MINUTES

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

August 18 and 19, 1976

Members Present

Senator Wesley H. Sowers, Chairman
Representative Richard Walker, Vice-Chairman
Senator Bert Chaney
Senator Elwaine Pomeroy
Representative Theo Cribbs
Representative Arthur Douville
Representative Sharon Hess
Representative Mike Johnson
Representative Marvin L. Littlejohn

Staff Present

Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office
Bill Wolff, Kansas Legislative Research Department

Others Present

Paul E. Fleener, Kansas Farm Bureau, Manhattan
Carla A. Lee, Wichita State University, Wichita
Richard A. Walsh, Wichita Branch, University of Kansas School of Medicine
Joseph F. Dominic, Wichita Branch, University of Kansas School of Medicine
Jerry Slaughter, Kansas Medical Society, Topeka
Cramer Reed, Wichita Branch, University of Kansas School of Medicine
Emerson Yoder, Kansas Medical Society, Denton
James H. Hayes, Division of the Budget, Topeka
David Waxman, Kansas University Medical Center, Kansas City
Doris A. Geitgey, Kansas University School of Nursing, Kansas City
Dean Kortge, Wichita Branch, University of Kansas School of Medicine
Archie R. Dykes, University of Kansas, Lawrence
Robert Kugel, Kansas University Medical Center, Kansas City
Mary J. Wiersma, Kansas Farm Bureau, Manhattan
Ruth C. Dickinson, Division of Planning and Research, Topeka
Elaine Crowther, Department of Social and Rehabilitation Services, Topeka
Barbara Brewer, R.N., Department of Social and Rehabilitation Services, Topeka
MaryLou Edmondson, R.N., Department of Social and Rehabilitation Services, Chanute
Phil Solter, S.W., Department of Social and Rehabilitation Services, Chanute
William E. Richards, Sr., Department of Social and Rehabilitation Services, Topeka
Robert C. Harder, Department of Social and Rehabilitation Services, Topeka
James C. Johnson, Kansas Public Nursing Home Administrators Association, Abilene
Charles W. Wurth, Mid-America, Wichita
William A. Newman, Department of Social and Rehabilitation Services, Topeka
George D. Blumb, Department of Social and Rehabilitation Services, Topeka
John F. Shockley, Department of Social and Rehabilitation Services, Topeka
Edgerton A. Taylor, Ombudsman, Topeka
Orus J. Jones, Kansas Public Nursing Home Administrators Association, Kansas City
Hazel Lee Simmons, National Retired Teachers Association and American Association of Retired Persons, Lawrence
Mrs. L.R. Pyle, Kansans for the Improvement of Nursing Homes, Topeka
Clara L. Kleweno, American Association of Retired Persons and Kansans for the Improvement of Nursing Homes, Hays
Petey Cerf, Kansans for the Improvement of Nursing Homes, Lawrence
Jessie Branson, Kansans for the Improvement of Nursing Homes, Lawrence
Frances Kottler, Kansas Association for Retarded Citizens, Wichita
Mary Ann Truitt, Kansas Association for Retarded Citizens, Wichita
Gary Robbins, Kansas State Nurses Association, Topeka,

Others Present (cont'd.)

Jim Klausman, Kansas Health Care Association, Valley Falls
Mrs. Cecile B. Roney, Kansas Retired Teachers Association, Lawrence
Mrs. Gladys N. Six, Kansas Retired Teachers Association, Lawrence
Judy Reno, Wichita-Sedgwick County Health Department, Wichita
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka
Doug Johnson, Kansas Pharmaceutical Association, Topeka
Stu Entz, Kansas Association of Homes for the Aging, Topeka
Lowell M. Wiese, M.D., Kansas Department of Health and Environment, Topeka
Richard S. Swanson, Kansas Department of Health and Environment, Topeka
James Mankin D.D.S., Kansas Department of Health and Environment, Topeka
Richard P. Brown, Kansas Health Care Association, Topeka
Larry Fischer, Kansas Health Care Association, Coffeyville
Jan D. Walker, Kansas University Medical Center, Kansas City
Pauline Bork, Kansas Department of Health and Environment, Topeka
George D. Marshall, M.D., Colby Clinic, Colby
Elizabeth Carlson, Board of Healing Arts, Topeka
V.O. Nellsch, Kansas University Medical Center, Kansas City
Joseph C. Meek, Kansas University Medical Center, Kansas City
Dan Suiter, M.D., Kansas University Medical Center, Kansas City
Ruth Murphy, R.N., Elk County Health Department, Howard
Lloyd L. Hall, Kansas Association of Osteopathic Medicine, Topeka
Doug Johnson, Kansas Pharmaceutical Association, Topeka
Clyde Hill, Advisory Committee to Outreach Task Force
Jim Schoenbeck, Abilene
Leon Boer, Abilene
Charlene Shamburg, Kansas Department of Health and Environment, Topeka
Russ Collins, State Fire Marshal, Topeka
Paul Markley, State Fire Marshal, Topeka
Particia Ramer, Homemaker Services, Hoxie
Wanda Heller, Homemaker Services, Palco
Lorena M. Peterson, Homemaker Services, Ellis
Harriet Nehring, Kansans for the Improvement of Nursing Homes, Lawrence

August 18, 1976

The meeting was called to order at 10:00 a.m. by the Chairman, Senator Wesley H. Sowers. He noted that the meeting would be an informal seminar to share what is being done and what can be done to solve the problem of adequate medical services for Kansans. (Proposal No. 33)

Data Collecting

A consensus was reached from discussion that a data collection program should be developed and implemented. Emphasis was given to the fact that the data collected must be relevant, useful and timely. For example, knowing the number of doctors is not too useful unless you know whether or not they are practicing, how much they are practicing, and how many patients they see.

Groups mentioned which could be given the responsibility for data collection were: Department of Health and Environment, Board of Healing Arts, Kansas University Medical Center and the Health Service Agencies. It was pointed out that whomever is responsible for the data collection must have the proper orientation. Also, data should be collected for all health care providers.

Discussants noted that the federal comprehensive health planning law states that data collection is the number one task of HSA's. A time table for this task has not been established because not all state level groups have been formed. An HSA member stated he felt this task would have to be completed within one year. Presently, the Department of Health and Environment is receiving $62,000 in federal money to establish a data collection system.

Dr. Kugel, Executive Vice-Chancellor, Kansas University School of Medicine, said that he will have recommendations as to types of data to be collected, as requested by the Committee, about September 1.

Reference was made to the study of nurses being done by Dr. Harkness in Legislative Research.

Definition of Underserved

Reference was made to maps prepared by the staff based on different definitions of "underserved," (Attachment A) and material from the Federal Register (Attachment B), the National Health Services Corps (Attachment C), and HEW (Attachment D) pertaining to "underserved."

No matter what definition is used, the Committee heard that the problem is not a matter of eastern versus western Kansas, or urban versus rural areas. Rather, there was some consensus that all of Kansas is medically underserved.

Dr. Jack Walker, Kansas University School of Medicine, noted that the problem in defining underserved is that underserved "is in the eye of the beholder." One way to approach the problem is to define a reasonably served area. If a community does not meet this definition, it probably has a problem. He felt a reasonably served area has a basic primary facility such as a hospital, with a group of doctors (two to four) providing the nucleus of health services 24 hours a day, no more than 25 to 30 minutes away.

Dr. Yoder stated he had developed the following guidelines when trying to define an underserved area: a doctor available within 25 miles; something like a general hospital within 30 to 50 miles; and no limit for distance to more sophisticated care.

What is Being Done

Kansas University School of Medicine and Medical Center. Programs outlined were: contacting schools throughout the state to see what they are doing to inform students about opportunities in the health care field, and to encourage students to enter these fields; developing plans to work with medical students and communities needing health services; creating the position of Special Assistant for Rural Health; exploring ways to get admissions committee to look toward getting students from underserved areas; maintaining the Physician's Exchange at the University; increasing enrollments; and emphasizing family practice and primary care programs.

A Committee member asked if the sophistication of the medical center did not tend to discourage a student from going to a rural area to practice. Dr. Meek stated he did not think so since the real emphasis is on the relationship to the patient, which is being taught by practicing doctors at the medical center. Nevertheless, perhaps some attention should be given to this issue.

Dr. Dan Suiter, House Officer, Medical Center, noted that students are hesitant to leave the educational environment before they have completed their education. They are concerned, he said, with what they will be in 20 years -- a number in a county, or a doctor who can meet the needs of his or her patients.

Kansas Farm Bureau. Paul Fleener, Kansas Farm Bureau, reviewed the Illinois program he had presented to the Committee at its July meeting. The Farm Bureau Board appointed a committee which has held an exploratory meeting with representatives of the Kansas Medical Society, the Kansas University School of Medicine and Senator Sowers to discuss the possibility of implementing a similar program in Kansas. This program would be created from private initiative rather than legislative mandate.

In discussion of the Farm Bureau proposal, it was mentioned that some question may exist whether student admission slots can be earmarked for such a program. While this point will be checked, courts have generally allowed colleges a greater latitude in considering social and economic factors into academic policies.

The Farm Bureau also will have a forum on health care services at its annual meeting December 5-7. Through Mary Wiersma, Farm Bureau county organizations and county medical societies are getting together to examine the problems and to look for practical solutions.

Kansas Medical Society. The Kansas Medical Society operates a physician clearing house which attempts to match doctors and communities. However, staff time for this program is limited. The Society also is cooperating in Kansas Health Day and other programs of the Kansas University School of Medicine.

Kansas Association of Osteopathic Medicine. Lloyd Hall, Executive Director, Kansas Association of Osteopathic Medicine, explained the loan fund of the Association and its successful efforts in getting students to return to or remain in Kansas upon completing their training. Mr. Hall noted that the osteopaths now have an internship program for six students in their Wichita hospital. Other hospitals are being considered for use on a rotational basis.

Nurse Clinicians and Practitioners Programs. Ruth Murphy, Elk County Health Department, stated there is one osteopath in his 70's, herself and one other RN to serve the medical needs of approximately 4,000 persons in a 651 square mile area. She explained that her program is based on preserving health and includes traveling clinics.

Carla A. Lee, Nurse Clinician Program, Wichita State University, stated that the WSU program has 113 graduated with 11 students finishing this September. The University will continue about 30 students in the program. Seventy-five percent of the nurse clinician graduates have stayed in Kansas, most of them in group practice settings. Ms. Lee described the 12 month program for RN's which includes a preceptorship. The statistics show an increase in productivity in physician offices which employ a nurse clinician.

Doris A. Geitgey, Kansas University School of Nursing, described the University nurse practitioner program. She noted that using services of health care providers other than physicians can be a partial solution to the problem. Ms. Geitgey sees the nurse practitioner as working interdependently with a physician and as giving emphasis to health education. One reason so many nurse clinicians and nurse practitioners return to smaller communities is the preceptorship phase of the program.

In response to a question about changes needed in present statutes relating to nurse clinicians and nurse practitioners, it was suggested that the Legislature look at the regulation issue if these programs are to reach their potential. Some states have regulated the licensee using assistants. There seemed to be some consensus for this approach in Kansas. However, the Board of Healing Arts feels they do not have this authority presently. The Board did draw up rules and regulations pertaining to these types of providers, but they were rejected by the Attorney General.

The Kansas Medical Society agreed to accept the responsibility for getting these groups together and will report at the September meeting of the Committee.

Suggestions for Committee Consideration

Beyond recommending that all interested parties work together for the resolution of the medically underserved areas problem, discussants raised the following subjects for consideration:

1. Educate communities to aggressively recruit health care providers based upon a logical analysis of the community needs and wants;

2. Develop, through legislative action, a regional approach for the delivery of health services. (Such a program should consider individual area needs; a sufficient supply of health care providers and necessary support personnel; and mobility patterns of health service consumers.);

3. More adequate financing for scholarship and loan programs as well as ample fringe benefits for students and residents. (Chancellor Dykes asked that consideration be given to reinstating the loan/scholarship program and having it administered at the medical school rather than from Topeka. More competitive salaries for residents and the payment of professional liability insurance premiums are also requested.);

4. Publicize the programs of total health care being provided through community public health agencies;

5. Enlist the support of the medical school staff to encourage students to consider practicing in underserved areas;

6. Encourage admissions committees to give greater weight to the geographic origin of applicants in the selection of medical students;

7. Authorize third party payments for services rendered by certain health care providers other than those licensed to practice medicine and surgery;

8. Emphasize the training of primary care physicians, but without disrupting the training of needed specialists and researchers; and

9. Recognize, as Mr. Clyde Hill noted, the complexity of the problem and its solution, taking caution to act in the future in a manner which will not lose what has been gained in the health services areas.

The meeting was adjourned at 5:00 p.m.

August 19, 1976

The meeting was called to order by the Chairman, Senator Wesley H. Sowers. He explained that the meeting would be conducted as an informal seminar on the topic of adult care homes. (Proposal No. 32) The Chairman said he intended to center discussion upon problem areas identified in earlier meetings.

Inspections

There are four types of inspection for nursing homes: (1) licensing inspection based on state regulations done by the Department of Health and Environment; (2) certification inspection of premises based on federal regulations done by the Department of Health and Environment under a contract with the Department of Social and Rehabilitation Services; (3) utilization reviews and medical reviews based on federal regulations done by the Department of Social and Rehabilitation Services for those homes participating in Title XIX; and (4) fire safety inspections based on state regulations for all homes, and on federal regulations for homes participating in Title XIX done by the State Fire Marshal under contract with the Department of Health and Environment.

In some instances the Department of Health and Environment contracts with local health departments to do the licensing inspections. The certification inspections, however, are done by specially trained members of its own staff.

Efforts have been made to coordinate the various inspections, but it has proven difficult to implement because of the different time frames involved. For example, licensing inspection is to be done 60 days before the license expires, but certification inspection is to be completed between 60 and 90 days of the provider agreement expiration. There is also the difficulty of coordinating time schedules of teams from different departments and from state and local agencies. The problem is further complicated if a home is not in compliance and is given additional time to comply. While much has been made of the inconsistency of inspections, Dr. Wiese said he had not received a single letter specifying information he requested.

With only 12 surveyor positions, the Department of Health and Environment can act only like a policeman to see if the homes meet the requirements, but surveyors do not have time to provide consultation and assistance to homes in removing areas of non-compliance.

It was noted that no home has lost its license because of minute violations. Some discussants stated that the report in which these minute citations are written is available to the public and might reflect negatively on the home. Also, if the home complies with requirements after the inspection, no changes will show on the original inspection report available to the public.

Dr. Wiese said that state regulations regarding adult care homes have been rewritten to follow the federal regulations more closely.

Mr. Paul Markley, Kansas Fire Marshal's Office, appearing at the Committee's request, noted that state inspections are usually done once a year and the personnel doing them live throughout the state. Federal inspections may be done as many as three or four times a year and are done by personnel who meet certain federal qualifications. Personnel doing state inspections are also responsible for inspecting more than health care facilities. Therefore, it is difficult to coordinate these inspections. This coordination problem is exacerbated in the larger areas where the local fire departments do the state inspections. In some cases a local code may be more stringent than the state code and the more stringent code prevails.

In answer to a question, it was clarified that there are no federal fire marshals doing inspections. The inspectors are all state employees some of whom do federal inspections for certification of homes participating in the federal program.

Ms. Charlene Shamburg, R.N., Department of Health and Environment, appeared at the Committee's request to explain the procedure used in inspections and surveys of adult care homes. She emphasized the need for additional time to consult and work with nursing homes personnel.

Ms. Barbara Brewer, Nurse Consultant, Department of Social and Rehabilitation Services, explained SRS survey programs. She said SRS attempts to coordinate activities with the Department of Health and Enviornment. She noted that in cases where people are found to be inappropriately placed, SRS does not mandate placement, but sends its recommendations to the attending physician.

At the suggestion of the Committee, the Chairman appointed Representative Mike Johnson, Chairman, Representative Marvin Littlejohn, Representative Sharon Hess, and Representative Arthur Douville as a subcommittee to accompany a team making inspections and to report to the Committee at its next meeting.

Training Programs

The proposed rules and regulations make aide training mandatory for all aides by July 1, 1978. Federal funds cover 90 percent of the cost of aide training with 10 percent or approximately $10 to $15 to be paid by a payee. Courses are offered by the area vocational technical schools.

Kansas Health Care Association contracted to offer the medications aides course required by federal regulations and to administer the test. Dr. Wiese stated he received a letter from HEW rejecting the course adopted. The course, Dr. Wiese said, is being revised by a committee appointed by him on the basis of their knowledge in this area and without consideration for organizational representation. A draft of the revised course will be sent to providers for review and comment before it is adopted. Presently this course is packaged by the Kansas Health Care Association and sold to nursing homes. The plan is to offer the revised course through the area vocational technical schools on a 90-10 basis. The Kansas Health Care Association questioned the need for this revision, the fact they had not been invited as an organization to participate in the revision and the cut-off point established on the test.

In answer to a question, it was claimed that if aides are given an increase in salary after passing the course, the aide turnover should decrease. But, increasing wages will also increase the cost to the patient or the state.

Representatives of nursing homes noted that federal regulations require them to pay an employee wage, including fringe benefits, while he or she is in school if the home requires the course. At the same time, homes must find and pay a replacement person to maintain coverage. Other mechanical and logistics problems were given. The feeling was expressed that these problems should be further examined and solutions worked out before mandatory training is written into the regulations.

Ombudsman Program

Mr. Edgerton A. Taylor, Ombudsman, Department of Social and Rehabilitation Services, made the following observations:

1. after nine months, people see him as someone to answer complaints;
2. any placing of mentally retarded persons in nursing homes should go very slowly;
3. more effort is needed to make people aware of patient's rights; and
4. grievances can be sent to the ombudsman or health department, not just to the administrator of the home.

The ombudsman program, he said, should be extended to mental institutions.

Mentally Retarded Placed in Nursing Homes

Ms. Frances Kottler, Kansas Association for Retarded Citizens, stated her organization is opposed to putting mentally retarded persons in nursing homes because they need different programs than those required by the elderly. ICF facilities specifically for mentally retarded are needed.

Mr. Taylor, Ombudsman, thought that placing mentally retarded persons in nursing homes may be a violation of patient's rights, and that this question may be tested in court.

Dr. Harder responded that SRS would like to have ICF's just for mentally retarded, but his agency is not advocating building buildings. The type of facility recommended for people leaving institutions is determined by professionals in the institution. However, where a person finally locates is determined by the person, parent or guardian. Dr. Harder reviewed the project reintegration. He noted that workshop and activity programs do not have to be at the facility where the person is living.

Suggestions for Committee Consideration

1. Employ a trained person in the health field to be responsible only for the adult care home programs. (Dr. Wiese responded to this suggestion noting that Mr. Swanson is an administrator who has health personnel under his supervision and a physician for an immediate superior.);
2. Employ more surveyors and inspection personnel to visit more homes on a more frequent basis to follow-up on complaints and to provide consultation and assistance to home administrators;
3. Make inspection reports available through county health departments. (Mr. Swanson agreed that these reports could be sent to the appropriate counties. The certification reports are available at the local SRS office.);
4. Consolidate in one agency the supervision and regulation of adult care homes;
5. Continue efforts to coordinate the various required inspections;
6. In the absence of consolidation, develop better communication between the Department of Social and Rehabilitation Services and the Department of Health and Environment, i.e., sharing reports and combining training of surveyor/inspector personnel;
7. Examine the total state payment program to adult care homes, taking into account time lags, the inflation factor and the definition of "reasonable charges";

8. Seek input from industry in the development of aide training courses and consider the impact of such training upon the cost of care; and

9. Consider the development of a more formal training program for adult care home administrators. (There seemed to be a consensus that management is an important factor in the resolution of adult care home problems.)

Proposal No. 36 - Welfare Overview

The Chairman noted that this proposal was not on the agenda, but since conferees had come so far they could appear on the proposal today.

Staff noted that no contract is in affect for homemaker services at this time because the contract with Upjohn Company expired and the Department of Social and Rehabilitation Services did not want to accept the low bid. SRS is planning to take over this program.

Ms. Wanda Heller, formerly coordinator of the Homemaker Program in her area, presented a written statement (Attachment E). The Committee asked Ms. Heller and the others present to return when this proposal is scheduled for consideration.

September Meeting

One day will be devoted to (1) consideration of action the Committee may wish to take on Proposal No. 33 - Health Care Services in Medically Underserved Areas; and (2) a report from Representative Walker on possible amendments to laws pertaining to physician assistant's programs. The second day will be devoted to other aspects of adult care home programs using the seminar format; a review of present statutes and bills before the legislature last session relating to adult care homes; and comments from various groups on these bills.

The meeting was adjourned at 4:20 p.m.

Prepared by Bill Wolff

Approved by Committee on:

_____
Date

area or the area in which such population group resides.

Section 110.203(g) of the health maintenance organization (HMO) regulations (42 CFR 110.203(g)) states that, in designating the medically underserved areas, the Secretary will take into consideration the following factors, among others:

(a) Available health resources in relation to size of the area and its population, including appropriate ratios of primary care physicians (both doctors of medicine and doctors of osteopathy) in general or family practice, internal medicine, pediatrics, obstetrics and gynecology, or general surgery, to population;

(b) Health indices for the population of the area, such as infant mortality rate;

(c) Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and

(d) Demographic factors affecting the population's need/demand for health services, such as percentage of the population age 65 or over.

The statute encourages health maintenance organization applicants to enroll members from medically underserved areas (MUAs) and population groups by providing priority ranking and up to 100-percent funding for HMOs that will draw not less than 30 percent of their membership from medically underserved populations. There is a limitation, however, that not more than 75 percent of the membership be from a medically underserved population unless that area is also rural (see sections 1301(c)(3), 1303(b)(2), and 1304(b)(6) of the PHS Act).

The purpose of this notice is to:

(a) Describe how a methodology for identifying MUAs was developed,

(b) Show how the methodology was applied to specific data to produce a list of MUAs,

(c) Summarize the comments of comprehensive health planning (CHP) agencies on the methodology and its application,

(d) Set forth the procedure for ongoing revisions of the list of MUAs, and

(e) Publish the current MUA list, as revised following receipt of the CHP agency comments and recommendations.

Background and Computation of the Index of Medical Underservice

The technique used to identify medically underserved areas and population groups resulted from a developmental effort carried out over a number of years. Even before passage of the HMO Act in 1973, efforts were underway to develop criteria for measuring adequate primary care; with passage of the Act, this effort was reoriented toward development of criteria for defining medically underserved areas. It was decided that the development of an index of medical underservice (IMU) would be the best means to identify medically underserved areas, and the development of an index was begun.

The purpose of using an index approach, rather than individually examining a number of separate indicators against criteria for each indicator, is to allow for simultaneous consideration of all the criteria used. The chosen indicators of medical underservice are weighted according to their importance in identifying medical underservice. Because of the interdependence of the indicators, it is unlikely that any single indicator can show that an area of population group is or is not underserved. Furthermore, an index approach allows for later inclusion of any additional criteria which can be shown to make the index more predictive of underservice. Finally, an index can be used to identify gradations of underservice and, with appropriate changes in the criteria or their relative weights, a similar index can be used for other health service programs.

Initially, dimensions of medical underservice were delineated by an interdisciplinary group of experts in the fields of health care delivery, health care administration, health status and health services measurement. The dimensions studied included availability of health manpower and health facilities; physical and economic access to and effective utilization of health resources by segments of the population; health status of the population; and appropriateness and quality of health care. Seventy-two indicators of these dimensions were identified and circulated to other experts who were requested to select those which would enable health care experts to compare areas on the overall level of medical underservice. Through a combination of mail exchanges and panel discussions, the list of 72 was reduced to 20 indicators which were ranked by the experts according to their relative importance. The 20 were reduced to 9 indicators by rejecting those with low relative weights as well as those for which data were considered unavailable or difficult to collect.

Conferences were convened at which panels of experts were asked to weight the nine indicators against each other with respect to their importance for determining the relative medical underservice of various areas. The nine remaining indicators were: ratio of practicing physician equivalents to population, infant mortality rate, preventable death rate, percent of population with family incomes below the poverty level, percent of population aged 65 or over, average travel time of area residents to regular sources of primary care, per capita expenditures for health care, average travel time to emergency care, and ratio of (acute) hospital beds to population. The experts were asked to establish "utility" transformation curves for each indicator, relating possible values of each indicator to a common scale ranging from 0 (grossly underserved) to 100 (adequately served). This transformation to a common scale allowed for the summing-up of the indicator values into a single index score. Then, using a multiattribute utility estimation approach,[2] the weights and utility curves were combined into a 9-variable index of medical underservice.

Further analysis was carried out on subsets of the nine indicators. In addition to the 9-variable model, an 8-variable, a 6-variable, and a 4-variable model were analyzed. Because of data collection problems with some of the indicators in the 8- and 9-variable models and the fact that the 4-variable model's predicting ability appeared superior to the 6-variable model, the 4-variable model was selected for further study. It was found, after validation tests using sites from a wide range of geographic areas and from an extensive urban/rural mix of areas, that the chosen subset of four indicators predicted expert judgment of medical underservice almost as well as larger subsets. Also, data on the four indicators selected were considered to be the most accessible to both national and local health planners.

The indicators of medical underservice selected as the basis for the IMU are as follows:

(a) Ratio of primary care physicians to population;

(b) Infant mortality rate;

(c) Percentage of the population which is age 65 or over; and

(d) Percentage of the population with family incomes below the poverty level.

The IMU is computed using data on the four indicators, for a given area, in the following manner:

(a) The measured value for each indicator is converted to a value on a common scale of 0 to 100, using a "utility curve" established for each indicator. The curves thus relate the indicators to criteria for optimal values of the indicators in adequately served areas; the actual values can then be applied to the curves to carry out the conversion to utility values.

(b) The IMU for a given area is computed as the sum of the weighted utility values for the four indicators.

The list of medically underserved areas was produced by use of this methodology applied to national data.

Application of the Index

An initial list of MUAs was developed by applying the IMU described above to national data on the four indicators. Specifically, county-level data were used for the physician ratio and infant mortality rate. For the two census indicators (percent of the population below poverty and percent of the population age 65 or over), county and/or Minor Civil Division (MCD) or Census County Division (CCD) data were used in nonmetropolitan areas, and census tract data were used in metropolitan areas.

When the IMU was computed for all U.S. counties, it was found that the median county score was 62, therefore 62 was chosen as the cut-off point between underserved and adequately served areas. Areas with scores of 62 or less were considered underserved.

In nonmetropolitan areas the index value was computed for each county, and all counties with index values of 62 or

[2] Huber, George, "Multi-Attribute Utility Models: A Review of Field and Field-like Studies," Management Sciences, June 1974, Vol. 20, No. 10.

below were included on the list. In nonmetropolitan counties with index values above 62, the IMU was then recomputed for each MCD and CCD; those with scores of 62 or below were added to the list.

In metropolitan areas, defined here as census tracts which lie within standard metropolitan statistical areas (SMSA), the IMU was computed for each census tract. All census tracts with IMU values of 62 or below were included on the list.

Areas with a population of less than 500 (whether counties, census tracts, or MCDs) were not included in the evaluation in an effort to eliminate the listing of areas such as parks and airports.

In order to comply with the HMO Act, before a national list could be prepared, applicants for Federal assistance were encouraged to identify medically underserved areas themselves, using an index methodology described to them in draft guidelines. Proposed areas were submitted to CHP agencies for review as part of the HMO application process, and were considered for designation as underserved on an individual basis. Several HMO applicants whose projects involve service to underserved areas designated in this manner have been approved and funded. Such areas (if not also included in the national list of designated areas) will continue to be designated only until their current grants expire. Future funding under the underserved-area provisions of the HMO Act will be available only to applicants planning to serve areas on the list, or areas subsequently added to this list via the procedures described herein.

The list of areas produced by application of the IMU, plus the areas identified by HMO applicants, were submitted to CHP agencies for their review. The list incorporates revisions resulting from that review process.

SUMMARY OF COMMENTS FROM AGENCIES

On January 15, 1975, all State and areawide comprehensive health planning agencies were sent a draft list of medically underserved areas within their jurisdictions, and a complete description of the index of medical underservice methodology and the technique used to apply the IMU to their areas. CHP agencies were asked to submit their comments and recommendations within 60 days as follows: (a) comment on the IMU method and the technique used for its application, (b) recommend additions to the list based on a recomputation of the IMU using better data available to the agency at the local level, and (c) recommend deletions from the list based on the agencies' knowledge of the area(s) or based on a recomputation of the IMU using better data available to the agencies at the local level. The CHP agencies were informed that they should also include a description of the method used for local public review of their recommendations. In reply, numerous telephone calls and 39 written comments were received.

The areas of various types on the draft list, and on the list after CHP review, are as follows:

	Number on draft list of MUA's	Number on list after CHP review (table A)	Changes
Counties	1,495	1,492	−3
Minor civil divisions/census county divisions	1,454	1,516	+62
Census tracts identified individually	5,304	5,228	−76
Census tracts identified as part of neighborhood groups	0	42	+42

Approximately 25 percent of the total population of the United States resides in the listed MUAs. The increase in the number of MCDs and CCDs after CHP comments on the list, and the decrease in the number of counties listed, represent an attempt by the CHP agencies to identify pockets of underservice within counties. The addition of the category, "Census Tracts Identified as Part of Neighborhood Groups," reflects the decision to allow local agencies to include all census tracts which are part of a natural neighborhood if the entire neighborhood MUA index score meets the cut-off level chosen as indicating medical underservice.

