Approved 2-25-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

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

3:45 a.m./p.m. on February 20, 1992 in room 522-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Legislative Research
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Andrew O'Donovan, Alcohol and Drug Abuse Services, SRS
Carolyn HIll, Youth Services, SRS
Bob Geers, The Association for Retarded Citizens of Kansas, Inc.
Rita Kay Ryan, Bureau of Family Health, Department of Health and Environment
C. Tucker Allen, Maternal and Infant Care project, Topeka-Shawnee Co. Health Center
Lori Callahan, Kansas Medical Mutual Insurance Company
Jerry Slaughter, Kansas Medical Society
Linda Kenny, Department of Health and Environment
Maureen Collins, Planned Parenthood Federation of America

The Chairman called the meeting to order at 3:45 p.m. in Room 522-S.

The Chairman announced continuation of hearing on **SB 532.**

Andrew O'Donovan, SRS, continued his testimony on **SB 532** and provided the Committee with information from the U.S. Department of Health and Human Services that the rate of mental retardation of newborns in the general population is 8%, while in alcohol abuse cases it is 15-35%.

Carolyn Hill, SRS, expressed her support of **SB 532,** but with two concerns in Section 9 that Mr. O'Donovan had addressed at the morning session. Ms. Hill also stated that cocaine is one of the more seductive and addictive drugs, and just because a child has been exposed to a substance doesn't mean they are at-risk for child abuse. Too many of these women do not seek prenatal care, and this is a high level of concern. There have been a number of efforts to make this a criminal offense, and they would rather get the services involved and provide counseling. Outreach and wrap around services for these families were also discussed.

Bob Geers, Association for Retarded Citizens of Kansas, Inc., submitted written testimony and stated his support for **SB 532**. He stated the association has been a strong advocate for prevention and early intervention of mental retardation and believes this bill can go an extra step to provide educational material available to alter the lives of children and families. (Attachment 1)

Rita Kay Ryan, Maternal and Infant Program, Department of Health and Environment, submitted written testimony in support of **SB 532** with the exception of the patient counseling documentation form required in Sec. 4, and deletion of Sec. 9. Ms. Ryan stated that Sec. 9 should be in child abuse statutes and not in the bill. (Attachment 2)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 522-S, Statehouse, at 3:45 ~~a.m.~~/p.m. on February 20, 1992

C. Tucker Allen, Topeka-Shawnee County Health Center, submitted written testimony and stated her agency supports the basic concept of **SB 532** with some hesitation regarding referral to local health departments for coordination of services. Ms. Allen stated they support the non-punitive approach to helping substance using pregnant women deal with their problems. (Attachment 3)

Lori Callahan, Kansas Medical Mutual Insurance Company, submitted written testimony and stated her organization opposes the portions of **SB 532** which places an obligation on health care providers as these obligations create new private causes of action for the failure of a health care provider to comply with the requirements of the bill. Ms. Callahan stated that in regard to the protocols, they create a legislative standard of care which all health care providers must follow, and while her organization fully supports the concept of education of both the public and health care providers such as is outlined in Sections 1-3, the bill places independent obligations upon health care providers to comply with the law, such new obligations adversely affect medical malpractice premiums and consequently access to health care. (Attachment 4)

Jerry Slaughter, Kansas Medical Society, submitted written testimony on **SB 532** and stated KMS supports the intent of the legislation but has several concerns with various provisions. Mr. Slaughter outlined these concerns to the Committee, along with a balloon of the bill showing several amendments. (Attachment 5) During Committee discussion, Mr. Slaughter stated KMS supports and encourages the educational concept addressed in the bill.

Linda Kenney, Department of Health and Environment, provided information to the Committee regarding counties in Kansas that are covered by M and I programs. Ms. Kenney stated that three most important parts of the bill address public awareness, educational materials and guidance, and health professional education and training. Risk assessment and availability of educational material were also discussed.

Maureen Collins, Planned Parenthood Federation of America, submitted written testimony and stated her organization appreciates the concept and intent of **SB 532** with exceptions in language in Sec. 4 and Sec. 5. Ms. Collins stated that the bill fails to address the real problem which is access to prenatal care. She stated that many poor women usually wait well into their pregnancies to see a pan, and this counseling may be too late for them. (Attachment 6) After Committee discussion, it was pointed out by staff that the term health care provider is not defined in the bill and may be a problem if some of these sections remain.

Written testimony was also provided to the Committee from Cheryl DeBrot, Kansas Respiratory Care Society, Betty Glover, Kansas Action for Children, Inc., and Terri Roberts, Kansas State Nursing Association. (Attachments 7, 8, an 9)

The meeting was adjourned at 5:15 p.m. The next meeting of the Committee is scheduled for February 24, 1992, 10:00 a.m., Room 526-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 2-20-02 PM

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Shelly A. Bucher	SRS
Carolyn Risley Hill	SRS
Linda Kenney	KDHE
Rita Kay Ryan	KDHE
Nancy Jorn 3116 W. 28th Circle Lawrence 66047	Lawr-Dg Co. Health Dept
C. TUCKER ALLEN 1307 SE 43RD TOPEKA 09	MCH PROJECT. TOP. SH. CO HEALTH DEPT
BOB GEERS TOPEKA.	ARC/Ks.
Andrew O'Donovan	SRS/ADAS
Julie J. Hein	Hein, Ebert Rosen
Maureen Collins	Planned Parenthood
Jenifer Brandeberry	Pro Choice Action League
Tom Bell	Ks. Hosp. Assn.
Lori Callahan	Kammco
JUSTIN OLMSTEAD	INTER SENATOR ROCK

THE ASSOCIATION FOR
RETARDED CITIZENS OF KANSAS, INC.

Hope through understanding

P.O. BOX 676 • HAYS, KS 67601

February 21, 1992

TO: Sen. Roy Ehrlich, Chair
Members of the Senate Public Health and Welfare Committee

FROM: Lila Paslay, Chair
Bob Geers, Coordinator
Legislative Affairs Committee

RE: S. B. 532

I am speaking today on behalf of the 5,000 members of the Association for Retarded Citizens of Kansas.

The association has been a strong advocate for prevention and early intervention of mental retardation since its beginning in 1955. We worked very hard to have the state of Kansas include screening of newborns for phenylketonuria (PKU) in the late 60's. We have continued to be supportive of every initiative which could result in more children getting a good start in life.

