state by increasing the supply of dentists available throughout Kansas but particularly in rural Kansas, improving the access of Kansas' most vulnerable citizens, and by using the existing infrastructure to allow dental hygienists to deliver more care without a dentist being present.

SB 132 includes the expansion of dental Medicaid to include all Medicaid eligible adults, reinstituting the funding for the Donated Dental Services (DDS) program for disabled and elderly Kansans that was cut in FY 2010, creating a student loan forgiveness program to incent dentists to practice in certain areas of our state. These are complex and potentially costly issues and the KDA continues to explore a variety of alternatives methods to accomplishing our ambitious goals to improve oral health.

The KDA has been in communication with the Brownback administration and the Secretary George about the Governor's rural opportunity zone (ROZs) proposal. Yesterday, I testified in favor of HB 2331 in the House Committee on Taxation as it would provide loan repayment for

persons who locate in the 44 most depressed Kansas communities. Since the Governor's rural opportunity zone concepts parallels the "Dentistry Bridging Loan Program" contained in Section 2, the KDA has decided to pursue that option as we believe it will provide incentives equal to that of the Dentistry Bridging Loan Concept.

The KDA will soon be meeting with Lt. Governor Colyer regarding dental Medicaid. We hope to add dentistry into the Medicaid Task Force discussions. The KDA would like this discussion include improvement to the current dental Medicaid system as well as the inclusion of adult dental Medicaid.

Dental Medicaid for adults is a critical component to truly improving oral health in Kansas. For each of the past 10 years the Kansas Dental Charitable Foundation has treated thousands through its Kansas Mission of Mercy (KMOM) free dental clinic. Dentists are both applauded for the care they provide at KMOM and scolded for not doing more. People ask, *"how can that many Kansans be without a dentist...we must need more!?"* At each of the first six KMOM events we received grant funds to survey the patients to help find an answer to that question. An average of 8% of the patients said they didn't like to go to the dentist or didn't think they needed care, less than 3% said there was no dentist in their area and an overwhelming majority of **87%** said they did not have insurance or other means to pay for a dentist. Adult dental Medicaid would greatly impact the lives of these people.

So that brings us to the Donated Dental Services (DDS) program. Dr. Roufs and Dr. Sherwood are both Donated Dental Services provider and members of the Kansas Foundation of Dentistry for the Handicapped Board of Directors. They will discuss the benefits of the DDS program. Let me just say that the program has survived for the past 1 ½ years by begging for money but at this point its survival is in the balance.

SB 132 contains and expansion of services for dental hygienists in Section 4. Back in 2002, the KDA and Kansas Dental Hygienist Association hammered out the agreement that became the Extended Care Permit (ECP) Dental Hygienist. The KDA was also involved and supported changes to the ECP I and II legislation in 2007. SB 132 adjusts the language for an ECP working in schools with children and creates a further expansion to the Dental Hygienist Extended Care Permit law to create an ECP III. An ECP III would have the same infrastructure, practice locations/populations and dental supervision that the current ECP I and II have. These include nursing homes, prisons, indigent health clinics, head start programs and children in schools. The ECP III Dental Hygienist would be allowed to use additional procedures that would assist them in treating these patients:

These new procedures that the ECP III dental hygienist could perform are:

- (A) Removal of extraneous deposits, stains and debris from the teeth and the rendering of smooth surfaces of the teeth to the depths of the gingival sulci;
- (B) the application of topical anesthetic if the dental hygienist has completed the required course of instruction approved by the dental board;

- (C) the application of fluoride;
- (D) dental hygiene instruction;
- (E) assessment of the patient's apparent need for further evaluation by a dentist to diagnose the presence of dental caries and other abnormalities;
- (F) identification and removal of decay using hand instrumentation and placing a temporary filling, including glass ionomer and other palliative materials;
- (G) adjustment of dentures, placing soft reline in dentures, checking partial dentures for sore spots and placing permanent identification labeling in dentures;
- (H) Smooth a sharp tooth with a slow speed dental handpiece;
- (I) Use of local anesthetic, including topical, infiltration and block anesthesia, when appropriate to assist with procedures where medical services are available in a nursing home, health clinic, or any other settings. If the dental hygienist has completed a course on local anesthesia and nitrous oxide as required in this act
- (J) Extract deciduous (baby) teeth that are partially exfoliated with class 4 mobility;
- (K) prescription of fluoride, chlorhexidine, **antibiotics** and antifungal as directed by a standing order from sponsoring dentist,

KDA's Immediate Past President Dr. Brett Roufs, Newton is here to discuss ECP III.

Finally, we come to section 8 which would require Kansas dental students who attend the University of Missouri-Kansas City (UMKC School of Dentistry as part of the Kansas Board of Regents agreement with Missouri to provide four years of dental service of Kansas. It also directs the Board of Regents to investigate 3-5 additional seats for Kansas residents with the stipulation that they return to practice dentistry in underserved areas of the state.

Though the concept of a service agreement for dental students has been discussed often before by the KDA and oral health advocates, it has recently come to light that such an agreement may actually make Kansas students ineligible for federal National Health Service Corp. money that is used to encourage new graduates to locate in FQHC clinics. As a result, the KDA would ask that section 8 be deleted at this time until we can get more information.

Be that as it may, KDA Secretary Dr. Cindi Sherwood, Independence will discuss dental school education with the committee so the members have a better understanding of the issue.

So where are we? I would suggest that sections 4, 6, 7, 9 and 10 be left in SB 132 and the others sections deleted as the KDA and others gather further information and pursue their implementations through other means.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions at this time.

Testimony on Senate Bill 132

Dr. Brett A. Roufs DDS
400 Allison
Newton, KS 67114

I am a general dentist from Newton and the immediate past President of the Kansas Dental Association (KDA). I graduated from UMKC School of Dentistry in 1996 and joined a private practice in Newton. In 1998 I bought the practice and became a single doctor practice at that time. I have been a Dental Medicaid for 6 years and have volunteered in 8 of 10 KMOM projects held to date. I have also volunteered ate the Harvey County Health Ministries dental clinic since 1996.

I am here today to testify on behalf of Senate Bill 132. Our bill has 2 specific areas that I will be discussing today that will address some of the barriers to oral health care here in Kansas.

As a Dental Medicaid provider I have experienced the difficulties associated with the Medicaid system. While many of these issues have been addressed and improved there can still be issues with payment and occasionally with timely payment on claims submitted. These are some of the reasons that many dentists in the state do not participate in this system. Senate Bill 132 addresses possible changes in the Medicaid system to ensure that dentists can more easily participate in this system. In our state we have what can be called a provider network that a dentist MUST sign a contract to provide care to the Medicaid population if the dentist is going to attempt to be reimbursed by Medicaid. This contract allows the Medicaid system great access to patient files in a practice and many offices choose not to participate in a provider network type of system. The current contract has been reviewed by outside legal sources and it is often recommended but such council to not sign this type of contract. Another issue with the Medicaid system is the reimbursement level. In my office I have reviewed these levels and have found them to be around 40% of my usual fees that other insurance companies and private pay patients regularly pay. The biggest issue I have heard from around the state seems to be one of patients not showing for scheduled visits and it therefore taking extra appointments to address the needs of these patients. You may here statistics that while 90% of medical offices accept Medicaid fees and provide services to this population only 25% of dental offices do the same. While these numbers may show a great disparity between dental and medical offices we should look at these numbers more closely. Medical Medicaid covers both adults and children while Dental Medicaid covers only children. The pediatric dentists of our state participate at about an 80% level. Even with only 25% of the dentists participating in the Medicaid system nearly 70% of Medicaid enrolled patients had a dental encounter in the last year. In comparison to the private insurance system in Kansas the #1 dental insurance provider saw a usage rate of only about 52% so Medicaid patients are being seen at a higher rate than private paying

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patients and studies by the American Dental Association (ADA) show that approximately 60% of patients use their dental insurance in a given year. If there were adult Medicaid reimbursement for comprehensive oral health care the participation rates among dentists in the state may very well increase. Another issue between Medical and dental are the amount of reimbursement for the same procedures. A study cited in Dentaltown magazine by Dr. Kenton Johnson DDS from Minnesota found that Medicaid reimbursed $455.21 per Emergency room visit for true Dental emergencies. My own research has found that some hospitals receive nearly $350 for this same type of visit while a dental office is likely to charge around $75 for this same type of visit and receive around $30-$40 in Medicaid reimbursement. Another issue with the Medicaid system is the difference in reimbursements that Federal clinics receive versus private practice providers. Private practices are only paid by procedure codes while a Federal clinic can receive an occurrence rate that is based on the number of visits a clinic sees regardless of the procedures they do on any one visit.

In our bill we have introduced changes in the dental practice act to allow trained hygienists to offer more services to patients in need of emergent dental care and to allow these hygienists to practice at the top of their license. We met several times with the Kansas Dental Hygiene Association (KDHA) and came up with a way to allow these newly trained hygienists to help us address some of the barriers to oral health care in our state. This will be an Extended Care Permit Hygienist III (ECP III). We currently have ECP I and II working in our state and doing great work in addresses some barriers such as nursing home care, head start and school screenings and other services they can perform without a dentist being present. I personally have experience with these ECP's as I sponsored the first such hygienist in the state. The program I ran addressed the elderly care gap in our state and especially those people that are in a nursing home setting. The ECP was able to go into nursing homes and under the program we developed saw patients and performed initial screenings, radiographs, and cleanings and then distributed this information to any dentist that the patient chose so that they could schedule and continue treatment in that dental office. With the expansion of current regulations and ECP III could perform even more treatment and address some of the issues that we frequently found in the nursing home setting. These additional procedures could be performed in other settings as well. The ECP hygienist could help make a patient more comfortable with some of these expended treatments that they could be allowed to perform and help the patients get to see a dentist. While there will be opponents of our bill that will say that we don't go far enough in allowing more treatment by these hygienists any of the expanded functions we are seeking have been agreed upon by the KDHA and can be done safely and effectively and have significant effects on certain dental populations in need of care. The duties we have brought forward should need less training that true surgical procedures like fillings in permanent teeth and the extraction of primary or permanent teeth. It would also be expected that any additional training could be developed quickly and therefore allow a timely implementation of this new hygiene practitioner. Some other models will require development of entirely new programs, locations for the training to take place, recruitment of educators, and at least 1-2 years of additional training beyond current hygiene education levels. Our bill requires about 18 hours of class time and 2000 hours of hygiene experience beyond their initial

hygiene licensure. An experienced hygienist can become an ECPIII hygienist in 1-2 weekends of coursework and begin having an immediate effect on some of the barriers to care in our state. Another advantage of our discussions with the KDHA and development of this hygiene practitioner is that they will be able to practice in more settings than they are currently able to and therefore deliver more treatment to people of Kansas. Other proposed practitioners use the FQHC system to utilize new practitioners to deliver care to our underserved population. These clinics typically receive $650,000 annually from the Federal government plus Medicaid occurrence rate fees to make this a sustainable model of care in our state. A private dental Medicaid provider is not allowed to be reimbursed on an occurrence base. Without the additional support from the Federal government these 18 clinics in our state will not remain viable. This is another entitlement program that could become a drain on the state if Federal funding is decreased.

