Approved 2-18-91
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader at
Chairperson

1:30 ~~a.m.~~/p.m. on February 12, 1991 in room 423-S of the Capitol.

All members were present except:

Representative Theo Cribbs, excused
Representative Melvin Neufeld, excused

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Steve McDowell, Office of Local/Rural Health Systems, Divison of Health Department of Health/Environment
Dr. Charles Konigsberg, Director, Div. of Health, Dept. Health/Environment
Elizabeth Taylor, Association of Local Health Departments
Dr. Darrel Newkirk, Director Ks. City, Wyandotte County Health Dept. (Written testimony only)

Chair called meeting to order, drawing attention to committee minutes presented. Rep. Hackler moved to approve minutes of February 11, 1991 as presented, seconded by Rep. Weiland, motion carried.

Chair drew attention to (Attachment No. 1), prepared by Research Department in answer to a question raised regarding ICFs/MR beds. Mr. Rick Shults, Director of Community MR programs supplied printed information.

Chair then invited Ms. Correll to explain the procedure required for requesting an Interim study. Ms. Correll gave procedures, and noted the final decision lies with the Legislative Coordinating Council as to what legislation will be referred to Interim.

Chair then drew attention to **HB 2019,** calling on Ms. Correll to give a briefing on the bill.

Ms. Correll gave a detailed history and explanation of HB 2019 , section by section. She drew attention to New Sec. 1, page 1, noting perhaps members might wish to underline "within the limits of appropriations available therefor" since it would be a topic under discussion when the bill is worked in Committee. She noted Sec. 2 might be viewed by some as controversial. Ms. Correll answered numerous questions.

Steve McDowell, Director office of Local/Rural Health Systems, Department of Health/Environment offered hand-out (Attachment No. 2), background information and testimony on **HB 2019.** He gave detailed background information in regard to policy goals for the Department of Health/Environment, access to health care for rural Kansans, and models for solutions to health care access both urban and rural. He noted the Department of Health/Environment has two technical concerns about **HB 2019** , i.e., the date for completed applications to KDHE would be more appropriate as October 1, 1991; the evaluation and review of projects should perhaps be delegated to someone outside of the pilot projects. He stated a primary concern of KDHE is the medically indigent. He outlined clinics presently on line, indicating start-up costs, and costs per client annually. He noted fiscal impact to the state would be based on the determination of the amount of general fund support given for the operation of these demonstration sites. He answered numerous questions.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on February 12, 19 91

HEARINGS CONTINUED ON HB 2019: A lengthy discussion and questions ensued, i.e., "primary care".

Dr. Charles Konigsberg, Department of Health/Environment also answered numerous questions and talked about the definition of "primary care".

Elizabeth Taylor, Association of Local Health Departments offered hand-out (Attachment No. 3), the Association's paper on primary care for the medically indigent. Ms. Taylor outlined the role of Local Health Departments in the delivery of primary care, i.e., locations already in the communities; preventive health services should be integrated into the delivery of primary care services; other states have adopted the model of utilizing local health departments in delivery of primary care services; would strengthen the image and influence of local health departments in communities. She spoke also about why local health departments should not provide primary care services, i.e., if they're strapped with delivering illness care too, there is concern resources will be shifted away from preventive care to illness care. There is great concern with funding decreases. She noted recommendations of the Association, i.e., new and separate adequate funding be provided for 3 pilot projects; physicians working in or for local health departments be considered as charitable medical providers and considered as state employees as far as medical malpractice coverage is concerned; working in any local health department be considered acceptable payback of time owed to the state in its medical and nursing scholarship programs. She noted amendment recommendations, i.e., pilot project for the smallest population base should be 25,000 to 50,000.

Ms. Taylor also offered hand-out (Attachment No. 4), printed testimony from Dr. Darrel Newkirk, Director Kansas City-Wyandotte County Health Department. (Dr. Newkirk was unable to present testimony in person). Ms. Taylor highlighted a few of Dr. Newkirk's comments, i.e., his support for **HB 2019**, and the approach to fund 3 pilot projects is a cautious, reasonable approach in the delivery of primary illness care; concerns regarding funding. Prevention care funding should not be used for primary care is a services.

