Approved 4-11-92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

1:55 ~~a.m./~~p.m. on March 24, 19__ in room 423-S of the Capitol.

All members were present except:

Rep. Bishop, Rep. Carmody, Rep. Love, all excused

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Sue Hill, Committee Secretary

Conferees appearing before the committee:

John Kiefhaber, Executive Vice President, Kansas Health Care Association
Dick Morrissey, Deputy Director, Division of Health, Department of Health/Environment
Elizabeth Taylor, Executive Director, Kansas Association of Local Health Departments
Chip Wheelen, Kansas Medical Society
John Holmgren, Catholic Health Association
Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine
Tom Hitchcock, Executive Secretary, Kansas Board of Pharmacy
Kyle Smith, Assistant Attorney General, Ks. Bureau of Investigation/ Narcotics Strike Force.

Chair called the meeting to order at 1:55 p.m., drawing attention to hearings to be continued on **SB 182.**

HEARINGS CONTINUED ON SB 182.

John Kiefhaber, Kansas Health Care Association offered hand-out (Attachment No. 1). He stated opposition to **SB 182**, and noted it had been heavily amended to make it more reasonable, and it is duplicative of civil penalty authority and is not needed. Sanctions for issuing penalties against nursing home facilities are already available, should serious harm come to a resident of a nursing facility. He drew attention to terms, "serious harm" and imminent risk", noting it would be difficult for the Secretary of Health/Environment to define and to administer fairly. In his view, **SB 182** is not good legislation as it attempts to solve a problem that we do not have with a remedy that is arbitrary and subjective and one-sided. He urged defeat. He also noted that administrators, staff members, care-providers work very hard to provide quality care for residents of these facilities, and if a patient/resident was to have harm caused, these individuals would want the perpetrator penalized. If the facility management does not do all they should do to operate the facility in a way that prevents this type of thing from happening, then the operators of the facility should also be penalized. He answered questions.

HEARINGS CLOSED ON SB 182.

BRIEFING ON SB 728.

Ms. Correll gave an explanation of **SB 728**, detailing the proposed changes; the progression this topic has taken over the years. She noted Committee members may wish to inquire about the phrase, "under the medical direction of the qualified physician licensed by the Board of Healing Arts". She noted the clarity of this language fitting into all circumstances detailed in the bill is perhaps not consistent throughout. She answered questions.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:55 a.m./p.m. on March 24, 1992

HEARINGS BEGAN ON SB 728.

Dick Morrissey, Department of Health/Environment, offered 2 hand-outs. (See testimony in(Attachment No. 2), (Attachment No. 3,)a blue booklet indicating Kansas Service Profiles for 1991 for the Medically Underserved). He explained the booklet, noting 9 of 18 clinics listed have received grants, and 2 of those were pilot programs. He drew attention to four things that were the original focus and intent of this program. 1) to allow Medicaid recipients to be a part of the population served by charitable health care providers; 2) to expand liability coverage to include charitable health care providers giving care to the medically indigent in any local health department or not-for-profit indigent health care clinic who receive renumeration for their services; 3) to expand liability coverage to include charitable health care providers giving care in any local health department or not-for-profit indigent health care clinic; and 4) to provide liability coverage to charitable health care providers whether or not the local health department or the not-for-profit indigent health care clinic charges a fee based on federal poverty guidelines. He then recommended that Section 1 (f) (2) be restored to its original intent i.e., including under the definition of Charitable Health Care Provider physicians who are renumerated for their services to the medically indigent in any local health department or indigent health care clinic. With this recommended change, he urged support. He answered questions.

Elizabeth Taylor, Association of Local Health Departments, offered handout, (see Attachment No. 4). She noted the Association had supported **SB 728** when it was in the Senate. She asked members of this Committee to consider restoring the language that would allow the health care provider to be paid. She detailed rationale for this request, noting for years the continued local health department's struggle for funding resources. Some very small health deprtments may use volunteers, but in most cases, the staff would be paid providers, receiving a fee for service provided under the federal poverty guidelines which is a very small fee. In the alternative, she asked the Committee to consider amending the Health Stabilization Fund for those health care providers who work solely in a health department or a charitable health setting so that they could be exempt from keeping their insurance under the Health Care Stabilization Fund. The way **SB 728** stands now, after the Senate amendments, it does noting for the local health departments.

Chip Wheelen, Kansas Medical Society, offered hand-out (Attachment No.5), and gave background information on the Charitable Health Care Providers concept. He stated it is the view of the Kansas Medical Society that a person who gratuitously provides health care services to a patient who is dependent upon the state of Kansas for medical care should be considered an employee of the state for the purposes of that episode of care. Immunity is not created, but simply shifts the liability from the physician or other health care professional to the state of Kansas. He urged support. He drew attention to a 1987 report indicated in his hand-out. He answered numerous questions, noting he prefers **SB 728** be passed in its current amended form.

John Holmgren, Catholic Association, stated they are in agreement with Mr. Wheelen's remarks. He urged support.

Harold Riehm, Kansas Association of Osteopathic Medicine, noted a valuable group of individuals mentioned by Rep. Praeger could be utilized as providers of services to the medically indigent in Charitable Health Care Provider Clinics. Many of these physicians, who would like to cut down on their practice, could perhaps be reimbursed for these efforts in providing services related to language in **SB 728.** The bill does not address this, but it would be a good idea. (See Attachment No. 6).

HEARINGS CLOSED ON SB 728.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S Statehouse, at 1:55 a.m./p.m. on March 24, 1992

BRIEFING ON SB 737.

Ms. Correll gave background on **SB 737** and detailed the proposed changes in the schedule of drugs. She pointed out technical changes, and how difficult it is for printing changes because of the plus and minus signs used for these drugs.

HEARINGS BEGAN ON SB 737.

Tom Hitchcock, Executive Secretary of the Kansas Board of Pharmacy, offered hand-out (Attachment No. 7). He detailed all changes proposed in statutes by amendments suggested in his testimony. These proposed changes are to comply and conform with the Federal Drug Enforcement Administration regulations. He cited all the technical rationale for changes proposed. He noted the request for the de-regulation of the drug Propylhexedrine which requires the removal of the drug from schedule V per the copy of the Federal Register in his hand-out. He drew attention to information in his hand-out in respect to the drug in benzedrex inhalers which should not be controlled according to the current statute. He answered questions.

Kyle Smith, Assistant Attorney General, Narcotics Strike Force, Kansas Bureau of Investigation (KBI), provided hand-out (Attachment No. 8). He noted support of **SB 737** with one exception. He related a story about an individual who had broken down (cooked down) chemicals from inhalers to obtain the drug propylhexedrine for resale and personal use. He asked members of the Committee, on behalf of the KBI, that propylehexedrine not be removed from the Controlled Substances Act, as it still appears to be a commonly abused drug. He noted it is imperative that the Bureau have the ability to deter individuals who would synthesize this drug from inhalers either for personal use or resale. He answered numerous questions. He wants only to repeal (c) in **SB 737.**

A lengthy discussion ensued. There was confusion as to formulating language to conform with federal regulations; leaving an abused substance on or off the Controlled Substances Schedule; perhaps to identify a quantity of this drug would work; need for the ability to arrest the person who is selling the drug in the broken-down form.

At this time, Chairperson Sader recommended that Mr. Smith and Mr. Hitchcock confer with staff to work on language that would offer the best solution to this concern.

At this point, Chair consulted with members in regard to Committee meeting scheduling. It was the consensus that a 5:00 p.m. meeting would work best for most members. Chair then announced the following schedule, 1:30 and 5:00 p.m. meetings on March 25th, 26th, and on Friday the 27th, on adjournment of the House.

Chair recognized Rep. Hackler who offered a hand-out (Attachment No. 9.) from Brenda Eddy, Kansas Commission for the Deaf/Hearing Impaired. This was provided per request, and is recorded as "Provide for a Program of Regulation and Certification of Interpreters".

Chair adjourned the meeting at 3:05 p.m.

Note: (Attachment No. 10) testimony provided several days after Committee meeting by John Holmgren, Catholic Health Association of Kansas on **SB 728.**

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-24-92

NAME	ORGANIZATION	ADDRESS
Harold Riehm	KAOM	Topeka
Annette Sieben	KMHA	Topeka
[illegible]	KDOT	Topeka
Joseph F Howe	Hall PF	Topeka
Garth Wilcox	KDHE	Topeka
Tracy Robinson	LWV of Ks.	Topeka
Tom Hitchcock	Bd. of Pharmacy	Topeka
John L. Kiefhaber	Ks. Health Care Assn	Topeka
Kyle G Smith	KBI	Topeka
John Holmgren	Catholic Health Conn	Topeka
Chip Wheelen	Ks Medical Soc.	Topeka
Larry Buening	Bd of Healing Arts	Topeka
ELIZABETH E. TAYLOR	KS ASSO OF LOCAL HEALTH DEPTS	TOPEKA
Wendell Strom	AARP-CCTF	Topeka
Martha Jenkins	AIA	Topeka
Lisa Getz	Wichita Hospitals	Wichita
David Hazlick	KS Dental Assn	Topeka
H. Philip Elwood	Ks Dent. Bd - Looded for	Topeka
ESTEL LANDRETH	Dental Board Pres.	Wichita
Natalie Eshom	KS Dentist for Progress	Wichita
Pam Winter	KS Dentists for Progress	Wichita
DR. TERRY DUNCAN	Ks Dentists for Progress	WICHITA
Margot Lenzi	Boehringer Ingelheim	Columbia, Mo.
David Hanson	Ks Dental Assist Assoc	Topeka
Brenda Long CDA	Ks Dental Assist. Assoc.	Topeka
Richard Morrissey	KDHE	Topeka
KEITH A LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Marilyn Bradt	KINH	Lawrence

Attachment #2
Presented 3-24-92

KHCA

Member of ahca

Kansas Health Care Association
221 SOUTHWEST 33rd STREET
TOPEKA, KANSAS 66611-2263
(913) 267-6003 • FAX (913) 267-0833

TESTIMONY

before the

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

by

John L. Kiefhaber, Exec. Vice President

KANSAS HEALTH CARE ASSOCIATION

Senate Bill No. 182

"AN ACT....authorizing the secretary of health and environment to assess civil penalties against....homes for certain violations"

Chairperson Sader and Members of the Committee:

The Kansas Health Care Association, representing over 200 professional nursing facilities across the State, appreciates the opportunity to speak in opposition to passage of Senate Bill 182. This bill, even though it has been heavily amended to attempt to make it more reasonable and to fit within the confines of Kansas law, is duplicative of civil penalty authority the Department already has and is therefore not needed.

There are already plenty of penalties on the books that could be used to sanction a facility if serious harm were ever to come to a nursing home resident. We do not have information that serious harm would occur to a resident of a Kansas nursing facility in the first place. Kansas nursing homes are recognized nationwide as being very good, and they are getting even better.

P&HW
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Attm #1.
1-2

We would also like to draw the Committee's attention to the terms "serious harm" and "imminent risk" that are very subjective and would be extremely difficult for the Secretary of Health and Environment to define and administer fairly.

Members of the Committee, this is not a good piece of legislation. It attempts to solve a problem that we do not have with a remedy that is arbitrary and subjective and one-sided. The health care professionals staffing our nursing facilities are already working very hard each day to assure that their residents are well taken care of. We ask you not to pass Senate Bill 182.

Presented
3-24-92
Attm # 1,
pg 2 of 2.

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony presented to

House Committee on Public Health and Welfare

by

The Kansas Department of Health and Environment

Senate Bill 728

On April 1, 1991, the Charitable Health Care Provider Program became effective. Enacted by S.B. 736, the program was largely spearheaded by retired physicians looking for a means to offer their professional services to the medically indigent without having to maintain an active medical license. The statutory authority provided in K.S.A. 75-6101 through 75-6120, modifies the Kansas Tort Claims Act to allow health care providers to be considered employees of the state, for liability purposes, when they gratuitously donate their professional services to the medically indigent. The program applies to all statutorily defined health care providers.

Response to the program, by the health care provider community, has been good. In mid-March, with the help of the Kansas Medical Society and the Kansas Association of Osteopathic Medicine, virtually every doctor licensed in the state received an information packet on the Charitable Health Care Provider Program. To date, there are 427 physicians, 34 dentists, 68 nurses, 2 physical therapists, 2 optometrists, 2 podiatrists and 3 physicians' assistants registered with the state as charitable providers. Twenty-nine of the registered providers are retirees with exempt or inactive licenses.

