Approved 2/8/90
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p~~x~~m. on January 30, 1990 in room 526 of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Sandra Nash, Committee Secretary

Conferees appearing before the committee:

The Chairman called the Committee meeting to order and asked for presentation of proposed legislation. The first appearing was Carl Schmittenhenner of the Kansas Dental Association. He submitted a proposal to allow dentists to administer intravenous sedation. (Attachment 1)

The Chair asked for a motion for a committee bill. Senator Reilly made the motion for a committee bill. Senator Kanan seconded the motion. The motion passed.

The Chairman call Chip Whelan, of the Kansas Medical Society. Mr. Whelan distributed a rough of the proposed bill.(Attachment 2) The reason he is requesting this bill through the Public Health and Welfare Committee is primarily because the Chairman and Senator Anderson as well have served on the Commission on Access to Health Care for the Medically Indigent and Homeless. There are a number of physicians we call exempt licensees who do not have liability insurance protection. A significant number of these exempt licensees indicated that if possible to identify them some way, that they would be willing to spend a certain number of hours per week working in charity clinics or in other capacities where they could render health care to indigent patients. What we have done, in order to address that concern, is draft amendents to the Kansas act which governs liability of the state and its political sub-divisions. What we propose to do is define the phrase "charitable health care provider" in a way that would allow them to render charity care to indigent patients and thereby receive liability protection compliments of the state of Kansas.

Senator Burke wanted to know why this wasn't presented to the Judiciary Committee.

Mr. Whelan said he assumed it would be Judiciary Bill but he was requesting here because of the Chairman's participation in the Commission, as well as Senator's Anderson's participation because they understand this issue pretty well.

The Chairman recognized a motion by Senator Langworthy to present this as a committee bill. Senator Strick seconded the motion. The motion passed.

The Chairman called on Senator Reilly to present S.B. 529, who had sponsored the bill. Senator Reilly passed out the lastest facts from the National Conference of State Legislatures concerning AIDS.(Attachment 3) S.B. 529 is relative simple. Whenever any physician has information indicating a positive test for the HIV virus, that physician would immediately report it to the Secretary of Health. However, it does not include the name or identity of the person who has tested positive. This would merely mean that we

would be able to gather this information which is very important. At a NCSL meeting in New York they indicated that the three major wars of New York City were drugs, AIDS and other sexually transmitted diseases. New York had 23% of the cases of AIDS in the U.S., but only 3% of the population.

We have a requirement now that if a person is suffering or dying from AIDS, that knowledge is reported immediately to the Secretary together with the name and the address. This would merely give us another set of information relative to those who have tested positive with the HIV virus.

Senator Salisbury said she had a question with the language in Lines 26 through 31 and what it means.

Staff Furse said that language was the current law language for addressing those situations where the physician may be reviewing insurance physical. It wouldn't be within the course of their practice but through their employment they came upon it.

Senator Salisbury asked if this was aimed only at diagnostic?

Staff Furse said he wouldn't characterize it necessary as that but the inception would exclude those individuals who are reviewing, like for insurance and workers compensation.

Staff Correll said in essence the bill was intended to prevent double reporting.

The Chairman called for proponents to S.B. 529.

The first appearing was Chip Whelan, of the Kansas Medical Society. Mr. Whelan stated that a year ago that we discussed the same subject but at the time the legislation would have required that each report of HIV positivity be accompanied by the name and other characteristics of the patient. As explained last year, we have always stressed and firmly believe that it is extremely important to offer confidential testing for HIV. The reason is that even tho someone may not be HIV positive, that person has engaged in behavior that would put that person at risk of exposure to HIV, then it's extremely important that the physician or other health care provider counsel that person to discourage that person from continuing that type of activity or to take precautions in order to avoid exposure. Of course, if the person would test HIV positive, they need very important counseling and perhaps medication to delay the onset of AIDS.

In regards to S.B. 529 it does not require reporting of the name of the patient and therefore, would not jeopardize confidentially. We agree with the concept of reporting cases of HIV positivity because of the epidemiological value to the people at the Deparment of Health and Enviroment. It is important that only those cases of confirmed positivity should be reported. Furthermore, there may be additional information that may be obtained that would be of value to those that specialize in infectious diseases. S.B.553 would accomplish the same goal as S.B.529 but would accomplish that goal in a somewhat different manner. I would respectfully suggest to you the wording in S.B.553 should be incorporated in S.B.529 in order to make it a more effective piece of legislation. The other alternative would be the passage of S.B.553 for S.B.529.(Attachment 4)

The Chairman called proponent Dr. Charles Konigsberg of the Kansas Department of Health and Environment. Dr. Konigsberg stated KDHE backed this bill because it was clear that accurate data was needed to monitor HIV and AIDS in Kansas.(Attachment 5) Dr. Konigsberg pointed out the Intergovernmental AIDS Reports attached to the testimony entitled "HIV Reporting In the States". Only eight states have no HIV reporting requirement, Kansas is one of those. Dr. Konigsberg said KDHE had some techinical concerns about the bill. The bill does not allow for laboratory reporting which is an important source of information and there is a need for definition of certain terms. And we should be attentive to the discrimination and confidentiality provisions whenever dealing with AIDS legislation. He said that S.B. 529 is responsive to our public health concerns, but feel S.B.553 would provide more comprehensive reporting of HIV. It would also clarify what is to be reported.

Staff Correll said it was her understanding any reporting is to be confirmed by a second testing.

Dr. Konigsberg said yes. You get a lot of false positives with the screening tests which currently the HIV antibody tests. So its important, first of all, that those be repeated and if still positive, confirmed by a test such as the Western Blot or our lab uses another test. Those are what should be reported.

Staff Correll asked how it can be avoided having duplicate reports of AIDS victims if you don't have their names. I assume that's why you want some type of identification as in S.B.553.