Chair entertained continued questioning, and Mr. McDowell and Dr. Konigsberg both answered questions at this time.

Chair asked both Mr. McDowell and Dr. Konigsberg to be present when further discussion on **HB 2019** continues. They agreed to do so.

Chair adjourned meeting at 3:04 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb. 12, 1991

NAME	ORGANIZATION	ADDRESS
KEITH Ry LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Charles Konigsberg, M.D.	KDHE	Topeka
Steve McDowell	KDHE	Topeka
Mike Atwood	Ks Acad Fam Phys.	Topeka
Doug Bowman	Children & Youth Advisory	"
Cathie Seal	SRS OMP	Topeka
Martha Gabehart	Ks Com. on Disability Concerns	Topeka
Richard Morrissey	KDHE	"
Ken Bahr	Ks. Hospital Assn	"
ALAN COBB	WICHITA HOSPITALS	WICHITA
Tom Gress	KHA	Topeka
Gregg Felix	K-NASW	Topeka
Jack Chasen	KTLA	"
John Holmyer	Catholic Health Assn	Topeka
LISA GETZ	WICHITA Hospitals	WICHITA
ELIZABETH E. TAYLOR	Asso of Local Health Depts	TOPEKA

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

Mental Health & Retardation Services
Fifth Floor North
(913) 296-3561

February 8, 1991

To: Laura Howard

From: Rick Shults
Director, Community MR Programs

Subject: ICF/MR Beds

Attached is our projected list of ICFs/MR beds in Kansas as of March 1st. During the last seven to eight months, two six-bed homes in Greenleaf voluntarily left the program in favor of HCB waiver funding. Sixty (60) beds are closing at Pioneer Village in Topeka and are being replaced with 57 beds in seven facilities operated by CLO in Lawrence. Lorraine House in Hutchinson is leaving the program in favor of HCB waiver funds March 1. Apostolic Christian has been allowed to open one 12-bed facility in Sabetha in March or April.

I hope this addresses your questions. If not, don't hesitate to call me.

RS:eb

Attachment

Pltfee
2-12-91
Atm# 1

Social and Rehabilitation Services
Mental Health and Retardation Services

ICF/MR CAPACITY
Projected March 1, 1991

ICF/MR Facility	# Of Facilities	# Of Beds
Bethpage Mission	2	16
Community Living Oppor.	13	108
Cranford	1	6
DSNWK	7	42
Faith Village	3	45
Focus	1	75
Golden West	1	53
Hartford Manor	5	88
Hutch Heights	1	15
Lakeside Terrace	1	12
LifeCare - Haven	1	74
LifeCare - Medicine Lodge	1	49
Living Skills Cntr.	1	60
McPherson Diversified	5	30
New Horizons - Pittsburg	1	88
New Horizons - Valley Center	1	100
Northview	1	15
Parkview	1	54
Shields Adult Care Home	1	50
Starkey	2	12
Totals	50	992

P&C
2-12-91
Attm # 1-2

State of Kansas
[redacted]
Joan Finney, Governor
Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290
Reply to: _____
FAX (913) 296-6231

Acting
Stanley C. Grant, Ph.D., Secretary

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 2019

Madam Chairperson, members of the committee thank you for this opportunity to speak with you concerning HB 2019. This legislation is one of a number of proposals to deal with the health care access issue for medically indigent citizens in our state. To adequately analyze HB 2019, I will provide you with certain background information concerning the following five issues

1. Policy goals
2. Health care access in rural Kansas
3. Models for rural solutions to health care access
4. Health care access in urban Kansas
5. Models for urban solutions to health care access

POLICY GOALS

There are three policy goals to utilize when evaluating models for programs which will increase access to health care for medically indigent citizens.

1. The model must provide comprehensive primary care services.

   Providing someone access to a clinic that cannot provide for diagnostic tests, antibiotics, dental work, eyeglasses, case management, follow up or referral in those cases requiring specialty care is of little practical use.

2. The model must be integrated into the existing delivery system.

   The community and the health care system must view the clinic as providing continuous, quality care. The health professions training programs should utilize the clinic as a training site. This helps introduce the latest practice expertise to the clinic, and exposes the trainees to this type of practice model.

