Approved 2-4-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

10:00 a.m./p.m. on January 29, 1992 in room 526-S of the Capitol.

All members were present except:

Committee staff present:

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

Conferees appearing before the committee:

Joanne Hurst, Secretary, Department on Aging
Larry Buening, Board of Healing Arts
Chip Wheelen, Kansas Medical Society
Richard Morrissey, Department of Health and Environment
Dr. James Price, Dean of the University of Kansas School of Medicine

Chairman Ehrlich called the meeting to order at 10:00 a.m.

The Chairman called for Committee bill requests. Joanne Hurst, Department on Aging, requested introduction of a bill to change the local match requirement for the Senior Care Act. The Chairman asked for wishes of the Committee. Senator Hayden made a motion the Committee introduce the bill requested by the Department on Aging, seconded by Senator Walker. No discussion followed. The motion carried.

Chip Wheelen, Kansas Medical Society, requested introduction of a bill that concerns the providing of false information to a practitioner for the purpose of obtaining a prescription-only drug. The Chairman asked for wishes of the Committee. Senator Burke made a motion the Committee introduce the bill request, seconded by Senator Kanan. No discussion followed. The motion carried.

Larry Buening, Board of Healing Arts, requested introduction of three bills: (1) relating to the expiration date of licenses and registrations issued, (2) relating to receipt of criminal history record information and confidentiality of reports, and (3) relating to issues involving physical therapists and physical therapist assistants. The Chairman asked for wishes of the Committee. Senator Hayden made a motion the Committee introduce the three bills requested by the Board of Healing Arts, seconded by Senator Burke. No discussion followed. The motion carried.

Continued hearing on **SB-490:**

Richard Morrissey, Department of Health and Environment, submitted written testimony and appeared before the Committee regarding SB 490. Mr. Morrissey stated the University of Kansas School of Medicine has fared better than the national average of graduates seeking careers in primary care, however, those numbers have been insufficient to stem the outflow of primary care doctors from rural Kansas. Information from the federal Office of Rural Health Policy was given outlining seven

program approaches for medical schools to consider in order to increase their numbers of primary care graduates. The state of Minnesota was given as an example of facing the challenge of physician shortage, and after implementing major changes in their medical school's curriculum, Minnesota achieved the virtual elimination of medical under service in their state. (Attachment 1)

The Chairman called upon Senator Ward to introduce his two pages from Topeka who assisted at the Committee meeting.

Written testimony was provided to the Committee from the Kansas Medical Society regarding SB 490 which stated while the Kansas Medical Society supports the objectives articulated by the Kansas Academy of Family Physicians, they cannot support SB 490 because it takes a punitive approach which could have the unintended effect of undermining the medical school's ability to increase its production of primary care physicians. KMS would prefer to support legislation or programs which provide incentives to the medical school to increase production of primary care physicians. (Attachment 2)

Dr. James Price, Executive Dean of the KU School of Medicine submitted written testimony and appeared before the Committee in opposition to SB 490. Dr. Price believes the bill would not accomplish its stated goal and might do just the opposite. He is in agreement with the Kansas Academy of Family Physicians to "set aside" SB 490 so that the "family" of groups, organizations, institutions and individuals who are interested in obtaining more physicians in rural Kansas work together to bring forward a plan to help accomplish a common goal. Dr. Price stated that the Curriculum Committee will be reviewing the training given students with two objectives: (1) come up with a plan in the next six months aimed at introducing first year students to patient contact that will be continued throughout the rest of the next two years, and (2) review the entire curriculum with the objective of assessing the degree to which it is meeting the demands of the day and making recommendations to that end. (Attachment 3)

Dr. Price was assisted by Una K. Creditor, Associate Dean of Admissions, KUMC, with Committee discussion that followed regarding the objectives of the KUMC Curriculum Committee, admissions process and percentage of Kansas residents vs. out-of-state students admitted to the KU School of Medicine. Ms. Creditor stated there were 322 Kansas residents who applied this year and only 180 were offered admission.

It was suggested by a member of the Committee that Dr. Price review the seven program approaches for medical schools to consider in order to increase their number of primary care graduates that was offered by the federal Office of Rural Health Policy and address those suggestions with programs applied at KUMC.