Dr. Konigsberg said we have talked to some of our staff about that the issue raised about getting duplicate reports. I think the feeling is that while we would not have names we would have sufficient demographic information that would enable us to sort out duplicate reports.

Staff Correll said she would suggest when looking at S.B. 553 in some small communities it might be fairly easy to identify it by the individual.

Dr. Konigsberg said the information would come directly to KDHE rather than through the county health departments which is different than the way we do other reporting. We also have been very careful not to report AIDS in less than 10 cases in a small area.

Senator Salisbury asked what the states that require reporting AIDS victims by names accomplish by having the names?

Dr. Konigsberg said there are two benefits from reporting. One benefit is knowing the pattern of infection. What you do not get without names is the opportunity to offer the partner a prevention program.

Senator Salisbury asked if the physician wouldn't have the opportunity to contact the partner?

Dr. Konigsberg said he thinks the physician has that opportunity now to provide some counseling and to try to seek some help from public sources such as the local health departments when that's necessary. Of course, that takes voluntary cooperation on the part of the patient.

Senator Salisbury said she was trying to decide what a governmental agency could do that a person closest to them can't do.

Dr. Konigsberg said he thinks that trained personnel to do sensitive interviews could obtain more information than someone untrained.

I think it's a shared responsiblity. I don't think a public agency is never a substitute for the physician. There is a tremendous time issue here in length of time to counsel, amount of time it takes to try and find out who the contacts are and get those people in for counseling. There are a lot of special things that have to go on and techniques that makes sure that confidentiality be maintained.

Senator Salisbury asked if the names are not being requested or reported because it was a compelling reason not to do it or that it was not politically feasible?

Dr. Konigsberg said that what we proposed was most feasible and most acceptable at this point.

Staff Correll asked if there is any data on persons being tested out of state.

Dr. Konigsberg said no.

Staff Correll pointed out Colorado laws requirement to report names. In Boulder they have announced they are not reporting names and they have had an enormous increase in the testing since that policy was adopted. The publc health people in Colorado said they were aware that the people in Colorado go out of there to have testing done.

Dr. Konigsberg said they are aware of it. Goodland has a number of Colorado residents come in for testing. The concern is that if the program required names, it could run people off from being tested.

The Chairman asked if the Local Health Departments do the testing?

Dr. Konigsberg said that many of the testing sponsors are local health departments.

The Chairman said that would be one example how vitally important Local Health Departments are.

Dr. Konigsberg said yes, very definitely.

The Chairman called the proponent to S.B.529 Harold Riehm from Osteopathic Association. He was speaking for Dr. William Wade, who couldn't be present. He presented written testimony, pointing out Dr. Wade treated persons who tested HIV positive and suffering from the disease of AIDS. He and Dr. Wade appear in support of the bill, to maintain confidentiality. Dr. Wade requested Page 1, lines 23 and 30 and Page 2, line 34, the words "a person (who) has tested positive for HIV..." be reconsidered because it is vague. These words would be substituted "a person has been confirmed positive for evidence of HIV infection...". Also, the time requirement be changed from "immediately" to a specified time, such as ten days. Dr. Wade reports that often it is a period of six months after there has been an initial false positive can actually determine if there is an accurate positive. Attachment 6

The Chairman called Elizabeth Taylor, of the Association of Local Health Departments, a proponent for S.B.529. Ms. Taylor stated there are three options as listed on Page 2 of her testimony. A. Continue education and anonymous testing. B. Continue education and voluntary anonymous testing of high risk individuals and mandate reporting of HIV positive blood tests. Voluntary follow-up of contacts should be authorized. The last one (C) is the one the Association was favoring. Supply increased funding for AIDS.

In essense it would continue testing, counseling and education, mandate reporting without names of positive HIV blood tests, support public health departments in their efforts, offer voluntary testing in clinics for family planning and sexually transmitted diseases, provide voluntary testing for individuals not in high-risk groups. Attachment 2

The fiscal impact would be to draw blood for the test and provide counseling is estimated at $20.00 person to the Local Health Department.

Mrs. Taylor said to follow up on a question by Senator Salisbury, they encourage testing and encourage reporting by name. As an association of Local Health Departments, their primary concern is diminishing the spread of the disease and we feel that reporting of names is essential. However, their position in this bill, is that names would be withheld.

We support S.B.529 and also support the addition in the language you will hear tomorrow on S.B.583

Mrs. Taylor said that the Local Health Departments offers both anonyomous testing and confidential testing. We can only do follow-ups with their participation. And some chose to not participate in partner notification. There is a real problem with that.

Chip Whelan requested to be recognized. The only reason he asked was to point out in the draft of his testimony the balloon copy that addresses the question of partner notification. I anticipated that might come up today. This would allow the physician to inform the spouse.(Attachment 4)

The Chairman said concerning the hearings held last week on the parents of foster care, the intent of the Chairman is to point a Sub-Committee. Any member who would like to serve on the Sub-Committee speak to Senator Walker, the Ranking Minority Member of the Committee or Vice-Chair Senator Langworthy.

The Chairman said Senator Langworthy wanted to offer some changes to S.B.434(Attachment 8). This would strengthen the intent of what most people are interested in, the foster family make an important decision regarding their acceptance of a child and the problems they could run into. Page 1, line 34 , after the word "shall" add "seek to obtain and shall" and at the end of line 35 add "As the information becomes available to the secretary." The intent is to insure that S.R.S. doesn't say they don't have any information. It encourages them to try to get the information and then provide it to the foster parent.

The Chairman called for a motion to approve the amendment. Senator Langworthy made the motion. Senator Salisbury seconded the motion. The motion carried.

The Chairman called on Staff Furse.