SUMMARY OF CHP COMMENTS ON THE INDICATORS, THE IMU, AND THE TECHNIQUE USED FOR ITS APPLICATION; WITH RESPONSES TO THE COMMENTS

The CHP critiques of the IMU and suggestions for its improvement were divided into comments on the four indicators which make up the IMU, and comments about their application. (In this summary, the Public Health Service response follows the comment and is indented.)

A. *Comments on the Indicators.* 1. It was suggested that neither of the census-related indicators (i.e., percentage of population with family incomes below the poverty level, percentage of population age 65 or over) is a measure of medical underservice.

While none of the indicators actually measures medical underservice directly, each indicator correlates with or predicts a dimension of underservice, and evaluations of the IMU method indicate that the combination of indicators does effectively parallel the experts' judgments about the medically underserved areas.

2. Some CHP agencies noted that the 1970 census poverty data used in the IMU do not reflect the extent of poverty in 1975 and that the definition of poverty used makes it difficult to obtain more recent comparable data.

The 1970 census is the most recent nationally available source of small-area poverty data. Standard census definitions of poverty are used in computing the IMU for the various areas throughout the Nation. CHP agencies were encouraged to use any other more recent official data on any of the indicators to support suggested additions to or deletions from the MUA list.

3. The percentage of "preventable deaths" was suggested as a better indicator of medical underservice than the "infant mortality rate" used in the IMU.

The indicators used were chosen by panels of health administrators, planners, providers, and consumers from lists of indicators which included percentage of "preventable deaths." In choosing the indicators, it was necessary to consider availability of the data, and the ability to arrive at agreed-upon operational definitions for each indicator.

4. County-wide infant mortality rates were used to arrive at the IMU for all areas including sub-county areas. The adequacy of county-wide data for evaluating urban sub-county areas was questioned by the agencies.

The Department could not use sub-county infant mortality data in developing the initial list as such data were not available on a national basis. CHP agencies, however, will be allowed in the future to submit infant mortality data for sub-county areas having at least 4,000 births over a 5-year period. This level of births has been chosen to ensure the reliability of the infant mortality rate. Such areas must be defined in census units and the new rate must be used for all units comprising such sub-county areas.

5. There were four types of comments relating to the use of the physician-to-population ratio as one indicator in the IMU: the presence of physicians in an area does not necessarily represent an available service to the total population of that area; physician full-time equivalents should be computed or estimated by excluding physicians over 65 years of age and those in ill health who are in active practice; county physician-to-population ratios are not meaningful in assessing sub-county areas; and Public Health Service physicians in the National Health Service Corps (NHSC) and the Indian Health Service (IHS) should not be included as primary care physicians.

It is recognized that availability does not assure accessibility of medical care, but measurement of accessibility is not feasible at this time. Indices of accessibility are being studied, however, for possible use in the future.

Accurate measurements of "physician full-time equivalents," if available, would be more useful than the simple number of physicians spending at least 50 percent of their time in primary care, which is now used to count physicians for this indicator. Standardized measures of "physician full-time equivalents" are now being discussed and will be used if and when such data become available and can be gathered uniformly for all areas.

The use of sub-county physician ratios is being studied by the Health Resources Administration and the Health Services Administration. A uniform definition of medical service areas (primary-care service areas) is being developed for programs delivering primary medical care. County physician-to-population ratios will be used in the IMU until a medical service area definition is established.

The use of NHSC and IHS physicians in rural areas is supported on the basis

that they are a resource available to supply medical care to their particular local communities. Consideration will be given to accepting CHP agency recommendations for excluding IHS physicians, if native Americans are also excluded.

6. The use of additional indicators for the IMU was proposed, such as: population ages 16–64 who are disabled; percent of mothers receiving prenatal care in the first trimester; number of health facilities in an area; and unemployment rate.

As noted, many variables, including some of the above, have been considered. Additional indicators will be studied in future evaluations of the IMU variables.

B. *Comments on the Application of the IMU.* The principal concern expressed (and noted above in comments on the indicators) was that county data often obscure problems of maldistribution of services within counties, and that local agencies should have the option of defining natural geographic areas needing primary care service and of providing the data on all four indicators for such areas. Another concern was that the IMU did not address problems of accessibilty of primary care. The agencies recommended that, in revising the IMU, consideration be given to time and distance in relation to obtaining primary care, including such things as geographic barriers or inclement weather.

Some agencies raised questions about special problems in their areas. For example, one agency recommended that special consideration be given to areas with heavy seasonal influxes of vacationers.

All but the last of these general comments were discussed under the section on *Comments on the Indicators.*

Although the IMU does not fully reflect special local problems such as seasonal influxes, local agencies can recommend deletion of any area, or an area can be added if the locally computed IMU for that area is below the designated cut-off level. Efforts are being made to evaluate various means of refining the IMU so that it will accurately reflect local conditions and concerns. In its present state, the IMU represents a beginning in the effort to accurately assess medical underservice and identify underserved areas and population groups and, as refinements are made, they will be reflected in updated lists. Such lists will be coordinated with local planning agencies, and published periodically in the FEDERAL REGISTER.

ONGOING REVISIONS IN THE MUA LIST

The MUA list will be continuously revised using national updates including changes recommended by official CHP agencies. National updates will be based on changes in the actual value or weights of the indicators, additions or deletions of indicators, or adjustments in the cut-off level. CHP agency recommendations will be considered according to the procedure described below.

It is expected that official CHP agencies will, on a continuous basis, recommend additions to and deletions from the MUA list. (Only recommendations from official CHP agencies will be considered.) The material submitted should include a description of the method used for public involvement in the recommendation. The description may include, for example, documentation of relevant public meetings, copies of the agency's published notice of intent to review its area to identify pockets of medical underservice, or satisfactory demonstration that the Agency Advisory Board, as representative of the community, has had adequate review opportunity and has approved the agency recommendations.

If recommendations for additions and deletions are based on a recomputation of the index of medical underservice, all computations, as well as data sources and dates, must be submitted with the recommendations.

HMO applicants who intend to seek priority funding based on an intent to enroll members from MUAs should consult with the official CHP agency in the area and obtain information on the latest published MUA list. Medically underserved areas which were identified by HMO applicants prior to this Notice will be considered to be MUAs only through the term of any existing HMO grant award to the applicant, unless the area is or becomes part of the list according to the procedure described below.

Deletions. Recommendations for deletion of any area from the list must be accompanied by the reasons for the recommendation, the demonstration of public involvement in the decision and, if the recommendation is based on a recomputation of the IMU, the computations with data sources and dates. The method for computing the IMU is described in paragraph (c) below, "Computation of the Index of Medical Underservice."

Additions. The following information is required when CHP agencies recommend addition of areas to the MUA list:

(a) Geographic identification of the area. An area proposed for designation as medically underserved must be either:

(1) A county (in nonmetropolitan areas),

(2) A Minor Civil Division (MCD) or Census County Division (CCD) (in nonmetropolitan areas),

(3) A census tract (in metropolitan areas), or

(4) A group of census tracts, MCDs, or CCDs which constitute a "natural neighborhood" for MUA designation.

(CHP agencies may aggregate individual census tracts, MCDs or CCDs with contiguous tracts, MCDs or CCDs, and recommend that they be listed as underserved if the IMU for the combined area scores 62 or below. Such groupings may constitute more "natural" areas for designation as medically underserved than units such as census tracts, MCDs and CCDs because of the homogeneity of the neighborhood.)

(b) Data on the four indicators of underservice. The following data must be provided for any area recommended for designation as a medically underserved area:

(1) Ratio of primary care physicians-to-population in the county which contains the MUA. This ratio should be computed by taking the number of primary care physicians in the county containing the identified area, dividing this number by the resident population minus the resident members of the Armed Forces and inmates of institutions, and multiplying the result by 1,000. Figures used here (number of primary care physicians, resident population, resident members of the Armed Forces, and inmates of institutions) and their sources, should be stated. For the purpose of these computations, primary care physicians are defined to include the total number of active doctors of medicine (M.D.) and doctors of osteopathy (D.O.) who spend at least 50 percent of their time engaged in direct patient care in the fields of general or family practice, internal medicine, pediatrics, or obstetrics and gynecology. In metropolitan areas the computations should include all non-Federal physicians meeting the above definition. In nonmetropolitan areas the computation should include Public Health Service physicians in addition to non-Federal physicians.

(2) Infant mortality rate. This rate should be computed as an aggregate rate for the 5-year period 1965 through 1970, or more recent period of five consecutive years, as follows: Total number of infant deaths (deaths between birth and age 1 year) during the 5-year period in the county containing the identified area should be divided by the total number of live births in the county during the same period and the result multiplied by 1,000. For counties with fewer than 100 births over the 5-year period, the IMU may be computed using the State infant mortality rate instead of the county rate. The infant mortality rate for subcounty areas including the identified area and having at least 4,000 births over the 5-year period will be accepted in lieu of the county rate. The number of infant deaths and live births for the area and the sources of data used must be stated, together with the infant mortality rate computed from them. Data on infant deaths and live births may be obtained from official State agencies or the annual editions of the U.S. Public Health Service publication entitled "Vital Statistics of the United States." Unpublished data, for years later than those for which data have been published, can be obtained for specific areas from the Mortality Statistics Branch, National Center for Health Statistics, Department of Health, Education, and Welfare, Washington, D.C. 20852.

(3) Percentage of population aged 65 or over. This should be computed from 1970 U.S. census data or more recent update thereof, if any, as follows: the number of persons age 65 and over in the identified area should be divided by the resident population of that area, and the result multiplied by 100.

The figures used to compute this percentage (number of persons age 65 and over and the resident population) must be stated. These data can be obtained

from U.S. Census Bureau documents or tapes. If data are obtained from some other more recent source, that source must be identified.

(4) Percentage of population with family incomes below the poverty level. The definition of poverty used is the 1964 Social Security Administration version adopted by the Federal Interagency Committee in 1969 and revised annually to account for changes in the cost of living. This should be computed from 1970 census data or more recent update thereof, if any, as follows: the number of persons in families with incomes below the poverty level in the identified area should be added to the number of unrelated individuals with incomes below the poverty level; this total should be divided by the resident population minus members of the Armed Forces living in barracks, college students in dormitories, and inmates of institutions, and the result multiplied by 100.

The figures used to compute these percentages (the resident population, the Armed Forces living in barracks, the inmates of institutions, students in dormitories, and the number of persons with income below poverty level) must be stated. They may be obtained from the U.S. Census Bureau documents or tapes. If the data are obtained from a more recent source, the data and source should be identified.

(c) Computation of the Index of Medical Underservice. The IMU must be computed as follows to determine whether an area can be designated as medically underserved.

(1) For nonmetropolitan areas (those outside of the SMSAs) identified as an entire county, compute the IMU using county-level data for each indicator (except that for counties having fewer than 100 births over a 5-year period, the State-level infant mortality rate may be used).

(2) For nonmetropolitan areas identified as MCDs or CCDs, or groups thereof, compute the IMU using MCD/CCD-level data for the poverty and age indicators, and county-level data for the physician ratio and infant mortality rate for the county containing the areas. Sub-county infant mortality rate may be used in areas which have 4,000 or more births during the 5-year period.

(3) For metropolitan areas (SMSAs) identified as census tracts or groups of census tracts, compute the IMU using census tract-level data for the poverty and age indicators, and county-level data for the physician ratio and infant mortality rate for the county containing the census tracts. Sub-county infant mortality rate may be used in areas with 4,000 or more births during the 5-year period.

The IMU is computed by using the values from the tables set out below, in the following formula:

$$IMU = V_1 + V_2 + V_3 + V_4$$

where

V_1=weighted value for percent of population below poverty level (see table V_1);

V_2=weighted value for percent of population age 65 or over (see table V_2);

V_3=weighted value for infant mortality rate (see table V_3); and

V_4=weighted value for primary care physicians per 1,000 population (see table V_4).

If the IMU score is 62 or below, the area may be recommended for designation as an MUA.

TABLE V_1

PERCENTAGE OF POPULATION BELOW POVERTY LEVEL

In the left column find the range which includes the percentage of population below poverty level for the area being examined. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Percent below poverty:	*Weighted value V_1*
0	25.1
0.1–2.0	24.6
2.1–4.0	23.7
4.1–6.0	22.8
6.1–8.0	21.9
8.1–10.0	21.0
10.1–12.0	20.0
12.1–14.0	18.7
14.1–16.0	17.4
16.1–18.0	16.2
18.1–20.0	14.9
20.1–22.0	13.6
22.1–24.0	12.2
24.1–26.0	10.9
26.1–28.0	9.3
28.1–30.0	7.8
30.1–32.0	6.6
32.1–34.0	5.7
34.1–36.0	4.7
36.1–38.0	3.4
38.1–40.0	2.1
40.1–42.0	1.3
42.0–44.0	1.0
44.1–46.0	.7
46.1–48.0	.4
48.1–50.0	.1
50+	0

TABLE V_2

PERCENTAGE OF POPULATION AGED 65 AND OVER

In the left column find the range which includes the percentage of population aged 65 and over for the area being examined. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Percent aged 65 and over:	*Weighted value V_2*
0–7.0	20.2
7.1–8.0	20.1
8.1–9.0	19.9
9.1–10.0	19.8
10.1–11.0	19.6
11.1–12.0	19.4
12.1–13.0	19.1
13.1–14.0	18.9
14.1–15.0	18.7
15.1–16.0	17.8
16.1–17.0	16.1
17.1–18.0	14.4
18.1–19.0	12.8
19.1–20.0	11.1
20.1–21.0	9.8
21.1–22.0	8.9
22.1–23.0	8.0
23.1–24.0	7.0
24.1–25.0	6.1
25.1–26.0	5.1
26.1–27.0	4.0
27.1–28.0	2.8
28.1–29.0	1.7
29.1–30.0	.6
30+	0

TABLE V_3

INFANT MORTALITY RATE

In the left column find the range which includes the infant mortality rate for the area being examined or the area in which it lies. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Infant mortality rate:	*Weighted value V_3*
0–10.0	26.0
10.1–11.0	25.6
11.1–12.0	24.8
12.1–13.0	24.0
13.1–14.0	23.2
14.1–15.0	22.4
15.1–16.0	21.5
16.1–17.0	20.5
17.1–18.0	19.5
18.1–19.0	18.5
19.1–20.0	17.5
20.1–21.0	16.4
21.1–22.0	15.3
22.1–23.0	14.2
23.1–24.0	13.1
24.1–25.0	11.9
25.1–26.0	10.3
26.1–27.0	9.6
27.1–28.0	8.5
28.1–29.0	7.3
29.1–30.0	6.1
30.1–31.0	5.4
31.1–32.0	5.0
32.1–33.0	4.7
33.1–34.0	4.3
34.1–35.0	4.0
35.1–36.0	3.6
36.1–37.0	3.3
37.1–38.0	3.0
38.1–39.0	2.6
39.1–40.0	2.3
40.1–41.0	2.0
41.1–42.0	1.8
42.1–43.0	1.6
43.1–44.0	1.4
44.1–45.0	1.2
45.1–46.0	1.0
46.1–47.0	.8
47.1–48.0	.6
48.1–49.0	.3
49.1–50.0	.1
50+	0

TABLE V_4

PRIMARY CARE PHYSICIANS PER 1,000 POPULATION

In the left column find the range which includes the ratio of primary care physicians per 1,000 population for the county being examined, or the county in which the area being examined lies. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Primary care physicians per 1,000 population:	*Weighted value V_4*
0	.0
.001–.050	.5
.051–.100	1.6
.101–.150	2.8
.151–.200	4.1
.201–.250	5.7
.251–.300	7.3
.301–.350	9.0
.351–.400	10.7
.401–.450	12.6
.451–.500	14.8
.501–.550	16.9
.551–.600	19.1
.601–.650	20.7
.651–.700	21.9
.701–.750	23.1

REGION VII
NATIONAL HEALTH SERVICE CORPS SITES AVAILABLE FOR PHYSICIAN PLACEMENT-1976

CODES

● APPROVED APPLICATIONS

▲ PENDING APPLICATIONS

○ APPROVED SITES FOR PSYCHIATRISTS

NATIONAL HEALTH SERVICE CORPS
601 EAST 12th STREET
KANSAS CITY, MISSOURI 64106

AVAILABLE COMMUNITIES REGION VII 1976

(* DENOTES OPENING FOR ONE PHYSICIAN ONLY - ALL OTHERS ARE TWO PHYSICIAN OPENINGS)

Iowa

1. Adair - Adair County - New practice one hour to Omaha

2. Parkersburg - Butler County
25 miles from Waterloo, Iowa. Good financial base, good board, new practice.

*3. Eldora - Hardin County
Existing NHSC practice active and two years old. In building with two other physicians. Very well equipped new hospital and emergency system.

4. Corydon - Wayne County
New practice. One other physician in town.

*5. Rock Rapids - Lyon County
Two new physicians (Surgeon, Peds) began July 1976. Looking for one physician Family Practice or Internal Medicine. 24 miles to Sioux Falls, S.D.

6. Ida Grove - Ida County
New hospital, new office building, three other physicians in town, 60 miles to Sioux City.

7. Toledo - Tama County
Existing NHSC practice with physician and P.A. Will be part of health system with Traer. 40 miles to Cedar Rapids. 30 miles to Waterloo. 20 miles to Marshalltown-215 bed hospital.

8. Traer - Tama County
Filled, no longer available.

9. Sioux City
Urban five physician group. Need fully trained Family Practitioners, Internal Medicine and Peds.

10. Athen - Woodbury County
35 miles to Sioux City; New Practice-two physician.

Kansas

1. Osawatomie - Miami County
35-40 miles to Kansas City metropolitan area. Need two physicians this site. Hospital 10 miles away.

2. Valley Falls - Jefferson County
28 miles to both Topeka and Lawrence (Kansas University). Sailing, horses. New Practice.

3. Oskaloosa - Jefferson County
Three physicians recruited. Will join with Valley Falls to form group-type practice. Close to Lawrence and Kansas City.

4. Yates Center - Woodson County
Very prosperous town, rolling hills near waterfowl preservers. New practice Southeastern, Kansas.

*5. Mound City - Linn County
Two community NHSC projects with two NHSC physicians, and nurse practitioner. Looking for additional physician. 65 miles to Kansas City, Missouri.

6. Montezuma - Gray County
Southwestern Kansas. 25 miles to Dodge City. New well equipped clinic. New practice.

7. Lincoln - Lincoln County
Prosperous town 30 miles from Salina.

8. Haven - Reno County
Two physicians needed. 30 miles to Wichita.

9. St. Francis - Cheyenne County
180 miles to Denver. Needs two physicians.

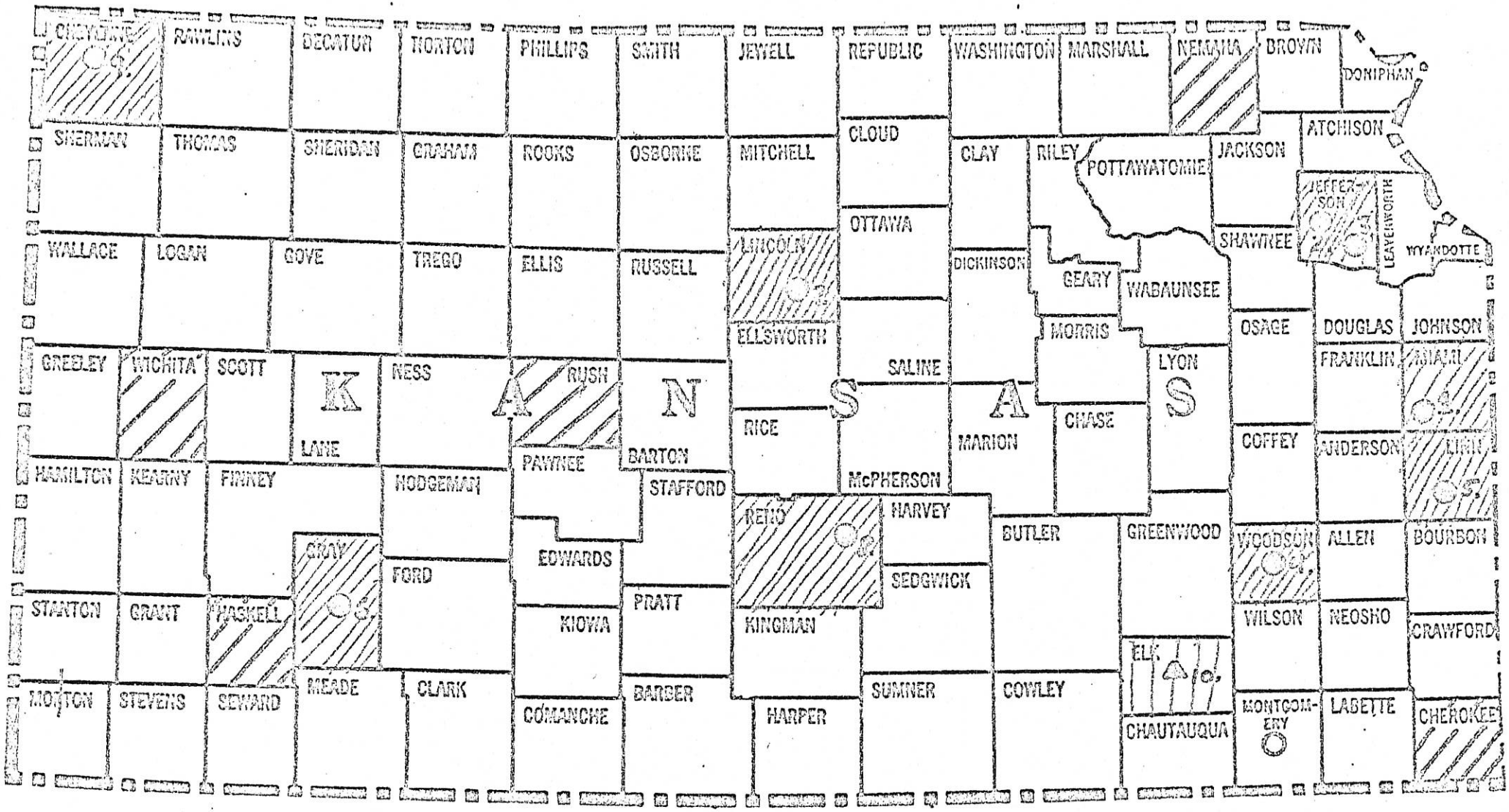
10. Elk County
Pending application for

Missouri

1. Winona - Shannon County
Existing NHSC practice with two physicians, nurse practitioner and dentist. Hunting, fishing, camping, canoe float trip;developing rural health system.

*2. Gainesville - Ozark County
Looking for one physician and physician extender. New practice on Arkansas border. Many lakes for boating.

3. Princeton - Mercer County
North Central Missouri. Two other physicians in town. New practice.



NHSC SITES IN KANSAS - 1976

APPROVED APPLICATIONS

PENDING APPLICATIONS

LIST OF PHYSICIAN SHORTAGE AREAS

DESIGNATED UNDER SECTION 741F, PUBLIC HEALTH SERVICE ACT
UPDATED AS OF MAY 15, 1976

PREPARED BY:

MANPOWER ANALYSIS BRANCH
BUREAU OF HEALTH MANPOWER

HEALTH RESOURCES ADMINISTRATION
U . DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BHM/OPD/MAB
5/15/76

Physician Shortage Areas

This is the list of areas designated as physician shortage areas under section 741(f) of the Public Health Service Act. Under this provision if a physician agrees to practice his profession for at least a two-year period in one of the specified areas, the Secretary of HEW agrees to repay 60 percent of the outstanding principal (and interest) on any educational loan made for the cost of the physician's professional education. An additional 25 percent of such outstanding principal will be repaid for a third year of practice under an agreement.

The Secretary of Health, Education, and Welfare has designated these areas as having a need for physician services, after consultation with the appropriate State Health Authorities. The list is subject to addition or deletion as changes occur in area population, number of practitioners, and other factors related to shortage. Areas listed are counties or specified parts of counties, except where multi-county service areas are indicated.

(This list is also applicable for cancellation of a portion of Health Profession Student Loans received prior to November 18, 1971, in accordance with section 741(f) (5) of the PHS Act.)

Areas designated under section 329(b) of the Act as critical medical shortage areas are also eligible service areas for primary care physicians who wish to apply for loan repayment benefits under section 741(f). A few such areas do not appear on this list; a separate list of those areas is attached.

PHYSICIAN SHORTAGE AREAS

INDIANA

JACKSON
JASPER
JAY
JENNINGS
KOSCIUSKO
LAGRANGE
MARTIN
MIAMI
MORGAN
NEWTON
NOBLE
OHIO
ORANGE
OWEN
PARKE
PERRY
PIKE
POSEY
PULASKI
RANDOLPH
RIPLEY
RUSH
SCOTT
SHELBY
SPENCER
STARKE
STEUBEN
SULLIVAN
SWITZERLAND
TIPTON
UNION
VERMILLION
WARREN
WARRICK
WASHINGTON
WHITE
WHITLEY

IOWA

ADAIR
ADAMS
APPANOOSE
AUDUBON
BENTON
BREMER
BUTLER
CEDAR
CHICKASAW
CLARKE

IOWA

CLAY
CLAYTON
CRAWFORD
DELAWARE
FAYETTE
FRANKLIN
GRUNDY
HANCOCK
HARRISON
HOWARD
HUMBOLDT
IDA
IOWA
JASPER
JONES
KEOKUK
KOSSUTH
LOUISA
LUCAS
LYON
MILLS
MONONA
MUSCATINE
O BRIEN
PALO ALTO
PLYMOUTH
POCAHONTAS
RINGGOLD
SAC
SHELBY
SIOUX
TAMA
TAYLOR
VAN BUREN
WARREN
WASHINGTON
WAYNE
WORTH

KANSAS

ALLEN
ATCHISON
BARBER
BROWN
BUTLER
CHASE
CHAUTAUQUA
CHEROKEE
CHEYENNE

PHYSICIAN SHORTAGE AREAS

KANSAS

CLARK
CLAY
COFFEY
COMANCHE
CRAWFORD
DECATUR
DICKINSON
DONIPHAN
EDWARDS
ELK
ELLSWORTH
FINNEY
FRANKLIN
GEARY
GOVE
GRAHAM
GRANT
GRAY
GREELEY
GREENWOOD
HAMILTON
HASKELL
HODGEMAN
JACKSON
JEFFERSON
JEWELL
KEARNY
KINGMAN
KIOWA
LANE
LEAVENWORTH
LINCOLN
LINN
LOGAN
MCPHERSON
MARION
MARSHALL
MEADE
MIAMI
MONTGOMERY
MORTON
NEMAHA
NEOSHO
OSAGE
OSBORNE
OTTAWA
PHILLIPS
RAWLINS
RICE
ROOKS
RUSH
RUSSELL

KANSAS

SCOTT
SEWARD
SHERIDAN
SHERMAN
SMITH
STANTON
STEVENS
THOMAS
WABAUNSEE
WALLACE
WASHINGTON
WICHITA
WILSON
WOODSON

KENTUCKY

ADAIR
ALLEN
ANDERSON
BALLARD
BATH
BOONE
BRACKEN
BREATHITT
BRECKINRIDGE
BULLITT
BUTLER
CALDWELL
CARLISLE
CARROLL
CARTER
CASEY
CLARK
CLAY
CLINTON
CRITTENDEN
CUMBERLAND
EDMONSON
ELLIOTT
ESTILL
FLEMING
FLOYD
GALLATIN
GARRARD
GRANT
GRAVES
GRAYSON
GREENUP
HANCOCK

CRITICAL MEDICAL SHORTAGE AREAS

INDIANA

Marion

IOWA

Hardin--Etna, Clay, Concord, Grant, Eldora, Tipton, Sherman, Union, Providence townships--part of Eldora medical service area
Marshall--Vienna, Liscomb, Bangor, Liberty townships--part of Eldora medical service area
Story--Lincoln and Warren townships--part of Eldora medical service area

KANSAS

Reno--Albion, Castleton, Center, Haven, Lincoln, Ninnescan, Summer, Troy, Yoder township - part of Haven medical service area
Segwick--Greely township - part of Haven medical service area
Shawnee--Soldier township - part of Valley Falls medical service area

KENTUCKY

Bell--Pruc[illegible]-Fork C.C.D.--part of Jellico medical service area
Letcher
Lyon
Perry-- Dice-Dwarf C.C.D.
Whitley--Pearl C.C.D.--part of Jellico medical service area

LOUISIANA

Iberia--Division 4
Vermilion-- town of Gueydan
Vermilion--Divisions 5, 9, 6
West Carroll

MAINE

Knox--Vinalhaven Island, North Haven Island and Matinicus Island

MARYLAND

Baltimore City--Census Tracts 802, 803.01, 803.02, 804 thru 808, 901 thru 909, 1001, 1204
Baltimore City--Census Tracts 2601.01, 2601.02--O'Donnell Heights medical service area

Gentlemen:

Thank you for the opportunity to express our concern about the Homemaker program to you today. There were those who advised us not to come on the basis that the only ones who do come to these meetings are those who are cranks or crack-pots, those who have lost jobs, (we all have) or are disgruntled in some way. We were told we would be given a polite hearing but that it would fall on the deaf ears of people who have already made up their minds. We chose not to be disuaded but to believe that surely there are those on this committee who have an open mind and are concerned about the people of Kansas. We have traveled 300 miles and six hours this morning in order to be here today. If our consideration were only for the loss of our jobs, we would not have come this distance or assumed this additional expense.