The meeting was adjourned at 11:00 a.m. The next meeting of the Committee is scheduled to be held January 30, 1992, 10:00 a.m., Room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 1-29-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Betty M. Glover	KS Action For Children
Marlon Rees	KUMC
Una R Oredetter	KUMC
Jane L Rhys	KUMC
Bob Wunsch	KUMC
Dave Toplikar	Capt. Journal-World
Katrina Clark	
Lisa May	
Jen Baker	Ks. Hospital Assn.
Barbara Riegan	KAOM
Neil Buchanan	Sen. Walker's office
Chris Steineger	KCKS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
David B. Dallam	Div of Budget
Jane Faubion	KOHE
LISA Getz	WICHITA hospitals
JOE FURJANIC	KCA
Carmie Tiede	Healing Arts
Larry Buening	Bd of Healing Arts

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-29-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Jerry Slaughter	KMS
Chip Wheelen	Ks Medical Society

State of Kansas
Joan Finney, *Governor*

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

Reply to:

Testimony presented to

Senate Public Health and Welfare
by

The Kansas Department of Health and Environment

Senate Bill 490

It is no over-statement to say that Kansas is on the threshold of a crisis in terms of access to medical care. To be sure there is no shortage of physicians in the U.S. or in Kansas for that matter. What's lacking is **primary care** physicians and what compounds the problem is the mal-distribution of the ones we have. Primary care represents the traditional entry point into the medical system for most people. Primary care doctors have specialties in family practice, general practice, internal medicine or pediatrics. In Kansas, about 80% of the physicians practicing in rural settings are primary care doctors.

Nationally, commitment to primary care practice has declined almost 14% in eight years, with only 23.6% of medical school graduates seeking careers in primary care in 1989. The University of Kansas School of Medicine has fared better than the national average, in 1990 showing an average of around 36% of its graduates choosing primary care specialties. As admirable as that sounds, those numbers have been insufficient to stem the outflow of primary care doctors from rural Kansas. Figures put together by the Rural Health Research Center at the University of Washington indicate that from 1976 to 1985, only about 11.5% of KU Med's primary care graduates practiced in non-metropolitan areas. If that percentage holds true for the seniors who chose primary care residencies in 1990, then less than 10 will actually practice in a rural setting, not necessarily in Kansas.

The Kansas Medically Underserved Areas Report released in December of 1990 indicated that 64 of Kansas 105 counties were considered medically underserved, 51 of them critically so. This means that they have less than one primary care doctor for every 2695 people in the underserved counties, less than one primary care doctor for every 3000 people in critically underserved counties. This often-quoted reference doesn't tell the whole story, however. Between January 1, 1991 and December 31, 1991, 24 more primary care physicians left their practices, mostly in rural counties. This exodus resulted in 12 more counties achieving an "underserved" or "critically underserved" status during the year.

As bad as this picture looks, it is guaranteed to get worse. Preliminary findings from reports generated from Board of Healing Arts licensure data indicate that over the next nine years, rural primary care doctors will be reaching age 65 about 50% faster than their urban counterparts. It appears that rural counties can anticipate losing about 16% of their primary care doctors to retirement by the turn of the century. Considering that 80% of rural physicians are primary care, this loss is very troubling. Simply to replace retiring physicians, Kansas needs at least 182 new primary care doctors by the year 2000, or about

Senate P H &W
Attachment #1
1-29-92

20 a year. Add on the number of non-retiring primary care physicians who choose to relocate out of rural areas and, if it continues as badly as 1991, we'll need upwards of 40 new doctors a year.

To correct this situation, we need not just more primary care doctors but more primary care doctors who choose to practice in underserved areas in Kansas. With the dearth of primary care doctors nationwide, KU grads can find attractive positions just about anywhere else, and, apparently, have been.

The federal Office of Rural Health Policy recognizes the role that medical schools play in terms of the percentages of primary care specialists they produce. In a speech before the U.S. Senate, Jeffery Human, Director of the Office outlined seven program approaches for medical schools to consider, in order to increase their numbers of primary care grads:

1. Find and encourage children from rural areas with scientific aptitude well before they are ready for college. These children often are committed to their communities and will return.

2. Do a better job of admitting residents from rural areas to medical schools. Include rural family physicians on admissions committees.

3. Redesign medical curriculums to emphasize community practice equally with hospital practice.

4. Offer medical students clerkships with rural physicians as part of their undergraduate medical education.

5. Develop "medical schools without walls" - schools that can offer support to rural physicians,

6. Follow medical students through their residencies and match them to rural communities in need.

7. Develop more interdisciplinary training programs. Physicians alone cannot solve the problem. We need training programs that bring together physicians, nurse practitioners, physician assistants, and other health professionals in multidisciplinary teams to serve rural areas.