Staff Furse said the Chairman received a letter from Dr. Thomas White of El Dorado concerning legislation of S.B. 434. The letter points out the question of definition of foster family. The foster family is defined as all persons living in the foster home other than the foster children. This was picked up from S.R.S.'s Rules and Regulations. This would include also the foster home licensee, the spouse and the children of that person. So the question is whether this information should be made available to all the family. The information needs to be made available

but Dr. White is pointing out that it shouldn't be made available to all the family, including the children of the foster parent. (Attachment 9)

The Chairman said with the magnitude of the letter that Staff Furse has broken down, it would be placed for study in a Sub-Committee. Chairperson will be Senator Langworthy, Senator Walker and Senator Salisbury.

The Committee adjourned at 11:00a.m. The next meeting will be January 31, 1990, in Room 526-S, at 10:00a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 1/30/90

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Charles Konigsberg, M.D.	KDHE
Richard Morrissey	KDHE
Bob Williams	Ks. Pharmacists Assoc
Carl Schmirthenner	Ks Dental Assn.
PAT HAYS	KDHE
Tom Gress	KS Hos. Assn.
Rebecca Harsh	Rep Charlton's office
Beth Powers	Ks. Choice Alliance
ALAN COBB	KS RESP. CARE SOCIETY
Howard Liebb	KAOM
Kelly Waldo	KCA
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Deborah K. Taylor	KDHE
Robert French	KDHE
	SRS
Rick Sabol	FOP
Elizabeth C. TAYLOR	Ks Assn of Local Depts Health
Mike Lane	Intern - Sen. Burke.
Jerry SLAUGHTER	KNS

Please sign on next page if this is full.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 1/30/90

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Chip Wheelen	Ks Medical Society
Dave Ranney	Home Nurs Serv
Gary Hulett	Governor's Office

PROPOSED STATUTORY AMENDMENT TO

K.S.A. 65-1444

65-1444. Drugs; surgery; anaesthetics; appliances. A dentist shall have the right to prescribe drugs or medicine, perform such surgical operations, administer <u>analgesia</u>, ~~general or~~ local anaesthetics and use such appliances as may be necessary to the proper practice of dentistry. <u>Dentists may be authorized to administer intravenous sedation and general anaesthetics subject to regulations concerning qualification or certification of such dentists as may be adopted by the Board</u>.

SP H+W
Attachment 1
1/30/90

K.S.A. 1988 Supp.

75-6102. Definitions. As used in K.S.A. 75-6101 through 75-6118, and amendments thereto, unless the context clearly requires otherwise:

(a) "State" means the state of Kansas and any department or branch of state government, or any agency, authority, institution or other instrumentality thereof.

(b) "Municipality" means any county, township, city, school district or other political or taxing subdivision of the state, or any agency, authority, institution or other instrumentality thereof.

(c) "Governmental entity" means state or municipality.

(d) "Employee" means any officer, employee, servant or member of a board, commission, committee, division, department, branch or council of a governmental entity, including elected or appointed officials and persons acting on behalf or in service of a governmental entity in any official capacity, whether with or without compensation. "Employee" does not include an independent contractor under contract with a governmental entity. "Employee" does include former employees for acts and omissions within the scope of their employment during their former employment with the governmental entity.

(e) "Community service work" means public or community service performed by a person (1) as a result of a contract of diversion entered into by such person as authorized by law, (2) pursuant to the assignment of such person by a court to a community corrections program, (3) as a result of suspension of sentence or as a condition of probation pursuant to court order, (4) in lieu of a fine imposed by court order or (5) as a condition of placement ordered by a court pursuant to K.S.A. 38-1663 and amendments thereto.

History: L. 1979, ch. 186, § 2; L. 1982, ch. 374, § 1; L. 1983, ch. 299, § 1; L. 1987, ch. 353, § 1; July 1.

DRAFT

SPH+W Attachment 2 1/30/90

("Employee" does include any charitable health care provider for purposes of any claim arising as a result of professional services rendered by the charitable health care provider to a medically indigent person pursuant to an agreement between the charitable health care provider and the secretary of social and rehabilitation services. Such charitable health care provider shall be considered an employee of the state under the provisions of such agreement.

("Charitable health care provider" means a health care provider as defined in K.S.A. 40-3401 and amendments thereto and K.S.A. 65-4921 and amendments thereto who has entered into an agreement with the secretary of social and rehabilitation services which stipulates that when such health care provider renders professional services to a medically indigent person that such services will be provided gratuitously.

(f) "Medically indigent person" means a person who meets eligibility criteria established by administrative regulations adopted by the secretary of social and rehabilitation services which determine that the person lacks resources to pay for medically necessary health care services.

off (g)

Chapter 143, '89 Laws

Sec. 7. K.S.A. 75-6115 is hereby amended to read as follows: 75-6115. *(a)* The Kansas tort claims act shall not be applicable to claims arising from the rendering of or failure to render professional services by a health care provider *other than a hospital owned by a municipality and the employees thereof.* Claims for damages against a health care provider that is a governmental entity or an employee of a governmental entity *other than a hospital owned by a municipality and the employees thereof,* arising out of the rendering or failure to render professional services by such health care provider, may be recovered in the same manner as claims for damages against any other health care provider.

(b) As used in this section:

(1) "Health care provider" shall have the meaning provided by K.S.A. 40-3401, and amendments thereto.

(2) "Hospital" means a medical care facility as defined in K.S.A. 65-425, and amendments thereto, and includes within its meaning any clinic, school of nursing, long-term care facility, child-care facility and emergency medical or ambulance service operated in connection with the operation of the medical care facility.

a charitable health care provider or

(3) "Charitable health care provider" shall have the meaning provided by K.S.A. 75-6102, and amendments thereto.