S.B. 532 offers that possibility. Even though the state cannot mandate appropriate prenatal care and concern, we believe that expectant mothers and fathers should have every opportunity to know the results of irresponsible behavior during pregnancy.

We would hope that through the public education required in this legislation we could alter the lives of children and families. Public awareness, the availability of educational materials, educational opportunities and counseling could make a difference in some individuals lives.

There are few causes of mental retardation that can be eradicated. Fetal Alcohol Syndrom can be! We should never again have children experiencing the devastating disabilities that can result from the use of alcohol and other substances known to cause birth defects.

We urge your support of S. B. 532.

Senate P. H & W
Attachment #1
2-20-92 PM

arcfacts
Association for Retarded Citizens

August 1988

FACTS ABOUT ALCOHOL AND OTHER DRUG USE DURING PREGNANCY

What is meant in warnings to pregnant women not to drink alcohol?

Research has shown that even small levels of alcohol consumed during pregnancy may affect the fetus in damaging ways. In pregnant women, alcohol is not only carried to all organs and tissues, but also to the placenta, where it easily crosses through the membrane separating maternal and fetal blood systems. In this way, alcohol is transported directly to the fetus and to all its developing tissues and organs.

When a pregnant woman drinks an alcoholic beverage, the concentration of alcohol in her unborn baby's bloodstream is the same level as her own. Unlike the mother, however, the liver of a fetus cannot process alcohol at the same adult's rate of one ounce every two hours. High concentrations of alcohol, therefore, stay in the fetus longer, often for up to 24 hours. In fact, the unborn baby's blood alcohol concentration is even higher than the mother's during the second and third hour after a drink is consumed.

What kind of damage can occur to the fetus from alcohol consumption by the mother?

There are two degrees of damage that can occur. The most severe is Fetal Alcohol Syndrome (FAS). The Fetal Alcohol Syndrome Study Group of the National Council on Alcoholism outlines minimal criteria for the diagnosis of FAS as being, "evidence of abnormalities in three specific areas: growth, central nervous system functions and facial characteristics."

Alcohol-Related Birth Defects (ARBD) include less severe birth defects in the same areas. In both FAS and ARBD, birth defects are caused when a woman drinks alcohol during pregnancy. FAS and ARBD form the single largest class of birth defects that are 100 percent preventable.

Is there a safe amount of alcohol that a pregnant woman can drink?

No. A safe level of alcohol consumption for pregnant women has not been established. Although alcohol consumption at any time during pregnancy is potentially harmful to the fetus, timing and duration of exposure can be related to the type of damage likely to occur. Early exposure presents the greatest risk for serious physical defects, and later exposure increases the chances of neurological and growth deficiencies or miscarriage.

- **The First Trimester** — This appears to be the most critical time when abnormal features can be caused. Alcohol may affect the way cells grow and arrange themselves as they multiply, altering tissue growth in the part of the fetus that is developing at the time of exposure. The brain is particularly sensitive to alcohol which diminishes the number of cells growing in the brain. Consequently, the brain is smaller and often its neurons are found in the wrong places. The early loss of cells in the developing fetus may help explain overall retarded growth and low birth weight in babies with FAS.
- **Second Trimester** — Miscarriage is a major risk during this time. There may be times of fetal distress related to binge drinking (irregular periods of heavy drinking).
- **Third Trimester** — During this period the fetus normally undergoes rapid and substantial growth. Alcohol can impair this growth. This is also the time of greatest brain development. Research with animals indicates the brain and central nervous system are at greatest risk during the third trimester.

How common are FAS and ARBD?

Full-blown FAS occurs in an estimated one out of every 750 live births. Less severe ARBD occurs in approximately 10 to 12 live births out of 1,000 (36,000 babies per year). Among known alcohol-abusing women, however, FAS occurs in 30 percent of recorded live births.

What are the problems of children born with these disorders?

Typically, children born with FAS and ARBD have the following symptoms:

* Low birth weight and failure throughout their lives to catch up to their peers in physical growth.
* Head:
  - Small head size
  - Narrow eye slits
  - Flat midface
  - Low nasal ridge
  - Loss of groove between nose and upper lip
* Central nervous system:
  - Mental retardation
  - Alcohol withdrawal at birth
  - Poor sucking response
  - Sleep disturbances
  - Restlessness and irritability
  - Developmental delays
  - Short attention span
  - Learning disabilities
* Organs and body parts:
  - Muscle problems
  - Bone and joint problems
  - Genital defects
  - Heart defects
  - Kidney defects

Can FAS be treated?

Birth defects related to alcohol use are permanent. Surgery can repair some of the physical problems, and schools and day care centers offer programs to improve mental and physical development. However, children born with FAS remain below average in physical and mental development throughout their lives.

How can FAS be prevented?

Recent studies have shown that pregnant women will reduce or cease their alcohol intake if they are made aware of

the harmful effects of alcohol on their babies. However, the most critical period for the fetus is in the first trimester when the mother may not even suspect she is pregnant. For such women, an early warning system is imperative.

A public education campaign for youth, who are tomorrow's parents, is one prevention strategy. The ARC has produced a set of curriculum materials especially for educating young people about FAS and ARBD. The materials consist of teacher's and student's texts, a community project book and a cartoon booklet and are ideal for use with high school students, church youth groups, civic organizations, seminar audiences and others.

A set of the materials (one copy of each) costs $9.50. Quantity costs of the student's booklets and additional details about the curriculum can be obtained by calling the Publications Desk at ARC National Headquarters.

Yet another strategy for public education is to require warning labels on alcoholic beverages. A bill introduced in 1988 in the U.S. Senate states the belief that "warning labels on the containers of alcoholic beverages concerning the effects on the health of individuals resulting from the consumption of such beverages would assist in providing such education." Of the five different warning statements proposed, one refers to alcohol and pregnancy: "Warning: The Surgeon General has determined that the consumption of this product, which contains alcohol, during pregnancy can cause mental retardation and other birth defects."

Why is it especially important to educate young people about FAS and ARBD?

There are rising numbers of teen pregnancies and teens who use alcohol.

Statistics illustrate the problems: According to McDonald's Corporation, the average age of beginning alcohol use is 12.5. The National Council on Alcoholism has said that nearly 100,000 ten- and 11-year olds get drunk at least once a week.

