Approved: 05/05/10
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on March 9, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Amanda Nguyen, Intern, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the Committee:
Ray Dalton, Deputy Secretary, Disability and Behavioral Health Services, Social and Rehabilitation Services
Phyllis Gilmore, Executive Director, Kansas Behavioral Sciences Regulatory Board
Stuart Little, representing Kansas Association of Addiction Professionals
Barbara Burks, Kansas Association of Addiction Professionals
Marla Rhoden, Director, Health Occupations Credentialing, Kansas Department of Health and Environment
Janace Maynard, Licensed Specialist Clinical Social Worker
Ron Hein, representing Kansas Association for Nurse Anesthetists
Doug Smith representing Greg Unruh, MD, Kansas Society of Anesthesiologists
Dan Morin, Director Government Affairs, Kansas Medical Society

Others attending:
See attached list.

HB 2577 - Addictions counselor licensure act

Terri Weber briefed those attending on the proposed legislation which would create the Addictions Counselor Act, with oversight and regulation through the Kansas Behavioral Sciences Regulatory Board.

Stuart Little, appearing on behalf of the Kansas Association of Addiction Professionals, spoke in support of **HB 2577**. He indicated the bill will protect consumers, ensure appropriate oversight of the substance abuse treatment side of public health, and does not create more government or costs to the State (Attachment 1). Included in his testimony is the report from the Kansas Department of Health and Environment related to their recommendations following a review by the Health Occupations Credentialing office (Attachment 2).

Barbara Burks, Kansas Association of Addiction Professionals, discussed the background of addiction counselors from 1970 through 2009 and defined the term "addiction counselor." She described the focus of counseling, practice areas, educational requirements, benefits of licensure, and other states requiring licensure of counselors (Attachment 3). She encouraged favorable passage of this legislation.

Marla Rhoden, Kansas Department of Health and Environment, Health Occupations Credentialing, provided documentation concerning this group's effort in demonstrating need and rationale for licensing of addictions counselors (Attachment 4). She supported favorable passage of **HB 2577**.

Janace Maynard, private citizen and a Licensed Specialist Clinical Social Worker, spoke from a neutral position and raised concerns about the practice of addiction counselors (regardless of education) in assessing a client with the inclusion of a "diagnostic impression" (Attachment 5). Ms. Maynard proposed an amendment prohibiting anyone below the highest/independent level from diagnosing or utilizing the DSM-IV TR criteria and classification system in a "diagnostic impression."

Senator Barnett accepted written testimony from:

Ray Dalton, Deputy Secretary, Kansas Department of Social and Rehabilitation Services (Attachment 6)
Phyllis Gilmore, Executive Director, State of Kansas Behavioral Sciences Regulatory Board (Attachment 7)

Senator Barnett closed the hearing and indicated this legislation would be considered for possible final action at a later date.

HB 2619 - Registered nurse anesthetists duties

Iraida Orr, Legislative Research Department, reported **HB 2619**, as amended by the House Committee on Health and Human Services, would change current law regarding the scope of practice allowed for registered nurse anesthetists (RNAs). The bill would allow RNAs, upon the order of a physician or dentist and as a member of a physician or dentist directed health care team, to order or administer appropriate medication and anesthetic agent in the pre- and post-analgesia phase and during the peri-anesthetic or pre-analgesic period; order necessary medications and tests in the peri-anesthetic or peri-analgesic period and take appropriate action.

Ron Hein, on behalf of the Kansas Association of Nurse Anesthetists, spoke in support of **HB 2619**, indicating this legislation resulted from a collaborative effort with the Kansas Medical Society, the Kansas Hospital Association, and the Kansas State Board of Nursing (Attachment 8).

Doug Smith, representing Greg Unruh, MD, Kansas Society of Anesthesiologists, reiterated the Society of Anesthesiologists had spent numerous hours to assist in crafting legislation that would allow nurse anesthetists to deliver safe, effective, and efficient anesthesia care for Kansas patients within the structure of a physician or dentist directed health care team (Attachment 9).

Dan Morin, Kansas Medical Society, supported the favorable passage of **HB 2619**, indicating consensus on the recommendations for amendment to existing law had been achieved (Attachment 10).