Our main concern is for the recipients of the program who were given this service for a short time and were just beginning to believe it was really true, that they were important and did count, when the rug, so to speak, was pulled out from under them. We would like to relate to you the many personal stories of how this program had a positive affect on the lives of the clients who received the service, but time does not allow. It was stated by Dr. Harder in the press release of August 15 " In some cases, we were talking about yard work, some minor home maintenance, some cleaning up around the house--so these would not be viewed as life and death" Our experience does not verify this statement. The chore service part of the program was almost non existant in our area. The real needs of our clients involved meal preparation and service that was associated with the safety and the physical well-being of the elderly and disabled. These may not have been "life and death" matters, but in many cases it did make the

difference between living in ones own home or being institutionalized. For many it would have been better if the program had never started than to have it so abruptly interrupted.

One of the main difficulties encountered by the co-ordinators of this program was the credibility gap between the government and the people. The people said that the program would not last; we spent much time assuring them it was here to stay, but they were right. Some people received only a few days service before it was abruptly halted.

Governor Bennett has made the statement that he wanted private enterprise to do some of the work instead of expanding government payrolls. This is what was being done when Upjohn had the contract and would have been continued if Visiting Homes Services had received the new contract. If SRS administers the program it will mean an expansion of government payroll. We have great respect for the social workers with whom we were so closely associated. They also had a deep concern for the clients, but were already carrying a heavy work load and had difficulty keeping up with the requirements of the Homemakers program.

The newspaper article also stated that the program could not be provided at a reasonable price. If the accepted price of $4.21 was reasonable when Upjohn received the contract six months ago, why is the $4.11 bid by Visiting Homes Services not a reasonable price today?

The criticism was raised [illegible] that the contract was weak. Possibly so, but from our contact with both companies, they were very anxious to comply with all government requirements.

Another important concern is for <u>our own</u> credibility. A part of our job was informing the public about the service. We talked to Rotary and Lions Clubs and various other civic and service organizations. We were assured

of the continuity of the program and we expressed our enthusiasm through our public relations assuring them of the good faith behind our work. Now we are embarrassed to face these people when they question us about the program. Our own credibility is suspect.

When a person quits a job he usually is required to give reasonable notice. Most employers also give notice when a person is dismissed from his job. The notice given to the 40+ workers in our area and the many workers in the rest of the state was one half day.

In conclusion we would like to say that we hope in the future that a humanistic approach be adopted. The human beings: clients, workers, SRS staff, who are drastically affected by any social program must be given a higher consideration.

Patricia Ramer

Patricia Ramer, Hoxie

Wanda Heller

Wanda Heller, Palco

Lorena Peterson

Lorena Peterson, Ellis

Belle Farmer, Colby

Aug 15, 1976 HAYS DAILY NEWS

State Agency Is Taking Over Homemaker Program

TOPEKA, Kan. (UPI) — The secretary of Social and Rehabilitation Services says his department plans to take over the six-month-old Homemaker Services because of problems in finding a suitable contractor at a good price.

Recipients of the services, which abruptly halted in June when the original contract expired, have done without the services since then. Secretary Robert Harder said at least two additional weeks will be required to initiate the proposed new policy.

"We sent a letter to the Department of Administration recommending that all bids be rejected and that we handle the program within the department," Harder said. "I can't predict for any department, but my own, so I couldn't make any predictions on how long their end of it will take. We could get information to the field within two weeks after closure of contract negotiations."

Harder said about 1,250 persons were receiving Homemaker Services in June. For some of those, the services would mean the difference between staying at home and having to enter a nursing home, Harder said.

"In some cases, we were talking about yard work, some minor home maintenance, some cleaning up around the house — so these would not be viewed as life and death," Harder said.

"No action was taken to notify persons their services were being suspended because we didn't anticipate this long a gap," Harder said. "We want to provide the service. I'm not debating that."

The proposal Harder is recommending would involve hiring part-time persons who would work fewer than 1,000 hours on an annual basis. Harder said Homemaker Upjohn, the original contractor, was the high bidder and the low bidder was Visiting Home Services, Inc. But the secretary said some of the bidders' service proposals did not match the department's requirements, besides being costly.

Attachment A

NURSING HOME OMBUDSMAN PROGRAM
State of Kansas

August 6, 1971, the President of the United States stated, "I have also directed the Department of Health, Education, and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse."

This statement authorized an Ombudsman's office in each State. It was precipitated by a report from the Special Committee on Aging, United States Senate, dated November 1974. The findings of this Committee were alarming. The committee found that, "... a coherent, constructive, and progressive national policy has not yet been developed to meet the long-term care needs of the elderly." It further stated, "As a result, millions of older Americans who have already received care in nursing homes have not received maximum help. In many cases they have not even received humane treatment. And in an alarming number of known cases, they have actually encountered abuse and physical danger, including unsanitary conditions, fire hazards, poor or unwholesome food, infections, adverse drug reactions, over-tranquilization and frequent medication errors. In addition, they have been exposed to negligence on the part of nursing home personnel. The net impact is that far too many patients have needlessly sustained injury, and, in some cases, death."

It is with this obligation and responsibility in mind that the Kansas Nursing Home Ombudsman's Office has been created.

The office of the Nursing Home Ombudsman is administratively attached to the Services for the Aging Section of the State Department of Social and Rehabilitation Services and is funded by a grant from the Federal Older Americans Act.

The Nursing Home Ombudsman is an independent and neutral examiner who receives and investigates complaints from the public against nursing homes and those administrative agencies whose task it is to guide and regulate nursing homes. The Nursing Home Ombudsman's only charge is to help those members of the public (primarily patients) who question their treatment by nursing homes or agencies involved with or bearing responsibilities for nursing home licensure, Title XIX certification, and/or administration.

On November 18, 1975, the ombudsman program was established in Kansas. As of January 1976, the ombudsman program had been established in forty-three states.

One thousand posters (see Exhibit A) have been printed publicizing the program and are in the process of distribution. Citizen complaints are received by mail or by means of a toll-free WATS telephone line, as well as from the Attorney General's Office (all complaints received in the Attorney General's Office are referred to the ombudsman's office). Since January, 97 complaints and inquiries have been received.

The majority of complaints are: patients not getting enough food, poor medical services, filthy homes, and mistreatment of patients.

Because of the cooperation of the majority of nursing home administrations, many complaints have been resolved without the necessity of referring the complaints to the responsible state department.

What Has Been Accomplished:

1. This office has investigated approximately 40 complaints out of approximately 97 received. The investigation of a complaint, in the

majority of cases, involves going to the city in which the complainant resides and getting information from the complainant and the nursing home. (The ombudsman's visit is never pre-announced.) From the information received, a determination of the validity of the complaint is made. (See Exhibit B)

2. A local ombudsman network is being established. The guidelines for the Kansas ombudsman program have been published. (See Exhibit C) A local program has been established in the North Central Flint Hills Area Agency on Aging in Concordia, Kansas, under the auspices of the Nazareth Motherhouse, a Catholic order of nurses and hospital administration. This is a volunteer program. It is expected that the local ombudsman program will be established in all areas of the state.

3. Because of the numerous complaints concerning food, the Director of Medical Services of SRS has consented to add the quality and quantity of food to the check items of the Periodic Medical Review Team's check list.

4. Procedures are being developed, in conjunction with the Department of Health and Environment and Social and Rehabilitation Services, and the Attorney General to ensure that patient's rights in skilled and intermediate care facilities are appropriately handled. (See Exhibit D) Review and enforcement of these rights by guardians, and as appropriate, by applicable state agencies, will have a positive impact on the improvement of conditions in many nursing homes in the State of Kansas.

5. With the help of the Senior Law Center of Washington, D.C. and San Francisco, California, and a local attorney, a law suit is being filed concerning the violation of a patient's rights. The suit is being filed for monetary damages. The successful prosecution of this suit and the award of damages to the complainant should have significant

impact on nursing homes, and result in more positive responsiveness and concern by nursing home operators and administrators toward their obligations to nursing home clients.

What Is To Be Accomplished:

1. To develop a city or county wide Ombudsman Advisory Committee in at least 25 Kansas counties by October 1976.
2. To identify a local ombudsman volunteer on a city and/or county level in at least 25 cities and/or counties by October 1976.
3. To create an Ombudsman Advisory Committee in at least 50 nursing homes by December 1976.
4. To provide ombudsman services to at least 1,000 nursing home patients and/or families, or concerned persons, by July 1977.

Anticipated Problem Areas Requiring Ombudsman's Review and Assessment:

1. Formulation and implementation of patient's rights grievance procedures.
2. Development of in-service training kit for local ombudsman.
3. Ensure appropriate placement of nursing home patients in facilities capable of meeting their needs and ensuring the maintenance of a high quality nursing home environment for all residents.
4. Finalize the establishment of a statewide network of local ombudsman.

Presented to the Welfare Overview Committee on July 14, 1976.

ARE YOU ?

A NURSING HOME RESIDENT,
OR RELATED TO ONE,
OR A PERSON,

WITH A CONCERN FOR A NURSING HOME RESIDENT?

CONTACT YOUR NURSING HOME OMBUDSMAN

CALL (TOLL-FREE) 1-800-432-2912
TOPEKA AREA CALL 296-4986

WHO? EDGERTON A. TAYLOR IS THE NURSING HOME OMBUDSMAN FOR THE STATE OF KANSAS.

WHAT? THE NURSING HOME OMBUDSMAN IS AN INDEPENDENT AND NEUTRAL EXAMINER WHO RECEIVES AND FOLLOWS UP ON CONCERNS OF NURSING HOME RESIDENTS, THEIR FAMILIES OR FRIENDS.

WHEN? OFFICE HOURS ARE 8 AM TO 5 PM MONDAY THROUGH FRIDAY.

WHY? ENABLE RESIDENTS UTILIZE THE HIGH QUALITY SERVICES AVAILABLE IN NURSING HOMES.

WHERE? THE OMBUDSMAN OFFICE IS LOCATED AT 2700 WEST 6TH ST., BIDDLE BUILDING, TOPEKA, KANSAS 66606.

CASE RECORD

NAME OF COMPLAINANT: _____

ADDRESS: _____

PHONE: _____

NAME OF PATIENT: _____

NAME OF NURSING HOME: _____

ADDRESS: _____

PATIENT'S NEAREST RELATIVE OR GUARDIAN: NAME: _____

ADDRESS: _____ PHONE: _____

PERSON RECEIVING COMPLAINT (Name) _____

1. POSITION (circle one): 01 Clerical Staff 02 Professional Staff 03 Voluntary staff
2. COMPLAINT RECEIVED BY: (circle one) 01 Phone 02 Mail 03 Office Visit 04 Ombudsman Outreach
3. COMPLAINANT IS (circle one):
   - 01 Patient
   - 02 Relative of Pnt.
   - 03 Friend of Pnt.
   - 04 Employee of Home (Specify)
   - 05 Ombudsman
   - 06 Anonymous
   - 07 Regulatory Agency Staff
   - 08 Service Agency Staff
   - 09 Other (Specify)
4. HOW DID COMPLAINANT LEARN ABOUT OMBUDSMAN?

II COMPLAINT

1. DOES THE COMPLAINT INVOLVE HOME IN GENERAL? 01 YES 02 NO

2. DETAILS OF COMPLAINT:

3. COMPLAINT CATEGORIES:

   01 Quality of Institutional Life (dignity, privacy)
   02 Formalized Programs (religious, educational, social, recreational)
   03 Lack of Professional and Technical Services
   04 Quality of Professional and Technical Services (care)
   05 Financial
   06 Legal
   07 Nursing Home Administration--Rules, Regulations, Policies (visiting, room assignments, transfers, admissions, etc.)
   08 Dietary
   09 Physical Facilities
   10 Regulatory and/or Service Agency
   11 Other

4. IF COMPLAINT INVOLVES MORE THAN ONE OF ABOVE, INDICATE:

   01 TWO 02 THREE 03 FOUR OR MORE

TI PATIENT CHARACTERISTICS

1. AGE: 01 (Under 50) 02 (50-64) 03 (65-74) 04 (75-84) 05 (85 & OVER)

2. SEX: 01 Male 02 Female

3. LENGTH OF STAY IN THIS NURSING HOME:
   01 Less than 2 months
   02 2-6 months
   03 6 mos. - 1 yr.
   04 1 yr. - 3 yrs.
   05 more than 3 yrs.

4. MOBILITY: 01 Ambulatory 02 Not Ambulatory

5. ABILITY TO COMMUNICATE:

   01 Coherent, orally or in writing

   02 Marked difficulty in oral, written, or sign communication

   03 Unable to communicate

6. HOW OFTEN DOES PATIENT HAVE CONTACTS WITH PEOPLE OUTSIDE THE NURSING HOME?

01 NEVER 02 WEEKLY 03 MONTHLY 04 LESS FREQUENTLY

7. IF YES, SPECIFY:

01 Relative(s)
02 Friend(s)
03 Group(s)
04 Community Agency
05 Other (specify)

8. METHOD OF OUTSIDE CONTACT: 01 Visit 02 Phone 03 Mail

9. FREQUENCY OF OUTSIDE CONTACT: 01 Weekly 02 Monthly 03 Less frequently

10. SOURCE OF PATIENT'S FUNDING IN HOME:

01 Medicare
02 Medicaid
03 Private Health Insurance
04 V.A.
05 Personal or Family
06 Public Assistance
07 Other (specify)

IV CHARACTERISTICS OF HOME

1. TYPE OF FACILITY

01 Skilled Nursing (including ECF)
02 Intermediate
03 Personal Care
04 Boarding Home
05 Other (specify)

2. NUMBER OF BEDS IN HOME: _____

3. PERCENTAGE OF "PRIVATE" PATIENTS: 01 Less than 10%

02 10% - 50% 03 more than 50%

4. OWNERSHIP: 01 Proprietary 02 Voluntary non-profit 03 Public

5. CONTROL: 01 Corporate 02 Individual/Partnership

03 Religious Group 04 Public

6. STATUS OF FACILITY: 01 Licensed 02 Provisionally Licensed

03 Unlicensed

7. MEMBERSHIP IN NURSING HOME ASSOCIATION: 01 YES 02 NO

V INVESTIGATION AND VERIFICATION

INVESTIGATOR: _____

1. POSITION

   01 Clerical staff 02 Professional staff 03 Voluntary staff

2. INVESTIGATION CONTACTS:

   01 Patient
   02 Complainant (if other than patient)
   03 Nursing Home Administrator
   04 Other Nursing Home Staff
   05 Other Patients
   06 Agency (specify _____
   07 Other (Specify _____

3. MEANS OF CONTACT: 01 Visit 02 Phone 03 Mail

4. DID OMBUDSMAN OBSERVE COMPLAINT CONDITION/INCIDENTS?

   01 YES 02 NO

5. RESULT: 01 Verified 02 Not Verified 03 Questionable

6. SERIOUSNESS OF COMPLAINT:

7. IF NOT VERIFIED OR QUESTIONABLE, WHY? _____

_____

VI RESOLUTION

METHOD OF RESOLUTION

1. DISCUSSION WITH:

   01 Home
   02 Regulatory Agency
   03 Service Agency
   04 Other (Specify) _____

2. REFERRAL TO: 01 Regulatory Agency 02 Service Agency

   03 Other (Specify) _____

3. USE OF OUTSIDE RESOURCES

01 Media 02 Community Pressure 03 Nursing Home Assoc.

04 Other (Specify) _____

4. INSTIGATION OF LAW SUIT 01 Yes 02 No

5. IDENTIFY SUCCESSFUL METHODS _____

6. IF MORE THAN ONE, RATE: _____

7. RESOLUTION:

Date	Staff	Action Taken	Contact	Result

Comments:

8. TIME REQUIRED TO CLOSE CASE:

01	Less than one week	04	One to Three Months
02	One to two weeks	05	More than three months
03	Two weeks to one month		

9. WAS COMPLAINT RESOLVED? 01 Yes 02 No

10. IF COMPLAINT NOT RESOLVED, DISCUSS REASONS:

11. COMPLAINANT NOTIFIED OF RESULT: 01 Yes 02 No

12. COMPLAINANT SATISFIED: 01 Yes 02 No

COMMENT:

13. OMBUDSMAN SATISFIED: 01 Yes 02 No

COMMENT:

14. IS SOLUTION STILL IN EFFECT? 01 Yes 02 No

Date Checked _____

IF "no" SPECIFY UNDER COMMENTS

COMMENT:

TIME SPENT IN OMBUDSMAN WORK ON COMPLAINT _____

THE KANSAS NURSING HOME OMBUDSMAN PROGRAM

I. The purpose of the Ombudsman system in the State of Kansas is to involve patients, nursing homes, local governments, local communities, State Government and the citizens of the State of Kansas in providing the best possible services for nursing home consumers.

II. To achieve the above stated purpose the following objectives are identified.

A. Establish the office of Kansas Nursing Home Ombudsman to:

1. receive and investigate concerns and questions from nursing home residents, their families and concerned persons; and

2. plan and organize a nursing home ombudsman system to be implemented in planning and service areas through Area Agencies on Aging with concantration the first year in three areas (Central Plains, Capital and Kansas City

B. Action steps to achieve the above objectives.

1. Establish a State Ombudsman Advisory Committee with responsibility to:

a. provide advice and counsel to the State Office of Nursing Home Ombudsman; and

b. evaluate the statewide ombudsman experience to recommend action and changes to various regulating and licensing agencies.

c. The committee shall be composed of:

1) the state nursing home ombudsman;

2) ten city and/or county nursing home ombudsman representing each of the ten planning and service areas established under the State Plan for Aging program, selected by the Area Agency Boards;

3) three directors of Area Agencies on Aging;

4) one delegate from Kansans for the Improvement of Nursing Homes;

5) one delegate from SAS/SRS;

6) one delegate from the Kansas Department of Health and Environment; and

7) three at-large concerned citizens appointed by the State Nursing Home Ombudsman.

d. The committee shall meet as needed but no less than bi-monthly. The committee shall establish its organizational structure.

e. Advise the Kansas Nursing Home Ombudsman on forms, records and reports needed for operation of the ombudsman system.

2. The Area Agency in each PSA is requested to implement a local ombudsman system according to the following guidelines:

a. Establish a City and/or Countywide Ombudsman Advisory Committee with responsibility to:

1) receive and resolve questions and concerns referred from local nursing home Ombudsman Advisory Committees:

2) refer questions and concerns impossible to resolve on the city and/or county level to the office of the State Nursing Home Ombudsman;

3) involve the local community(ies) in nursing home programs;

4) work with nursing homes to increase life satisfaction services available to residents;

5) visit in nursing homes; and

6) meet as needed but at least bi-monthly.

7) The committee may be composed of:

a) the local ombudsman;

b) one delegate from the Ombudsman Advisory Committee of each nursing home;

c) three at-large concerned citizens appointed by the Ombudsman;

d) one representative of the local health department, if any, and;

e) one representative from the dominant unit of local government.

f) The committee shall establish its own organizational structure.

8) Establish a local ombudsman (a volunteer) on a city and/or county level with responsibility to:

a) create an Ombudsman Advisory Committee for each nursing home in the area with responsibility to:

(i) work with the nursing home administration to resolve questions and concerns from residents;

(ii) visit with nursing home residents to receive their questions and concerns; and

(iii) work closely with the office of the Local Nursing Home Ombudsman.

(iv) The committee shall be composed of:

at least three relatives of consumers resident within the nursing home and

one concerned citizen.

The committee shall meet as needed but at least bi-monthly.

b) communicate with the Ombudsman Advisory Committee on situations in the nursing homes;

c) receive from the Ombudsman Advisory Committee questions and concerns the committee has been unable to resolve and further pursue the resolution of these;

d) refer questions and concerns impossible to resolve on the local level to the office of the State Nursing Home Ombudsman;

e) arrange and conduct meetings of the Ombudsman Advisory Committee located in his/her area of responsibility as needed; and

f) cooperate with the office of the State Ombudsman in the selection of representatives to the Statewide Advisory Committee.

AFB:bmm
3-11-76

PROVISIONS FOR PATIENTS' RIGHTS IN SKILLED NURSING FACILITIES

§ 405.1121(k) Standard: Patients' rights. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsering agency(ies), or representative payee selected pursuant to section 205)j) of the Social Security Act, and Subpart Q of Part 404 of this chapter, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensures that, at least, each patient admitted to the facility:

1) Is fully informed, as evidenced by the patients' written acknowledgement, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles 18 or 19 of the Social Security Act, or not covered by the facility's basic perdiem rate;

3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

4) Is transferred or discharged only for medical reason, or for his welfare or that of other patients, or for non-payment for his stay (except as prohibited by titles 18 or 19 of the SSA), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

5) Is encouraged and assisted, throughout his stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restrainst, interference, coersion, discrimination, or reprisal;

6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in comformance with State law;

7) Is free from mental and physical abuse, and free from chemical and (except in emergencies), physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient

from injury to himself or to others;

8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and care for his personal needs;

10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his record);

12) May meet with, and participate in activities of social, religious, and community groups at his discretion, unless medically contraindicted (as documented by his physician in his medical record);

13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record);

14) If married, is assured privacy for visits by his/her spouse; if both are in-patients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by his attending physician in the medical record).

All rights and responsibilities specified in paragraphs (k)(1) through (4) of this section - as they pertain to (a) a patient adjudicated incompetent in accordance with State law, (b) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (c) a patient who exhibits a communication barrier - devolve to such patient's guardian, next of kin, sponsering agency(ies), or representative payee (except where the facility itself is representative payee) selected pursuant to section 205)j) of the Social Security Act and Subpart Q of Part 404 of this chapter.

Att A
7-14

Attachment B

THE UNIVERSITY OF KANSAS

Office of the Chancellor
223 Strong Hall, Lawrence, Kansas 66045
(913) 864-3131

July 14, 1976

MEMORANDUM

TO: Members of Special Interim Committee
on Health and Welfare
Senator Wesley H. Sowers, Chairman

FROM: Archie R. Dykes

In recent months considerable attention has been focused on the health care needs of Kansas. This attention has reflected a growing concern about the need to improve the distribution of health care professionals and, hence, the availability of health care throughout Kansas. As an institution committed to serving the needs of the people of our state, the University of Kansas intends to do everything possible to help meet the health care needs of Kansas.

Because I thought they might be of interest to you, I shall use this means to summarize briefly some of the important steps which we have been taking and will be taking to improve the availability of health care in our state.

1. Increased Numbers of Medical Students

We are attacking the shortage of physicians in our state through the increase in the number of students now studying medicine at the University of Kansas School of Medicine. In 1970, the entering class in our School of Medicine numbered 125. This year we have 200 students in the first year of the medical program--a 60% increase in five years. Based on number of medical students in ratio to population, we are now educating doctors in Kansas at a rate approximately 50% higher than the national average.

The recent approval by the national Liaison Committee on Medical Education to increase enrollment to 50 students in the Wichita Clinical Branch of our School of Medicine is another significant step forward in our effort to educate more physicians.

2. Increased Numbers of Allied Health Professionals and Physician Extenders

To increase the amount of time physicians have to devote to medical problems which they are uniquely able to handle, we have made a concerted effort to expand training programs for physician extenders and allied health professionals We have recently presented to the Health Education Committee of our Board of Regents a proposal for three baccalaureate programs--in emergency medical services, nurse anesthesiology, and respiratory therapy. As the number of highly trained allied health personnel increases, some of the current workload of the practicing physicians can be relieved, allowing them to devote more of their

time to matters which require their personal attention.

We are also increasing the enrollment in the School of Nursing in response to needs throughout the state, especially at the graduate level.

3. Emphasis on Primary Care

We are making a major effort to attract more of our medical students to primary care programs, especially Family Practice. Our goal is to have 50% of our medical residencies in primary care fields.

4. Integrated Family Practice Residency Program

The priority health need of Kansas is clearly the need for more family practitioners. Consequently, one of our most ambitious efforts is the planned development of the Integrated Family Practice Residency Program. This program will begin in the summer of 1977 with 12 new residencies in Family Practice. For the first year of residency in this program, students will be exposed to the basic medical disciplines either at Kansas City or Wichita; then for the second and third years of training, these residents would be based in headquarters cities over the state where community-based physicians would serve as faculty and mentors. While based in headquarter cities, the residents would also rotate into small communities for periods of time, thereby gaining exposure to the benefits of establishing medical practice in communities and areas which are not now sufficiently served by medical practitioners. Although the program will begin next summer with just twelve residencies, we expect to enlarge it systematically in succeeding years. We believe it represents a truly excellent opportunity to attract doctors to the smaller communities of Kansas.

5. Strengthening the Medical Preceptorship Program

We are strengthening the medical preceptorship program. Under the restrictive three-year curriculum, undergraduate medical students are only able to spend one month in a preceptorship, but under the new flexible curriculum, students will spend a minimum of two months with a practicing physician in a community setting.

6. Medical Residencies

Of all factors determining where a young doctor will locate, the place where medical residency is served apparently is the most important. Studies have shown that there is a relatively high probability that a doctor will establish medical practice in the area where he or she serves a medical residency. Consequently, we have increased the number of programs for training residents outside of Kansas City and Wichita. In the 1975-76 school year, 39 residents spent 106 man-months in residencies away from Kansas City and Wichita; this year, 68 residents will have spent 175 man-months in such residencies; and plans call for further expansion. At the present time, we have residents in Family Practice, Internal Medicine, Pediatrics, General Surgery, and Obstetrics-Gynecology serving in residency rotations in Topeka, Garden City, Halstead, Hays, Kingman, Norton, Minneola, Belleville, Phillipsburg, Howard and other locations. Having our residents spend part of their residencies in such commun-

ities throughout the state serves, we believe, three major purposes: it broadens their education, it exposes them to the advantages of practice in communities other than major metropolitan areas, and it provides additional medical service in the communities to which they are assigned.

7. Continuing Education for Physicians

As doctors are encouraged to establish medical practices in the smaller communities and rural areas of our state, it is essential that opportunities be provided for profesional stimulation and growth. Increased emphasis is being given to programs of continuing education for practicing physicians so that they may engage in professional renewal and avoid the harmful effects of isolation from professional colleagues. This is a critical component of our total effort to provide improved health care services and each year almost half of the practicing physicians in the state enroll in some program offered through our Division of Continuing Education.

8. Services for Practicing Physicians

In order to provide services to practicing physicians, we have established inward WATS and MATCH lines so that physicians may call clinical specialists at the Medical Center about unusual medical problems. Additionally, we have a long-established service of providing medical library materials quickly on request to practicing physicians.

9. Development of a Locum Tenens Program

Working in concert with the Kansas Medical Society, the University has completed the development of a locum tenens program. This program will make available advanced medical residents who can relieve practicing physicians who need time for vacation, to attend postgraduate courses, or because of illness. Moreover, residents serving in a locum tenens program can provide extra medical help in a community as need may arise.

10. Development of a Model Rural Health Care Center

We are in the process of planning a model rural health care center, to be located in a small community in a rural area of the state. Briefly, it would be a clinic for ambulatory patients and would serve as a training center for Family Practice residents. Moreover, the center would be used as the site for medical continuing education programs for area physicians.

11. Kansas Health Day

The University is planning this Fall two Kansas Health Days, one each in Kansas City and Wichita. These will be designed to bring citizens and community leaders from throughout Kansas in direct contact with our faculty and students and hopefully create improved understanding on the part of our students of the advantages of practicing medicine in Kansas. Already more than 40 communities have indicated an interest in participating.

12. State Scholarship Program

This program, developed under the leadership of Senator Wesley Sowers, is designed to provide financial assistance to medical school students who wish to practice in medically underserved areas of the state.

13. Admissions Process

Efforts to refine the admissions process and to secure external participation continue. Hopefully, we can find ways of bringing into the medical school students who are strongly committed to Kansas and who are likely to practice their profession here.

The foregoing points describe efforts which we are making to address the health care needs of our state. While you are familiar with most of them, I thought it might be helpful to list them all in a single, brief report. If you have questions about any of these items, or if you would like additional information, be sure to let me know.

DRAFT

Attachment 2

Summary of Comments by D. Cramer Reed, M.D., Vice Chancellor, WSU Branch, UKSM and Vice President for Health Education, Wichita State University, to the Kansas Senate Special Committee on Public Health and Welfare, July 14, 1976.

Maldistribution of health care providers is virtually synonymous with the shortage of physicians because allied health professionals and nurses generally follow practice patterns similiar to those of physicians.

To help people die young as late in life as possible----should be the function of our health care system. There are several indications that we in the health care field are not doing all that we should to assure compliance with this statement.

Two mechanisms should receive increased attention to help improve the health delivery system in this country. (1) Greater utilization of physician extenders (physicians agents) such as P.A.'s, Nurse Clinicians, Nurse Practioners, etc. (2) Placing greater emphasis on ambulatory care, preventive medicine and public health education.

I have been asked to discuss the WSU Branch and the role of physician extenders in addressing the maldistribution of health manpower. I would like to speak first about the role of physician extenders (agents) and more spcifically about the Nurse Clinician and Physician's Assistant programs as conducted at Wichita State.