2-7

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Chip Wheelen
Director of Public Affairs

1990 Session
ALE

AIDS FACTS TO CONSIDER

AUGUST 1989 UPDATE

Compiled by Tracey A. Hooker

HIV/AIDS INFORMATION AND EDUCATION PROJECT
FOR STATE LEGISLATORS

Health and Mental Health Program

National Conference of State Legislatures
1050 17th Street, Suite 2100
Denver, CO 80265
303/623-7800

SPH+W
Attachment 3
11/30/90

DESCRIPTION

* The Centers for Disease Control (CDC) considers a case of acquired immune deficiency syndrome (AIDS) reportable when an individual has an **unusual opportunistic infection** including **protozoal, fungal, bacterial,** and **viral**, or **rare malignancy** which occurs in an otherwise healthy individual. The infection or malignancy must suggest immune deficiency. The individual must have no prior illness or medication use that would independently increase risk for the clinical manifestations.

* As of October 1987, the CDC included the **wasting syndrome** (emaciation) and **dementia** in the definition of AIDS.

* Fungal, parasitic, and viral infections are **rarely curable** and are often **life-threatening** to persons with AIDS (PWAs). Although the infections can be controlled during an acute episode, the patient usually requires long term suppressive therapy.

* The occurrence of **infections** in PWAs are **rarely single**. Infections with different organisms often occur at the same time or consecutively.

* HIV-infected persons may develop **neurologic disorders** which can cause **forgetfulness, short-term memory loss, loss of coordination, partial paralysis**, and **dementia**. These symptoms may occur in the absence of any other symptoms of AIDS.

CASELOAD TRENDS

* As of **June 1989** there were **99,936** reported **cases of AIDS** in the United States and territories. Number of known **deaths** since June 1981 is **58,014.**

* The Public Health Service estimates that between **945,000 and 1.4 million** Americans are infected with the human immuno-deficiency virus (HIV).

* A June 1989 **General Accounting Office** (GAO) study, concludes that the CDC **underestimated** its **1991 forecast** for cumulative AIDS cases by about **30%**. While CDC projects between **185,000 and 320,000** cases, the **GAO** believes a more realistic range lies between **300,000** and **485,000** cumulative AIDS cases by the **end of 1991**. The GAO also believes the true proportion of **heterosexual cases** to be **higher** than CDC estimates.

* The **CDC** estimates by the end of **1992** there will be a cumulative total of **365,000** cases of AIDS. Newly diagnosed cases by the end of 1992 will total **80,000** and **170,000 patients will be under treatment for clinical symptoms.**

* **Blacks** compose **12%** of the **U.S. population**, but constitute **27% of AIDS cases. Hispanics** compose **6%** of the **U.S. population** and constitute **15% of AIDS cases.**

* Sample blood tests taken on 19 college campuses suggests that about **1 in 500 college students are infected with HIV**. This rate is slightly higher than that reported for military recruits.

* To date, the highest cumulative numbers of AIDS cases have been reported in **New York, California, Florida, New Jersey, Texas, Illinois, Pennsylvania, Puerto Rico, Georgia, Massachusetts, and Maryland.**

* Between 1986 and December 1987, low incidence states increased 100% or more in their number of AIDS cases. These states include: **Missouri, Oregon, Alabama, Rhode Island, New Hampshire, West Virginia, and Vermont.**

* AIDS is becoming a **suburban** and **rural disease**. Many persons with AIDS are returning to live in hometown communities.

* The U.S. Public Health Service has predicted **80% of AIDS cases** diagnosed in the early 1990's will be **outside** of current **high incidence areas.**

INCUBATION

* A CDC and San Francisco Department of Public Health study indicated an average **incubation period of 7.8 years** for the sample of homosexual men. An average incubation period for development of AIDS from contaminated blood is **8.2** years. Other studies show the incubation period can be as long as **15** years.

TRANSMISSION

* The human immunodeficiency virus (HIV), the virus that causes AIDS, is transmitted through **sexual contact** and **exposure to infected blood or blood components** and **perinatally** from mother to child. Epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

* As of May 1989, the CDC reports the following percentage of cases in exposure categories for those 13 years and older at time of diagnosis: male homosexual/bisexual contact - **61%**, intravenous (IV) drug use - **20%**, male homosexual/bisexual contact and IV drug use - **7%**, hemophilia/blood coagulation disorder - **1%**, heterosexual contact - **5%**, receipt of transfusion of blood, blood components, or tissue - **2%**, undetermined (due to incomplete information) - **3%**.

* The percentage of **new AIDS cases** attributed to **IV drug use** continues to **climb**, from **21%** in **May 1988** to **23%** in **May 1989**. During the same time period, the percentage of **new cases** attributed to **male homosexual/bisexual contact** continue to **drop**, from **60%** to **57%.**

* Intravenous drug use is the principle cause of the spread of AIDS in the heterosexual population and to children through perinatal transmission.

PEDIATRIC AIDS

* As of June, 1989 there were **1681** reported AIDS cases among **children** under age thirteen of which **79%** had been born to mothers with or at risk of AIDS.

* It is estimated that by **1991** there may be **10,000** to **20,000** symptomatic HIV infected infants and children in the United States.

* A study at Yale New Haven Hospital in Connecticut indicated children infected with HIV are incurring hospital bills of more than **$90,000,** often because they have nowhere else to go.

COSTS

* Very little is known about the cost of treating people with wasting syndrome, dementia and other manifestations of HIV.

* A February 1989 study from the National Center of Health Services Research (NCHSR), estimates **lifetime treatment cost** for a person with AIDS at **$60,000**.

* A cost analysis in Science, February 5, 1988 suggests that the **lifetime cost** of medical care for an **AIDS patient** will not exceed $80,000. In comparison, for males age 35 to 44, lifetime per-patient medical costs (in 1986 dollars) are **$67,000** for **heart attack** and **$47,500** for **cancer** of the digestive system. Lifetime costs are **$68,700** for individuals of all ages with **paraplegia** as a result of motor vehicle accidents.