Senator Barnett called attention to written testimony submitted by the following:

Rachel Edgerton, President of the Kansas Association of Nurse Anesthetists (Attachment 11).
Brian Smith, Director of Anesthesia, St. Catherine Hospital, Garden City (Attachment 12)
Nancy A. Whitson, CRNA, Past President, Kansas Association of Nurse Anesthetists (Attachment 13)
Mary Blubaugh, MSN, RN, Kansas State Board of Nursing (Attachment 14)

Upon a motion by Senator Schmidt and a second by Senator Pilcher-Cook to move **HB 2619** out favorably for passage, the motion carried.

Draft Letter to Senate Leadership - Regarding HMO Privilege Fee/Medicaid MCO Contract Fees/Expenditures

Senator Barnett distributed a draft letter to Senate President Steve Morris for review by committee members. The purpose of the letter is to provide some direction to the leadership regarding the enhancement of a Medicaid cost saving proposal (Medicaid Reinvestment Fund) and the return of ongoing funds generated by the privilege fee to the MCOs (from which the privilege fee is derived) for use in reducing any Medicaid provider reimbursement cuts and/or enhancing payment rates to providers.

Senator Schmidt requested that the letter be sent no only to President Morris but also to Senator John Vratil (Vice President of the Senate), and Senator Derek Schmidt, Senate Majority Leader. Senator Barnett will send the letter under his signature to the individuals noted above.

The meeting was adjourned at 2:34 p.m.

PUBLIC HEALTH AND WELFARE
GUEST LIST
March 9, 2010

NAME	AFFILIATION
Marla Rhoden	KDHE
Cara Greeve	KHA
Patrick Vogelsberg	Kearney and Associates
Nancy Zogleman	Polsinelli
Janae Maynard	Private Citizen
Catie Rech	KNASW
Kelsey Nepote	KNASW
Sarah Tidwell	KSNA
Bill Anderson	KSBN
[illegible]	KSBN
Shannon Bell	LGR
Sarah Hansen	Corner House, Inc.
Doug Smith	KSSA
[illegible] Heck	Ks Assoc Nurse Anesthetists
Brad Smoot	FHP
Natalie Bright	KAHP
Leigh Keck	Hein Law firm

Senate Public Health and Welfare Committee
Testimony on House Bill 2577

March 9, 2010

Dear Chairman Barnett and Members of the Committee

I am appearing today on behalf of the Kansas Association of Addiction Professionals. I will be followed by Barbara Burks who will discuss our support for House Bill 2577 in greater detail. The bill is a straight-forward licensure bill modeled after other behavioral health care fields. Ms. Burks will provide an overview of substance abuse treatment field.

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

- Unify the substance abuse treatment system in Kansas
- Protect consumers and ensure appropriate oversight of the substance abuse treatment side of the public health system
- Ensure oversight of state and federal funds
- Does not create more government or increase costs to the state—will place addiction counselors under the Behavioral Sciences Regulatory Board
- House Bill 2577 is modeled after the exact same legislation used for marriage and family therapists, counselors, and social workers. We are not asking the Legislature to reinvent the wheel. House Bill 2577 uses the same structure and organization to transition or "grandfather" in the current field as was used for others in BSRB
- House Health and Human Services Committee amended the bill to ensure that only licensed clinical addiction counselors (masters level) could provide a diagnosis. House amendments further articulated the scope of practice for licensed addiction counselors (bachelors level)

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

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DEPARTMENT OF HEALTH
AND ENVIRONMENT
Division of Health

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

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**FINAL REPORT TO THE LEGISLATURE
FROM THE SECRETARY ON THE APPLICATION
FROM THE KANSAS ASSOCITATION OF ADDICTION COUNSELORS**

November 4, 2009

The Kansas Association of Addiction Counselors submitted an application requesting credentialing at the level of licensure. The application has been reviewed in accordance with the Kansas Act on Credentialing by a technical review committee and the Secretary of Health and Environment. The technical committee conducted four fact-finding meetings, including a public hearing, to investigate the issues. According to K.S.A. 65-5005, within 120 days of receiving the technical committee's report the Secretary is to issue a final report to the Legislature. The technical committee's report was submitted to the Secretary on November 4, 2009. (Attached is the technical committee's report.) This is the final report of the Secretary to the Legislature.

The statutes state that the Secretary is not bound by the recommendations fo the technical committee, nor is the Legislature bound by the Secretary's recommendations.

K.S.A. 65-5005 requires that all of the criteria are to be found met and a need for credentialing established prior to the technical committee or Secretary making a recommendation that the application be approved. The technical committee concluded that all criteria were met. The technical committee determined that there was sufficient need shown for licensing of addiction counselors in order to protect the public from the documented harm, therefore, the technical committee recommends that the application be approved.

