Approved 3-27-90
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn Chairperson at

1:40 ~~a.m.~~/p.m. on March 20, 1990 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Charles Konigsberg, Director of Health/Department of Health/Environment
Chip Wheelen, Kanss Medical Society
Harold Riehm, Kansas Association of Osteopathic Medicine
Elizabeth Taylor, Association of Local Health Departments
John Hart, American Civil Liberties Union
Carolyn Bloom, President of Physical Therapists Association
Tom Bell, Kansas Hospital Association
Jennie Atwood, Former Instructor of Physical Therapy/Washburn University
Karla Jo Raveling, Kansas Chapter of American Physical Therapy Association
Steve Chandler, Practicing Physical Therapist, Hiawatha, Kansas
Elva Strand, Physical Therapist's Assistant, Herrington, Kansas
Dr. Darrell Newkark, Kansas Health Department, Wyandotte County, Kansas City, Kansas
Dr. Walter Crockett, representing AARP, Lawrence, Kansas

Chair called meeting to order at 1:40 when quorum was present. (House Session ran long today). He recognized Local Health Department Administrators attending meeting this date.

Chair noted there were numerous conferees today on three bills scheduled, and he asked all try to be concise, but as brief as possible. He drew attention to Hearings.

SB 529. (Reporting of AIDS information to Department of Health/Environment)

Chair asked Ms. Correll to give committee members a briefing on SB 529. She noted the bill amends three statutes that were enacted in 1987. The changes allow for HIV positive tests reporting, but reporting to be made without names. She detailed what is required in reports. She detailed provisions of the bill, noting efforts guarding against duplicative record keeping. She explained efforts to maintain strict confidentiality. Noted additional thought might need to be given to the type of information reported about an individual for whom the positive HIV test is reported. The intent of the Department of Health/Environment is to gather data on HIV positive results. She answered questions from committee members. She noted the conflict on Page 4, Section 3 is something members might wish to consider when the bill is worked.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:40 a.m./p.m. on March 20, 1990

HEARINGS BEGAN ON SB 529.

Charles Konigsberg, Director of Health/Department of Health/Environment, (Attached No. 1), noted over the last few years AIDS is viewed as a chronic disease and the need for more complete data of reporting is needed, i.e., incidence and prevalence of HIV infection in communities. More complete records are needed to monitor the spread of HIV infection. Provisions in SB 529 allow for laboratory reporting which will help to develop good sources of information, yet will protect against discrimination gainst individuals or groups with regard to employment, medical care, housing, education, transportion. Their Department is supportive of reporting HIV positives without names, feeling this measure will still allow them to gain essential data. He recommended favorable consideration. He answered questions, i.e., yes, we do offer a variety of reporting; yes, reporting is required only after a confirmed positive is determined; their staff feels if sufficient information is given it will be easy to weed out duplicative information.

Deborah Taylor, Director of AIDS program, Department of Health and Environment also answered questions.

Chip Wheelen, (Attachment No. 2) spoke to the necessity of confidentiality in reports of HIV tests. He noted their Society supports the general concept of reporting confirmed cases. It is clear that people knowing names will not be reported are encouraged to come in for testing for this virus. Confidential reporting will continue to allow those exposed to receive the benefit of counseling, this is the importance of confidentiality and anonymous testing. It is now understood that early detection can allow a person the option of taking a drug, (AZT) which can delay the onset of the AIDS virus. Because of this drug, life can be prolonged, and those persons enjoy a much better quality of life. It is the view of the physicians in regard to duplicative reporting, it is better to have some duplication than to miss some cases of HIV. He noted it is correct that SB 529 needs to be amended in line 30 to insert a comma after "health care providers", and strike "or" add a comma after "emergency personnel" and insert, "spouse or partners". He noted the term partners is not defined in the bill. He noted further, "emergency personnel" might also need to be more clearly defined in the bill in regard to the Department of Corrections.

Harold Riehm, Kansas Association of Osteopathic Medicine, (Attachment No. 3) spoke in support of SB 529, noting their Association has been consistent in urging required reporting by physicians with confirmed positive test results for HIV not to require names. He is pleased that SB 529 provides that confidentiality. He noted the concerns of Dr. Wade, (a noted physician working with the AIDS program), have already been addressed in the bill, i.e., confidentiality, and duplicative reporting. He stated their Association does concur with the amendment proposed by Chip Wheelen today. He answered questions.

Elizabeth Taylor, Association of Kansas Local Health Departments, (Attachment NO. 4), noted the primary concern of their Departments is found on Page 4, new Section 3, (b). If an amendment in fact is offered, they would support language clarifying partner to read "sexual partners or needle sharing partners". They have long supported notification of partners in order to help stop the spread of this virus. She noted further, they would not support an amendment that would restrict partners/spouses unable to disclose their condition. We would encourage partners or spouses notify on their own, but if they should not, we would want the ability in the Health Departments to make that notification. She noted further--

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:40 a.m./p.m. on March 20, 1990

HEARINGS CONTINUED ON SB 529. (Ms. Taylor continued:---)

Health Departments envision AIDS being reported and notification being given the same as for any sexually transmitted disease. It is possible to do partner follow-up and keep confidentiality in place, she said.

John Hart, representing American Civil Liberties Union, (ACLU), (Attachment No. 5) spoke in support of SB 529. One change was suggested to improve the bill. Discrimination against those who test positive for HIV or who develop AIDS with regard to employment should be prohibited. This change would encourage people to seek testing, and treatment. This provision would also prevent employers from firing infected individuals and pass along costs of their treatment to the taxpayers of this State. He suggested the bill be amended to add the word "employment" in line 22, on Page 3.

HEARINGS CLOSED ON SB 529.

SB 543.

Chair asked Ms. Correll to give members a brief explanation of SB 529. She began by noting there is a revised supplemental note available that contains corrected language. She explained the bill in full detail, noting specific provisions appear in lines 26 through 33.

Chair stressed at this time it would be necessary for all conferees to be as concise and brief as possible since there are a number of conferees to be heard on SB 543, and one other bill scheduled yet today for hearing.

HEARINGS BEGAN ON SB 543.

Carolyn Bloom, President of Ks. Physical Therapy Association (Attachment No. 6) noted shortages in rural areas of Physical Therapists. Their Association continues to work to remedy this by providing free job placement services for small rural hospitals, speaking to students on merits of rural practice. There are concerns in regard to a Certified Physical Therapist Assistant (CPTA) being allowed to provide patient care before an evaluation by a Physical Therapist (PT). She noted a CPTA is not trained in evaluation techniques. She noted changes in their industry, i.e., insurance reimbursement for the patient; addressing the problem of shortages of PT's in rural or small hospitals that do not have such services. In order to respond to a Senate Public Health sub-committee during the 1989 session, they have met numerous times with other groups trying to work out concerns. She detailed what their Association recommended. She drew attention to (Attachment No. 7) committee minutes from Senate Public Health/Welfare referring to her testimony there on SB 543. She answered questions.

Tom Bell, Kansas Hospital Association, (Attachment No. 8) noted they commend the Kansas Physical Therapy Association for introducing SB 543. This legislation will provide flexibility by allowing an initial order for a patient to be made pursuant to telephone contact, therefore many patients will receive more timely treatment. This has been a severe problem in rural areas in the past. Approval of SB 543 should solve this issue.

HEARINGS CONTINUED ON SB 543.

Harold Riehm, Executive Director, Ks. Association of Osteopathic Medicine, (Attachment No. 9) noted their support for SB 543. This has been a continued problem in parts of rural Kansas. This legislation will retain the role of the Physical Therapist approving therapy, but permits it to be done by telephone contact with the Physical Therapist's Assistant, then following up with the treatment of the patient. This compromise solution will offer more quicker treatment for patients. He commended the Kansas Physical Therapy Association for their willingness to address the problem in this manner. He answered questions.

Jennie Atwood, Physical Therapist, Topeka, Kansas (Attachment No. 10) discussed the differences in education requirements between the Physical Therapists and Physical Therapy Assistants. She drew attention then to why it is the Physical Therapist who evaluates the patient, designs the treatment program, and directs and supervises that treatment program. It is the responsibility of a Physical Therapist to determine which patients can be seen by a Physical Therapist Assistant. She stated she believes requiring the Physical Therapist to evaluate the patient, establish a plan of treatment as soon as possible with a minimum weekly review of the PTA will help to assure continued safe/quality care for Kansans.