* A February 1988 report from the Minnesota Department of Health estimated **non-hospital costs** per patient year, including AZT, at **$7,630.** Range of **total medical care** and related services costs for an **AIDS patient** are estimated between **$19,880** and **$41,700** per patient year. Medical care and related services costs for an **ARC patient** are estimated between **$13,290** and **$24,300** per patient year.

* Evidence suggests increased knowledge about AIDS and development of new **coordinated, community based systems of care** that depend less on hospital care have **lowered the costs** of treating an AIDS patient.

* Federal AIDS spending now makes up **10%** of the **Public Health Service budget** and **40%** of the **CDC budget.**

* In **1989** the **federal government** will spend **$2.2 billion**, on AIDS--research (40%), education and prevention (20%), medical care (34%), and cash assistance (6%)--or about **1%** of all federal health expenditures. The federal spending represents **over one third** of all estimated **national HIV expenditures**, and **triples state expenditures.**

* Indirect costs attributable to loss of productivity resulting from morbidity and premature mortality, are estimated to be **$541,000** to **$623,000** per AIDS patient.

DRUG TREATMENT

* **Azidothymidine** (**AZT**) is the **only medication licensed** for the treatment of AIDS, but is approved for use only in the sickest patients.

* A study announced by the National Institute of Health concludes that **AZT** can **significantly delay** the **onset of AIDS** in people just starting to show symptoms of decline in the immune system. Between 100,000 and 200,000 Americans are estimated to have mild symptoms of AIDS and may benefit from early treatment.

* The cost of **AZT** is between **$7,000** and **$8,000** a year. Cost per bottle of 100 AZT tablets at a pharmacy is about **$185.00**. Refills are needed every 8 to 12 days.

* About **one third** to **one half of AIDS patients** who begin AZT treatment **discontinue** because of adverse side effects such as severe anemia.

* A recent study indicates AZT may be less toxic to people in earlier stages of HIV illness.

* According to a study by Burroughs Wellcome Company, producer of AZT, several strains of HIV have become resistant to the drug. The company also reported that the longer patients are treated with AZT, the less effective the drugs appeared in those patients.

HOSPITAL UTILIZATION

* A preliminary study of hospital treatment done by National Public Health and Hospital Institute indicated between 1986 and 1988, on average, the hospital AIDS caseload has risen over **35%** for **private hospitals** and **100%** for **public hospitals.**

* The National Public Health and Hospital Institute study indicates **average length of stay** at **20.29 days,** number of **days per patient per year** at **31.5** and **admissions** per patient year at **1.55** for 1987.

* The NPH and HI study pointed out that fewer than **30%** of all hospitals utilized **case management.** Although, **public hospitals** were more likely to use case management than private hospitals (**40%** versus **19%** respectively).

* Hospitalized AIDS patients require **two and one-half times more nursing care** than medical/surgical patients.

* By 1991, about **5.9 million hospital days of care** will be provided to AIDS patients, more than twice (2.8 million) the number for lung cancer patients.

MEDICAID / MEDICARE

* Nationally **40%** of all persons with AIDS are **covered under Medicaid.** The proportion may be as high as **65%** to **75%** in some areas of New York City and New Jersey.

* The Health Care Financing Administration estimates that **Medicaid spent** about **$400 million** on AIDS medical care in **1987** and will spend **$2.4 billion** by **1992.**

* **Medicare benefits** are available to persons with AIDS who survive a **24-month waiting period** after becoming disabled and receiving Social Security benefits, or who are 65 years or older.

* **California, Hawaii, New Jersey, New Mexico, Ohio, and South Carolina** have active Medicaid waiver programs, providing home- and community-based services for people with AIDS and AIDS-related complex. **Illinois** and **North Carolina** use existing Medicaid waivers for the disabled to provide services to children with AIDS.

* The federal government grants Medicaid waivers for home and community-based services only if states can prove that such care will cost less than traditional, institution-based care.

TESTING

* As of August 1989, **Illinois** reported **50 positive premarital HIV antibody tests** out of **250,000** tests done since January 1, 1988. The state estimates at a conservative cost of $35 per test, each documented case of HIV infection cost about $175,000. As of December 9, 1988, **51%** of all marriage licenses issued in Kenosha County, Wisconsin, were to Illinois residents.

* **Louisiana**, the only other state to pass legislation mandating **premarital AIDS testing, repealed** the law in 1988.

* At least **23 states** require HIV testing to be **voluntary** and based on the individual's **informed consent** (except under certain circumstances).

* Researchers from the University of California, Los Angeles, report that **HIV can remain dormant** in an infected individual for up to **three years** without triggering the production of antibodies.

CRIMINAL PENALTIES

* At least **12 states** make it a **criminal penalty** for knowingly or willfully **exposing others** to HIV infection.

DISCRIMINATION

* At least **20 states** have developed targeted **antidiscrimination protections** for people with AIDS. The laws relate to testing, use of information, employment, insurance, and access to medical care.

EDUCATION

* Some form of **public school AIDS education** is required in **28 states and Washington D.C.**

NEEDLE EXCHANGE

* **New York City, Boulder, Colorado, and Tacoma, Washington** have implemented **needle-exchange programs** even though these jurisdictions are located within states which have laws against the use or possession and sale or delivery of hypodermic needles.

WORKER NOTIFICATION

* At least **34 states** have passed laws requiring or permitting **workers** (mostly emergency medical technicians and funeral personnel) to be **notified** of **potential exposure to HIV.**

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

January 30, 1990

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheeler

SUBJECT: Senate Bill 529; HIV Reporting

Thank you for this opportunity to offer a few comments about 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 current form, SB529 would appear to require reporting by a physician of all positive HIV tests, whether confirmed or not. This would distort any statistics obtained and would thereby jeopardize the epidemiological value of HIV reporting.