There are 65 points of entry into the program for people looking for charitable care. Fifty-two of the points of entry are county health departments and 13 are indigent health clinics.

S.B. 728 was originally intended to make four important modifications to the Charitable Health Care Provider program:

1. **It was intended to allow Medicaid recipients to be part of the population served by Charitable Health Care Providers.** Many of the points of entry around the state don't distinguish between people without any medical insurance and those on Medicaid when determining eligibility for services. This can be a serious problem if they have an exempt license charitable physician. According to current law, that doctor has no liability protection if he or she sees a person on Medicaid and that person files a suit.

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Attm #2

Landon State Office Building • 900 SW Jackson • Topeka, Kansas 66612-1290 • (913) 296-1500

Additionally, points of entry that accept both people without insurance and those on Medicaid are currently obliged to keep two sets of records in order to be able to correctly make quarterly reports to the Kansas Department of Health and Environment. KDHE only wants to know about persons seen charitably, and that can't include Medicaid right now. This double record keeping is extremely taxing on already over-burdened staffs. For several months, a health department in a large urban area decided against participating in the program specifically because of the administrative nightmare this type of separation would provoke.

2. **It was intended to expand liability coverage to include Charitable Health Care Providers giving care to the medically indigent in any local health department or not for profit indigent health care clinic who receive remuneration for their services.** Current language allows only health care providers who give their time gratuitously or for a fee paid by a local health department participating in a primary care pilot program to be considered charitable health care providers. This limiting language prevents employed or contracted providers that are not part of the primary care demonstration project from enjoying liability protection under the Tort Claims Act. S.B. 728 would give to those providers the same protection now allowed to providers in local health departments that are primary care pilot projects.

3. **It was intended to expand liability coverage to include Charitable Health Care Providers giving care in <u>any</u> local health department or not for profit indigent health care clinic.** This means that providers in local health departments or indigent health care clinics who provide clinical services to the medically indigent could be afforded liability protection. An example would be health department Maternal and Infant clinics. Providers would not have to be involved in a formal primary care program to benefit from the Tort Claims Act protection.

4. **It was intended to provide liability coverage to Charitable Health Care Providers whether or not the local health department or the not for profit indigent health care clinic charges a fee based on federal poverty guidelines.** Many sites have sliding fees based on the clients ability to pay, using federal poverty guidelines as their basis. These fees help defray the overhead costs of operating a clinic. This provision of S.B.728 assures that such a practice will not affect the liability protection of the Charitable Providers.

The Senate Committee of the whole amendments change the second of these four objectives by eliminating coverage to Charitable Health Care Providers who receive remuneration for their service in any local health care department or not for profit indigent health care clinic. We recommend that Section 1, (f)(2) be restored to its original intent of including under the definition of Charitable Health Care Provider physicians who are remunerated for their services to the medically indigent in any local health department or indigent health care clinic.

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attm #2
ag284

Since the program's inception, there have been no suits filed against any Charitable Health Care Providers in Kansas. We are unaware of any suits filed against any of the indigent health care clinics in Kansas since they began starting up some 7-8 years ago.

Recommendation: The Kansas Department of Health and Environment recommends that the Committee amend Section 1 of S.B. 728 and report it favorably for passage.

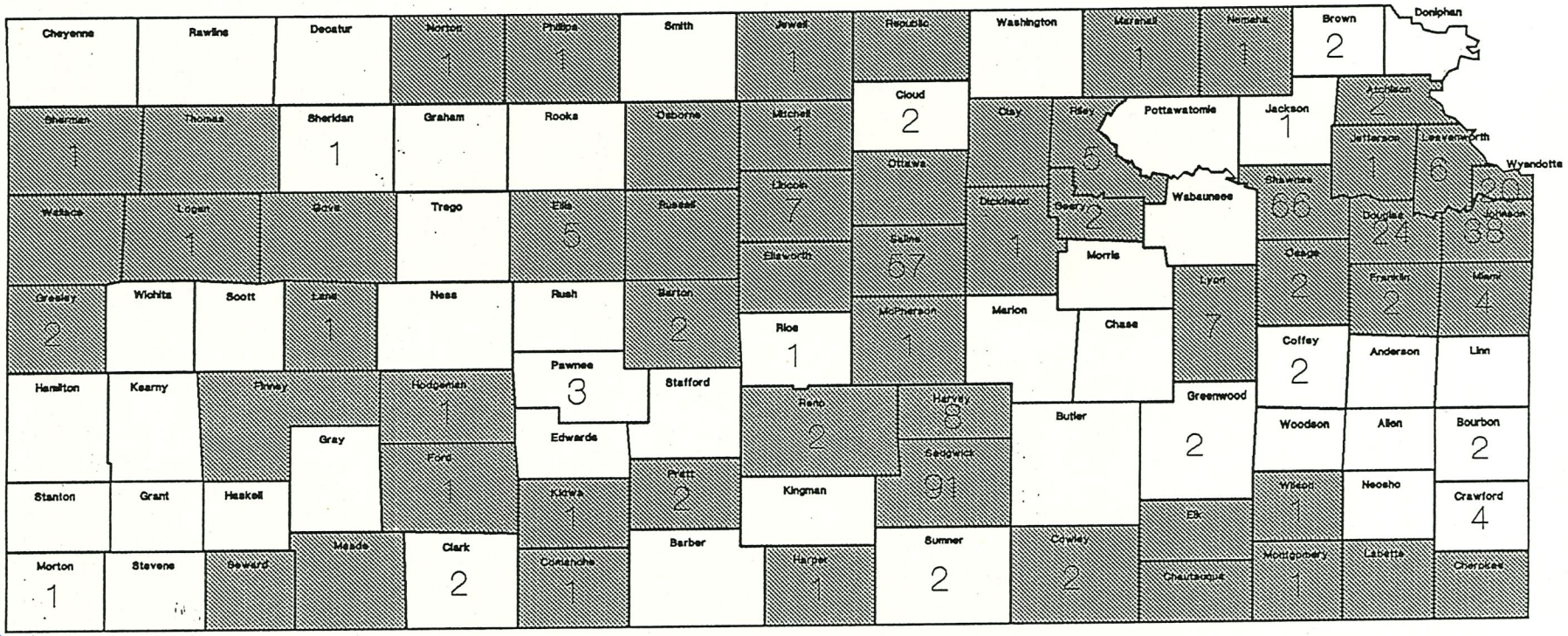
Testimony presented by: Richard J. Morrissey
Deputy Director
Division of Health
March 24, 1992

Attached
3-24-92
Attachment #2
SB 384.

Charitable Health Care Provider Program

Distribution of Charitable Health Care Providers and Points of Entry, January 1, 1992

Kansas Department of Health and Environment
Office of Local and Rural Health Systems
(913) 296-1200



* Shaded counties indicate one Point of Entry. Exceptions: Cowley (2), Johnson (2), Sedgwick (5) and Wyandotte (3).
* Number in county represents the number of charitable doctors in that county.

January 1, 1992, there were 388 charitable doctors, 61 nurses and 30 dentists. There were 65 Points of Entry into the system: 52 local departments of public health and 13 indgent health care clinics.

Kansas Association for the Medically Underserved

Service Profiles 1991

Implementing activities that promote and emphasize health care to the medically underserved in the state of Kansas

PH&CW
3-24-92
Attm #3
1-44

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Case Studies

KAMU members provide a wide range of services to their patients and to their communities. Our members provide primary health care to all populations including migrant, indigent, substance abusers and the homeless. These case histories are an example of the clientele of Guadalupe Clinic, a representative member of KAMU.

Maria is a 24-year old pregnant mother of a two-year old, three-year old and a six-year old who was abandoned by her husband. She is an illegal alien who does not speak English and is struggling to survive by working in a factory for $3.50 an hour. She has no health insurance benefits. Her prenatal care and delivery will be taken care of by Guadalupe Clinic volunteer family practice physicians. The routine care of her other children is also occurring at Guadalupe Clinic.

Mrs. Jones was widowed two years ago and was left without any financial support. She is ineligible for federal or state aid. She has five children still at home, three are preschoolers. Guadalupe Clinic has treated several of her children for common childhood illnesses.

Bobby, a three-year old boy, was noted to have developmental problems during a well baby check at Guadalupe Clinic. He was referred to a screening clinic and diagnosed as having vision, speech and hearing deficits. Through multiple agency cooperation, he is now enrolled in a special school and his mother, a single parent of three, is receiving state and federal aid.

The Martin family is very large, with seven young children. Both parents work full-time in unskilled jobs without benefits. They have no health insurance and are ineligible for federal or state assistance. Members of the Martin family have been treated for many different ailments at Guadalupe Clinic, including the surgical removal of an ingrown toenail, tubes in the ears of two children, suturing lacerations, treatment of many upper respiratory and urinary tract infections, dental care, and chronic illnesses. The children have received their immunization, well baby checks, screening for physical and developmental problems and routine physicals. Medications and medical supplies have been provided when needed.

Clinic Profiles

Duchesne Clinic

Directors

Executive Director: Amy Willcott
Financial Director: Dan Maurin
Program Director: Janice Koelzer, CSJ, RN, MN
Medical Director Sharon Lee, MD

636 Tauromee
Kansas City, KS 66101
(913) 321-2626

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care				x
Well Child Exam	x		x	
Immunizations		x		
Nutrition	x			x
WIC	x			
Counseling	x			x
Other				
Social Services				
Counseling	x			
Medicaid Assist.	x			
Dental	x			x
Eye Exams	x			x
Eyewear Prescription	x			x
Hearing Testing	x			x
Hearing Aids	x			x
Pharmacy	x		x	x
Prescription Assistance	x		x	
Samples Only	x			
Contract Pharmacy		x		
Durable Medical Equipment	x			
Home Care		x		
Translation	x		x	x
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians			21
Midlevel		1	
Nurses		1	15
Social Workers			
Support staff		2.5	30

New patients per month: 148

Client contacts per month: 360

Patient fees are:
Based either on a sliding fee ($6, $12 or $18) OR on voluntary contributions.

Primary Service Area is:

Cities: Kansas City, KS

Counties: Wyandotte, Johnson and Jackson

Funding sources include:

Federal: McKinney Funds (Swope Parkway Health Clinic of Kansas City, MO)
City: HUD grants
Private: H & R Block and Hallmark Corporations
Non-Profit: United Way, Churches, Groups and Individual contributions

Comments:

PHRW

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Att #3
5-44

Age

0-12	19%
13-19	5%
20-35	33%
36-54	41%
55+	2%

Gender

Male	45%
Female	55%

Health Insurance

Medicaid	0%
Medicare	0%
Private Insurance	0%
Other	0%
No Insurance	100%

Patients with insurance or other third party pay are usually referred.

Ethnicity

Caucasian	35%
African American	45%
Hispanic	15%
Native American	2%
Other	3%

Eligibility Guidelines

Eligibility guidelines - 200% of poverty level.
Average client income - 100% of poverty level.

Five Most Common Diagnoses

1. Bronchitis
2. Hypertension
3. Urinary Tract Infections
4. Injuries and Sprains
5. Skin Disorders/Sexually Transmitted Diseases

Episcopal Social Services/Venture House

Directors

Executive Director: Robert V. Parker
Financial Director: Judy Martin
Program Director: Linda Bemis
Medical Director: Dr. William Butin
Health Ministries Director: Elana Benson, RN, BSN

233 S. St. Francis
Wichita, KS 67202
(316) 269-4160

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	
Health Monitoring	x		x	
Prenatal Care				
Well Child Exam				
Immunizations				
Nutrition				
WIC				
Counseling	x		x	
Other	x		x	
Social Services				
Counseling	x		x	
Medicaid Assist.				
Dental				
Eye Exams	x			x
Eyewear Prescription	x			x
Hearing Testing				
Hearing Aids				
Pharmacy				
Prescription Assistance	x		x	
Samples Only				
Contract Pharmacy				
Durable Medical Equipment	x			x
Home Care				
Translation				
Other- Pregnancy testing	x		x	

Staff

Staff	FTE	Salaried	Volunteer
Physicians			
Midlevel			
Nurses	4	1	3
Social Workers			
Support staff	10		10

New patients per month: 40

Client contacts per month: 450-500

Patient fees are:
No fees.

Primary Service Area is:
Wichita Metropolitan Area

Funding sources include:

Federal: Health & Human Services (Homeless Health)

Private: Church Foundations, the Boeing Good Neighbor Fund and individual private donations.

