Approved May 6, 1992

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Senator August "Gus" Bogina, Chairperson, at 1:40 p.m. on May 4, 1992 in Room 123-S of the Capitol.

All members were present except:

Senators Brady, Harder and Salisbury

Conferees appearing before the committee:

Paul Klotz, Association of Community Mental Health Services
Mary Ellen Conlee, Wichita Hospitals
Chris McKenzie, Executive Director, League of Municipalities
Laura Kelly, Kansas Recreation & Parks Association
Lyndon Drew, Kansas Department on Aging
Jim Coder, Legal Counsel, State Fire Marshal

SB 674 - Moneys granted to area agencies on aging under Kansas senior care act.

Lyndon Drew, Ph.D., Department on Aging, appeared before the Committee in support of SB 674 and provided Attachment 1. He stated that if the suggested amendment was adopted (Attachment 1-2), the effect of the bill would be to change the Senior Care Act matching ratios just for the first year on new projects. He added that the program could be effectively implemented statewide to coincide with appropriations made in HB 2720.

The Chairman stated that he had visited with Secretary Hurst and was told that, according to a survey taken of the Area Agencies on Aging, local services would be reduced if the state passed SB 674 with the same level of funding.

In answer to Senator Gaines, Dr. Drew said that the Senior Care Act provides in-home services on a sliding fee scale to those persons who are not SRS eligible.

It was moved by Senator Feleciano and seconded by Senator Winter that **SB 674** be amended by section 1 of Attachment 1-3. The motion carried on a voice vote.

Senator Feleciano moved, Senator Winter seconded, that **SB 674** as amended be recommended favorable for passage. The motion carried on a roll call vote.

SB 770 - Concerning the local alcoholic liquor fund and disbursements made for parks and recreation programs and alcohol and drug abuse treatment programs.

Paul Klotz, representing the Association for the Community Mental Health Centers of Kansas, appeared before the Committee in support of SB 770 and presented the testimony of Bill Pursinger, Chief Executive Officer of the Kanza Health and Guidance Center, Inc. (Attachment 2).

Mary Ellen Conlee testified on behalf of the Wichita Hospitals in support of SB 770 and reviewed Attachment 3.

Chris McKenzie, Executive Director, League of Kansas Municipalities, provided and reviewed testimony in opposition to SB 770 (Attachment 4). Senator Gaines expressed concern about the domestic violence program in Butler County which receives funding from the Parks Department.

In response to item 4 of Mr. McKenzie's testimony, Senator Moran expressed concern about the involvement of SRS in the determination of how the money is used. In answer to Senator Kerr, Paul Klotz stated that there are a number of providers that are funded (not certified or licensed), but are controlled by SRS.

In answer to Senator Parrish, Mr. McKenzie stated that the total amount of

money distributed to cities and counties is $10.4 million annually.

Laura Kelly, Executive Director of Kansas Recreation and Parks Association, appeared before the Committee in opposition to SB 770 and reviewed Attachment 5.

In answer to a question, she stated that she believes there is a direct correlation between parks and recreation programs and the prevention and treatment of drug abuse. She noted that Menninger's recommended recreation intervention in the treatment of mental health, and that the mental health centers themselves refer clients to recreation programs for after care treatment.

Senator Feleciano recalled an audit of monies spent on drug and alcohol abuse programs that indicated substantial waste and cautioned against funding without further studying the issue.

Senator Rock noted two areas which he believed should be audited: the therapy program under Workmen's Compensation and drug and alcohol abuse treatment programs across the state.

It was moved by Senator Doyen and seconded by Senator Rock that **SB 770** be recommended favorable for passage.

Senator Moran offered a substitute motion which was seconded by Senator Parrish to amend **SB 770** by striking the language on lines 42 and 43 of page 2 and lines 34, 35, and 36 of page 3 and by reinserting the stricken language. Senator Kerr expressed concern that the substitute motion would result in more money going to poor treatment programs. The substitute motion failed on a voice vote.

The primary motion to report **SB 770** favorable for passage carried on a roll call vote.

It was moved by Senator Kerr and seconded by Senator Feleciano that the Senate Ways and Means Committee request a Post Audit report and an interim study on the therapy programs under Workmen's Compensation and the drug and alcohol abuse treatment programs across the state. The motion carried on a voice vote.

HB 3198 - State fire marshal, registration and certificate programs under Kansas fire prevention code, fee, fee fund.

The Chairman explained that HB 3198 was recommended by a House subcommittee to permit the production of and establish a fee structure for the production of fireworks. Proposed amendments to the bill (Attachment 6) were reviewed by Jim Coder, Legal Counsel for the Fire Marshal's Office. The Committee reviewed the annual maximum fees designated on page 1 of the bill.

It was moved by Senator Gaines and seconded by Senator Doyen that **HB 3198** be amended by the technical adjustments contained in Attachment 6 and by reducing the maximum fees as follows:

1. explosive blaster permits, not more than $100 per year;
2. explosive user permits, not more than $100 per year;
3. explosive site permits, not more than $100 per year;
4. bottle rocket manufacture permits, not more than $500 year
5. fireworks manufacture permits, not more than $500 per year;
6. public fireworks display operator permits, not more than $50 per occurrence;
7. registration of businesses installing or repairing fire detector systems, not more than $300 per year; and
8. registration of businesses installing or repairing fire sprinkler systems, not more than $300 per year.

The motion carried.

Senator Gaines moved, Senator Rock seconded that **HB 3198** as amended be recommended favorable for passage. The motion carried on a roll call vote.

The Chairman adjourned the meeting at 2:50 p.m.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE: May 4, 1992

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
LAURA KELLY	TOPEKA	KS Rec & Park Assn
Chris McKenzie	"	Lg. of Ks. Mun.
Cathy Holderman	Wichita	City of Wichita
Jim Crawford	Topeka	KDOR
Jim Coder	Topeka	State Fire Marshal
LISA Getz	WICHITA	WICHITA Hospitals
Mary Ellen Conlee	Wichita	Wichita Hospitals
Pamela M. Kilroy	Topeka	Assn of CMHC's Ks, Inc.

Testimony on SB 674
Senior Care Act Match

before the
Senate Ways and Means Committee
May 2, 1992

by the
Kansas Department on Aging

Mr. Chairman and members of the committee, the Kansas Department on Aging appears today in support of the proposed amendment to SB 674. The Senior Care Act has succeeded in providing home care services to hundreds of older Kansans during the last two and a half years. However, a change in the Senior Care Act matching ratios is necessary to effectively expand the program statewide.

The Legislature has voted funding to make the program available statewide. The committee report on the KDOA budget recommended a reduction of the $1 for $1 local match requirement to $2 state dollars to every $1 of local funds. The report recognized that some areas of the state would have trouble raising enough local money to match a program.

Local mill levies for aging services are capped as a part of the 1990 Property Tax Lid Law; therefore, local increases in aging mill levies can only come at the expense of other services. A bill (SB 501) has been introduced and heard in the Senate Assessment and Taxation Committee to remove the aging mill levies from the aggregate tax limit; the Senate amended the language of this bill into HB 2738.

In 1990, the Senate unanimously approved SB 567, which would have allowed the Secretary of Aging flexibility in setting the matching ratio. Unfortunately, that bill died. We now foresee, by the House committee's action, a new fate for SB 674.

KDOA recently conducted a survey of the Area Agencies on Aging, asking what match each could provide to bring the Senior Care Act into their area. Most AAA's were hesitant to provide concrete figures; AAA Directors expressed the reservation that many bills in the legislature would have an impact on their ability to raise local funds. Uncertainty of what the final match ratio would be left county commissions vague about their commitment. The current dollar-for-dollar is seen as too great a burden; both counties and Area Agencies on Aging prefer the one local to three state dollar match originally contained in SB 674. However, all areas found they could provide match to begin projects in their areas at the 1-2 level.