The 1985 Statistical Abstract developed by the U.S. Department of Commerce showed there were 239,000 pregnancies of girls between the ages of 14 and 18.

Given the estimates of the incidence of FAS and ARBD, more than 3,300 babies, born to teenagers, might be affected by FAS or ARBD in one year.

What about prescription and non-prescription drugs; can they cause birth defects similar to FAS?

Different drugs have different effects. In some cases the risk is clear-cut. Valium, Librium and Miltown have carried labels since 1976 warning they may be dangerous if used during the first three months of pregnancy. Studies indicated an increased incidence of cleft palate, heart defects and nervous system defects in children born to women who had taken those tranquilizers, while pregnant.

The anti-acne drug Accutane is receiving considerable attention for its reported links to birth defects. Despite warnings by the manufacturer, government scientists estimated in April 1988 that 900-1,300 babies have been born with severe birth defects because of their mothers' use of the drug.

About the same time, experts warned that Tegison, a drug used to treat the chronic skin disease psoriasis is probably even more likely to produce birth defects than Accutane. The drug can remain dormant in body tissue for years after it is taken and can cause birth defects long after a woman stops taking it.

Even aspirin, a commonly-used yet potent drug, has been linked to excessive bleeding during childbirth and should be avoided during the last three months of pregnancy. Newborns in this instance also are more likely to bleed at childbirth.

In general, any drug that has an effect on an adult may affect a pregnant woman's fetus because, like alcohol, the drug crosses to the fetus through the placenta.

Many drug labels carry warnings to pregnant women, but the best rule of thumb is for a pregnant woman to consult with her physician before taking any drug at all.

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 532

KDHE public health priorities for pregnancy and substance abuse include: 1) prioritizing treatment for pregnant substance abusing women, 2) multidisciplinary and interagency follow up of pregnant and parenting women and infants, 3) health care professional training and public awareness activities, 4) no criminal prosecution for the pregnant substance abusing women who enter treatment, in order to encourage participation in treatment, and 5) reduce negative consequences attributed to perinatal alcohol and drug abuse on infant health and development. Generally, Senate Bill 532 is in line with these priorities.

In the fall of 1989, the Kansas Department of Health and Environment collaborated with the SRS Alcohol and Drug Abuse Services on a grant proposal for model projects for pregnant substance abusing women. This collaborative effort began an association which has proved mutually beneficial in terms of information sharing, health professional education and provision of services to pregnant women. Prior to 1989 there had been a number of public health activities related to fetal alcohol syndrome prevention.

In late fall of 1989, the Bureau of Family Health staff met to address the year 2000 objectives relating to the health of mothers and children. An overall objective for all programs was health professional education. All of the programs in the Bureau of Family Health for pregnant women and infants incorporate health professional education relating to identification, prevention, and early intervention. We are providing some information to the public through our Baby Your Baby public awareness campaign. The WIC and MCH programs in collaboration with ADAS provide local agencies with educational materials. Risk assessment is currently being done in the WIC and M&I programs as part of Standards of Care consistent with the standards of the American College of Obstetricians and Gynecologists (ACOG). ACOG standards are available to private physicians as guidance.

Service coordination is available in all counties with M&I services. Service coordination in other counties would depend on the availability of staff and funding. The SRS/KDHE Interagency Agreement signed in December 1991 specifies that pregnant women will receive priority for substance abuse treatment. (A copy of this section of the agreement is appended.) Bureau of Family Health maintains a toll-free information line that pregnant women and others can access for information and referral. What we conclude from the above review is that many of the provisions of this bill are already in place in Kansas. The expansion of these activities beyond the current level through Senate Bill 532 would require additional resources.

Senate P. H&W
attachment #2
2-20-92 PM

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

Printed on Recycled Paper

In general, KDHE supports this bill with the exception of the patient counseling documentation form required in Sec. 4 and Sec. 9 (child protective services) which should be deleted from the bill. The requirement that patients sign a statement acknowledging receipt of counseling serves no useful function. Currently, the health provider documents that counseling has been provided which we find adequate given the costs involved in instituting a standard form. Monitoring for compliance with state law would be difficult, if not impossible, and expensive.

Regarding Section 9, this section belongs in child abuse statutes and not here. Perinatal addiction should be regarded as primarily a public health matter and not a punitive matter. When provisions are included related to child abuse, the effect is to focus on punishing women rather than getting them into treatment. The American College of Obstetrics and Gynecology reviewed state laws on pregnant women and substance abuse. The State Legislative Fact Sheet which is appended to this written testimony generally categorizes the provisions of state laws as either punitive in nature of those of public health significance. Clearly, inclusion of child abuse or neglect is considered punitive.

Recommendation

In general, KDHE supports this bill with the exception of the patient counseling documentation form required in Sec. 4 and Sec. 9 (child protective services) which should be deleted. No fiscal resources were included for this activity in the Governor's budget.

Testimony presented by: Rita Kay Ryan
Coordinator, Maternal & Infant (M&I) Program
Bureau of Family Health
February 20, 1992

COOPERATIVE AGREEMENT

Kansas Department of Health and Environment

and

Kansas Department of Social and Rehabilitation Services

SRS

Kansans caring for Kansans

December, 1991

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M. SUBSTANCE ABUSE SERVICES

The purpose of this section of the inter-agency agreement between the Kansas Department of Health and Environment and the Kansas Department of Social and Rehabilitation Services, specifically Alcohol and Substance Abuse Services (ADAS), is to: establish methods for ongoing collaboration and coordination; prevent duplication of efforts; promote dissemination of information regarding risks of substance abuse (alcohol and abuse of legal and illegal substances) to all Kansas citizens; and, establish methods for collection, sharing and analysis of data.

o PROGRAM INFORMATION AND SERVICE

SRS and KDHE will:

1. Assure staff participation on permanent and/or ad hoc intra- and inter-agency committees related to joint public health and substance abuse initiatives/services.

2. Share written program/agency plans regarding substance abuse initiatives.

KDHE will:

1. Provide to SRS/ADAS information about public health activities related to substance abuse prevention and early intervention initiatives.

2. Promote cooperative intra- and inter-agency program planning and monitoring of public health substance abuse efforts at the state and local levels.

3. Incorporate substance abuse prevention, client identification, early intervention, and referral to substance abuse treatment services in all public health protocols and standards.