In summary, the technical committee findings and conclusions are:

- The unlicensed practice of the occupation can harm the public and the potential for harm is recognizable and not remote. Criterion I is met.
- The practice of the occupation requires an identifiable body of knowledge acquired through a formal period of advanced study; and the public needs, and does benefit, from assurances of initial and continued education. Criterion II is met.
- Information provided indicates that services provided by addiction counselors are, for the most part, not under the direction of other health care personnel but are performed independently. Evidence was provided which indicates that this arrangement is not adequate to protect the public from harm. Therefore, Criterion III is met.

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 200, TOPEKA, KS 66612
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Senate Public Health & Welfare
Date: 03/09/10
Attachment: 2

- Criterion IV is recognized as asking for documentation on why registration and certification or other, less regulatory means, are not effective in protecting the public from harm. Evidence was provided which indicates that the level of credentialing of registration or certification is not adequate to protect the public from harm. Thus Criterion IV is found to be met.

- Licensing the occupation appears to have minimal impact on the cost of health care. Criterion V is met.

- Licensing the occupation appears to have minimal impact on the availability of health care personnel providing services. Thus, Criterion VI is met.

- The scope of practice of the occupation is identifiable. Criterion VII is met.

- From the information provided, it appears that the licensure of addiction counselors would have minimal effect on the scope of practice of other health care personnel. Therefore, Criterion VIII is met.

- Nationally recognized standards of education for addiction counselors exist and are identifiable. Criterion IX is met.

- With the first nine criteria having been found to be met, credentialing of the profession to protect the public from the documented harm is appropriate. Licensure was determined to be the least regulatory means of ensuring that the public is protected from the documented harm.

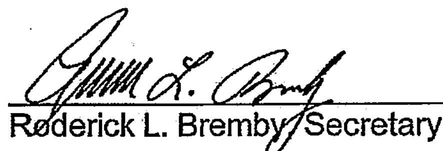
<u>The Secretary of Health and Environment's Findings, Conclusions and Recommendations Are:</u>

- After consideration of the technical committee's report and the evidence and testimony presented to the committee, I concur with the technical committee's findings and conclusions. I find that the first nine criteria have been met.

- I concur that sufficient evidence was presented to warrant credentialing of addiction counselors in order to protect the public, and that licensure is the appropriate level of credentialing to ensure protection from the documented harm.

- I concur that the Behavioral Sciences Regulatory Board is the appropriate regulatory body.

- I recommend that legislative action be taken on the credentialing application



Roderick L. Bremby, Secretary

12/15/2009
Date

Senate Public Health & Welfare
Date: 03/09/10
Attachment: 3

Health and Welfare Committee
Testimony in Support of House Bill 2577

March 9, 2010

Presented by

The Kansas Association of Addiction Professionals (KAAP)
Barbara Burks

Background

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

Who Are Addiction Counselors?

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

Kansas Addiction Workforce Survey, 2006

What Do Addiction Counselors Do?

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

Where Do Addiction Counselors Practice?

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

Why is Addiction Counseling Unique?

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

Why Is Addiction Counseling Important?

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

    Kansas Comprehensive Substance Abuse Treatment Needs Assessment, DataCorp, 2006
- Vulnerability of our client population
  - Economically disadvantaged--indigent, unemployed, homeless
  - Stigmatized
  - Medically compromised
  - At high risk of co-occurring mental illness

Why is House Bill 2577 Needed?

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

Benefits of Licensure

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

Benefits of Licensure

- Advancement of the Field
  - Current workforce "swept in" (Same process as implemented for marriage and family therapists, social workers, counselors, etc.)
  - Attraction and retention of a professional workforce
  - Opportunity for addiction counselors to have parity with other behavioral health professionals
  - Other professions not negatively impacted – our scope of practice limited to substance use disorders. Other professions would continue to practice as currently allowed.