As identified previously, one possible solution to the medical maldistribution problem has been the utilization of other types of health personnel by extending the skills of such professionals as R.N.'s and Physician's Assistants. This has been an endorsed solution by a number of national groups such as the AMA, ANA, AAPA, as well as the federal government.

Nurse Clinician Program has three major objectives: (1) To extend the geograp distribution of health care services, (2) Expand the scope of both preventive and episodic care and (3) Increase the productivity of the health care team.

In Kansas, the expansion of the skills of the registered professional nurse was developed by the Kansas Regional Medical Program under the title of Nurse Clinician Program presently housed administratively within the College of Health Related Professions, Wichita State University. The program was initiated at KUMC in 1971 and transferred to WSU in 1972. The program has continued to accept R.N.'s into the 12 month, two-phase program (didactic 10 weeks and preceptorship 10 months) on an annual basis admitting three to four classes per year depending upon available funding. To date, 110 have graduated (105 female, 5 male), 51% continue to serve in rural and primary care sites (retention rate in site placed is currently 76%). In addition, 15 of the student/graduates have served in federally defined HEW medically underserved areas. There are 21 students currently in various phases of the program. There are presently 35 counties in Kansas with Nurse Clinicians, and there are 22 states with graduate and/or NHSC students either working or serving preceptorships. While our efforts have been primarily directed to retaining Nurse Clinician graduates within the confines of Kansas because the program has been partially funded by grants to the National Health Service Corps, students from that program have been placed as far away as Alaska, Oregon, Nevada, California, Pennsylvania, Virginia, Florida, etc. Thus, it is believed that Kansas is repaying its federal obligation by educating Nurse Clinicians to serve in various other states of this country. In terms of patients served, in 1974, 202,830 patients were attended under supervision by Nurse Clinicians. Similar data collected in 1975 shows 342,530 patient visitis by Nurse Clinicians performing under the supervision of their medical preceptors. Patient acceptance has been high, physicians continue to support the utilization of Nurse Clinicians and expanded services and nurses continue to be interested in the program. The average age of the R.N. seeking admission to the Nurse Clinician Program of WSU is 38.9 and the average years of nursing experience is 10. More registered nurses desire to attend the program than can be accepted. Most

id and do return to practice in the referral geographic area. DRAFT

In order for this particular concept to remain a potential solution to medical maldistributio three actions need to be considered by the State of Kansas. (1) Increased state funding needs to be made available for perpetuation of the Nurse Clinician and Physican's Assistant programs in order to increase supervising staff and to increase the number of classes conducted per year and to enhance the outreach educational programs approved by the Kansas Legislature for WSU initially in 1975. Cognizance must be taken that federal grants initially supporting both of these programs are terminating.

(2) Kansas Legislature should consider funding of developmental projects to demonstrate the feasibility of establishing satellite clinics to be staffed by teams of M.D.'s, R.N.'s as Nurse Clinicians, and P.A.'s supported by capitation funds for both groups because they are generally financially deprived on the basis of their agreeing to continue to serve in rural areas upon completion of their training. A serious problem has developed in recent years because state capitation funds have not existed to aid the registered professional nurses desiring to attend the program, but who can not afford the additional cost of leaving their families generally in rural areas to come to Wichita for the initial period of didactic education. It is believed that additional numbers of nurses could be attracted to rural settings if they could be assisted financially to make it possible for them to participate in the formal program. Over 75% of the nurses applying for admission to the Nurse Clinician Program at WSU have requested some form of financial aid.

(3) Correlative to (1) and (2), efforts need to be made to identify components of state laws such as the Medical and Nurse Practice Acts rules and regulations of both of these governmental bodies that currently do not facilitate reasonable expansion of licensed R.N. skills thru formal education to practice interdependently (not independently) as certified Nurse Practitioners/Clinicians under the supervision of licensed physicians for "extender" functions.

ched are the following: (1) An outline map of the State of Kansas indicating location of undergraduate and graduate students of the WSU Nurse Clinician Program; the outline map of the United States indicating the location of undergraduate and graduates of the WSU Nurse Clinician Program, and finally, the names of Nurse Clinician students with their preceptorship practice location sites, their current home addesses, and present work locations.

I would now like to briefly discuss the Physician's Assistant program at WSU. This is a two-year, generally a Baccalaureate Degree oriented program. The first year is essentially didactic, consisting of classroom and supervised clinical exposures, with the second year being spent in preceptorships conducted in various areas of the state with a preponderance involvement in Western Kansas. Generally speaking, the classes have always been over subscribed since first starting in January, 1971. Mention should be made of the very substantial Veterans Administration involvement in this particular program. Offices and practice areas utilized largely during the first didactic year have always been located on Wichita VA Hospital grounds. A building was dedicated to this program in 1971 and is at the present time undergoing extensive remodeling to better accommodate the program as well as provide laboratory space for the expanded medical technology program of the College of Health Related Professions. It is recently estimated that exclusive of the federal grant to implement the program that the VA has devoted some three-quarters of a million dollars in behalf of the P.A. program.

In terms of P.A. students, brief comment should be made concerning the 60 graduates. Seven are presently located out of Kansas, 13 are with physicians in urban areas of Kansas, and 40 are presently practicing in rural Kansas areas. This constitutes a 75% retention of graduates in this state. Further, graduates are currently located in 30 different Kansas communities; 22 of the 24 August, 1976 graduating class will remain in Kansas. There have been consistantly more job offers than there are available graduates. Western Kansas physicians appear to be increasingly interested concerning the availability of graduates

w[illegible] now come from physicians located within a 25 mile radius of the site where a g[illegible]uate P.A. is currently serving.

In spite of the apparent increasing acceptance of the concept by physicians, there remain two nagging problems for which adequate solutions have not been found. The first has to do with hospital acceptance. While the laws are generally favorable to permit public institutions such as hospitals, there are a number located in various communities that will not accept P.A.'s to serve with their responsible physicians. The general reason for this seems to be a fear of liability either on the part of the hospital administration or by representatives of the medical staff. Generally these concerns have been unfounded since the liability exposure rate for P.A.'s has been excellent; basically, the cost of liability insurance for physicians having P.A.'s has not increased significantly in the past three years. The second area of concern is one previously referred to in comments made regarding Nurse Clinicians. Both of these physicians agents desperately need better and established regulatory mechanisms than currently exist. The Nurse Clinicians are regulated through the Nurse Practice Act and the State Board of Nursing and the P.A.'s whether they are male or female are only partially recognized (certainly not regulated) by the State Board of Healing Arts. Repeated efforts have been made by the office which I represent to urge the Healing Arts Board to address the issue of the P.A. However, I have been repeatedly informed that they are unable to do so because of a decision by the State Attorney General indicating that the law does not permit the State Board of Healing Arts to implement rules and regulations affecting the P.A. and that that agency is to serve only as a registration mechanism. All of this creates confusion and precludes the necessary addressment of the issue of what kind of physician supervision is necessary for the P.A. serving under his professional guidance. Until this matter is settled, the effective role of the P.A. and the Nurse Clinician will not be evident. In essence, an effective mechanism for dealing with at least a part of the maldistribution of health care problems cannot be noted. A possible solution to a part of the dilemma would be to establish a composite board of representatives from the Board of Nursing and the State Board of Healing Arts to develop joint rules and regulatio

taining to both groups. Two years ago dialogue was initiated regarding establ ng such a conjoined body, however, to my knowledge, very little if anything has been done subsequent to those efforts.

I would like to conclude my remarks by speaking very briefly about the Branch.

Much, of course, could be said concerning this new kind of community-based medical education However, I will confine my comments to its concern for the health manpower maldistribution issue.

In as much as the WSU Branch is an integral part of the University of Kansas School of Medicine, there is a certain commonality of efforts to counteract maldistribution. Consequently, I would not wish to reiterate information which you've already been given or which will be presented by others later this afternoon. Following are a list of activities presently being conducted by the Branch that have the potential for producing a beneficial effect on the maldistribution of physicians in the state. (1) Physicians Clearinghouse Project. This project originally initiated by KRMP is conducted on a zero budget in cooperation with the sister campus in Kansas City and the Kansas Medical Society. The purpose of the project is to serve as a centralized clearinghouse for communities in need of additional physician manpower. There could be much greater use of this project if additional funds were available for keeping it current and to provide additional opportunities for visibility in the education areas and throughout the state. The files were recently updated in April of this year and are presently considered current.

(2) Physician-Community Awareness Day - Kansas Health Day. In 1974 and 1975, the Branch sponsored a Physician-Community Awareness Day Conference. It is our belief that these conferences served a useful purpose and attracted a number of representatives from rural communities identified as being medically deprived or in need of additional physician manpower. This year that particular conference will be replaced by Kansas Health Day to be held on two separate dates, September 10 in Kansas City and September 16 in Wichita.

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urpose of this particular activity is two-fold: (1) to provide a form for com ty leaders from a number of smaller communities to discuss methods of recruiting health manpower and to share experiences with others in designing alternatives for recruiting; (2) to provide a vehicle whereby communities and house officers (resident physicians) and allied health students can initiate dialogue which will hopefully result in further discussions relative to practice location for physicians and allied health students such as med-techs, physical therapists, P.A.'s, etc., and nurses.

(3) Integrated Family Practice Residency Program. This Kansas School of Medicine program is designed to increase the number of Family Practice Residency positions available in the state. The University of Kansas School of Medicine will soon graduate its initial class of 200 students. A logical assumption is that there should be at least an equal number of residency positions available in the state. The number of presently available Family Practice Residency positions is especially important at this point in time because it is believed that Family Physicians are those who will be most likely to return to smaller communities to practice. As of the present date, there are only 28 first-year Family Practice Residency positions available in Kansas. (20 of these are available in Wichita and 8 in Kansas City).

In terms of the newly proposed integrated program, it has the potential of making available 40 positions in Family Practice as early as July, 1977. It is believed that only through such innovative efforts will it be possible to increase the number of family practitioners for which the state shows a definite and continuing shortage. More comments will be forthcoming regarding the Integrated Family Practice Program by Dr. Jack Walker.

(4) Student Involvement in Rural Health. Continuing efforts are made on the part of Branch administration and educators to emphasize either formally or informally the importance of rural health and concern for inter-city health problems. Mention should be made that while there is legitimate and justifiable concern for the inadequacy of health care in the rural areas, a similiar shortage confronts city dwellers where at any one time there is

an identifiable deficiency in the number of family practitioners and/or primary care specialists. In the hope of exemplifying the responsible role of Family Practice, Branch students are required to take a four-week Family Practice clerkship conducted primarily in the offices of participating part-time faculty. The required preceptorship necessary for all Kansas graduates must be served out of Wichita, thus, further exposing the students to non-urban practice settings. Concerted efforts are made to expose medical students along with allied health students to integrated practice patterns conducted essentially in rural areas. Thus, demonstrating the effectiveness of the so-called "health care team" and the viability of practice in rural communities.

(5) Other Less Tangible But Directed Branch Activities Relating to Physician Maldistribution. There are a number of these, each worthy of some further discussion if time permitted. However, I will only catalog them at this time and should you desire additional information concerning any or all, I will be glad to discuss them at the conclusion of my remarks. A variety of Outreach activities are conducted in cooperation with Wichita Hospital Family Practice Residency Programs; the Department of Post-Graduate Education of the Branch conducts seminars and work-shops in a number of rural communities and/or for Family Practice physicians in Wichita; the Harper Seminar Series for rural physicians in south central Kansas; the Department of Pediatrics specialty clinics which are being developed to serve at least three off-campus sites in southeast and western Kansas; the mobile hospital in-service program provides a continuing education program for hospital personnel in smaller community facilities that otherwise could not afford an in-service program; the mobile Hypertension-Diabetes screening unit has traveled to some 60 different rural communities and virtually all of the county fairs conducted in the state over a period of the past three years is primarily directed toward consumer health education. A final area that is worthy of mention has to do with physician placement (recruitment). As previously mentioned the physician's clearinghouse project could be made considerably more effective if financial assistance were made available to extend this particular project's effectiveness by having an actual physician recruiter who could work with communities to help further

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ify strategies for manpower recruitment.

I would be pleased to attempt response to any questions the committee might wish to present.

DCR/pm

RECORD OF ADMISSIONS TO THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

OVER THE LAST TWENTY-THREE YEARS

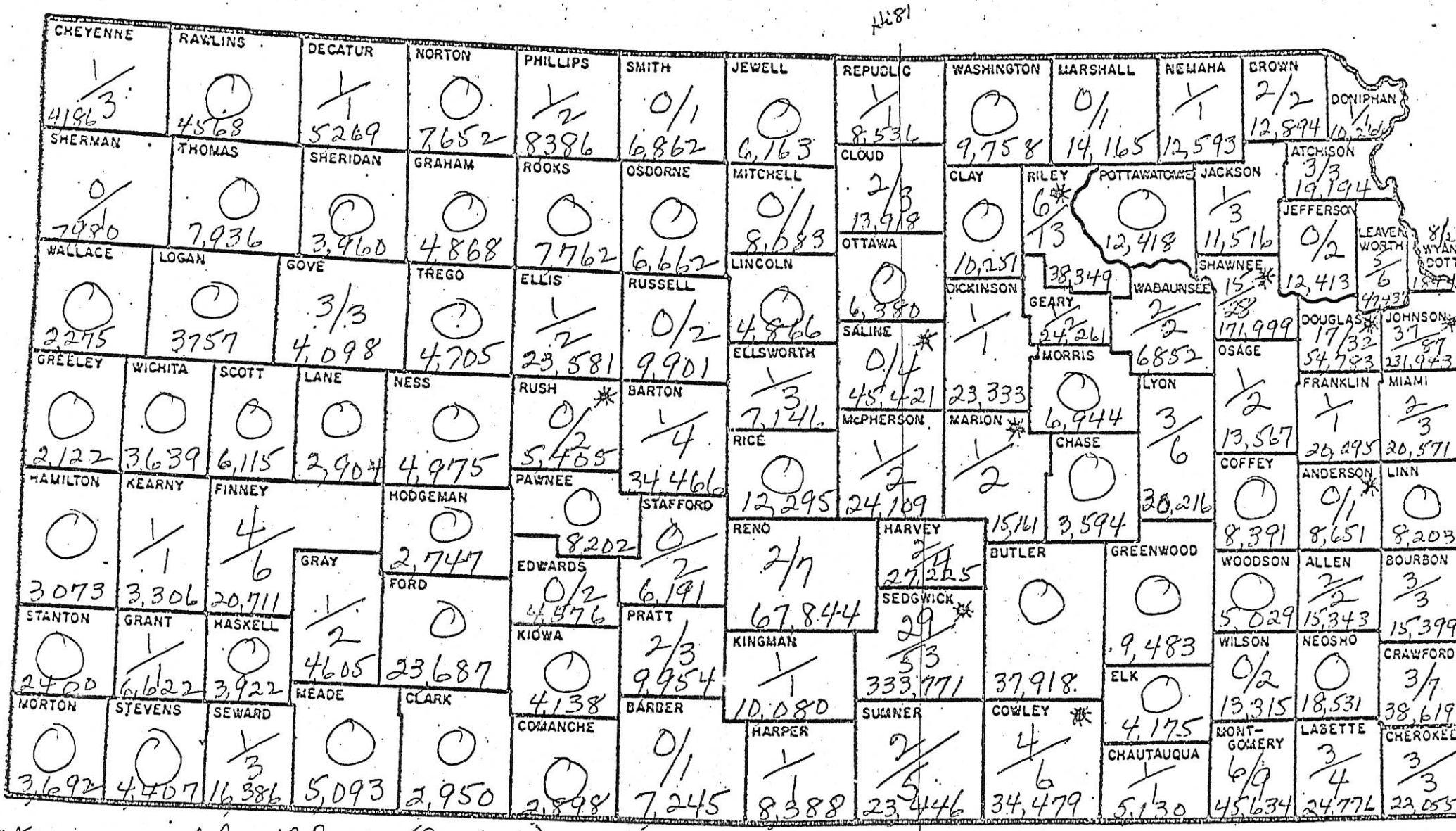
Dwight J. Mulford
Dean for Admissions

Year	Total Applications Received			Total No. Acceptance Letters Sent Out			Total No. Enrolled Of Those Receiving Acceptance Letters		
	Kansas Residents	N-Kansas Residents	Total	Kansas Residents	N-Kansas Residents	Total	Kansas Residents	N-Kansas Residents	Total
1954	173	141	314	97	20	117	90	11	101
1955			354	94	20	114	88	13	101
1956	158	202	360	88	33	121	85	22	107
1957	191	173	364	106	13	119	93	7	100
1958	160	145	305	99	17	116	88	10	98
1959	144	140	284	107	19	126	87	13	100
1960	175	157	332	107	16	123	95	8	103
1961	140	179	319	102	25	127	92	16	108
1962	140	197	337	99	33	132	88	24	112
1963	174	303	477	110	22	132	98	10	108
1964	194	480	664	100	29	129	94	14	108
1965	183	345	528	106	30	136	91	18	109
1966	179	347	526	117	30	147	103	23	126
1967 ← DSM, chm.	166	537	703	120	32	152	107	20	127
1968	214	720	934	128	14	142	120	5	125
1969	273	482	755	142	2	144	124	2	126
1970	255	338	593	143	13	156	125	4	129
1971	307	303	610	158	12	170	137	7	144
1972	356	400	756	172	14	186	146	8	154
1973	368	508	876	167	25	192	147	16	163
1974	392	606	998	172	23	195	153	10	163
1975	461	627	1088	203	20	223	185	13	198
1976	386	561	947	~~212~~ 219	~~18~~ 19	~~230~~ 238	~~192~~ 193	~~8~~ 7	200

Beginning in 1969 a $15 fee was assessed each N-Kansas applicant
as ~~of May 20, 1976~~
8/11/76

Attachment D

Applicants - 1976



Hi 81

Hi 81

* Kansans accepted with drawing (by county)

Anderson - 1
Cowley - 1
Douglas - 2
Johnson - 13
Marion - 1
Riley - 2
Saline - 1
Sedgewick - 1
Shawnee - 2
Wyandotte - 2

At enrollment
June 30, 1976

Top figure: No. of applicants accepted

Bottom figure: No. applicants - 1976

0 indicates no applicants

THE PROCESS USED IN ACCEPTING APPLICANTS TO THE UNIVERSITY OF KANSAS SCHOOL OF MEDICINE

Dwight J. Mulford, Ph.D.
Dean for Admissions
1976

The following is the procedure used by the Selection Panel to recommend who among all of the applicants to be interviewed should receive acceptances into Medical School at the University of Kansas.

At the interview, three applicants will be seen together by a team of interviewers. The team will be composed of four persons; two faculty members representing basic science and patient care disciplines, a physician in practice in the State of Kansas sent to serve on the Panel by the Kansas Medical Society, and a layperson chosen by the Governor. Six teams of this composition will interview applicants at the same time. Thus, twenty-four people will be involved.

The interview will go for a period of 45 minutes to an hour. The academic credentials will not be available to members of the teams of interviewers at the time of the interview. Only the applicants' applications will be available to the interviewers. The team of interviewers will predict with ranking based on the interview, how well each applicant will perform as a future physician.

At the end of each day of interviewing applicants, all members of the six interview teams will meet together as the Selection Panel.

All credentials of each applicant interviewed will be made available to each member of the Selection Panel. These include the undergraduate and premedical science requirement grade point averages, the percentile rank on each of the four parts of the Medical College Admissions Test, the semester to semester trend in academic performance and the premedical advisor's appraisal. The team of interviewers of the applicant will report on the observations and findings gleaned during the interview, and the team's prediction as to the applicant's potential performance in the practice of medicine as a future physician. Following this a motion to accept or not to accept the applicant for medical school is made by a member of the Selection Panel and seconded. After discussion, the question is called for and the outcome is decided by majority vote of the Selection Panel members.

The vote by the Selection Panel determines who among all the applicants interviewed will be recommended for acceptance or for denial of acceptance. These recommendations go to the Subcommittee on Admissions members, all of whom serve on the teams of interviewers and the Selection Panel. The Subcommittee recommendations in turn go to the Academic Committee which in turn makes its recommendations to the Executive Vice Chancellor for his action which is final. Most of the members of the Academic Committee serve on the Selection Panel.

MEMBERS OF THE SELECTION PANEL – 1976

Basic Science Faculty Members

Larry Sullivan, Ph.D., Department of Physiology, KUMC Campus
Stata Norton, Ph.D., Department of Pharmacology, KUMC Campus
John Clancy, Ph.D., Department of Anatomy, KUMC Campus
Daniel Carr, Ph.D., Department of Biochemistry, KUMC Campus
Thorkil Jensen, Ph.D., Department of Microbiology, KUMC Campus
Charles Wallas, M.D., Director, Blood Bank, KUMC Campus

Clinical Faculty Members

Charley W. Norris, M.D., Department of Otorhinolaryngology, KUMC Campus
Barbara Lukert, M.D., Department of Medicine, KUMC Campus
Leo F. Cooper, M.D., Department of Family Practice, KUMC Campus
Marvin Dunn, M.D., Cardiovascular Section, KUMC Campus
Paul Laybourne, M.D., Department of Psychiatry, KUMC Campus
George Dyck, M.D., Department of Psychiatry, Wichita Branch Campus

Visiting Physicians From State of Kansas

Marvin H. Wilson, M.D., Topeka, also member of Kansas Medical Society
Richard R. Brummett, M.D., Neodesha, also member of Kansas Medical Society
Kenneth P. Zabel, M.D., Pittsburg, also member of Kansas Medical Society
Benjamin Matassarin, M.D., Wichita, also member of Kansas Medical Society
William M. Kane, Jr., M.D., Hays, also member of Kansas Medical Society
Donald D. Goering, M.D., Salina, appointed by Dr. John Travis, President of Kansas Medical Society to represent KMS

4.

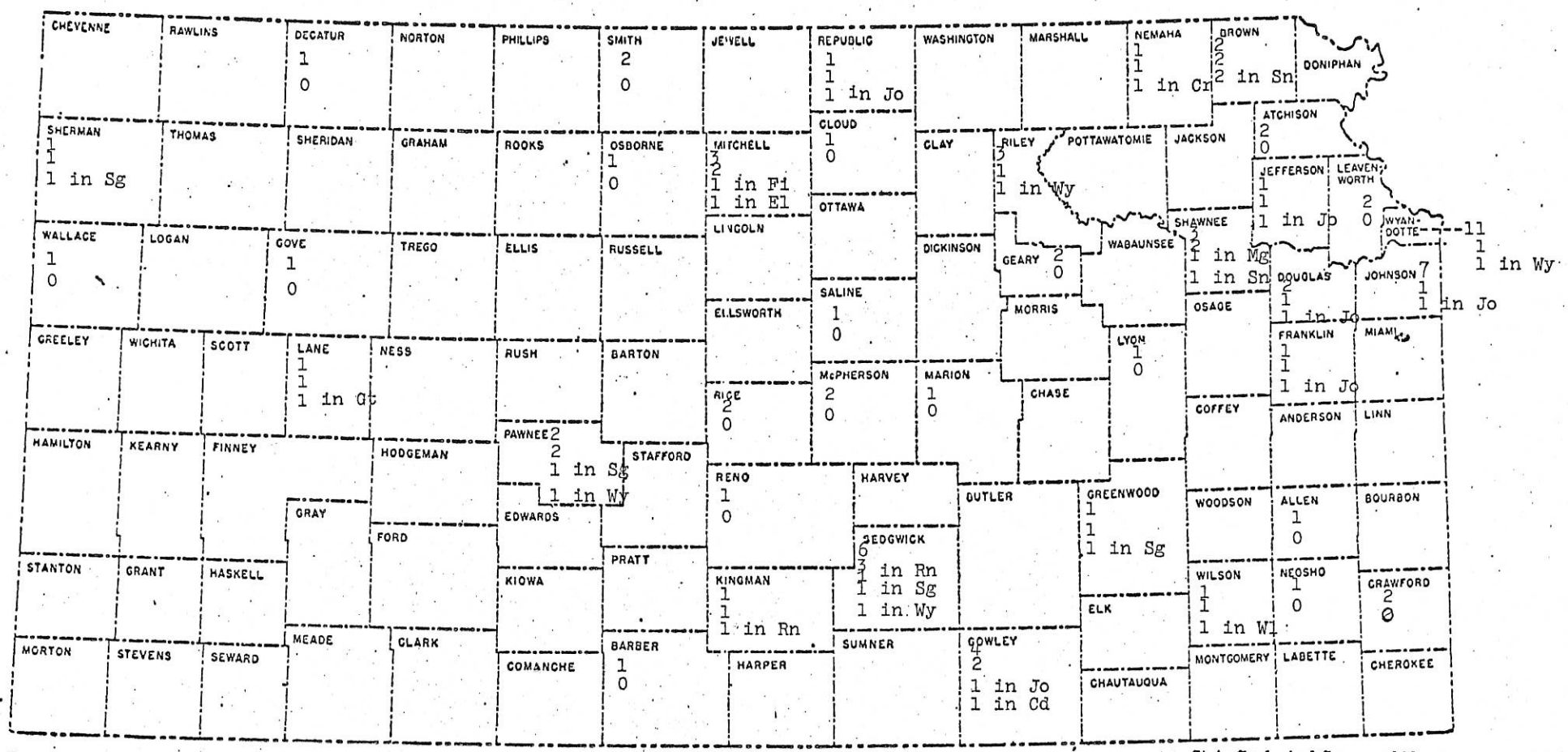
Laypersons From State of Kansas

Mr. Hylton Harman, Kansas City, Kansas
Mr. James Davis, Kansas City, Kansas (Alternate for Mr. Harman)
Mr. Charles Henshall, Chanute, Kansas
Mrs. H. William Reece, Scandia, Kansas
Mr. Dan Hamrick, Coffeyville, Kansas
Mr. Paul Fleener, Manhattan, Kansas
Mrs. John Glades, Yates Center, Kansas

101 graduates in '65

University of Kansas
College of Health Sciences and Hospital
School of Medicine

Number of graduates of the 1965 class by county and state and location of the graduates remaining in Kansas ten years after graduation from Medical School



State Geological Survey of Kansas

Ca	Mt	NY
1	1	1
0	0	0
Co	**Ms**	**OK**
1	1	2
0	0	1
Il	**ND**	1 in Cl
1	1	
0	0	
Mo	**NJ**	**SD**
5	1	1
0	0	0

Top number - No. accepted to Med. Sch.
Middle number - No. located in Ks.
Bottom number - Where located in Ks.

Attachment F

Statement to the
Special Committee on Public Health and Welfare

Health Care Services in Medically Underserved Areas
Presented by
Paul E. Fleener, Director
Public Affairs Division--Kansas Farm Bureau
July 15, 1976

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

My name is Paul Fleener. I am Director of Public Affairs for Kansas Farm Bureau. We welcome the opportunity to appear before your committee and to discuss with you the concerns of our members regarding the topic of your study--Health Care Services in Medically Underserved Areas.

Please do not be concerned by what appears to be a rather voluminous statement. You will find that the bulk of the material presented to you is various exhibits which we believe would be of interest to you. My statement will be rather brief.

Exhibit A, a part of the material submitted for your consideration, contains policy positions adopted by voting delegates of my organization for various years. The first demonstrated interest in a problem not unlike that which you study today was addressed by our membership in 1949. We had another statement in 1950. From our records there appears to be no policy position for the balance of the 50's and 60's. However, in each of the last few years our members have addressed several items related to health care in Kansas. I would quote briefly, and only in part, from the 1976 statement adopted by our membership:

We favor development of additional residency programs to provide in-state programs for those graduates interested in primary care medical practice. Until the state of Kansas can provide additional residency programs, we cannot expect to keep a greater percentage of physicians in Kansas.

We urge the Board of Regents to develop new residency programs . . .

We urge the Legislature to finance such new programs.

Such programs would benefit the smaller communities of Kansas by having medical professionals pursuing residencies in areas where physicians are most needed.

We continue to support the training programs for the physician's assistant and nurse clinician as now developed by KUMC. We encourage Kansas communities to utilize the services of these medical "extenders" whenever qualified personnel can be recruited.

. . . we will continue to support a state loan forgiveness program. We suggest that any such loan program be based on need and require a year's service in a rural Kansas community or a Kansas inner-city area for each year of schooling funded by a state medical loan.

Mr. Chairman, in a few moments I want to return to and elaborate on those items excerpted from our current Farm Bureau policy position. At this point I would like to identify for you the additional exhibits attached to this statement.

Exhibit "B" is a history (to May, 1972) of the operation of the Illinois Medical Student Loan Fund Program. This program, which was begun in 1948 as a cooperative effort of the Illinois Farm Bureau (Illinois Agricultural Association) and the Illinois Medical Society. The purpose of the program was and is to help qualified applicants to hurdle financial need or border-line academic barriers to a medical education.

Exhibit "C" describes--slightly differently--the Illinois Medical Student Loan Fund Program. This is in the words of Dr. D. E. Stehr, Chairman of the Loan Fund Board.

Exhibit "D" is a brief on the Illinois Medical Student Loan Fund Program geared to the applicant.

Exhibit "E" is an evaluation of the success of the Illinois program. I would particularly invite your attention to pages 5-15, with particular reference to the Tables contained in those pages which indicate graduation progress, location of internships, location of residency of graduates and location of present practice of graduates, among other items of interest.