At the time this hearing was scheduled, SB553 was not yet referred to this Committee. Senate Bill 553 accomplishes the same general goal as SB529 but defines a number of terms and imposes more elaborate reporting of demographic characteristics in order to be of greater value to epidemiologists and other infectious disease specialists. For this reason, we respectfully suggest that SB529 be amended or substituted to incorporate the provisions of SB553. Another option of course would be to recommend passage of SB553 in lieu of SB529.

Thank you for considering our concerns. We trust that you will take appropriate action.

CW:lg

SPH+W
Attachment 4
1/30/90

K.S.A. 1989 Supp. 65-6004 is hereby amended to read as follows:

65-6004. Physician authorized to disclose to certain ~~health care providers~~ information about patient who has AIDS or who has had a positive reaction to an AIDS test; confidentiality of information; immunity in judicial proceedings. (a) Notwithstanding any other law to the contrary, a physician performing medical or surgical procedures on a patient who the physician knows has AIDS or has had a positive reaction to an AIDS test may disclose such information to other health care providers who will be placed in contact with bodily fluids of such patient ~~during such procedures.~~ The information shall be confidential and shall not be disclosed by such health care providers except as may be necessary in providing treatment for such patient.

(b) Any physician who discloses information in accordance with the provisions of this section in good faith and without malice shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such disclosure. Any such physician shall have the same immunity with respect to participation in any judicial proceeding resulting from such disclosure.

History: L. 1988, ch. 232, § 4; July 1.

persons

or emergency personnel

have been or

or emergency personnel

Notwithstanding any other law to the contrary, a physician who has reason to believe that the spouse of a person who has had a positive reaction to an AIDS test may have been exposed to HIV and is unaware of such exposure, may inform the spouse of the risk of exposure.

(c) Nothing in this section shall be construed to create a duty to warn any person of possible exposure to HIV.

(d)

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290

Stanley C. Grant, Ph.D., Secretary

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

Testimony Presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

Senate Bill 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 that 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.

SPH+W
Attachment 5
1/30/90

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.

There are some technical concerns we have about Senate Bill 529. The bill does not allow for laboratory reporting which is an important and reliable source of information and does not 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.

Recommendations

The Department is supportive of reporting of HIV positives without names, feeling that this measure will gain essential data. Senate Bill 529 is responsive to our public health concerns, but we feel that Senate Bill 553 would provide more comprehensive coverage of HIV reporting.

Testimony by:

Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
January 30, 1990

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. 5-5

FAMILY MEDICINE AND COUNSELING

1115 SW 10TH STREET SUITE A TOPEKA, KS 66604-1105 (913) 233-8268

January 30, 1990

Public Health and Welfare Committee, Senate
Senator Roy Ehrlich, Chair
Statehouse
Topeka, Kansas

RE:**Senate Bill No:529**

Senator Ehrlich,
Members of the Public Health and Welfare Committee:

Senate Bill No. 529 is "an ACT requiring reporting of certain information relating to human immunodeficiency virus to the secretary of health and environment; amending K.S.A. 1989 Supp. 65-6002, 65-6003,65-6005 and 65-6006 and repealing the existing sections."

I support this bill by Senators Steineger and Reilly, in principle. The new reporting provisions will enable Kansas Department of Health and Environment to more accurately track the incidence of HIV infection in Kansas. I applaud the provision for reporting without patient identification. Identification of the patient would provide unnecessary breach of patient-physician confidentiality and serves no useful purpose.

Due to the increasing number of laboratory tests available to conclusively determine the status of HIV infection, the definition of "a person [who] has tested positive for HIV..." (pg 1, lines 22,30; and pg 2, line 34) is vague and in danger of misinterpretation by some physicians.

Attachment 6
1/30/90

FAMILY MEDICINE AND COUNSELING
1115 SW 10TH STREET SUITE A TOPEKA, KS 66604-1105 (913) 233-8268

False positive and indeterminate test results continue to occur, especially in populations of people who have no history of "at-risk" behavior. In deference to this fact, and to avoid over reporting of persons not actually infected with HIV, I propose the following:

Wherever the phrase "...a person has tested positive for HIV..." occurs (pg 1, lines 33 and 30; and pg 2, line 34), this phrase should be replaced by: **"...a person has been confirmed positive for evidence of HIV infection..."** Also, I recommend changing the time requirement from "immediately", wherever it occurs, to a specified time, such as ten days.

Clarification of what it means to "test positive for HIV" by the above proposed change will prevent the reporting of false positive and indeterminate cases.

As we struggle to balance the interest of public health and welfare with the respect for individual confidentiality, I feel Senate Bill 529, with the implementation of these changes, will do both.

Respectfully Submitted

William E. Wade, D.O.
Family Medicine and Sexually Transmitted Diseases

6-2

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

SPHTW
Attachment 7
1/30/90

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

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

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.