Benefits of Licensure

- Simplification of Credentialing
  - Addiction Counselor Licensure will replace the confusing mix of current substance abuse credentials and set education, training, competency testing, supervision standards for all addiction counselors
  - HB 2577 uses an existing regulatory agency--Behavioral Sciences Regulatory Board (BSRB)
  - HB 2577 uses a similar structure and process to implement Addiction Counselor licensure as was successfully used for licensure of other behavioral health professionals -- social workers, marriage and family therapists, and professional counselors

Current Credentialing

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

Other States - Licensing

- All states regulate addiction counseling
- 23 states have enacted licensure
  - All use the same SAMHSA core competency framework used for the Kansas addiction counseling program curriculum

House Bill 2577 Proposal

- Two levels of licensed addiction counselors
  - LAC – Licensed Addiction Counselor (Bachelor's level)
  - LCAC – Licensed Clinical Addiction Counselor (Master's level)

- Only LCAC (master's level) would have:
  - Authority to diagnose
  - Authority to practice independently (without an SRS program license)

New Licensed Addiction Counselor (LAC)

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

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

New Licensed Clinical Addiction Counselors (LCAC)

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

LAC "Grandfathering"

- Licensed Addiction Counselor (LAC)
  1. AAPS or KAAP credential
  2. Proof of competency
     - Documentation of professional alcohol/drug work experience <u>or</u> documentation of passing score on national addiction counselor examination
  3. Evidence of meriting public trust
  4. Application/fees

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LCAC "Grandfathering"

- Licensed Clinical Addiction Counselor (LCAC)
  1. AAPS or KAAP credential
  2. BSRB license at <u>clinical</u> level
  3. Proof of competency
     - Documentation of professional alcohol/drug work experience <u>or</u> documentation of passing score on national addiction counselor examination; and
     - Documentation of completion required continuing education units in diagnosis of substance use disorders
  4. Evidence of meriting public trust
  5. Application/fee

Conclusion

- We are asking for your support in moving addiction counselor licensure forward.

- Questions?

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

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Testimony on House Bill 2577
Licensure of Addictions Counselors

Presented to
Senate Public Health and Welfare Committee

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

March 9, 2010

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

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

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

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

BUREAU OF CHILD CARE AND HEALTH FACILITIES
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March 9, 2010

Senate Public Health and Welfare
Neutral - Senate BILL 2577 Addictions Counselor Licensure

Good afternoon. My name is Janace Maynard. Thank you for allowing me to speak and address you on Bill 2577. I am a Licensed Specialist Clinical Social Worker, receiving that license in 1996. I also am AAPS certified. I chose my social work career to be in mental health and substance abuse and I have been in that area of practice since 1990. I obtained a Master of Social Work from the University of Kansas, on the clinical tract which included a course on psychopathology. I served a one year internship at the Menninger Community Service Office, which included a weekly course on diagnostic criteria and weekly case presentations on diagnoses and treatment. I received two years of post graduate clinical supervision and I continue to obtain 6 hrs of continuing education every 2 years regarding diagnosis & treatment. Most recently I worked as an independent contractor / consultant providing clinical oversight of AAPS certified individuals specifically regarding diagnosing substance abuse disorders.

I am here to urge you to amend this bill. When this bill was heard in the house, an issue of concern and area of debate was who should be authorized to diagnose substance abuse disorders. An amendment was added, which allowed the bill to pass through the house, allowing for diagnosis only at the highest / independent level of licensure.

I am deeply concerned regarding both the current standard of practice in the addictions field and an apparent contradiction between this practice and the bill. Currently, anyone and everyone in the addiction field can and does complete a client assessment which includes a "diagnostic impression." This "impression" is derived from the same DSM –IV TR criteria and classification system utilized to determine a "diagnosis." If this practice is not addressed, individuals may become licensed at the lower level and utilize the same criteria and classification system for diagnosing which would create serious statutory and ethical conflicts. I propose an amendment specifically prohibiting anyone below the highest / independent level from diagnosing or utilizing the DSM criteria & classification system in a "diagnostic impression".

From my professional experience reviewing the actual work of current AAPS certified individuals, they did not appear qualified to diagnosis. Specifically, individuals with a bachelor degree or less did not appear to have the education / experience resulting in the clinical judgment, skill, and expertise necessary to diagnosis. The following are problems I encountered. Any specific examples are either a generic composite or have been altered to protect client confidentiality.

Problems encountered

- Incorrect identification of primary substance abuse diagnosis
- Incorrect classification of substances
- Lack of documentation of criteria in support of diagnosis
- Erroneous criteria
- "Over diagnosing" when clients present with dual diagnosis / co morbidity

Ramifications of inaccurate diagnosis or diagnostic impression

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

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

- What the book says – "who should and should not " utilize the DSM
- Sectioning off an integrated / interactive manual based on differential diagnosing – difficulty of "carving out" substance abuse disorders from the rest of the manual

Amending this bill by prohibiting any diagnostic practices at the lower level of licensure will address the discrepancy in the bill between the proposed licensure standards and current practice. However, it would appear the current practice of issuing "diagnostic impressions" by counselors without statutory authority to diagnose or by counselors with licenses specifically prohibiting diagnosing will continue to occur unless or until this bill goes into effect. Thank you for your time and again, I urge y
I will be happy to respond to questions.