One other part of our bill is for the state to re-establish funding for the Donated Dental Service program in our state. I am currently a provider and a board member for this organization. By re-establishing funding the legislature and provide nearly $630,000 of direct patient care to citizens of our state for the amount of $70,000. This 9:1 return on investment (ROI) is a great investment in the people of Kansas. We have been able to keep this program going over the last year thanks to private funding and grants from other agencies. There are nearly 250 dentists willing to continue providing care at no charge if the administrative and partial laboratory costs can be covered by a $70,000 investment by the state.

The KDA and the dentists of the state have worked with other organizations to develop a safe, well trained addition to the dental team that can help address and overcome some of the barriers to dental care in our state. While there are organizations from outside our state willing to experiment on our citizens with new dental practitioners they have not involved the dentists of our state in developing a program for our citizens. The Pew Foundation is trying to gain support by attempting to show dentists how much we can make by utilizing these new workers. The dentists are still worried about the safety and effectiveness of these new providers. Other organizations like the Kellogg Foundation are using models from Alaska, New Zealand and other countries with a much more socialized medical model to say they have the solution to bring down the barriers in our and other states in the Midwest and East coast. Kellogg foundation is willing to spend $16 million on developing programs in 5 states, including Kansas, yet $0 on direct care to help people in need.

Our state may have many areas without a dentist currently but over the last 10 years there has been an increase in the number of dentists (13%) while the population has grown at an 8% rate. Increasing the number of dentists in Kansas is something we all want and should work towards but we are making progress without becoming a test site for projects that may have little effect on improving oral health in Kansas. The maldistribution of dental providers in our state is a concern but something that most rural states are having to deal with and will likely be a state by state solution. Our state has done such a great job of building and maintaining our road infrastructure that very few citizens in our great state are over 40 miles from a dentist and while there are barriers to

getting the care people want and need the dentists of Kansas are doing their part to address some of these issues.

In closing I would ask for your support for Senate Bill 132 and welcome any questions that you feel I may be able to answer for you.

Testimony of Dr. Cindi Sherwood, DDS, Independence
in Support of SB 132

Thank you for this opportunity to testify on the Kansas Comprehensive Oral Health Initiative (SB 132). My name is Cindi Sherwood and I am a general dentist practicing in Independence, Kansas. I went to Wichita State and became a registered dental hygienist and then returned to school to become a general dentist. My husband and I returned to my home town to live and work and raise our children.

I would like to briefly speak on three points. First, we would ask that the legislature fund the existing Donated Dental Services (DDS) program. Donated Dental Services is a program that provides comprehensive dental treatment to people that are disabled, elderly or medically at-risk. Since 1996, 396 Kansas dentists and 125 dental labs have agreed to provide free treatment in their offices and labs to 2, 616 patients. Those patients received $6,677,340 worth of comprehensive dental treatment. The annual funding from the state was $70,000. This covered one part-time employee who determines applicant eligibility, links patients with nearby volunteer dentists, monitors the patient's progress and other administrative tasks. The money also covers incidental dental lab costs. The Kansas Health Policy Authority cut funding for the program in 2010. With a lot of begging, various foundations, dental societies, and individuals donated money to match a challenge grant from the United Methodist Health Ministries Fund to allow the program to continue in 2011.

I am a DDS provider. I have had the privilege to provide care for a number of patients over the years. My most recent referred patient is a 70 year old woman from Cherryvale who had to quit work several years ago to stay home and care for her elderly mother. Her biggest dental issue was that she had dropped and broken her upper denture into two pieces. She superglued it back together but it didn't fit quite right. It made terrible sores in the roof of her mouth. She was putting it in only to eat and then taking it out because it made her so miserable. My staff and I had the pleasure of making her a new, beautiful well-fitting denture and seeing her tears of gratitude and relief when she received her "new teeth".

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I also recently saw a gentleman from Parsons who needs a kidney transplant. The patients in need of transplants have to have their mouths healthy and infection free before they can be put on the transplant list. We completed the extractions and fillings that he needed and are keeping our fingers crossed with him that he is able to get a new kidney soon.

While this program is a small part of dealing with the barriers to dental care in Kansas, it is a great return on investment for the state. For $70,000 we can provide $600,000 in dental services.

The other two points I wish to make involve dental education in Kansas. First, Kansas has an agreement with the University of Missouri – Kansas City that they will accept Kansas residents to the dental school; and the state has an arrangement with Missouri that these students will not have to pay out-of-state tuition. The number of dental school graduates from Kansas the last five years are – 2006 – 19, 2007- 19, 2008 – 21, 2009 – 23 and 2010 – 27. The current tuition and fees at UMKC (which vary a little depending on their year in school) is between $29,296 for a resident of Missouri and $53,760 for a non-resident. (the most expensive year of dental school is $37,325 for a resident and $67,905 for a non-resident.)

We must continue to educate Kansas residents in dentistry to have a reasonable supply of dentists return to the state to practice. But we would recommend that Kansas residents that accept the in-state tuition arrangement be required to practice dentistry in the state of Kansas equal to the number of years that they received the reduction in tuition, up to four years. If they choose to go to another state to practice, then they will be required to pay the money back to Kansas that they received in dental school. Many states that don't have dental schools, like Kansas, have this as a requirement. This should help encourage our Kansas hometown young women and men to return to our state to work.

We recently learned that this requirement to pay back tuition could affect dentists who receive loan repayment to work for the Public Health Service. We are investigating how other states have handled this issue; and hope to be able to

make this change and still encourage dentists from Kansas to join the Dental Public Health Service. Kevin will let you know what he finds out.

The last point I want to recommend is that the Board of Regents be asked to investigate the possibility of increasing the number of dental school seats open to Kansas residents by 3-5 additional seats. These seats could be at UMKC or other area dental schools. Dental schools in the region include the University of Nebraska, Creighton University, Baylor University and others. The stipulation on these additional seats is that the students accepting the subsidy would be required to practice dentistry in UNDERSERVED areas of the state. This is yet another small piece to help remove barriers to dental care in Kansas.

Thank you for your interest and anyone has any questions when we are finished with our testimony, I will try to answer them.

Division of Health
Bureau of Oral Health
1000 SW Jackson, Suite 300
Topeka, KS 66612

Phone: 785-296-5116
Fax: 785-291-3959
http://www.kdheks.gov/ohi

Robert Moser, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

Testimony on SB 132

Presented to
Senate Public Health and Welfare Committee

By
Katherine Weno DDS, JD
Bureau of Oral Health
Kansas Department of Health and Environment

February 16, 2011

Chairperson Schmidt and members of the committee, I am Dr. Kathy Weno, the Director for the Bureau of Oral Health at the Kansas Department of Health and Environment, the State Dental Director. Thank you for the opportunity to speak to the committee today about Kansas' dental workforce and on Senate Bill 132.

The Bureau of Oral Health is the state's public health section dedicated to oral health. We collect data on the oral health of Kansans, administer a Dental Recruitment program and provide funds for community based oral health improvement projects.

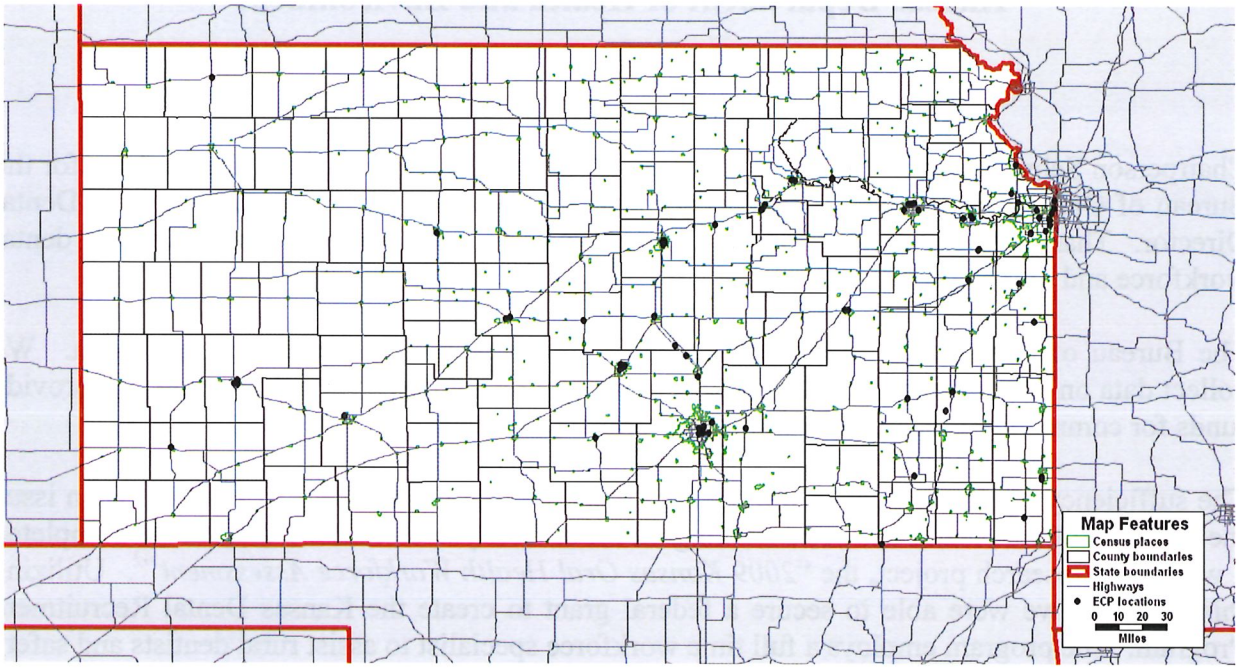
The sufficiency of Kansas' dental providers to meet the oral health needs of Kansans is an issue the Bureau of Oral Health has been working on for several years. In 2009 the Bureau completed a workforce research project, the "*2009 Kansas Oral Health Workforce Assessment*"[1]. Utilizing this research, we were able to secure a federal grant to create the Kansas Dental Recruitment Program. The program employs a full time workforce specialist to assist rural dentists and safety net clinics in dental professional recruitment and offers workforce incentives like student loan re-payment and provider grants to subsidize community based projects like school sealant and nursing home programs. We also created "Dental Club", a program for high school students to interest them in dental careers. Dental Club provides students with work/study and mentoring opportunities as well as college scholarships for students willing to commit to a dental career. Lastly, the grant includes an on-going task group, the Dental Workforce Cabinet, where a diverse group of stakeholders work together on workforce issues.