Karla J. Raveling, Physical Therapist Assistant (Attachment No. 11) noted she practices is a small rural community and favors SB 543 because it will solve the problem of delaying treatment when the Registered Physical Therapist is not immediately available for evaluation. Secondly the bill insures supervisory relationship of the therapist over the assistant which is essential for a successful treatment program. This bill allows for greater flexibility which has been needed in the past in rural settings. She urged for favorable passage.

Steve Chandler, Physical Therapist, (Attachment No. 12) noted the hospitals he and others work in in rural areas are small (25 beds). It is possible for a Physical Therapist to visit each hospital only 2 or 3 times a week, at times causing delay in the initiation of patient care in some cases. SB 543 will address this problem by adding flexibility without endangering the traditional supervisory role of the Physical Therapist to their Assistants. He answered questions in regard to how can problem of shortages of PT's and PTA's in rural areas be addressed. He noted salary, good working environment.

Elva Strand, PTA from Harrington, Kansas, (Attachment No. 13) spoke in support of SB 543. This legislation will enable us to see our patients without delays. This is essential in acute cases. Their goal is to give the best quality of care as soon as possible to patients, and SB 543 will allow them to do so. She answered questions.

HEARINGS CLOSED ON SB 543.

SB 446.

At request of the Chairman, Ms. Correll gave a comprehensive explanation of SB 446.

HEARINGS BEGAN ON SB 446.

Dr. Darrel Newkark, Wyandotte County Health Department, K. City, Ks., thanked Ms. Correll for an excellent explanation of SB 446. He noted a recent survey indicates 16% of their population does not have Medicaid or private health insurance. This is close to 25,000 people, most being women and children. This need was recognized by the Commission on Medically Indigent, and he commends them for their efforts. It is appropriate to look to local health departments for primary care for this population. He noted the need to supply preventative care as well as illness care. Many local health departments already have the staff and capacity to provide this care. He noted a couple of changes in SB 446 that would improve it, i.e., line 32, word "emergency" might be changed to "urgent", he felt this more appropriate to treatment offered in a community health center, or local health department. A further change, he proposed that on Page 2, line 11, (d) after the word "secretary", add, "or local health departments". This would allow more flexibility for funding of the proposed program. He answered questions,i.e., urgent care means a child with a high fever and in need of immediate care, but not a life threatening emergency as an accident victim might be. He feels an accident victim would be an emergency case, therefore he feels urgent better wordage to use in the bill. Discussion on funding was held.

Walter H. Crockett, member of State Legislative Committee on the American Association of Retired Persons, (AARP), (Attachment No. 14) noted their Legislative Committee has carefully followed hearings held by the Commission on Services for Medically Indigent and they are impressed with the thoroughness of their investigation and judiciousness of the recommendations coming from that Commission. This demonstration program will provide a beginning and they urged committee to support this legislation.

Elizabeth Taylor, Local Health Departments, noted their Association does support the concept behind SB 446. She stated their only caution would be not utilize preventative care dollars to provide for primary care. It is our hope this program will be given new funding.

Dr. Charles Konigsberg, Jr. Director of Health/Department of Health and Environment, (Attachment No. 15) noted they can see the need for this demonstration program. They see the expanded role of public health as one needed to address the problem of indigent care. He drew attention to technical points in language of SB 446. The bills calls for one demonstration in a county of less than 20,000 population. Studies indicate counties with population between 10,000 and 50,000 have the highest percent of citizens on Medicaid and lowest per capaita income. Secondly if the intent of the bill is to maintain 24 hours service, that would be an unnecessary duplication of existing hospital emergency services. He added because there is no funding available in the proposed budget, the Department of Health/Environment cannot support passage of SB 446. He answered questions. There was discussion in regard to the fiscal note on SB 446. Chair noted it was being challanged.

HEARINGS CLOSED ON SB 446.

Chair drew attention to a letter that had been distributed to all committee members, (Attachment No. 16). Mary Ann Gabel, Executive Director Board of Behavioral Sciences wished to clarify comments she had made on SB 433 at an earlier meeting.

Chair adjourned meeting at 3:20 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date 3-20-1990

Name	Organization	Address
Claire McCurdy	KA. Dept. on Aging	Topeka.
JOHN HART FOR GORDON RISK	ACLU	TOPEKA
DAVE Newkirk MD	Ks City, Ks-Cty. Co. Health Dept	Ks City
Bob Burkhardt	AARP	Burlen, Ks
W. W. Crockett	AARP	Lawrence
Jerry Hixson	AARP	Topeka.
Roger Kirkwood	AARP - KANSAS	Topeka
Connie Screw, CPTA	KPTA	Abilene, Memorial Hospital
Maureen Riordan, P.T.	KPTA - Memorial Hosp.	Abilene, KS.
Jean Schu	KPOA	TOPEKA
Carolyn Bloom	Ks Physical Therapy Assn	Topeka, KS
Leticia Carlson	Washburn Nsg. School	Topeka
ALAN COBB	KS RESP CARE SOC.	TOP
Denyse Hewitt	Harvey County Health Dept.	Newton KS
ELIZABETH E. TAYLOR	KS ASSO OF LOCAL HEALTH DEPTS	TOPEKA
Deborah Y Taylor	Ks. Dept. of Health & E.	Topeka
Roberta A Hartman	KPTA	Wichita
Candace A Bahnen	KPTA	Beloit, KS
Jennie Atwood, PT.	KPTA	
KJ Raveling, CPTA	Morris County Hosp	Council Grove KS
Elva Strand CPTA	Hermgton Municipal Hospital	Herington KS
Frances Kastner	Ks Physical Therapy Assn	Topeka, Ks
Faris P. McFarland	KAHA	Topeka, K

Lisa Getz	Wichita	St. Francis Reg. Med. Center
Mary Ellen Conlee	Wichita	Wichita Center for Grad. Med. Ed.
Charles Konigsberg	Topeka	KDHE
Beverly Gaines	El Dorado	Bi-County Health Dept
Bill Dean	O.P. Ks	Ks Assn of Psyche
Harold Riggs	TOPEKA	KAOM
Tom Bell	"	ICHA
Richard Hannon	"	Bd of Healing Arts
Larry Buening	Topeka	"
Mary Ann Kabel	"	BSRB
Steve Chandler	Hiawatha	Ks Physical Therapy Assoc.

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

(913) 296-1343
FAX (913) 296-6231

Testimony Presented to

House Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill No. 529

Background/Introduction

Senate Bill 529 would amend existing statutes to require reporting of positive antibody tests for Human Immune Deficiency Virus (HIV), the causative agent for Acquired Immune Deficiency Syndrome (AIDS).

There has been an evolution in the concept of AIDS to one of a chronic infection with HIV, with a progression over a period of years with gradual loss of immune capacity, culminating ultimately with AIDS as the final chapter in the disease process. In short, HIV is increasingly viewed as a chronic disease. During the past few months, new scientific findings have shown that early medical intervention with drugs such as AZT can delay the progression of HIV disease to symptomatic stages. In addition, early intervention offers the opportunity for education and voluntary partner notification as measures to prevent the spread of HIV.

It is clear that the true extent of the AIDS epidemic is measured not just by counting full-blown cases of AIDS but by knowing the incidence and prevalence of HIV infection in the community. It is also clear that for early intervention to be effective both from a public health perspective as well as for the individual's perspective, knowledge of one's HIV antibody status must be known.

Diagnosed cases of AIDS are reportable by law in all 50 states. The consensus among public health officials around the nation is that better data are needed to monitor the spread of HIV infection. Over the past several years, the clear trend in the states has been to some sort of HIV reporting system. As of late 1989, 42 states required some sort of reporting of HIV, some by name and others without names. The trend seems to be toward named reporting. Only 8 states, Kansas being one of them, had no requirements for HIV reporting.

PHW
3-20-90
attn: #1.

Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

Issues

Senate Bill 529 would facilitate an important public health objective by providing data on the levels of HIV infection in the community. It would not provide much opportunity for early intervention because names would not be obtained.

The bill does allow for laboratory reporting which is an important and reliable source of information and does define certain terms such as HIV. We also believe that any AIDS/HIV legislation should strengthen provisions preventing discrimination against any individual or group with regard to employment, medical care, housing, education and transportation.

The senate amendments authorize physicians to notify emergency personnel who have been in contact with bodily fluids of a person who has AIDS or who has had a positive reaction to an AIDS test. Also, physicians may notify spouses or partners of a person who had a positive reaction to an AIDS test when the physician has reason to believe that the spouse or partner may have been exposed and is unaware of such exposure.