Senate Public Health & Welfare
Date: 03/09/10
Attachment: 5

DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

Don Jordan, Secretary

Senate Public Health & Welfare Committee

March 9, 2010

HB 2577 – Licensure of Addiction Counselors

Disability & Behavioral Health Services
Ray Dalton, Deputy Secretary

For Additional Information Contact:
Patrick Woods, Director of Governmental Affairs
Docking State Office Building, 6th Floor North
(785) 296-3271

Senate Public Health & Welfare
Date: 03/09/10
Attachment: 6

HB 2577 – Licensure of Addiction Counselors

Senate Public Health & Welfare Committee
March 9, 2010

Chairman Barnett and members of the Committee, thank you for the opportunity to appear before you today to present testimony on HB 2577. SRS supports HB 2577, which would make addictions counseling a licensed profession regulated by the Behavioral Sciences Regulatory Board (BSRB). Licensing of addiction counselors would align the profession with social workers, marriage and family therapists, psychologists and licensed professional counselors. Twenty-three states already professionally license addiction counselors.

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

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

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

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

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

State of Kansas
Behavioral Sciences Regulatory Board

KATHLEEN SEBELIUS
Governor

PHYLLIS GILMORE
Executive Director

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SENATE TESTIMONY
PUBLIC HEALTH AND WELFARE COMMITTEE
March 8, 2010

HB 2577

Mister Chairman and Committee Members:

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

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

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

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

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

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

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

Testimony re: HB 2619
Senate Public Health and Welfare Committee
Presented by Ronald R. Hein
on behalf of
Kansas Association of Nurse Anesthetists
March 9, 2010

Mr. Chairman, Members of the Committee:

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

KANA supports HB 2619, which is designed to respond to an Attorney General's opinion which ruled that a practice which the CRNAs had been performing for years, could not legally be done pursuant to his reading of their scope of practice. CRNAs can perform certain functions, such as injecting medication by their scope of practice, but the AG ruled that they could not order a nurse to perform that same act. If CRNAs are involved in a case, with someone under anesthesia, and the nurse comes in and indicates a prior case, in recovery, is vomiting, the CRNA can walk into the other room and can give the anti-nausea medication (although they can't leave their current patient), but they can NOT order the nurse to give the previous patient the anti-nausea drug. This inability of the CRNA to be able to conduct his or her practice with the assistance of other personnel, results in poor patient care.

KANA met with the Kansas Medical Society (KMS), the Kansas Hospital Association (KHA), the Kansas State Board of Nursing (KSBN), and developed this compromise solution to the problem identified in the other written testimony for this hearing.

We would also like the legislative intent of this legislation to be well understood by this committee and the entire legislature, and we would ask that the statements of intent attached to my testimony be recognized by the committee, and be attached to the formal minutes of this hearing. These attachments are a letter signed by the President of the KANA and approved by the KANA Board, and another statement of intent approved by KANA, KMS, KSBN, and the legal counsel for the KSBN, to the effect that no change is necessary in K.S.A. 65-1113 in order to permit nurses to follow orders from CRNAs pursuant to this legislation.

We urge the committee to pass HB 2619 as amended by the House..

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

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

February 9, 2010

House Health & Human Services Committee
Room 784, Docking State Office Building
Topeka, Kansas 66612

Dear Members:

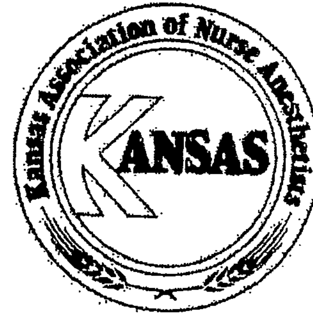
This letter states the official position of the Kansas Association of Nurse Anesthetists (KANA). It has been approved by all current members of the KANA Board of Directors and Officers. This letter is intended to define the goals of KANA in sponsoring amendments to K.S.A. 65-1158. In all respects the amendments invoke patient contacts that are a part of the registered nurse anesthetist's (RNA) training, education and skill set. The purpose of the proposed amendments can generally be stated to:

- Protect the safety of patients undergoing any form of an anesthetic in Kansas;
- Ensure that RNAs practice within a statutorily defined scope of practice;
- Ensure that RNAs work in cooperation with physicians, dentists, and other licensed healthcare providers who also participate in the care of our patients; and
- Address concerns raised by Attorney General Opinion No. 2009-4 issued on January 26, 2009.