Two brief quotes from Exhibit "E" appear in order at this time:

On page 14

The data for both MSLFB participants and for non-Cook enrollees in general, give support to the concept that a person who comes from a rural background is more likely to return to practice in a rural area. It is interesting to note that persons from a rural background also remained in the State of Illinois whether

in rural or non-rural areas with greater frequency than enrollees who came from urban areas.

From page 15

The results of this evaluation of the MSLFB program in Illinois should encourage members of admissions committees of professional schools. Faced with an abundant number of qualified candidates for admission, committees would like to make choices which will reflect the needs of society rather than simply choosing candidates on the basis of minute differences in academic credentials. The difficulty is that it is seldom possible to demonstrate objectively that there is any benefit to society from such an attempt. The results of this study are an exception and, as such, should be carefully considered by other admissions committees.

Exhibit "F" is an article from the February, 1976 edition of Kansas Medical Society Journal. It pertains to "Primary Health Care Manpower Problem in Kansas."

Exhibit "G" is, as far as we are able to ascertain, the most current HEW designation of critical shortage areas--dental and medical. On this latest list there are 21 dental and 25 medical shortage areas in the state of Kansas. That compares to 14 dental and 16 medical--again indicated by HEW in February, 1975.

Our policy statement indicated support for additional primary care medical residencies. We urge the Board of Regents to develop such new residency programs.

We would be remiss if we did not express our appreciation to the Regents, to the University of Kansas, to Chancellor Archie Dykes, and to Executive Vice-Chancellor, Dr. Robert Kugel for the energy and resources --human and financial--which have already gone into A) Increasing the number of medical students; B) Increasing the number of allied health professionals and physician extenders; C) Making a major effort to attract more medical students to primary care programs; and D) Undertaking the development of an Integrated Family Practice Residency Program. We applaud as well the strengthening ~~of an~~ and additional time allotted to the Medical Preceptorship Program.

The next step may be up to the Legislature, Mr. Chairman. If an expanded and admittedly ambitious residency program is to be successful there will need to be additional financial support. We believe such support is imperative if the citizenry is to have available the health care services required. Perhaps--and I use that word advisedly because of limited reading in this area--no single program is as important as the residency program in determination of final location for practice of medical school graduates.

Health care services should be available to all of us whether we are rural, urban, suburban, inner-city residents or people who live in mid-sized communities.

There are some things the state, with its financial and other resources can do to help assure availability of health care services.

There are also, Mr. Chairman, and members of the Committee, some things that we as private citizens--through our various organizations, as committees of concerned individuals, and as communities--can and should be doing to assist in this effort. My own organization is re-examining, to determine applicability and mechanical procedures, the successful Illinois Medical Student Loan Fund Program. We looked once in 1972. No action was taken, and while that may be regrettable, our organization--as does the state--must make periodic determinations on allocation of resources. Now is the time for reexamination, and hopefully action. I report this to you today simply to indicate that you will not be alone in studying this issue, you will not be alone in seeking solutions to the problems related to health care delivery. Hopefully, you will not be alone in allocating financial resources to meet the needs of prospective students, those already enrolled, those in internship and residency programs.

While we, and I am sure others, ask this Committee to make a recommendation for a financial investment in additional residency programs --and the support personnel necessary for such programs--we pledge to you and the citizens of this great state our best efforts, our energies and a portion of our financial well-being to bring about adequate health care services in medically underserved areas in Kansas.

1949

RURAL HEALTH—We give our unqualified support to the three-fold rural health plan which has been presented to our governor: (1) To expand our state medical center so that more doctors can be trained. (2) To encourage local communities to finance new doctors in the community, and (3) To establish a system of post-graduate training for doctors throughout the state. We Galley 5
urge our state legislature to make a thorough study of the funds required to put such a plan into operation and to appropriate such necessary funds.

We believe that voluntary group health plans may be a very effective method of providing a more sound and wholesome medical economy and health care program by placing important emphasis upon preventive measures and upon efficient group medical practice.

We believe that these plans may well play an important part in facilitating and implementing the three-point health program outlined above and that any proposed legislation should be designed to lend them full encouragement and support.

1950

RURAL HEALTH - We commend our Kansas legislature for the special appropriations to our Medical Center which will make possible the training of a larger number of doctors to meet our critical rural needs. We will support every effort to assure that this increase in trained physicians be encouraged to practice in rural communities. We ask that our legisiture continue to make funds available to provide post graduate training and adequate contact with modern practice for doctors who practice in rural areas.

1973

Medical Training Facilities In Kansas

Current medical training programs in the state of Kansas are inadequate to meet the state's needs. The shortage of family physicians is becoming more acute each year. Fewer and fewer physicians are establishing practices in the rural areas of Kansas.

We support the use of bond financing to speed up construction of additional training facilities for doctors and medical assistants at the KU Medical Center.

The development of expanded internship programs in Wichita and new internship programs in other cities (i. e., Salina, Topeka, etc.) is another program which needs to be implemented as soon as feasible, with special priority given to students specializing in the practice of family medicine.

Many states have developed training programs for the physician's assistant (paraprofessional medical workers) and have found the graduates of such programs to be assets in the delivery of medical services. We believe Kansas should establish a training program for paraprofessionals and establish legal guidelines for the practice of paraprofessionals in Kansas.

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1975

Medical Professionals in Kansas

Kansas University Medical Center at Kansas City will, by July, 1975, begin to educate 50 additional medical students per year. We applaud the efforts of the Kansas Legislature to increase classroom and clinical space on the Kansas City campus, and to develop an expanded program on the Wichita campus.

As the class size increases at KUMC, we would favor development of additional residency programs to provide in-state programs for those graduates interested in family practice. Until the state of Kansas can provide additional residency programs, we cannot expect to keep a greater percentage of physicians in Kansas.

We urge the Board of Regents to develop new residency programs, with particular emphasis given to on-site programs in communities which can meet KUMC and AMA specifications. We urge the Legislature to finance such new programs. Primary care physicians could train in local hospitals and with local physicians who have attained faculty status at KUMC. Such programs would benefit the smaller communities of Kansas by having medical professionals pursuing residencies in areas where physicians are most needed. Kansas taxpayers would also benefit since the cost of on-site residency programs would, we believe, be less than programs maintained on the KUMC campus.

We continue to support the training programs for the physician's assistant and nurse clinician as now developed by KUMC. We encourage Kansas communities to utilize the services of these medical "extenders" whenever qualified personnel can be recruited. We will continue to work for established legal guidelines for the practice of paraprofessionals in our state.

As a practical inducement to qualified youth interested in a medical career, we will support development of a state loan forgiveness program. We would suggest that any such loan program be based on need and require a year's service in a rural Kansas community or a Kansas inner-city area for each year of schooling funded by a state medical loan.

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Attachment G

STATEMENT OF LLOYD L. HALL
EXECUTIVE SECRETARY
KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE

JULY 15, 1976

The Kansas Association of Osteopathic Medicine has been working for several years in an effort to increase the availability of general practice physicians in the State of Kansas. Several proposals for extension and improvement of the program have been made to the Kansas Legislature since 1970.

Osteopathic Medicine Provides Family Physicians

We believe the most significant point which must be considered is the essential fact that the colleges of osteopathic medicine prepare physicians for the general practice of medicine.

Over 70% of the graduates of these colleges engage in general practice and primary care. Less than 30% enter into specialty practice. Therefore, although the number of colleges of osteopathic medicine is limited, they do constitute a major source of supply for general practice or family physicians in the nation.

Reasons for This Result

There are undoubtedly several reasons why this school of medicine trains such a high proportion of physicians who remain in general practice. We can outline some of the more salient reasons, which are:

1. Osteopathic Colleges have over the decades as a general rule operated and developed to their present status with no or modest state or tax-supported funding.

   As a consequence, their efforts have been directed toward training primary care physicians, with less emphasis upon research or with sub-specialty training programs than has existed in tax supported schools possessed with funding for other programs;

2. The militant opposition of organized medicine to the osteopathic school of medicine and its colleges throughout the first three quarters of this century has, in some measure, caused the profession and its colleges to seek excellence in the training of primary care physicians.

3. The osteopathic colleges of medicine have general policies which permit qualified students to enroll in the professional educational program at an age level higher than that which is normally true in regular schools of medicine. Where the motivation is great, and the student is fully qualified, as a general rule they will be admitted to age 28, and with some exceptions for exceptional students beyond that age.

   The consequence of a policy such as this has been that students who complete four years of professional education and one required year of rotating intern training are frequently in the area of from 32 to 35 years of age by the time they are ready to enter practice. In most cases they have wife and children, major financial obligations, and to postpone the effective date of practice for three more years, following residency training, is virtually beyond consideration.

4. The American Osteopathic Association, as the recognized accrediting agency, has long had, and has today, an absolute requirement that graduates must complete one year of rotating internship upon completion of their professional schooling. This policy has been and is in force to assure that all physicians training in the osteopathic school of medicine are qualified for general practice, with any specialty training to follow the completion of the rotating internship.

Recognition of this Fact by Other States

In recent years, with the focus of the nation on the severe shortage of general practice physicians, and especially in the rural practice areas, many states and the federal government have become aware of the special qualities which exist within the sphere of osteopathic medical education.

Among states which have acted to date are:

1. Michigan, in 1970, created a new college of osteopathic medicine located on the Campus of Michigan State University in East Lansing.

2. Oklahoma, in 1973, created a new college of osteopathic medicine, located in Tulsa. This college admitted its first class in 1974. Construction of additional facilities is now under way in Tulsa.

3. Texas, in 1971, commenced state funding of the Texas College of Osteopathic Medicine, which admitted its first class in 1971.

4. West Virginia, in 1975, authorized a new state supported college of osteopathic medicine.

5. New Jersey, in 1975, authorized a new college of osteopathic medicine, which it is believed will be ready to admit its first students in 1977.

6. Ohio, in 1975, authorized a new state-supported college of osteopathic medicine.

7. New York, According to a bulletin just received, has authorized a new college of osteopathic medicine, to enroll its first freshman class in 1977. According to this announcement the Board of Regents of the State of New York has approved a Charter for the New York College of Osteopathic Medicine of the New York Institute of Technology.

8. Illinois, six years ago, engaged in a capitation program to increase the number of Illinois students admitted to medical and osteopathic colleges. Under the Illinois program, the number of Illinois students the college had in 1966 became the base figure. For every Illinois student who came to the college over the base figure, the college received $6,000 for each of the four years. Secondly, the college received $1,000 for each Illinois student it had in its student body. Thirdly, the state awarded $50,000 for capital growth on a one-time basis for each student over the base figure of 20. And Fourth, for each student over 20 the college reeeived a one-time grant of $20,000.

Thus under the Illinois capitation program, the first 20 Illinois students added over base provided $78,000 for each student; The next 116 students provided approximately $50,000 per Illinois student.

Reportedly great progress has been made in Illinois under this program, and it is expected to expire in another three years.

9. Minnesota enacted legislation in 1976 directed toward entering into agreements with colleges of osteopathic medicine for acceptance of Minnesota students. It is anticipated that the contracts will be entered into and funding provided for Minnesota students commencing with the 1977 entering classes.

My understanding of the Minnesota plan is that it will provide annual support to colleges of osteopathic medicine in the area of $12,500 per year, with the agreement to provide that the contracting college will accept from the student the equal amount as is charged by the Minnesota state medical school. I am advised that the Kansas City College of Osteopathic Medicine has under consideration a contract to provide 30 positions in each Freshman class under such a program.

10. Pennsylvania has for many years funded the Philadelphia College of Osteopathic Medicine on the same basis as all other medical colleges in the State of Pennsylvania.

11. Iowa has in recent years been providing funding for a portion of the budget of the Des Moines College of Osteopathic Medicine.

The major free standing colleges of osteopathic medicine, without strong financial committments to or from the state in which they are located, are the Kansas City College of Osteopathic Medicine and the Kirksville College of Osteopathic Medicine--both located in the State of Missouri, and both easily accessible to Kansas students.

Colleges of Osteopathic Medicine, located in states where they are fully or strongly state-supported, necessarily select most of their Freshmen class students from citizens of that state. We in Kansas do, on occasion, have a student admitted into the colleges in Oklahoma, Texas, Des Moines or Chicago, but these are infrequent, and it can be expected to remain so. We have one Kansas student admitted to the Michigan College for the Fall of 1976, which will be the first Kansan since its inception.

KANSAS STUDENTS IN OSTEOPATHIC COLLEGES

In previous testimony it was stated that an estimate of from 7 to 10 Kansas students were admitted in 1975 to colleges of osteopathic medicine. The number admitted is substantially higher than that estimate.

Table I shows the Kansas students enrolled as of March 1, 1976 in colleges of osteopathic medicine. They are currently enrolled in the following five colleges:

Kansas City	116
Kirksville	7
Michigan State	1
Oklahoma	2
Texas	1

At this time it appears that over 30 Kansas students will be admitted in August 1976 entering classes, which will bring the total number of Kansas students in colleges of osteopathic medicine and in internship to 157. Additional Kansas students are currently enrolled in residency training programs throughout the nation.

Kansas Association of Osteopathic Medicine

LLOYD HALL
EXECUTIVE SECRETARY

913-234-5563

835 WESTERN
TOPEKA, KANSAS 66606

TABLE I

March 1, 1976

Colleges of Osteopathic Medicine in the United States

Chicago College of Osteopathic Medicine	380	total
Chicago, Illinois	0	Kansas students
College of Osteopathic Medicine and Surgery	523	total
Des Moines, Iowa	0	Kansas students
Kansas City College of Osteopathic Medicine	577	total
Kansas City, Missouri	116	Kansas students
Kirksville College of Osteopathic Medicine	487	total
Kirksville, Missouri	7	Kansas students
Michigan State University College of Osteopathic Medicine	265	total
East Lansing, Michigan	1	Kansas student
Oklahoma College of Osteopathic Medicine and Surgery	90	total
Tulsa, Oklahoma	2	Kansas students
Philadelphia College of Osteopathic Medicine	798	total
Philadelphia, Pennsylvania	0	Kansas students
Texas College of Osteopathic Medicine	234	total
Fort Worth, Texas	1	Kansas students
West Virginia College of Osteopathic Medicine	77	total
Lewisburg, West Virginia	0	Kansas students

Total number of Kansas students enrolled in Colleges of Osteopathic Medicine 127

Table II shows the number of Kansas students admitted to colleges of osteopathic medicine each year since 1974. The Number has increased from 3 and 2 in 1964 and 1965 to the point where 35 were admitted in 1973, 34 in 1974 and 46 in 1975.

Table III shows the combined number of Kansas students engaged each year since 1967 in the four-year professional training program and in the one year of rotating internship. This has increased from 16 in 1967 to 140 in 1975, and a projected 157 in 1976.

The increased number of Kansas students admitted in recent years has been due almost entirely to the decision made by the Kansas City College of Osteopathic Medicine to provide more positions for Kansas students. In recent years, Kansas has had the largest contingent of Freshmen students at the Kansas City College, even higher than that given to the state of Missouri.

The Students admitted each year at the Kansas City College come from an inquiry list of nearly 5,000 students each year, and from completed applications in the area of 2,000 each year.

We have reason to believe that the number of Kansas students admitted for the Fall of 1976 will decline, and will continue to decline in subsequent years, absent any affirmative action by the state of Kansas. Preferential treatment of Kansas applicants cannot be expected on a long-term basis, in the face of urgent requests from states throughout the nation, and in the face of other funding programs which are or may become available to free-standing colleges of osteopathic medicine.

TABLE II

KANSAS STUDENT ENROLLMENT IN COLLEGES OF OSTEOPATHIC MEDICINE

FRESHMAN CLASS

Year	Kansas City	Kirksville	Oklahoma	COMS	CCO	Texas	Mich	Total
1964	3							3
1965	4							2
1966	2	2						4
1967	6	1						7
1968	6							6
1969	10							10
1970	3							3
1971	13							13
1972	11	1		1				13
1973	33	1			1			35
1974	31	1	1				1	34
1975	42	2	1		1			46
*1976								30*

*Est.

TABLE III

COMBINED NUMBER OF KANSAS STUDENTS ENROLLED IN COLLEGES OF OSTEOPATHIC MEDICINE AND IN INTERN TRAINING

Year	In Prof. School	School & Internship
1967	16	16
1968	19	22
1969	27	29
1970	26	30
1971	32	39
1972	39	45
1973	64	74
1974	94	97
1975	127	140
1976*	144	157

We have suggested to the Kansas legislature for the past several years that a program designed to assist colleges of osteopathic medicine which accept Kansas students would be for the benefit of the people of Kansas, and a sound investment on any costs-benefits analysis.

It is virtually impossible to segregate out all costs involved in funding of a medical school today, and especially a school containing the breadth of programs undertaken at KUMC. Without making any effort to make any such allocation of costs, the basic expenditures can be noted, and compared with physician production.

In 1966 124 students were admitted into the Freshman class at KUMC. In 1976, this number has been increased to 200 Freshman class students.

In 1966 general fund appropriations were $6,157,811. In 1976, the general fund appropriations had increased to $28,514,204 according to our review of budgetary appropriations,

Thus, in broad outline, there has been an increase in the number of students admitted to the Freshman class of 76 students per year, and there has been an increase in the annual appropriations during that period of time of over $22,000,000.00.

In addition to general fund apprpriations, additional funds have been made available for construction projects at both Kansas City and Wichita, including the Revenue Bond Issue authorization of $64,000,000.

It must definitely be recognized that the increase in funds required is due to many factors, including replacement of obsolescent plant and equipment, inflationary costs of all services and supplies, salary increases, expansion of other health-related programs, etc.

In view of the testimony that 12 new family practice residencies will come on line this year under legislative authorization, and that at the end of three years this will require funding of 36 positions in a three year residency program, and in further recognition of the fact that additional family practice residencies will need to be funded in order to bring the state up to maximum number possible of family practice residencies located in the state of Kansas, in its effort to retain as many Kansas graduates for this state as possible, and especially those who are trained in primary care or general practice,

and in further recognition of the continuing upward trend of all costs in general, and especially those connected with medical education, it can be predicted that the days when Kansas will be called upon to appropriate anywhere from $35,000,000 to $50,000,000, and even more, out of general funds for operating purposes for the medical eenter are not far distant.

What we have proposed, and continue to propose, is a program which we believe will be a genuine bargain for the state of Kansas.

The primary need throughout the state, in at least 100 out of our 105 counties, is more family or general practice physicians.

We know from decades of experience that approximately 35% of the graduates of the in-state medical school remain to practice in Kansas. We have no reason to believe that this figure will change dramatically in the next few years. Kansas has had an emigration of its educated youth going on for many years, and nothing on the horizon indicates that this will change at this time.

WE can reasonably predict that as many Kansas students graduating from colleges of osteopathic medicine will opt to remain in practice in Kansas as graduates from other professional schools. It might be higher, but it would be a safer assumption to assume a figure of 35% based on other records available.

If Kansas adopted a program funding 100 Kansas students per year as a maximum (assuming that number of students could be placed each year, which is not too probable), even such a funding program would not be grossly expensive for this state, compared to other programs established or contemplated.

For purposes of this illustration, I am assuming 100 students per year authorized, under contractual agreements with colleges, whereby the college would agree to accept from Kansas students the same tuition charged to students at KUMC. (At the present time I understand this is $1,500 for a full 12-month year, which would equate to $1,125.00 per year for a four-year academic year.) If we use $13,500 as the annual compensation figure provided to the college under such an agreement, the total cost per year based on 100 students would be:

Yr 1	100 x $13,500 =	$1,350,000.00
Yr 2	200 x $13,500 =	2,700,000.00
Yr 3	300 x $13,500 =	4,050,000.00
Yr 4	400 x $13,500 =	5,400,000.00

Under this proposal, it should be noted:

First, Kansas has no investment in land, construction, buildings or equipment.

Second, The size of the class would be 50% of the total number of students admitted to K.U. Medical Center each year under the present 200-person Program;

Third, The State would not be involved in funding under this general program internship or residency training programs. It might or might not at a later date make a decision to participate in in-state internship or residency training programs for Kansas students graduating from colleges of osteopathic medicine.

Fourth, With the experience of the osteopathic profession that over 70% of its graduates go into general practice, and with a high percentage locating in other than metropolitan areas, it can be anticipated that 70 out of each 100 graduated will be in general practice. If we secured only 35% of each year's graduating class back in Kansas, this would be 35 doctors, of whom 25 would be G.P.'s.

Fifth, The osteopathic profession continues to require one year rotating internship, which means a doctor is ready for practice four years after admission if he is in a three-year curriculum, and five years after entering professional school if he is in a four-year school. This must be compared with the completion date where a three year family practice residency is required, which results in a delay of from one to two years more in the date the physician is actually in the field in practice.

Sixth, When the day comes that the physician needs of the stateof Kansas have been or are being met, the State of Kansas can terminate the program as to future entering classes, without any further committment for operating costs, and without any loss incurred on any land, buildings, equipment, supplies or otherwise.

A valid alternative would be the construction of a college of osteopathic medicine in the State of Kansas. As noted previously, many states in the last few years have made this decision, and have constructed or are ready to begin construction of a new college of osteopathic medicine. The people in many states throughout the nation have the same problem as does Kansas, and they are taking steps to meet their needs.

We believe Kansas is fortunate to have in the neighboring states two colleges of osteopathic medicine, which are not state supported, and which are probably in a position to provide a large number of positions to Kansas students each year for the next several years. There may bee other osteopathic colleges which could accept some students.

The opportunity is available today for Kansas to enter into such a program. It is impossible to say whether such an opportunity will continue to be available in future years. Certainly the need is now, and Kansas could avail itself of an opportunity to educate many of its students desiring to be trained in medicine in quality educational institutions at a minimum of cost to the state, and with no long-range committments of funds.

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka

ROBERT F. BENNETT
Governor

May 4, 1976

VETO MESSAGE

TO THE SENATE OF THE STATE OF KANSAS:

I have signed Senate Bill No. 1034, however, I have applied a line item veto to the following line items contained therein for the reasons specified:

2. Section 33, that part of subsection (a) which reads:

"Payments to colleges of osteopathic medicine . . . . . 300,000"

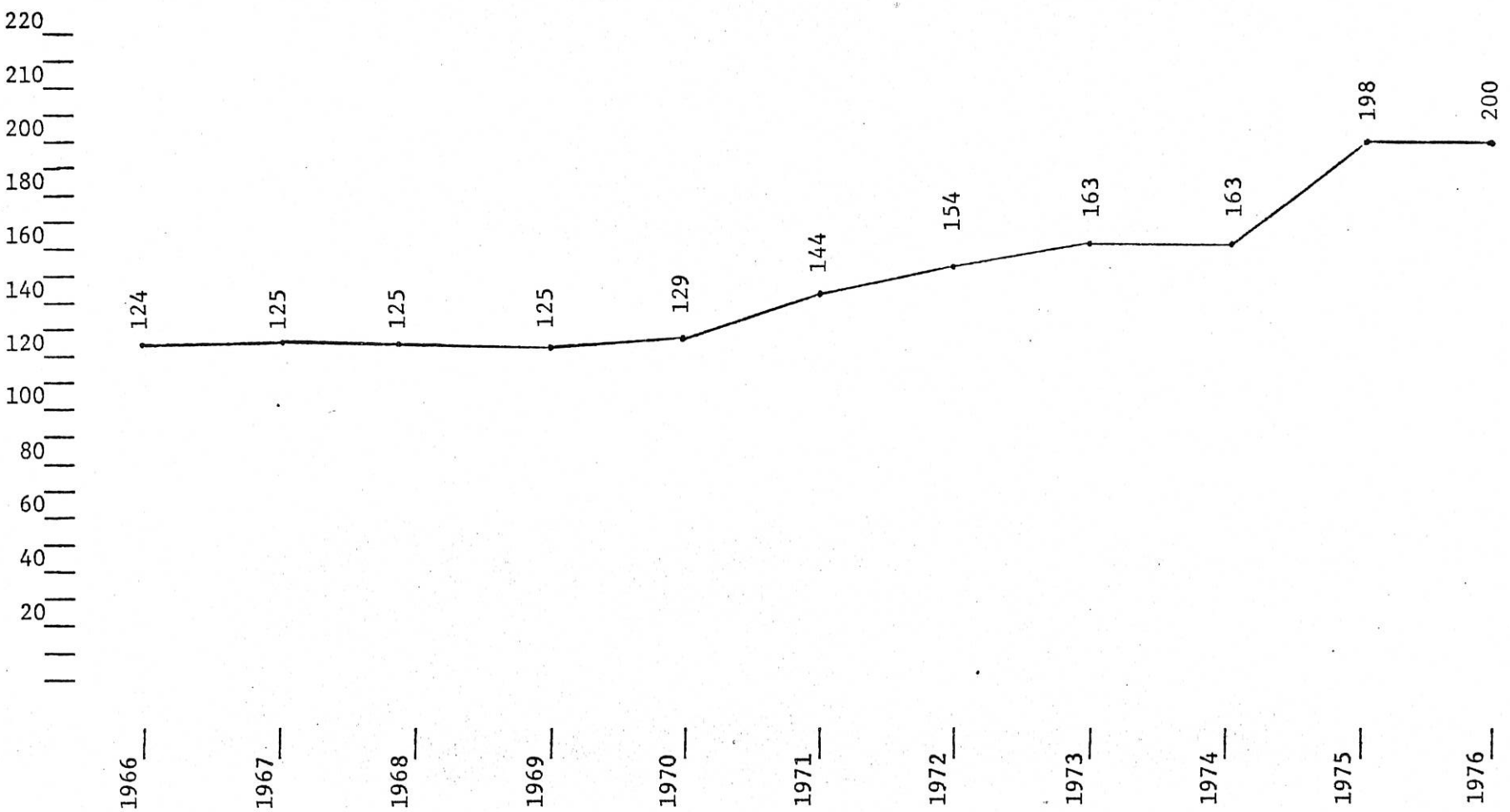
together with the proviso clauses attached thereto

Although I believe that the opportunity to increase the number of doctors serving rural Kansas has great merit, reference is made in this item of appropriation to provisions of a bill which was not enacted by the Legislature. In the absence of proper statutory authority, the Board of Regents would be entering into agreements with students and such agreements could presumably lack the force of law.

There are risks involved in all forms of student assistance and this type of support for osteopathic students adds an additional risk factor due to reference to a bill which was not passed by the Legislature.

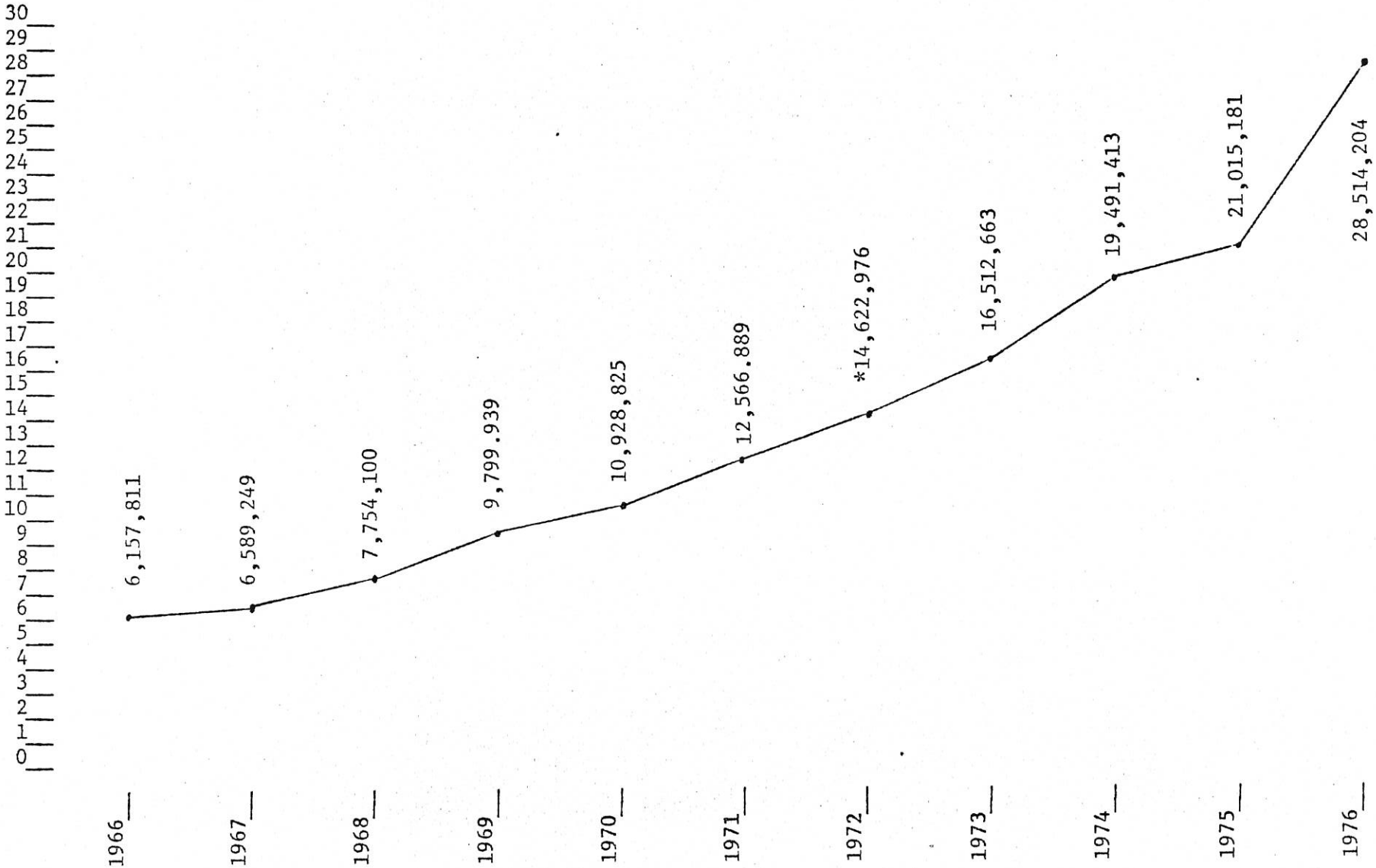
A well defined program for payments to colleges of osteopathic medicine is supportable because the potential is high, though not assured, that those making use of such a program will stay in Kansas and locate in our rural communities. Notwithstanding this fact, however, the appropriation set forth in this subsection, together with its proviso, is a poor and questionable vehicle to circumvent the normal legislative process, regardless of one's agreement or disagreement with the results of that process. The proviso language attempts to incorporate by reference a bill which did not become law, thus depriving members of the Legislature of the opportunity for amendment and approval of the final version of the bill. The use of the omnibus bill, usually drafted and enacted in the final hectic days of a legislative session, to pass not only appropriation measures but also substantive legislation by reference, is a most objectionable procedure constitutionally, philosophically and practically. I trust that the Legislature will continue in the 1976 interim to study and to recommend, within the fiscal restraints existing, an appropriate and fundable program for payments to colleges of osteopathic medicine and that in the 1977 Legislature the matter will be studied and properly considered.