Previous experience with the three pilot areas has shown that once projects start in an area, the counties generally continue or increase their support. However, we have also found that there are

SWAM
May 4, 1992
Attachment 1

cases where the increasing pressures on the source of local funding, especially county health departments, is threatening the area's ability to match.

The three existing pilot projects had 1 dollar local , 3 dollars state funding ratios in their first year, and went dollar for dollar in the succeeding years. The amendment proposed would give the new projects a year to get started before the dollar-for-dollar match took effect.

Our common goal is to reduce the premature institutionalization of our older Kansans. This bill as amended helps that process succeed.

Senate Bill No. 674
Amendment

Section 1. K.S.A. 75-5929 is hereby amended to read as follows: 75-59029. (a) After July 1, ~~1990~~ 1993, all funds granted to an area agency on aging under this act shall be matched with funds from other than the federal or state government on a dollar for dollar basis. Before July 1, 1993, all funds granted to an area agency on aging under this act shall be matched with funds from other than the federal or state government on a dollar for dollar basis except for funds granted to an area agency on aging receiving funds for the first time after July 1, 1992; such funds shall be matched with funds from other that the federal or state government ~~on a dollar for dollar basis~~ by one matching dollar for every ~~three~~ two state dollars. Client fees may be used to meet this requirement. Funds shall only be granted to area agencies on aging based on plans approved by the secretary.

Honorable committee members, my name is Bill D. Persinger, Jr., and I am the Chief Executive Officer of the Kanza Mental Health and Guidance Center, Inc. located in Hiawatha, KS.

I am before you today to encourage you to enact SB 770. This piece of legislation will help align public funding with public policy. That is, we're all committed to reducing the devastating effects of chemical abuse on our society, but we must also provide the resources required to effect such a policy.

Most Kansans would identify alcohol and drug abuse as our number one societal problem. It is also a major economic problem: Alcohol and drug abuse cost this state and its citizens nearly one billion dollars per year. Health problems, child abuse, poor work performance, law enforcement, crime and punishment, traffic fatalities, and the demise of the family are some of the elements comprising that figure.

SB 770 directs alcohol and drug funds to programs which are proven in their ability to improve lives. I have provided you with research conducted by the Kansas Dept of Social and Rehabilitation Services, Division of Alcohol and Drug Abuse, which demonstrates that treatment and prevention work. Your dollars are well spent on programs licensed by the division.

SB 770 not only directs such spending, it increases such spending, but does so without raising one additional dime in taxes. The money has been raised for over a decade, but has not been spent on prevention and treatment programs to the degree that is detailed in SB 770.

Those dollars which are raised through the liquor tax should return to the communities and the counties in which they were actually generated. Further, those funds should be spent on alcohol and drug programs. These programs are effective and accountable.

For every dollar you spend on effective alcohol and drug programs in Kansas, you will save $11.54 in costs associated with the various social problems noted above.

If I may, I'd like to direct your attention the attachments you have before you. They demonstrate that treatment and prevention do indeed work.

Thank you for your consideration of my testimony. I will gladly answer any question.

SWAM
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Attachment 2

THE KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES EVALUATES THE BENEFITS OF TREATMENT

The Department of Social and Rehabilitation Services, Alcohol and Drug Abuse Services (ADAS) evaluates the outcome of treatment for clients six months after they have completed treatment. Clients served in these state-funded programs are reporting improvement from admission to follow-up.

Quality treatment shows improvement with sobriety, employment, living arrangements or housing, better family functioning, legal issues and education.

Information from a twenty percent sample of client admissions indicates the following in fiscal year 1990:

Alcohol and Drug Consumption Decreases
43.6 percent were abstinent from alcohol for at least four months following primary treatment.

45.5 percent were abstinent from other drugs for at least four months following primary treatment.

Less Legal Involvements
Persons reporting no arrests in more than six months increased from 41.2 percent at admission to 52.7 percent at follow-up.

Better Employment Opportunities and Functioning
67.3 percent were employed at follow-up while only 57.6 percent had been employed at time of admission.

56.4 percent of those employed were satisfied with their work. Only 42.3 percent had been satisfied at admission.

78.2 percent reported good to excellent on their ability to handle problems. This is an improvement from 55.4 percent at admission.

General enjoyment of life improved for these clients from 64.2 percent at admission to 72.8 percent at follow-up.

The portion seeing their family as a source of support increased from 79.2 percent at admission to 81.9 percent at follow-up.

Recovery from alcohol and drug addiction requires more than not drinking or using drugs. Learning how to live a meaningful life without drugs is the primary goal. Recovery requires a person to resolve family, work, spiritual, and social problems that were created by addiction--one day at a time.

PREVENTION WORKS

Nationally, fewer people are starting to use alcohol and other drugs and, of those who have started, more are stopping. Alcohol and other drug prevention and treatment programs are intended to maintain these declines and, if possible, accelerate them.

Prevention is a pro-active process to create conditions and/or develop personal skills to reduce alcohol and other drug abuse. Alcohol and other drug problems have multiple interrelated causes resulting from the interaction of the individual, the drug and the environment. A variety of prevention approaches must be developed and coordinated across community agencies and organizations. Research indicates that a combination of the following six strategies are the most effective in preventing alcohol and other drug abuse:

-Accurate information

-Life skills development

-Drug-free alternatives

-Social policy development

-Community mobilization

-Intervention programs

Alcohol and other drug prevention programs target the whole population, but focus primarily on youth and adolescents. Prevention emphasizes zero tolerance of illicit drug use by all persons and the use of alcohol by youth.

THE KANSAS PREVENTION EVALUATION PROJECT

In 1986, the Kansas Department of Social and Rehabilitation Services, Alcohol and Drug Abuse Services (ADAS) began grant funding for a project to monitor the frequency of alcohol and other drug use, among Kansas 5th through 12th grade students, and to evaluate what works best in prevention. The project, conducted by Dan Schulte, M.A., DCCCA in Lawrence, Kansas, evaluates data from one-third of Kansas's 5th through 12th grade students. The study examines the amount of alcohol and other drug abuse with the level of prevention activity occurring in both schools and communities.

The data highlighted in this publication is from a three year state-wide survey of Kansas students. The 1990 survey included approximately 70,000 students.

The Kansas prevention study indicates an overall decrease in alcohol and other drug use by Kansas students, and prevention activities are key to this decrease.

PREVENTION IS WORKING

Schools that implement a high level of alcohol and other drug prevention strategies show less students using alcohol and other drugs than do schools that use few or no prevention strategies. Studies have shown these successful strategies include:

* Establishing a specially trained school alcohol and other drug prevention team of educators and community members.

* Ensuring the involvement of the schools principal in the drug prevention team.

* Presenting in-services on drug education to all school staff members.

* Establishing a drug prevention curriculum for students with policies against alcohol and other drug use by students.

* Conducting frequent drug prevention team meetings to design and evaluate prevention activities.

* Conducting a variety of student anti-drug programs.

* Involving parents in the school's drug abuse prevention program.

* Including alcohol and other drug abuse prevention and treatment professionals in the schools' anti-alcohol and other drug prevention programs.

* Providing additional training for the school drug prevention team members.

* Evaluating the school's impact on student alcohol and drug knowledge, attitudes, and use.