The purpose of the proposed amendments to K.S.A. 65-1158 is specifically not intended to:

- Open a door for RNAs to independently establish and operate chronic pain management clinics; or
- Expand the practice of RNAs beyond what is necessary to safely care for a patient who is to undergo any chosen form of an anesthetic.

KANSAS ASSOCIATION OF NURSE ANESTHETISTS



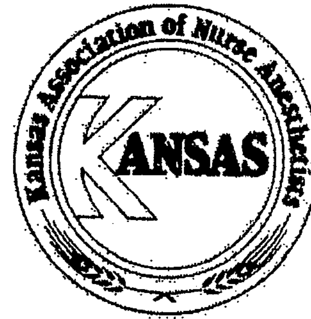
K.S.A. 65-1158 requires revision to properly reflect current practice settings. In the current practice setting physicians or dentists always initiate the anesthetic process, regardless of the method of administration selected. This will not change with the proposed amendments. RNAs evaluate the patient, identify necessary tests, medications, etc. that are indicated before the anesthetic is undertaken. In most circumstances it falls to others to implement the pre-anesthetic tests, medications, etc. As a specific example, if an EKG is indicated before an anesthetic is provided, EKG technicians would ultimately perform the test. The statutory amendments endorsed by KANA are intended to allow the smooth movement of the patient through the practice setting. They would allow the RNAs to order the necessary tests, medications, etc. in preparation for the chosen form of anesthetic.

During the anesthetic the RNA is present and personally delivers the anesthetic. But the patient's condition may require additional testing or the RNA may require assistance from others attending the patient. As an example, an intraoperative blood test may be necessary which would require an operating room nurse to transmit a blood sample to a laboratory technician. The statutory amendments are intended to facilitate this type of care for the patient.

After the anesthetic the patient is often under the direct supervision of a nurse and the RNA moves on to other duties. Frequently the RNA moves immediately to undertake the anesthetic of another patient. Should the need arise in the first patient for additional tests, medication, etc., the required response should be immediate. The statutory revisions would allow RNAs to issue orders for other nursing and allied personnel to implement in such a circumstance.

These are broad generalized examples of patient needs within an operating room setting and how the RNA frequently needs the assistance of other licensed healthcare providers when the RNA is about to provide an anesthetic, is in the process of providing some form of anesthetic, or has recently completed an anesthetic. Strict interpretation of the current statute, K.S.A. 65-1158, either prohibits or significantly and unacceptably delays the services from being provided to a patient. This is not to suggest that a RNA's practice is limited to an operating room setting or to a specific type of anesthetic method. The example used herein is simply a most common setting example. RNAs frequently practice in the labor and delivery area of a hospital, in a procedure room which is not strictly an operating theater, in the emergency department, in free standing specialty facilities such as where eye surgery is carried out, etc. RNAs assist physicians and dentists with patient care by providing a safe chosen form of anesthesia in many different patient care areas. Amendments to this statute are not intended to change the general practice that currently exists today. Instead, the proposed amendments to K.S.A. 65-1158 are intended to facilitate safe management of the anesthetic before it is undertaken, while it is in progress, and as the patient recovers.

KANSAS ASSOCIATION OF NURSE ANESTHETISTS



As noted at the beginning of K.S.A. 65-1158, the anesthetic process begins upon order of a physician or dentist. RNAs are not seeking to diagnose a medical condition or to independently or unilaterally select specific treatments for the condition. Indeed, K.S.A. 65-1158(c) states that "[a] registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team." Hence RNAs are not seeking the authority to independently establish and operate chronic pain management clinics. If a physician or dentist orders a RNA to administer a medication for a patient with chronic pain, the RNA may fulfill the order, but the RNA is not seeking to independently diagnose the medical condition and independently select the appropriate treatment in this setting. As used in this letter, the term anesthetic is intended to include all manners of rendering a patient insensitive to painful stimuli. Your consideration is most appreciated.