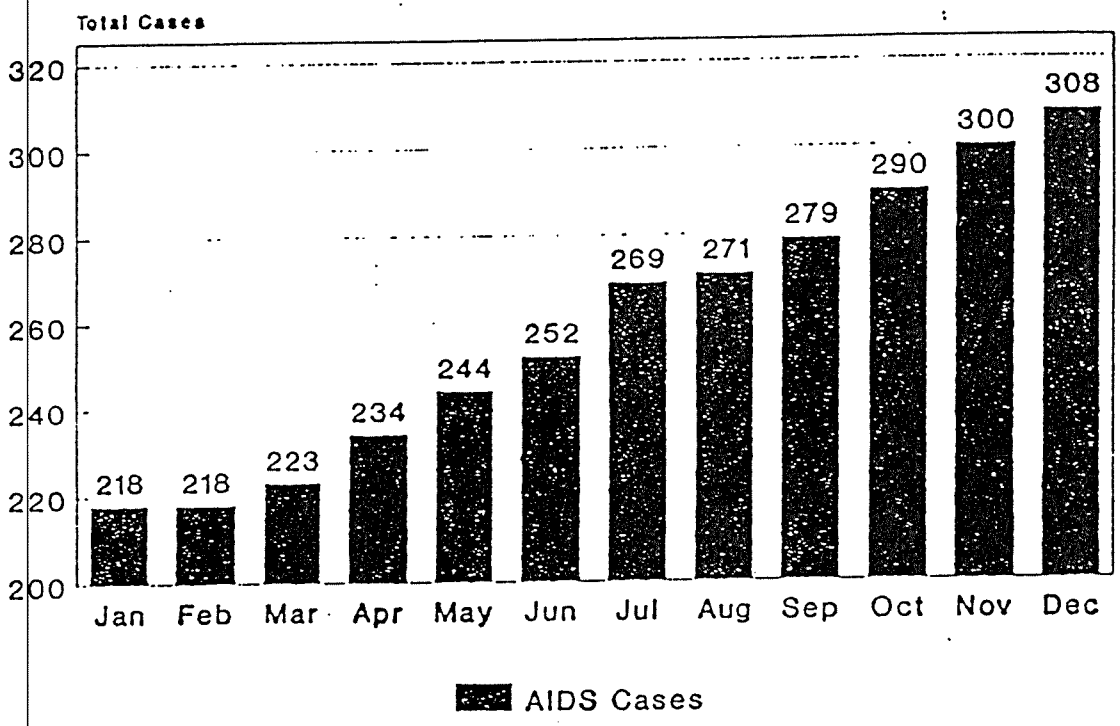
VIII. Supporting Documents

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

Approved by KALHD Board of Directors January 22, 1990

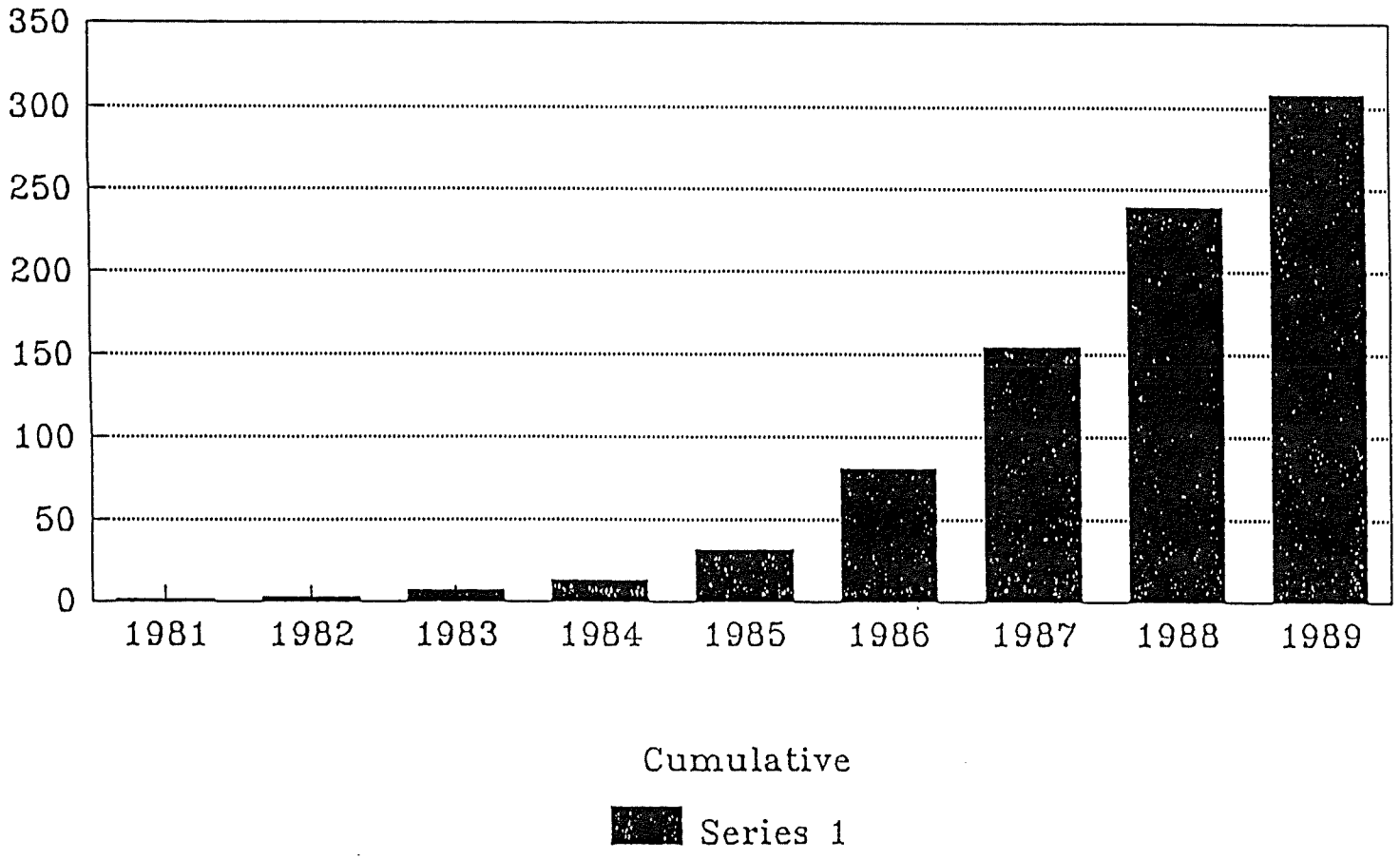
Cumulative AIDS Cases in Kansas to Date

1989 Statistics



Kansas AIDS Cases to Date

Progression of Cumulative Data



(All cases have not yet been reported)

SPHW
Attachment 8
1/30/90

Session of 1990

SENATE BILL No. 434

By Special Committee on Public Health and Welfare

Re Proposal No. 46

12-21

AN ACT concerning foster care of children; relating to information available to the foster family from the secretary of social and rehabilitation services.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) As used in this section:

(1) "Child" means a person under 18 years of age who has been removed from the home of a relative as a result of judicial determination and whose placement and care is the responsibility of the secretary.

