Approved 4-2-91
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~~m~~ on March 28, 1991 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Richard J. Morrissey, Division of Health, Department of Health and Environment
Elizabeth Taylor, Kansas Association of Local Health Departments
Carolyn Middendorf, R.N., Kansas State Nurses Association
Pat Goodson, Right to Live of Kansas, Inc.
Steve McDowell, Department of Health and Environment

Chairman Ehrlich called the meeting to order at 10:05 a.m.

Richard Morrissey, Department of Health and Environment, requested a Concurrent Resolution be introduced regarding developing alternatives for rural hospitals, such as emergency services, primary care services, public health services, home health services and long term care services. (Attachment 1) The wishes of the committee were asked, and Senator Langworthy made the motion to introduce the Senate Concurrent Resolution, seconded by Senator Hayden. The motion carried.

HB 2018 - Changes in funding for local health departments.

Elizabeth Taylor, Kansas Association of Local Health Departments, appeared in support of HB 2018. The bill amends several of the statutes that provide for the distribution of state financial assistance to local health departments. The bill, as amended by House Committee, creates a new formula to be followed in the distribution of state funds, eliminates the per capita cap on state financial assistance in the current statutes, and clarifies the legislative intent in terms of several of the existing statutes. Ms. Taylor said she supports the proposed amendment that would be submitted by the Department of Health and Environment that addresses the maintenance of effort policy.

Chairman Ehrlich introduced his two pages who served in the Senate and assisted at the committee meeting. Dr. Simpson, father of one of the pages and doctor of the day, was also introduced.

Carolyn Middendorf, R.N. submitted written testimony and appeared before the committee in support of HB 2018. The Kansas State Nurses Association supports the bill which deletes the $.75 per capita cap on funding that may be distributed to local health departments from funds appropriated to the Department of Health and Environment for state assistance. (Attachment 2)

Richard J. Morrissey, Department of Health and Environment, submitted written testimony and supported the bill, as amended by the House, with one suggested change. He submitted a balloon of the bill showing an amendment regarding the maintenance of effort policy be continued. (Attachment 3) Additional funding, tax revenues to local public health services, diminished services, maintenance of effort requirements, and clarification of language in the proposed amendment were discussed.

Pat Goodson, Right to Life, appeared in opposition to HB 2018. Her objection was to any increase in funds to local health departments that would be used for family planning.

HB 2019 - Pilot projects by local health departments to provide outpatient and none-emergency primary care services.

Elizabeth Taylor, Kansas Association of Local Health Departments, submitted written testimony and appeared before the committee in support of the bill. Ms. Taylor stated her association supports improving access to primary care for all Kansans, regardless of their ability to pay. (Attachment 4) Testimony was also read from Dr. Darrel Newkirk, Director, Kansas City - Wyandotte County Health Department in support of HB 2019. (Attachment 5)

Carolyn Middendorf, R.N., Kansas State Nurses Association, submitted written testimony and appeared in support of HB 2019. Ms. Middendorf stated her organization supports the requisite funding necessary to implement the three pilot projects to provide primary care health services. Many of the services provided would require registered nurses and advanced registered nurse practitioners. The provision of the bill which allows these and other health care providers falls under the definition of "charitable health care provider" for purposes of civil liability and would be helpful in recruiting the professional staff to provide these services. (Attachment 6)

Steve McDowell, Office of Local and Rural Health Systems, Kansas Department of Environment, submitted written testimony on HB 2019 and stated in order for primary care services to be effective, they need three basic goals: (1) be comprehensive, (2) integrate into existing delivery system and (3) maximize federal revenues.
(Attachment 7)

The meeting was adjourned at 11:00 a.m.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 3-28-91