Sincerely,

Rachel Edgerton CRNA MSNA

BY: Rachel Edgerton, CRNA
President
Kansas Association of Nurse Anesthetists

Agreement has been reached among legislators, Kansas Board of Nursing, Kansas Association of Nurse Anesthetists, and Kansas Medical Society regarding the effects of HB 2619 on other licensed nurses in Kansas. Because K.S.A. 65-1158 as amended by HB 2619 begins with a physician or dentist's order, it is agreed that other licensed nurses are acting within their scope of practice in following orders issued by registered nurse anesthetists (RNAs). Initiation of the anesthetic process by a physician or dentist's order is sufficient direction pursuant to K.S.A. 65-1113 to allow licensed nurses to follow the orders of RNAs. In so doing all listed professionals are acting within their role as members of the physician or dentist directed healthcare team.

Kansas Society of Anesthesiologist

Remarks Concerning House Bill No. 2619

Senate Public Health and Welfare Committee

March 9, 2010

Chairman Barnett and Members of the Senate Committee:

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

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

The new language contained in House Bill No. 2619 will allow nurse anesthetists to practice safely and effectively within their Scope of Practice as delineated in K.S.A. 65-1158, utilizing their skills and abilities to provide optimum and safe patient care while maintaining the role of the operating physician in delivering that care.

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

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

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

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

KSA has not supported changes to K.S.A. 65-1158 that enable an expanded scope of practice for nurse anesthetists. In particular, KSA opposes any movement of nurse anesthetists into the practice of critical care or chronic pain management, and no such expansion is in House Bill No. 2619.

The leadership of the Kansas Society of Anesthesiologists remains committed to finding legislative language that allows nurse anesthetists in Kansas to continue to deliver safe, effective, legal and efficient anesthesia care for Kansas patients within the structure of a physician or dentist directed health care team. **The KSA is in full support of House Bill No. 2619 in its present form and we encourage this committee to take favorable action on the measure.**

Thank you for allowing our Society to appear here today.

Testimony provided by Greg Unruh, MD

Dr. Unruh is an Anesthesiologist licensed to practice the Healing Arts in Kansas. He is a graduate of Southwestern College in Winfield and the Kansas University School of Medicine and practices anesthesiology at Kansas University Hospital. He is Associate Professor and Director of Residency Education for the Hospital and also serves as Legislative Chair for the Kansas Society of Anesthesiologists.

To: Senate Committee on Public Health and Welfare

From: Dan Morin
Director of Government Affairs

Date: March 9, 2010

Subject: HB 2619; Concerning registered nurse anesthetists

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

The statutes governing RNAs are quite specific to their unique advanced nursing practice, because the selection and administration of anesthetics is at one of the intersections of specialized advanced nursing practice and the practice of medicine. The groups most affected by legislative changes in this area of practice - the Kansas Association of Nurse Anesthetists, and the Kansas Society of Anesthesiologists, the Board of Nursing, and KMS – have worked together closely over the years to address practice questions as they arise. We have met over the past year with the abovementioned groups to discuss the issue and the approach contained in HB 2619 and have reached consensus on the recommendation for amendments to existing law before you today.

Thank you for the opportunity to offer these comments.

Senate Public Health & Welfare
Date: 03/09/10
Attachment: 10

March 9, 2010

Sen. Jim Barnett
Chair, Senate Public Health and Welfare Committee
Topeka, Kansas 66612

Chairman Barnett

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Rachel Edgerton, CRNA
President, Kansas Association of Nurse Anesthetists

Brian K. Smith, CRNA, MSNA
Director Of Anesthesia,
St. Catherine Hospital, Garden City, KS, 678 6
March 5, 2010

To: Senate Public Health and Welfare Committee
Re: HB 2619

Dear Committee Members;

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

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

Independent Practice, Topeka, Kansas

To: The Kansas Senate Public Health and Welfare Committee --

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

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

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

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

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

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

Thank you for your consideration.

Respectfully submitted, Nancy A. Whitson, CRNA, MS

KANSAS
STATE BOARD OF NURSING

Mark Parkinson, Governor
Mary Blubaugh MSN, RN
Executive Administrator
www.ksbn.org

Public Health and Welfare Committee
March 9, 2010

Written Testimony in Support of HB 2619

Mary Blubaugh MSN, RN
Executive Administrator

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

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

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

LANDON STATE OFFICE BUILDING, 900 SW JACKSON ST., S
VOICE 785-296-4929 FAX 785-296-392