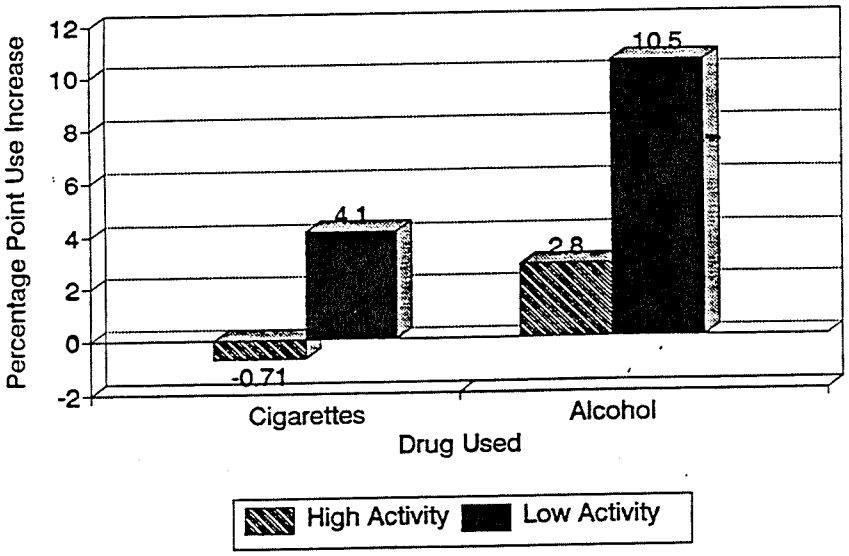
Results have been consistent. The more prevention activities used, the greater the effect.

Elementary Schools

Schools with a high level of prevention activities reported 4.8 percentage points less use of cigarettes than schools with little or no prevention activities.

Schools with a high level of prevention activities reported 7.7 percentage points less use of alcohol than schools with little or no prevention activities.

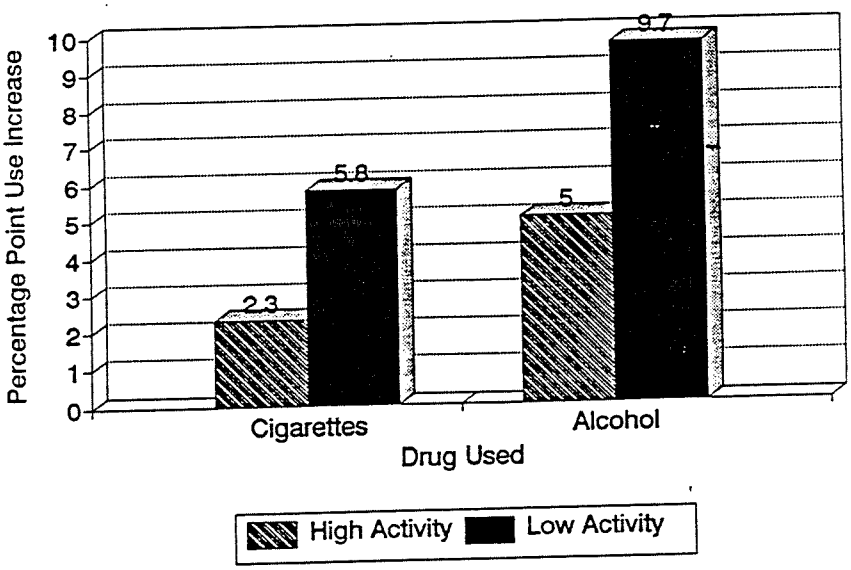
High Activity vs Low Activity Schools
Elementary Schools 1990



Junior High Schools
Schools with a high level of prevention activities reported 3.5 percentage points less use of cigarettes than schools with little or no prevention activities.

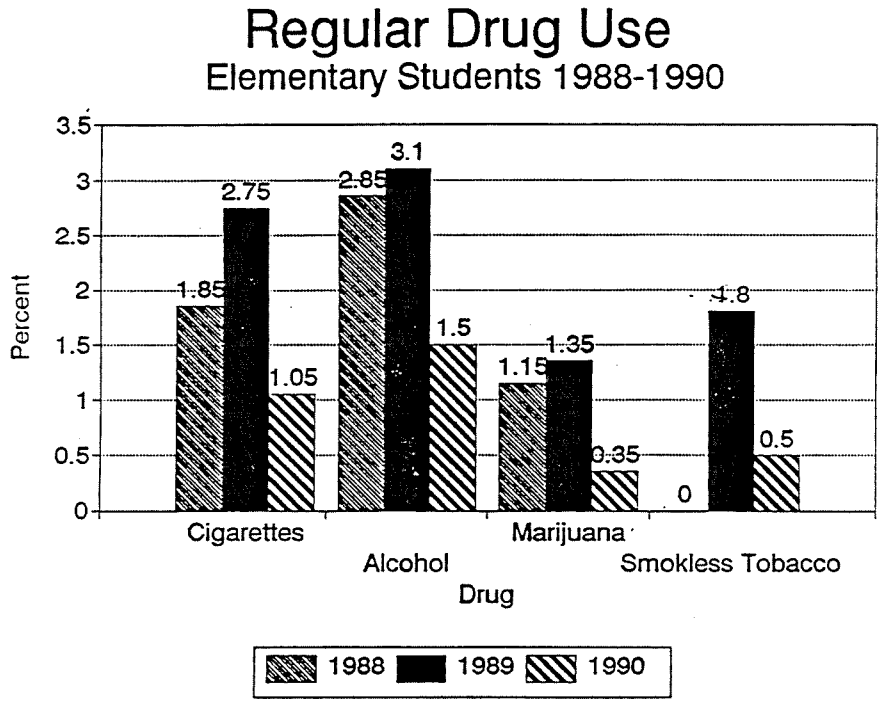
Schools with a high level of prevention activities reported 4.7 percentage points less use of alcohol than schools with little or no prevention activities.

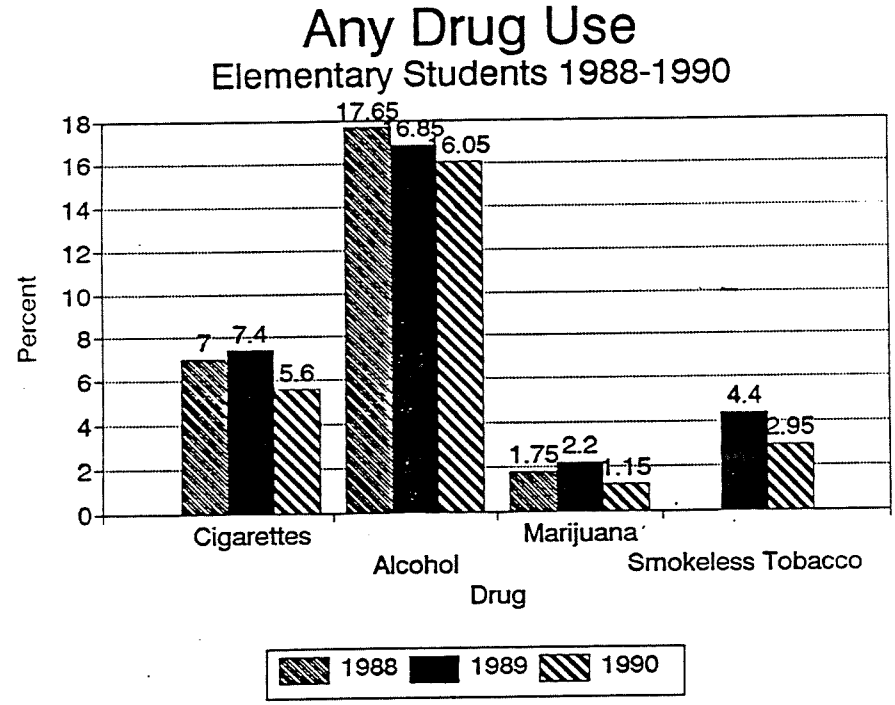
High Activity vs Low Activity Schools
Junior High Schools 1990