SB132 proposes changes to the Dental Practice Act (65-1456) regarding Kansas' community dental hygienist model, the Extended Care Permit. This bill will allow registered dental hygienists with ECPs to provide an expanded scope of services to patients while working in outreach sites, and will give them more access to students in Kansas schools. The Bureau of

[1] http://www.kdheks.gov/ohi/download/2009_Oral_Health_Workforce_Assessment.pdf

Oral Health is supportive of ECP dental hygienists, and provides funding for their work across the state. ECPs are actively treating underserved populations outside of traditional dental practice in outreach sites such as nursing homes and elementary schools. Although this model is one way to get dental care to remote populations, Bureau of Oral Health data indicates that ECPs are underutilized. The ECP has been available since 2003 but only 124 out of 1750 active licensed hygienists have an ECP permit. Below is a map of these ECP's primary practice locations. The majority of these hygienists are located in population centers, primarily in areas with a dental safety net clinic. It should be noted that some ECPs travel to provide treatment in rural sites around these cities and this is not reflected on this map. It is also true that many of these ECPs are not actively practicing outside their primary practice locations, and even for those who are, 66% reported working eight hours a week or less in community based practice sites.

Primary Practice Locations for Dental Hygienists with Extended Care Permits
Source: Kansas Dental Board, 2010



One of the primary goals of the Bureau of Oral Health's federal workforce grant is to increase the utilization of the Extended Care Permit, particularly in rural and underserved areas. Current activities include educational outreach about ECPs to dental hygienists and dentists explaining how their work can benefit a dental practice or dental safety net clinic activities. The underuse of ECPs was one of the first topics tackled by the Workforce Cabinet. The group includes several hygienists with ECPs who explored what barriers they were facing and what needed to be done to make this model work better in Kansas. The Cabinet agreed upon two strategies, first ECPs needed to expand their scope of practice to better address unmet dental needs in community sites. Hygienists in nursing homes wanted to be able to adjust dentures and do relines. Others noted the need for more palliative care like temporary fillings. The other thing that ECPs needed was more access to low income children in schools, a primary outreach

9-2

location for community dental programs. The Workforce Cabinet, the Kansas Dental Hygienists Association, Oral Health Kansas and the Kansas Dental Association worked together to craft changes to the Dental Practice Act to address this issues. SB132 contains these changes.

Currently the Bureau of Oral Health uses ECP hygienists to staff school based preventive programs in Atwood, Garden City, Salina, Junction City, Atchison, Lawrence, Emporia, Wichita, Arkansas City, Olathe, Pittsburg and Wamego. Current law only allows ECP school programs to treat children on Medicaid or the Free and Reduced Lunch program. School based ECPs encounter many uninsured children who are not on any publically funded meal or health programs with unmet dental needs. It is unfortunate and inefficient that ECPs cannot legally treat these children in need due to the current statute. Additionally ECPs often encounter difficulty in confirming patient eligibility because schools will not provide information about which children are on the free and reduced lunch program due to privacy concerns. If this information is not obtained, only Medicaid children can be seen, further reducing the number of children that can be seen in the school based ECP program. Section 4 of SB132 will amend 65-1456 to allow ECPs to see all school children on Medicaid and HealthWave AND children who "*have not been seen by a dentist during the previous 12 months for a dental exam*". This removes the free and reduced lunch barrier, allowing the programs to access many more children at risk of dental disease. The Bureau of Oral Health strongly supports the ECP changes reflected in Section 4 of SB 132.

SB 132 also proposes new workforce incentives for young dentists and students currently in dental school that may be considering practicing in Kansas. It is clear that Kansas needs to recruit new dentists. Kansas' dentists are aging, especially in rural and frontier counties. The average age of a Kansas dentist is 50, but as the population of a Kansas county decreases, the age of their dentist increases. The average age of a dentist in a frontier county is 57. 54.3% of these dentists plan to retire in the next 3-5 years. We also know recruiting dentists to work in Kansas is difficult. For dentists who reported their practice was for sale, 75% indicated the practice had been for sale for a year or more. Among those looking to hire an additional dentist to their practice, 48.5% reported that recruitment had been difficult.

Kansas does not have a dental school, but has a reciprocity agreement with the University of Missouri – KC School of Dentistry. 69% of Kansas dentists surveyed in 2009 were UMKC graduates. Sections 8(a) and (b) of SB 132 requires all dental students using this reciprocity agreement at UMKC to come back to Kansas to practice for a minimum of four years. The bill will also create a new Dental Bridging Loan program to provide tuition assistance for students currently in dental school. This loan will be administered by the Dental Recruitment Program at the Bureau of Oral Health.

It is important to understand the effect that these provisions of SB 132 will have on the currently funded student loan re-payment programs available to Kansas dentists and hygienists. The KDHE Bureau of Local and Rural Health administers two federally funded loan programs for primary care health care professionals: the National Health Service Corp (NHSC) loan re-payment program and the State Loan Re-Payment Program (SLRP). To be eligible for these funds, a dentist or dental hygienist must practice in a federally designated shortage area, be a Medicaid provider and offer a sliding fee scale to low income patients. These programs are

primary recruitment tools for dental safety net clinics, as a dentist can receive up to $60,000 for two years of service to apply to their student loans. Last year 24 dentists and dental hygienists received either NHSC or SLRP funds. Almost all of them worked in Kansas safety net clinics.

SB 132 would make all students receiving in-state tuition under Section 8(a) and 8(b) ineligible for NHSC and SLRP loan re-payment. Federal eligibility rules require that the recipients of these programs have no other obligations to practice in specified locations. Sections 8(a) and 8(b) create an obligation for the new dentist to practice in Kansas for four years. Therefore, under the proposed bill a dentist would be not be eligible for NHSC or SLRP loan re-payment until after he/she completed the bill's four year period of obligation. Almost all Kansans at the UMKC School of Dentistry receive in-state tuition as part of the current reciprocity agreement, so none of these graduating dentists could receive funds from these federal programs. Recruiting dentists to work in underserved parts is already difficult, and without the benefits of governmental loan re-payment programs, this will become even more challenging. The Bureau of Oral Health recommends the removal of Sections 8(a) and (b) from SB 132.

The Bridging Loan in Section 3 is a much smaller program, providing funds for a maximum of four dental students per class. The Bridging Loan is intended for dentists who choose to work in an independent private practice setting, not a safety net clinic, and requires a community match. Bridging Loan recipients can only practice outside Kansas' most populous counties, so this bill could feasibly increase the numbers of independent dental practitioners in rural underserved counties. The dentists receiving the Bridging Loan would not be eligible for NHSC or SLRP, but as the Bureau of Oral Health at KDHE would administer this program, we have the expertise to advise all applicants of consequences and obligations of all of the available loan re-payment programs prior to their enrollment. The Bureau of Oral Health already administers one Dental Loan re-payment program that works collaboratively with NHSC and SLRP, and is able to add the Bridging Loan with no additional administrative costs to the state.

Thank you for your attention and the opportunity to appear before you today. I will now stand for questions.

ORAL HEALTH KANSAS

Public Health & Welfare Committee
February 16, 2011

Madam Chair and members of the Committee, thank you for the opportunity to talk with you today about SB 132. My name is Tanya Dorf Brunner, and I am the Executive Director of Oral Health Kansas, Inc. We are the statewide advocacy organization dedicated to promoting the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter. We achieve our mission through advocacy, public awareness, and education. Oral Health Kansas has over 1,100 supporters, including dentists, dental hygienists, educators, safety net clinics, charitable foundations, and advocates for children, people with disabilities and older Kansans.

We see three types of barriers to accessing oral health in our state: access to a payment source; access to a provider; and willingness to access services. A variety of approaches to all three types of access must be present in order for all people to have adequate access to oral health care. With our partners in the oral health field, we are working to address each of these through a variety of means.

SB 132 addresses the payment source and provider access issues; therefore, Oral Health Kansas supports this bill.

Medicaid dental coverage

The first section of the bill creates a dental benefit for all people eligible for the Kansas Medicaid program. Currently children are eligible for dental services under Medicaid and HealthWave, but their eligibility ends when they turn 21.

Research shows that people who receive routine dental services are able to better manage oral health problems that could lead to more serious and costly health problems, including pneumonia, strokes, and heart conditions. Investing in routine, preventive dental services can help reduce future health costs.

Losing dental services at a young age has serious consequences for people. I had the chance to meet William Waterhouse three weeks ago at the 2011 Kansas Mission of Mercy. He was there to have all his teeth extracted. He is on Medicaid and Medicare and hasn't had access to dental services since he was 21. I didn't ask his age, but he couldn't be much older than his early thirties. As William told me, "Once you get one bad tooth, if you don't get that taken care of, it cause them all to go bad." He said he was hopeful he could get fitted for dentures after he healed up.

800 SW Jackson, Suite 1120
Topeka, KS 66612

785.235.6039 (phone)
785.233.5564 (fax)
ohks@oralhealthkansas.org

www.oralhealthkansas.org

Frequently when people have dental pain, but do not have a way to pay for dental services, they end up in the emergency room. The only thing emergency rooms can do is help alleviate the pain. People may get temporary relief, but it comes at a high cost – both in the cost of emergency room services and in the human cost of not fixing the medical problem associated with the dental pain.

There are studies on the cost of emergency room usage for dental pain in several states, including recent studies in Minnesota, Washington and California. Oral Health Kansas is working with the Kansas Hospital Association to begin to determine that cost in Kansas.

We support any efforts to implement an adult dental benefit in the Kansas Medicaid program. We believe it will not only save money in emergency room visits, but improve the overall health of people on Medicaid.

Section 5 of SB 132 also creates a commission to explore barriers dental participation in Kansas Medicaid. Given our organization's dedication to improving Medicaid's dental services and to a collaborative approach to policymaking, we also support this provision.

Dental Hygiene services for schoolchildren

Last fall Oral Health Kansas helped convene a group of stakeholders, including dentists, hygienists, and a school administrator, to review the Extended Care Permit law, KSA 65-1456. The stakeholder group concluded the Extended Care Permit (ECP) law is a tremendous asset in creating access to dental hygiene services to underserved populations in Kansas. One key barrier the group noted was that the children who are eligible to be seen by ECP hygienists in schools are not always able to see the ECP hygienists.

KSA 65-1456 (f) specifies that ECP hygienists may provide services to children who are on the free or reduced lunch program. We have learned that many school districts are uncomfortable sharing this list with ECP hygienists who request it. The primary reason seems to be concern over stigmatizing the students who are on free or reduced school lunches.

In one remarkable school district, all of the children in the district who do not have a dental home are able to be seen by an ECP hygienist. The Galena School District worked with their local community health center to set up a system at enrollment for parents to allow their children to be seen by the ECP hygienist. As a result, all of the children who did not have a dental home now are able to receive services from the ECP hygienist at the school each year.