SRS will:

1. Inform and refer substance abuse applicants/recipients to appropriate public health and community-based services.

2. Participate with KDHE in cooperative program planning and monitoring of public health efforts at the state and local levels.

3. Provide KDHE and other designees with SRS/ADAS program brochures related to substance abuse.

4. Establish methods for KDHE to gain access to client demographic information as needed.

o CONSULTATION AND CONTINUING EDUCATION

SRS and KDHE will:

1. Provide inter-agency consultations on request regarding public health and substance abuse initiatives.

2. Participate in mutual evaluation of the impact of public health/substance abuse services and client access through data collection and analysis.

KDHE will:

1. Plan, present and/or participate in workshops held by SRS/ADAS related to substance abuse issues and services.

2. Respond to questions and issues presented by SRS/ADAS staff.

3. Provide substance abuse data to SRS/ADAS, as requested.

SRS will:

1. Plan, present and/or participate in workshops held by KDHE relating to substance abuse issues and services.

2. Respond to questions and issues presented by KDHE.

3. Share reports and data relating to substance abuse programs and studies with KDHE.

o TREATMENT SERVICES

KDHE will:

1. Support through consultation and funding (if available) substance abuse treatment services at the community level.

2. Report to SRS/ADAS documented concerns relating to treatment services availability and/or barriers for Medical Assistance clients and other substance abusers.

3. Provide recommendations for public health standards for substance abuse services.

4. Work with SRS/ADAS and local providers to resolve barriers to treatment services.

SRS will:

1. Identify substance abuse services to be covered by Medical Assistance, utilizing KDHE consultation.

2. Work with KDHE and local providers to resolve barriers to substance abuse treatment and local public health services.

3. Provide a pilot project in cooperation with KDHE to place a drug counselor on site in one of the major metropolitan health departments and evaluate the effectiveness of an on-site counselor vs. referral.

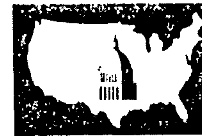
4. Provide a pilot project in cooperation with KDHE to place a drug counselor on site in one of the major metropolitan health departments and evaluate the effectiveness of an on-site counselor vs. referral.

o FEES AND REIMBURSEMENT

SRS and KDHE will:

1. Identify existing reimbursable and potentially reimbursable substance abuse services.

2. Identify gaps in service delivery related to public health and substance abuse and propose potential solutions.



STATE LEGISLATIVE FACT SHEET

STATE LAWS ON PREGNANT WOMEN & SUBSTANCE ABUSE, 1991*

		PUNITIVE				PUBLIC HEALTH			OTHER
STATE	YEAR	DEFINES AS CHILD ABUSE OR NEGLECT[1]	MANDATORY TESTING (woman;newborn)	MANDATORY REPORTING (woman;newborn)	CRIMINAL PROSECUTION (Partial listing only)	LAW PROTECTS AGAINST PROSECUTION	TREATMENT/ PREVENTION (pregnancy related)	HEALTH PROFESSIONAL TRAINING	TASK FORCE/ STATE OFFICE (pregnancy related)
AZ	1990;1991	X					X[2]		
CA	1990;1991				X	court opinion	X	X	X
CO	1991						X		
CT	1989;1991						X		X
DE	1991						X		
DC					X		X		
FL	1988;1990	X		X (newborn)	X	X	X		X
GA	1991						X[2]		
HI	1990	X		X (newborn)			X	X	X
IL	1989;1991	X		X (newborn)	X	X	X[2,3]	X	X
IN	1987	X		X (newborn)					
IA	1990			X (newborn)		X	X[2]	X	X
KY	1990								X
LA	1991						X[2]	X	X
ME	1990;1991						X[3]		
MD	1990								X
MA	1988	X		X (newborn)					
MN	1989;1990 1991	X	X (both)	X (both)[4]			X		
MO	1991			X (both)[5]		X	X[2]	X	
NH	1990								X

2-7

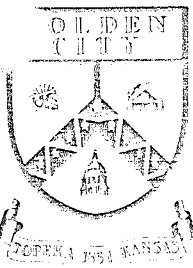
		PUNITIVE				PUBLIC HEALTH			OTHER
STATE	YEAR	DEFINES AS CHILD ABUSE OR NEGLECT[1]	MANDATORY TESTING (woman;newborn)	MANDATORY REPORTING (woman;newborn)	CRIMINAL PROSECUTION (partial listing only)	LAW PROTECTS AGAINST PROSECUTION	TREATMENT/ PREVENTION (pregnancy related)	HEALTH PROFESSIONAL TRAINING	TASK FORCE/ STATE OFFICE (pregnancy related)
NM					X				
NY	198-;1991			X (newborn)			X		
NC	1991						X		
OH	1990						X		X
OK	1989;1991	X		X (newborn)					X
OR	1989;1991		X (woman)	X (woman)		X	X	X	X
PA	1989						X		
RI	1989								X
SC					X[6]				
TN	1990						X		X
UT	1988	X		X (newborn)					
VA	1990;1991								X
WA	1989						X		
WI	1989		X (newborn)	X (newborn)			X	X	X

*Current as of September 1991

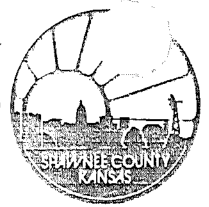
Explanation

1. This column shows those states that have enacted legislation making drug use during pregnancy a crime or, classifying neonates with controlled substances in their systems as a new category of child abuse or neglect.
2. The state is required by law to give pregnant women *priority* access to new or existing substance abuse treatment services.
3. Child care vouchers or services are available to women undergoing treatment for substance abuse.
4. Infant toxicology test results must be reported on birth certificates and fetal death reports.
5. Pregnant women may not be reported to the health department without their consent.
6. Voluntary reporting of pregnant women to local law enforcement agencies does take place but is not mandated by law.

Source: *Government Relations Department, American College of Obstetricians and Gynecologists*
409 12th Street, SW Washington, DC 20024-2188 Telephone (202) 863-1631 / FAX (202) 488-3985



Topeka-Shawnee County



Health Agency
1615 W. 8th Street
Topeka, Kansas 66606
Phone 913-233-8961

C. Tucker Allen, RN, Coordinator
Maternal and Infant Care Project
February 20, 1992

I'm Tucker Allen, nursing coordinator of the Topeka Shawnee County Health Department Maternal and Infant Care Project.