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Cheryl Shores	Topeka	KCSL
Dorothy Woodin	Topeka	KCOA
Marilyn Bradt	Lawrence	KINH
Tom Gress	Topeka	KHA
Richard Morrissey	Topeka	KDHA
Cathie Sakuma	Topeka	KDHA
Richard Hamaker	Sterling	KAPA
Carolyn Middendorf	Topeka	KSWA
Marty Kennedy	"	Div. of Budget
Charles Moore	Topeka	Med Prog SRS
ELIZABETH E TAYLOR	TOPEKA	Ks Asso of Local DEPT HEALTH
JAN BUEKER	TOPEKA	K-NASW

WHEREAS, the Kansas Legislature believes that the residents of rural Kansas are entitled to comprehensive community health services which include Emergency Services, Primary Care Services, Public Health Services, Home Health Services and Long Term Care Services; and

WHEREAS, comprehensive health services are threatened by shortages of physicians and nurses for the provision of primary care, a decline in the number of Emergency Medical Services volunteers, the inadequacy of rural hospital reimbursement, the increasing inability of small rural hospitals to finance certain basic services, a lack home health and other services for the elderly; and

WHEREAS, the Wesley Foundation understanding the need for the development of new models focusing on comprehensive services for rural communities, provided leadership in funding a public /private partnership between the Kansas Department of Health and Environment, the Board of Emergency Medical Services and the Kansas Hospital Association to study rural health delivery options; and

WHEREAS, this public/private partnership developed a Technical Advisory Group comprised of 30 Kansans representing health care providers and rural Kansas citizens which has reviewed and approved all aspects of the model development; and

WHEREAS, the United States Congress has passed legislation to fund developmental projects to reorganize rural health care delivery through designation of certain existing hospitals as Essential Access Community Hospitals (EACH) and others as Rural Primary Care Hospitals (RPCH); and

WHEREAS, the Technical Advisory Group of the rural health delivery options study and the Kansas Hospital Association, the Kansas Department of Health and Environment and the Kansas Board of Emergency Medical Services have recommended that the EACH demonstration project is a viable model for improving the availability and integration of community health services in rural Kansas communities; and

WHEREAS, the legislature finds that the EACH project has great promise for the systematic development of comprehensive community health services and that Kansas would be an ideal state for such a project;

NOW, THEREFORE, BE IT RESOLVED BY THE KANSAS HOUSE OF REPRESENTATIVES, THE SENATE CONCURRING THEREIN:
That the State of Kansas should pursue status as a EACH project state in order to: 1) receive grant funds for implementation of the Essential Access Community Hospital Program and continued development of comprehensive health services for rural Kansas citizens.

Senate P H&W
Attachment #1
3-28-91

KSNA

the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:

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March 28, 1991

H.B. 2018 LOCAL HEALTH DEPARTMENTS - ELIMINATION OF PER CAPITA CAP ON STATE FINANCIAL ASSISTANCE

Chairman Erhlich and members of the Senate Public Health and Welfare Committee, my name is Carolyn Middendorf M.N., R.N. and I am a registered nurse representing the Kansas State Nurses' Association.

The Kansas State Nurses' Association supports H.B. 2018 which deletes the $.75 per capita cap on funding that my be distributed to local health departments from funds appropriated to the Department of Health and Environment for state assistance. Additionally, the bill provides a minimum of $7,000 for each local health department requesting funds. There is also a new formula for the distribution of monies appropriated to KDHE for local health departments after the minimum $7000 distribution has been made.

We believe that these new formulas and the elimination of the $.75 cap will provide the necessary financial support to the local health departments, and at the same time provide greater latitude for lower populated parts of the state local health departments to enter into joint and cooperative agreements with other health departments without the risk of reducing the amount of funding they will receive from the state. This has the potential to provide a greater variety of services, to a larger number of Kansans with the opportunity to pool resources and work cooperatively.

The interim committee on Public Health and Welfare studied extensively both the funding and services by local health departments. This is just one of the legislative initiatives recommended as a result of that study, which provided an excellent analysis of public policy issues related to financing local health departments and also a review of the services that they provide to Kansas citizens.

We hope that you will support H.B. 2018 and thank you for the opportunity to speak today.