Recommendations

The Department is supportive of reporting of HIV positives without names, feeling that this measure will gain essential data. We recommend that the Committee report Senate Bill 529, as amended by the Senate, favorably for passage.

Testimony by:

Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
March 20, 1990

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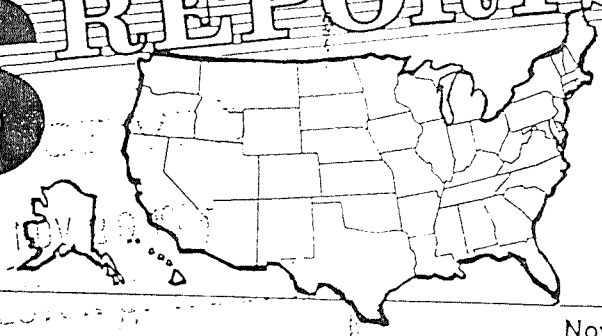
attn: #1.
SB 529.

THE GEORGE WASHINGTON UNIVERSITY

INTERGOVERNMENTAL AIDS REPORTS

INTERGOVERNMENTAL HEALTH POLICY PROJECT



EDITOR:
Linda Demkovich
EDITORIAL DIRECTOR:
Richard E. Merritt
CONTRIBUTORS:
Ingrid A. Bowleg
Lucy Dunaway
Randi Shafton

Volume 2, Number 5

November - December 1989

HIV REPORTING IN THE STATES

Introduction

One of the more controversial issues surrounding HIV infection continues to be whether positive test results should be reported to public health officials with patient identifiers. Currently, each state is responsible for establishing its own HIV reporting system and most require some sort of reporting, even if the reports are aggregate and patients remain anonymous. With recent recommendations to give prophylactic doses of AZT in certain circumstances and the need for constant follow-up and monitoring, however, health officials around the country are modifying, if not rethinking, their reporting systems.

To capture the most recent trends, the AIDS Policy Center conducted a telephone survey of HIV reporting requirements in all 50 states and the District of Columbia. The results indicate that states are clearly moving away from strictly anonymous testing, towards implementing regulations or systems that require names or patient identifiers to be reported in at least some circumstances. The data show that more than half of the states have some kind of name reporting requirements. The results also demonstrate that there is a clear trend to ensure that health officials have access to patient names, primarily to guarantee that patients receive more follow-up care, to project for future health planning needs and to expand partner notification programs.

As the chart shows, 41 states and the District of Columbia make some type of anonymous testing available. Nine require name reporting, as a matter of policy or law. Of the 42 jurisdictions that allow some anonymity, 15 require name reporting, with some opportunity for anonymous testing; four have a basically anonymous system, with names reported only in special situations (e.g., blood banks); 15 have an anonymous system where only demographic information is reported (no names are required); and eight have no HIV reporting requirements.

Trends

Several interesting developments emerged from the survey. In North Dakota, for instance, only nine percent of physicians are currently reporting sexually transmitted diseases, primarily because of fears of patient discrimination and breach of patient confidentiality. To emphasize the urgency of such reporting, North Dakota's legislature in July made it a felony offense for physicians to fail to report HIV infection test results.

Another significant trend involves states that require confidential testing to also maintain a few anonymous test sites. Beginning in March, for example, Arizona implemented an emergency 18-month regulation that allows both confidential name reporting and anonymous testing to occur. Before then, Arizona's permanent regulations required HIV name reporting across the board; health officials felt committed to giving individuals an opportunity to be tested anonymously, however, and thus instituted the 18-month emergency rule. Officials will evaluate the experiment before pursuing a permanent regulation change.

California, like Delaware, Oregon and Tennessee, has maintained a strong anonymous reporting system. The question of whether HIV should be reportable was proposed to the California voters last year and was defeated overwhelmingly. "Since the 1988 election, there has been no legislation introduced in the California legislature to make HIV a reportable disease," according to Anna Ramirez, chief of prevention services with the Office of AIDS. Assemblyman Terry Friedman (D-Sherman Oaks) said he feels strongly that "with the value of early intervention, it is more important than ever to encourage voluntary testing of people who believe they may be at risk for HIV. This early intervention and treatment can both maximize an individual's health and well-being as well as save public health dollars overall."

INTERGOVERNMENTAL AIDS RESOURCE PROJECT

"Intergovernmental AIDS Reports" is published nine times per year by the AIDS Policy Center at the George Washington University, Intergovernmental Health Policy Project. Its objective is to report on significant and exemplary AIDS-related program and policy initiatives occurring within state, county and municipal governments nationwide. Important policy research findings, as well as interviews with state and local policymakers, will also be featured.

"Intergovernmental AIDS Reports" is made possible by support from the Robert Wood Johnson Foundation and the Ford Foundation, as well as by numerous corporate contributions.

The Intergovernmental AIDS Resource Project serves the information, research and technical needs of state, county, municipal and tribal elected officials who are responsible for shaping solutions to the many public policy issues emanating from the AIDS epidemic. The AIDS Resource Project is comprised of two major components: the AIDS Policy Center at IHPP, which provides basic research, policy analysis, and technical assistance, and the AIDS Resource Network, which consists of ten national organizations representing elected officials at the state, county and municipal levels. These organizations are:

Natl. Association of Counties
Natl. Association of Latino Elected Officials
Natl. Black Caucus of Local Elected Officials
Natl. Caucus of Black State Legislators
Natl. Conference of Black Mayors
Natl. Conference of State Legislatures
Natl. Congress of American Indians
Natl. Governors' Association
Natl. League of Cities
U.S. Conference of Mayors

Except when expressly identified as otherwise, the material presented in this issue is provided by the AIDS Policy Center at IHPP. Information presented and views expressed in the newsletter should not be interpreted as representing the official position of any of the organizations which comprise the AIDS Resource Network.

Participation Rates

Colorado, a leader nationwide in implementing the first confidential system (name reporting), has had tremendous success with its participation rates, according to Cathy Raevsky, department chief of the STD/AIDS Division in the state's Department of Health. Raevsky notes that "Colorado's participation rates for testing are the highest per capita nationwide, except for the state of Alaska." However, Julian Rush, executive director of Colorado's Task Force on Anonymous Testing, is concerned with the state's mandate for HIV reporting. In the task force's opinion, he said, the reporting requirement has been "a serious hindrance" to Colorado's efforts to encourage testing and to control the spread of AIDS. In addition, the requirement "is an obstacle to providing the early medical treatments that both prolong lives and save public health dollars." According to Rush, each task force member feels strongly that the option of anonymous testing would significantly increase the number of persons at risk who would be tested for HIV and would help reestablish trust between those tested and the Department of Health, which in turn will increase contact tracing efforts.

Oregon has also had high participation rates since its reporting system was modified from name reportability only to a mixed anonymous or confidential system. A survey in December 1986 demonstrated that when clients were offered the option of either anonymous or confidential testing, overall testing increased by 50 percent (125 percent among homosexual/bisexual men; 56 percent among female prostitutes, 17 percent among intravenous drug users; and 32 percent other clients). The number of gay clients who were tested tests increased from a mean of 42 per month during the four months before anonymity was available to 108 per month during the four months after. In addition, twice as many seropositive persons were identified during the four months after anonymous testing became available. The option of anonymous testing and counseling therefore attracted individuals who had previously not sought services under Oregon's confidential reporting system.

In a recent system change, Rhode Island began requiring HIV anonymous reporting by demographics and risk factors only. The results demonstrate the difficulty in getting doctors to report risk factors such as sexual orientation and drug history in detail for fear of breaching patient confidentiality.