We at Topeka Shawnee County support the basic concept of Senate Bill 532. We know that education and treatment of substance abusing pregnant women can increase the likely hood of a healthy baby. As an example, a 24 year old woman, pregnant for the first time, enrolled in our M & I program. She admitted to using LSD once early in her pregnancy and the continued use of 10-12 marijuana joints a day, 1-2 drinks of alcohol a day, and one pack of cigarettes a day. After much counseling and encouragement from the M & I staff, she began treatment at the Women's Recovery Center (the Women's Recovery Center is a 30 day in-patient substance abuse treatment program for women). The client stopped using drugs and alcohol but continued to smoke cigarettes. She delivered a healthy 6 lbs. 12 Oz. full term infant. The baby is now four months old and the mother continues to successfully breastfeed and remains drug free.

The portion of this bill that we have some hesitation in supporting is the referral to the local health departments for coordination of services. The Topeka M & I program is primarily for the low income populaton and we follow WIC income guidelines in determining eligibility for services. Our services aren't available to the middle and upper income population. We don't have the staff or financial resources to provide service coordination to all the substance abusing pregnant women in our area. Also, referral is optional. What services are available to women who refuse consent? It would be more appropriate for some women to receive coordination of services and referral for treatment through the physician's office. We also feel the support services M & I provides of nutrition, nursing and social work should be available to <u>all</u> pregnant women and not just those women who qualify for our program.

We support the non-punitive approach to helping substance using pregnant women deal with their problems. Pregnancy is a time when most women are open to advice and education concerning their health and the well being of their babies. With the education programs as stated in the bill, health care professional will be able to provide on-site patient education and counseling, an important aspect in helping women decrease or stop their substance use.

Thank you to the senators and health professionals for addressing the difficult issue of prenatal substance use in a positive manner. Prevention and education will help insure a healthy future for the children of Kansas.

Senate P. HEW
attachment #3
2-20-92 PM

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

AND

KANSAS MEDICAL INSURANCE SERVICES CORPORATION

TO: Senate Public Health and Welfare Committee

FROM: Lori Callahan, General Counsel, KaMMCO

RE: S.B. 532

DATE: February 20, 1992

The Kansas Medical Mutual Insurance Company, KaMMCO, is a Kansas Domestic, physician-owned, professional liability insurance company formed by the Kansas Medical Society pursuant to legislation enacted by the Kansas Legislature. KaMMCO currently insureds over 800 Kansas physicians.

KaMMCO supports the concept of S.B. 532 which is to require the Department of Health and Environment to conduct not only public awareness, but also professional educational materials and guidance to health care providers for the purpose of advising the public of the preconceptual and prenatal effects of the use of tobacco, alcohol, and controlled substances. KaMMCO, however, opposes the sections of the bill which create an obligation on behalf of health care providers to counsel with their patients, record such counseling through reporting, and to report abuse. Additionally, KaMMCO opposes the requirement for the Secretary of Health and Environment to promulgate protocols to be utilized by health care providers to identify pregnant women at risk for prenatal substance abuse.

KaMMCO opposes the portions of the bill which place an obligation on health care providers as these obligations create new private causes of action for the failure of a health care provider to comply with the requirements of the bill. Even if the health care provider did in fact comply with the provisions of the bill, an independent private cause of action by the mother and or the child could be filed alleging the health care provider's failure to comply. It would then be the burden of the health care provider to prove there was compliance. This would require civil litigation proceeding all the way to a jury trial since the compliance or non-compliance is a fact question which under Kansas law can only be resolved by the fact-finder, which is the jury.

Senate P. H&W
attachment #4
2-20-92

P.O. BOX 2307 • TOPEKA, KANSAS 66601-2307
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With regard to the protocols, protocols create a legislative standard of care which all health care providers must follow. Currently, the standard of care is developed by health care providers themselves and the failure to comply with the standard of care subjects health care providers both to discipline through peer review as well as liability in tort actions. Additionally, the availability of testing makes the standard of care different in one part of the state then from that in another. Thus, a state-wide protocol may be too high for some areas of the state and too low for others.

While KaMMCO fully supports the concept of education of both the public and health care providers such as is outlined in Sections 1-3 of S.B. 532, to the extent S.B. 532 places independent obligations upon health care providers to comply with the law, such new obligations adversely affect medical malpractice premiums and consequently access to health care.

Thank you for your consideration. We support and encourage aggressive public and professional education, as long as new independent causes of action are not created.

1 who provides obstetrical or gynecological care shall counsel all preg-
2 nant patients as to the perinatal effects of the use of tobacco, the
3 use of alcohol and the use of any controlled substance as defined in
4 schedule I, II or III of the uniform controlled substances act for
5 nonmedical purposes. Such health care providers shall further have
6 all patients sign a written statement, the form of which shall be
7 prepared by the secretary of health and environment, certifying that
8 such counseling has been received. All such executed statements
9 shall be maintained as part of that patient's medical file.
10 Sec. 5. (a) The secretary of health and environment shall prom-
11 ulgate protocols based on a risk assessment profile for substance
12 abuse to be used by health care providers to identify pregnant women
13 at risk for prenatal substance abuse.
14 (b) Any health care provider who provides services to pregnant
15 women shall utilize protocols pursuant to this section to identify
16 pregnant women who are at risk for perinatal substance abuse. The
17 health care provider shall upon identification inform such women of
18 the availability of services and the option of referral to the local
19 health department for service coordination.
20 (c) Upon consent by the woman identified as having a high risk
21 pregnancy, the physician or health care provider shall make a referral
22 for service coordination within 72 hours to the local health
23 department.
24 (d) ~~Any health care provider complying with the provisions of~~
25 ~~this section, in good faith, shall have immunity from any civil liability~~
26 ~~that might otherwise result by reason of such actions.~~

There shall be no civil or criminal cause of action related to the rendering or failure to render any such services.