ANY USE OF DRUGS AND REGULAR USE OF DRUGS DECREASES OVERALL AT THREE GRADE LEVELS

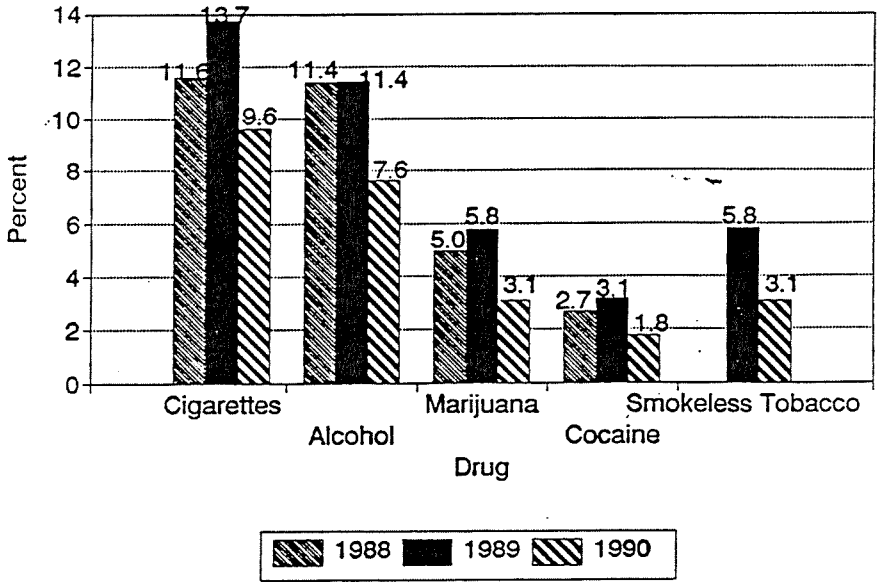
Regular use is using alcohol or other drugs on a weekly to daily basis. Any use is using alcohol or other drugs yearly or more frequently.





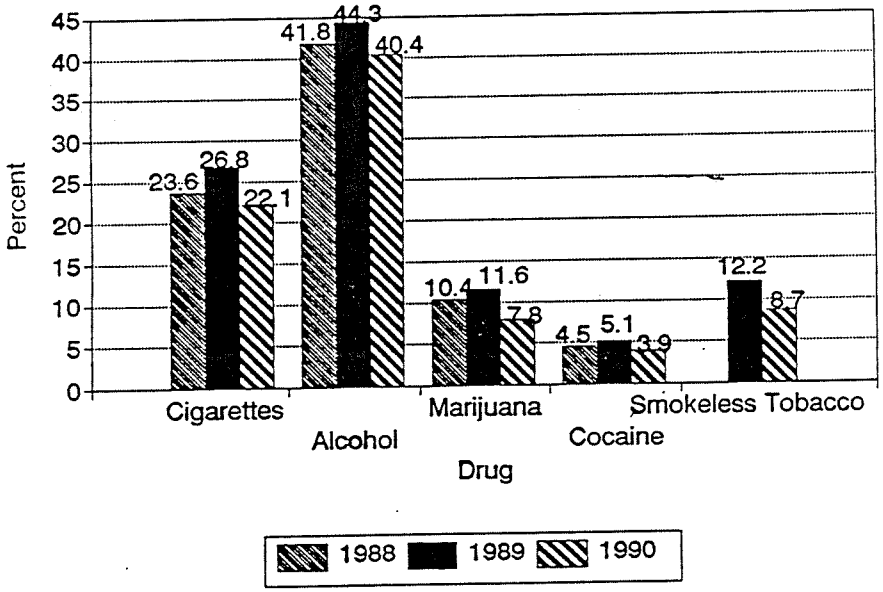
Regular Drug Use

Junior High Students 1988-1990



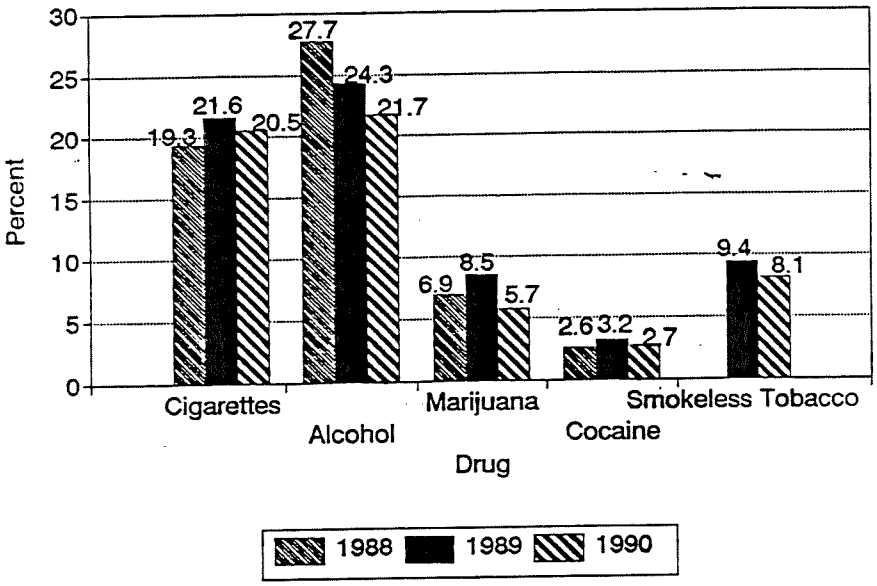
Any Drug Use

Junior High Students 1988-1990



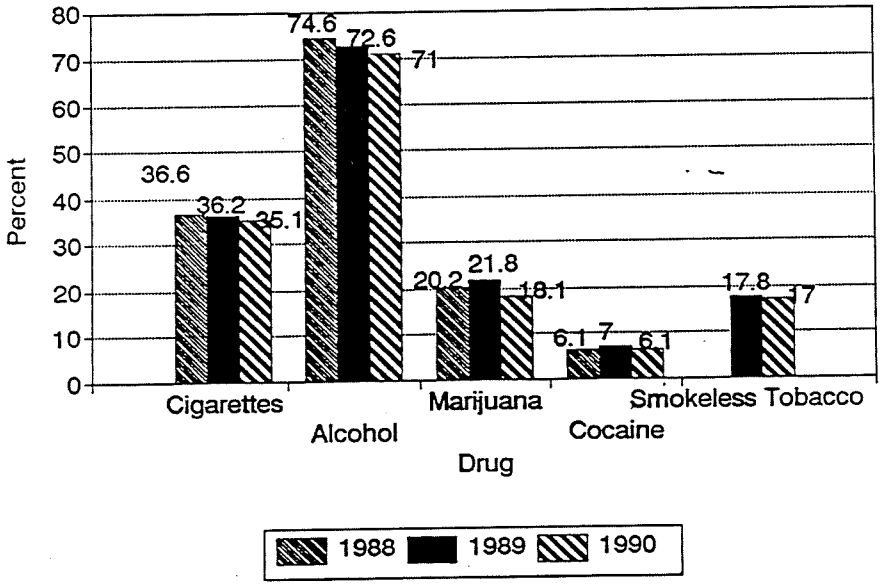
Regular Drug Use

High School Students 1988-1990



Any Drug Use

High School Students 1988-1990



CONLEE
CONSULTING
GROUP

TESTIMONY BEFORE SENATE WAYS AND MEANS

May 2, 1992

Chairman Bogina, members of the committee, I am Mary Ellen Conlee, representing the Wichita Hospitals in support of SB 770. In 1991, the Wichita Hospitals participated in, and provided the major funding for, a community coalition study to evaluate how Sedgwick County treats substance abusers who are acting out. We looked at where they're taken, what's involved in getting them there, what their immediate needs are, what it costs to provide treatment in different settings, and how other communities in Kansas (and beyond) are finding alternative methods of care other than expensive emergency room settings.