Senate P H&W
Attachment #2
3-28-91

State of Kansas
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Division of Health
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FAX (913) 296-6231

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

Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill No. 2018

as Amended by

House Public Health and Welfare Committee

Proposal No. 32 directed the Special Committee on Public Health and Welfare to "review the current funding for local health departments, including state formula aid and local matching and maintenance of effort requirements; identify and review state and federal mandates affecting local health departments including impact of state mandated tax lids; and review the financial needs of local health departments resulting from a changing role in health care delivery."

The study which resulted from that directive presented a wealth of information about the public health system in Kansas, it's organization and financing, and major issues to be addressed. House Bill No. 2018 was recommended to implement two additional policy conclusions reached by the Special Committee:

> ". . . to remove the statutory cap of $.75 per capita to provide the Legislature with the opportunity to increase the state grant to local health departments within existing fiscal constraints rather than within statutory constraints," and "include a provision excluding user fees and one-time special project grants from the (maintenance of effort) requirement during the process of apportioning the state formula grant."

KDHE was in agreement with these policy conclusions.

HB No. 2018, as amended, removes the per capita cap. In addition, the House committee amendments made several other significant changes.

1. A new formula is created to be implemented by KDHE in distributing general health funding. Under the new formula the total amount of state financial assistance available for distribution would be determined and allocated to local health departments making application in proportion to the ratio the

Senate P H&W
~~Attachment #3~~
3-28-91

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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

population served by each applicant bears to the population served by all departments that apply. In making the distribution, KDHE would allocate at least $7,000 to an applicant regardless of the amount that the agency would receive under the allocation which was based on population - a state funding "floor." In addition, no applicant would receive more than was budgeted for the applicable county fiscal year from local tax revenues. It would appear that this bill would provide a nominal increase to small counties since there would be no proration of a minimum unless the funding appropriation was insufficient to fund all counties at the $7,000 "floor."

2. Grants would be based on the calendar year (counties' Fiscal Year) rather than the state's Fiscal Year. In addition, there would be one annual payment made to each applicant rather than the current four quarterly payments. To convert to the January 1 through December 31 award period intended by this bill would require an additional FY 92 appropriation of $994,354 above the governor's recommendation, with spending authority from July 1, 1991 to December 31, 1992.

3. The current policy of requiring counties to maintain the level of local tax revenue available to local health departments would be eliminated. Without this "maintenance of effort" requirement, counties would be able to substitute state funding for existing local tax funding, resulting in a reduction in services available.

   During FY 90, 22 counties did not meet their maintenance of effort and the 1990 legislature added a proviso to the appropriation measure limiting their awards to 75% of the amount that they would have otherwise received. The FY 91 Senate Ways and means Subcommittee report in their recommendation No. 2, as approved by the full committee, contained the following statement: "The Subcommittee vigorously supports the maintenance of effort requirement . . . . . ."

Recommendation

KDHE supports HB NO. 2018, as amended, with two exceptions. We recommend that the maintenance of effort policy be continued and have attached a proposed amendment to that effect. Also, the additional funds required to change the grant year are not included in the Governor's Budget.

Presented by: Richard J. Morrissey
Deputy Director
Division of Health
March 28, 1991

Sec. 2 5. K.S.A. 65-246 is hereby amended to read as follows: 65-246. *(a)* Moneys available under this act for financial assistance to local health departments shall not be substituted for or used to reduce or eliminate moneys available to local health departments from the federal government or substituted for or used to reduce or eliminate moneys available from local tax revenues. Nothing in this act shall be construed to authorize a reduction or elimination of moneys available to local health departments from the federal government or to authorize the reduction or elimination of moneys made available by the state to local health departments in addition to moneys available under this act.

(b) Moneys received by local health departments from fees charged for services or one-time special project grants shall not be included in the sum of money which the local health department receives from local tax revenues when determining the amount such department will receive from state financial assistance pursuant to K.S.A. 65-242, and amendments thereto.