PHW
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Attm. # 2

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

Roger Carlson, Ph.D.
Director of the Kansas Health and Environment Laboratory

3. The model must maximize federal revenues.

The next sections of the testimony delineate a number of differences between urban and rural health care access issues. Though the needs and solutions for urban and rural areas are different, the public policy goals are the same for both urban and rural models.

HEALTH CARE ACCESS IN RURAL KANSAS

In the 61 rural Kansas counties with a population of 10,000 or less, there is an impending crisis in access. The health care delivery system is based on the physician/inpatient hospital model. Since 1984 with the advent of the prospective payment system, many of the services for which the rural hospital in Kansas was established are now provided on an outpatient basis. In addition, many service needs - home health, management of chronic disease and public health services - are inadequate or non-existent. Health professions training programs are not training students to practice in rural settings. Forty-five percent of the rural family physicians are planning to retire before the year 2000. Currently both nationally and in Kansas the medical schools are only training 15% of the physicians needed for replacement. There is a need to develop a community health system for rural areas which more adequately meets the total needs of the community.

There are six health functions which comprise a comprehensive community health system.

* Emergency services
* Primary care
* Public health
* Community based physical rehabilitation
* Community based chronic disease management
* Long term care and Hospice care

In analyzing the rural health care system in Kansas and convening meetings of health care experts and rural citizens around the state, the Office of Rural Health heard time and again that the problems in rural Kansas require unique solutions that are suited for the rural environment. Rural models of delivery, not downsized urban models, are needed. Out of these meetings came a set of five Basic Assumptions for Kansas Rural Community Health Systems. They must:

1. Be locally governed.
2. Provide comprehensive community health services.
3. Manage the planned entry and return from health care provided outside the community.
4. Be incorporated into the health professions training curriculum in meaningful ways.
5. Provide equal access to all citizens of the community.

PHHC
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Attm # 2-2

MODELS FOR RURAL SOLUTIONS TO HEALTH CARE ACCESS

The Federal government has recognized the problems in rural health care and has created two significant incentives for local rural health systems. These incentives focus on creating comprehensive primary care services and provide for cost based reimbursement.

Rural Health Clinic--P.L. 95-210

The Rural Health clinic model was established in 1977 under P.L. 95-210. This model requires the use of nurse practitioners and/or physicians assistants, along with physicians, in an outpatient clinic. This model offers cost based reimbursement for outpatient care at rates which assure that a rural practice is as financially rewarding as a similar practice in an urban area. The model also reduces the regulatory barriers to adding home health and other needed services at cost based reimbursement rates. Kansas has taken advantage of new federal legislation to expand the option of the Rural Health Clinic to all the counties in the state that are designated medically underserved.

E.A.C.H. Demonstration Project

Integrated and coordinated networks of care are an essential part of assuring access to care in Rural Kansas. This federal demonstration project passed as a part of OBRA 89. It is designed to assist states in maintaining access to health care services in rural areas. The goal of the demonstration is to create coordinated health care delivery networks. The focus is to take the small rural hospital and use its resources to provide a comprehensive system of primary care service. This rural comprehensive system is focused on the entire spectrum of primary care a local community needs. The Wesley Foundation awarded a grant to the Kansas Department of Health and Environment, the Kansas Hospital Association and the Kansas Board of Emergency Medical Services to study the applicability of this delivery model for Kansas. This public/private partnership is now in the process of preparing an application for Kansas to become a demonstration state.

These two models take advantage of federal incentives to assure that health care access can be maintained in rural Kansas. The federal incentives are substantial and lead to the type of system change that has the potential for assuring that access to health care can be maintained in the 61 small rural counties in Kansas.

HEALTH CARE ACCESS IN URBAN KANSAS

In contrast to Rural Kansas, Urban Kansas is not facing either a need to develop a new delivery model or struggling to maintain an adequate number of health professionals. The dilemma is economic. An increasing number of people lack the economic resources to get

Exhibit
2-12-91
Attm # 2-3

health care. This is most pronounced for primary care services. A person without health insurance, who is in an auto accident and rushed to the emergency room by ambulance, receives care.