Comments: The Wichita area is unable to keep up with the demand for dental services.

Age

0-12	5%
13-19	5%
20-35	30%
36-54	30%
55+	30%

Gender

Male	75%
Female	25%

Health Insurance

Medicaid	10%
Medicare	0%
Private Insurance	0%
Medikan	20%
No Insurance	70%

Ethnicity

Caucasian	45%
African American	45%
Hispanic	5%
Native American	5%
Other	5%

Eligibility Guidelines

Eligibility guidelines - none.

Five Most Common Diagnoses

1. Alcohol/Drug Abuse
2. Malnutrition
3. Mental Illness
4. Chronic Diseases
5. Injuries

Finney County Health Department

Directors

Executive Director: Marilyn Peterson
Financial Director: Marilyn Peterson
Director of Family Planning: Debra Dockter, ARNP
Director of Maternal/Child: Gemma Doll, ARNP/MSN
Director of Maternal/Infant: Esther Oppliger, RN/MSN

919 Zerr Road
Garden City, KS 67846
(316) 272-3600

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations	x		x	x
Nutrition	x		x	x
WIC	x		x	x
Counseling	x		x	
Other		x		
Social Services	x		x	
Counseling	x		x	
Medicaid Assist.	x			
Dental		x		
Eye Exams	x			
Eyewear Prescription		x		
Hearing Testing	x		x	
Hearing Aids		x		
Pharmacy	x		x	
Prescription Assistance	x			
Samples Only		x		
Contract Pharmacy		x		
Durable Medical Equipment		x		
Home Care		x		
Translation	x		x	
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians		contract	
Midlevel	2	yes	
Nurses	2	yes	
Social Workers	1	yes	
Support staff	7		

New patients per month: N/A

Client contacts per month: 1490

Patient fees are:
Primarily sliding fees.

Efforts are being made to move all services over to the sliding scale system.

Primary Service Area is:

Cities: Garden City, KS

Counties: Finney

Funding sources include:

Federal: As administered by the state
State: Grants for Family Planning, Healthy Start, Maternal and Infant Formula, HIV Testing/Counseling and Maternal/Child.
County: General funds

Comments: Greater need for obstetrics in this geographical area.
Primary care services are provided for children.

PHHW
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Age

0-12	45%
13-19	15%
20-35	26%
36-54	11%
55+	3%

Gender

Male	36.6%
Female	63.4%

Health Insurance

Medicaid	30%
Medicare	-
Private Insurance	-
No Insurance	70%

Ethnicity

Caucasian	51.3%
African American	2.3%
Hispanic	41.2%
Native American	.1%
Asian	5.1%
Other	.4%

Eligibility Guidelines

Eligibility requirement - none.
Average income - 100 - 150% of poverty level.

Five Most Common Diagnoses

1. Immunizations
2. Reproductive Care
3. Child Health
4. Adult Health
5. Sexually Transmitted Diseases

Good Samaritan Clinic

Directors

Executive Director: Dr. Richard Spann
Financial/Program Director: Wm. Daniel Curnutt
Medical Director: Dr. Kim Snapp

3701 E. 13th St.
Wichita, KS 67208
(316) 688-5020

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	
Health Monitoring	x		x	
Prenatal Care		x		
Well Child Exam		x		
Immunizations		x		
Nutrition				
WIC	x			
Counseling		x		
Other				
Social Services				
Counseling		x		
Medicaid Assist.		x		
Dental	x		x	
Eye Exams		x		
Eyewear Prescription		x		
Hearing Testing		x		
Hearing Aids		x		
Pharmacy		x		
Prescription Assistance	x		x	
Samples Only	x			
Contract Pharmacy		x		
Durable Medical Equipment	x		x	
Home Care		x		
Translation		x		
Other-		x		

Staff

Staff	FTE	Salaried	Volunteer
Physicians	5	1	4
Midlevel			
Nurses	2	1	1
Social Workers			
Support staff	3	1	2

New patients per month: 15

Client contacts per month: 300

Patient fees are:
No more than $5.00 per visit

Primary Service Area is:
Wichita

Funding sources include:
Individual and church donations

Comments:

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Age

0-12	0%
13-19	5%
20-35	25%
36-54	30%
55+	40%

Gender

Male	35%
Female	65%

Health Insurance

Medicaid	0%
Medicare	20%
Private Insurance	5%
No Insurance	75%

Ethnicity

Caucasian	25%
African American	70%
Hispanic	5%
Native American	0%

Eligibility Guidelines

Average patient income - 100-150% of poverty level.

Five Most Common Diagnoses

1. Urinary tract infection
2. Hypertension
3. Sexually transmitted disease
4. Diabetes
5. Upper respriatory infections

Guadalupe Clinic

Directors

Executive Director: Director of Catholic Charities
Program Director: Betty Jean McElhaney, RN
Medical Director: Daniel Tatpati, MD

940 S. St. Francis
Wichita, KS 67216
(316) 264-5615

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	
Prenatal Care		x		
Well Child Exam	x		x	
Immunizations	x		x	
Nutrition	x		x	x
WIC	x		x	x
Counseling	x		x	
Other	x		x	x
Social Services	x			x
Counseling	x			x
Medicaid Assist.		x		
Dental	x			x
Eye Exams	x			x
Eyewear Prescription	x			x
Hearing Testing	x			x
Hearing Aids	x			x
Pharmacy	x		x	
Prescription Assistance	x		x	
Samples Only	x		x	
Contract Pharmacy	x			x
Durable Medical Equipment	x		x	
Home Care		x		
Translation	x		x	x
Other- MD attention	x		x	x
Testing/Diag. X-Ray	x		x	x

Staff

Staff	FTE	Salaried	Volunteer
Physicians			x
Midlevel			
Nurses	1.5	yes	
Social Workers			
Support staff	.5	yes	

New patients per month: 120-130

Client contacts per month: 1550

Patient fees are:
Voluntary.

Primary Service Area is:

Cities: Wichita
Counties: Sedgewick, Harvey, Summner and Butler.

Accepts all areas within the Wichita Diocese.

Funding sources include:

County: Mill Levy Grant
Private: Small Foundation Grants
Other: Individual donations and two annual fundraisers.

Comments: The Clinic sees many transients and "illegals". According to clinic officials, there is a need for dental, medication assistance, transportation and low or no-cost O.B. Care in this geographical area.

Age

0-12	29%
13-19	6%
20-35	36%
36-54	17%
55+	11%

Gender

Male	33%
Female	67%

Health Insurance

Medicaid	N/A
Medicare	N/A
Private Insurance	N/A
Other	N/A

Majority of patients have no insurance.
Patients with insurance or other third party pay are generally referred.

Ethnicity

Caucasian	61%
African American	7%
Hispanic	29%
Native American	0%
Other	2%

Eligibility Guidelines

Eligibility requirement - 200% of poverty level.
Average patient income - statistics not available.

Five Most Common Diagnoses

1. Otitis Media
2. Upper Respiratory Infection
3. Hypertension
4. Gyncological Problems
5. Diabetes

Health Care Access, Inc.

Directors

Executive Director: Judy Eyerly
Financial Director: Judy Eyerly
Medical Director: Brad Phipps, M.D.

P.O. Box 531
Lawrence, KS 66044
(913) 841-5760

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care		x		
Well Child Exam		x		
Immunizations		x		
Nutrition	x		x	x
WIC		x		
Counseling	x		x	x
Other				
Social Services		x		
Counseling		x		
Medicaid Assist.		x		
Dental	x			x
Eye Exams	x			x
Eyewear Prescription		x		
Hearing Testing		x		
Hearing Aids		x		
Pharmacy	x		x	x
Prescription Assistance	x		x	x
Samples Only				
Contract Pharmacy				
Durable Medical Equipment		x		
Home Care		x		
Translation	x		x	
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians	.16		.16
Midlevel			
Nurses	.41	.25	.16
Social Workers			
Support staff	3.0	1.0	2.0

New patients per month: 24 - for clinic only.
Dental and Pharmacy are separate programs.
Client contacts per month: 88

Patient fees are:
Based on a sliding fee, with a maximum charge of $5.00

Primary Service Area is:
Douglas County

Funding sources include:
City: Community Development Block Grant
Private: Rice Foundation, St. Joseph Foundation, Kimbrell Foundation and Georgia Willman Trust
Other: Rotary Club, area churches, local corporations, private donations and fundraisers.

Comments:

Age

0-12	10%
13-19	6%
20-35	36%
36-54	38%
55+	10%

Gender

Male	34%
Female	66%

Health Insurance

Medicaid	10%*
Medicare	3%
Private Insurance	3%
Other	1%
No Insurance	83%

*Dental and pharmacy only.

Ethnicity

Caucasian	83%
African American	9%
Hispanic	3%
Native American	2%
Other	3%

Eligibility Guidelines

Eligibility guidelines - 150% of poverty level for clinic visits
Pediatrics - 185% of poverty level.

Five Most Common Diagnoses

1. Diabetes
2. Hypertension
3. Gynecological
4. Upper Respiratory Infection
5. Otitis Media

Health Ministries of Harvey County, Inc.

Directors

Executive Director: Rojean DuBois, RN, MN
Medical Director: Timothy Wiens, MD

316 Oak
Newton, KS 67114
(316) 283-6103

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	
Prenatal Care	x		x	x
Well Child Exam	x		x	x
Immunizations		x		
Nutrition	x		x	
WIC		x		
Counseling	x		x	x
Other				
Social Services		x		
Counseling				
Medicaid Assist.				
Dental		x		
Eye Exams		x		
Eyewear Prescription		x		
Hearing Testing		x		
Hearing Aids		x		
Pharmacy		x		
Prescription Assistance	x			
Samples Only	x			
Contract Pharmacy		x		
Durable Medical Equipment		x		
Home Care		x		
Translation	x			
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians	2.5		x
Midlevel	1.5		x
Nurses	8.5	1-20 hrs.	x
Social Workers	.5		x
Support staff	21.5	1-20 hrs.	x

New patients per month: N / A

Client contacts per month: 137 and growing rapidly

Patient fees are:
Sliding scale

Primary Service Area is:
Harvey, McPherson, Marion and Butler Counties

Funding sources include:

Private: Family Health Plan Charitable Foundation (44%)

Other: United Way (5%), Churches (38%), Individual Contributions (6.5%), Businesses and Clubs (3%)

Comments:

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17-44

Age

0-5	17%
6-15	16%
16-24	13%
25-55	48%
55+	6%

Gender

Male	27%
Female	73%

Health Insurance

Medicaid	0%
Medicare	0%
Private Insurance*	5%
Other	0%
No Insurance	95%

* Patients with private insurance are generally those with catastrophic coverage only.

Ethnicity

Caucasian	71.0%
African American	8.5%
Hispanic	17.0%
American Indian	1.5%
Other	2.0%

Eligibility Guidelines

Eligibility guidelines - 200% of poverty. 65% of clients served are at or below 100% of poverty.

Five Most Common Diagnoses

1. Well child exam
2. Pregnancy
3. Skin disorders
4. Well adult exam
5. Upper Respiratory Infection/Otitis

The Hunter Health Clinic, Inc.

Directors

Executive Director: Bert G. Steeves
Financial Director: Cynthia Parsons
Program Director (Homeless): Shirley Harris
Program Director (Perinatal): Jane Schlickau
Program Director (Social): Evelyn Wheelhouse
Medical Director: Daryl Thomas, MD

2318 East Central
Wichita, KS 67214
(316) 262-3611

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations	x		x	
Nutrition				
WIC		x		
Counseling		x		
Other	x		x	
Social Services				
Counseling	x		x	
Medicaid Assist.	x		x	
Dental	x			
Eye Exams		x		
Eyewear Prescription		x		
Hearing Testing	x			x
Hearing Aids		x		
Pharmacy		x		
Prescription Assistance	x			x
Samples Only	x			x
Contract Pharmacy		x		
Durable Medical Equipment		x		
Home Care		x		
Translation	x		x	
Other- Laboratory	x		x	

Staff

Staff	FTE	Salaried	Volunteer
Physicians	2.6	yes	
Midlevel	1	yes	
Nurses	2	yes	
Social Workers	1	yes	
Support staff	6	yes	

New patients per month: 300

Client contacts per month: 1600

Patient fees are:
Sliding fees based on federal poverty income guidelines.

No fees are assessed for homeless or home hardship cases.