27 (e) Referral and associated documentation provided for in this
28 section shall be confidential and shall not be used in any criminal
29 prosecution.
30 (f) The consent required by subsection (c) shall be deemed a
31 waiver of the physician-patient privilege solely for the purpose of
32 making the report pursuant to subsection (c).
33 Sec. 6. Upon referral pursuant to subsection (c) of section 5, the
34 local health department shall offer service coordination to the preg-
35 nant woman and her family. The local health department shall co-
36 ordinate social services, health care, mental health services and
37 needed education and rehabilitation services. Service coordination
38 shall be initiated within 72 hours of referral.
39 Sec. 7. A pregnant woman referred for substance abuse treat-
40 ment shall be a first priority user of substance abuse treatment
41 available through social and rehabilitation services. All records and
42 reports regarding such pregnant woman shall be kept confidential.
43 The secretary of social and rehabilitation services shall ensure that

family oriented substance abuse treatment is available. Substance abuse treatment facilities which receive public funds shall not refuse to treat women solely because they are pregnant.

Sec. 8. The secretary of health and environment shall maintain a toll free information line for the purpose of providing information on resources for substance abuse treatment and for assisting with referral for substance abusing pregnant women.

Sec. 9. (a) Any physician or other health care provider shall refer to the secretary of social and rehabilitation services child protective service families in which a newborn child may have been exposed to a controlled substance listed in schedules I, II and III of the uniform controlled substances act or alcohol as evidenced by:

(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or

(2) results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child; and

(3) a written assessment made or approved by a physician, health care provider or by the department of social and rehabilitation services which documents the child as being at risk of abuse or neglect.

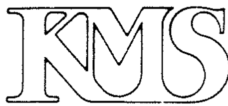
(b) Nothing in this section shall preclude a physician or other individual from reporting abuse or neglect of a child as required under K.S.A. 38-1522 and amendments thereto.

(c) Upon notification pursuant to subsection (a), the secretary of social and rehabilitation services shall conduct a child protective service investigation and intervene according to regulations of the secretary of social and rehabilitation services based on the results of the investigation. Child protective services shall be initiated within 72 hours of notification. If the local health department was involved with the family during the perinatal period, the secretary of social and rehabilitation services and the local health department will coordinate provision of services to the family.

(d) ~~Any health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions.~~ — There shall be no civil or criminal cause of action related to the rendering or failure to render any such services.

(e) Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.

Sec. 10. This act shall take effect and be in force from and after January 1, 1993, and its publication in the statute book.



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

February 20, 1992

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: Senate Bill 532; Concerning the Identification and Reporting of Pregnant Women at Risk for Prenatal Substance Abuse

The Kansas Medical Society appreciates the opportunity to comment on SB 532, which would establish new law for the purpose of better identification and coordination of services for pregnant women who are substance abusers. Obviously, pregnant women who abuse controlled substances jeopardize the health of their children, at great cost to such children, and often society as a whole. It is a significant challenge to change the behavior of substance abusers, but the intent of the bill, to provide more education and improve the availability of services is commendable. While we support the intent of the legislation, we have several concerns with various provisions. We have suggested amendments which we believe will strengthen the bill.

Section 4 of the bill would create a new standard of care for all physicians who provide services to pregnant women. It requires that physicians "counsel" all pregnant patients and also requires that such patients indicate that they have received such counseling by signing a written statement which would become part of the medical file. This undefined "counsel" would create a new standard that could become the grounds for an allegation of medical malpractice in the event that the patient did not believe (or would not sign a document attesting) that she received appropriate counseling and information. For these reasons, we recommend that Section 4 be amended to simply require that physicians who care for pregnant patients provide to those patients the published materials distributed to the physician by the Secretary of Health and Environment. We believe that this is a far more reasonable and practical approach.

We also have concerns about Section 5 wherein in the Secretary of Health and Environment would be required to promulgate protocols which must be used by health care providers to identify pregnant women at risk for prenatal substance abuse. Our concern here is that again a new standard of care is being imposed by statute, based on protocols developed by the Department of Health and Environment, which at this time, does not even have a full-time staff physician. This requirement will create a new cause of action against physicians providing obstetrics, an already litigious area of medical practice. We would much prefer that instead of protocols, that the Department of Health and Environment develop a risk assessment profile that may be used as a guide to assist physicians identify substance abusers. We have suggested amendments in (a) and (b) which we believe will accomplish the objective of the bill without exposing physicians to greater liability as a result of the new cause of action which is created.

Senate PH&W
Attachment #5
2-20-92 PM

In subsection (c) of Section 5 we have suggested another amendment which requires physicians to report patients to KDHE instead of the local health department. Then KDHE can be responsible for further referral for coordination of services. The amendment also makes it clear that a "referral" to the health department can be satisfied by simply reporting the woman's name who has been identified as having a high risk pregnancy. Finally, in subsection (d) of Section 5 we have inserted language which we believe more clearly expresses the intent of providing liability protection for physicians who comply with the act.

We also have concerns with the provisions of Section 9 which create a new reporting requirement that is redundant in that it duplicates provisions of existing law requiring physicians to report suspected abuse of children. Furthermore, it assumes erroneously that physicians may test delivering women or infants for the presence of alcohol or drugs without their consent. This would be a violation of current law. Our requested amendments to Section 9 would simply clarify that if a physician suspects that a newborn infant has been exposed to alcohol or drugs, the physician will be obligated to make a report pursuant to current child abuse reporting laws.

Thank you for considering our concerns. We respectfully request that you adopt the attached amendments prior to recommending the bill for passage.

JS:ns

who provides obstetrical or gynecological care shall ~~counsel~~ all pregnant patients ~~as to the perinatal effects of the use of tobacco, the use of alcohol and the use of any controlled substance as defined in schedule I, II or III of the uniform controlled substances act for nonmedical purposes. Such health care providers shall further have all patients sign a written statement, the form of which shall be prepared by the secretary of health and environment, certifying that such counseling has been received. All such executed statements shall be maintained as part of that patient's medical file.~~

Sec. 5. (a) The secretary of health and environment shall promulgate ~~protocols based on~~ a risk assessment profile ~~for substance abuse to be used by~~ health care providers to identify pregnant women at risk for prenatal substance abuse.

(b) Any health care provider who ~~provides services to pregnant women shall utilize protocols pursuant to this section to identify pregnant women who are~~ at risk for perinatal substance abuse. ~~The health care provider~~ shall upon identification inform such ~~women~~ of the availability of services and the option of referral to the local health department for service coordination.

(c) Upon consent by the woman identified as having a high risk pregnancy, the physician or health care provider shall make a referral for service coordination ~~within 72 hours~~ to the ~~local health~~ department.