The language on page 4 of SB 132 would ensure all Kansas school children who have not had a routine dental visit in the last year are able to see an ECP hygienist, with parental permission. The language in this section was developed by this stakeholder group as a way to expand access to dental hygiene services to all schoolchildren in the state.

Extended Care Permit III

Oral Health Kansas recognizes the need to expand and strengthen the dental workforce in Kansas. We believe access to both a provider and a payment source need to be strengthened in order to ensure all Kansans have access to good oral health care. Our board supports the efforts being undertaken to address workforce issue through SB 132 and HB 2280/SB 192. HB 2280/SB 192 creates a new Registered

Dental Practitioner, which is considered to be a midlevel professional with a scope of practice between a dental hygienist and a dentist. Oral Health Kansas is dedicated to collaboration; as such, we encourage the parties working on dental workforce models to collaborate on a model that works best to meet the oral health needs of all Kansans.

UMKC School of Dentistry

Oral Health Kansas has worked with the Kansas Dental Association on the proposal in section 8 to require Kansas students who benefit from our state's agreement with UMKC for in-state tuition to practice dentistry in Kansas for at least four years after graduation. We believe this is one very concrete approach to increasing the number of dentists in our state every year.

We learned this week that there are complicating factors to requiring Kansas dental school graduates to practice in Kansas. We are sympathetic to those factors and stand ready to work with all the parties to determine if there is another way to address the issue.

Currently there is no tracking mechanism to determine whether Kansas students graduating from the UMKC School of Dentistry come back to practice in Kansas. Creating such a mechanism sounds simple, but is not. It is something we believe needs to be explored.

Thank you for your time today. I am happy to stand for any questions.

Kansas Dental Board
Landon State Office Building
900 SW Jackson, Room 564-S
Topeka, KS 66612

phone: 785-296-6400
fax: 785-296-3116
www.ks.gov/kdb

Betty Wright, Executive Director

Kansas Dental Board

Sam Brownback, Governor

Testimony re: SB 132
Senate Public Health and Welfare Committee
Presented by Betty Wright, Executive Director of the Kansas Dental Board
February 16, 2011

Madame Chair and Members of the Committee:

My name is Betty Wright, and I have been the Executive Director of the Kansas Dental Board since December 2005. The Board consists of nine members: six dentists, two hygienists and one public member. The mission of the Dental Board is to protect the public through licensure and regulation of the dental profession, consisting of 4517 licensees, 2112 dentists and 2403 hygienists.

The Kansas Dental Board is in support of Senate Bill 132. The bill creates a higher level of extended care permit dental hygienist, called a Level III. The Board currently has 43 Level I extended care permit hygienists and 81 Level II extended care permit hygienists. This broadening of powers of the hygienists has allowed the expansion of dental hygiene services to many school children, nursing home patients, and indigent clinic patients throughout underserved populations and communities. The new extended care permit III hygienist will be able to perform more functions with sponsorship and monitoring by a Kansas licensed dentist.

I am glad to stand for questions by the Committee.

Sincerely,

Betty Wright

Betty Wright
Executive Director
Kansas Dental Board

Senate Public Health and Welfare
Date 2-16-2011
Attachment 6

Committee members:

Thank-you for allowing me to provide written testimony to your committee. I regret being unable to attend this meeting. If you have any questions for me, I have left my personal contact information with the KDA Executive Director Kevin Robertson. Please feel free to contact me.

I ask you to support the initiatives presented by the KDA. They represent a multifaceted approach to provide dental care for Kansans no matter where on the spectrum of prosperity or geography they reside.

For our at risk population we want to provide more opportunities for them to break a cycle that many times exists in low income populations with regards to dental health. We know that literacy is important for the caregivers responsible for children in this population.

•Lower Caregiver literacy was associated with deleterious oral health behaviors, including nighttime bottle use and no daily brushing/cleaning. Caregiver literacy has a multidimensional impact on reported oral health outcomes in infants and young children.
Journal of Dental Research Oct 2010

We must always remember that all children begin with health

Our first goal is to preserve the oral health we are blessed with and with the Extended Care permit 3 for dental hygienists we are focusing upon prevention and

Senate Public Health and Welfare
Date 2-16-2011
Attachment 7

literacy. We want to create opportunities for children and their caregivers to receive preventive care and education in facilities other than a dental office such as Headstart facilities. This initiative will also develop opportunities for nursing home residents to receive triage care and facilitate care with a dentist.

As President of the Kansas Dental Association, I have had many calls or contacts from dentists asking about Kansas or just wanting to talk about opportunities but two recent emails from out of state dentists showed me the importance of our rural incentive initiatives. One dentist wants to return home to South East Kansas and one wants to move from a neighbor state and is looking seriously at very rural area of SW Kansas. Both mentioned, they are following dental news in Kansas and are hopeful a program will be developed.

A couple of years ago, a sample survey of our members showed some interesting possibilities for non traditional ways to apply Medicaid to efforts by dentists to provide dental care for our at risk / low income population. Of course being non traditional also means that at this time they are not funded. Currently the Medicaid program has rules that limit its participation to about 25% of dentists. Our survey indicated that many more dentists are available to care for people in the Medicaid program if simplification and rule changes can be implemented. We are encouraged by Lt. Governor Colyer's emphasis and we also recommend a commission to explore and make changes.

All the initiatives from the KDA will help provide a foundation from which Kansas residents can receive dental care. I ask that you support this bill presented by the KDA.

Thank-you,

David Hamel DDS
1200 Broadway
Marysville, KS 66508
785-562-5512
Kansas Dental Association President

KAMU
THE PRIMARY CARE ASSOCIATION OF KANSAS
strength
unity
advocacy

Testimony on:

SB 132

Written testimony to:

Senate Public Health and Welfare Committee

By:

Cathy Harding, Executive Director
Kansas Association for the Medically Underserved

February 16, 2011

For additional information contact:

KAMU
1129 S Kansas Ave., Ste. B
Topeka, KS 66612
Ph: (785) 233-8483
Fax: (785) 233-8403

Senate Public Health and Welfare
Date 2-16-2011
Attachment 8

Good afternoon Madame Chair and members of the Senate Public Health and Welfare Committee. I am Cathy Harding, Executive Director for the Kansas Association for the Medically Underserved (KAMU). I am providing written testimony for SB 132.

KAMU has been the Primary Care Association of Kansas for 22 years. As the Primary Care Association, KAMU, represents 39 primary care safety net clinics that all share the same mission of providing health care services without regard for the patients' ability to pay. KAMU and our members believe Kansas should be a state where all individuals have access to comprehensive, affordable and quality health care. Our 39 member Safety Net Clinics along with their 26 satellite sites provide Kansans a total of 65 access points.

We continue to celebrate and recognize the growth of the number of Kansans served by safety net clinics in Kansas over the years. In 2009 our 39 clinics provided care for over 223,000 underserved Kansans – a 31.6 % increase in patients in just two years (2007 – 2009). With the current economic climate in our state the number of individuals who are uninsured and underinsured will continue to rise. This demand for care has increased so much in just the past year that six new applications are expected for state funding this year through KDHE's Primary Care Grant Program, and the possibility of two more.

SB 132 provides increased access to dental services for Kansans. Eighteen safety net clinics in Kansas provide dental care to some of our most vulnerable Kansans. Any legislation that will increase access and open up opportunities for new services and new patients improves the overall health of Kansans, and so is a concept we support.

However, KAMU has concerns about two sections of SB 132, specifically– the Bridging Loan Program and the expansion of seats at the UMKC Dental school requiring that the students return to practice in underserved areas in Kansas. As we understand it, both sections create an "obligation" by the dentists that take advantage of these programs. If they would participate in these programs/initiatives, they would be disqualified from participating in federal and state loan repayment programs like the National Health Service Corps and the State Loan Repayment Program.

Currently nine of our 18 safety net dental programs use the loan repayment programs, thus this could create a problem for our clinics in recruiting dentists.

One Federally Qualified Health Center (FQHC) wrote that the student loan repayment program is one of the few things they can leverage when recruiting dentists. This member clinic is currently working to recruit a dentist, and the loan repayment program is the one thing that keeps candidates interested in the employment opportunity.

Although in general KAMU supports this bill, we can do so only if these two sections are removed or modified so as not to jeopardize graduating dentists' ability to participate in established loan repayment programs.

Thanks for hearing our concerns and please feel free to contact me if you have any question or need additional information.

KANSAS ASSOCIATION FOR THE MEDICALLY UNDERSERVED
1129 S. Kansas Ave., Suite B | Topeka, Kansas 66612
tel 785.233.8483 | fax 785.233.8403 | www.kspca.org

GACHES, BRADEN & ASSOCIATES
Government Relations & Association Management

825 S. Kansas Avenue, Suite 500 • Topeka, Kansas 66612 • Phone: (785) 233-4512 • Fax: (785) 233-2206

Testimony of Kansas Dental Hygienists' Association
In support of Senate Bill 132: Concerning Access to Dental Care
Submitted by Ron Gaches, legislative counsel
Before the Senate Public Health and Welfare Committee
Wednesday, February 16, 2011

Senator Schmidt and members of the Committee, the Kansas Dental Hygienists' Association (KDHA) supports enactment of SB 132, a proposal intended to increase the number of Dentists serving Kansas and expanding the role of Dental Hygienists with Extended Care Permits.

KDHA worked with the Kansas Dental Association to develop the ECP III proposal, and while the Dental Association was not supportive of broadening the authority of the ECP as fully as the KDHA leadership thought was appropriate, the proposal here is a significant improvement over current law and has our support. This proposal allows for the ECP III to provide minor temporary dental care until the patient can be seen by a dentist.

The other provisions of the bill are mostly intended to increase the number of dentists working in Kansas over time, and are also worthy of your support. However, passage of SB 132 is not sufficient to meet the unmet oral health needs of many Kansans without access to dental care.

IN ADDITION, KDHA encourages your favorable consideration of the Registered Dental Practitioner (RDP) proposal in Senate Bill 192 (also in this committee). The RDP proposal is designed to provide a mid-level oral health practitioner whose scope of practice will be greater than a dental hygienist but less than a dentist. All RDPs would be required to complete the dental hygienists training before receiving an additional 12 – 18 months of education, training and clinical experience before they could become a Registered Dental Practitioner. RDPs would be required to have a minimum of 500 hours working directly with a dentist before they could work under the general supervision of a supervising dentist. RDPs would provide a valuable extension of a dentist's practice and allow a less expensive option to meeting the needs of those Kansans who currently don't receive adequate oral health care.