Finally, Louisiana's mixed reporting system allows individuals to choose whether they will be tested anonymously or confidentially. To date, this combined system has proved to be successful, allowing public health officials to monitor the spread of HIV and report names and encourage persons to return for follow-up care and at the same time, encourage

HIV REPORTING IN THE STATES

CONFIDENTIAL NAMES & IDENTIFIERS	MIXED REPORTING NAMES/IDENTIFIERS WITH SOME OPPORTUNITY FOR ANONYMOUS TESTING	MIXED REPORTING BASICALLY ANONYMOUS WITH NAMES REPORTED ONLY IN SPECIAL SITUATIONS	ANONYMOUS EPIDEMIOLOGIC DATA REQUIRED (NO NAMES, DEMOGRAPHICS ONLY)	NO REQUIREMENTS
Alaska	Arizona	California [2]	Florida	Connecticut [4]
Alabama	Arkansas	Delaware	Georgia	District of Columbia
Colorado	Indiana	Oregon	Hawaii	Kansas
Idaho	Kentucky	Tennessee	Illinois	Nebraska
Minnesota	Louisiana		Iowa	New Mexico
North Dakota	Michigan		Maine	Massachusetts
South Dakota	Mississippi		Maryland	Pennsylvania
South Carolina	Missouri		Montana	Vermont
Virginia	North Carolina [1]		Nevada	
	Oklahoma		New Hampshire	
	Ohio		New Jersey	
	Utah		New York	
	West Virginia		Rhode Island	
	Wisconsin		Texas [3]	
	Wyoming		Washington	

[1] Reviewing current system

[2] Except for blood banks

[3] Reviewing current system

[4] Reviewing current system

all who believe they are at risk to come in for testing. Although data are not available, public health officials in the state are convinced that lack of anonymous testing does inhibit individuals from seeking testing, making it difficult to measure the spread of HIV or to provide risk reduction education.

Overall, the recent telephone survey (compared to the Center's earlier March survey) demonstrates that states want to preserve some measure of anonymity and that public health officials are unwilling to let go of anonymity as a viable and necessary provision of testing. The fear of discrimination has proven to be a powerful motivator in designing responsible and effective HIV provisions. Public health officials in several states said they will not move to a name reporting system until they strengthen their anti-discrimination statutes, to ensure that protections are in place before implementing mandatory named reporting.

Security Systems

In addition to anti-discrimination measures, public health officials are also looking at implementing or improving their systems for protecting HIV-related information, and several states are currently examining the cost of implementing such a security system. Steve Modisett, seroprevalence/surveil-lance coordinator in Oregon's Health Division, said the cost of the state's existing security system is "minimal, because [the division] requires that all HIV-related information be stored in a locked file cabinet in a locked room with limited access. This system proves to be cost-effective and secure." Colorado, meanwhile, puts the cost of its security system at $1,500.

Public health officials are also examining STD and communicable disease laws. In some states, health care and treatment is required as a part of the surveillance component of existing STD programs. With the onset of new and more extensive HIV reporting provisions, states will have an additional commitment to finance ongoing treatment of STDs in the future. In addition to the increased cost of care and treatment, states are also examining the increased cost of case management.

The trends indicate that a majority of the states, if they do not already have a HIV reporting system in place, are shifting towards name reporting. It seems, however, that the states that are more likely to move towards named reporting are those with moderate to low HIV incidence, while the states that are maintaining some degree of anonymous testing have a higher incidence of HIV. Based on informal comments by various national public health officials, at least ten states are considering closing all anonymous test sites. North Carolina, for example, is currently reevaluating its HIV reporting procedure and may consider closing all anonymous test sites at some future date.

The consensus among public health officials seems to be that better data are needed to monitor the spread of HIV infection. The questions remaining are what the most effective reporting model is and whether anonymous test sites will continue to exist.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 20, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 529; HIV Reporting

Thank you for this opportunity to endorse the provisions of SB529. The Kansas Medical Society supports the general concept of reporting confirmed cases of HIV positivity so long as the identity of the patient remains confidential.

As you probably know, HIV testing is done in two stages; the first test being a less expensive screen which can result in a false positive result. In those instances when the screening test indicates positive, a more expensive and more precise test is conducted in order to confirm the presence of HIV antibodies in the person's blood.

In its amended form, SB529 defines a number of terms and requires reporting of demographic characteristics in order to be of value to epidemiologists and other infectious disease specialists. In addition, it grants broadened authority to physicians to inform persons who may have been exposed to HIV of the risk of that exposure.

We respectfully request that you recommend passage of SB 529. Thank you.

CW:lg

PH&W
3-20-90
Attm. #2

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

March 20, 1990

To: Chairman and Members, House Public Health Committee

From: Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Subject: KAOM Testimony on S.B. 529

The Kansas Association of Osteopathic Medicine supports passage of S.B. 529. KAOM has consistently urged that any required reporting by physicians of persons with a positive reaction to a test for HIV Infection not require that the name of the person(s) with such positive reactions be a part of the report. S.B. 529 provides that confidentiality.

KAOM also supports Sec. 3 of the Bill providing disclosure of AIDS Infection to other health care providers who have been or will be in contact with bodily fluids of such a patient, the permissive reporting to a spouse under conditions stated, and the immunity provisions provided physicians making reports required or permitted under S.B. 529.

Thank you for this opportunity to express our views on S.B. 529.

PHealth
3-20-90
Attm #3

KALHD

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

AIDS PREVENTION AND CONTROL
FY 1991

I. Issue Definition

The public health aspects of acquired immune deficiency syndrome (AIDS) should be handled as other communicable diseases in that positive blood tests without names should be reported by laboratories and physicians to the Kansas department of health and environment and partner notification should take place. All medical information should be kept confidential as it is with other communicable diseases.

II. Background

AIDS is a fatal disease caused by a virus that is transmitted by sexual intercourse and blood, the latter usually is through sharing of contaminated needles by intravenous drug abuse. Since AIDS was first reported in the United Stated in mid 1981, the U.S. Public Health Service has received reports of about 115,158 cases with a case fatality ratio of 59%. Approximately 60% of the cases has occurred in homosexual/bisexual men and 20% has occurred in intravenous drug abusers. While the percent of cases in these groups has remained constant, there has been a significant increase in heterosexual cases. AIDS is a public health problem that merits serious concern and is a major priority of the U.S. Public Health Service. The AIDS virus is spread by sexual contact and needle sharing and may be transmitted from infected mother to infant during pregnancy or birth, or shortly after birth (probably through breast milk). The risk of infection with the virus is increased by having multiple sexual partners, either homosexual or heterosexual. Through January 1, 1990, there have been 308 AIDS cases in Kansas with a case fatality ratio of 62%.

The current recommendations for the prevention and control of AIDS is through education in schools, the workplace, high risk groups and the general public and through anonymous/confidential testing of individuals in high risk groups. Positive blood tests from physicians and laboratories are not reported to local or State health officials. The number of people estimated to be infected with the AIDS virus in the United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Scientists predict that 30% - 50% of those infected with the AIDS virus will develop AIDS within five years. Traditionally the control of communicable diseases has been to report known cases to official public health agencies, so their contacts can be investigated. Also, individuals who are infected and capable of transmitting the infection are reported to public health officials so their contacts can be investigated.

continued

Passed 3-20-90 Attm #4

933 Kansas Avenue, Topeka, Kansas 66612, 913-354-1605

over

III. Options

A. Continue with education and anonymous testing and hope that it diminishes further spread of the AIDS virus.

B. Continue education and voluntary anonymous testing of high risk individuals and mandate reporting of positive HIV blood tests. Voluntary follow-up of contacts should be authorized.

C. Supply increased funding for AIDS with the following priorities:

1. Support the continued testing, counseling and education of individuals with high risk behaviors.

2. Mandate reporting without names of positive HIV blood tests to Secretary of KDHE by laboratories and physicians.

3. Support public health departments in their effort to do partner notification and follow-up of cases of those with positive HIV test results.

4. Continue with education about AIDS in schools, workplaces, and for the general public.

5. Offer voluntary testing in clinics for family planning and sexually transmitted diseases and for anyone thought to be at risk.

6. Provide voluntary testing for individuals not in high-risk groups.

IV. Recommendation

The Kansas Association of Local Health Departments recommends option C. AIDS is a sexually transmitted disease and testing, counseling, education and follow-up are necessary public health components.

Many of the patients attending family planning and sexually transmitted disease clinics may be in high-risk categories and therefore testing should be offered and followed by counseling about the risks of promiscuity. The follow-up of positive HIV tests will help public health authorities control the spread of this infection. These practices have been successful in syphilis and other communicable diseases.

V. Fiscal Impact

The cost of performing the procedures under option C would be high but case treatment costs are extremely high. The cost to draw blood for the test and provide counseling is estimated at $20.00 per person. The number of positive tests will probably be manageable and the number of contacts to be followed should not be overwhelming.

continued

PH&W
3-20-90
Attm #4
Pg. 2.

VI. Legislative Implications

Legislation would be needed to mandate reporting by physicians and laboratories of positive HIV tests without names.

VII. Impact on Other Agencies

Option C and accompanying legislation would have an impact on the KDHE laboratory and epidemiology unit, local health departments that would test and counsel individuals, and private physicians that would do voluntary testing.