(d) ~~Any health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions.~~

(e) Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.

(f) The consent required by subsection (c) shall be deemed a waiver of the physician-patient privilege solely for the purpose of making the report pursuant to subsection (c).

Sec. 6. Upon referral pursuant to subsection (c) of section 5, the local health department shall offer service coordination to the pregnant woman and her family. The local health department shall coordinate social services, health care, mental health services and needed education and rehabilitation services. Service coordination shall be initiated within 72 hours of referral.

Sec. 7. A pregnant woman referred for substance abuse treatment shall be a first priority user of substance abuse treatment available through social and rehabilitation services. All records and reports regarding such pregnant woman shall be kept confidential. The secretary of social and rehabilitation services shall ensure that

provide educational materials published by the secretary of health and environment pursuant to section 2 to

who receive obstetrical or gynecological care from the health care provider

to assist

identifies a pregnant woman who is

woman

by reporting such woman's name

of health and environment within 5 working days.

Any health care provider complying with the provisions of Sections 4 and 5 shall have immunity from liability in any civil action that might result from the rendering of or failure to render any such services.

53

family oriented substance abuse treatment is available. Substance abuse treatment facilities which receive public funds shall not refuse to treat women solely because they are pregnant.

Sec. 8. The secretary of health and environment shall maintain a toll free information line for the purpose of providing information on resources for substance abuse treatment and for assisting with referral for substance abusing pregnant women.

Sec. 9. (a) Any physician or other health care provider ~~shall refer to the secretary of social and rehabilitation services child protective service families in which~~ [who determines that] a newborn child may have been exposed to a controlled substance listed in schedules I, II and III of the uniform controlled substances act or alcohol ~~as evidenced by:~~ [shall make a report pursuant to]

~~(1) Medical documentation of signs and symptoms consistent with controlled substances or alcohol exposure in the child at birth; or~~

~~(2) results of a confirmed toxicology test for controlled substances performed at birth on the mother or the child; and~~

~~(3) a written assessment made or approved by a physician, health care provider or by the department of social and rehabilitation services which documents the child as being at risk of abuse or neglect.~~

~~(b) Nothing in this section shall preclude a physician or other individual from reporting abuse or neglect of a child as required under~~ K.S.A. 38-1522 and amendments thereto.

~~(c)~~ [(b)] Upon notification pursuant to subsection (a), the secretary of social and rehabilitation services shall conduct a child protective service investigation and intervene according to regulations of the secretary of social and rehabilitation services based on the results of the investigation. Child protective services shall be initiated within 72 hours of notification. If the local health department was involved with the family during the perinatal period, the secretary of social and rehabilitation services and the local health department will coordinate provision of services to the family.

~~(d) Any health care provider complying with the provisions of this section, in good faith, shall have immunity from any civil liability that might otherwise result by reason of such actions.~~ [(c) Any health care provider complying with the provisions of this section shall have immunity from liability in any civil action that might result from the rendering of or failure to render any such services.]

~~(e)~~ [(d)] Referral and associated documentation provided for in this section shall be confidential and shall not be used in any criminal prosecution.

Sec. 10. This act shall take effect and be in force from and after January 1, 1993, and its publication in the statute book.

To: Senate Committee on Public Health and Welfare

From: Maureen Collins,
Planned Parenthood Federation of America

Amy C. Bixler,
National Organization for Women

Re: Joint Testimony in Conditional Support of
Senate Bill 532

Date: February 20, 1992

Chairman Ehrlich and Members of the Committee,

Planned Parenthood Federation of Kansas and Kansas N.O.W. come before you to offer their unified, but conditional, support of Senate Bill 532. We appreciate the concept and intent of this bill, and would propose only the following amendments.

Section 4 (page 2, line 2): After the word "patients", insert, "who intend to carry to term". Although controversial, abortion remains legal in this state, and this legislation should exempt abortion providers.

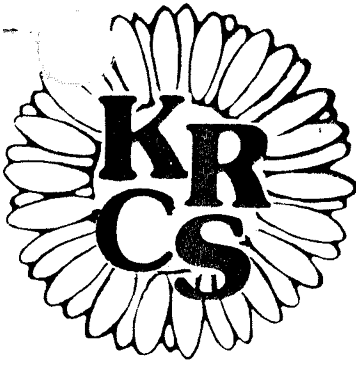
Section 4 (page 2, lines 5-9): Delete these lines. This entails unnecessary paperwork and only serves to police responsible practitioners who already provide this information.

Section 5 (page 2, line 20): After the word "Upon", insert, "written". This consent is an effectual waiver of the doctor-patient privilege; hence, any waiver of this magnitude must be in writing to protect all parties. This written waiver shall be on a form prepared by the Secretary of Health and Environment and shall contain all rights, privileges, and immunities provided for in this statute.

We commend the sponsors of Senate Bill 532 for taking a non-punitive approach to women facing pregnancy and addiction. No woman should shy away from substance abuse counseling for fear of prosecution as a result of harm to her fetus.

While this measure is admirable, it fails to address the real problem: access to prenatal care. Many poor women usually wait well into their pregnancies to see a physician, and this counseling may be too late for them. Let this be seen as a first step in an on-going effort to provide affordable health care for all women.

Senate P. H&W
attachment #6
2-20-92 P.M.



Kansas Respiratory Care Society

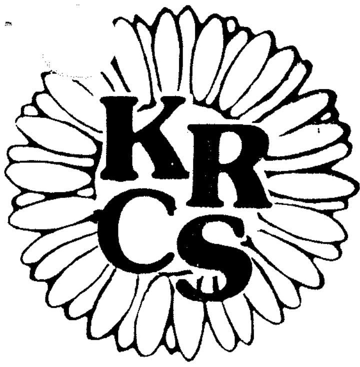
Testimony in Support of SB 532

I am sorry that I am unable to appear in person before your committee today in support of SB 532 because of work committments. It is with great enthusiasm that the KRCS lends its support to the purposes of this bill.

Because of the scope of our professional duties, we see first hand the results of the perinatal effect of tobacco use by the mother. It has been cited in several studies that the use of tobacco by pregnant women results in lower birth weights of babies as well as their having more respiratory and medical problems. Citing from the Report of the Surgeon General in 1989: "Smoking in pregnant women is associated with increased risk of miscarriage, stillbirth, and low birth weight infants, and retarded physical and mental development of offspring. Also Smoking Cessation before or during pregnancy can partially reverse the reduction in birth weight often caused by the mother's smoking habit. Pregnant smokers have more miscarriages, premature births, low birth weight babies, and babies who die early in infancy."