800 SW Jackson St., Suite 1414
Topeka, KS 66612

Kansas

phone: 785-296-4056
fax: 785-296-8420
pharmacy@pharmacy.ks.gov
www.kansas.gov/pharmacy

Debra L. Billingsley, Executive Secretary

Board of Pharmacy

Sam Brownback, Governor

Testimony concerning
Committee on Public Health and Welfare
Concerning the Dental Act
Presented by Debra Billingsley
on behalf of
The Kansas Board of Pharmacy
February 16, 2011

Madam Chair, Members of the Committee:

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

The Board met on February 10, 2011 and reviewed the proposed language in SB 132. The Board is neutral on the bill except for the provision on page 8 line 11 and 12 that would permit a dental hygienist to prescribe fluoride, chlorhexidine, antibiotics and antifungals as directed by a standing order from a sponsoring dentist. This bill would permit a dental hygienist that has 18 hours of training to prescribe drugs. Those are not 18 hours in pharmacology but 18 hours of some unknown training. Eighteen hours of pharmacology is not even sufficient to train a person on drug interactions, allergies, etc. Providing a prescription for antibiotics, antifungals, and even floride can have serious consequences if the prescriber is not properly trained. A pharmacist is required to complete 6 years of training in pharmacology and to obtain a doctorate before they can dispense and they don't have the authority to prescribe. The Board finds this to be a dangerous change that will risk the lives of the patients being treated.

Further, the bill indicates that the hygienist would write prescriptions based on a standing order. That would presumably mean that the hygienist would be permitted to write a prescription for any patient that met certain criteria rather than the hygienist doing a full examination of each patient on a case by case basis. The Board of Pharmacy will not permit a pharmacy to fill a prescription if it is based on a standing order and we are unaware of any other prescriber using a standing order as a means to determine whether a patient receives a prescription.

Thank you for permitting us to provide our testimony.

Testimony In Support of SB195

Presented By: Sandy Wilkes

Senate Public Health & Welfare

February 16, 2011

Chairwoman Schmidt, members of the Senate Committee on Public Health and Welfare:

Thank you for hearing us today. We appreciate your time.

Kansas needs licensure for Acupuncture and Oriental Medicine (AOM) practitioners for several reasons.

- **To protect the public** from unsafe or ineffective practices by unqualified practitioners.
- **To provide a basis for the public to make informed decisions** on the level and type of training of acupuncture practitioners.
- **To maintain the national level of quality, effectiveness and safety** in the practice of AOM, for the public and the profession.
- **To protect the public's freedom** to access trained and qualified specialists in AOM.

Patients ability to access acupuncture seems like a given, yet without licensing we as practitioners are vulnerable to being shut down at any time. We are vulnerable to legal action for simply practicing our chosen profession, and our patients are vulnerable to being denied the care they seek. As an example: This past year one of our qualified AOM practitioners received a "cease and desist" from the legal counsel of the Board of Healing Arts. There was NO COMPLAINT against her. She was simply "shut down" for two months until their next meeting. Thousands of dollars and two months later at their next scheduled meeting, they reviewed her training and she was told she could resume her work.

Another qualified AOM practitioner who was employed at the KU Medical Center Program for Integrative Medicine was sent a certified letter telling her that state statute allowed that she could no longer work there legally, effective immediately. She had been certified by the hospital and had worked there "legally" for two years, and nothing pertaining to her work situation had changed in the statute since that time.

We are subject to the random reinterpretation of statute relating to our profession. And it seems our predicament can only be remedied with licensing.

The bright spot in all of this is that there is ample precedent for licensing Acupuncture and Oriental Medicine in the U.S.

- **Forty-four states and the District of Columbia have all licensed AOM practitioners.** (see map included)

- Twenty-six states specifically include herbal use in the scope of practice of their acupuncture license. (see map included)

Acupuncture is safe, effective, and inexpensive. According to the 2007 National Health Interview Survey an estimated 3.1 million U.S. adults and 150,000 children had used acupuncture in the previous year, and use of acupuncture is on the rise.

There are over 27,000 licensed practitioners of Acupuncture and Oriental Medicine in the United States today. The effective, quality care, and high educational standards maintained by the AOM profession, may be part of the reason for the rise in acupuncture use.

Our profession is regulated largely by two organizations

The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is the national agency recognized by the U.S. Department of Education to accredit Master's-level programs in acupuncture and Oriental medicine. This accreditation process is extensive with many levels of competency that must be met by the institution and, like any college accreditation process, takes several years. Currently, ACAOM has over 60 schools and colleges in accredited or candidacy status. Continued vigilance to maintain accreditation guarantees the quality and high standards of our schools, and so our graduates and professionals, nationwide.

We have an excellent AOM college in Overland Park Kansas, The Kansas College of Chinese Medicine, that has attained candidacy for accreditation with ACAOM.

The National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) established in 1982, is the only national organization that validates entry-level competency of AOM practitioners through professional certification. (see Code of Ethics included) A passing score on the NCCAOM certification examinations are documentation of competency for licensure by 43 states plus the District of Columbia, which represents 98% of the states that regulate acupuncture.

NCCAOM contracts approved examinations through the same nationally recognized company that provides testing for Doctors, Surgeons, Registered Nurses, and other health professionals.

In order to qualify for NCCAOM certification, applicants are required to meet extensive academic and practical standards. To achieve the Certification in Oriental Medicine the following requirements must be met:

- **Graduate from a formal, full-time school or college Master's level** acupuncture program accredited by ACAOM.

- **Complete a minimum of 2,625 hours of education** which represents four years of education. This includes 450 hours of didactic Oriental herbal studies along with 870 hours of clinical training.

- **Complete 510 hours of education in biomedical clinical sciences.** These hours ensure the necessary skills to know when to refer a patient to a medical doctor and allows acupuncturists to converse knowledgeably with western medical practitioners.

- **Finally applicants must pass four separate examinations:** Foundations of Oriental Medicine, Acupuncture with Point Location, Biomedicine, and Chinese Herbology.

There are Medical Doctors and Chiropractors that practice acupuncture after certification courses of only 100 hours, which can establish only an introductory knowledge of the potential of acupuncture treatment. **The National Institutes of Health (NIH) have acknowledged Oriental Medicine, also called Traditional Chinese Medicine, as a complete medical model.** It has it's own theories, diagnostics, syndrome differentiation, and treatment modalities. The NIH have conducted hundreds of research studies in Oriental Medicine therapies, and recognize not only acupuncture but Oriental Medicine as a whole, including herbs, exercise and hands-on techniques. They acknowledge the importance of proper training in this quote from their website:

> *"If you are thinking about trying TCM herbal remedies, it is better to use these products under the supervision of a medical* ***professional trained in herbal medicine*** *than to try to treat yourself."*

The best way to identify trained herbalists is through state licensure of Acupuncture and Oriental Medicine practitioners. The American Acupuncture Council, the largest insurer of AOM Practitioners in the nation, verifies the safety of herbal use in a letter we have included in your packet. Abuse and misuse of herbs can happen easily when

people are self-medicating or overmedicating, getting their information from the internet, from an unqualified practitioner, or from an opportunistic retailer. The public would benefit from access to AOM herbal specialists when seeking knowledgeable advice and care.

The citizens of Kansas deserve the right to access quality practitioners of Acupuncture and Oriental Medicine for their healthcare maintenance and improvement.

Please consider the Acupuncture and Oriental Medicine Practice Act worthy of your vote.

Thank you.

Respectfully,
Sandra Wilkes L.Ac. D.O.M.
Vice President of the Kansas Association of Oriental Medicine
Acupuncturist and Diplomate of Oriental Medicine (NCCAOM)
20622 Nall
Stilwell, KS 66085

Information Sources:

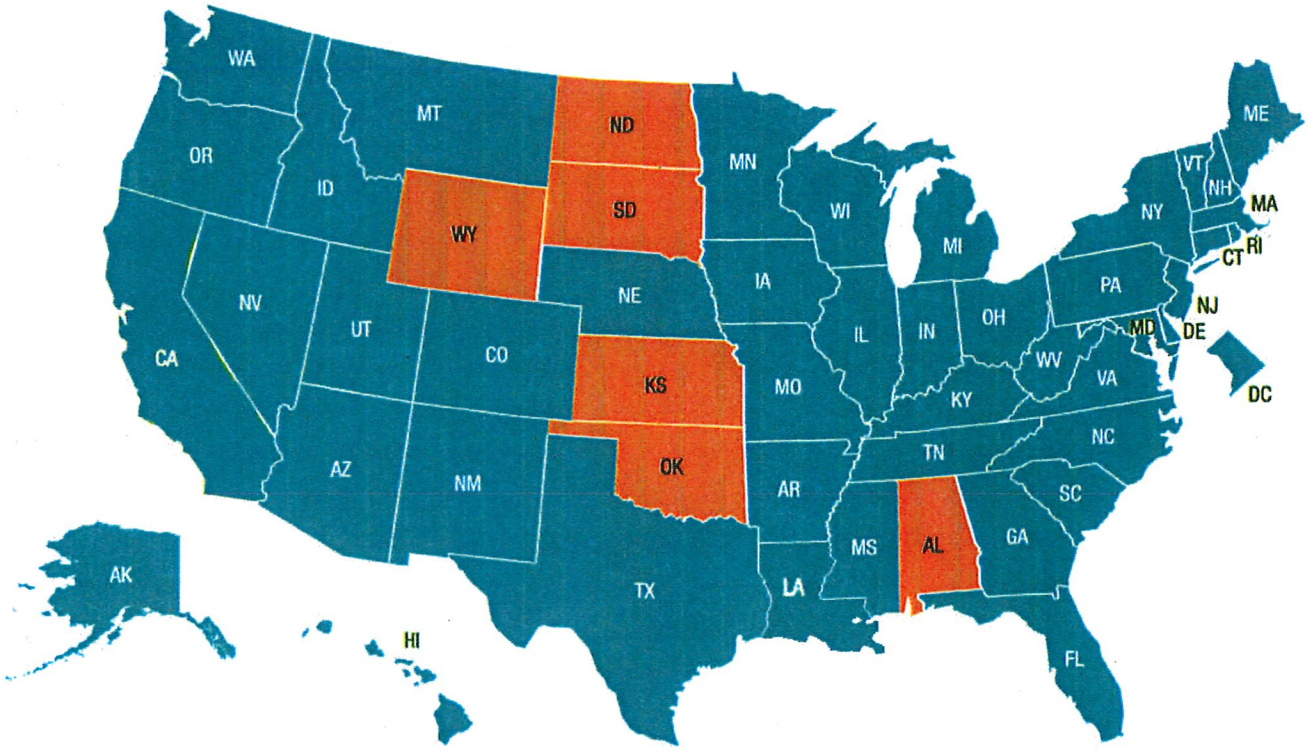
nccaom.org

accaom.org

nih.gov

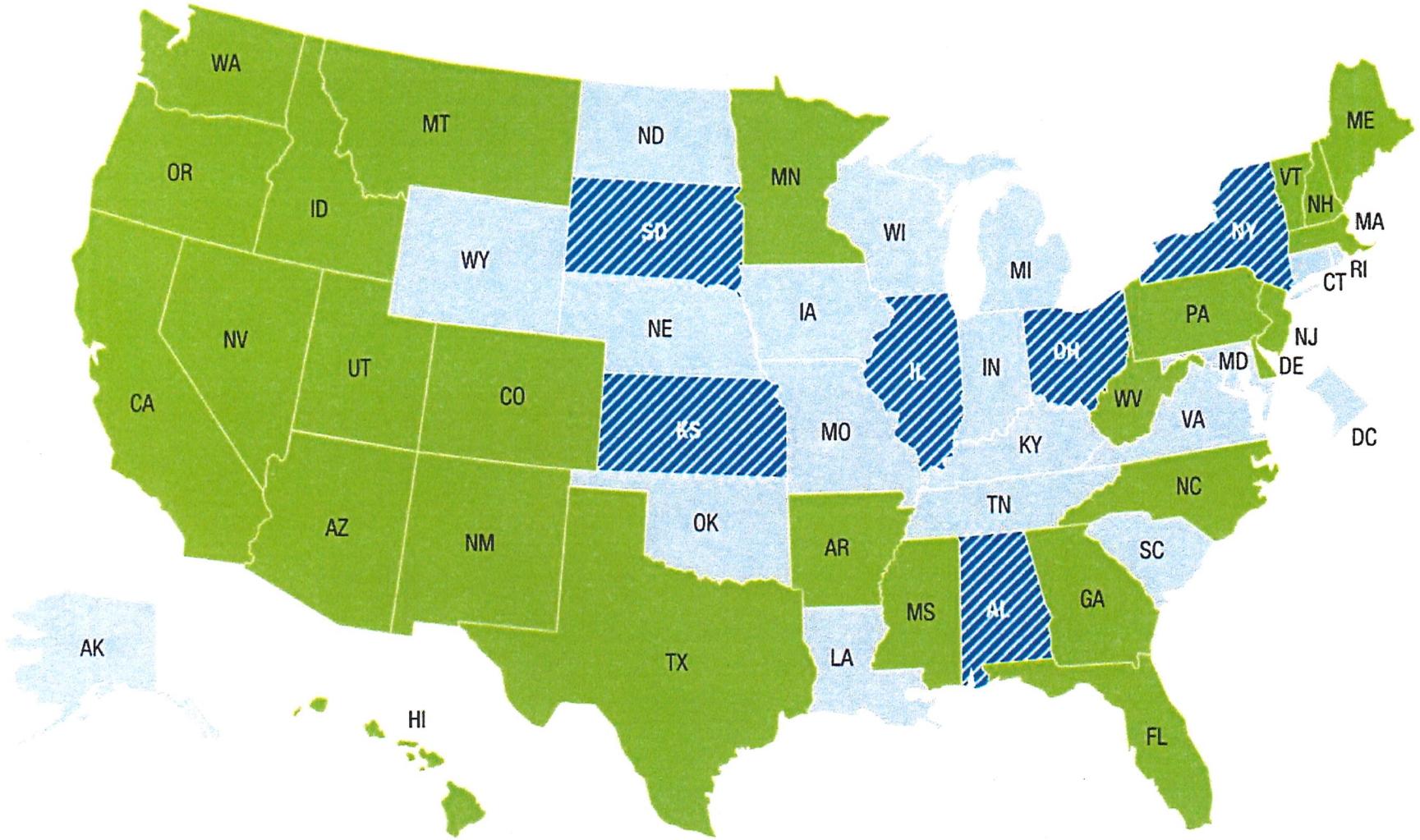
and attached letter from AAC.

44 states with Acupuncture and Oriental Medicine Licensure



Kansas is one of only 6 states without AOM Licensure

States That Include Chinese Herbs in the Scope of Practice for Acupuncturists



- States that include Chinese Herbs in the Scope of Practice for Acupuncturists
- States that have Active Legislation in place to add Chinese Herbology

National Certification Commission for Acupuncture and Oriental Medicine

STATE LICENSURE INFORMATION *please check with the state licensing agency to confirm all licensing requirements

State	Practice Act	Certification Required	Examinations Required					Title	Web Address
			FOMM*	ACU*	PLM*	BIO*	CHE*		
Alabama	NO	NO	NO	NO	NO	NO	NO	N/A	
Alaska	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac./Lic.Ac.	http://www.dced.state.ak.us/occ/pacu.htm
Arizona	YES	NO	YES	YES	YES	YES	NO	L.AC. - AAC-Auricular Ac Certification	http://www.azacuboard.az.gov/
Arkansas	YES	YES	YES	YES	YES	YES	YES	L.Ac.	http://www.asbart.org/
California	YES	NO	NO	NO	NO	NO	NO	L.Ac./Lic.Ac.	http://www.acupuncture.ca.gov/
Colorado	YES	YES	YES	YES	YES	YES	NO	L.Ac./R.Ac./Dipl.Ac./D.O.M. (Doctor of Oriental Medicine)	www.dora.state.co.us/acupuncturists
Connecticut	YES	NO	YES	YES	YES	NO	NO	Acupuncturist-Certified Auricular Acupuncturist	http://www.dph.state.ct.us/
Delaware	YES	YES	YES	YES	YES	YES	NO	Acupuncture Practioner	http://delaware.gov/
Florida	YES	NO	YES	YES	YES	NO	NO	Licensed Acupuncturist, A.P., D.O.M., R.Ac.	http://www.doh.state.fl.us/mqa/med-boards.html
Georgia	YES	YES	YES	YES	YES	YES	NO	L.Ac.-Acupuncturist-ADS Auricular Detox Specialist	www.medicalboard.georgia.gov
Hawaii	YES	NO	YES	YES	YES	NO	NO	L.Ac./Lic.Ac.	www.hawaii.gov/dcca/pvl
Idaho	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac.	http://www2.state.id.us/ibol/acu.htm
Illinois	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac./Lic.Ac.	http://www.ildpr.com/WHO/acupnt.asp
Indiana	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist	http://www.in.gov/hpb/boards/iaac/
Iowa	YES	YES	YES	YES	YES	YES	NO	L.Ac.	www.docboard.org/ia
Kansas	NO	NO	NO	NO	NO	NO	NO	N/A	
Kentucky	YES	NO	YES	YES	YES	YES	NO	Other - Certified Acupunturist	http://www.kbml.ky.gov/
Louisiana	YES	NO	NO	NO	NO	NO	NO	Acupuncturist/Acupuncture Assistant	http://www.lsbme.org/
Maine	YES	YES	YES	YES	YES	YES	NO	L.Ac./Lic.Ac.	http://www.maineprofessionalreg.org/
Maryland	YES	NO	NO	NO	NO	NO	NO	L.Ac.	www.dhmh.state.md.us/bacc
Massachusetts	YES	YES	YES	YES	YES	YES	NO	L.Ac./Lic.Ac.	www.massmedboard.org/acupuncture.htm
Michigan	YES	NO	YES	YES	YES	NO	NO	N/A	http://michiganacupuncture.org/
Minnesota	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac.	http://www.bmp.state.mn.us/
Mississippi	YES	YES	YES	YES	YES	YES	NO	Acupuncturist/Licensed Acupuncturist/Lic.Ac./L.Ac.	http://www.msbml.state.ms.us/acupunctureforms.htm
Missouri	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac.	www.ecodev.state.mo.us/pr
Montana	YES	NO	YES	YES	YES	NO	NO	Acupuncturist	http://bsd.dli.mt.gov/dli/bsd/license/bsd_boards/med_board/acu.asp
Nebraska	YES	NO	YES	YES	YES	NO	NO	Acupuncturist	http://www.hhs.state.ne.us/
Nevada	YES	NO	YES	YES	YES	NO	YES	DOM or Acupuncture Assistant	http://oriental_medicine.state.nv.us/
New Hampshire	YES	YES	YES	YES	YES	YES	NO	L.Ac./Lic.Ac.	http://www.dhhs.nh.gov/DHHS/DHHS_SITE/default.htm
New Jersey	YES	YES	YES	YES	YES	YES	YES	Licensed Acupuncturist	http://www.njconsumeraffairs.org/
New Mexico	YES	NO	YES	YES	YES	YES	YES	D.O.M. (Doctor of Oriental Medicine)	www.rld.state.nm.us/b&c/acupuncture/
New York	YES	NO	YES	YES	YES	NO	NO	Licensed Acupuncturist/Certified Acupuncturist	www.op.nysed.gov/
North Carolina	YES	NO	YES	YES	YES	YES	NO	L.Ac.	www.ncalb.com
North Dakota	NO	NO	NO	NO	NO	NO	NO	N/A	
Ohio	YES	YES	YES	YES	YES	YES	NO	R.Ac./C.A./Acupuncturist	http://www5.state.oh.us/med/
Oklahoma	NO	NO	NO	NO	NO	NO	NO	N/A	
Oregon	YES	YES	YES	YES	YES	YES	NO	L.Ac.	http://www.bme.state.or.us/
Pennsylvania	YES	YES	YES	YES	YES	YES	YES	L.Ac.	www.dos.state.pa.us/ost
Rhode Island	YES	NO	YES	YES	NO	NO	NO	Doctor of Acupuncture	http://www.health.ri.gov/hsr/professions/acup.php
South Carolina	YES	YES	YES	YES	YES	YES	NO	Acupuncturist	www.LLR.state.sc.us/pol/podiatry
South Dakota	NO	NO	NO	NO	NO	NO	NO	N/A	
Tennessee	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/L.Ac.	www.tennessee.gov/health
Texas	YES	NO	YES	YES	YES	YES	YES	Licensed Acupuncturist/L.Ac./Lic.Ac.	www.tsbme.state.tx.us/professionals/acuinfo/acuinfo.htm
Utah	YES	YES	YES	YES	YES	YES	NO	L.Ac./Lic.Ac.	http://www.dopl.utah.gov/
Vermont	YES	NO	YES	YES	YES	YES	YES	Licensed Acupuncturist/L.Ac.	www.vtprofessionals.org/opr1/acupuncturists
Virginia	YES	YES	YES	YES	YES	YES	NO	Licensed Acupuncturist/Lic.Ac./L.Ac.	www.dhp.state.va.us/
Washington	YES	NO	YES	YES	YES	NO	NO	East Asian medicine practitioner/Acupuncturist/L.Ac./Lic.Ac.	http://www.doh.wa.gov/
Washington D.C.	YES	NO	YES	YES	NO	NO	NO	L.Ac	http://hpla.doh.dc.gov/hpla/cwp/view.A.1195.Q.488827.hplaNav.|30661|.asp
West Virginia	YES	NO	YES	YES	NO	NO	NO	L.Ac./Lic.Ac.	http://www.wv.gov/OffSite.aspx?u=
Wisconsin	YES	NO	YES	YES	YES	NO	NO	Acupuncturist	http://www.drl.state.wi.us/
Wyoming	NO	NO	NO	NO	NO	NO	NO	N/A	

Code of Ethics

All practitioners certified by the National Certification Commission for Acupuncture and Oriental Medicine must be committed to responsible and ethical practice, to the growth of the profession's role in the broad spectrum of American health care, and to their own professional growth. All Diplomates, Applicants and Candidates for certification agree to be bound by the NCCAOM Code of Ethics.