The coalition concluded that the substance abuser in crisis was being cared for in the most expensive setting at a high cost to Medicaid, the Police and Sheriff's Departments and to the Wichita Hospitals.

As a result of the study, it was determined that a 10-bed secured 24-hour emergency detox facility would be more cost effective and would provide more appropriate treatment for these patients. Without any identified source of funding, the group requested proposals from the licensed alcohol and drug abuse providers and from Sedgwick County Mental Health. Recovery Services Council (RSC) and Parallax responded with proposals in the $600,000 - $700,000 range. Without a source for such funding, the project is on hold. In the meantime, the executive board of the coalition is seeking ways to reduce the cost of the detox project by integrating it into an existing program site.

Bottomline: we support SB 770 because it would increase funding for programs that keep inappropriate emergency room utilizations down, by redirecting patients in need of detox services to a more cost effective setting.

Attached are a memorandum describing the substance abuse treatment dilemma in Wichita that led to the creation of the coalition, and, the 3/15/92 page one Wichita Eagle article dealing with the broad issue of the emergency room crisis in Wichita.

SWAM
May 4, 1992
Attachment 3

Governmental Relations and Public Affairs Consulting

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M E M O R A N D U M

A coalition representing the Wichita hospitals, The City of Wichita, Sedgwick County Mental Health, UKSM-W, The Alliance for the Mentally Ill (AMI) and the psychiatric community has determined the need to divert certain substance abuse patients away from hospital emergency rooms to a secure screening center capable of holding this difficult population in need of detoxing.

An evaluation of the current system in Sedgwick County reveals a need to create a community site, a 10-bed secure detox facility, for patients with limited or no resources and short-term acute treatment need. The facility would serve as the front door for patients who fall between the categories of those needing CD in-patient medical care and those needing social detox beds. Patients would be admitted for a period up to 4 days for observation, assessment, medical stabilization and referral. The goal is to take pressure off the emergency rooms while maximizing cost-effective utilization of police and provider services in the community.

One outcome of this system reform will involve reestablishing police guidelines on CD crisis intervention. A recent police department survey reveals that 42% of the officer respondents indicated they spend an average of 2-3 hours at the emergency room every time they bring patients in for CD related care (due to lower priority by comparison to medical traumas). Aggregate hospital emergency room figures indicate that in the 30 months from January of 1989 to July of 1991 the police brought an average of 75 CD/dual diagnosis patients a month into ERs. Redirecting the police to a front door facility for many of these cases presents an opportunity to reduce police time involved in the stabilization process by more than 2/3.

In order to be economically sound, the concept of a 10-bed secure detox facility requires public awareness be raised to a point where families as well as police recognize this as a place to bring the out-of-control family member experiencing CD related symptoms.

Patient care at this facility would follow general protocols: crisis stabilization, evaluation, disposition to the appropriate next step. Although counseling at the facility will attempt to transition the detox patient to an intermediate care program, it is recognized that rehabilitation is contingent on program availability and patient cooperation.

The coalition is seeking proposals for a secure, 10-bed clinically competent model (medically supported) that meets all applicable licensing requirements pursuant to SRS regulations for a detox facility including; Chapter 9 / Referrals, Chapter 15-1 / Emergency Acute Care Treatment, in compliance with Food Service

and Lodging Licensure and State Fire Marshall Inspection. The proposed unit could be publicly or privately run, could be an add-on to an existing health care delivery model and could be a joint effort between staffs including UKSM-W residents.

The coalition is dedicated to assisting in the pursuit of seed money and operations funding for this project through local, state and federal units of government. No funding authority is yet established.

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DAYBREAK
Sending the wrong message?
The debate over pop culture/ **1E**

CITY & STATE
It's up to you
What's at stake in April 7 recall vote on Thorp/ **1B**

Your Vote Counts

SPORTS
No need to ... KU has a lo... on No. 1 se...
Jayhawks whip S... face OSU in fina...

SUNDAY
March 15, 1992
The Wichita Eagl...

More than 34 million people in the United States – 230,000 of them in Kansas – do not have medical insurance.

In 1991, Wichita hospitals wrote off $33.2 million in bad debt and charity care.

Statewide, Kansas hospitals write off more than $100 million a year.

Annual premium increases for private insurance companies are averaging more than 20 percent a year, three times more than the national inflation rate.

"Our volume is such that it tends to be borderline harried all the time. You actually lose some ability to judge whether it's an emergency or not."
Dr. Marty Sellberg,
St. Joseph Medical Center

"Our country can't afford the care I can give them, and I don't know where we go with that."
Dr. Daniel Caliendo,
HCA Wesley Medical Center

If the system worked and the emergency room only treated emergency patients, "I wouldn't need 25 to 30 percent of my staff."
Kathryn Conley, emergency room administrator,
St. Francis Regional Medical Center

A state of Emergency

Kellie Dockers is one of the tens of thousands of people using Wichita emergency rooms for their primary medical care. Some of those people abuse the system, some do not know any better, and some — like Dockers — simply have nowhere else to go. All the while, your costs for medical treatment and insurance premiums continue to rise. Discover why your nearest emergency room is in worse shape than many of the patients who are using it.

Pages 10A to 12A

Articles by Thomas B. Koetting

Photos by Fernando Salazar

A state of Emergency

Hospitals inundated with thousands left out of health care system

By Thomas B. Koetting
The Wichita Eagle

The most alarming image in Wichita emergency rooms is probably not the screaming drunk at St. Francis Regional Medical Center who runs up $1,000 in bills every few days without a prayer of paying them.

Nor is it the middle-aged woman who rides an ambulance to Riverside Hospital once a week primarily because she wants attention, and then berates staff members if they do not give her cab fare home.

Nor is it even the people with minor problems who stream over to HCA Wesley Medical Center for treatment when trauma patients arrive by helicopter just because they want to watch the commotion.

Instead, the most alarming image may be the fatigued, 22-year-old figure of Kellie Dockers, her sick 18-month-old son clinging to her chest, self-consciously asking a family practice resident in the St. Joseph Medical Center emergency room one quiet, simple question:

"How do you ... um ... pay ... um ... how do you work the money?"

The worker's answer might determine whether Dockers makes a follow-up visit to the hospital's family clinic. She already cannot pay the emergency room bill, and she may not be able to afford a prescription for her son's ear infection until payday. A visit to the clinic, which the doctor strongly advises, is out of the question if it requires money up front.

"All the way over to the hospital I think about what I'm going to say," she says later. "I even ask for (prescription) samples. It's humiliating."

Dockers is one of the tens of thousands of people using Wichita emergency rooms for their primary medical care. Some of those people abuse the system, knowing it's the one place that cannot legally turn away a patient, and some do not know any better. Some — especially the approximately 12 percent of the area's population without medical insurance — are like Dockers and simply have nowhere else to go. All the while, expenses for hospitals, insurers and patients continue to rise.

As a result, the emergency room system is in worse shape than many of the patients who are using it. And the trend is not just in Wichita, but across the nation. Good emergency room medicine, everyone seems to agree, is practiced in spite of the system, surely not because of it.

"It can't go on," says Fred Lucky, vice president of finance for the Kansas Hospital Association. "In five years, you're not going to see the same system you have now. The political system and the economic realities will force a change."

In the past five years, emergency room visits at Wichita's four hospitals have increased 25 percent, far outpacing the 3 percent increase in both hospital admissions and the Sedgwick County population. And although an emergency room operation may seem small when compared to an entire hospital operation, budget officials say its financial performance is significant.

At St. Joseph, for example, the emergency room's net revenue for 1991 was $1.7 million, with expenses of $2.5 million. The hospital lost $800,000.