VIII. Supporting Documents

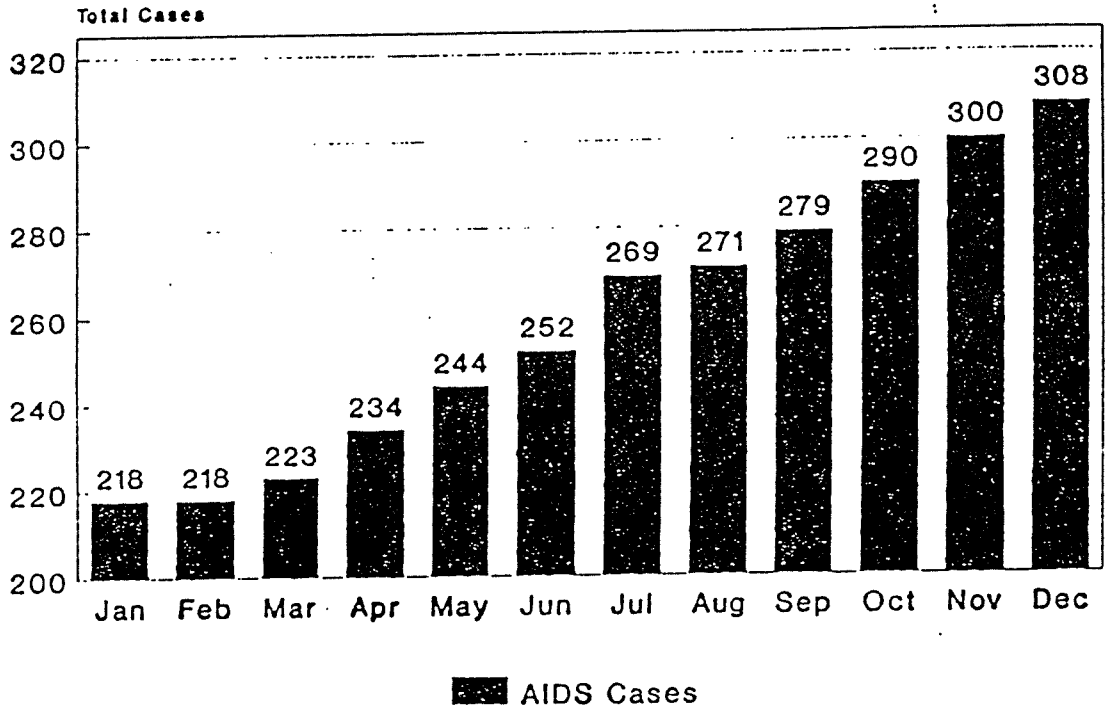
Surgeon General's report on Acquired Immune Deficiency Syndrome. AIDS Statistics.

Approved by KALHD Board of Directors January 22, 1990

PHall
3-20-90
Attm. #4.
pg. 3.

Cumulative AIDS Cases in Kansas to Date

1989 Statistics



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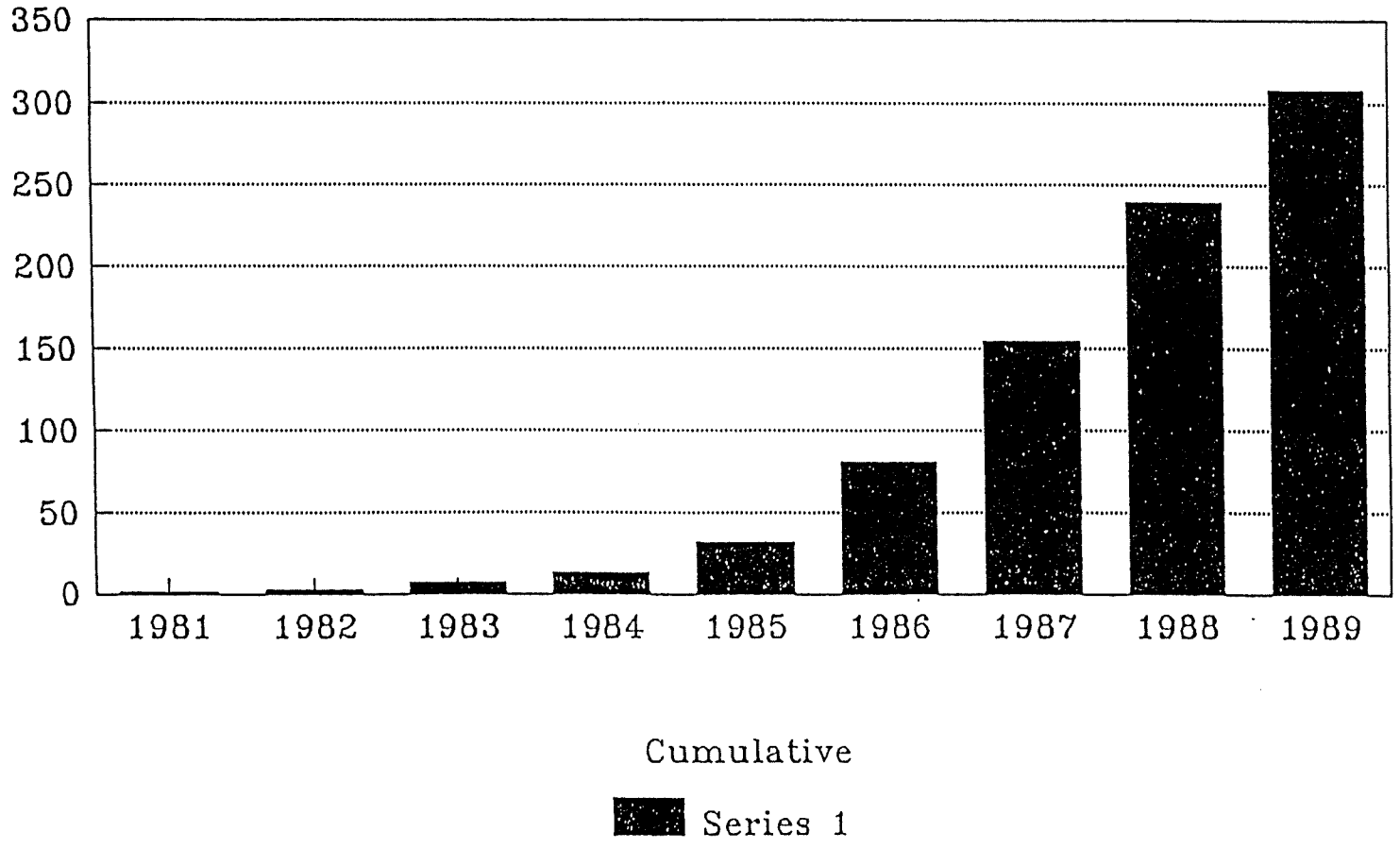
Attm. #4.
Pg. 4

Kansas AIDS Cases to Date

Progression of Cumulative Data



(All cases have not yet been reported)

PNBW
3-20-90
Attm. #4
pg. 5.

KANSAS FEDERATION OF LICENSED PRACTICAL NURSES, INC.
Affiliated with NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.
933 Kansas Avenue Topeka, KS 66612 913-354-1605

PNeed
3-20-90
Attm. #4.
Pg. 6.

S.B. 529

Testimony of Gordon Risk, president of the American Civil Liberties Union of Kansas.

This is a good and thoughtful bill, which we support. One change, however, would improve it significantly. Discrimination against those who test positive for HIV or develop AIDS with regard to employment should be prohibited. This change would encourage people to get themselves tested and to seek treatment for the infection, good public health policy, endorsed by President Reagan's Commission on AIDS, which called for strong Federal laws and directives to prevent discrimination against people who carry the AIDS virus. (1) This provision would also prevent employers from firing infected individuals and passing along the costs of their treatment to the taxpayers of this state. A concern for the public health and the public pocketbook would argue for this addition to the bill ("employment" could be added to line 22, page 3).

(1) The New York Times, June 3, 1988.

Passed
3-20-90
Attm. #5

KANSAS CHAPTER

AMERICAN PHYSICAL THERAPY ASSOC., INC.

March 20, 1990
Carolyn Bloom, PT
1045 SW Gage Blvd.
Topeka, KS 66604

Senate Bill 543

Mr. Chairman and Members of the House Public Health Committee.

My name is Carolyn Bloom and I am President of the Kansas Physical Therapy Association which represents about 90 percent of the Physical Therapists practicing in the State.