That same person who has a sore throat and fever, or who needs a tooth filled, or who should have a regular physical and screening tests for high blood pressure, cancer et cetera is unable to access this routine care. Proposals to create universal access to care would hopefully solve this situation. The lack of a national health policy to deal with this issue finds Kansas utilizing various private initiatives to fill the void.

MODELS FOR URBAN SOLUTIONS TO HEALTH CARE ACCESS

In several Kansas communities, the demand for health care services for the medically indigent has been great enough that clinics have been developed or are in development in fourteen cities in the state. Leavenworth, Kansas City, Johnson County, Lawrence, Topeka, Wichita, Great Bend, Dodge City, Garden City, Liberal, Ulysses, Manhattan, Salina, Newton and Hutchinson have programs or are in process of planning programs to facilitate access to care for the medically indigent. The models for these programs fall into three categories.

1. Comprehensive primary care clinic--These clinics provide medical, dental, lab, pharmacy and optometric services on site.

2. Basic primary care clinic--These clinics provide basic medical services on site. They tend to be for episodic conditions only and have various arrangements for referral for dental, lab, pharmacy, et cetera.

3. Gatekeeper -- These clinics provide for a gatekeeper to assess need and equitably refer cases among all available personnel who volunteer to see indigent clients in their own offices.

What type of delivery model is most efficient

All three of these models are providing immediate needed help to citizens in Kansas today. Access to primary care should mean access to a medical home; it should mean access to a clinic that keeps an ongoing medical record, focuses on prevention, screening and early detection; it should mean access to a clinic that makes a comprehensive assessment of the individual's total health needs and provides the overall management of care. The comprehensive primary care clinic is the most efficient long range strategy for dealing with the demands for service. The comprehensive center provides a medical home, a permanent record and focuses on preventive health services. The Federal government has been promoting and developing this type of center since the early 1970s.

CHCA
2-12-9
Attm # 2-4

Nationally, the federal government developed criteria to designate geographic areas as health manpower shortage areas. Federally funded community health centers were developed to provide comprehensive primary care services for Medicare, Medicaid, and indigent clients. Federally funded community health centers are funded nationally with over $350,000,000.

Costs of a comprehensive primary care clinic

Currently in Kansas there are three clinics which offer comprehensive primary care services--Hunter Health Clinic in Wichita, the Marian Clinic in Topeka and the ~~Mexican-American~~ Ministries Clinic in Southwest Kansas. These three operations all provide a full range of primary care services to indigent clients. Each reports needing $50,000 to $75,000 for capital equipment start up costs. The operating costs at these clinics ranges between $125-$175 per patient per year.

House Bill 2019

The idea for this type of pilot program was ~~initially suggested by~~ the Commission on the Medically Indigent and Homeless. The commission focused on preventive and primary care as the essential services needed by the medically indigent. This bill, to establish primary care demonstration projects under the direction of public health departments, would meet the three policy goals outlined earlier. It would provide comprehensive primary care services, it integrates the demonstration model into the existing delivery system and it leaves open the potential to maximize federal revenue. These demonstration projects would be best suited for trial in the any of the 44 counties with a population base of greater than 10,000. The 61 counties with populations less than 10,000 are best served by working on developing their community health systems and taking advantage of the very specific rural incentives available from the federal government.

KDHE has two technical concerns about the bill.

1. The bill requires local health departments to have completed applications to KDHE by ~~September 1, 1991.~~ KDHE recommends an October 1, 1991 deadline for receipt of applications to allow local communities more adequate time to develop an effective application.
2. New Section 1 (e) calls for reports providing for review and evaluation of the project. The responsibility for the reports is given exclusively to the three pilot projects. What is in the report is solely up to what the "Local Health Department deems appropriate". KDHE does not believe it is good public policy to fund an organization and then statutorily mandate that the organization evaluate itself.

PSCC
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There is no fiscal impact on the KDHE FY 92 budget for state operations. KDHE has placed the issue of health care access for the medically indigent as a top priority. The Department has been developing the capacity for dealing with primary care issues in the Office of Local and Rural Health Systems. With the addition of the Federal Primary Care Cooperative Agreement, the Department has the capacity to provide technical assistance, regular consultation and evaluation for these demonstration projects.