Other states have experimented with these approaches to increasing their supply of primary care doctors in underserved areas, one of the most successful among them being Minnesota. Minnesota currently boasts the best primary care physician to population ratio in the nation. Twenty years ago, however, Minnesota was faced with a physician shortage crisis comparable to or worse than Kansas'. After implementing major changes in their medical school's curriculum, Minnesota has achieved the virtual elimination of medical underservice in their state. By 1985, all 87 of its counties had at least one physician for every 2,500 people.

Minnesota recognized the role that the medical school plays in influencing a graduate's choice of specialty. They also accepted research findings that doctors are more inclined to settle in areas in which they have had prior contact. Challenged to specifically design

a program to redistribute physicians into underserved rural areas, The University of Minnesota Medical School designed the Rural Physician Associate Program (RPAP), in order to "create the right kind of physician for the right place".

RPAP represents a major departure from traditional medical school curriculum. For nine months during their third year,students study with carefully selected preceptors in community settings. The curriculum is largely problem based and self-directed. On average, three-fourths of the learning activities take place in office-type settings, compared to the typical third year experience of 85% hospital encounters.

The RPAP is a voluntary program that carefully screens candidates during their second year for academic ability, maturity, potential to return to a rural setting, independence, learning style and preference for location. Students are expected to become computer literate as computers are extensively used at all placement sites. Preceptors and teaching site are screened as rigorously and receive seven or more visits a year from a combination of RPAP and specialty faculty.

The RPAP has met the goals it set out to achieve. In particular, the program has had a profound effect on the distribution and specialty selection of its graduates. Of 457 graduates in practice throughout the U.S., 74% had chosen primary care. Sixty-six percent or 284, remained in Minnesota. Two hundred fifty-two, or 88.6% were in primary care 58.8% or 167 were in rural areas.

Of 182 RPAP students recently interviewed, 87% stated that RPAP influenced their decision to practice in a rural setting.

The RPAP has been an inexpensive innovation in medical education. Serving an average of 32 students a year, its costs have been comparable to educating non-RPAP students.

The RPAP has successfully demonstrated that real curriculum change does have an impact on student's career choices, and in particular, on their tendency to select primary care careers in rural settings.

Testimony presented by: Richard J. Morrissey
Acting Director
Office of Local and Rural Health Systems
January 28, 1992

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

January 29, 1992

TO: Senate Public Health and Welfare Committee

FROM: Kansas Medical Society

SUBJECT: SB 490; Concerning Appropriations to the University of Kansas School of Medicine and the Training of Primary Care Physicians

The Kansas Medical Society appreciates the opportunity to comment on SB 490, which would reduce appropriations to the KU Medical School if certain goals for the training of primary care physicians are not met in the future.

First, KMS supports the overall objective of training, recruiting and retaining more primary care physicians for the state. The excellent report titled, "Where Have All The Doctors Gone?", which was prepared by the Kansas Academy of Family Physicians, thoroughly analyzes the many factors which have contributed greatly to the problem of declining numbers of primary care physicians, especially in our state's rural underserved areas. As our state studies ways to improve access to health care, there may be no more difficult and complex challenge than how to assure an adequate supply of primary care physicians for our state's rural areas. The KAFP identifies many thoughtful and constructive suggestions for action designed to improve the situation, one of which gave rise to the concept in SB 490.

While we support the objectives articulated by KAFP in terms of producing more primary care physicians, we cannot support SB 490. This bill takes a rather punitive approach which could have the unintended effect of undermining the medical school's ability to increase its production of primary care physicians. We would prefer to support legislation or programs which provide incentives to the medical school to increase production of primary care physicians. We were encouraged to hear from Dr. Roger Tobias' testimony yesterday on SB 490 that discussions with leadership at the medical school were taking place and the prospects for progress seemed good. We support KAFP's recommendation to the Committee that SB 490 be held for the time being in order to give these discussions more time to produce results on a very complex problem.

Thank you for the opportunity to offer these comments.

JS:ns

Senate P H&W
Attachment #2
1-29-92

January 29, 1992

TESTIMONY ON SENATE BILL 490

UNIVERSITY OF KANSAS MEDICAL CENTER

Mr. Chairman and Members of the Committee: I am James Price, Executive Dean of the School of Medicine of the University of Kansas. I am a Family Physician and before coming to the Medical School, practiced 26 years in a rural Colorado town of about 4500 population.

I am appearing here today in opposition to Senate Bill 490 for essentially the same reasons that were voiced by Dr. Tobias yesterday. We believe the bill would not accomplish its stated goal and indeed, might do just the opposite. With the exception of the first recommendation of the KAFP "White Paper", the School of Medicine is in agreement with almost all of the remainder of the document, and indeed, have had programs in place for several months to accomplish manyu of them. In concert with the Kansas Academy of Family Physicians, we suggest that Senate Bill 490 be set aside, and that the "family" of groups, organizations, institutions and individuals who are interested in getting more physicians into rural Kansas work together to bring forward a plan to help us accomplish our common goal.