It is commonly recognized that there is a shortage of health care providers in Kansas, especially in the rural areas. Small hospitals have been especially affected with difficulty in locating or competing in reimbursement for full time professionals.

The Kansas Physical Therapy Association recognizes the problem of the current health care manpower shortage. Our Association has taken steps to help alleviate the situation. We supported legislation, passed last year, that increases the numbers of Physical Therapy students at the University of Kansas Medical Center, and that provides for scholarships for nursing students. Our Association provides free job placement services for small or rural hospitals including a "job board" at our state meetings and educational seminars held two or three times a year. Our officers speak to students on the merits of rural practice. We have allowed time at state forums for speakers who represent rural hospitals, and printed their articles in our state professional newsletter.

PHeW
3-20-90
Attm #6

An issue that has come before the Kansas Legislature in the past several years is the concern of initiating Physical Therapy services to patients in small hospitals quickly by allowing Certified Physical Therapist Assistants to provide patient care before the Physical Therapist evaluates the patient and establishes a plan of care.

The Kansas Physical Therapy Association is opposed to this concept for the following reasons:

1. Concern of maintaining safety of all patients in receiving care

2. Certified Physical Therapist Assistants are not trained in evaluation techniques and the majority of physician orders for physical therapy services are "evaluate and treat", not giving the CPTA direction on treatment.

3. This changes the traditional supervisory role of the Physical Therapist to the Certified Physical Therapist Assistant which is clearly outlined in the Kansas Physical Therapy Practices Act and the accompanying rules and regulations.

4. Increases potential problems with malpractice liability; many Physical Therapist's liability insurance covers the Physical Therapist Assistant and the treatments given by the assistant. The Physical Therapist must be involved in the responsibility of care.

5. May pose difficulty with insurance reimbursement for the patient

6. This concept still does not address the problem of finding a Physical Therapist for rural or small hospitals that do not have such services.

PNew
3-20-90
Attm't 6 - pg 2.

In response to a directive of the Senate Public Health Subcommittee during the 1989 session to reach a compromise, our Association's representatives met numerous times with representatives of the Kansas Hospital Association, the Kansas Association of Osteopathic Medicine, the Kansas Medical Society and the Kansas Board of Healing Arts. Representatives of each organization have compromised to agree on the current language in S.B. 543 that will allow patient care to be started even if the Physical Therapist is not at the hospital for several days. There are several considerations as follows:

1. Since the Certified Physical Therapist Assistant is not trained in evaluation techniques or in interpreting data regarding the patient, the phone consultation with the Physical Therapist may allow direction in proper initiation of treatment.

2. If the patient's condition warrents intense care, the phone call will alert the Physical Therapist of the need to modify his or her schedule and return sooner than scheduled to that hospital to personally evaluate that patient as quickly as possible.

3. If the Physical Therapist is ill or on vacation, the Physical Therapist will have another therapist "cover" and accept such phone calls from the Certified Physical Therapist Assistant.

4. The required phone consultation will keep the Physical Therapist knowledgable of the patient care being given for which that Physical Therapist is liable.

PHHW
3-20-90
attm # 6
pg. 3

The membership of the Kansas Physical Therapy Association still has some concerns on this issue; however, the majority of our members agree with the amended version of S.B. 543 which passed the Senate 40 - 0 on February 28, 1990.

6-3

Please note on the latest version of S.B. 543 that was written after passage from the Senate Health and Welfare Committee, the words " with a minimum weekly review" were not italicized to denote new language to the current law. The Supplemental Note on S.B. 543 expressed concern of several conferees that a doctor's order would not be required prior to the initiation of Physical Therapy services by a Physical Therapist Assistant. S.B. 543 will not change the current law requiring a physician's order for referral to Physical Therapy services.

I will be pleased to answer any questions.

PHeed
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Attm #6

BG-4

Approved 3/1/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by SENATOR ROY M. EHRLICH
Chairperson at

10:00 a.m./~~p.m.~~ on February 21, 1990 in room 526 of the Capitol.

All members were present except:

Committee staff present:
Norman Furse, Revisor's Office
Bill Wolff, Legislative Services
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the meeting to order, asking for approval of the minutes of February 14 and 15, 1990. Senator Hayden made a motion to approve the minutes. Senator Langworthy seconded the motion. The motion carried.

The Chairman called for action on bills previously heard. S.B. 543 is the bill on the physical therapist. Tom Bell of the Kansas Hospital Association and Caroline Bloom of the Physical Therapist Association have met and have come up with a workable solution to S.B. 543.

Tom Bell of the Kansas Hospital Association presented the change worked out by the Kansas Hospital Association and the Physical Therapist Association. (Attachment 1) Mr. Bell said they also talked with the Kansas Association of Osteopathic Medicine and the Kansas Medical Society and they have no objection to this compromise. What has been done is to withdraw the request to put the except in to allow the physician to initial the order and then in line 31, delete the language, "no later than the third treatment" and amend that to say after the word "treatment" add "as soon as possible".

Senator Ehrlich asked Caroline Bloom of the Physical Therapist Association to confirm what Mr. Bell declared, that this is a compromise.

Ms. Bloom said the Kansas Physical Therapist Association agrees with the compromise and are comfortable with the language and would like to see S.B. 543 passed out of the Senate. Ms. Bloom said that she felt the basic issue of getting physical therapy to patients in rural hospitals as quickly as possible will be met with this bill.

The Chairman asked for the wishes of the Committee on S.B. 543. Senator Hayden made a motion to accept the amendments as proposed. Senator Langworthy seconded the motion. The motion carried.

The Chairman asked for the wishes of the Committee on S.B. 543 as amended. Senator Langworthy made a motion to pass S.B. 543 as amended. Senator Hayden seconded the motion. The motion carried. Senator Langworthy will carry S.B. 543.

PH/WC
3-20-90
Attm. #7

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 20, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: **SENATE BILL 543**

The Kansas Hospital Association appreciates the opportunity to comment on the provisions of Senate Bill 543, relating to physical therapists and physical therapist assistants. The issue has been discussed during past legislative sessions and has remained unresolved until now.

Senate Bill 543 would amend the physical therapy statutes to create an exception to the rule that the physical therapist must see all patients initially. The exception would be created in those cases in a hospital setting where the physical therapist is not immediately available. When that happens, the physical therapist assistant may initiate treatment after telephone conversation with the physical therapist. The physical therapist must then evaluate the patient and establish a plan of treatment as soon as possible.

We would like to commend the Kansas Physical Therapy Association for introducing this bill. We realize that in the past there has been a great amount of resistance by physical therapists with regard to this issue, and we think the introduction of Senate Bill 543 indicates a greater willingness on the part of the Physical Therapy Association to discuss this issue.

Current Kansas statutes create a problem of access to care for certain people needing physical therapy services. Our law says that the physical therapist must see all patients before any treatment is started by a physical therapist assistant. In some cases, the physical therapist may not be available to see the patient when necessary, and that patient will not receive the necessary care until such time as the physical therapist is available. Obviously, this is not a desirable situation, and something must be done to develop a plan to take care of these difficulties. The problem here is largely a rural one and is related to the significant shortage of physical therapists in our state. Our most recent Kansas Hospital Association personnel

PHEW
3-20-90
Attach 8

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

survey showed a vacancy rate for physical therapists of 3 percent in urban areas and 16 percent in rural areas. Clearly, there is a problem in rural areas that could be helped if more flexibility was built into the statutes to ensure patients could receive treatment when it is needed, instead of having to wait.

We think Senate Bill 543 helps to provide this flexibility. By allowing the initial order to be made pursuant to telephone contact, many more patients will receive timely treatment. In addition, the Senate amendment does not tie the establishment of the plan of treatment to the original restrictive "third treatment" requirement. This ensures that patients who require several treatments in a short period of time will continue to receive that treatment.

Thank you for your consideration of our comments.

TLB:pj
Attachment

PHCC
3-20-90
Attn # 8
SB 543

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
(913) 234-5563

March 20, 1990

To: Chairman and Members, House Public Health Committee

From: Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Subject: KAOM Testimony on S.B. 543

The Kansas Association of Osteopathic Medicine supports passage of S.B. 543 as amended and passed by The Kansas Senate.

In 1986, KAOM first asked for the introduction of a bill to address the problem which is the subject of S.B. 543, i.e., a delay in the commencement of physical therapy treatment due to the shortage and subsequent unavailability of physical therapists in some rural settings to "see" a patient before a physical therapist assistant could begin treatment.