FRESHMAN ADMITTING CLASS
UNIVERSITY OF KANSAS MEDICAL CENTER



Figures based on information supplied by Admissions Office, KUMC, July, 1976

GENERAL FUND OPERATING EXPENDITURES
UNIVERSITY OF KANSAS MEDICAL CENTER



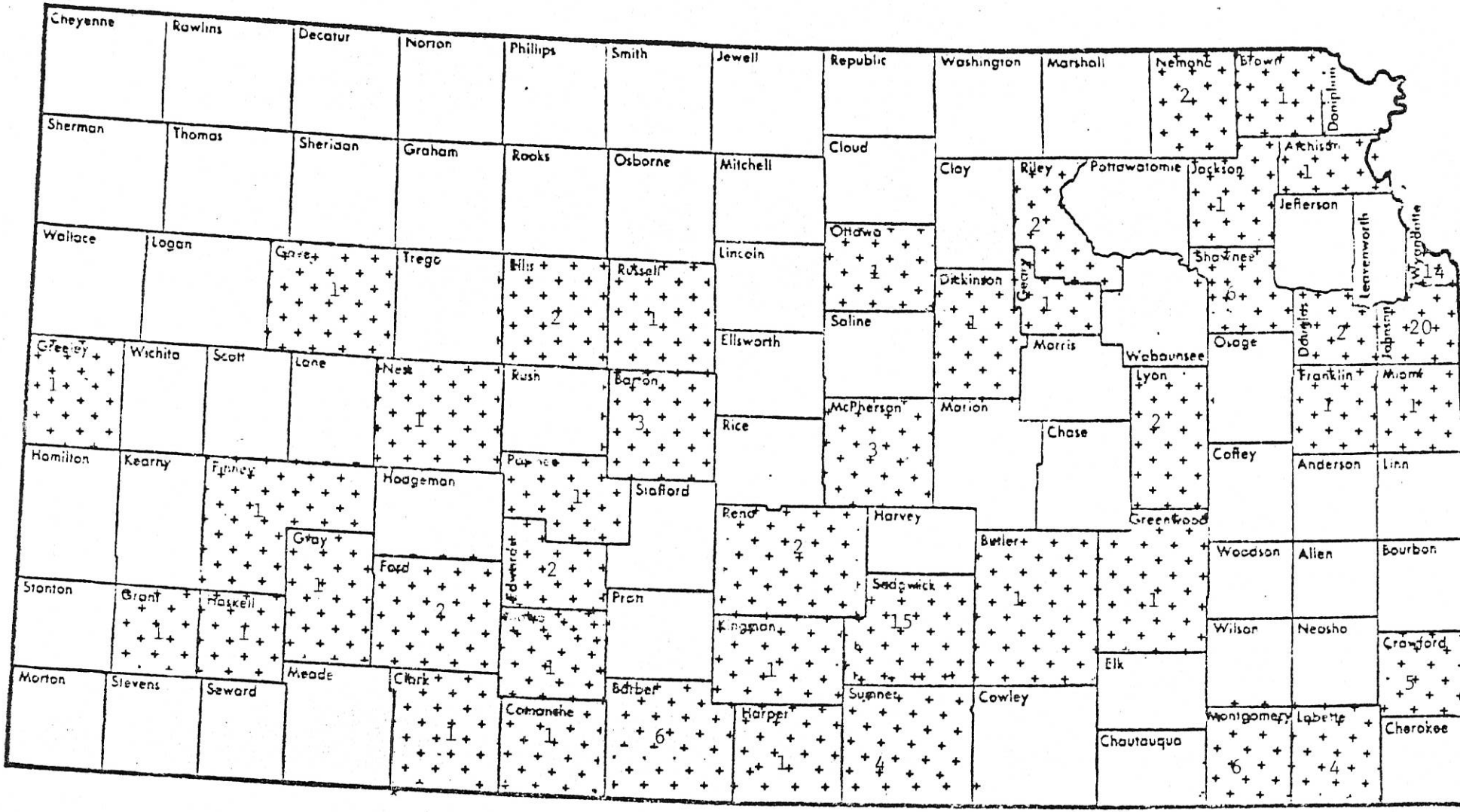
Figures based on information taken from 1970-1976 "Session Laws of Kansas" and do not include building and construction funds.

*1972 SB756, Revenue Bond Issue, $64,000,000, Construction of Clinical & Basic Science Bldgs., KUMC

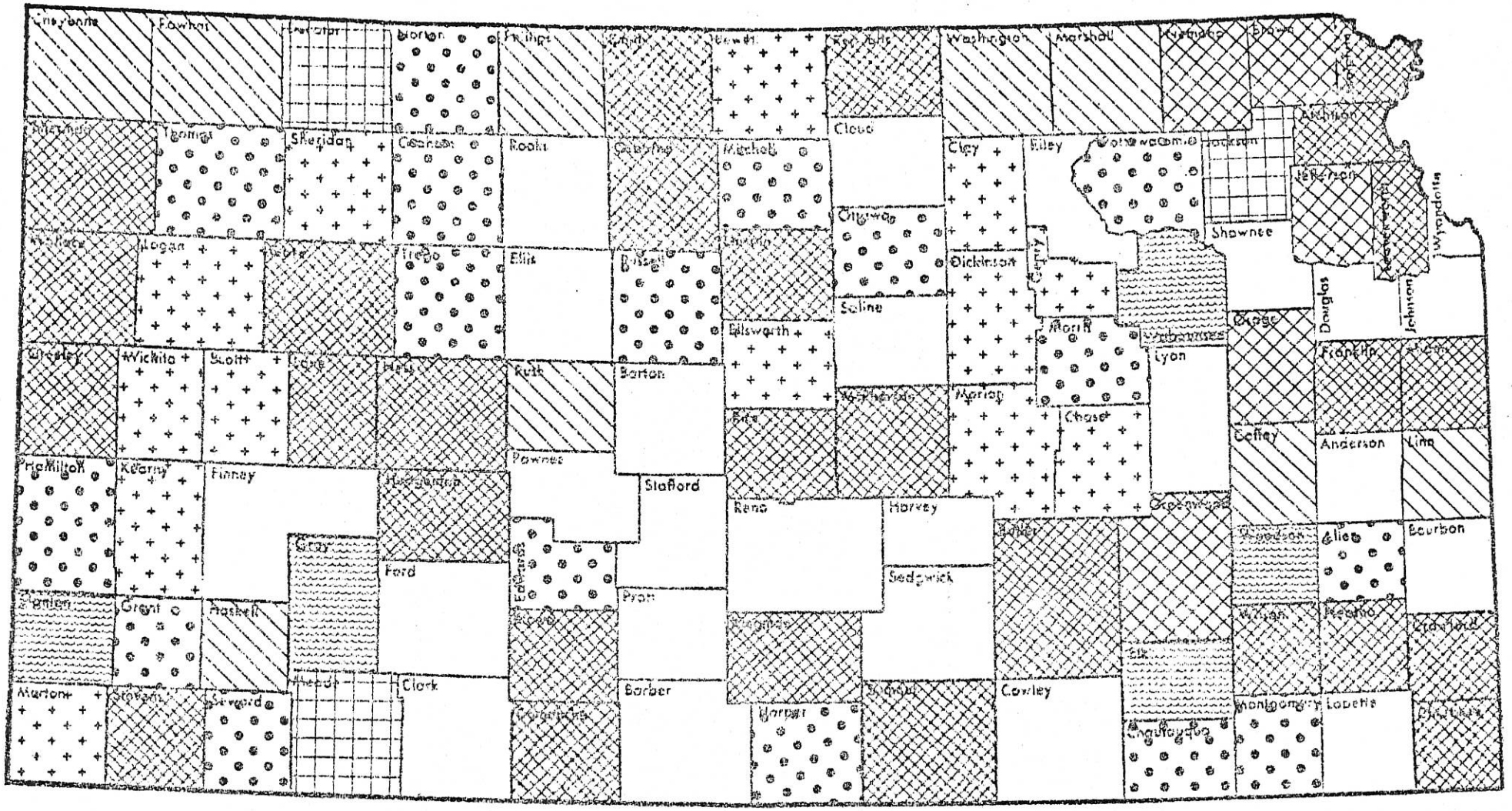
Incomplete Listing--KANSAS STUDENTS IN OSTEOPATHIC COLLEGES & INTERNSHIP--1975-1979 Classes

-126 accounted for

- West ofHIWAY 81 (excluding Sedgwick County): 39/126 = 31%
- From Rural Counties of Kansas (excluding Johnson-Wyandotte-Shawnee-Sedgwick): 71/126 = 56.4%



PHYSICIANS (M.D. & D.O.) IN KANSAS UNDER AGE 65 IN 1975



No Physicians

Over 6,000 per Physician

5,000 - 6,000 per Physician

4,000 - 5,000 per Physician

3,000 - 4,000 per Physician

2,000 - 3,000 per Physician

1,500 - 2,000 per Physician

Less than 1,500 per Physician

Attachment A

Kansas State Dental Association

July 15, 1976

TESTIMONY
ON
PROPOSAL NO. 33
HEALTH CARE SERVICES IN UNDERSERVED AREAS

BEFORE THE INTERIM PUBLIC HEALTH & WELFARE COMMITTEE

Mr. Chairman and Members of the Committee:

The Kansas State Dental Association has maintained a Committee on Manpower Development for some time. The purpose of that Committee was to attempt to provide an adequate supply of Dentists for the populace of Kansas. The activities of this Committee were largely aimed at securing slots in Dental Schools outside of the State for Kansas students. Recently, however, we have found that we are attempting to justify our "shortage" areas to those designated by H.E.W.

As nearly as we can tell from the Federal Register Kansas has eighteen (18) counties designated as critical shortage areas (less than one Dentist to 5,000 people). We have some rather serious questions about how well this ratio works in Kansas and what a real dental shortage area is. As a result of a recent certification request by the National Health Service Corps we surveyed the Dentists in the area to attempt to determine if the populace of the county was underserved. Naturally, we did not answer that question, but the information we received raised some other considerations. The big one is dental utilization - how many people or what percentage of that 5,000 will become dental patients or seek dental care? Our survey showed that in the area the doctors were running about 2800 patient visits a year and, while it is safe to assume many were multiple visits for the same patient, some people really do not require more than one or two visits a year in order to maintain good health. Good dentistry relies heavily on prevention which brings up other questions relative to determining a shortage. What is the dental I.Q. of the populace? Do they seek care? Is the community fluoridated? What is the transportation situation? How are the roads and highways, etc.? In Western Kansas do people consider it normal to drive fifty (50) miles to make minor purchases? Do patients in Galena go to Joplin for their care? Where do the people who live in Carbondale, but work in Topeka, seek care? Do we re-draw boundaries for the low populace counties?

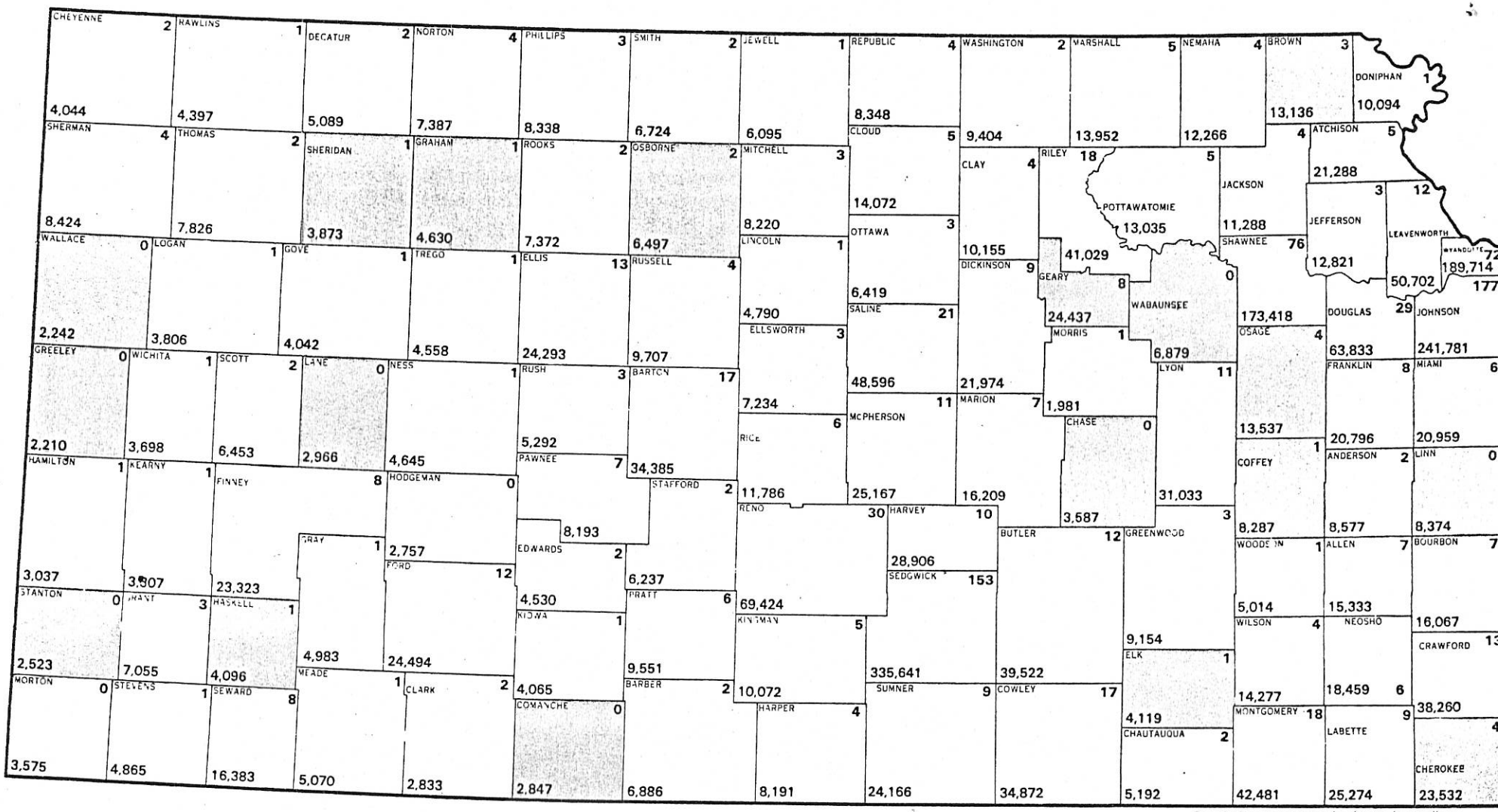
We don't have the answers and we do feel there may be some maldistribution of Dentists. We feel that, in comparison to physicians who for the most part rely on a hospital, we have an advantage in that a Dentist maintains his own hospital and, in this case, I believe that has helped us maintain our wide distribution across Kansas.

4301 Huntoon, Topeka, Kansas 66604 • 913-272-7360

We are currently developing questions for our membership concerning the availability of dental care in the different areas of the State and, through discussions with our members, we hope to locate the true shortage areas, or at least develop more "meaningful" criteria for the selection of a shortage area. We also are planning to request that H.E.W. reclassify those counties where no critical shortage "under their classification" exists - Osage, Elk, Linn, Haskell, Osborne - for example.

We have some good information, but there are many other considerations that apply to an underserved situation.

Carl C. Schmitthenner, Jr.
Executive Director



Population per county is shown in medium
Number of dentists per county is shown in bold

HPSA Critical Shortage Areas

Attachment J

TESTIMONY
ON
PROPOSAL NO. 33
HEALTH CARE SERVICES IN UNDERSERVED AREAS

BEFORE THE INTERIM PUBLIC HEALTH & WELFARE COMMITTEE

July 15, 1976

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to be able to address this Committee this afternoon. As Chairman of the Kansas State Dental Association Council on Dental Education and Manpower I am particularly pleased to address this Committee as I have been looking forward to being able to discuss with members of the Kansas Legislature developments which have been taking place within the last few years that are going to have direct effects on the dental services to the residents of Kansas.

I first want to make some points concerning the critical dental shortage areas of Kansas as established by the Federal Department of Health, Education and Welfare. I question the actual critical need for dentists in the approximately eighteen counties as designated by H.E.W. Just because, in some areas of the United States, there may be a shortage of dentists and a law is passed to possibly alleviate the situation; does this mean Kansas has critical dental manpower problems? Because of the inconsistent and ambiguous criteria which H.E.W. uses to designate a critical need area, I have serious questions of their application to Kansas. An example of this criteria used is consideration of mountainous areas or waterways which would impede access to dental service areas. There are many examples used that just don't apply to Kansas. Considering the ambiguities and inconsistences of this Federal Law, do we have to make Kansas fit the Law? Isn't it better for Kansans, through the cooperation of the Kansas State Dental Association and the Kansas State Legislature, to address ourselves to the problems and solutions of our own dental manpower problems. In many instances I feel that this Federal help is in many ways similar to the O.S.H.A. Agricultural Potty Problems Bill.

Directing my discussion to the dental manpower problems of Kansas, the Kansas State Dental Association Council on Dental Education and Manpower feels that the dental manpower problems of the state can be confronted from several areas. First and foremost in importance and practicality is through preventive dentistry. In dentistry we know a substantial percentage of dental diseases can be prevented if an individual is so educated and motivated. Also I ask, does anyone in this room know how many years the Kansas State Dental Association has been promoting a statewide fluoridation program without success in the Kansas Legislature? We know people can be taught to control dental disease in their own mouths. If they don't have the desire or motivation to help themselves, I question how much State and Federal money should be spent for them.

The second approach to solving the dental manpower problems could be through producing more dentists and dental auxiliaries.

Kansas has a dental education program that assures a certain number of Kansas students a place in the UMKC Dental School each year. Also, in the last few years

there have been numerous dental hygiene and dental assistant schools open in the state.

The third approach to the dental manpower problem is through expanding the functions of the dental auxiliaries. The Kansas State Dental Association is actively cooperating with the American Dental Association to determine what duties can be delegated to the auxiliaries thus freeing the dentist to treat more patients.

The fourth approach to the dental manpower problem is being handled by the Public Health Service, placing public health dentists in the assumed critical need areas. Whereas the Kansas State Dental Association is cooperating with the Public Health Service, we are at the same time attempting to fill the actual need areas with private practicing dentists.

In closing, I would like to say that the Kansas State Dental Association has been and is continuing to approach the dental manpower problems of Kansas with a sincere effort to learn as much as possible as quickly as possible about the dental manpower problems of the state. Although this is a relative new area to us we are sending representatives to other states to examine their methods of approaching the problems in their state. For example, Minnesota has developed a computerized program dealing with dental placement and we are looking at their program extensively.

Again, I want to thank you for inviting me to speak to you and may I say the Kansas State Dental Association is anxious to cooperate and work with the Kansas Legislature in any way that will help to bring the residents of Kansas the quality dental care they deserve.

Richard Bennett, D.D.S., Chairman
Council on Dental Education & Manpower
Kansas State Dental Association
909 Commercial
Emporia, Kansas 66801
316 342-7225

Attachment A

NURSING HOME CARE IN KANSAS

STATEMENT TO LEGISLATIVE COMMITTEE ON HEALTH AND WELFARE

Progress Report on Monitoring

By Kansans for Improvement of Nursing Homes

September 22, 1976

In April, 1976, Kansans for Improvement of Nursing Homes, the Committee on Monitoring, launched a project to carry out site visits on nursing homes in selected areas of the state. The purpose of the project is to make on-site observations of conditions which exist, to determine quality of care, and to report findings to responsible state officials and to the legislature.

To date, a total of 26 nursing homes have been visited. Trips have been made to South Central, Southwest, Southeast, and North Central Kansas. KINH received complaints on approximately 50% of the homes visited; the remainder were selected at random.

On each visit the team consists of two or three members of KINH. The chairman of the Monitoring Committee, a registered nurse, participates in each visit.

Visits are unannounced. Upon arrival a request is made to speak with the administrator and/or the director of nursing. Members of the monitoring team identify themselves and the organization (KINH), and describe the purpose of KINH. Questionnaires are used, and additional comments and observations are recorded. In addition to the administrator and/or the director of nursing, team members also visit with aides and other employees and with the residents and their relatives whenever possible.

Entrance beyond the administrator's office was refused in one home - the home which required the greatest travelling distance and about which the greatest number of complaints had been received. In four homes a satisfactory assessment could not be made due to lack of cooperation by the administrator.

Findings in the KINH study thus far indicate that there is an alarmingly high percentage of nursing homes in Kansas which fail to meet minimal standards of acceptability by concerned citizens. We believe that this should be cause for deep concern to those charged with the public trust of protecting our citizens against such abuses.

Please refer to the attached chart which documents findings of the KINH survey to date.

NOTE:

1a = Administrator refused to allow tour of facility or to give any information

2a = Administrator answered limited number questions about home, evaded questions, and prevented a satisfactory tour of home

? = Unable to determine

xx = particularly severe deficiency

Complaints - Complaints are screened: nurses - local PHN, KINH members who are nurses; multiple complaints from family, employees, etc. on a given home; legislator; health professionals

VIOLATIONS and DEFICIENCIES - please see pages 3 and 4 for numbered list

SUMMARY

KINH believes that findings to date from the monitoring endeavor have been extremely enlightening. These findings, documented in the chart attached, reflect patterns in deficiencies as well as a high incidence of deficiencies and violations. The findings indicate that the following are critical points of concern:

1) Lack of adequate inspection and enforcement -

   a) Of 26 homes monitored - 4 homes with 10 or more deficiencies or violations - all 4 homes under full licensure and certification

   b) Of 26 homes monitored - 7 homes with 6 to 10 deficiencies or violations - all under full licensure and certification

2) Nurse aide problem - understaffing, under paid, not trained

3) Inappropriate placement of non-geriatric mentally handicapped in nursing homes

4) Lack of rehabilitation programs

5) Lack of space and equipment for rehabilitation programs and other services

6) Physician problem - lack of participation

7) Administrator problem - lack of competent administration

VIOLATIONS AND DEFICIENCIES

Following is a list of violations and deficiencies observed and recorded. The numbers at left correspond with those under the heading VIOLATIONS and DEFICIENCIES on the chart. Each column checked on the chart indicates that one or more of the deficiencies included in the corresponding category was cited.

1) Dirty - dirt and litter on floors; soiled linen on floors; dirty, dusty, scurmy bedside tables and bed frames; wax build-up on floors and counters; dirty walls; soiled woodwork, especially around doorways; bathrooms dirty - stench - smudges of feces on walls/floor

2) Call bells lacking, not within reach, or present only for a few residents; hand bells, whistles, etc. used in lieu of push buttons; call bells not working

3) Patients "hanging out" of geriatric chairs; not aligned or well positioned in geriatric chairs, beds; periods of time in geriatric chairs too lengthy; ambulatory (non-geriatric MI) restrained to room; resident (MR) restrained in chair with strips of sheets

4) Strong urine odor - upon entrance, in hallways, in residents' rooms, worst in bathrooms

5) Unemptied urinals, bed pans, commodes with stale, concentrated urine on bedside tables, floors of residents' rooms and bathrooms; unemptied bedpans with feces on bed or bedside chair

6) Facility and equipment in state of disrepair - faucets leaking, window shades stained, torn; cupboard doors hanging loose; floor tiles loose; privacy screens lacking or not working; construction flaws (floors bumpy, not level, hazardous, etc.); walls, woodwork, trim in need of repair, paint

7) Facility dreary, drab, dark, rooms dingy; exterior of building unattractive; grounds unattractive, littered, very few or no plantings; not pleasantly situated

8) Unsatisfactory, inconvenient floor plan or arrangement of rooms, wings; converted from old school building or other old building with additions of wings to old parts, etc. narrow hallways; no toilets or lavatories in or connected to residents' rooms

9) Service rooms and equipment inadequate/non-existent - service rooms too small; P.T. room non-existent; activity room non-existent; P.T./activity rooms poorly equipped or not equipped; P.T. room not used; service rooms combined - dirty/clean laundry, dirty/clean linen, dirty/clean utility, utility/laundry/janitor, P.T./activity, P.T./storage of wheel chairs, walkers, etc., linen closet/storage of wheel chairs, walkers, etc.; Oxygen tanks stored in various service rooms

10) Very limited or no rehabilitative program

11) Physician problem - difficulty getting physicians to visit routinely or for emergencies; nurses write orders; "P.A." used (qualified??) for perscriptions; nurse talks to physician on 'phone in lieu of physician making required Medicaid, Medicare visit

12) Beds untidy, soiled; residents appear not well groomed or clean

13) Food unappetizing; trays with cold, stale food sitting at bedside

14) No drinking water at bedsides

15) Nurse aide problem - not enough aides, aides appear rushed; not supervised; poorly paid; untrained; high turnover; untrained aides giving medications; not well groomed; unprofessional

16) Residents generally appear sluggish, drowsy, in stupor - over drugging? or appear generally very subdued

17) Administrator problem - administrator confused, unable to answer questions; disorganized; complains of being overworked; not licensed; co-administrators; administrator bitter toward owner, unhappy; long absences

18) Fire exits barred; fire safety questioned; narrow hallways; no sprinkler system

19) Charges extra fees over flat rates for services such as feeding, bathing, bed care

20) Uses aides for laundry

21) Uses MR/MI residents for laundry, kitchen work, etc. without paying

22) Scanty supply of wash cloths, towels or soap in bathrooms, at bedsides; short supply linens in linen room

[illegible] MONITORING STUDY

DATA — VIOLATIONS — DEFICIENCIES

HOME	Type Home	No. Beds	[illegible] Medic-aid	Approx No. MR/MI	Chain	Compl-aints	[illegible] lic./cert.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Total	1a	[illegible]
[illegible]	S	100	80	?			yes							X	XX	X	X	X		X		X			X	X				9		
B	I	45	35	4-9			yes	X	X		X		X			X	X	X			X	X		X						10		
C	I	100/76	52	3	X		yes									X	X	X		X		X							X	6		
D	S?	50	14	4-9			yes									X	X	X				X								4		
E	I	100/60	35	20+	X	X	Prov.								X	X	X	X				XX		X						6		
F	I	50	25	25		X	yes	X	X	X	XX	XX	X	X	X	X	XX	X	X	X	X	XX				X	X	X	X	19		
G	I	60	36	6-8			yes											X									X			2		
H	I	81	81	81		X	Prov.	X	X	X			X	XX	XX	X	XX	X	X	X	X	X			XXX		X	X		16		
I	I	50	?	0			yes			X						XX	XX	X				X	X	X						7		
J	I	96/85	26	0	X		yes									X		?			X	X				X				4		
K	I	60	45	5	X		yes	X							X	X	X	X				X						X		7		
L	I	100	55	25	.	X	yes	X	X	X	X	X	X			X	X	X	X	X		XX		X		X		X	X	16		
M	I	64	48	2	X		Prov.						X			X	X	X				X		X						6		
N	I	36	23	5		X	yes		X	X		X			XX	XX	XX	X				X		X	X					10		
O	I	46	42	44	X	X	Prov.		X	X			X	X	X	XX	XX	X		X	X	X	X	X	X			X		15		
P	I	41	?	3			yes									X	X					X		X						4		
Q	I	50	32	1	X		yes				X					XX	X	X				X		X			X			7		
R	I	32	27	4		X	yes		X				X	X	X	XXX	XX	X				X		X	X		X	X	X	13		
S	I	100	50	0?	X	X	yes			X	X					X	X	X				X	X							7		
T	I	53/45	30+	10	X	X	yes		X	X						XX	X	X				X			X					7		
U	I	100/70	60	25	X	X	Prov.	XX			X		X			X	X	X	X	X		XX		XX				X	X	12		
V	S	100			X	X	yes	X						X		X						X		X						5		X
W	I	50	15	1-3			yes															X		X	X	X				4		X
[illegible]	I	100/40	?	1-3	X		Prov																							0		X
Y	I	[illegible]	25	?	X	X	Prov															X								1		X
[illegible]	I	[illegible]				XX	yes															X		XX						[illegible]	X	

OFFICE COPY
Attachment

DEPARTMENT OF HEALTH AND ENVIRONMENT

Topeka, Kansas

September 13, 1976

M E M O R A N D U M

TO: Dwight F. Metzler, Secretary

FROM: Joe M. Marshall, Hearing Officer

SUBJECT: Report on Hearing on Proposed Rules and Regulations for the Licensure of Adult Care Homes (28-33-1 through 22, 28-39-30 through 50, 28-39-60 through 75, and 28-39-90).