(b) ~~Nothing in this section or in the provisions of K.S.A. 65-241 through 65-246, and amendments thereto, shall be construed to require any county or local health department to maintain a base amount of tax resources or expenditures, or both, for a local health department from one fiscal year to the next or to require any county or local health department to maintain a level of local financial effort for the funding of local health departments except as provided in subsection (b) of K.S.A. 65-242 and amendments thereto.~~

Nothing in this section or in the provisions of K.S.A. 65-241 through 65-246, and amendments thereto, shall be construed to permit any county to reduce new local tax revenues to a local health department from one fiscal year to the next.

Sec. 3 6. K.S.A. 65-242, 65-243, 65-244, 65-245 and 65-246 are hereby repealed.

Sec. 4 7. This act shall take effect and be in force from and after its publication in the statute book.

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)

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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)

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)

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.

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

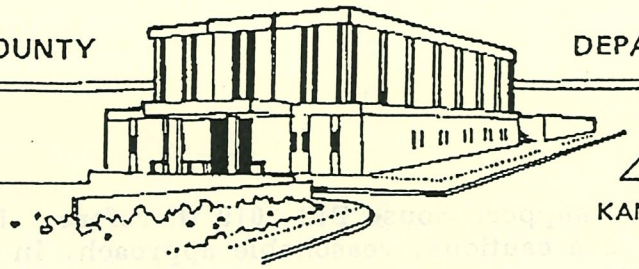
Fiscal projection would need to be developed for recommendation #1 in keeping with federal guidelines for the planning and development of community health centers. There should be no fiscal impact with recommendations nos. 2 and 3.

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

PROMOTING GOOD HEALTH AND A CLEAN ENVIRONMENT FOR A BETTER COMMUNITY

KANSAS CITY - WYANDOTTE COUNTY DEPARTMENT OF HEALTH



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

MARCH 28, 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.

Senate P H&W
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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.

KSNA

the voice of Nursing in Kansas

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March 28, 1991

H.B. 2019 CREATING A NEW STATUTE THAT AUTHORIZES THREE PILOT PROGRAMS ESTABLISHED THROUGH LOCAL HEALTH DEPARTMENTS TO PROVIDE PRIMARY CARE HEALTH SERVICES.

Thank you for the opportunity to speak to you regarding H.B. 2019. I am Carolyn Middendorf M.N., R.N. a registered nurse representing the Kansas State Nurses' Association.

KSNA supports H.B. 2019 and the requisite funding necessary to implement the three pilot projects. Many of the services that will be provided in these clinics will be provided by registered nurses and advanced registered nurse practitioners. The provision of the bill which allows these and other healthcare providers to fall under the definition of "charitable health care provider" for purposes of civil liability will be helpful in recruiting the professional staff to provide these services.

As part of the application and implementation of this project we would recommend to the Secretary of the Kansas Department of Health and Environment that careful consideration be given to the definitions used in describing the primary care services offered by local health departments and the statistics and data to be submitted to that agency for compilation of the report due on June 30, 1994. Because this initiative is a pilot project, there needs to be great emphasis on recordkeeping, data collection and evaluation of these projects as part of the local health departments obligations for receiving funding. There should also be consistency in the reporting and data collection between all the sites. This will provide the necessary information about the effectiveness of the programs. Obstacles and barriers in the respective communities must also be tracked as well as the steps in overcoming them and strategies used.

It is our sincere hope that these projects will be approved for funding during this legislative session and we would be willing to assit the agency in any way during the implementation of these pilot projects.

Thank you again.

Senate P H&W
Attachment #6
3-28-91

State of Kansas
Joan Finney, Governor

Department of Health and Environment
Division of Health

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

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Testimony presented to

Senate Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 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 access to someone 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.

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.

Senate P H&W
Attachment #7
3-28-91

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

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. 45% 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.

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 financially equally as 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 who 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 get 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--Theses 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 amongst 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. 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.

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.

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