Bills addressing this subject passed the House on several instances in recent years, but not the Senate. The difference was whether or not the PTA could commence therapy under order or direction of a physician without involving a physical therapist, when the PT was not readily available.

S.B. 533 retains the role of the physical therapist approving therapy, but permits it to be done by telephone contact with the physical therapist for documented instruction. We think this is a compromise solution that will go a considerable way toward resolving this problem in some rural areas.

It was never the intent of KAOM to interfere in the relationship between physical therapists and physical therapist assistants and we think this Bill does little damage to that relationship. We applaud the Kansas Physical Therapy Association for their willingness to address the problem by seeking introduction of S.B. 529.

Thank you for the opportunity to appear on S.B. 529.

PH&W
3-20-90
Attm. # 9.

March 20, 1990

Jennie Atwood. PT, MA
3741 Stonybrook Drive
Topeka, Kansas

To: Mr. Chairman and Members of the House Public Health and Welfare Committee

My name is Jennie Atwood. As a Physical Therapist, I have worked in a variety of settings over the last twelve years. I have worked clinically with Physical Therapist Assistants and have had the opportunity as Assistant Professor at Washburn University to teach Physical Therapist Assistant students.

Let me discuss briefly the difference in education and clinical skills between the Physical Therapist and Physical Therapist Assistant. To become a Physical Therapist today, a person must complete three to four years in an accrediated college, then be accepted into a Physical Therapy program for two or three years of intensive study in anatomy, physiology and neurology, and must complete a clinical internship at which time they receive a Master's Degree. One of the most important aspects of the Physical Therapist's education is learning to evaluate the condition of the patient. Evaluation skills enable the Physical Therapist to determine what the Physical Therapy problem is, thereby allowing the therapist to safely and effectively develop a treatment program for the patient.

PH&W
3-20-90
attm # 10

Physical Therapist Assistants complete a two year program, receiving an Associate Degree. This education includes limited study in anatomy, physiology and neurology. The student completes a clinical internship under the direction of a Physical Therapist. The Physical Therapist Assistant receives excellent technical training in physical therapy skills but is not trained in evaluation skills, and thus must work under the direction and supervision of the Physical Therapist.

Typically, the clinical scenario goes something like this. The Physical Therapist evaluates the patient to determine the appropriate treatment and designs the treatment program. He or she may then treat the patient or supervise and direct the Physical Therapist Assistant as they treat the patient. It is the Therapist's responsibility to re-evaluate the patient as often as necessary. It is also the Physical Therapist's responsibility to determine which patients should not be seen by a Physical Therapist Assistant. Specifically, any patient whose medical condition requires constant re-evaluation should not be treated by the Physical Therapist Assistant. In a hospital setting, many patients fall into this category. For example, a patient with a recently unstable cardiac condition or a patient with a complicated fracture should not be treated by the Physical Therapist Assistant.

PPRC
3-20-90
attm #10
pg. 2.

Our goal as Physical Therapists is to provide safe, effective care in a timely fashion. In some situations in rural or small hospitals where the Physical Therapist is unable to immediately evaluate the patient, I believe that it is appropriate for the Physical Therapist Assistant, given their education and training, to initiate certain treatments but only after receiving instructions from the Physical Therapist. I also believe that requiring the Physical Therapist to evaluate the patient and establish a plan of treatment as soon as possible with a minimum weekly review of the Physical Therapist Assistant will help to assure continued safe and quality Physical Therapy care for Kansans.

Thank you for your time. I would be happy to answer any questions at this time.

PNeel
3-20-90
attm. #10
pg 3

K.J. Raveling, CPTA
Morris County Hospital
Council Grove, KS 66846

To: Mr Chairman and Members of the Public Health and Welfare Committee

I'm a physical therapist assistant from a small rural community. I am in favor of bill 543 for the following reasons. First, I believe this bill will solve the problem of delaying treatment for the rural patient when a registered physical therapist is not immediately available for evaluation. Secondly, as stated this bill insures the supervisory relationship of the therapist over the assistant which is essential for a successful treatment program. Also, direction of the patient's physical therapy program remains the responsibility of the therapist, first by phone and then by evaluation, establishment of a treatment program, and weekly program review.

I feel this bill allows for greater flexibility, while insuring quality care for the patient requiring physical therapy in the rural setting.

P. Hall
3-20-90
Attm. #11

COMMUNITY THERAPEUTICS, INC.

REHABILITATIVE HEALTHCARE

STEPHEN M. CHANDLER, R.P.T.
RICK A. MORRISON, M.A., CCC-SP

103 SOUTH SIXTH
HIAWATHA, KANSAS 66434

(913) 742-2874
(913) 742-2464

Steve Chandler, P.T.
R. R. 5
Hiawatha, KS 66434

House Public Health & Welfare Committee
Testimony on Senate Bill 543
March 20, 1990

Mr. Chairman and Members of House Public Health & Welfare Committee:

My name is Steve Chandler and I am a physical therapist providing therapy services in Northeast Kansas. I am here today to support Senate Bill 543 in its current language.

I am co-owner of a rehabilitation agency located in Hiawatha, Kansas, my hometown. At present, we provide physical therapy services for hospitals in Seneca, Holton and Horton, Kansas. I employ a physical therapist, supportive staff, as well as physical therapist assistants to provide patient care for these hospitals.

The physical therapy needs of a rural community are not limited to its hospital, they also include home health visits, nursing home consultation, and visits to schools to treat special education students.

Each hospital is staffed daily by a physical therapist assistant who provides routine patient care following an established program developed by the physical therapist. This program, or plan of treatment, is developed during an evaluation performed by the physical therapist following referral of the patient by the physician.

It has been my experience working in the rural area for fourteen years, that in most cases the physician may identify the need for physical therapy but relies heavily on the expertise of the physical therapist to determine which type of treatment may best benefit his patient, as well as the responsibility to directly oversee the performance of the treatment procedures and assessing the patient's response to the treatment.

The hospitals we serve are small, no larger than 25 beds. At this time a physical therapist is able to visit each hospital only 2 or 3 times a week causing at times a 2 or 3 day delay in the initiation of patient care.

This problem is what SB 543 addresses. In its present language this bill would provide an opportunity to initiate treatment by the physical therapist assistant prior to a physical therapist's evaluation following documented telephone contact between the physical therapist and the physical therapist assistant.

PHeal
3-20-90
Attm. #12

In past years there was suggested language where a physical therapist assistant would begin treatment "pursuant to a physician's order" for the purpose of initiating care in small hospitals where a physical therapist was not immediately available.

Senate Bill 543, I feel, would alleviate this problem for the hospitals I serve and most importantly, leaves the responsibility, both legally and ethically, for the initiation and provision of physical therapy treatments by the physical therapist assistant with that assistants supervising physical therapist.

In a letter from the Department of Health and Human Services dated February, 1986, "Supervision of physical therapy services by a physician, regardless of his/her specialty (physiatry included), is not an acceptable alternative to supervision by a qualified physical therapist". A copy of this letter is included with my testimony.

In closing, I believe SB 543 in its current language would add a measure of flexibility to the practice of physical therapy so patient care may begin a little quicker in the hospitals I serve as well as other rural hospitals throughout Kansas where a physical therapist is not always immediately available. Most importantly, SB 543, as introduced, adds this flexibility without endangering the traditional supervisory role of the physical therapist to their assistants.

I would be happy to respond to any questions at this time.

PHHS
3-20-90
attm # 12
pg 2

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Admir on

6325 Security Boulevard
Baltimore, MD 21207

FEB 4 1986

Ms. Carmen Colon
Board of Physical Therapy Examiners
Department of Health
Commonwealth of Puerto Rico
Medical Sciences Campus
College of Health Related Professions
Physical Therapy Program
GPO Box 5067
San Juan, Puerto Rico 00936

Dear Ms. Colon:

This is in follow-up to a conversation that Alfreda Staton of my staff had with Ken Davis of the American Physical Therapy Association. Mr. Davis explained that your office has encountered a situation in which a physiatrist believes that he may supervise the duties of a physical therapy aide in a Medicare facility, and as a result has initiated legal proceedings. The purpose of this letter is to confirm answers given to Mr. Davis and to furnish you with documentation concerning whether physical therapy services provided by other than a qualified physical therapist may be covered under Medicare if they are rendered under the supervision of a physiatrist.