Primary Service Area is:
Cities: Wichita

Counties: Sedgwick and Butler

Funding sources include:

Federal: Public Health Services
State: Kansas Department of Health & Environment
City: HUD Homeless Contract
Other: Indian Health Services

Comments: In the past five years, the clinic has experienced an increase in demand for services and has responded by expanding existing services and increasing the types of services offered. The clinic has seen an increase in the number of patients at or below poverty guidelines needing services.

Age

0-12	31.3%
13-19	8.3%
20-35	30.6%
36-54	27.0%
55+	2.8%

Gender

Male	36.4%
Female	63.6%

Health Insurance

Medicaid	40%
Medicare	2%
Private Insurance	4%
No Insurance	54%

Ethnicity

Caucasian	58.5%
African American	24.5%
Hispanic	7.2%
Native American	.3%

Eligibility Guidelines

Eligibility guidelines - none
Majority of clients earn approximately $7,800/year.

Five Most Common Diagnoses

1. Pregnancy
2. Diabetes
3. Otitis Media
4. Hypertension
5. Upper Respriatory Infection

Johnson County Public Health

Directors

Executive Director: Bernice "Debby" Sullivan
Financial Director: Constance K. Murphy
Program Director (Facilities): Barbara Riley
Program Director (Health Ed.): Ellen Rangel
Program Director (Personal/Health): Martha L. Hutcheson

301-B Sourth Clairborne
Olathe, KS 66062
(913) 782-9400
(913) 791-1580

6000 Lamar
Mission, KS 66202
(913) 791-5660

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	
Health Monitoring	x		x	x
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations	x		x	x
Nutrition	x		x	
WIC	x		x	
Counseling	x		x	
Other				
Social Services	x		x	x
Counseling			x	x
Medicaid Assist.	x		x	
Dental				
Eye Exams	x		x	
Eyewear Prescription		x		
Hearing Testing	x		x	
Hearing Aids		x		
Pharmacy	x			
Prescription Assistance	x			x
Samples Only		x		
Contract Pharmacy	x			x
Durable Medical Equipment		x		
Home Care		x		
Translation	x		x	
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians	.75		
Midlevel	6		
Nurses	35		
Social Workers	3		
Support staff	16 clerical staff; 10 volunteers		

New patients per month: 2,198

Client contacts per month: 5,428

Patient fees are:
Sliding fees for clinical services

Voluntary contributions for adult wellness programs

No fees if unable to pay

Primary Service Area is:
Johnson County (Kansas)

Funding sources include:
Federal/State: WIC, Healthy Start, Family Planning, AIDS Health Ed., Adolescent, Maternal & Child Health Formula and Lay Home Visitor

County: Immunization grants, communicable disease, adult wellness, prenatal, family planning, well child, area nursing, facilities inspection, health education support services and administration.

Comments: Survey includes all of health department services, not just primary care.

Age

0-12	34.0%
13-19	5.6%
20-35	44.6%
36-54	2.8%
55+	5.8%

Gender

Male	40%
Felmale	60%

Health Insurance

Medicaid	30%
Medicare*	
Private Insurance	5%
No Insurance	65%

* Statistics not recorded for Medicare since clinic service is not an approved provider.

Ethnicity

Caucasian	93%
African American	2%
Hispanic	1%
American Indian	0%
Other	4%

Eligibility Guidelines

Eligibility guidelines - none
Average patient income - 150% of poverty or below
Medical indigent clinic - 200% of poverty

Five Most Common Diagnoses

1. Upper Respiratory Infection/Otits
2. Rashes
3. Chronic disease problems
4. Urinary Tract Infections
5. Gynocological Problems

Lyon County Health Department

Directors

Executive Director: Eileen Greischar

802 Mechanic
Emporia, KS
(316) 342-4864

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations	x		x	
Nutrition				
WIC	x		x	
Counseling	x		x	
Other				
Social Services				
Counseling	x		x	
Medicaid Assist.				
Dental				
Eye Exams				
Eyewear Prescription				
Hearing Testing	x		x	
Hearing Aids				
Pharmacy				
Prescription Assistance				
Samples Only				
Contract Pharmacy				
Durable Medical Equipment				
Home Care				
Translation				
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians		contract	3
Midlevel	2	yes	
Nurses	5.5	yes	
Social Workers	.5		
Support staff	12.5		

New patients per month: 250

Client contacts per month: 1000-1500

Patient fees are:
Sliding fees

Primary Service Area is:
Lyon County

Funding sources include:
Various federal, state and county grants.

Comments: Large percentage of clients are children.
Survey includes all of health department services.

PHCW

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23-44

Age

0-12	60%
13-19	15%
20-35	10%
36-54	5%
55+	-

Gender

Male	-
Female	-

Health Insurance

Medicaid	47%
Medicare	0%
Private insurance	8%
No Insurance	42%
Unknown	2%

Ethnicity

Caucasian	88%
African American	3%
Hispanic	5%
Native American	1%
Asian	3%

Eligibility Guidelines

Eligibility guidelines - none.
Poverty guidelines used to establish discounted fees.
Average patient income - 100% of poverty level.

Five Most Common Diagnoses

1. Well Child/Nutrition
2. Reproductive Care
3. Pregnancy
4. Upper Respiratory Infections
5. Skin Disorders

Marian Clinic

Directors

Executive Director: Pat Hurley, RN

1001 SW Garfield Ave.
Topeka, KS
(913) 233-8081

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care		x		
Well Child Exam	x		x	
Immunizations		x		
Nutrition				
WIC		x		
Counseling				
Other				
Social Services				
Counseling	x		x	
Medicaid Assist.	x		x	
Dental	x		x	
Eye Exams	x		x	
Eyewear Prescription	x			
Hearing Testing	x		x	
Hearing Aids		x		
Pharmacy	x		x	
Prescription Assistance	x		x	x
Samples Only	x		x	
Contract Pharmacy	x			x
Durable Medical Equipment	x		x	
Home Care		x		
Translation	x		x	
Other- Medical Care	x		x	

Prenatal vitamin supply - assistance in finding physician
Social service limited - short term assistance only, then referral

Staff

Staff	FTE	Salaried	Volunteer
Physicians			150
Midlevel			
Nurses	3	3	15
Social Workers			1
Support staff	3	3	

New patients per month: 250

Client contacts per month: 500 - 550

Patient fees are: Flat fee of $10.00 for medical services, $10.00 for dental services, $20.00 to enter the dental program.

Primary Service Area is:
Topeka area, Shawnee County

Funding sources include:
Private donations, patient fees

Comments: Pharmacy care - samples, prescriptions, coupons and those purchased by Marion Clinic are distributed.

Age

0-18	28%
18-35	43%
36-55	22%
55+	7%

Gender

Male	-
Female	-

Health Insurance

Medicaid*	
Marion Program Insurance - enrolled	100
No Insurance	90%

*Well child physicals, well baby exams, dental, school and job physicals.

Ethnicity

Caucasian	74%
African American	15%
Hispanic	9%
Asian	1%
Native American	1%

Eligibility Guidelines

Eligibility guidelines - 200% of poverty level.
Average Income - 65% of patients are at or below 100% of poverty level.

Five Most Common Diagnoses

1. Dental
2. Hypertension
3. Physicals
4. Upper Respiratory Infections
5. Ear Infections

Reno County Health Department

Directors

Executive Director: Judith A. Seltzer

209 West 2nd
Hutchinson, KS 67501
(316) 665-2900

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations	x		x	x
Nutrition				
WIC	x		x	
Counseling	x		x	x
Other				
Social Services				
Counseling	x		x	
Medicaid Assist.	x		x	
Dental	x			x
Eye Exams	x		x	
Eyewear Prescription		x		
Hearing Testing	x		x	
Hearing Aids		x		
Pharmacy	x		x	
Prescription Assistance	x			x
Samples Only	x		x	
Contract Pharmacy				
Durable Medical Equipment		x		
Home Care	x			x
Translation	x		x	
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians	11	10 contract	1
Midlevel	.6	contract	
Nurses	19	19	
Social Workers	1.2	1.2	
Support staff	12	12	

New patients per month: 100

Client contacts per month: 4000

Patient fees are:
Sliding scale and voluntary

Certain services are no charge

Primary Service Area is:
Reno, Rice, McPherson and Stafford Counties

Funding sources include:

State: WIC, Family Planning, HERR, Lively, Healthy Start, State Formula Funds, AIDS Testing and Day Care.

County: Elderly Mill Funds and Local Ad Volorum

Other: Donations from Hutchinson Rotary for Dental Program for children

Comments: Survey includes all health department serivces.

Age

0-4	31%
5-14	13%
15-19	9%
20-44	33%
45-64	6%
65+	8%

Gender

Male	-
Female	-

Health Insurance

Medicaid	28%
Other Insurance	3%
No Insurance	69%

Ethnicity

Caucasian	89%
African American	4%
Hispanic	5%
Other	6%

Eligibility Guidelines

Income guidelines - 200% of poverty level.
Sliding fee scale.
Average patient income - 100-150% of poverty level.

Five Most Common Diagnoses

1. Pregnancy
2. Communicable Diseases
3. Hypertension
4. Diabetes
5. Anemia

Saint Vincent Clinic

Directors

Executive Director: Sister Amy Willcott
Financial Director: Nancy Martin
Medical Director: Dr. Stewart Grote

422 Walnut
Leavenworth, KS 66048
(913) 651-8860

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	
Health Monitoring	x		x	
Prenatal Care		x		
Well Child Exam	x			
Immunizations		x		
Nutrition	x		x	
WIC		x		
Counseling	x			x
Other				
Social Services				
Counseling	x			
Medicaid Assist.		x		
Dental	x			x
Eye Exams	x			x
Eyewear Prescription	x			x
Hearing Testing	x			x
Hearing Aids	x			
Pharmacy	x		x	x
Prescription Assistance	x			
Samples Only	x		x	
Contract Pharmacy		x		
Durable Medical Equipment	x			
Home Care		x		
Translation		x		
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians			
Midlevel	1		
Nurses	1		
Social Workers			
Support staff	2.5		

New patients per month: 65

Client contacts per month: 200

Patient fees are:
Sliding scale ($6.00, $12.00 or $18.00)

Primary Service Area is:
Leavenworth County

Funding sources include:
City: Community Development Funds

Other: United Way
Sisters of Charity of Leavenworth

Comments:

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29-44

Age

0-17	30%
18-44	57%
45-64	13%

Gender

Male	39%
Female	61%

Health Insurance

Medicaid	1.0%
Medicare	.5%
Private Insurance	.1%
No Insurance	97.0%

Ethnicity

Caucasian	77%
African American	17%
Hispanic	1%
Native American	1%

Eligibility Guidelines

Income guidelines - 200% of poverty level.
Average patient income - 100-150% of poverty level.

Five Most Common Diagnoses

1. Upper Respiratory Infections
2. Bronchitis/Asthma
3. Gynecological
4. Urinary Tract Infections
5. Skin Disorders

Topeka Shawnee County Health Department

Directors

Executive Director: Katharine Rathbun, MD, MPH

1618 W. 8th
Topeka, KS 66606
(913) 233-8961

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	x
Prenatal Care	x		x	x
Well Child Exam	x		x	x
Immunizations	x		x	x
Nutrition				
WIC	x		x	x
Counseling	x		x	x
Other				
Social Services				
Counseling	x		x	x
Medicaid Assist.	x		x	x
Dental		x		
Eye Exams	x		x	
Eyewear Prescription		x		
Hearing Testing	x		x	
Hearing Aids				
Pharmacy	x		x	
Prescription Assistance	x		x	
Samples Only	x		x	
Contract Pharmacy				
Durable Medical Equipment		x		
Home Care	x			x
Translation	x		x	x
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians	1.7		
Midlevel	0		
Nurses	3		
Social Workers	1.5		
Support staff	4		

New patients per month: 200

Client contacts per month: 900

Patient fees are: Sliding fee scale

Primary Service Area is:

Funding sources include: Federal, state, city county, contracts, private pay

Comments:

Age

0-12	26%
13-19	18%
20-35	29%
36-54	23%
55+	4%

Gender

Male	-
Female	-

Health Insurance

Medicaid	70%
Medicare	-
Other Insurance	2%
No Insurance	28%

Ethnicity

Caucasian	52%
African American	36%
Hispanic	9%
Asian	2%
Native American	1%

Eligibility Guidelines

Income guidelines - 200% of poverty level.
Average income - 100% of poverty level.