Commitment to the Patient

I will

Respect the rights and dignity of each person I treat.

Accept and treat those seeking my services in a nondiscriminatory manner.

Keep the patient informed by explaining treatments and outcomes.

Protect the confidentiality of information acquired in the course of patient care.

Maintain professional boundaries in relationships with patients and avoid any relationships that may exploit practitioner/patient trust.

Keep accurate records of each patient's history and treatment.

Treat only within my lawful scope of practice.

Render the highest quality of care and make timely referrals to other health care professionals as may be appropriate.

Avoid treating patients if I am unable to safely and effectively treat due to substance abuse, physical or psychological impairment.

Bill patients and third party payers accurately and fairly.

Not engage in sexual contact with a current patient if the contact commences after the practitioner/patient relationship is established.

Not engage in sexual contact with a former patient unless a period of six (6) months has elapsed since the date that the professional relationship ended. A sexual relationship must not exploit the trust established during the professional relationship.

Commitment to the Profession

I will

Continue to work to promote the highest standards of the profession.

Provide accurate, truthful, and non-misleading information in connection with any application for licensure, certification, NCCAOM disciplinary investigation or proceeding or recertification.

Report any changes to the information on my application regarding professional ethics and my on-going fitness to practice, including but not limited to reporting to the NCCAOM any disciplinary action taken by a school or regulating agency against me, and any criminal charges or civil actions that may be relevant to my health care practice or fitness to practice.

Comply with NCCAOM Examination Policies.

Report to NCCAOM or appropriate licensing authorities information about any violations by me or by my peers of the Code of Ethics or Grounds for Professional Discipline.

Commitment to the Public

I will

Provide accurate information regarding my education, training and experience, professional affiliations, and certification status.

Refrain from any representation that NCCAOM certification implies licensure or a right to practice unless so designated by the laws in the jurisdiction in which I practice.

Use only the appropriate professional designations for my credentials.

Advertise only accurate, truthful, non-misleading information and refrain from making public statements on the efficacy of Oriental medicine that are not supported by the generally accepted experience of the profession.

Respect the integrity of other forms of health care and other medical traditions and seek to develop collaborative relationships to achieve the highest quality of care for individual patients.

Comply with all public health and public safety reporting duties imposed on licensed health care professionals.

Effective October 14 2008

Dear Kansas Legislator,

I am writing this letter to ask you to please support the Kansas Acupuncture and Oriental Medicine Practice Act.

Dec. 12, 2007, I went to St. Francis Hospital for what Dr. Pence said was a simple two (2) hour surgery to repair my spine where it was sloughing off a tool. Seven (7) hours later I woke up in a halo and full body brace attached to traction and was told they stopped surgery because I flat lined and was permanently paralyzed from under my arms down.

Dec. 16, 2007, Dr. Pence had a CT done and found a screw was placed in my spinal column. He didn't know how it got there but was very apologetic.

Dec. 18, 2007, Dr. Pence surgically removed the screw. Then my nightmare began.

Dec. 21, 2007, I went to Our Lady of Lourdes to begin learning how to transfer myself from bed to wheel chair and so on. My family had to learn how to use a catheter on my bladder and to digital stimulate my bowels. This was the most humiliating time of my life. I was told to get used to it, this was the way my life was going to be from now on. No working bladder or bowel and life in a wheel chair and bed.

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Dr. Reig told us some patients were having success with acupuncture and suggested we meet with Dr. Dao. Dr. Dao came to OLOL to meet me. He evaluated my condition by inserting a needle in the bed of each toe nail. He told me this was the most painful part of the body. One by toe he applied more + more pressure with the needle, asking me if I felt anything. Nine (9) times nothing, but on the last toe I felt the needle. Praise God! If I had not felt any pain in any of my toes, Dr. Dao later told me he would have not treated me. That was the beginning of my recovery. CLOL took me to his clinic at Evergreen Wellness Center, five (5) days a week.

After the first week, my bladder and bowels were working on their own and have ever since. All the medical doctors and nursing staff were stunned and said they have never heard of that kind of change. It was absolutely unheard of for someone with my kind of injury.

I eventually put the wheelchair in my attic, used a walker and graduated to forearm crutches and I use regular canes at home where I can use furniture, walls, and countertops to steady me.

Today I am still in acupuncture treatment and owe my life to the doctors at Evergreen Wellness Center.

They have always treated me with respect and I never felt like a number or a lost cow in a herd waiting to see a doctor for five (5) minutes. They could not be more professional and I owe them my life. Thank you, Sue Britt

Sue Britt 634 Chatta Haysville, KS. 67060

February 3, 2011

Dear Senators and Representatives,

The Kansas Legislature should pass an Acupuncture and Oriental Medicine (AOM) practice act.

Acupuncture has been utilized in the United States, with practitioners providing good care, for decades now. Forty-four states and the District of Columbia have all recognized and licensed acupuncturists by statute. The FDA has approved acupuncture needles for medical use by qualified practitioners. The U.S. National Institutes of Health (NIH) have recognized Oriental Medicine as a complete medical model and have approved acupuncture as a viable treatment for many conditions. The NIH and National Center for Complementary and Alternative Medicine (NCCAM) continue to research and explore AOM and its usefulness for many conditions. The World Health Organization (WHO) has lists of conditions for which they recommend the use of acupuncture. Our neighboring states have acupuncture licensing and are providing good, safe care.
Yet Kansas has not acknowledged and licensed our highly-qualified acupuncturists.

There are over 60 accredited schools of AOM in the United States. We have an excellent school of AOM here in Kansas. It is accredited-nationally, was supported by the Board of Healing Arts, and awarded degree-granting authority by the Kansas Board of Regents. The college has been approved and accredited by the federal government, the state government and the national accrediting body for the profession.
Yet the graduates of this college, with nearly 3,000 hours of AOM training, and holding a Master of Science in Oriental Medicine degree, must seek licensing in other states.

We know acupuncture works. It has been proven. It is widely practiced. It is widely utilized. The American Association of Medical Acupuncture has over 7,000 member MD's practicing acupuncture. Kansas has hundreds of Chiropractors practicing acupuncture. Mayo Clinic, Stanford Medical Center, and other highly-respected hospitals acknowledge the benefits of acupuncture treatment. Acupuncture is safe. When practiced by qualified practitioners it is safer getting acupuncture than getting to an acupuncture appointment.
Yet Kansas has not licensed our own highly-qualified practitioners specializing in this field.

The time has come.
Acupuncturists and Oriental Medicine Practitioners should be recognized and licensed in Kansas.
Please vote to pass the Acupuncture and Oriental Medicine Act.

Respectfully,

Dr. Richard Yennie, DC
Acupuncturist & Chiropractor
Acupuncture Instructor for Cleveland College of Chiropractic in Overland Park, Kansas

DOMINADOR T. PERIDO, Jr., MDPA
DIPLOMATE AMERICAN BOARD OF SURGERY

January 21, 2011

Re: Kansas Acupuncture and Oriental Medicine Practice Act

Dear Member of the Kansas Legislature:

This letter is written in support of the Kansas Acupuncture and Oriental Medicine Practice Act that is being presented to you for consideration. I fully support the proposal as I see the need for an alternative source of treatment for my patients from adequately trained personnel. With acupuncture utilized under proper circumstances by trained, licensed personnel, I am certain we would see a decrease in the use of narcotics to control the pain of patients that I see.

I feel there should be standards set for this profession just as there are standards for physicians, lawyers, teachers, etc. No longer should a person be able to practice in the acupuncture profession if he or she has not met standards set by the state. Week-end conferences should not qualify a person to practice acupuncture in the State of Kansas. Properly trained, the acupuncturist has a place within the realm of medicine and he or she should be able to provide services in an unsupervised capacity.

Not only have I utilized the services of acupuncture in my clinic for my patients by an acupuncturist having a Masters Degree in Oriental Medicine, but I have had those services utilized for treatment of sinus and pain issues for myself. I feel quite comfortable that he is providing a service for my patients that I am not trained to do. Your support of the Kansas Acupuncture and Oriental Medicine Practice Act would be greatly appreciated. Should the Act be passed by the Kansas Legislature, another avenue in pain management will be opened to the patient and physician alike within the state.

Thanks for your continued work in the State of Kansas - I greatly appreciate it.

Respectfully,

D. T. Perido, MD

Dominador T. Perido, MD

DTP:bp

P.O. BOX 997, ELKHART, KANSAS 67950 TELEPHONE 620-

Senate Public Health and Welfare
Date 2-16-2011
Attachment 14

American Acupuncture Council™

1100 W. Town & Country Road, Suite 1400 Orange, CA 92868

800-838-0383 • 714-571-1855 • 714-571-1863 FAX

February 15, 2011

Kansas Legislature
Kansas State Capitol Building
10th and Jackson
Topeka, KS 66612

Dear Sir or Madam:

The American Acupuncture Council ("AAC") wishes to go on record with its support of Senate Bill 195 and the Kansas Association of Oriental Medicine. The AAC has over 15,000 licensed acupuncturists as members and has been keeping statistics on malpractice claims against acupuncturists for the last 25 years. In this context, we have found that herbs are probably the safest modality employed by acupuncturists. There have been only two small claims in 25 years, both of which were minor in nature. The AAC stands ready to provide coverage for herbs in Kansas at no additional charge.

I appreciate your consideration of this information.

Sincerely yours,

Michael J. Schroeder
Vice-President and General Counsel

MJS.2335

c: Mr. Doug Petrie, KAOM President

Senate Public Health and Welfare
Date 2-16-2011
Attachment 15

ANNE HODGDON

20320 W. 83RD STREET · LENEXA, KS 66220 · 913.284.4844

February 15, 2011

Dear Members of the Kansas Legislature,

Those of you who know me might be surprised to receive this letter advocating on behalf of the proposed Kansas Acupuncture and Oriental Medicine Practice Act, since you know I am, in general, a pretty 'hard sell.' So, with that in mind, I ask that you please give this important matter of licensure serious consideration.