The conditions of participation for hospitals, skilled nursing facilities, home health agencies and outpatient physical therapy/speech pathology providers require that physical therapy services be provided by, or under the supervision of a qualified physical therapist. (Supervision of physical therapy services by a physician, regardless of his/her specialty (physiatry included), is not an acceptable alternative to supervision by a qualified physical therapist.) This position is predicated on our judgment that health professionals accept and use the principle that supervision of care must be carried out by the professional in that field.) While all medical care is furnished under the general supervision of a physician, he or she does not directly oversee the performance of treatment procedures. The physician identifies the need for a treatment procedure, formulates orders or prescribes the plan of treatment. Consequently, it is our determination that the substitution of a physiatrist, in lieu of a physical therapist, for supervision of physical therapy services in a Medicare provider/supplier setting is not acceptable.

Sincerely yours,

/S/

Antoine J. Elias
Acting Director
Division of Institutional
and Ambulatory Services
Office of Survey and Certification
Health Standards and Quality Bureau

cc: Mr. Ken Davis

PH+W
3-20-90
attach 2 pg 3

HERINGTON MUNICIPAL HOSPITAL
100 E. Helen • Herington, Kansas 67449 • 913-258-2207

Elva L. Strand CPTA
1600 W. Walnut
Herington, KS 67449

Mr. Chairman and Members of the Public Health and welfare Committee:

I am a Physical Therapist Assistant from a rural community and I am in favor of SB# 543.

This bill will enable us to see our patients without delays. In acute cases it will be very beneficial to be able to initiate a form of treatment to make the patient more comfortable until he/she can be evaluated by a Physical Therapist.

This bill maintains the supervisory position of the Physical Therapist by phone contact, which I feel is very important. We are Phsyical Therapist Assistants and our training is based upon PT/PTA teamwork to provide the best quality care to our patients.

Having another Health Care worker directly over us would not enable us to see a patient any sooner than what this bill will allow.

Our goal is to give the best quality of care as soon as possible to our patients and this bill will help us to do that.

Thank You.

Passed
3-20-90
Attm. #13

Testimony on SB 446: Establishing a Community Health Center

Demonstration Program for Medically Indigent

The Chairperson and Members of the House Public Health and Welfare Committee:

I am Walter H. Crockett, a member of the State Legislative Committee of the American Association of Retired Persons. Our Committee has adopted, as one of its five priority items for this year, support of a comprehensive program to improve access to health care for uninsured persons, both young and old.

Every day brings new evidence that a substantial portion of our population simply does not have access to adequate health care; instead, it is cut off not only from the treatment of acute afflictions but also from medical attention designed to maintain health and to forestall the development of severe conditions. In a nation with the best medical techniques and the most up-to-date medical facilities in the world, as many as one-sixth of our population--young people as well as the elderly, employed workers as well as the unemployed--find themselves simply unable to afford decent medical care.

Our State Legislative Committee has carefully followed the hearings of the Commission on Access to Services for the Medically Indigent and Homeless. We have been impressed with the thoroughness of their investigation and the judiciousness of their recommendations. The bill before you today will establish a demonstration program to provide health care for the medically indigent in the context of community health centers. That program will not solve overnight the health-care problems of the uninsured and the underinsured. Instead, it is one of a number of proposals that are directed at diverse aspects of our crisis in health care. The present proposal, along with others that have been presented to this session of the legislature and still others that will be presented in years to come, represents a measured, rational beginning to an assault on one of the major problems that is faced by our state today. The AARP State Legislative Committee strongly supports this bill, as it expects to support others that emanate from the Commission in the future.

PHed
3-20-90
Attm. #14

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

(913) 296-1343
FAX (913) 296-6231

Testimony presented to

House Committee on Public Health and Welfare

by

Kansas Department of Health and Environment

Senate Bill 446

I appreciate the opportunity to testify regarding Senate Bill 446 that would establish a community health center demonstration program to provide primary care medical services to the medically indigent, using local health departments.

The 1989 report of the Commission on the Medically Indigent and Homeless documented the scope of the problem of indigent care in Kansas and proposed a number of strategies to deal with the problem, including expanding the role of the public health delivery system. In June, 1989, I testified before the Commission, and among other points, supported exploring expanding the role of local health departments in Kansas to include medical care. I also have been in contact with various local health directors in the state to assess their level of interest, and there are a few who are interested. We see the expanded role of public health as one aspect of a comprehensive strategy needed to address the entire problem of indigent care.

There are a number of current efforts around the state addressing the delivery of primary care to the indigent. These include the Medicaid program, voluntary sector clinics such as the Marian Clinic here in Shawnee County, the Hunter Clinic which is a federally sponsored community health center in Wichita and some limited efforts by the Topeka-Shawnee Health Agency and the Wyandotte County Health Department. While many states have a large number of federally sponsored community health centers, the movement largely passed Kansas by, with the exception of the Hunter Clinic. The efforts of the two local health departments involved with primary care delivery are limited, but do demonstrate that there is a viable resource there.

PH&W
3-20-90
Attm #15

Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

The traditional roles of health departments have been oriented to prevention and the care of special populations, rather than toward comprehensive medical care. However, over the past two decades, many health departments around the nation have successfully made the transition of integrating the traditional preventive programs into a system of comprehensive care. The recent Institute of Medicine Report entitled The Future of Public Health pointed out that one of the most basic functions of public health is assurance of needed health services. It is consistent with this function to look to public health for diagnosing the problems in a community health system and taking leadership to see that services are provided.

The Department of Health and Environment has an increasing interest in the area of health care delivery as evidenced by the creation of the Office of Rural Health and the efforts on our part to develop an office of primary care in cooperation with the federal Department of Health and Human Services as is the case in many other states. We are collaborating with the Kansas Association for the Medically Underserved and others to develop this proposal as well as looking at various options to assist local communities in providing primary care.

I would like to call to your attention two important technical considerations in the language of the bill. First, the bill calls for one demonstration in an urban county and one in a county of less than 20,000. Studies by Kansas, Inc. have demonstrated that counties with a population between 10,000 and 50,000 have the highest unemployment, highest percent of citizens on Medicaid and the lowest per capita income. The new indigent care clinics which have opened outside of the urban areas have all been in counties with populations of 20,000 to 40,000. Second, the bill calls for the provision of "primary care medical services including emergency health care services." If this means maintaining 24 hour services, it would be an unnecessary duplication of existing hospital emergency services. If it means creating a service that assures prompt access to primary care without the need for an appointment for those clients with acute needs, then that is a manageable goal.

The public health system in Kansas may be able to assist in meeting the needs for primary care services for the medically indigent as part of an overall strategy. Unfortunately, because no funds for this purpose are available in the proposed budget, the Department cannot support the passage of Senate Bill 446 at this time.

Testimony presented by: Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
March 20, 1990

PHealth
3-20-90
Attm #15

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STATE OF KANSAS

Landon State Office Building
900 S.W. Jackson, Room 855-S
Topeka, Kansas 66612-1220
913/296-3240 KANS-A-N 561-3240

BEHAVIORAL SCIENCES REGULATORY BOARD

March 20, 1990

RE: S.B. 433

Rep. Marvin Littlejohn, Chairperson
Rep. Frank Buehler, Vice-Chairperson
House Public Health and Welfare Committee
State Capitol, Room 426-S
Topeka, KS 666912

Dear Rep. Littlejohn and Rep. Buehler:

In reflecting on the testimony I presented on behalf of the board and my response to questions posed by the committee and staff concerning S.B. 433 and the amendments in Section (h) (page 2, line 28), I feel I may have provided an incomplete response.

The board's written testimony was predicated on statements made prior to and testimony offered during the Senate Public Health and Welfare Committee's hearing on this bill. Proponents of this legislation stated the amendments in this section were intended to "speed up" the process of issuing temporary licenses to applicants. If this is the intent of the legislation, the board is of the opinion the amendment will not accomplish this intent, but rather will impede the timeliness of issuing the temporary license. If, on the other hand, it is the legislature's intent to address the procedures currently utilized by the board to handle the 400-500 applications for social work licensure received yearly, the board will certainly explore alternative ways in which to accomplish this task.

If I can provide any further information or clarify any statements, please do not hesitate to contact me.

Thank you.

Sincerely,

Mary Ann Gabel

Mary Ann Gabel
Executive Director

MAG/jh
cc: Committee Members and Staff
Dr. Marvin A. Kaiser
Dr. William L. Albott

P&W
3-20-90
Attm. #16