This hearing began at approximately 11:00 A.M. on September 8, 1976, in the auditorium at the Topeka-Shawnee County Health Department, 1615 West Eighth Street, Topeka, Kansas. There was a total of 123 persons in attendance. Representing the Kansas Department of Health and Environment were Dr. Lowell Wiese, Dr. James Mankin, Mr. Richard Swanson, and Mrs. Patricia Casper.

Several statements were presented orally and/or in writing, many questions were asked, and many comments were made. If there was one main theme of the comments and questions received, it was that the adult care homes would be glad to provide almost any required additional services if they knew that those additional services would be paid for. A recurring question was whether we felt that the Department of Social and Rehabilitation Services would increase their payments to cover the additional costs of new requirements (training for aids, etc.). One Adult Care Home Administrator who is also a C.P.A. supplied detailed cost estimates of those additional requirements.

I have listened to the comments made by various interested persons appearing at the hearing and I have reviewed the suggestions offered by representatives of the various groups who met with department staff prior to the hearing. Accordingly, I submit the following recommendations regarding the proposed adult care home regulations as they appear in the draft dated August 12, 1976 and the amended sections dated August 17, 1976.

I recommend that all changes, additions, or modifications to these regulations resulting from meetings with providers

and staff, as described on the attached sheets 1 through 6 and as coded "A", be adopted. I also recommend that those changes coded "C" not be adopted. On sheets 7 through 9 I have made specific recommendations regarding those items coded "B" as well as additional recommendations that resulted from the various comments during the hearing itself. I have not attempted to comment on "housekeeping" changes to clear up inconsistencies, etc. These were noted by staff and will be dealt with accordingly.

I recognize that third party payment may be a controversial element in the adoption and enforcement of some aspects of these regulations. However, it must be kept in mind that the Department as the licensing agency has a primary responsibility to the resident as mandated under K.S.A. 39-924.

Attached at the back of this report is a 4-page booklet containing a resume of comments made by persons who attended the hearing. Clipped to that booklet are written statements submitted to the Hearing Officer at the time of the hearing.

Jack M. Marshall
Hearing Officer

JMM:jla

Attachments

A 1 (Q) and 30 (P)

The definition of full time changed to "a work week of not less than 30 hours."

A 3 (N) and 33 (N)

The first sentence amended to read: "All incoming mail shall be promptly delivered to the resident intact and unopened unless contra-indicated by the resident's physician in writing for medical reasons."

A 18 and 46 (A)(1)(h)

First sentence amended to read: "Visual privacy shall be provided for each resident in multi-bed rooms with permanently mounted ceiling hangers and curtains or free-standing folding screens."

A 18 and 46 (A)(2)(c)

Delete requirement for nurse's locker room and lounge.

A 18 and 46 (A)(2)(e)

Delete requirement for sterilizer in each nursing unit; require at least one sterilizer in each facility unless sterile disposables are used or there is an agreement with a licensed medical facility for sterilization service.

A 19 and 47 (A)(23)

Sentence amended to read: "Paper towel dispenser and waste receptacles shall be provided at all handwashing fixtures except those located in resident care areas."

B 18 and 46 (K)(2)(o)

Delete requirement for self-dispensing icemaking facilities.

A 18 and 46 (L)(1)(f)

Sentence amended to read: "Laundry rooms shall not open onto nursing unit."

A 6 (L)(1)(b) and 40 (E)(1)(b)

Sentence amended to read: "The administrator shall be responsible to see that . . . is functioning correctly."

A 30 (S)

Change definition to read: ". . . a person who is licensed to practice practical nursing in Kansas under the Nurse Practice Act."

A 1 (DD)

Change definition to read: "Resident - any person admitted to an adult care home for observation, treatment, or care of illness, disease, injury, or other dependency."

A 1 (K) and 30 (K)

Amend definition of dietitian to read: ". . . a person who has received . . . approved by the American Dietetic Association and is a registered dietitian or is registration eligible, pending successful completion of the examination within a period of one year."

A 1 (V) and 30 (W)

Amend definition to read: ". . . any unlicensed person who has satisfactorily completed a state-approved training program in medication administration."

A 1 (X) and 30 (Y)

Amend definition to read: ". . . any unlicensed person who has satisfactorily completed a state-approved training program for nursing home aides."

A 6 (K)(1)(a) and 40 (D)(1)(a)

Amend to read: "All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall complete a . . . to continue employment."

C 1 (EE) and 30 (FF)

Add following to definition: ". . . or; has satisfactorily completed the Kansas Activity Director's Program."

A 2 (A)(5) and 31 (A)(5)

Amend first sentence to read: "Two copies of final plans and specifications will be submitted to the licensing agency and approval to commence construction will be granted upon review of these documents according to a prearranged time schedule."

A 2 (G)(2) and 31 (G)(2)

Amend first sentence to read: "A notification of a change of administrator received during the term of the license shall be accompanied by a fee of fifteen dollars ($15.00).

A 3 (A)(1)(a) and 33 (A)(1)(a)

Amend sentence to read: "The health care, safety, social, psychological, and self-esteem needs of the resident."

A 3 (B) and 33 (B)

Amend section as follows:

(1) The facility shall have an advisory committee consisting of a physician, a nurse, a religious advisor, and other local citizens who will give advice and counsel to the administrator on matters of resident and community interest.

(2) The committee shall meet as often as necessary but not less than once every six months. Minutes of each meeting shall be kept on file in the facility.

A 3 (E) and 33 (E)

Add the following as (5): "The facility shall not accept or shall discharge a resident requiring, according to attending physician's orders, the services of an unavailable qualified consultant."

C 6 (A)(3)

Amend the sentence to read: "Licensed nursing personnel shall be required for all tours of duty."

C 40 (B)(1)

Amend the sentence to read: "Licensed nursing personnel shall be required during the day tour of duty."

B 6 (A)(7)

Amend the sentence to read: "Resident care provided by resident care personnel shall be a minimum average of 2.0 hours per resident per 24 hours. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation."

B 40 (B)(2)

Amend the sentence to read: "Resident care provided by resident care personnel shall be a minimum average of 1.75 hours per resident per 24 hours. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation."

C 6 (A)(6) and 40 (B)(4)

The paragraph shall be amended to read: "The licensing agency, after consultation with the administrator and selected members of the advisory committee to include the health professions membership, may require an increase . . . of the residents."

A 3 (F)(4) and 33 (F)(4)

Amend first sentence to read: "Upon admission or within 48 hours of admission, referral information must be made available."

C 42 (A)(2)

Amend the first sentence to read: ". . . at least quarterly on methods . . ."

C 42 (B)(2)(h)

Amend the sentence to read: "The brand name or corresponding generic name and the distributor's name and the strength unless otherwise specified by the prescriber."

A 14 (A)(1) and 43 (A)(1)

The following shall be added as a third sentence: "All resident records shall be the property of the facility."

A 43 (D)(2)

Omit the following: "In a skilled nursing home."

A 43 (E)

Change all references of "nurse's" to "nursing."

A 17 (B)(2) and 45 (B)(2)

Amend the sentence to read: "A record shall be maintained of each fire drill to include date and number of residents and employees participating in the drill."

A 3 (F)(7) and 33 (F)(7)

Amend first sentence to read: "A resident who becomes mentally disturbed or whose social or medical condition changes after admission and who may . . ."

C 3 (F)(9) and 33 (F)(9)

Change the paragraph to read in part: ". . . in the opinion of the attending physician or the administrator . . ." and "The physician or the administrator must document . . ."

B 3 (J)(23) and 33 (J)(23)

Omit this requirement since it conflicts with the ability to provide "unit dose" medication system.

A 4 (A)(10)

Change the sentence to read: "Every resident's total program of care (including medications and treatments) shall be reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the resident."

C 6 (K)(1) and 40 (D)(1)

The following shall replace (a) and (b) and will appear under "(1) Education":

> All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, at the time of being employed, be enrolled in an educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of employment and produce evidence of satisfactorily completing the course of instruction."

A 18 (K)(2)(j) and 46 (K)(2)(j)

Delete words "and storage areas."

A 21 (E)(2)(e) and 49 (E)(2)(e)

Delete the requirement for bedpan flushing devices.

A 2 (B)(3) and 31 (B)(3)

The following shall be a second sentence to this section: "All facilities holding a current license on December 31, 1976, and found to be in compliance with the requirements of the applicable fire safety standards and the American National Standards Institute as they relate to the physically handicapped shall be permanently waivered from compliance with changes in physical plant requirements contained in these regulations if they do not adversely affect in a substantial way the health and safety of the residents."

28-39-6 (K)(1)(a) and 28-39-40 (D)(3)(a)

Delete the following paragraph:

(a) All nursing home aides employed in skilled nursing homes shall complete a program of education, approved by the Department of Health and Environment, on or before July 1, 1978 or shall within 30 days following employment be enrolled in the next available course and shall complete the program in order to continue employment.

Substitute the following paragraph:

(a) All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, within 30 days following employment, be enrolled in the next available educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of beginning the course and produce evidence of satisfactorily completing the course instruction.

28-39-6 (A)(7)

Delete the sentence which reads:

(7) Nursing home aide care for each 24-hour period for each resident shall be a minimum of 2.0 hours.

Substitute the following:

(7) Direct individual resident care provided by resident care personnel shall be a minimum average of 2.0 hours per resident per 24-hour period. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation.

28-39-40 (B)(2)

Delete the sentence which reads:

(2) Nursing home aide care for each 24-hour period for each resident shall be a minimum of 1.75 hours.

Substitute the following:

(2) Direct individual resident care provided by resident care personnel shall be a minimum average of 1.75 hours per resident per 24-hour period. Resident care personnel shall not include employees whose primary duties are administration, dietary, housekeeping, maintenance, or consultation.

28-39-3 (J)(23) and 28-39-33 (J)(23)

Delete this sentence which reads:

(23) The resident shall have the right to choose his own pharmacy for purchase of medications and where other goods and services for that individual's personal use are to be purchased.

Substitute the following:

(23) The resident shall have the right to choose his own pharmacy where goods and services for personal use are purchased except for prescription medications when the facility provides a "unit dose" or similar medication distribution system.

28-39-40 (B)(1)

Delete the following sentence:

(1) Licensed nursing personnel shall be required during the day tour of each nursing unit.

Substitute the following:

(1) There shall be licensed nursing personnel on duty at each nursing unit during the day tour of duty and a designated "charge person" on duty at all other times.

28-39-3 (P)

Add the following paragraph to this section:

(P) All current regulations under Nursing Services relating to personal hygiene, rehabilitative nursing care, and supervision of resident nutrition shall be posted in a conspicuous location in the facility where they can be observed by both residents and visitors.

28-39-33 (P)

Add the following paragraph to this section:

(P) All current regulations under the section entitled HEALTH SERVICES relating to personal hygiene and the entire section entitled REHABILITATIVE SERVICES shall be posted in a conspicuous location in the facility where they can be observed by both residents and visitors.

PUBLIC HEARING - ADULT CARE HOME LICENSING REGULATIONS

September 8, 1976
Topeka-Shawnee County Department of Health Auditorium

The following is a resume of comments made by persons who attended the hearing. Participants may have commented at various times but their remarks are combined under their name and address.

William Tevington, Kansas City

He submitted a written statement regarding the increase in labor costs and building construction costs that would occur if ICF standards were adopted. He also suggested that regulations allow waiver of new construction requirements if final plans and specifications were approved prior to December 31, 1976.

Clarence Madsen, Hiawatha

He was not familiar with aide training requirements and asked for clarification. No changes were suggested.

Marge Gehring

She questioned the type of exam for experienced aides to "quiz out" and suggested that there be continuing education requirements for aides who become certified, similar to present requirements for RNs and LPNs.

Jeannine Grubbs, Topeka

She questioned the need to make any time requirements regarding physician visits to the facility and suggested that any reference to time frames be deleted and the words "as necessary" substituted.

Marian Weaver, Osawatomie

She suggested that the requirement for an advisory committee is a duplication of effort of "utilization review" committee and should be deleted.

Wes Worthington, Mound City

He questioned whether the state was fully aware that the proposed regulations would increase the cost of resident care and would the Department of Social and Rehabilitation Services be willing to increase Medicaid reimbursement to meet these costs. He also questioned the proposed requirement that the surveyor be given the authority to require an increase in resident care staff if the situation warrants.

Ross Martin, Topeka

He suggested that a definite time frame be included in the regulations for the approval of plans and specifications for proposed projects. He was willing, however, to accept the words "according to a prearranged time schedule" as being satisfactory.

Ferrill Williamson, Wichita

He reiterated the cost impact of the proposed regulations that was brought up by Mr. Worthington.

Jesse Branson, Lawrence

She submitted written recommendations as representing Kansans for Improvement of Nursing Homes. These recommendations are attached. She described the recommendations and put particular emphasis on the following:

(a) KINH suggests that only geriatric mentally retarded persons be admitted to nursing homes.

(b) KINH requests that all deficiencies found by state surveyors be published in a local newspaper.

(c) KINH requests that all rules and regulations relating to resident care be conspiciously posted in the nursing home.

Larry Fischer, Coffeyville

He submitted a written statement regarding the increase in employee costs if health care personnel-resident ratios are adopted and the increase in construction costs if proposed environmental standards are adopted. These written comments are attached.

Thomas C. Wentz, Newton

He supported staff recommendation to include in the designated responsibility of the home "social, psychological, and self-esteem needs of the resident." He questioned the method to be followed by the state in evaluating homes such as his (Presbyterian Manors) which provide various levels of care.

Shirley Edgerton, Eskridge

She submitted a written statement which is attached. In general, her statement suggests the following:

(a) The ICF have a "director of nursing" instead of a "health services supervisor."

(b) The ICF have an RN consultant for eight hours per week in lieu of four hours per week as proposed in regulations when health services supervisor is an LPN.

(c) She suggests ratios to be "health care personnel" instead of just "aides." The inclusion of aides would discourage use of licensed persons.

Kay Kent, Lawrence

She submitted a written statement which is attached. These comments consist primarily of "housekeeping" language, suggestions for clarification of terms, etc. There are no suggestions of fundamental additions or modification.

Petey Cerf, Lawrence

She requested a clear definition of "nurse aide" and that it be required that the nurse aide confine her duties to resident care.

Andrew Johnson, Madison

He suggested that resident's mail be withheld and opened if permission is granted by resident's guardian.

Henry Steinhaus, Prairie Village

He made an oral presentation regarding nursing homes and their ability to meet their responsibility in caring for their residents. The remarks were made to suggest that licensing standards should not set ratios between resident care personnel and residents.

Marion Ewert, Newton

He requested a clarification regarding staff opposition to changes requested by providers in aide training requirements. A discussion with Dr. Wiese resulted in staff approval of change when a minor change of language was made. He also suggested that laundry water temperature requirement be lowered from 180°F. to 160°F. to accommodate no-iron fabrics.

Charles Wurth, Wichita

He made comments regarding the apparent problems connected with the method of training aides as proposed by the Department of Education. He commented on excessive turnover in employment and the possibility of numerous aides being absent from duty during training, etc. He also suggested a further change in wording of aide training requirement that was acceptable to Dr. Wiese. Later he inquired if regulations were contemplated for facilities for the mentally retarded. Staff answered that such regulations were not being proposed.

Stu Entz, Topeka

He continued discussion of wording of aide training requirement which resulted in proposing the following:

6 (K)(1), 40 (D)(1), and 65 (B)(2)(a)

All unlicensed employees who provide direct individual care to residents exclusively or in addition to other duties shall, within 30 days following employment, be enrolled in the next available educational program approved by the Kansas Department of Health and Environment and which shall be conducted in a location by an instructor acceptable to the Kansas Department of Education in order to insure that the aides are capable of rendering high quality nursing care to residents. This training program shall include both didactical and clinical instruction. Each newly employed aide shall complete this course within six months of the date of beginning the course and produce evidence of satisfactorily completing the course instruction.

He also asked if all environmental requirements would be the same for Residential Care Facilities as for Intermediate Care Facilities. Staff answer was "yes." He also expressed publicly appreciation to the Department for the opportunity of all concerned to have the opportunity to review and comment on the proposed regulations.

Harold D. Martin, Mulvane

He asked if the regulations were designed to provide any difference in requirements between a small nursing home (he has a 23-bed facility) and a large home. Staff responded that requirements were the same regardless of capacity.

Attachment

Kansans for Improvement of Nursing Homes

September 22, 1976

SUGGESTIONS FOR RAISING THE LEVEL OF CARE IN KANSAS NURSING HOMES

KINH suggests that raising the level of care in adult care homes (nursing homes) can be effected by:

I. Action by the Legislature
   - A. Establishment of a system of fines for violations of KDHE
   - B. Outlawing Provisional Licenses for nursing homes with deficiencies.

II. Action by the Kansas Medical Society
   Establishment of a plan to insure adequate medical supervision for all nursing home residents.

III. Action by the Kansas Department of Health and Environment to Eliminate Tilt Towards the Nursing Home Industry.
   - A. By adopting KINH suggestions for changes in proposed regulations (see Branson critique of July 13, 1976)
   - B. By informing the news media about violations, naming the offending nursing homes.
   - C. By making licensure reports available to the public in compliance with the law.
   - D. By improving communication with local health departments and improving enforcement of regulations.
   - E. By appointing a qualified health professional whose sole responsibility would be supervision of adult care program.

I. Action by the Legislature

A. Establishment of a system of fines for violation of KDHE regulations. KINH suggests that the Legislature establish a system of graduated fines for violations of KDHE regulations. The importance of such a system to the level of care in nursing homes cannot be exaggerated, as at present KDHE has no tool to compel compliance with regulations other than revocation of the home's license. Because a nursing home cannot be built without a Certificate of Need, precluding any competition in the area, it is generally impossible to find beds for displaced residents without sending them out of county, should a home's license be revoked. Naturally, authorities are reluctant to revoke the license. KINH supports a system of fines as a most necessary tool.

B. Outlawing Provisional Licenses. At present, a nursing home with serious deficiencies may be given a provisional license by KDHE, two concurrent provisional licenses being the limit allowed. KINH feels that provisional licenses encourage substandard conditions. We suggest that they be discontinued, as it is clearly not in the residents' interests to

live under substandard conditions which may endure for as long as a year.

KINH finds no valid excuse for a nursing home to permit substandard conditions. Industry spokesmen may imply that deficiencies cannot be remedied because of the expense involved, but available evidence does not support this contention. (See below: Elimination of tilt towards the nursing home industry.)

II. Action by the Kansas Medical Society.

Establishment of a plan to insure adequate medical supervision for all Kansas nursing home residents. Improving the level of care in Kansas nursing homes calls for a definitive plan of action by the Kansas Medical Society; a plan which is long overdue. The gross lack of medical supervision in nursing homes is both shocking and inexcusable.

III. Action by the Kansas Department of Health and Environment to Eliminate Tilt Towards the Nursing Home Industry.

KINH finds that all available evidence indicates a healthy financial picture for the nursing home industry.

First, it is not difficult for the owner to spend less per day on each resident than the fee charged per day. In a fifty bed home, saving a dollar a day per resident (the average fee charged being twelve dollars a day) would mean fifteen hundred dollars a month net profit.

Second, the owner may utilize to his advantage the cash flow resulting from the depreciation allowance, and I quote from Dr. David Shulman's "Reorganizing the Nursing Home Industry", section on depreciation and cash flow: "As long as the depreciation is larger than the amortization of principal, the nursing home is generating cash flow in excess of net income. Cash flow can thus be positive even while net income may be negative . . . . our typical nursing home bed generates cash at the rate of 29 cents per dollar of investment. This is considered a very high return in both real estate and non-real estate circles. This high return accounts for the large amount of capital attracted to the industry and thus for the industry's growth."

Third, nursing home ownership may hold interests in the companies from which it obtains goods and services for the homes it controls. The mark-up on these goods and services when sold to the nursing home may be considerably inflated, and may therefor provide another very substantial source of profits to the owners.

It is interesting to note that at least one of the three largest nursing home corporations in Kansas has increased its profits by over forty percent in the last year.

Therefore, KINH finds no reason to tailor the regulations to the industry's demands for fear the industry will wither on the vine. We suggest that KDHE tilt towards the twenty-three thousand nursing home residents who are in need of improved care, and towards all Kansans.

A. By adopting KINH suggestions for changes in proposed regulations (See Branson critique of July 13, 1976)

At the KDHE public hearing on the proposed regulations on September 8th, Mrs. Branson read a KINH statement which summarized suggestions KINH has made in the interests of nursing home residents. To date, KINH suggestions have been ignored, with perhaps one or two minor exceptions, whereas the industry's suggestions have been given much attention by KDHE.

KINH asks: why this tilt towards the industry?

Assuming it is appropriate to ask those who are being regulated for suggestions on the regulations (an assumption some might be reluctant to make), surely consumers' suggestions should carry more weight than the industry's.

The KINH statement of September 8th includes suggestions for:

1) Eliminating the use of ambiguous language to make enforcement possible.
2) Not allowing the admission of non-geriatric, mentally handicapped persons to homes which house geriatric residents (except under carefully stipulated conditions.)
3) Employing the ratio for nursing aide time per resident recommended in the recent Mid-America Health Systems Agency's report.
4) Requiring a "Charge Person" for Intermediate Care Facilities.
5) Not permitting co-administrators, and stipulating the amount of time the administrator is allowed to be away from the home.
6) Posting selected regulations on residents' rights and care, along with the request that observers of violations notify the local health department; name, address and phone number of the department being supplied.

This statement of September 8th summarizes suggestions KINH has made many times over since January, 1976. We have received no communication from KDHE about our suggestions. However, KDHE has held several conferences with the industry and has embodied many of their suggestions in the proposed new regulations.

KINH asks: why this tilt towards the industry?

B. By informing the news media about violations, naming the offending nursing homes. As well as our request to post KDHE regulations, KINH has suggested repeatedly to KDHE that the news media be informed of nursing homes with violations. Posting the regulations on nursing home walls and releasing information to the media call for little, if any, funding; and would be most effective in raising the level of care in nursing homes. And the thick cloak of secrecy which the industry maintains over substandard care homes would be partially lifted, to the benefit of all Kansans.

Because KINH has had no response from KDHE on these two suggested procedures, Mr. Richard Swanson was asked at the September 8th hearing if he knew of any reason why they should not be adopted. His answer was: "It is sensitive."

Again, KINH asks: why this tilt towards the nursing home industry?

How can members of the public make an intelligent and informed choice between nursing homes if they are kept in the dark about violations? And how can nursing home residents and their families learn of the regulations so important to their welfare unless they are posted in the nursing home? And how can they know where to register complaints unless this information is posted?

Why should Kansans kow-tow to the nursing home industry?

C. By making licensure reports available to the public in compliance with the law. Mr. Swanson tells us that of the ninety local health departments in Kansas, thirty-six participate in the KDHE adult care home program.

During the summer months, Mrs. Nehring undertook for KINH a study of these participating local health departments, visiting thirty-two of the thirty-six; in each case, she interviewed either the public health nurse supervising the nursing home inspection program, or the nurse who actually functions in the program. She divided her study into two parts. The first part addressed the impact on local health departments of Senator Booth's bill which was passed into law by the 1975 Legislature. The intent of this bill is to make available to members of the public all filed reports relating to the licensure of adult care homes, particularly the names of the care homes mentioned in the reports.

KINH discovered several months ago that these reports were seldom available to the public and we wrote Mr. Metzler about it. He replied, and I quote from his letter dated June 14, 1976: "In response to your request about KSA 39-934, we did notify the local health departments that have licensure reports in their files that they were obligated to make their contents available to the public."

But Mrs. Nehring was able to see copies of the licensure reports in only ten of the thirty-two participating departments. The fact that KDHE has failed to make all licensure reports available to the public is not in compliance with the law; and this failure is most helpful in maintaining the cloak of secrecy over substandard nursing homes. KINH asks: why this tilt towards the nursing home industry?

We have been discussing the thirty-six "participating" health departments. KINH feels that the intent of Senator Booth's bill is to make filed reports available to the public in every one of the ninety local health departments, not just in thirty-six. Therefore KINH has requested KDHE to see that this be done. Mr. Metzler replied (and I quote from his letter of June 14th, 1976): "It did not seem necessary to notify those departments that have no such information. We are most willing to have this information available to interested persons and will do what we can to see that it is placed in a strategic location."

It seems that KDHE did not find the fifty-five other local health departments strategic locations, as the licensure reports are not available there; nor have these departments received any word from KDHE about the change in the law effected by Senator Booth's bill.

Again, KINH asks: why this tilt towards the nursing home industry?

D. By improving communication with local health departments and improving enforcement of regulations. The second part of Mrs. Nehring's study addressed itself to assessing the authority and responsibilities of local health departments.

KDHE spokesmen have emphasized the importance of working with local health departments to the nursing home program. I quote from Mr. Swanson's memo of January 12, 1976, directed to "All County Health Officers, Nurses, and Sanitarians: . . . It has long been the policy of the state licensing agency to encourage the active participation of local health departments in the licensure program. We feel that the most productive approach toward maintaining the 'day to day' success of a facility in meeting licensure standards is through the involvement of the local health department. Local nurses and sanitarians can work more effectively in their own communities than can state surveyors based miles away."

But Mrs. Nehring's study shows that of the thirty-six participating health departments, few are involved in the licensure program. Many of the nurses in these departments did not know the difference between licensure and certification. They told Mrs. Nehring that they had received no direction from KDHE and have no idea what is required of them.

KINH asks: why not?

Enforcement problems. According to Mrs. Nehring's study, eighteen of the participating local health departments reported serious deficiencies in nursing homes, and requested help from KDHE. Three departments received support and cooperation from KDHE. Fifteen did not. A typical comment made to Mrs. Nehring was: "A short time ago we were having severe problems with nursing homes; I received no help, nor even any response from the State Health Department."

KINH asks: why not?

Because Mrs. Nehring's study covered only participating health departments, KINH made a test call to Dr. Terry Hunsberger, the Health Officer of Finney County, a non-participating county. We asked him for his experiences with KDHE and the nursing home program. Dr. Hunsberger has strong feelings on the subject, and we have his permission to quote him: "In one home, the stink knocks you down when you go in there. The patients in wheelchairs look like they are going to fall out. There is no one to assist in feeding." Dr. Hunsberger complained of the many violations observed in this home to the area state surveyor many months ago, specifically asking for feedback. He got none. Dr. Hunsberger says he is fed up, and he wants to know why no one is doing anything about this home.

So does KINH.

E. By appointing a qualified health professional whose sole responsibility would be supervision of adult care program. KINH feels that all available evidence indicates little communication between KDHE and local health departments, in spite of Mr. Swanson's assessment of its importance. Because we agree with Mr. Swanson about the importance of such communication to the level of care in nursing homes, KINH repeats the request for the appointment of a qualified health professional to supervise the nursing home program across the state. KINH believes this is obviously a full time job. It may cost money, but KINH thinks that Kansans deserve the best.

It's time for KDHE to tilt towards Kansans, and towards the twenty-three thousand nursing home residents.

Attachment 2

FC 15
520-

To Ms. Emalene Correll, Res h
Associate, Room 545, State
House

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MEMORANDUM

FROM: Dr. Robert C. Harder, Secretary RCH

RE: Special committee on Public Health and Welfare meeting, September 22, 1976

DATE: September 24, 1976

This is in response to your request for material presented at the referenced meeting.

1. PERIODIC MEDICAL REVIEWS

Periodic Medical Reviews presently conducted by the Medical Services Section staff are a short notice inspection of the quality of care provided to Medicaid recipients. These inspections are performed at least annually in all nursing homes participating in the Medicaid Program. Distribution of the inspection results is to the local Social and Rehabilitation offices in which the facility is located, Area Social and Rehabilitation office, the facility, the Utilization Review Committee for the facility and the State Department of Health and Environment. The local office provides follow up on the deficiencies identified during the Periodic Medical Review inspection within 30-45 days of the receipt of inspection results. These Periodic Medical Inspection teams consist of one Registered Nurse, one Social Worker and in all skilled facilities a physician position. The physician services are on call if required during inspections of Intermediate Care facilities.

2. UTILIZATION REVIEW

Federal regulations require that each nursing home participating in the Title XIX program conduct a Periodic Utilization Review. The periodicity of the review is: Intermediate Care Facility, at least every six months. Skilled facility every 30 days for the first 90 days thereafter. Utilization Reviews are conducted by one or more physicians with Registered Nurse support. The object of Utilization Reviews is to insure that the patient is receiving the proper level of care consistent with his physical condition.