Let me briefly touch on some of our relevant activities to date. A few months ago our school was nationally ranked as number six of the nation's schools in educating Primary Care physicians. Attached to the text of my testimony which has been distributed to you, is a variation of the chart which you received yesterday. This one is

limited to Primary Care disciplines and shows the annual percentages of students entering Primary Care and Family Practice. A glance at the chart shows that the percentages do vary annually, sometimes to a considerable degree. Two years ago there was a dip in students entering Primary Care to the lowest point since 1982--but the following year (1991) reflects a sharp increase almost equal to the highest year for Family Practice. The national average for all medical school shows that 10 percent of graduates enter Family Practice. Over the last 10 years, the UIniversity of Kansas has averaged 19 percent.

Our departments of Family Practice are developing outrwach programs which will take residents into the rural areas and all of our preceptorship program is held outside the metropolitan areas. We're working with pre-medical students to increase the number of applicants and to acquaint them with rural medical practice. These, and other activities, are aimed at increasing the number of our graduates who enter Primary Care.

Without question, there <u>are</u> things that we can do to influence student choices as to ultimate residency, and we'll intensify and expand our efforts to do those things. However, the size of an educational debt, family pressures, and individual preference will always be important factors in any given student's selection of residency.

In the last month, I have met with Chairpersons of the Departments of Family Practice from both the Wichita and Kansas City campuses, with Dean Joseph Meek from Wichita, with top level administration of the national American Academy of Family

Physicians, with the joint faculties from both campuses last week in Emporia and with the leadership of the Kansas Academy of Family Physicians. All of these meetings centered around activities in progress or the with planning for new activities--all related to enticing more young Kansans to enter the field of medicine, choose the University of Kansas for their undergraduate work, apply to our school of medicine, and once here, set the goal of Family Medicine or other primary care discipline as a vocational choice. Plans for additional such meetings have been made, and the next one with the KAFP will be February 16th in Emporia.

I have charged our Curriculum Committee to review the training we give to students with two objectives in mind--first, they must, in the next six months, come up with a plan aimed at introducing first year students to patient contact that will be continued throughout the rest of the next two years. I believe that this can be done without breaching any implied curricular contract with the students. Second, with all prudent haste tthe curriculum committee is to review the entire curriculum with the objective of assessing the degree to which it is meeting the demands of the day and making recommendations to that end.

We were asked about the Kansas Scholarship Program yesterday, and since it's been only two years since the terms were tightened, this means that the residents under the new guidelines are still in training. It's still a little early to gauge the effect of the last legislative fine tuning. However, the percentage of students in compliance is continuing to increase steadily. The numbers of these scholarships available has been reduced by the legislature on several

occasions. With the effectiveness of this program going up, making it available to more students might be seriously considered. Each time an individual receives one of these scholarships and complies with its terms, a primary care physician is placed in a community of 12,000 or less.

This whole issue of health manpower is complex and those of us at the Medical Center have been and will continue to be concerned about it and wish to work with each other and the legislature to create long term solutions. It is our belief that the groups that we're meeting with can generate plans which you can convert into much more productive action than that proposed in Senate Bill 490. Thank you. I'd be happy to respond to any questions rthe committee may have.

UNIVERSITY OF KANSAS MEDICAL CENTER

Residency Positions Selected by KU Graduates 1982 -- 1991

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	Total
Total Graduates	187	194	196	208	182	183	186	182	144	193	**1,855**
Family Practice	40	33	40	49	30	40	30	30	13	45	**350**
Other Primary Care:											
Gyn & Ob	10	13	11	12	14	8	16	17	9	8	**118**
Internal Medicine	60	50	50	55	48	43	46	48	36	38	**474**
Pediatrics	19	15	14	20	18	19	19	10	5	11	**150**
Subtotal	89	78	75	87	80	70	81	75	50	57	**742**
TOTAL PRIMARY CARE	129	111	115	136	110	110	111	105	63	102	**1,092**
OF GRADUATING CLASS:											
% Family Practice	**21.4**	**17.0**	**20.4**	**23.6**	**16.5**	**21.9**	**16.1**	**16.5**	**9.0**	**23.3**	**18.9**
% Primary Care	**69.0**	**57.2**	**58.7**	**65.4**	**60.4**	**60.1**	**59.7**	**57.7**	**43.8**	**52.8**	**58.9**