We have provided an extensive review of three primary care clinics currently operating in Kansas. The costs for providing care at the three comprehensive clinics in Kansas are between $125 and $175 per client per year. Each required $50,000-$75,000 for capital equipment start up costs. The mechanisms utilized for generating revenues are different in each clinic. Each clinic has found that at least 50% of the operating revenues needed can be obtained either from in kind service and/or local donation and/or third party reimbursement. Based on the figures for the three clinics in Kansas and utilizing the most conservative estimate of $125 per client per year, a clinic providing care for 2,500 clients would require from all sources a minimum of $302,500 plus capital equipment start up costs. The fiscal impact to the State of Kansas will be based on the determination of the amount of state general fund support for the operation of the demonstration sites.

Testimony presented by: Steve McDowell, Director
Office of Local and Rural Health Systems
Division of Health
February 12, 1991

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Fiscal Impact:

There is no fiscal impact on the KDHE FY 92 budget for state operations. The Department has been developing the capacity for dealing with primary care issues in the Office of Local and Rural Health Systems. With the addition of the Federal Primary Care Cooperative Agreement, the Department has the capacity to oversee the effective administration of this program should it be passed.

Currently in Kansas there are three distinct models of indigent care clinics which provide comprehensive primary care services--a Federally funded community Health Center (Hunter Health Clinic in Wichita), a private not for profit clinic operating completely through local fund raising and donations of professional time and equipment (the Marian Clinic in Topeka) and private not for profit clinic with both paid and volunteer health providers and with a mix of governmental grants and local fund raising (Mexican-American Ministries Clinic in Southwest Kansas). These three operations all provide a full range of primary care services to indigent clients. They have physicians on staff either paid or volunteer, they provide diagnostic work, dental services, laboratory services and pharmacy. An analysis of the budgets which includes both actual and in kind services demonstrates that costs per patient visit range from $49-$68 per year.

The Federally Qualified Health Center (FQHC) Model was established over 20 years ago. The funding sources are third party reimbursement primarily Medicaid and federal grants. In many states they are the primary provider of services to Medicaid eligible populations. With new legislation passed in Congress, the FQHC is now eligible for 100% reimbursement of costs from Medicaid. Congress made this change to assure that federal funds going to these health centers were used to provide services to the indigent and not to merely cover the differential in costs between what Medicaid paid and what it cost the center to stay open. This model operates on the assumption that 50% of the budget will come from fee for services primarily from Medicaid and sliding fee scale payments and 50% from grants.

The Marian Clinic, established in 1987, is a totally locally funded model and receives no third party payment. The clinic has effectively tapped the health resources of the Topeka community to maximize in kind services and donated equipment and supplies. This model currently operates roughly 50% from local donated funds and 50% from in kind services.

The Mexican American Ministries clinic serving communities in Southwest Kansas also established in 1987 is a model that receives both governmental and private funds. In Southwest Kansas the supply of health manpower is already stretched beyond capacity. The ability to gain significant in-kind services is more difficult due to the already overloaded system.

PHHC
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Federally Qualified Health Center Model

	Govt Grants	Revenue	In Kind	Total
Personnel	$ 99,530	$ 99,530	0	$199,060
Rent, Utilities	12,300	12,300	0	$ 24,600
Travel	0	0	0	0
Equip. & Supplies	8,250	8,250	0	$ 16,500
Malpractice	6,000	6,000	0	$ 12,000
Dental,Lab, Pharmacy, Specialty Medical	60,000	60,000	0	$120,000
	$186,080	$186,080		$372,160
Estimated Capital Equipment startup expense	$ 20,000	0	$20,000	$ 40,000

7200 patient visits per year
Cost per patient visit per year $51.68 (Operating costs only)

Mexican-American Ministries Clinic (Southwest Kansas)

	Govt Grants	Revenue	In Kind	Total
Personnel	$ 32,300	$102,000	$ 37,000	$171,300
Rent, Utilities	0	0	30,000	30,000
Travel	5,700	6,600	0	12,300
Equip. & Supplies	2,000	10,100	1,500	13,600
Malpractice	0	7,600	0 7,600	
Dental,Lab, Pharmacy, Specialty Medical	40,000	31,500	15,000	86,500
	$ 80,000	$157,800 $321,300	$ 83,500	
Reported Capital Equipment start up expense	$ 40,000	0	$ 35,000	$ 75,000