Five Most Common Diagnoses

1. Hypertension
2. Upper Respiratory Infection
3. Cardiovascular
4. Adult Health Exam
5. Child Health Exam

Turner House Clinic for Children

Directors

Medical Director: F. Vaughters, MD

2052 N 3rd.
Kansas City, KS
(913) 371-5065

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x			
Health Monitoring	x	x		
Prenatal Care				
Well Child Exam	x			
Immunizations	x			
Nutrition				
WIC				
Counseling				
Other	x			
Social Services				
Counseling				
Medicaid Assist.				
Dental				
Eye Exams	x			
Eyewear Prescription		x		
Hearing Testing		x		
Hearing Aids		x		
Pharmacy	x			
Prescription Assistance		x		
Samples Only		x		
Contract Pharmacy		x		
Durable Medical Equipment		x		
Home Care		x		
Translation		x		
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians			2.5
Midlevel			
Nurses	1	1	3
Social Workers			
Support staff	3.5	1	2.5

New patients per month: N / A

Client contacts per month: 100

Patient fees are:

$10.00 per visit (includes medical, immunizations and exam)

Primary Service Area is:

Wyandotte County

Funding sources include:

Private: Space donated by Turner House, Inc.
Private grants

Comments:

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33-44

Age

0-12	80%
13-19	20%
20-35	0%
36-54	0%
55+	0%

Gender

Male	50%
Female	50%

Health Insurance

Medicaid	5%
Medicare	
Private Insurance	
No Insurance	95%

Ethnicity

Caucasian	33%
African American	33%
Hispanic	33%
Other	1%

Eligibility Guidelines

Income guidelines - 200% of poverty level.
Majority of clients - 100 - 150% of poverty level.

Five Most Common Diagnoses

1. Acute Illnesses of Childhood
2. Upper Respiratory Infections
3. Otitis Media
4. Urinary Tract Infections
5. Asthema

United Methodist Urban Ministry Medical Clinic

Directors

Financial/Program Director: Sandra L Parker
Medical Director: Jana Nisly, MD

1611 North Mosley
Wichita, KS 67214
(316) 263-7455

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	
Health Monitoring	x		x	
Prenatal Care	x		x	
Well Child Exam	x		x	x
Immunizations	x		x	
Nutrition	x		x	
WIC		x		
Counseling	x		x	x
Other				
Social Services	x		x	x
Counseling	x		x	x
Medicaid Assist.	x		x	x
Dental	x		x	x
Eye Exams	x		x	x
Eyewear Prescription	x			x
Hearing Testing	x			x
Hearing Aids		x		
Pharmacy	x		x	x
Prescription Assistance	x		x	
Samples Only		x		
Contract Pharmacy	x			x
Durable Medical Equipment	x		x	
Home Care	x			
Translation	x		x	x
Other- Colposcopy/Cryotherapy	x		x	

Staff

Staff	FTE	Salaried	Volunteer
Physicians	1	x	
Midlevel	3	x	
Nurses	7	3	4
Social Workers	5	3	2
Support staff	10	2	8

New patients per month: 10

Client contacts per month: 975

Patient fees are:
Nominal ($5.00) or on a voluntary basis

Primary Service Area is:
Cities: Wichita

Counties: Sedgwick

Funding sources include:
Federal: Stewart B. McKinney Homeless Assistance Section 340 of the Public Health Service Act
State: AIDS Education, Living Skills Instructor, Case Manager for Hispanic families, Kansas Dept. of Health & Environment, Social Rehabilitation Services
Private: United Methodist Health Ministry Fund, Wesley Foundation, Board of Global Ministries, and the Health Concepts Foundation.

Comments:

Age

0-12	15%
13-19	15%
20-35	40%
36-54	20%
55+	10%

Gender

Male	40%
Female	60%

Health Insurance

Medicaid	3%
Medicare	1%
Private Insurance	0%
No Insurance	96%

Ethnicity

Caucasian	50%
African American	15%
Hispanic	32%
American Indian	1%
Other	2%

Eligibility Guidelines

Income guidelines - 200% poverty
Average patient income - 100% of poverty

Five Most Common Diagnoses

1. Otitis media
2. Hypertension
3. Diabetes
4. OB-Gynecological
5. Musculoskeletal

United Methodist Western Kansas Mexican-American

Directors

Executive/Financial Director: Penney Schwab
Medical Director: Karen L. Nonhof, M.D.

Box 766 - 224 North Taylor
Garden City, KS 67846
(316) 275-1766

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion	x		x	x
Health Monitoring	x		x	
Prenatal Care	x		x	
Well Child Exam	x		x	
Immunizations		x		
Nutrition	x		x	
WIC				
Counseling	x		x	
Other				
Social Services	x		x	
Counseling	x		x	
Medicaid Assist.		x		
Dental	x			x
Eye Exams	x			x
Eyewear Prescription	x			
Hearing Testing	x		x	
Hearing Aids		x		
Pharmacy	x		x	x
Prescription Assistance	x		x	
Samples Only	x		x	
Contract Pharmacy	x			x
Durable Medical Equipment	x		x	x
Home Care		x		
Translation	x		x	x
Other-	x		x	x

Staff

Staff	FTE	Salaried	Volunteer
Physicians	1.2	1	.02
Midlevel	1	1	
Nurses	2		2
Social Workers			
Support staff	5	3	2

New patients per month: 70-80

Client contacts per month: 600-675

Patient fees are:

$5.00 nominal fee or on a voluntary basis.

Primary Service Area is:

Counties: Finney, Ford, Seward, Grant and surrounding counties.

Funding sources include:

Federal: 329 (Migrant) funds by sub-contract with State of Kansas

Private: United Methodist Health Ministry Fund, Wesley Foundation, March of Dimes, United Way and various individual and church donations.

Comments:

Age

0-12	20%
13-19	10%
20-35	50%
36-54	15%
55+	5%

Gender

Male	25%
Female	75%

Health Insurance

Medicaid	5%
Medicare	0%
Private Insurance	15%
No Insurance	80%

Ethnicity

Caucasian	35%
Hispanic	55%
Southeast Asian, African American, Native American	10%

Eligibility Guidelines

Income guidelines - 200% of poverty level.
Average income - 100 -150% of poverty level.

Five Most Common Diagnoses

1. Pregnancy
2. Urinary Tract Infections
3. Well Child Exams
4. Respiratory/Ear Infections
5. Diabetes

We Care Project

Directors

Program Director: Donna Johnson

3007 10th
Great Bend, KS
(316) 792-6367

Services Provided

Services	Yes	No	On-site	Off-site
Health Promotion				
Health Monitoring				
Prenatal Care				
Well Child Exam				
Immunizations				
Nutrition				
WIC				
Counseling				
Other				
Social Services				
Counseling	x			x
Medicaid Assist.				
Dental	x			x
Eye Exams	x			x
Eyewear Prescription	x			x
Hearing Testing				
Hearing Aids				
Pharmacy	x			x
Prescription Assistance	x			x
Samples Only				
Contract Pharmacy				
Durable Medical Equipment				
Home Care				
Translation				
Other-				

Staff

Staff	FTE	Salaried	Volunteer
Physicians			
Midlevel			
Nurses			
Social Workers			
Support staff	1	x	

New patients per month: 10

Client contacts per month: 12-24

Patient fees are:
Nominal charge

Primary Service Area is:
Barton County

Funding sources include:
Donations from hospital employees and churches

Comments: Project directors stated that the clinic, and the geographical area as a whole, needed more family physicians to take Medicaid clients and more dentists who will work with no-income clients.

Age

0-12	11%
13-19	0%
20-35	26%
36-54	11%
55+	52%

Gender

Male	68%
Female	32%

Health Insurance

Medicaid	5%
Medicare	6%
Private Insurance	1%
Other	78%

Ethnicity

Caucasian	78%
African American	5%
Hispanic	17%
American Indian	0%
Other	0%

Eligibility Guidelines

Average patient income 100% poverty.

Five Most Common Diagnoses

1. Cardiovascular
2. Diabetes
3. Musculoskeletal
4. Respiratory
5. Injuries

Survey Summary

In the summer of 1991, The Kansas Association for the Medically Underserved, with assistance from the Kansas Department of Health and Environment, Office of Primary Care, and the Heartland Coalition, conducted a survey of voluntary non-profit health clinics, migrant health clinics, community health centers and several health departments involved in delivery of primary care services in the state. Through this survey, information has been compiled which describes the variety of services offered and provides statistical data concerning the population served. A total of twenty-nine questionaires were mailed. Twenty-two were returned, thirteen from voluntary non-profit agencies and seven from local health departments. Three of the clinics provide Migrant Health Services. One clinic is a federally funded Community Health Center. Two questionaires were imcomplete and therefore not included in the results.

Clinic Serivces

One hundred percent of the centers who responded provide health education (referred to a health promotion in the profile) and health monitoring, treatment and/or referral for medical problems. Prenatal Care is given by nine of the responders, fourteen provide well child services. Nine of the clinics also provide dental care and eyewear prescriptions. In fifteen of the clinics, patients are able to receive pharmacy assistance. Approximately 7059 patients are served each month by paid staff and over 330 volunteers. 3320 of the patients served each month visit the clinic for the first time. Total contacts, which include inquiries, health education, referrals and direct care average 18,668 per month.

Characteristics of Population Served

Age Distribution:	0-12 years	24.0%
	13-19 years	11.7%
	20-35 years	31.0%
	36-54 years	21.5%
	55+	11.8%

Income: 200% of the Federal Poverty Guideline is used by the majority of clinics to determine patient eligibility and pay status. No one is turned away for inability to pay. Discounted fees or nominal fees are established for all serivces.

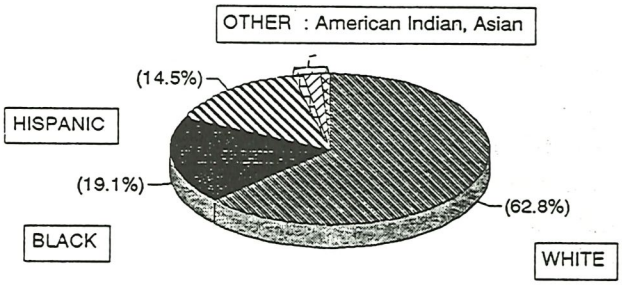
Insurance Status: Ten of the sites accept Medicaid clients. All of the clinics serve clients who are without health insurance. 83.2% of all patients served are without insurance or underinsured. Fifteen of the centers file or seek reim bursement from third party pay, primarily Medicaid.

Race/Ethnicity:	Caucasian	62.8%
	African American	19.1%
	Hispanic	14.5%
	Native American	1.0%
	Asian	1.5%
	Other	1.1%

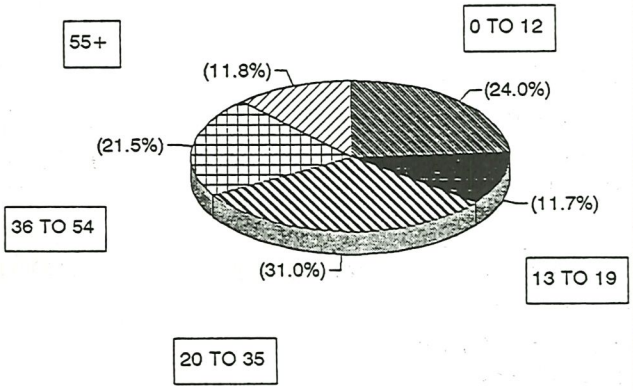
Common Diagnosis/Problems:

Upper respiratory infection, otitis media, diabetes, hypertension, and urinary tract infections are the five most common reasons for needing services. Other problems or conditions treated or referred include sexually transmitted diseases, pregnancy, gynecological problems, rashes and asthma.