(2) "Family foster home" means a private home in which care is given for 24 hours a day for children away from their parent or guardian and which is licensed under K.A.R. 28-4-311 et seq.

(3) "Foster family" means all persons living in the foster home other than foster children.

(4) "Secretary" means the secretary of social and rehabilitation services.

(b) In order to assist the foster family to make an informed decision regarding their acceptance of a particular child, to help the foster family anticipate problems which may occur during the child's placement and to help the foster family meet the needs of the child in a constructive manner, the secretary shall provide the following information to the foster family:

seek to obtain and shall

as the information becomes available to the secretary

(1) Strengths, needs and general behavior of the child;

(2) circumstances which necessitated placement;

(3) information about the child's family and the child's relationship to the family which may affect the placement;

(4) important life experiences and relationships which may affect the child's feelings, behavior, attitudes or adjustment;

(5) medical history of the child, including third-party coverage which may be available to the child; and

(6) education history, to include present grade placement, special

strengths and weaknesses.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

P.O. Box 89, 1805 Hazlett
El Dorado, Kansas 67042
January 11, 1989

Chairman, Senate Special Committee on Public Health & Welfare
Kansas Senate
Capitol Building
Topeka

Dear Chairperson:

This is regarding Senate Bill No. 434, Re Proposal No. 46, "AN ACT concerning foster care of children; relating to information available to the foster family from the secretary of social and rehabilitation services."

The act is far too inclusive, and provides for the virtually unlimited and uncontrolled intrusion of privacy by foster families into the lives of children in placement, and of their natural families. Note that under the act even minor natural or adopted children of the foster parent(s) would be privy to confidential information concerning foster children in placement!

Many foster parents are themselves quite limited: About the only requirement which they must meet under the regulations is that they be 18 years of age. Is is a very common situation that foster mothers have cohabitating boy friends living with (and all too often doing inappropriate things, including sexual abuse of) foster children. As you may be aware, a study by the ACLU indicates that children in foster placement are about ten times as likely to be abused in foster placement, including sexual abuse, as are children in the general population. Teen aged girls placed in the homes of foster mothers with cohabitating boy friends are almost <u>certain</u> to be sexually abused or exploited, a very common although rarely reported or even acknowledged occurrence in the SRS foster placements of puberty and teen aged girls in the state of Kansas. Under provisions of the act, "Foster family' means all persons living in the foster home other than foster children", [Section 1. (a) (3)]. This means that virtually unlimited information concerning the child in placement and his or her natural family would be indiscriminately shared with all manner of people residing in the home, not limited to the licensee, and including live-in boy friends, and other friends and relatives residing in the home.

Moreover, Section 1. (b), makes it <u>mandatory</u> that the secretary "<u>shall</u> provide the following information to the foster family" (underlining mine). Thus, the most sensitive and embarrassing information concerning a child and his natural family would <u>in every case</u> be shared with every adult in the foster placement environment, and with minor natural

SPH&W
Attachment 9
1/30/90

and adoptive children of the foster parent(s).

It is my opinion that information concerning Section 1 (b), items (2) through (4) (circumstances necessitating placement, information about the child's family and the child's relationship to the family which may affect placement, and important life experiences and relationships which may affect the child's feelings, behavior, attitudes or adjustment) is best evaluated by the professional social worker handling the placement, and shared with the foster family only on a "need to know" basis, as determined by the responsible professional in each case.

A pervasive problem with this proposed act is that it by nature violates the code of professional responsibility for social work and social workers as set out by the Kansas Behavioral Sciences Regulatory Board as it addresses issues of professional confidentiality, as specified in the relevant Kansas Administrative Regulations.

The proposal of and for this act, Senate Bill 434, is illustrative of what happens when such proposals are made by a secretary of social and rehabilitation who is not a professional social worker, and by a commissioner of protective services who, likewise, is not a professional social worker. Neither administrator sufficiently appreciates the demonstrated need to maintain high professional standards of social work and social work services in the state's social services, including child protective services. This proposed bill is an example of pervasive efforts to deprofessionalize public (SRS) social work, and to degrade services to children.

At the very minimum, "foster family" should be defined as the principal licensee; the phrase "secretary shall provide" should be amended to read "secretary may provide", and the phrase "following information to the foster family" should be made to read "following information to the foster family according to the professional discretion of the social worker of record in each case:"

Actually, the entire bill is superfluous. A competent child welfare worker is professionally equipped and motivated to share such information, but <u>only</u> such information, as is in the best interests of the child, keeping in mind the principle of professional confidentiality governing the practice of social work from both the strictly professional and Behavioral Science Board points of view. This bill would, in effect, substitute the judgement (and the curiosity) <u>of even potential foster parents</u> for that of the SRS social worker in matters of the disclosure of information relating to foster home planning and placement.

I would respectfully submit that the proposed bill is, as

noted, unnecessary, inimical to the best interests of children in need of care, and contrary to the spirit and intent of professional social work as embodied in the Kansas Behavioral Sciences Regulatory Board code of professional responsibility.

I urge the Special Committee, as well, to realize that most children placed in foster care should be in such care only temporarily, and that most should rejoin their natural families at the earliest practicable time. It is naively unrealistic to expect foster parents and "family" to maintain confidences indiscriminately shared with them concerning the most intimate aspects of the life of the foster child and of his or her natural family. This bill would create a situation in which children in need of care and their natural families would rapidly become the subjects of the most inane and vicious gossip imaginable. This might satisfy some people who think that natural parents and children in need of care are less than human, but it won't do anything in a positive way for the future adjustment of the children and natural families so affected.

Thank you for your kind attention to these views.

Copy: Hon. Kenneth Green

Sincerely yours,

Thomas S. White

Thomas S. White,
LMSW, Ph.D.