"We're the ace in the hole, we're the stopgap, and if you can't go anywhere else, you go to the emergency room," says Daniel Caliendo, Wesley emergency room medical director.

Part of the new emergency room volume is made up of an increasing number of acutely ill patients, a trend attributable to a population that is aging and more violent. The median age in the Wichita area has increased 7 percent in the past 10 years and 2 percent in the past five, and the incidence of crime involving bodily harm has increased 11 percent in the past 10 years and 17 percent in the past five. In emergency rooms, that means more heart attacks and gunshot wounds.

But that trend, however disconcerting, at least falls under the traditional purview of emergency room work. It is the other part of the volume increase — the patients needing primary care who really should be seeing family doctors — that presents the larger problem.

"The trauma cases are what we're here for," says Kathryn Conley, administrative director of emergency services for St. Francis. "That's what we're trained to do and, although it sounds kind of sick, that's what ER nurses like to do. They're not here to take care of runny noses; they didn't want to become ER nurses to do that. They want to get that adrenaline rush and take care of sick people."

An informal survey last month for The Wichita Eagle helps illustrate the situation. For three days — a Sunday, Monday and Tuesday, which hospital officials say was representative — emergency room workers tracked how many patients had true emergency medical problems. They found that 44 percent of the patients at St. Francis, 26 percent at Riverside, 17 percent at St. Joseph and 2 percent at Wesley failed to meet their criteria.

And surprisingly, they think those numbers are extremely low, and that the St. Francis percentage is more the rule than the exception. Wesley officials, for example, have seen a dramatic drop in patients seeking primary care in their emergency room because construction has made access a little difficult.

Many have no insurance

The problem with non-emergency patients is blamed at least in part on economics.

Annual premium increases for private insurance companies are averaging more than 20 percent a year, three times the inflation rate. And although the local economy is relatively healthy — disposable income in Sedgwick County has been rising and the unemployment rate consistently lags behind national levels — an increasing number of company work forces are made up of part-time or contract workers who do not receive medical insurance through their employers.

About 50,000 people in Sedgwick County do not have medical insurance — about 12 percent of the population. Kellie Dockers' family is part of that statistic.

In early 1989, already the mother of a baby girl named Misty, Dockers became pregnant with her second child. At the time, she lived in Pratt with her husband, Brian, and the family received medical coverage through his job as a millworker. But Brian Dockers lost his job, the family moved to his parents' home in Wichita, and when the fetus was diagnosed with heart disease and Turner's syndrome — a chromosomal abnormality — the couple began running up enormous medical bills.

Jennifer Dockers was born on Sept. 15 and lived nine days. Her mother still has trouble setting foot in the hospital where Jennifer died.

She also has trouble putting together details of the family's insurance situation. Their Texas-based insurer, which had continued coverage for a while after Brian Dockers' job loss, balked at paying the bills. And Medicaid, which the couple thought would at least pay their deductible expense, did not apply.

"To be honest, I'm kind of fuzzy on the details," she says. "We were grieving the loss of our daughter, it was a rough time just holding the family together, and we didn't have the energy to figure it all out."

To this day, the Dockers are not entirely sure what — if anything — was ever paid. They were hounded for a while by collection agencies asking for $250,000, and they still occasionally get an envelope filled with bills in the mail. They just throw it away.

Brian Dockers worked for a while at a gas station, and now works as an apprentice electrician at Miller Electric in Derby. He and his wife have enough money for an apartment, a car and a baby sitter for Misty and their third child, 18-month-old Nickolas.

But medical coverage? That has been too far a reach.

Instead, they relied on a doctor who never pushed for money to help with prenatal care before Nickolas' birth. And for everything else, they have used home remedies and emergency rooms, either paying what little they can on the bills or dodging them. They cannot even call the hospitals' health advice services, because they don't have enough money for a telephone.

One family's hope

A few weeks ago, Kellie Dockers was hired by Kansas State Bank and Trust, and she hopes medical insurance through her new job will kick in by summer so the emergency room visits can come to an end.

"To give you an idea of how important health insurance is, my salary goes for the baby sitter and my gas," says Dockers. "When that's done, I have $10 left. My husband told me, 'I don't care how much you make as long as you get medical care.' "

Dockers' situation, although particularly poignant, is not unusual.

Yolanda White, who lectures to school groups about teenage pregnancy, says numerous people in her audiences are in Dockers' situation, and teenage mothers in particular often take one of two paths: using the emergency rooms for primary care and ign[illegible] bills, or not getting their [illegible]rimary medical care at a[illegible] do not use, or do not bother to find out about, low-cost health clinics that might help.

"Some people are too lazy to do it," says White, an 18-year-old mother of two children. "That sounds stupid, but they're too lazy to get up and take their babies to the doctor. Something else is more important."

Drive-in health care

White does not give it a name, but her comment touches on what emergency room workers call the "McDonald's syndrome."

They believe that in a highly mobile society obsessed with two-minute dinners and two-week crash diets, the idea of developing a long-term relationship with a single physician has become antiquated. Everything from the limited office hours of family doctors to the rise of huge, impersonal clinics has aggravated the situation.

"They want McDonald's in health care," says Ronda Lusk, a St. Joseph emergency room nurse. "They want drive-in health care."

As she speaks, one patient after another arrives at the emergency room and unwittingly bolsters her observation. They describe their problem, give the name of their insurer and then draw a blank when questioned about their physician, often having to give phonetic spellings or play "It sounds like ... " guessing games with the admitting nurses.

Those nurses, and the doctors who work with them, resent the "drive-in care" mentality.

Kathy Prilliman, emergency room manager at Riverside, remembers a mother who showed up with five children, told the nurses that one son had influenza so they all needed to be checked, and then announced that she had to be at work in an hour so she expected immediate service.

"When people are judging you by a standard that you do not buy into, then that gets to be really stressful," Prilliman says. "They're expecting you to do something that is entirely unreasonable, and you want to tell them, 'That's not what I'm here for and it's not what the system is here for, and you're just going to have to wait.' "

So what is the effect of all those flu patients and others seeking primary care?

Emergency room workers have virtually given up on the idea that they will ever again be reserved only for unusual medical events.

"The emergency room is all those things it started out being, and all those things that keep getting added to it," says Conley. "It's absolutely everything in the medical care system that isn't handled somewhere else or slips through the cracks. And it includes things that slip through cracks outside the medical care system."

That means that on one night, Conley's staff might counsel the naive mother who gave her baby raspberry Kool-Aid, then thought the child was bleeding to death when it came out the other end.

On another night, they might check out the old man with no medical problems who was dumped off by angry police after a stakeout turned into an embarrassing mistake. A prostitute had called to report she was being held hostage; in fact, she was simply angry at the man because he fell asleep without paying, and she wanted to get him in trouble.

"Anything that nobody knows what to do with, they bring to the

See PATIENTS, Page 12A

PATIENTS

From Page 10A

emergency room," says Conley.

As for the cumulative effect of all those cases, doctors and nurses reluctantly acknowledge that in running what sometimes comes close to a social service agency, health care suffers.

They are not necessarily talking about misread X-rays or incorrect prescriptions. Instead, they are talking about being harried all the time, and running the emergency rooms like factory assembly lines. They are talking about seeing patients who need a continuum of care, and knowing that they cannot possibly provide it. And they are talking about developing what St. Joseph emergency room doctor Marty Sellberg calls "an edge," an attitude toward patients of us-against-them that can't be soothed in the five minutes they have to develop a rapport and make a diagnosis.