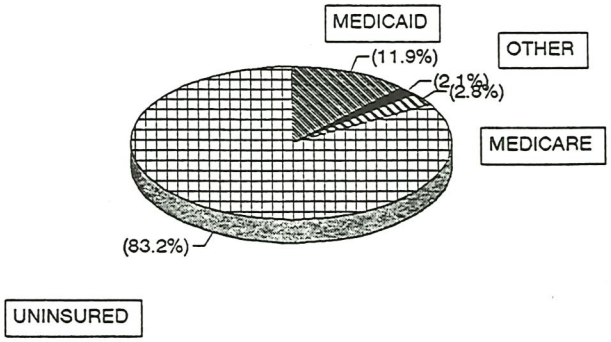
Clinic Population By Race/Ethnicity



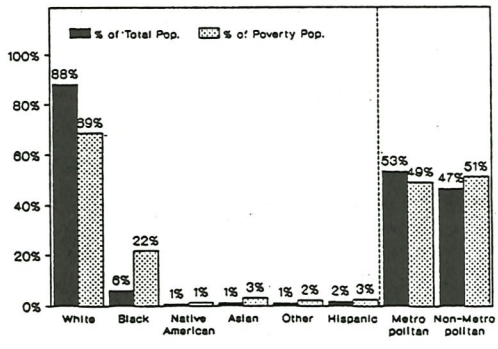
Clinic Population Age Distribution



Clinic Population Pay Source



Total Population and Persons in Poverty



DEMOGRAPHICS	Number of Persons	State Rank
Kansas Population 1989	2,434,320	33
Kansas Population below Poverty	245,209	34

42-44
Att #3

KAMU Board Members

Gerry Winget, President
United Methodist Urban Ministries
Wichita, Kansas
(316) 263-7455

Penney Schwab, Vice President
United Methodist Western Kansas
Mexican-American Clinic
Garden City, Kansas
(316) 275-1766

Judy Eyerly, Treasurer
Health Care Access
Lawrence, Kansas
(913) 841-5760

Janice Koelzer, CSJ, Secretary
Duchesne Clinic
Kansas City, Kansas
(913) 321-2626

At-Large Board Members
Pat Patton
Hunter Health Clinic, Inc.
Wichita, Kansas
(316) 262-3611

Jean McElhaney
Guadalupe Clinic
Wichita, Kansas
(316) 264-5615

KAMU Advisor
Joyce Volmut
Kansas Department of Health
and Environment
Topeka, Kansas
(913) 296-0613

KAMU Memberhsip

Catholic Health Hospital Association
Duchesne Clinic
Finney County Health Department
Guadalupe Clinic
Health Care Access, Inc.
Health Ministries of Harvey County
Hunter Health Clinic, Inc.
Sedgewick County Health Deparment
Saint Vincent Clinic
United Methodist Western Kansas Mexican-American Clinic
United Methodist Urban Clinics

Facts About Primary Care

What is Primary Care?
Primary Care is basic sick and well-maintenance care provided to patients when they first contact a health care provider. Organizationally, it is the entry point to the health care system. Primary care constitutes 85 to 90% of all diagnoses and treatments and may be provided in a variety of settings by physicians, nurse practitioners and physician assistants. Presently there are 18 voluntary non-profit clinics, one community health center, four migrant health centers, and 102 health departments providing some element of primary care across the state of Kansas.

Health Professional Shortage Areas
Approximately 850,000 Kansans live in 74 rural areas which have been designated by the Governor as medically underserved.

200,000 to 300,000 live in 62 communities and urban centers which have been designated medically underserved by the Federal government.

184,946 live in 18 service areas which have been Federally designated as Health Professional Shortage Areas, which means they have a physician to patient population ratio of greater than 3500 to 1.

Kansas Department of Health and Environment
The Kansas Department of Health and Environment provides administrative funding and technical assistance to the Kansas Association for the Medically Underserved through a Federal Primary Care Cooperative Agreement Grant. For more information on the activities of the Primary Care Cooperative Agreement please contact Joyce Volmut, Kansas Department of Health and Environment, 900 SW Jackson, Topeka, Kansas 66612-1290.

The 1991 KAMU Service Profiles was produced with the help of the Heartland Coalition for Primary Health Care. The mission of the Heartland Coalition for Primary Care is to explore and implement activities designed to promote the provision of quality, comprehensive, accessible and cost-effective primary health care services to the medically underserved urban and rural populations in Iowa, Kansas, Missouri and Nebraska.

KALHD

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

TESTIMONY PRESENTED IN SUPPORT OF SB 728
March 24, 1992

presented to the House Public Health & Welfare Committee
presented by Elizabeth E. Taylor, Executive Director

The Kansas Association of Local Health Departments, with 83 members representing local health departments serving 95% of the Kansas citizens, offers its support to SB 728.

The change of language allowing local health departments which may serve as primary care facilities, health care clinics for the medically underserved or the medically unserved as well as all local health departments to be covered for liability for their care providers will help expand the amount and quality of care given to this states poorest without great cost to the state.

The language also gives flexibility to local health departments for coverage of the liability regardless of whether the local health department charges a fee (in accordance with the Federal poverty guidelines).

Further, the original language would have allowed liability to be covered even in a health department which might offer some renumeration to its care provider. We ask that this language be restored or that there be a waiver given in the Health Care Stabilazation Fund for those health care providers who work solely in a health department.

Local health departments are asked every day to offer basic public health services (including environmental health services) to the citizens of Kansas regardless of their ability to pay. Health departments have struggled for years finding the resources to provide such expected services. Kansas provides state support of local health departments at a level of $2.50 per capita while the national average expended by state governments to local health departments is $5.63 per capita. While the language of this bill does not address the allocation of funds for public health services, it certainly does offer a solution to the problem most health departments have felt in not being able to provide care givers with adequate compensation and benefits so that citizens can be served.

Thank you, Mr. Chairman, for the opportunity to support this bill.

PH&W
3-24-92
Attm #4

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

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

March 24, 1992

TO: House Public Health and Welfare Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 728; Charitable Health Care Providers

The Kansas Medical Society supports the provisions of SB 728 because passage of this bill would remove one of the barriers that impedes access to health care for Medicaid patients.

In August 1991, we testified before the SRS Task Force Subcommittee on Medical Services regarding access to medical care for Medicaid clients. In our statement we identified three major barriers to access: (1) inadequate payment levels, (2) "hassle factors," and (3) liability concerns. We concluded that because our state's financial condition does not make it possible to improve reimbursement rates under Medicaid, that the Department of SRS should embark on a program of eliminating the so-called "hassle factors" and that the Legislature should consider ways of easing liability concerns of physicians.

We believe that it makes very good sense to consider a person who gratuitously provides health care services to a patient who is dependent upon the State of Kansas for medical care, to be considered an employee of the state for purposes of that episode of health care. This would not create any kind of immunity but would simply shift the liability exposure from the physician or other health care professional to the State of Kansas. This would likely overcome the pervasive myth shared by many physicians that Medicaid and other indigent patients are more litigious than the general population.

Attached to this statement is an article from a September 1989 "Journal of the American Medical Association" which discusses this subject. The article refers to a 1987 report by the U.S. General Accounting Office which found that Medicaid patients accounted for 5.8% of closed claims for which insurance status was known, while Medicaid recipients represent about 9% of the U.S. population. The article also cites other studies which all conclude that the Medicaid and indigent populations are actually less likely to sue than the general population.

We respectfully request that you recommend SB 728 for passage. Thank you for considering our comments.

CW/cb

PHWC
3-24-92
Attm # 5
1-3

Are Poor Patients Likely to Sue for Malpractice?

Q As I try to interest other physicians in providing medical care for the poor, I am finding that almost all physicians assume that their risk of being sued for malpractice will be higher if they take such patients into their practice, that is, they believe that the poor are more likely to sue physicians than are more affluent patients. Has this issue been studied? Are there data to substantiate whether the risk of suit is different in a practice among the poor than among the financially secure? If a physician takes poor people into his or her practice, is there a greater risk of suit?

David Hilfiker, MD
Washington, DC

A The perception that poor patients sue more for medical malpractice is a damaging myth. This myth hurts access to health care for indigent people by decreasing physician acceptance of Medicaid patients.

Until very recently, there were no data either to support or refute the assertion by insurance companies and doctors that indigent patients were more likely to sue for medical malpractice than were privately insured patients. However, current studies now universally demonstrate what common sense told us all along: poor people do not account for disproportionate numbers of malpractice suits—in fact, they are *less likely to sue* than are middle-class or privately insured patients. The fear of malpractice suits by indigent patients, therefore, is not a legitimate reason for denying patients health care. A brief summary of these studies follows.

A 1988 study conducted by the Texas Medical Association found that indigent and Medicaid/Medicare patients do not account for disproportionate numbers of suits and claims.[1] The proportion of lawsuits filed by indigent patients does not vary significantly from their proportions in the overall patient population, and suits filed by Medicaid patients are disproportionately low. Medicaid patients and indigents (or those without medical insurance coverage) each account for about 12% of patients seen by Texas physicians. The reported incidence of suits filed by indigent patients is 13.4%, and for Medicaid patients it is only 3.5%. Medicare patients account for 5.9% of lawsuits and patients with acquired immunodeficiency syndrome for less than 1% of the suits.

Similar perceptions and findings have been reported from Michigan. A survey there found that Medicaid recipients are significantly underrepresented in malpractice litigation. In 1988, the Michigan Department of Licensing and Regulation reviewed the Insurance Bureau's medical malpractice closed-claim database for the years 1985 through 1987.[2] They found that Medicaid-related closed claims accounted for only 6.23% of all closed claims, while the Medicaid-eligible population for that period ranged from 10% to 11%.

Other studies have reached similar conclusions.[3] A study of medical malpractice conducted by the National Association of Community Health Centers in 1986 showed that health center obstetricians (virtually all of whose patients have incomes that are <200% of the federal poverty level, and 25% to 40% of whom are eligible for Medicaid) have malpractice claim profiles approximately one fifth as great as those of office-based obstetricians.[4]

A 1987 report by the US General Accounting Office[5] found that Medicaid patients accounted for 5.8% of the closed claims for which insurance status was known, while Medicaid recipients total about 9% of the US population.[6]

Unpublished data on malpractice claims in Maryland from 1977 through 1985 showed that Medicaid patients accounted for 9.6% of all claims for which insurance status was known; recipients represent about 9% of the state population.[7] Self-pay patients filed 17.1% of the malpractice claims, about the same proportion estimated to be uninsured in the state. Medicaid recipients accounted for 13% of obstetric-gynecologic claims for which insurance status was known. In 1986, Medicaid recipients accounted for about 19% of admissions to Maryland hospitals.[8]

A 1988 article[9] examined malpractice experience associated with fertility-control services among a national sample of obstetricians-gynecologists. This study found no significant correlation between Medicaid participation and threatened or actual malpractice litigation.

The foregoing studies reinforce what logic tells us: for a variety of reasons, poor people are the most unlikely patients to sue.[10] The primary reason is that the poor are even less likely than the general population to perceive that any type of wrong has occurred or to assert their rights,[11] and much less likely to obtain legal counsel. Contrary to what many may think, there is not an "ambulance chaser" on every block, and indigent people have virtually no access to legal representation for malpractice suits. As a general rule, only members of the private bar can take malpractice cases, and, for economic reasons, hardly any take them for the indigent.

There are two reasons for the private bar's refusal to provide legal services in malpractice cases brought by low-income clients. First, malpractice plaintiff lawyers are usually paid on contingency; that is, the lawyer will get a percentage of the award if the plaintiff wins. Since malpractice awards are based largely on future earnings, and since poor people obviously have very low future earning potential, poor plaintiffs are unlikely to get large financial awards. In fact, a study showed that a Medicaid plaintiff's average malpractice award is approximately $50 000, compared with an average $250 000 award for privately insured patients.[12] Since the economic award probably will be small, private bar lawyers do not like to represent poor people; representation of the poor is not economically profitable.

If a private bar attorney is not available, the only other way for a low-income person to get legal representation is to qualify for a Legal Services lawyer. However, federal law prohibits Legal Services lawyers, the primary providers of free legal assistance to the poor, from taking malpractice cases unless that client first has been turned away by two private attorneys. Furthermore, the eligibility requirements for Legal Services are quite strict: a client's income must be under approximately $7000 per year to qualify.[13] Thus, as a practical matter, Legal Services lawyers virtually never take

Edited by Helene M. Cole, MD, Senior Editor.

Every letter must contain the writer's name and address, but these will be omitted on request. Questions are submitted to consultants at the discretion of the editor and published as space permits.

malpractice cases, and private bar lawyers virtually never take on a malpractice case for an indigent patient.

The same poverty that discourages lawyers from representing the poor likewise removes economic incentives for the poor to sue. In many states, Medicaid recipients must turn over to the state Medicaid agency their right to collect the money awarded by the court for medical care,[14] so the "successful" plaintiff may not get to keep any compensation. Another disincentive to poor people is the long delays in settlement of litigation. Finally, when compensation ultimately is received, it may be in the form of a lump-sum payment. Lump-sum payments usually disqualify the recipient from Aid to Families With Dependent Children, and therefore also disqualify the recipient from Medicaid. Thus, indigent plaintiffs who won their malpractice claim probably would lose their Medicaid coverage for other illnesses, preventive medical care, and their families' medical expenses as a result of receiving compensation for malpractice.