6,500 patient visits per year

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Cost per patient visit per year $49.43 (Operating costs only)

Marian Clinic--Topeka

	Govt Grants	Revenue	In Kind	Total
Personnel	0	$ 59,039	$101,148	$160,187
Rent, Utilities	0	29,333		29,333
Travel	0	0	0	0
Equip. & Supplies	0	6,550	0	6,550
Malpractice	0	3,385	0	3,385
Dental,Lab, Pharmacy, Specialty Medical	0	24,427	189,274	213,701
	$ 0	$122,734	$290,422	$413,156
Reported Capital Equipment start up expense	0	$ 20,000	$ 38,000	$ 78,000

6,000 patient visits per year
Cost per patient visit per year $68.84 (operating costs only

Data for this note were obtained on a cost per visit basis. Clinic management systems for primary care utilize a rate of 2.4 visits per client in determining cost per client per year. Utilizing this accepted multiplier the cost per client per year for these programs ranges from $118 to $163. A demonstration model as proposed in this bill using $125 per patient per year would need $312,500 to provide services to 2,500 patients. The fiscal impact to the State of Kansas will be based on the determination of the amount of state general fund support for the operation of the the demonstration sites.

2-12-91
Attn: 2-9

KALHD

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

ISSUE PAPER
PRIMARY CARE FOR THE MEDICALLY INDIGENT
FY 1992

I. Statement of the Problem

There are large numbers of Kansans who are medically indigent; i.e. they do not have the means to obtain access to needed medical services because of their inability to pay for their services or because they do not have 3rd party insurance coverage, such as private insurance. Medicaid or Medicare. It is estimated that 13% to 16% of Kansans would be considered medically indigent, or approximately 375,000 people most of whom are women and children.

II. Issue Definition

The issue is to determine what role the local health department should play in the community in making sure that all citizens have access to primary care medical services, regardless of their ability to pay.

III. Background

This paper will focus on the possible role of a local health department (LHD) in improving access to primary medical care in the community. In this paper primary medical care is defined as the initial medical care, either preventive or curative, that a patient receives as an out patient by a physician who normally provides primary care (i.e. family practitioner, pediatrician, obstetrician-gynecologist, internist) or by a physician's assistant/nurse practitioner working under a physician's supervision. It does not refer to specialty care or to inpatient medical care.

Local health departments have primarily been viewed and have primarily seen themselves as sources of preventive health care in the community and rightly so. There is no question that preventive health care has been and must always continue to be the top priority of local health department functions. Preventive health care services, such as immunizations, infectious disease control, well child care, family planning services, etc., are the backbone of local health department activities. But several sources have encouraged local health departments to become involved in the primary care issue and to see themselves as having a role to play in resolving this problem in their communities.

(continued)

Revised 2-12-91 Attm #3

For example, the Future of Public Health which was recently published by the Institute of Medicine described and 3 functions of public health: 1) assessment, 2) policy development, and 3) assurance. Primary Care is a legitimate public health issue which the public health system at the federal, state, and local levels must not neglect but on the contrary, must perform the assessment, policy development, and assurance functions as it does for any other public health issue. The I.O.M. report recognized the primary responsibility of the federal government in ensuring adequate access to health care for its citizens, but recommended, "The committee find that, until adequate federal action is forthcoming, public health agencies must continue to serve with quality and respect and to the best of their ability, the priority personal health care needs of the uninsured, underinsured, and Medicaid clients."

Another source recommending local health department involvement in primary care is Model Standards for Community Preventive Health Services which is a collaborative project of numerous national public health organizations. It says, "In summary, government at the local level has the responsibility for ensuring that a health problem is monitored and that services to correct that problem are available. Where services in any area covered by standards are already available, government may also (but need not) be involved in delivery of service. Conversely, however, where there is a gap in available services, it is the responsibility of government to have, or to develop, the capacity to deliver the services." An objective proposed by this document which pertains to primary care reads, " By 19__, the official health agency or other appropriate governmental agency will, in the absence of the provision of minimum health care services in the community provide such services directly; in addition, this agency will supplement existing services where they are inadequate."