Because of these harmful health effects, the cost of health care is definitely increased immeasurably. I have given to Sen. Erlich a copy of the American Association of Respiratory Care booklet written in conjunction with the Federal Government about Smoking Cessation.Pages 51-58 list the resources available from different National health organizations which would be available through their State Affiliates here in Kansas. Utilization of these materials for use by the health care providers would be helpful in saving the State of Kansas money in preparing and printing of these materials.

Senate P.H&W
attachment #7
2-20-92 PM



Kansas
Respiratory
Care
Society

There would also be a saving of state tax dollars realized by providing these services to pregnant women as a percentage of them would quit smoking because of the improvement in their own health and that of their baby. Attached to this testimony you will find a list of some of the chemicals present in cigarette smoke. No thinking person would give their unborn child any of these directly but yet the baby receives them through smoking. The Kansas Respiratory Care Society commends the authors of this legislation and it is our hope that your committee will pass it so as to help the protection of both the child and the mother.

Respectfully submitted,

Cheryl DeBrot BS RRT

Cheryl DeBrot, B.S.R.R.T.

Chairperson, Legislative Committee

Kansas Respiratory Care Society

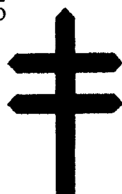
CIGARETTE SMOKE IS HARMFUL

CIGARETTE SMOKE HAS BEEN FOUND TO CONTAIN OVER 300 IDENTIFIED INGREDIENTS, SOME OF THESE ARE:

N I C O T I N E	A pack of cigarettes contains an amount of nicotine which, if given to a man in a single injection, would seriously injure and perhaps kill him.
A R S E N I O U S O X I D E	A form of arsenic.
C Y A N I D E	Gas used to execute criminals in gas chambers.
F O R M A L D E H Y D E	Powerful disinfectant gas; used as a surgical and general antiseptic and also as a preservative.
A M M O N I A	Alkaline gas.
C A R B O N M O N O X I D E	Favorite gas for people who want to commit suicide.
T A R	Condensate of tobacco smoke. Contains cancer causing carcinogens. The body will absorb an average 16 oz. of tar in one year from a pack of cigarettes a day.
N I T R O G E N D I O X I D E	Acutely irritating gas.
C A D M I U M	May damage air sacs in the lungs.

AMERICAN LUNG ASSOCIATION OF KANSAS
4300 Drury Lane, P.O. Box 4426
Topeka, Kansas 66604

(913) 272-9290



7-3

Because all children need someone who cares . . .

Kansas Action for Children, inc.

A non-profit, tax-exempt organization.

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TESTIMONY TO

SENATE PUBLIC HEALTH & WELFARE COMMITTEE

REGARDING: SB 532

I am Betty Glover, an MSW student at the University of Kansas, working this year with Kansas Action for Children.

KAC has long held the position that prevention is the best treatment; both in terms of scarce money and other resources being utilized, and in terms of long-lasting effects on the people involved. We recognize that there has been research which clearly shows that there are harmful effects associated with the use of alcohol, tobacco and drugs by pregnant women. This bill would provide that men and women are aware of those effects and provide for referral for services if requested.

KAC supports the provision of accurate information regarding the effects of the use of tobacco, alcohol and controlled substances by pregnant women. We urge you to report this bill favorably and believe this is a step forward in providing men and women with important information regarding the consequences of the use of alcohol, tobacco and drugs on the lives of unborn and newly born children.

Senate P.H&W
attachment #8
2-20-92 PM

KSNA
the voice of Nursing in Kansas

FOR MORE INFORMATION CONTACT:

Terri Roberts, J.D., R.N.
Executive Director
Kansas State Nurses' Association
700 S.W. Jackson Suite 601
Topeka, Kansas 66603-3731
(913) 233-8638
February 20, 1992

S.B. 532 AN ACT CONCERNING THE USE OF CERTAIN SUBSTANCES; PROVIDING FOR PUBLIC EDUCATION CONCERNING THE PERINATAL EFFECTS OF USING CERTAIN SUBSTANCES

Chairperson Ehrlich, and members of the Senate Public Health and Welfare Committee my name is Terri Roberts R.N. and I am a registered nurse in the state of Kansas and the Executive Director of the Kansas State Nurses' Association. Thank you for the opportunity to speak.

The Kansas State Nurses' Association endorses the concept and basic premise in S.B. 532. The issue of providing alcohol and drug treatment to pregnant women is a major health access issue on both coasts and we are beginning to see an increase in the number of pregnant women who are addicted to drugs and alcohol in our own state. Two years ago when KSNA officials attended national nursing meetings, the issue of "access" to drug treatment for pregnant women surfaced as a major issue. There was also attention from law enforcement agencies regarding probable criminal offenses for pregnant women who deliver "addicted" newborns. The debate that ensued amoung the nurses at the meeting was twofold:

Will pregnant women seek treatment if they are threatened with criminal prosecution for their addictive disorder?

What public policy will be in the best interest of the baby?
What public policy will be in the best interest of the mom?

Senate P. H&W
Attachment #9
2-20-92 PM

This bill will provide a proactive and positive step towards addressing an emerging problem. We are particularly pleased with the focus on the preparation of educational materials, the attention to preparing education materials and educating health professionals, and the statutory prioritization of treatment for pregnant women who enter alcohol and drug rehabilitation units. We support the imposing of a 72 hour time frame for the coordination of services by local health departments and the mandatory reporting provision to SRS child protection services for families in which a newborn child may have been exposed to a controlled substance or alcohol.

The specific requirement for an affadavit to be signed by all pregnant women treated by health professionals, and the creation of a new cause for action against licensees may be considered cumbersome and unneccessary. Health professionals who provide prenatal counseling should be routinely educating patients about the effects of these high-risk behaviors. The provision of educational materials and the educating of health professionals about the need to educate all pregnant women should be sufficient to change current practice.

We are hopeful that this bill is sincerely considered as an opportunity to reduce infant mortality and a positive step to addressing these issues.

Thank you for the opportunity to speak.

c:sb532