"I think this is a job that it's easy to start feeling negative about society because you see a lot of the underprivileged," says Conley. "Now, not everyone that comes to the emergency room is this way, but you see a lot of people with very low intelligence, with no resources, that are abusive to themselves or others. You see the victims of their abuse and you see a lot of lowlife. After a while, you start thinking, 'Is there nobody with an average intelligence in Wichita?' After a while, you think, 'I just can't take one more drunk throwing up on me.' That's where the burnout comes from."

Few health care officials have a sense of how to address the situation, beyond saying that people perhaps incorrectly believe that quality medical care is a right, not a privilege, and that the current system will not be able to fulfill that belief much longer.

"The emergency room is ... absolutely everything in the medical care system that isn't handled somewhere else or slips through the cracks.."

Kathryn Conley, St. Francis emergency services

But Pat Hall, emergency room patient care director at St. Joseph, says the first step may be realizing that doctors and nurses focus so much energy on meeting legal, insurance and paperwork requirements that the needs of their patients can become shrouded.

For example, Hall says a woman recently came into her emergency room in the middle of the night with a baby, saying it was sick and crying constantly. Nurses saw the baby was healthy, and realized it was the mother who was indirectly crying out for help, apparently unable to handle the demands of motherhood and perhaps fearing she would abuse the baby.

What the woman needed, Hall says, was not expensive medical treatment. She needed someone to talk with her, perhaps a nurse who could discuss the woman's baby and her home life, and put her in touch with some helpful community resources. Under the current system, with doctors often performing tests and dispensing medicine just to protect themselves against malpractice lawsuits, that kind of response is difficult.

"The most stressful part of the job is knowing that you're not meeting the needs of the patient," says Hall. "The problem, the real stress, is never medical."

That kind of approach — any kind of new approach — would be appreciated by the doctors, nurses and patients who see the frustration and the stress in emergency rooms firsthand. It also might end up helping some of the students who hear White speak. And perhaps, it might even help Kellie Dockers.

She and her husband spent four days giving Nickolas cool baths and ear drops to reduce his fever and soothe his ear infection before finally giving up and heading to the St. Joseph emergency room. Twice in the last six months, they waited so long that Nickolas developed pneumonia.

"The last thing my husband said when I walked out the door was 'Don't let them give you the most expensive prescription,' " she says.

A few hours later, family practice resident Ray Woodmansee gave her a prescription and pressed for a follow-up visit with him at the family practice clinic. He answered her money concerns by saying the clinic would find a way to accommodate the family's situation.

Dockers filled the prescription but never made the follow-up visit. She still had concerns about whether they would push her for money, and the clinic's limited hours conflicted with her work schedule.

Instead, less than a week later, she took Nickolas back to see a doctor because the boy still seemed sick. And she went to the one place where people may shake their heads in frustration, but never say no.

She went back to the emergency room.

Doctor's shift a mixture of minor cuts and death

By Thomas B. Koetting
The Wichita Eagle

Emergency room doctors love using the M*A*S*H television show analogy to describe their work: A shot of chaos with a near-death chaser and hold the emotion, thank you very much. Oh, and did you hear about the blonde in Room 6?

"For most things, we have a defense mechanism, and we joke about things we shouldn't joke about," says Daniel Caliendo, emergency room medical director at HCA Wesley Medical Center. "And it's not because we're making fun of it; it's because we need a way of dealing with it. It's a Hawkeye Pierce way of handling your stress. If you let every case get to you, you'd get out of the field and you'd go up in the psych ward, I guess."

The emergency room world is small. Most of the doctors and nurses in Wichita know each other, and their bond often transcends hospital affiliation. Mention Daria Davidson's name to a nurse at St. Joseph Medical Center, for example, and he nods and says, "She's good, she's very good," even though she does not work there.

This is one of her typical shifts:

1 p.m.

Davidson begins work at St. Francis Regional Medical Center, where she has been an emergency room doctor for the past five of her 41 years.

She is friendly and open, but her humor also has a streetwise edge that is common in emergency rooms. She immediately jumps into the hot topic of the night — the man who was in the emergency room a few days earlier with a 5-pound doughnut-shaped weight stuck on his penis. Davidson is doubled over in hoarse laughter as nurses tell the story of how doctors had to use a metal cutter and make an incision in his penis to get the weight off. The hoarseness in her laugh is due to an extremely bad cold — sore throat, laryngitis, runny nose, the works. As the night progresses, it becomes clear that Davidson is sicker than many of her patients.

1:15 p.m.

Davidson begins treating her first two patients, both of whom present specific problems.

The first is a mentally retarded girl with severe abdominal pain, whose doctor refused to see her for another week. Davidson suspects the pain is simply caused by the onset of menstruation, but she is sensitive to the girl's low comprehension level. She decides against a physical examination — "I'm a stranger; it would be like rape" — and instead gives her some medicine for cramps. A short time later, the girl's pain subsides.

The second case involves a girl with a runny nose and slight fever whose X-rays reveal a touch of pneumonia. Her parents have no medical insurance and give a feeble explanation for not seeing the man they listed as their doctor.

When Davidson writes a prescription, they ask for samples, a common request from people who cannot easily afford the medicine. Davidson has no samples to give.

1:50 p.m.

An 18-year-old man comes in with a cut so minor it does not even require stitches. He has a family doctor, but he headed to the emergency room the instant he saw blood. Either he or his insurance company will end up paying about $100 to have the cut cleaned and covered with an adhesive bandage.

"There are people with paper cuts who call an ambulance," Davidson says. "Others have chest pains and can't walk and their family drags them in. When you ask why they didn't use an ambulance, they say they didn't know they were that sick."

2:20 p.m.

A 76-year-old woman arrives with chest pains and is taken ahead of other patients because she appears to be in the initial stages of a heart attack. Davidson gives the woman a thrombolytic drug to open her cardiac vessels.

The woman is clearly frightened and in pain, but she manages to joke with nurses a bit while going over her medical history. In a few minutes, her cardiologist arrives from another part of the hospital.

3:15 p.m.

A bellow from one of the rooms elicits first a gasp of surprise and then laughter from the staff. Rick is back.

Not quite 40 years old, with a ragged face and clothes to match, the man has gone through two pints of bourbon in the 15 hours since he was last released from St. Francis. He registers .434 blood-alcohol content, more than four times the legal limit for driving.

Davidson and fellow emergency room doctor Vincent Imbriani decide to give him a CT scan, which will give them a detailed image of the bones and tissue in his head, because his facial bruises could indicate internal bleeding from a skull fracture. They are frustrated at having to perform the procedure, because the bruises are probably the result of Rick's continual falling.

He has no way of paying the bill and apparently no hope or interest in rehabilitation. That one procedure alone will cost about $600.

"But if we don't do a CT scan, it'll be the one time there's a problem and we won't find it," Davidson says.

5:15 p.m.

Imbriani is putting on his jacket and saying goodbye when a heart monitor alarm goes off — the woman with heart trouble has gone into cardiac arrest. Imbriani sprints into her room, followed by Davidson and a host of nurses. Doctors keep the woman alive, but are unable to stabilize her heartbeat.

The emergency room begins to back up. According to hospital rules, patients are treated in order of the urgency of their problem. Many of the patients truly do not need emergency care, so they have to wait.

5:40 p.m.

The woman has not regained consciousness, although doctors occasionally pick up an erratic heart rhythm. Nurses emerge only to get more equipment or ask for help.

The rest of the emergency room continues to back up; a dozen treatment rooms are filled and virtually every chair in the waiting room is taken. Family practice resident Paul Huser and a handful of nurses do their best to get people ready for whenever the doctors are free.

6:05 p.m.

Davidson emerges, her demeanor dark, and within minutes the cardiologist pronounces the woman dead.

At the one time of the evening when Davidson most needs some solitude, she faces a harried emergency room jammed with people who are agitated at having to wait.