Another related source is the document Basic Services for Local Health Departments in Kansas published by the Kansas Association of Local Health Departments and the Kansas Department of Health and Environment. The basic service listed pertaining to primary care states, "Participate in community efforts to assure adequate medical, mental, and dental health services for all persons." Actually delivering primary care is considered an expanded service of local health departments in this document. Another recent source recommending local health department involvement in primary care is the Report and Recommendations on Access to Services for the Medically Indigent prepared by the Governor's Commission on Access to Services for the Medically Indigent and Homeless in December, 1988. In this Report, "The Commission recommends that the services of local health departments be expanded and that where feasible the local public health agency's role be expanded to include the provision of primary health services.

(continued)

Attached 2-12-91 Attach. 2

Further , the Commission recommends that the Legislature expedite the delivery of primary health care through local health departments by removing barriers that may exist to the utilization of advanced registered nurse practitioners and other health care personnel in the delivery of primary care services and limitations on the ability of counties, cities, or regions to fund local health departments adequately."

Why should local health departments become involved in the primary care issue ? There are several reasons.

1). It is a fundamental part of the mission of public health. The mission of public health departments is to protect and promote the health of its citizens. Public health departments need to be concerned therefore if its citizens can't receive illness care for whatever reason. Although the foundation of public health departments and its top priority is preventive health care, local health departments must also be concerned about assuring the availability and accessibility of illness care as well.

2). Local health departments are already in the community. They are staffed by people who are local people who know the needs of the local community. It does not make sense to create new organizations or new entities in communities for the delivery of primary health care services when there are already existing local health departments which can be expanded and built upon to provide these services. Local health departments have already demonstrated the administrative and medical expertise to deliver preventive health services and with additional funding and resources they could administer the delivery of illness care services as well.

3). Another reason is because preventive health services should be integrated into the delivery of primary care services and this is an area where local health departments have a lot of experience. Local health departments already administer family planning clinics, prenatal clinics, well child clinics, immunization clinics, sexually transmitted disease clinics, WIC programs etc. all of which could be integrated into the delivery of primary care services.

4). Numerous other states have adopted the model of utilizing local health departments in delivering primary care services. Colorado, California, and Florida are just a few examples of states which look to their local health departments for the provision of primary care as a "provider of last resort" to the medically indigent.

5). It can strengthen the image and influence of the local health department in the community if it's seen not just as a center for preventive health services but as a center of total health care, both preventive and curative.

On the other side of the coin is the question why local health departments should not provide primary care services.

(continued)

PHHS
2-12-91
Attm# 3-3

The most obvious answer is that local health department's top priority is to provide preventive health care services and if they're strapped with delivering illness care services too, there is a danger that resources will be shifted away from preventive health care to illness care. This is a real danger to public health and must be guarded against at all costs. To decrease funding and resources for prevention in order to spend that money on cure is obviously short-sighted and ineffective in the long-run. Totally separate sources of funding for preventive health services and illness services would have to be established along with the legislative commitment not to merge the two, and not to decrease funding for prevention in order to pay for curative services.

IV. Recommendations

1). KALHD recommends that legislation with new, separate, and adequate funding be provided to fund at least 3 pilot projects in which local health departments provide outpatient non emergency primary care services. These 3 pilot projects should serve areas with small (25,000 - 50,000), medium (50,000 - 150,000), and large (150,000 plus) populations.

104,150

2). KALHD recommends that physicians working in or for local health departments either with or without compensation be considered as charitable medical providers and considered as state employees as far as
medical malpractice coverage is concerned.

3). KALHD recommends that working in any local health department in Kansas be considered to be acceptable payback of time owed to the State of Kansas in its medical and nursing scholarship program.

V. Fiscal Impact

Fiscal projection would need to be developed for recommendation #1 in keeping with federal guidelines for the planning and development of community health centers. There should be no fiscal impact with recommendations nos. 2 and 3.