In mid-2008, my husband JB and I left on a cruise in the midst of some serious family turmoil with an adult child. I spent the first few days of the cruise in front of the computer, writing and receiving long-winded emails while trying to persuade this child to make a choice different from the original plan. I was tremendously worried, and I felt like there was a tight knot in my stomach 24/7 – even when not engaged in the writing of the emails. This physical manifestation of stress frequently accompanied high-stress situations for me, whether they were personal or professional. On the third day of the cruise, an acupuncture information seminar was offered, and since we had no other plans for that hour, we attended. The presenter talked about acupuncture for stress management, and JB suggested I try a session. I thought it was a ridiculous idea, and laughed at the thought that I might benefit from acupuncture – it was just 'too weird' to consider. But JB was worried about me, and I finally agreed to go (very tongue-in-cheek); frankly, just to let him think I was 'trying.' Following the acupuncture session, I didn't think about it again – until a couple days later when I realized that I was still writing emails like crazy, and the stressful situation had not corrected itself, but I no longer had the physical manifestation of the knot in my stomach and sickly feeling. My body was better managing the stress. And the only thing that had changed was that I had a one-hour acupuncture session! I returned to Kansas City determined to find a qualified acupuncture technician. I did a good deal of research and due-diligence about the details of 'what makes a qualified practitioner?' and found that person in Shamayne Tate. I have been seeing Shamayne regularly ever since, and I consider my acupuncture treatments to be invaluable to my overall wellness. In addition to stress management, Shamayne has also treated me for that irksome issue that often accompanies getting a little older – waking up during the night to go to the bathroom. Thanks to acupuncture, I now sleep a solid and restful eight hours each night – and that matter alone makes Shamayne worth her weight in gold. While I have no pain issues, my daughter-in-law sees Shamayne for chronic back pain, and has had great results in being able to almost eliminate pain meds as the result.

The point I wish to stress is that I did the research; I didn't just look in the phone book. Not everyone will go to that effort. And not all acupuncturists have the same qualifications; in fact, some are charlatans with minimal education. Licensure will ensure the safety and well-being of Kansans by requiring that appropriate standards be met. Please consider that my acupuncturist was able to affect a positive change with respect to my kidneys and bladder. But what if she wasn't so educated and qualified? *Could she have done harm?* Please support licensure of practitioners engaging in the practice of Acupuncture and Oriental Medicine.

Respectfully,

Anne Hodgdon

Anne Hodgdon

Senate Public Health and Welfare
Date 2-16-2011
Attachment 16

Division of Health
Bureau of Child Care and Health Facilities
Curtis State Office Building
1000 SW Jackson St., Suite 200
Topeka, Kansas 66612

Phone: 785-296-1270
Fax: 785-296-3075
www.kdheks.gov

Robert Moser, MD, Acting Secretary

Department of Health & Environment

Sam Brownback, Governor

February 15, 2011

The Honorable Vicki Schmidt
State Capitol Room 552S
300 S.W. Tenth Avenue
Topeka, Kansas 66612

Dear Senator Schmidt,

I am writing in regard to Senate Bill 195, which would establish licensing and regulation of Acupuncturist under the Board of Healing Arts.

The Health Occupation Credentialing Act, K.S.A. 65-5001 et seq. establishes a process to determine if the public good is served by credentialing a health occupation. Ten criteria are identified to evaluate the impact of the practice not being regulated. These include the effect of regulation on the public, cost to healthcare, body of knowledge required, effect on other health professions and other criteria in the statute. A seven person technical committee is appointed by the Secretary of the Kansas Department of Health and Environment to evaluate the application. This is a very thorough and fair process resulting in a recommendation to the legislature.

Senate Bill 195 would bypass this important statutory review to determine if the public good is best served by the licensing of Acupuncturists. Accordingly, our department respectfully request that the committee not act favorably on Senate Bill 195, and refer the occupation to a review under the Health Occupation Credentialing Act.

Sincerely,

Joseph F. Kroll
Director Bureau of Child Care and Health Facilities

C Committee Members
Robert Moser M.D. Acting Secretary

Senate Public Health and Welfare
Date 2-16-2011
Attachment 17

KANSAS MEDICAL SOCIETY
Established 1859

To: Senate Public Health and Welfare Committee

From: Dan Morin
Director of Government Affairs

Date: February 16, 2011

Subject: SB 195; Concerning licensure of acupuncturists and practitioners of oriental medicine

The Kansas Medical Society appreciates the opportunity to appear to today in opposition to SB 195, which would enact the acupuncture and oriental medicine act.

As we outlined in our testimony for SB 88 (Naturopathy), the public policy question of how to regulate a professional group is not a decision without consequences for safe patient care. Government has an obligation to act with the utmost care with regard to the granting of practice privileges of health care professions. State recognition and approval of a group's scope of practice is in essence the state's "seal of approval" of the group's philosophy of care and competency to practice.

According to current information posted on the Kansas Department of Health and Environment's (KDHE) website, "Kansas law recognizes over 30 health occupational groups for which licensing, registration, or certification is provided. There are 11 regulatory bodies that issue credentials to those professions." There exists in Kansas the Credentialing Review Program, administered by the Health Occupations Credentialing arm of KDHE which is intended to be a screening mechanism for the Kansas Legislature with regard to health care professions licensing, certification and credentialing. Applications for health care professions seeking registration, certification, or state licensure are reviewed by a technical committee, which conducts hearings to review the applicant group's education, training and clinical exposure as well as receive public input in response to the application. The committee then forwards its findings to the Secretary of Health and Environment. The Secretary makes recommendations to the legislature and only then was the legislature intended

legislation to recognize certain health care professions. It is our understanding that this process has not yet been initiated with regard to acupuncturists and practitioners of oriental medicine.

Besides the abovementioned procedural concerns, we believe much of the language in the bill is unclear and overly broad. We also have concerns with specific language included in the bill. For example, Section 2, subsection k (at lines 5 through 10 on page 2), defines oriental medicine to mean:

> the distinct system of health care that uses health techniques of oriental medicine, both traditional and modern, to diagnose, evaluate, examine, manage and treat for the prevention, cure or correction of disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore, promote and maintain health.

In addition, Section 2, subsection c (lines 20 and 21) outlines that an "acupuncturist means any person licensed by the board in the practice of acupuncture or oriental medicine" which would seemingly allow the same scope outlined in subsection k. Such language may provide a scope exceeded only by medical doctors and doctors of osteopathy. Proponents may point to information showing 44 states license acupuncture and oriental medicine, however, the scope of practice outlined in many of those states is more narrowly defined than the language contained in SB 195. In fact, Texas law requires the license holder may only perform acupuncture on a person if the person was first evaluated by a physician or dentist or referred by a chiropractor.

We believe the legislature should refer the proponents of the bill to the Health Occupations Credentialing arm of KDHE for careful review and only then evaluate whether legal recognition should be pursued using specific and clear language about what is, and is not authorized.

Because of the reasons stated above, we cannot support this legislation, and we would urge that you not recommend it favorably for passage. Thank you for considering our comments.

KMS

KANSAS MEDICAL SOCIETY

February 11, 1999

TO: Senate Public Health and Welfare Committee

FROM: Meg Draper
Director of Government Affairs

SUBJ: SB 144: Acupuncture

The Kansas Medical Society appreciates the opportunity today to testify on SB 144. This bill relates to the practice of acupuncture and would allow acupuncturists to receive a license in Kansas if they meet certain criteria. KMS does not support the bill as currently drafted.

SB 144 would make it illegal for individuals to practice acupuncture unless they are licensed pursuant to this law. The purpose of licensing a health care provider group is to ensure that the public is protected. Only licensed individuals may practice within a provider's designated scope of practice. However, this bill creates a rather broad scope of practice for acupuncturists, permitting them to use "adjunctive therapies and diagnostic techniques for the promotion, maintenance and restoration of health and the prevention of disease." This implies that acupuncturists could perform a wide variety of treatments on patients, even treatments beyond what acupuncturists are trained to do. Additionally, the bill establishes no minimum level of education, clinical training or competency for this group. All that is required is certification as a diplomate in acupuncture by a national certification commission, licensure in a comparable state, or five years of practice in Kansas. The American Academy of Medical Acupuncture is an organization of physician acupuncturists. These physicians receive a minimum of 200 hours of training in acupuncture. We are unclear as to the level of education or training that non-physician acupuncturists receive and believe that minimum education requirements should be codified to help ensure competence and to protect the public.

KMS also suggests that the legislature wait to grant licensure to acupuncturists until they have completed the credentialing process through the Kansas Department of Health and Environment. Kansas law requires all health care provider groups seeking to be credentialed or requesting a change in their level of credentialing to file an application with KDHE, which reviews the application and makes a recommendation as to whether the change is warranted. The legislature may use the recommendations in determining whether to grant licensure to acupuncturists.

Studies have shown that acupuncturists, along with other alternative care providers, may provide beneficial care for certain conditions. Many states recognize these types of providers through some level of certification, and it is not our opinion that acupuncturists should not be able to practice their profession in the state. However, as the number of alternative health groups seeking recognition in Kansas grows - this committee has already held hearings on another alternative group, naturopaths - KMS believes that the legislature should study the education and training of alternative providers as a whole before acting on this legislation.

Thank you very much for considering our comments.

623 SW 10th Ave. • Topeka KS 66612-1627 • 913.235.2383 • 800.332.0156 •
Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 800.293.

Senate Public Health and Welfare
Date 2-16-2011
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KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Acting Secretary

February 11, 1999

The Honorable Sandy Praeger, Chair
Committee on Public Health and Welfare
128-S, State House

Dear Chairperson Praeger:

I am writing in regard to SB 144, an act which provides for the licensure of acupuncture.

The Credentialing Act found in KSA 65-5001 et seq. establishes a process to help the legislature determine whether a health occupation should be credentialed. Under the authority of K.S.A. 65-5001 et seq., more than 20 health care professions have either submitted a letter of intent or application for credentialing. A technical review is conducted during which time specific criteria established in statute and regulation are applied to gather critical information in order to evaluate the need for public protection from the unregulated practice of a given health care provider.

Senate Bill 144 establishes the licensing of acupuncture without appropriate documentation of the need under application through the Credentialing Act. The Act and its provisions are important tools for legislative decision-making. The applicant group desires to be able to be licensed to practice through amending the board of healing arts act without meeting any of the statutory requirements for a new health care profession in the state of Kansas.

With all due consideration to those who practice acupuncture, the department believes any decision to license persons to practice acupuncture must follow the process set forth in the Credentialing Act.

Sincerely,

Lesa Bray

Lesa Bray, Director
Health Occupations Credentialing
Bureau of Health Facility Regulation

c: Acting Secretary Graeber, KDHE
Lorne Phillips, PhD, Acting Director of Health
Joseph F. Kroll, Director, Bureau of Health Facility Regulation

Senate Public Health and Welfare
Date 2-16-2011
Attachment 20