Despite the studies and the commonsense reasons demonstrating the unlikelihood of increased malpractice exposure from caring for low-income patients, the pernicious myth that poor people are a "malpractice risk" persists. Perhaps one reason for the persistence of this damaging myth is that physicians confuse the distinction between the likelihood of *medically bad outcomes* and the likelihood of *malpractice suits* and paid claims.[15] It may indeed be true that indigent patients are at higher risk for poor outcomes, because their overall health is inferior to that of privately insured people. But higher risk in and of itself does not affect a physician's malpractice exposure *if the incidents do not become claims*. Insurance premiums are based on the amount of money paid out in claims, not on the number of bad outcomes. As both common sense and recent studies tell us, poor people who have been the victims of malpractice rarely pursue their right to compensation in court.

Molly McNulty, JD
National Health Law Program
Washington, DC

1. Conversation with Leslie Lanham, Children's Defense Fund, Austin, Tex (June 15, 1989), author of the Texas Medical Association Professional Liability Survey (summer 1988).
2. Michigan Dept of Social Services. *Medicaid Matters*. February 1989;3(2).
3. Two other states, Maryland and Washington, currently are studying the issue. The Institute of Medicine also is expected to issue a report by September 1989.
4. Rosenbaum S, Hughes D. The medical malpractice crisis and poor women. In: Brown S, ed. *Prenatal Care: Reaching Mothers, Reaching Infants*. Washington, DC: Institute of Medicine; 1988:229-243.
5. *Medical Malpractice: Characteristics of Claims Closed in 1984*. Washington, DC: US General Accounting Office; 1987. GAO-HRD-87-55.
6. Data recalculated by Deborah Lewis-Idema, *Increasing Provider Participation*. Washington, DC: National Governors Association; 1988:27. The recalculation corrected for the presence of closed claims for which the insurance source was not known.
7. Data provided by Laura L. Morlock, The Johns Hopkins University School of Public Health, Dept of Health Policy and Management, *cited* in Lewis-Idema, *supra* note 6, p 70.
8. *Ibid.*
9. Weisman CS, Teitelbaum MA, Morlock LL. Malpractice claims experience associated with fertility-control services among young obstetricians-gynecologists. *Med Care*. March 1988;26(3):298-306.
10. Stoll K. Don't blame the poor for the malpractice crisis. *Washington Post*. April 30, 1986. Health Section:6.
11. Dept of Health, Education, and Welfare Secretary's Commission on Medical Malpractice. *Consumer's Knowledge of and Attitudes Towards Medical Malpractice*. Washington, DC: Dept of Health, Education, and Welfare; 1973:658-694. These data do not mean that the poor experience fewer incidents of malpractice. Peterson hypothesized that low-income groups may be less likely to perceive a negative medical experience as a case of malpractice.
12. US General Accounting Office, *supra* note 5. The GAO data were retabulated by Laura L. Morlock, The Johns Hopkins University. The GAO-published report includes payout on behalf of plaintiffs in 1 year. Because large awards frequently involve payments over time, the averages in the published report understate the effect of these awards. The retabulation from the GAO database covers total expected value of the award to the patient. Reported in Lewis-Idema, *supra* note 6, note 48 on p 71.
13. A person's family income must be less than 125% of the federal poverty guidelines to be eligible for Legal Services. In 1989, these levels are as follows:

Family Size	Annual Income, $
1	7475
2	10 025
3	12 575
4	15 125

Federal Register. February 16, 1989;54:7098.
14. See, eg, *White v Sutherland*, 585 P2d 331 (NM Ct App 1978); *Brown v Stewart*, 129 Cal App 3d 331 (Calif Ct App 1981); and *Moss v Glynn*, 383 NE2d 275 (Ill App Ct 1978).
15. Rosenbaum and Hughes, *supra* note 4.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director
1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563

March 24, 1992

To: Chairman Sader and Members, House Public Health Committee

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

Subject: Testimony in Support of S.B. 728, as Amended

Thank you for this opportunity to provide written testimony in support of S.B. 728, as amended by the Senate Committee.

KAOM has been a consistent supporter of the Charitable Health Care Provider program in Kansas, during and since its inception. We have also consistently encouraged our members to participate in the program.

We think the expansion of the program, as provided in S.B. 728, is a much needed change. It will permit our physicians who are on exempt license, or those who are on regular license but choose to provide gratuitous services, to do so to an expanded base of Kansas citizens in need of medical care.

We also support and applaud the provision of permitting providers who render professional services, either for a fee or under contract, to medically indigent persons receiving medical assistance under SRS programs, to do so in any local health department and not for profit indigent health care clinics.

We think these changes will enhance a program which permits and encourages physicians to provide medical care under provisions of a more favorable malpractice tort claims milieu.

We urge your support of S.B. 728.

P&HW
3-24-92
Attm #6

Kansas State Board of Pharmacy

LANDON STATE OFFICE BUILDING
900 JACKSON AVENUE, ROOM 513
TOPEKA, KANSAS 66612-1220
PHONE (913) 296-4056

STATE OF KANSAS

JOAN FINNEY
GOVERNOR

SB 737

HOUSE PUBLIC HEALTH
AND WELFARE COMMITTEE

MARCH 24, 1992

MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS TOM HITCHCOCK AND I SERVE AS EXECUTIVE SECRETARY OF THE BOARD OF PHARMACY. I APPEAR BEFORE YOU TODAY ON BEHALF OF THE BOARD IN SUPPORT OF SB 737.

THE CHANGES IN THE STATUTES BY THE AMENDED SB 737 ARE AS FOLLOWS: PAGE 4, LINE 22 & 28; PAGE 5, LINES 11 THROUGH 14 AND LINE 42; PAGE 8, LINES 19 & 43; PAGE 9, LINES 1 & 30; PAGE 10, LINES 21 & 25; PAGE 11, LINES 13, 20, 26, 29 & 30, AND 34; AND PAGE 13, LINE 21 ARE ALL PROPOSED AND CHANGED OR AMENDED TO COMPLY AND CONFORM WITH THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION REGULATIONS THAT WE ARE AWARE OF BEING UP TO DATE.

THE LAST REQUEST FOR THE DEREGULATION OF THE DRUG PROPYLHEXEDRINE, AS LISTED ON PAGE 13 LINE 21, REQUIRES THE REMOVAL OF THE DRUG FROM SCHEDULE V EFFECTIVE DECEMBER 3, 1991 AS PER THE ENCLOSED COPY OF THE FEDERAL REGISTER. ALSO ATTACHED IS A COPY DENOTING THE DRUG IS IN BENZEDREX INHALERS WHICH ARE OVER THE COUNTER PRODUCTS OF A NON-NARCOTIC CHEMICAL WHICH ACCORDING TO KSA 65-4102(C) (COPY ATTACHED) SHOULD NOT BE CONTROLLED.

THE BOARD OF PHARMACY RESPECTFULLY REQUESTS THE FAVORABLE PASSAGE OUT OF COMMITTEE OF AMENDED SB 737.

THANK YOU.

PH&W
3-24-92
attm# 7
1-4

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

21 CFR Part 1308

Schedules of Controlled Substances; Removal of Propylhexedrine From Control

AGENCY: Drug Enforcement Administration (DEA), Justice.

ACTION: Notice of final rulemaking.

SUMMARY: This final rule is issued by the Administrator of the DEA in order to remove propylhexedrine from the Schedules of the Controlled Substances Act (CSA). As a result of this rule, propylhexedrine and products containing propylhexedrine will no longer be subject to the provisions of the CSA. Propylhexedrine was placed in Schedule V of the CSA in April 1988 in conformity with international control of the drug under the 1971 Convention on Psychotropic Substances. On June 10, 1991, the United States was notified that propylhexedrene had been decontrolled internationally, thus, obviating the need for domestic control under the CSA.

EFFECTIVE DATE: This action is effective December 3, 1991.

FOR FURTHER INFORMATION CONTACT: Howard McClain, Jr., Chief, Drug and Chemical Evaluation Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, telephone: (202) 307-7183.

SUPPLEMENTARY INFORMATION: On February 11, 1986, the United Nations Commission on Narcotic Drugs (UNCND) decided that propylhexedrine should be included in Schedule IV of the 1971 Convention on Psychotropic Substances. The Secretary of State was formally notified of this decision by the Secretary-General of the United Nations on February 28, 1986. Subsequently, the United States Government, believing that there was insufficient evidence to support scheduling of propylhexedrine under either the Convention or the CSA, requested that the UNCND reconsider its scheduling decision. The United States also requested that the World Health Organization (WHO) undertake a complete review of the UNCND's previous decision on the scheduling of propylhexedrine.

Section 201(d) of the CSA (21 U.S.C. 811(d)) makes provisions for temporary domestic control of substances when the United States formally request reconsideration of the international control. The purpose of these provisions is to insure that the United States, by establishing minimum controls, will remain in compliance with its obligations under the pertinent treaties and conventions. Accordingly, on April 4, 1988, the Administrator of the DEA, citing the United States efforts to obtain review of the UNCND scheduling action, published a final rule, placing propylhexedrine in Schedule V of the CSA. The final rule was published in the Federal Register, volume 53, at page 10869.

In September 1990, the 27th WHO Expert Committee on Drug Dependence examined the international scheduling of propylhexedrine. Based on new data, the Expert Committee recommended to WHO that propylhexedrine be removed from international control. WHO notified the Secretary-General of its recommendation and on April 29, 1991, the matter was presented to the UNCND which concurred with the WHO recommendation. The United States was formally notified of the deletion of propylhexedrine from international control on June 10, 1991.

Accordingly, pursuant to the provisions of 21 U.S.C. 811(d)(4)(B) the Administrator of the DEA hereby orders that propylhexedrine be, and it hereby is, decontrolled.

In accordance with the provisions of 21 U.S.C. 811(a), this action is a formal rulemaking "on the record after the opportunity for a hearing". Such proceedings are conducted pursuant to the provisions of 5 U.S.C. 556 and 557 and, as such, have been exempted from the consultation requirements of Executive Order 12291 (46 FR 13193).

Pursuant to 5 U.S.C. 605(b), the Administrator certifies that the decontrol of propylhexedrine will have no significant economic impact upon entities whose interests must be considered under the Regulatory Flexibility Act (Pub. L. 96-354). Decontrol of a substance relieves manufacturers and other registrants of the regulatory requirements relating to controlled substances.

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that this matter does not have sufficient federalism implications to warrant preparation of a Federalism Assessment.

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Narcotics and prescription drugs.

Under the authority vested in the Attorney General by section 201(a) of the CSA (21 U.S.C. 811(a)) and delegated to the Administrator of the DEA by Department of Justice Regulations (28 CFR 0.100), the Administrator hereby proposes that title 21 CFR, part 1308 be amended as follows:

PART 1308—[AMENDED]

1. The authority citation for title 21, CFR part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b), unless otherwise noted.

§ 1308.15 [Amended]

2. Section 1308.15 is amended by removing paragraph (d)(1) and redesignating paragraph (d)(2) as (d)(1).

Dated: November 20, 1991.

Robert C. Bonner,

Administrator of Drug Enforcement.

[FR Doc. 91-28808 Filed 12-2-91; 8:45 am]

BILLING CODE 4410-09-M

PNEW
3-24-92
Attn: #7
09284

Complete prescribing information for these products begins on page 184.

TETRAHYDROZOLINE HCl

Administration and Dosage:

Adults and children (≥ 6 years): 2 to 4 drops of 0.1% solution in each nostril as needed, no more than every 3 hours.

Children (2 to 6 years): 2 to 3 drops of 0.05% solution in each nostril every 4 to 6 hours, no more often than every 3 hours.

				C.I.*
Rx	**Tyzine Pediatric Drops** (Kenwood Labs)	**Solution:** 0.05%	In 15 ml.[1]	170
Rx	**Tyzine Drops** (Kenwood Labs)	**Solution:** 0.1%	In 30 and 473 ml.[1]	59

XYLOMETAZOLINE HCl

Administration and Dosage:

Adults (≥ 12 years): 2 to 3 drops or 2 to 3 sprays (0.1%) in each nostril every 8 to 10 hours.