VI. Legislative Implications - Legislation would need to be developed to implement all 3 recommendations.

Approved by KALHD Board of Directors April 17, 1990
Approved by KALHD Membership May 14, 1990

Attached
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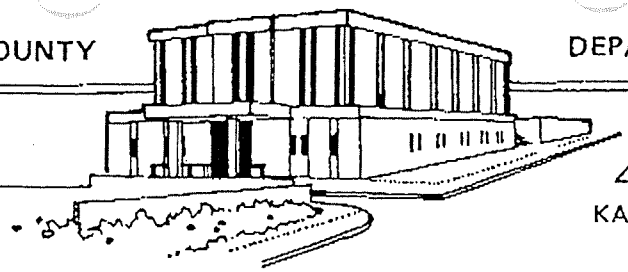
atm 3-4

PROMOTING GOOD HEALT 'D A CLEAN ENVIRONMENT FOR A BETT MMUNITY

KANSAS CITY - WYANDOTTE COUNTY DEPARTMENT OF HEALTH



619 ANN AVENUE KANSAS CITY, KANSAS 66101

PHONE (913) 321-4803

TESTIMONY BEFORE THE
HOUSE PUBLIC HEALTH & WELFARE COMMITTEE
CONCERNING HOUSE BILL 2019

FEBRUARY 12, 1991

By - Dr. Darrel Newkirk, Director
Kansas City - Wyandotte County
Health Department

Ladies and gentlemen of this committee -

First of all, I want to say that I am very sorry I cannot testify before you in person today concerning House Bill 2019, but I have to be out-of-town. I do hope however that you will accept my testimony by proxy as an indication of my strong support of House Bill 2019.

House Bill 2019 is an excellent bill which I urge you to support and pass out of committee. We are all aware of the great need of the medically indigent in Kansas. This is particularly true in an urban area such as Wyandotte County. Surveys in our county indicate that one out of every 6 of our citizens, or about 25,000 to 30,000 people are medically indigent, most of whom are women and children. So there is a great need to help provide care to these individuals.

Many have looked toward some local health departments in Kansas as being a viable and important resource in the community to provide primary illness care for the medically indigent. For example, the Governor's Commission on the Medically Indigent made such a recommendation as did this past summer's interim legislative committee on public health and welfare. Many other states utilize local health departments quite heavily in delivering both preventive health care as well as primary illness care. It is time that we too in Kansas made this leap and begin to take advantage of this already existing resource in Kansas, the local health department, for the delivery of primary illness care.

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Attmt 4

I wholeheartedly support House Bill 2019 therefore. It's approach to fund 3 pilot projects is a cautious, reasonable approach. In addition, the provisions in House Bill 2019 covering health care providers who work in these demonstration projects under the Kansas tort claims act is very important.

If House Bill 2019 is passed, our health department in Wyandotte County will be submitting an application to establish a pilot project in our urban area. Our department already operates an Outpatient Pediatric Clinic with federal MCH Block Grant funds we receive through the state health department. With this pilot project we would be able to expand this Pediatric Clinic to begin serving adults of all ages as well.

During the past year I have been working with several other health care providers in our community, including representatives from Bethany Medical Center, Providence St. Margaret's Hospital and the Department of Pediatrics in the University of Kansas Medical Center, in order to establish a comprehensive Community Health Center in our community. We all agree the need for such a Community Health Center is great. Our plan is to build on the existing pediatric services we presently provide in our health department and eventually apply for federal funds to support a much larger Community Health Center. We all feel the pilot project funds as provided in House Bill 2019 will be very important to do 2 things: First, it will allow our health department to expand our existing Pediatric Clinic so that we can start serving adults and people of all ages, and second these pilot project funds will be very important to show in our federal grant application that the state of Kansas is a real funding partner in this effort. So we believe these pilot project funds will become real "seed" money that will grow and allow us to leverage even more funds from the federal government.

In terms of a fiscal note for House Bill 2019, I agree with KDHE's estimate of $312,500.00 to provide primary care for 2500 patients who make 7200 visits per year. This is the amount we project we would need for an urban project in Wyandotte County. Estimating 2/3 of that amount for a medium-sized county would require $208,300 and estimating 1/3 of that amount for a small-sized project would be $104,150.00. Using these estimates, the total fiscal note would be $625,000. Even though we all realize these are difficult economic times for the state of Kansas I feel it is extremely important for us to make this important leap and begin to create these pilot projects. If they are successful, which I believe they will be, the health of thousands of Kansans will be improved as a result.

I urge you therefore to support and pass House Bill 2019, and I thank you very much for your consideration.

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