3. EDUCATIONAL SEMINAR--COST-RELATED REIMBURSEMENT

The Department of Social and Rehabilitation recognizes the need for proper utilization of cost studies by nursing home facilities to insure proper reimbursement rates established consistent with reasonable cost expenditures by the facility. Along these lines, the Department of Social and Rehabilitation Services intends to contract for an educational seminar to be provided to the nursing home industry through the state at the department's expense. This effort is being planned for the early calendar year 1977.

4. LIMIT ADJUSTMENT FOR THE HEALTH CARE COST CENTER

The department, having recognized the efforts of the State Department of Health and Environment to improve the quality of care provided in nursing homes, is in the process of evaluating raising the present percentile limitation on the health care cost center within the department's cost related reimbursement system. To date a budgetary impact of such action has not been developed.

5. MEDICAL SERVICES STAFF INCREASE

Effective with Fiscal Year 1977, July 1, 1976, the Medical Services Section was allowed to increase their medical review staff by 13 additional reviewers. It is projected that this additional staff, the Medical Services Section will be able to provide more consultation to the nursing homes during the inspections and follow-up when it is deemed appropriate by the team. The department has already received several letters from nursing homes expressing appreciation for the effort of the teams in providing assistance during inspections.

6. CERTIFICATE PROGRAM

The Department of Social and Rehabilitation Services has developed a program of a certificate to be delivered to a Nursing Home Facility that will be available for Public Display and will attest to their certification within the Kansas Medical Assistance Program. This program will become active as rapidly as the materials can be procured and will be a function of the Medical Services Section.

7. STAFFING RATIOS

The new Health and Environment rules and regulations include staffing ratios of Health Care personnel per patient at the following levels.

ICF - 1.75 hrs/patient day

SNF - 2.0 hrs/patient day

It appears that approximately 181 of the ICF's and 8 of the SNF's would need to add approximately 8 minutes/patient day of Health Care personnel to meet these ratios. This eight minutes equates to 30¢ per hour at the current minimum wage and a first year fiscal impact to the Nursing Home industry is estimated to be $2,450,000 and the state's share of that impact is estimated at $1,320,000.

(The computation of $5,000,000 for Mrs. Cerf's $1.30 per patient day proposal was reached by $1.30 x 10,700 patients x 365 days.)

cc: Senator Sowers
Mr. Dwight Metzler
Dr. Lowell Wiese

Attachment D

TITLE XX PROGRAM

We support the rehabilitative objectives of the Title XX Program. However, we are concerned about the Department of Social and Rehabilitative Services (State Welfare Department) using sub-standard housing facilities as Boarding Homes under the Title XX Program. (Some of these facilities were nursing homes that no longer meet licensure standards.) As one HEW official put it, "These places are unfit to be lived in and some are firetraps".

We have recommended that the licensure and inspection of Title XX Boarding Homes (Certified Adult Residential Homes) be under the Department of Health and Environment, Adult Care Home Section. We feel that this is necessary to assure the Title XX recipients sanitary living standards and adequate fire safety standards.

We furthermore recommend that all nursing homes licensed by the Department of Health and Environment Adult Care Home Section, be permitted to provide services for recipients of Title XX funds and Supplemental Security income.

Attachment E F

NURSE AIDE TRAINING
Bethel Home for Aged
Newton, Kansas

September 23, 1976

Cost of training nurse aides as required by the proposed rules and regulations for licensure of adult care homes

72 residents - Average occupancy January-June, 1976 - All residents in home

63 residents - Average occupancy January-June, 1976 - Residents receiving nursing care

21.1 - Nurse aide staffing full-time equivalent (FTE)
2.0 - LPN staffing FTE
2.6 - RN staffing FTE (Excluding full-time director)
25.7 - Total nurses on staff FTE

2.06 - Total nurse hours per resident per day

Cost of personnel giving nursing care, excluding director

Wages $6.53 per res/day - All 72 residents
$7.46 per res/day - 63 nursing care residents

Wages plus employee benefits* (Benefits = 15 percent of wages)
$7.50 per res/day - All 72 residents
$8.58 per res/day - 63 nursing care residents

*Health insurance, unemployment insurance, workmen's compensation, pension, etc.

Cost of mandatory nurse aide education

33 nurse aides employed = 21 nurse aides FTE
62.5 percent turnover rate = 54 nurse aides annually
$2.51 per hours = nurse aide current average wage
5 percent = projected cost of living increase in wage rate January 1, 1977, and January 1, 1978
15 percent = employee benefits
$3.04 per hour = projected 1977 nurse aide wage including benefits
$3.19 per hour = projected 1978 nurse aide wage including benefits
$3.35 per hour = projected 1979 nurse aide wage including benefits

$10,397 = Cost in 1977. 70 percent of 54 aides = 38 aides
X 90 hours in course = 3,420 hours
X $3.04 = $10,397.

$ 4,594 = Cost in 1978. 30 percent of 54 aides = 16 aides
X 90 hours in course = 1,440 hours
X $3.19 = $4,594.

$ 3,015 = Cost in 1979. 21 new aides due to turnover. Assume that 11 have completed nurse aide course.
10 aides X 90 hours in course = 900 hours
X $3.35 = $3,015.

Average cost per resident per month for mandatory nurse aide education:

1977 - $12.03

1978 - $ 5.33

1979 - $ 3.49

The above computation does not take into consideration tuition charges, the cost of books, transportation to and from the learning site, and other costs of this nature.

Attachment A 6

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

(P.L. 93-641)

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) was signed into law by President Gerald F. Ford on January 4, 1975. This new federal law, considered by many as the most important single piece of health legislation enacted by Congress in recent years, has vast potential for restructuring the health services delivery system in the United States. The Act was developed in Congress following two years of intensive study of health planning and development activities. The Act creates a single set of structures at the state and regional levels to deal with planning, resource allocation, and regulation in the health field. Since similar activities have been carried out in the past through a variety of organizational structures, considerable realignment of the nation's health planning and development mechanisms is required.

BACKGROUND

None of the content areas in this legislation represent new or unique federal interests. It is the structure in which planning, resource allocation, and regulation will be carried out that differs. A look at the pre-1975 elements may be helpful.

In terms of state planning, four distinct and loosely-related elements had evolved by 1974. One element was state facilities planning authorized under the federal Hill-Burton legislation, first enacted in 1946. A second element was categorical health-related program planning. These included a drug abuse plan, an alcoholism plan, a public health plan, and so forth. Federal law required such plans as a condition for release and expenditure of categorical federal financial support. The third element was the state comprehensive health plan required under Section 314(a) of the Public Health Service Act. This plan was to deal with broader health issues in the state, and although other plans were to be "consistent" with it, it exercised relatively little control over resource allocation. Finally, the 1972 amendments to the Social Security Act instituted a capital expenditure review program (Section 1122) in which the state had to review and approve or disapprove proposed capital expenditures of health care institutions on the basis of "standards, criteria, and plans" adopted in the state.

Organized federally-supported planning efforts at the substate or area level have a shorter history. The first organized support of this type of activity was provided under Section 318 of the Public Health Service Act, passed in 1961. This program provided financial assistance to facility planning agencies which worked closely with the state Hill-Burton planning activities previously mentioned. Successes with the regional facilities planning agency approach led to the adoption of much broader legislation in 1966. The Partnership for Health Act created a new Section 314(b) of the Public Health Service Act, authorizing assistance for areawide comprehensive health planning. Between 1967 and 1974, more than 200 of these "(b)" agencies were established across the country. The vast majority were non-profit corporations. They brought a community's consumer and provider interests together in an effort to develop plans for the organization and operation of a variety of health programs. Although these agencies had "review and comment" responsibilities on a variety of uses of federal funds, they lacked power to secure realization of their plans. The emphasis was on process rather than product, and the planning was not sanctioned through regulatory or quasi-regulatory authority.

The history of federal programs for allocating resources to the health care delivery system has been even more varied. Beginning with formula grant and project grant activities relating to public health in the late 30's, the process was largely a federal-state or federal-institutional relationship. Although the federal-state allocations were governed by the program plans mentioned earlier, direct grants to institutions and organizations were seldom reviewed for consistency with any overall plan. The Hill-Burton program, in 1946, tied allocation of resources for facilities construction to a state plan document, and the facilities planning agencies created under Section 318 also participated in this process.

Two programs created in the late 60's and early

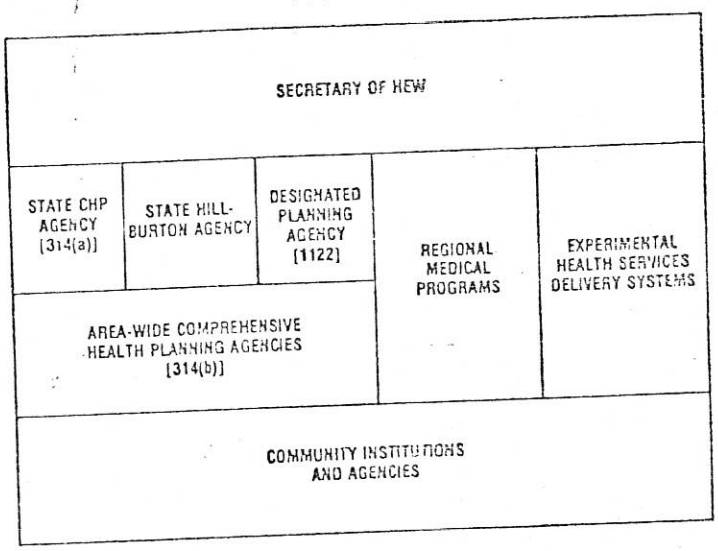
70's adopted a different model for allocating federal resources to specific health programs. The Regional Medical Programs (RMP) legislation followed the Report of the President's Commission on Heart Disease, Cancer, and Stroke, published in December 1964. Initially, the RMPs were to develop cooperative arrangements among health care institutions, medical schools, and research institutions with the goal of bringing the latest advances in treatment of health disease, cancer, and stroke directly to patients. More than 50 RMPs were established across the country, some interstate, some statewide, and others serving a region within a state. In the period between their creation in 1965, and 1974, the program emphasis shifted from specific diseases to primary care, regionalization of health care resources, and improved use of health manpower in underserved areas.

Planning and priority setting in the RMPs was vested in a regional advisory group, and ties to other planning mechanisms as a basis for allocation of the RMP financial resources were very loose. In the nine fiscal years between 1966 and 1974, more than half a billion dollars in federal developmental funds were channeled through the RMP mechanism.

In 1971, another developmental activity was launched by the federal government under the title Experimental Health Services Delivery Systems. A number of community demonstrations were funded by the federal government to assist grantees in the organization and operation of an independent management corporation for health services at the community level. These corporations performed a number of functions similar to both (b) agencies and RMPs, but with an emphasis on the collection of data and the establishment of management information systems for the health segment of the community.

By 1974, a complex of federally supported agencies and organizations, both governmental and nongovernmental, had been created to deal with health planning, health resource allocation, and regulation of the health services industry. Figure 1 graphically depicts the elements of the federally-supported structure at the end of 1973.

FIGURE 1



DEVELOPING A NEW APPROACH

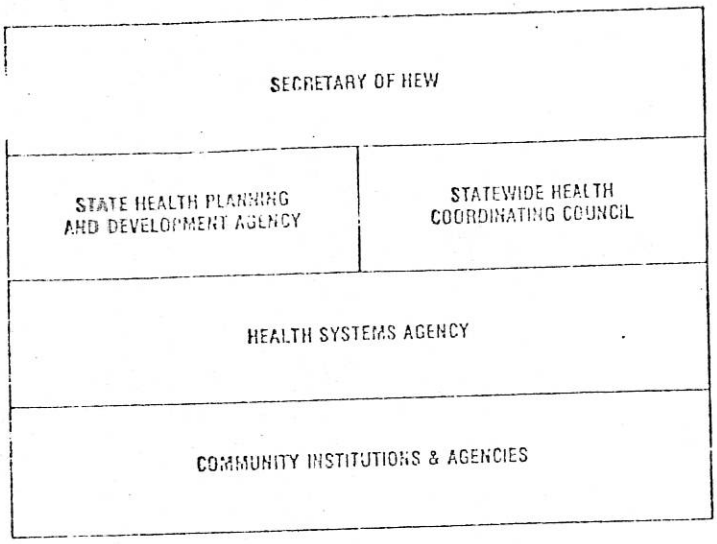
With the legislative authorities for all of these activities expiring at the same time, on June 30, 1974, Congress saw an opportunity to reexamine all of the issues of federal assistance for health planning and development activities. Their stated goal was to provide a more rational system for tying these functions together, while retaining the best features of the predecessor programs. Among the factors which the Congress considered were the following:

- Maldistribution of medical personnel and facilities in many areas of the country.
- Development of duplicative services and excessive beds in health care institutions in the absence of effective planning and control.
- Inaccessibility of health resources and lack of coordination in operation of community health institutions.
- Health care cost inflation, which Congress perceived as a result of excess capacity and inefficiency in utilization of resources.
- The imminence of enactment of national health insurance and the potential negative effect of increased demand in an inefficiently organized and operated system.

The process of developing the new legislation took nearly two years. It included consultation between congressional staffs and a variety of interest groups. Extensive hearings were held in both the House and the Senate. As a part of the developmental process, the House Commerce developed a series of principles to guide in the development of new legislation:

- Planning should be done by organizations which represent and incorporate the interests of consumers of health services, providers of the services, and concerned public and private agencies and organizations.
- In order to be effective, health planning must be adequately financed.

FIGURE 2

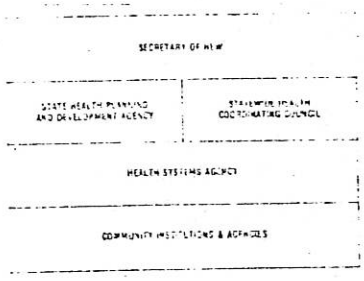


— Effective planning requires a strong emphasis on the implementation of plans, and implementation requires that planning agencies have authority with which to implement the plans.
— The generation of new health resources should be closely tied to health planning.
— If health planning is to be done, it must be good health planning.
— Effective federal, state, and areawide health planning will be possible only if the federal government itself engages in health planning.
— If health planning is actually to improve the peoples health, it must not be limited just to planning for medical care.

It was against this background that the Congress proceeded to develop a new structural approach to health planning and development, one that has been embodied in the National Health Planning and Resources Development Act of 1974.

STRUCTURAL ELEMENTS

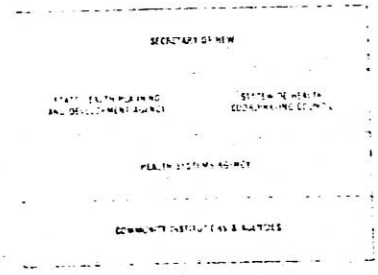
One of the easiest ways of gaining an understanding of the new law is to analyze the structure created at the federal, state, and regional levels under P.L. 93-641. The structural elements are depicted in Figure 2. The Act carefully defines each new element and describes the responsibilities of each.



Description: The Secretary of Health, Education, and Welfare is the principal federal official charged with carrying out the federal portion of P.L. 93-641. In operation, of course, the "Secretary" is represented by central administrations and bureaus of his Department, and by the ten regional offices across the country.

Functions: Among the principal functions of the Secretary in implementation of P.L. 93-641 are:

— Develops, in conjunction with a National Council on Health Planning and Development, and the various state and local agencies created under the Act, guidelines for national health planning policy.
— Establishes, after consideration of plans submitted by the Governors of the states, Health Service Areas throughout the United States.
— Issues regulations governing implementation of the Act.
— Designates Health Systems Agencies in each Health Service Area.
— Provides technical assistance to health planning and development agencies at the state and substate levels.
— Provides financial support to state and substate health planning development agencies.
— Designates state health planning and development agencies.
— Reviews health plans produced by state and substate agencies.
— Approves most federal assistance plans and project grants.

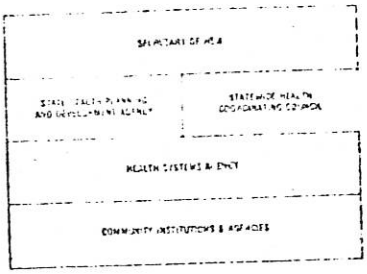


Description: The state health planning and development agency is an agency of state government designated by the Governor to carry out activities mandated by the act for such agencies, and possessing sufficient state statutory authority to do so. Some of the assigned functions may be carried out by other state agencies under agreements between the state health planning and development agency and the delegate agency subject to approval by the Secretary.

Functions: Among the functions of the state health planning and development agency are the following:

— Conducts health planning activities for a state.
— Implements or supervises the implementation of state health plans.
— Prepares a preliminary state health plan document for submission to the Coordinating Council.
— Serves as the designated planning agency for capital expenditure review under Section 1122.
— Administers a state certificate of need program.
— Reviews and makes findings concerning all new institutional health services in the state.
— Periodically reviews and determines whether or not existing institutional health services are appropriate.

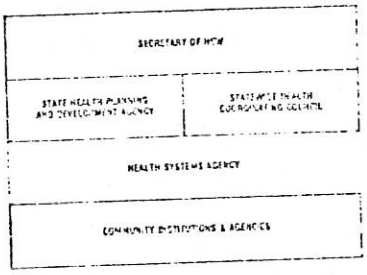
— Coordinates all health data activities in the state.
— Assists the Statewide Health Coordinating Council in its work.
— Administers federally-assisted facilities construction activities.
— Administers an optional rate review and approval program.



Description: The Statewide Health Coordinating Council is a consumer-majority council of citizens. Sixty percent of the members of the Council are selected by the Governor from among nominees of the health systems agencies in the state. The remaining 40 percent are designated directly by the Governor. The Council must have sufficient authority and resources to carry out the functions mandated by the Act.

Functions: The Statewide Health Coordinating Council carries out the following types of functions:

— Reviews and coordinates health planning activities of Health Systems Agencies.
— Prepares and approves a state health plan based on the preliminary state health plan and the Health Systems Plans of the Health Systems Agencies.
— Reviews and comments on the annual budgets of Health Systems Agencies.
— Reviews and comments on annual applications of Health Systems Agencies to the federal government.
— Advises the state health planning and development agency in its work.
— Reviews and approves all state plans and applications for funds made available to the state government under federal health legislation.



Description: The Health Systems Agency is a public agency, or a private non-profit agency, with a consumer majority board or advisory body which carries out the functions mandated for it by the Act in a defined geographic area, the health service area. The agency must maintain a professional staff of not less than five with expertise in administration, the gathering and analysis of data, health planning, and the development and use of health resources.

Functions: The health systems agency functions include the following:

PLANNING FUNCTIONS

— Assembles and analyzes data on health status and health programs in its area.
— Prepares and publishes a health systems plan (HSP) and an annual implementation plan (AIP) for its area.
— Coordinates its activities with other planning bodies in the area.

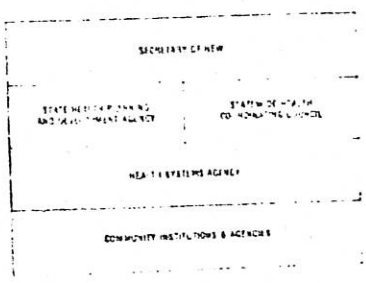
DEVELOPMENTAL FUNCTIONS

— Develops specific activities and projects which support plans.
— Implements plans through technical assistance, and through developmental grants to community agencies.
— Reviews and approves each use of federal funds in its area which support the development of health resources and services in the area.
— Recommends health facilities projects to the state for funding.

REGULATORY ACTIVITIES*

— Reviews and comments to state regulatory agencies on all capital expenditure and new service projects in area institutions.
— Periodically reviews and comments on appropriateness of all institutional health services offered in the area.

*The health systems agency is not a regulatory authority. It reviews and comments to a state regulatory agency on proposals which are subject to regulation.



Description: Community institutions and agencies represent the resources on which the activities of the other components ultimately focus. They carry out the programs which are planned, and utilize the resources which are allocated.

Functions: Among the principal activities of these agencies as they relate to the Act are the following:

— Participate in the governance of the health systems agency serving their area.
— Design and carry out developmental projects.
— Submit proposals and applications subject to review and approval to the health systems agency.

Attachment G-H

STATE OF KANSAS

PRIMARY CARE PHYSICIAN*/POPULATION RATIO

August, 1976

COUNTY	PCP/Pop	COUNTY	PCP/Pop	COUNTY	PCP/Pop
Allen	10/15,343	Greeley	1/2,122	Osborne	1/6,662
Anderson	6/8,651	Greenwood	4/9,483	Ottawa	4/6,380
Atchison	12/19,194	Hamilton	1/3,073	Pawnee	7/8,202
Barber	3/7,245	Harper	9/8,388	Phillips	4/8,386
Barton	21/34,466	Harvey	38/27,225	Pottawatomie	9/12,418
Bourbon	9/15,399	Haskell	1/3,922	Pratt	5/9,954
Brown	5/12,894	Hodgeman	2/2,747	Rawlins	2/4,568
Butler	10/37,918	Jackson	4/11,516	Reno	38/67,844
Chase	1/3,594	Jefferson	5/12,413	Republic	7/8,536
Chautauqua	5/5,130	Jewell	4/6,163	Rice	6/12,295
Cherokee	10/22,055	Johnson	185/231,943	Riley	23/38,349
Cheyenne	3/4,186	Kearny	0/3,306	Rooks	5/7,762
Clark	2/2,898	Kingman	9/10,080	Rush	1/5,405
Clay	7/10,251	Kiowa	2/4,138	Russell	5/9,901
Cloud	13/13,918	Labette	12/24,776	Saline	27/45,421
Coffey	3/8,391	Lane	1/2,904	Scott	3/6,115
Comanche	2/2,898	Leavenworth	18/47,437	Sedgwick	263/333,771
Cowley	26/34,479	Lincoln	2/4,866	Seward	8/16,386
Crawford	22/38,619	Linn	2/8,203	Shawnee	124/171,999
Decatur	1/5,269	Logan	2/3,757	Sheridan	2/3,960
Dickinson	11/23,333	Lyon	22/30,216	Sherman	5/7,980
Doniphan	5/10,266	Marion	10/15,161	Smith	2/6,862
Douglas	38/54,783	Marshall	9/14,165	Stafford	6/6,191
Edwards	3/4,576	McPherson	11/24,109	Stanton	2/2,400
Elk	2/4,175	Meade	2/5,093	Stevens	2/4,407
Ellis	15/23,581	Miami	7/20,571	Sumner	15/23,446
Ellsworth	3/7,146	Mitchell	5/8,083	Thomas	7/7,936
Finney	19/20,711	Montgomery	25/45,634	Trego	4/4,705
Ford	15/23,687	Morris	6/6,944	Wabaunsee	2/6,852
Franklin	15/20,295	Morton	3/3,692	Wallace	1/2,275
Geary	13/24,261	Nemaha	6/12,593	Washington	3/9,758
Gove	4/4,098	Neosho	15/18,531	Wichita	1/3,639
Graham	4/4,868	Ness	3/4,975	Wilson	6/13,315
Grant	4/6,622	Norton	6/7,652	Woodson	2/5,029
Gray	2/4,605	Osage	5/13,567	Wyandotte	183/189,491

*Primary Care Physicians include both M.D.'s and D.O.'s specializing in the fields of General Practice, Family Practice, Pediatrics, and Internal Medicine.

TOTAL PRIMARY CARE PHYSICIANS IN KANSAS: 1,546
TOTAL POPULATION OF KANSAS: 2,277,905

60.3%

PRIMARY CARE PHYSICIAN FACT SHEET

September, 1976

STATE	#PCP	POPULATION	RATIO
Iowa	1,506	2,869,800	1:1906
Kansas	1,546	2,277,905	1:1473
Missouri	2,573	4,763,000	1:1851
Nebraska	939	1,541,000	1:1641

Attachment H

State of Kansas . . . ROBERT F. BENNETT, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

DWIGHT F. METZLER, *Secretary*

Topeka, Kansas 66620

September 21, 1976

The Honorable W. H. "Wes" Sowers
Kansas Senate
State Capitol Building
Topeka, Kansas 66612

Dear Senator Sowers:

In response to your letter of August 31, 1976, I shall attempt to answer your three deceptively simple questions distinctly and forthrightly. First, let me reiterate the questions. Next, let me tell you why I said they are "deceptively simple" and tell you of the qualifications that must surround them. They have no simple answers. I'd like then to give you the best straightforward answers that are available for your questions.

(a) Your three questions pertain to governmental data collection efforts for health:

(1) "...whether the data being collected included meaningful information that will permit valid determination to be made as to the nature, extent of health care services in various areas in Kansas including a meaningful identification of underserved areas;"

(2) "...whether you have data which indicates whether or not our state has a crisis in respect to rendering of health care services and if so please identify and define it;"

(3) "...if on the basis of present data you can identify areas of our state that are underserved by health care provider services, please identify these and indicate the nature of the services in which there is a shortfall."

(b) The qualifications:

"Underserved" is a relative term impossible of definition. If one is in Wichita County and suffers a severe head injury, "underserved" means not having a neurosurgeon within 20 minutes availability, not having a hospital sophisticated enough to respond to the neurosurgeon's needs, not having a rapid emergency evacuation service, etc. In another context, "underserved" may mean having enough physicians but insufficient hospital beds. Again, the term may refer to

dentists, osteopaths, podiatrists, optometrists, physical therapists, nurses, public health services and a host of other factors related to total health care. The physician alone is like the airline pilot who, however skilled, is useless without an aircraft, mechanics, flight attendants, and a host of other things that make an airline run. The requirements for each of these components is not static either. Needs vary with time, economic variables, market forces, changes within the field itself, and a myriad of other factors. It is, therefore, no different from any complex industrial system. I must in candor comment that most folks think that the medical problem has to do with whether or not a town has a physician and is little more sophisticated than that. The Kansas Department of Health and Environment has patiently begun the laborious data collection that attempts to "get a handle" on each of these complex variables and their inter-relationship. I am not certain that the state of the art will allow us in the forseeable future to answer these complex problems definitively. This is not "weaseling" - it is an honest statement prompted by the fact that the Department will not promise what cannot be delivered. We will try, and we will do the best job that can be done, I will assure you of that fact. Mr. Metzler has already written you (August 4) of the kinds of efforts we are making in this regard.

(c) I can now give you some straightforward answers, but I shall limit them to the area of physician manpower, or this letter will turn into a book. If you wish more information in other areas, please tell me and I can get it for you if it is available. At the present time, based on the most recent federal data I have available, there are 29 states that have more physicians per 100,000 population than Kansas and 20 states that have fewer. Of our neighboring states, Colorado, Oklahoma, Nebraska, Missouri and Iowa, only Colorado and Missouri have more physicians per 100,000 population than has Kansas. We have no data to suggest that any of these states have any lesser urban-rural physician maldistribution problems than we have. Kansas presently has 126 physicians per 100,000 population (not including osteopaths). Approximately 34% of these are primary care physicians, that is, family practitioners, general practitioners, general internists, or general pediatricians. We have critical physician shortage areas which are defined by the federal government as an area having a primary care physician to population ratio of less than one to 4,000 in a county with a general physician to population ratio of less than one to 3,000 within the entire county in which the scarcity area is located. There are more qualifications, but that is the essence of it. On the basis of that definition and based on the most recent figures available from HEW as of December 5, 1975, our most critical shortage areas, both in physician need and in low per capita income, are:

Chautauqua	Gove	Rawlins
Cherokee	Hodgeman	Sheridan
Coffey	Nemaha	Washington
Elk		

There are also equal shortage areas in the following counties:

Allen	Edwards	Lane	Phillips
Atchison	Ellsworth	Leavenworth	Haven in Reno County
Barber	Finney	Lincoln	Rice
Brown	Franklin	Linn	Rooks
Butler	Geary	Logan	Rush
Chase	Graham	McPherson	Russell
Cheyenne	Grant	Marion	Scott
Clark	Gray	Marshall	Seward
Clay	Greeley	Meade	Sherman
Comanche	Greenwood	The Community of	Smith
Crawford	Hamilton	Lewisburg in	Stanton
Decatur	Haskell	Miami County	Stevens
Dickinson	Jackson	Montgomery	Thomas
Doniphan	Jefferson	Morton	Wabaunsee
The Haskell School	Jewell	Neosho	Wallace
Health Center	Kearny	Osage	Wichita
in Douglas	Kingman	Osborne	Wilson
County	Kiowa	Ottawa	Woodson

Of course, this fugure changes day by day with deaths, retirements, in-migration of physicians, etc. On the basis of these data, I conclude that we have no crisis in health delivery with respect to physician services more serious than that of the typical state. We seem to be right about in the middle.

On September 14, I met with the representatives of the University of Kansas Medical Center and the Wichita State University Branch* and found that they are not very far along in planning any daring solution. They have some interesting data on the ingress and egress of physicians in and out of Kansas and just what is happening to Kansas University graduates. Mr. Meredith of KUMC can give you a good report on this. Their approach is generally conservative and traditional.

I have had this letter typed in absentia while I am attending an out-of-state meeting, but I hope to be back for the committee hearings on September 23. In the meantime, if you need any further information, please contact my secretary, Mrs. Judy Stanley, at 296-7789 and we will to get you whatever you need. Best personal regards.

Respectfully yours,

Lowell M. Wiese, M.D. (js)

Lowell M. Wiese, M.D.
Director of Health

LMW:js
cc: Mr. Dwight Metzler
Dr. James Appelberry
Mr. Joe Harkins

* (Dr. Archie Dykes, Dr. Robert Kugel, Dr. Cramer Reed, Dr. James Appelberry and Mr. Glen Meredith)