Children (2 to 12 years): 2 to 3 drops (0.05%) in each nostril every 8 to 10 hrs.

				C.I.*
otc	**Otrivin Pediatric Nasal Drops** (Ciba Consumer)	**Solution:** 0.05%	In 20 ml dropper bottle.[2]	131
otc	**Xylometazoline HCl** (Various)	**Solution:** 0.1%	In 15 and 20 ml spray.	19+
otc	**Otrivin** (Ciba Consumer)		**Drops:** In 20 ml.[2]	76
			Spray: In 15 ml.[2]	80

Inhalers

Inhale through each nostril while blocking the other. Use as needed; avoid excessive use.

Abuse: Propylhexedrine has been extracted from inhalers and injected IV as an amphetamine substitute. It has also been ingested by soaking the fibrous interior in hot water. Chronic abuse has caused cardiomyopathy (severe left and right ventricular failure), pulmonary hypertension, foreign body granuloma (emboli), dyspnea and sudden death.

otc	**Benzedrex** (SmithKline Consumer)	**Inhaler:** 250 mg propylhexedrine	In single plastic tubes.[3]
otc	**Vicks Inhaler** (Vicks Health Care)	**Inhaler:** 50 mg l-desoxyephedrine	In single plastic inhalers.[4]

* Cost Index based on cost per 1 mg tetrahydrozoline or 1 mg xylometazoline.

[1] With benzalkonium chloride, EDTA and hydrochloric acid.

[2] With benzalkonium chloride.

[3] With menthol.

[4] With aromatics (eg, menthol, camphor, eucalyptol).

PA/MW
3-24-92
attm #7
pg 3 of 4

offering controlled substance for sale; failure of court to so instruct was error. State v. Werner, 8 K.A.2d 364, 367, 657 P.2d 1136 (1983).

11. Board of pharmacy's interpretation of K.A.R. was correct; revocation of defendant's pharmacy registration is affirmed. Hemry v. State Board of Pharmacy, 232 K. 83, 652 P.2d 670 (1982).

65-4102. Board of pharmacy to administer act; authority to control; report to speaker of house and president of senate on substances proposed for scheduling, rescheduling or deletion. (a) The board shall administer this act and may adopt rules and regulations relating to the registration and control of the manufacture, distribution and dispensing of controlled substances within this state. All rules and regulations of the board shall be adopted in conformance with article 4 of chapter 77 of the Kansas Statutes Annotated and the procedures prescribed by this act.

(b) Annually, the board shall submit to the speaker of the house of representatives and the president of the senate a report on substances proposed by the board for scheduling, rescheduling or deletion by the legislature with respect to any one of the schedules as set forth in this act, and reasons for the proposal shall be submitted by the board therewith. In making a determination regarding the proposal to schedule, reschedule or delete a substance, the board shall consider the following:

(1) The actual or relative potential for abuse;

(2) the scientific evidence of its pharmacological effect, if known;

(3) the state of current scientific knowledge regarding the substance;

(4) the history and current pattern of abuse;

(5) the scope, duration and significance of abuse;

(6) the risk to the public health;

(7) the potential of the substance to produce psychological or physiological dependence liability; and

(8) whether the substance is an immediate precursor of a substance already controlled under this article.

(c) The board shall not include any nonnarcotic substance within a schedule if such substance may be lawfully sold over the counter without a prescription under the federal food, drug and cosmetic act.

(d) Authority to control under this section does not extend to distilled spirits, wine, malt beverages or tobacco.

History: L. 1972, ch. 234, § 2; L. 1974, ch. 258, § 2; L. 1982, ch. 269, § 1; July 1.

65-4103. Nomenclature. The controlled substances listed or to be listed in the schedules in K.S.A. 65-4105, 65-4107, 65-4109, 65-4111 and 65-4113 are included by whatever official, common, usual, chemical, or trade name designated.

History: L. 1972, ch. 234, § 3; July 1.

65-4104.

History: L. 1972, ch. 234, § 4; Repealed, L. 1982, ch. 269, § 9; July 1.

65-4105. Substances included in schedule I. (a) The controlled substances listed in this section are included in schedule I and the number set forth opposite each drug or substance is the DEA controlled substances code which has been assigned to it.

(b) Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

(1)	Acetylmethadol	9601
(2)	Alfentanil	9737
(3)	Allylprodine	9602
(4)	Alphacetylmethadol	9603
(5)	Alphameprodine	9604
(6)	Alphamethadol	9605
(7)	Alpha-methylfentanyl • (N-[1-(alpha-methyl-beta-phenyl)ethyl-4-piperidyl] propionanilide; 1-(1-methyl-2-phenylethyl)-4-(N-propanilido) piperidine).	9814
(8)	Benzethidine	9606
(9)	Betacetylmethadol	9607
(10)	Betameprodine	9608
(11)	Betamethadol	9609
(12)	Betaprodine	9611
(13)	Clonitazene	9612
(14)	Dextromoramide	9613
(15)	Diampromide	9615
(16)	Diethylthiambutene	9616
(17)	Difenoxin	9618
(18)	Dimenoxadol	9617
(19)	Dimepheptanol	9618
(20)	Dimethylthiambutene	9619
(21)	Dioxaphetyl butyrate	9621
(22)	Dipipanone	9622
(23)	Ethylmethylthiambutene	9623
(24)	Etonitazene	9624
(25)	Etoxeridine	9625
(26)	Furethidine	9626
(27)	Hydroxypethidine	9627

P+HW 3-24-92 Attm # 7 cg 4z4.

KANSAS BUREAU OF INVESTIGATION

DIVISION OF THE OFFICE OF ATTORNEY GENERAL
STATE OF KANSAS
1620 TYLER
TOPEKA, KANSAS 66612-1837
(913) 232-6000

JAMES G. MALSON
DIRECTOR

ROBERT T. STEPHAN
ATTORNEY GENERAL

TESTIMONY
KYLE G. SMITH, ASSISTANT ATTORNEY GENERAL
KANSAS BUREAU OF INVESTIGATION
BEFORE THE HOUSE COMMITTEE ON HEALTH AND WELFARE
REGARDING SENATE BILL 737
MARCH 24, 1992

Madam Chairperson and Members of the Committee:

My name is Kyle Smith, and I am the Assistant Attorney General currently assigned to the Kansas Bureau of Investigation (KBI) Narcotic Strike Force. The KBI supports Senate Bill 737 with it's updates and changes in the Controlled Substances Act, with one exception.

Two weeks ago one of our undercover agents was involved in raiding a house here in Topeka. The occupants were cooking down inhalers to obtain the drug propylhexedrine, for resale and personal use by injection into their arms. One of the principals involved advised us that the 'high' obtained was better than that from methamphetamine or speed, although it only lasted two to two-half hours. This particular individual had black bumps all up and down his arms from the injections of this drug.

I spoke with Tom Hitchcock of the Board of Pharmacy regarding propylhexedrine and he advised that they were aware that it is a commonly abused substance, but that they had proposed deregulating it in Senate Bill 737, only because the FDA had deregulated the drug last December and it is generally both our agencies desires to maintain our schedules in conformity with the federal schedules. Propylhexedrine is located in Schedule V, the least controlled of the drug schedules, and the proposal to strike it is located on page 13, line 19.

P&HW
3-24-92
Attm #8
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I am here today to ask on behalf of the KBI that propylehexedrine not be removed from the Controlled Substances Act as it still appears to be a commonly abused drug. I feel that it is imperative that we have the ability to deter individuals who would synthesize this drug from inhalers either for personal use or resale. It is particularly true given the method of ingestion, being injection, with the concurrent risk of spread of AIDS.

Thank you for your consideration. I will be happy to answer any questions.

#077

Appell
3-24-92
Attm #8
C9223

offering controlled substance for sale; failure of court to so instruct was error. State v. Werner, 8 K.A.2d 364, 367, 657 P.2d 1136 (1983).

11. Board of pharmacy's interpretation of K.A.R. was correct; revocation of defendant's pharmacy registration is affirmed. Hemry v. State Board of Pharmacy, 232 K. 83, 652 P.2d 670 (1982).

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(3) the state of current scientific knowledge regarding the substance;

(4) the history and current pattern of abuse;

(5) the scope, duration and significance of abuse;

(6) the risk to the public health;

(7) the potential of the substance to produce psychological or physiological dependence liability; and

(8) whether the substance is an immediate precursor of a substance already controlled under this article.

Repeal

(c) The board shall not include any nonnarcotic substance within a schedule if such substance may be lawfully sold over the counter without a prescription under the federal food, drug and cosmetic act.

(d) Authority to control under this section does not extend to distilled spirits, wine, malt beverages or tobacco.

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(14)	Dextromoramide	9613
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(22)	Dipipanone	9622
(23)	Ethylmethylthiambutene	9623
(24)	Etonitazene	9624
(25)	Etoxeridine	9625
(26)	Furethidine	9626
(27)	Hydroxypethidine	9627

PHell 3-24-92 pg 383

KANSAS
Commission for the
Deaf & Hearing Impaired

300 S.W. Oakley, Biddle Bldg.
Topeka, Kansas 66606-1861
913-296-2874 V/TDD
800-432-0698 V/TDD
913-296-0511 FAX

Re: HB 2925

"Provide for a program of regulation and certification of interp."

Currently KCDHI certifies interpreters through our Quality Assurance Screening Test (QAST). However, we do not have a mechanism to deal with ethical issues that arise concerning interpreters.

I would like to establish a voluntary advisory board, appointed by the Commission, which could advise us on ethical issues relating to certifying sign language interpreters. This board would be comprised of recognized experts in the field and be responsible for guiding the commission in establishing standards for the interpreting profession.

There is no other "watch dog" agency to monitor these standards. We should be the agency to do it.

Attach #9
3-24-92

Catholic Health Association of Kansas

John H. Holmgren • Executive Director
Jayhawk Tower, 700 Jackson, Suite 801 / Topeka, KS 66603 / (913) 232-6597

TESTIMONY

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

CAROL SADER, CHAIRPERSON

REF: SENATE BILL 728

MARCH 24, 1992

Our Association has supported the Charitable Provider Concept since it originated in 1990, and supported the original bill and passage in 1991. We testified in support of SB 728 before the Senate Public Health and Welfare Committee on March 4, 1992 and we are attaching a copy of the testimony.

We have 5 clinics sponsored by Catholic hospitals in the cities of Kansas City, Leavenworth, Salina (St. John's and Asbury Hospitals), Topeka, and Wichita. These are non-profit indigent clinics and this bill would assist them in recruiting physicians to contribute their time and be covered under the state employee malpractice law, as long as these physicians did not receive a fee, even though the agency itself may receive a nominal fee. This would help our clinics increase their access for patients to be treated by physicians particularly the Medicaid patient group.

We urge your favorable consideration of SB 728.

John H. Holmgren
(913) 232-6597

P Haw
attm #10
3-24-92

PH-2

Catholic Health Association of Kansas

John H. Holmgren • Executive Director
Jayhawk Tower, 700 Jackson, Suite 801 / Topeka, KS 66603 / (913) 232-6597

TESTIMONY
Senate Financial Institution and Insurance Committee
Richard L. Bond, Chairman
March 4, 1992
Ref: Senate Bill 728

Our Association's members include Catholic hospitals, nursing homes, and charity clinics throughout Kansas. We were one of the providers supporting the original Charitable Provider Act in 1991, KSA 1991 supp. 75-6102 and 75-6117, and helped coordinate this support with Committees of the legislature, with the Department of Health and Environment, and with the Healing Arts Board. We felt at the time however, that the act did not go far enough because malpractice coverage for physicians only was limited to selected public health departments which were pilot projects.

Now, under Senate Bill 728, access for indigent patients would be increased throughout Kansas, to all not for profit health care clinics and would include SRS clients, and malpractice coverage would extend to other clinic staff members whether or not their services were compensated or gratuitous.

This bill should effectively increase the number of physician providers offering to work in a charitable, not for profit indigent health care clinic, on a fee or contract basis.

This is a bill that would address some of the problems now being experienced by charity clinics that operate under the sponsorship of Catholic hospitals.

Some of our charity clinics under Catholic sponsorship are now not seeing Medicaid patients because of the malpractice insurance problem and lack of fee coverage. This would particularly help increase access for those areas of the state, where there is a shortage of physicians accepting new Medicaid patients.

We ask your support of SB 728. Thank you.

John H. Holmgren
(913) 232-6597

PHRW
3-24-92
Attm. #10

Pg 2-2