Two of the patients have small cuts that could have been treated by family doctors. Two others — one of them a pregnant woman bleeding from her vagina — wanted to see their doctors but were told it would take days for an appointment.

One elderly patient has not had a bowel movement for three days, and her nursing home does not have a van to take her to a family doctor. The nursing home called an ambulance, which can only take patients to the emergency room.

And about the only humor comes from one man with high blood pressure whose toupee looks like Vegas on a bad night, and another man who demanded to be seen for a headache, was shown to a treatment room and then disappeared. Losing patients is common, the nurses acknowledge, either because the people leave without telling anyone or because they are put in the wrong room and forgotten.

The man is never seen again.

6:30 p.m.

Davidson finally ducks into a small alcove and nibbles on some Girl Scout cookies, the closest thing to a dinner she will get. The elderly woman's death is still on her mind.

"People die all the time, and that you get used to," she says. "But the ones you don't expect or can't explain, those irritate you because you ask yourself if you did something wrong or if there was something you missed. In this case, I think we did everything, but you still ask the questions.

"Pediatric codes (deaths) really bother everyone the rest of the night, and people our age dying really bothers us. It's almost like I'd much rather have someone come in who's critical and just can't be brought back. Then you don't have the questions, like you do with someone who comes in, you stabilize them, and then they die."

7:05 p.m.

A nurse walks up to Davidson, shows her a chart and asks, "Have you seen this patient?"

Davidson just stares. By this point in her shift, she cannot remember who she has and has not seen.

8 p.m.

Davidson treats Rigoberto Moran, a boy with a killer smile and a BB stuck in his finger, the result of careless play with friends. Moran's father, Valentin Castillo, wanted to take his son to their family physician, but the doctor recently retired. On the spur of the moment, Castillo headed for the emergency room.

The boy brightens Davidson's mood for the first time since the elderly woman's death. She methodically explains what she is doing in order to distract the boy while giving a painful shot of anesthetic. She then removes the BB and gives it to him as a souvenir.

9 p.m.

An ambulance brings in an elderly woman from a nursing home who believes one minute that she is at heaven's gate talking to angels, and the next minute that she is at home being beaten by her husband.

Davidson and fellow emergency room doctor Keith Green make sure the woman has enough painkiller. But the woman continues to cry out, and the only thing that seems to calm her down is Davidson's taking every spare moment to caress her and talk to her. When the woman says the pain is in her leg — and then shows Davidson her arm — the doctor plays along.

Within minutes, Davidson has another concern as police officers arrive with a man in his 40s who is extremely upset. The man's body is covered with sores and his mind is filled with visions of an electronic snake that has wrecked his home.

The man claims he is the victim of Agent Orange and has been treated at the Veterans Administration Hospital, but the VA hospital does not have any record of him. According to police, he poured boric acid around his home and sprayed Raid to fight the snake, which he says grew horns and shot darts.

Davidson and a nurse analyze a computer file on Agent Orange to see if it could account for the sores, but there is no clear answer.

9:55 p.m.

Davidson spends a few moments briefing emergency room doctor Kathy Forred, who is taking over the next shift. Forred will be left to treat the man with the sores.

Davidson's last minutes are spent filling out paperwork. By the time she leaves, her cold has worsened and her voice is just about gone.

In just nine hours, she will return for another eight-hour shift.

Davidson, family practice resident Paul Huser, left, and ER doctor Vincent Imbriani search for a new drug to give a patient.

The method

Every method of paying medical bills has some benefits, some problems and some glaring examples of how those problems affect emergency rooms.

Private insurance

Benefits: Depending on the type of plan, private insurance can be the most comprehensive coverage available. It was used by more than 30 percent of hospital patients nationwide in 1990.

Problems: Some plans give doctors an allotment of money for each patient. Those doctors are reluctant to authorize expensive emergency room treatment that would cut deeply into their allotment.

Kathy Prilliman, emergency room manager at Riverside Hospital, remembers too many cases of having to convince — or ignore — doctors who did not want to authorize emergency treatment.

"We've had people that are having a heart attack right in front of us — and of course we're going to treat that — and we call the doctor and we say we need approval for treatment," Prilliman says. "We had one doctor say, 'No, I'm not giving you approval for treatment unless that patient is dead.' "

Government insurance

Benefits: Government insurance covers people who might otherwise slip through the cracks of the health care system. Medicare covers people aged 65 and older or disabled, Medicaid covers people who are poor or disabled, and CHAMPUS covers military dependents. Some form of government insurance was used by more than 50 percent of hospital patients nationwide in 1990.

Problems: Government insurance does not pay the full amount of hospital bills, so hospitals either swallow the losses or make them up by raising rates.

In addition, unlike the case with private insurance, patients can receive emergency room treatment for virtually anything. Even Medicaid's requirement that patients be assigned a primary care doctor is of limited help because so few doctors participate that many are located far away from their patients and don't ever see them. A Wichita woman who recently showed up at St. Joseph Medical Center had been assigned a doctor in Topeka.

A woman in her 20s recently sought treatment at St. Joseph because a call from her husband — who is stationed overseas — made her feel lonely. Emergency room doctor Don Seery gave her one dose of Benadryl, an antihistamine that includes a mild muscle relaxant and causes drowsiness.

The $100 bill for the visit will go to CHAMPUS insurance, which is financed by taxes. Benadryl is available at any drug store for about $4.

"That person has a social problem that the ER is not set up to handle," says Seery.

Self-pay

Benefits: There are no benefits, except perhaps avoiding insurance premiums. Slightly less than 10 percent of hospital patients nationwide in 1990 did not have medical insurance.

Problems: The "self-pay" category of patients is responsible for the bulk of bad debt and charity care in hospitals. In 1991, St. Francis Regional Medical Center lost $12.5 million in unpaid bills, HCA Wesley Medical Center lost $12.1 million, St. Joseph lost $6 million and Riverside lost $2.6 million.

More than 34 million people in the United States do not have insurance, more than 230,000 of them in Kansas.

Courtney Curtis became pregnant while still a student at North High School. Her father's medical insurance would not pay for the bills, so he took out a loan.

The baby, now 21 months old, does not have medical insurance, and Curtis relies on her high school's health clinic for basic child care. For anything more serious, she must use the emergency room and rely on family members to chip in on the bill.

Curtis, 18, graduated from school in January, and is only eligible to use the school clinic another two months. She hopes by then to be qualified for insurance through her job with MCI Telecommunications Corp. She also hopes that until then, her baby girl stays healthy.

"We're just keeping our fingers crossed," she says.

There are places to go when you need care

By Thomas B. Koetting
The Wichita Eagle

People who truly need emergency care should not hesitate to head to an emergency room, hospital officials say. However, the key phrase is "truly need."

At St. Joseph Medical Center, for example, incoming patients are placed into one of four categories depending on the urgency of their problem, and then are seen for treatment in order of urgency. Most patients fall into the two categories of least urgency, so they have to wait.

"People are real adamant that waiting for 40 minutes is too long because they have a sore throat," says Marty Sellberg, a St. Joseph emergency room doctor. "When you explain to them that in the next room you have a chest (a person with chest pains, often a heart attack), and that case is taking precedence, 50 percent of them accept that. The others don't, and there's nothing you can say to them that will change their mind."

The wait might be exacerbated if a hospital is busy. In Wichita, it is not uncommon to wait an hour for treatment of minor problems, and on busy nights the wait can reach three hours.

"One night we're getting nothing but auto accidents and cardiac arrests and we're up to here in critical care, and we'll call over to St. Francis and they're bitching that they haven't had anything 'good' all night, nothing but runny noses," says Daniel Caliendo, emergency room medical director at HCA Wesley Medical Center. "There's no rhyme or reason to it."

One option for people seeking treatment might be the three minor emergency centers affiliated with St. Joseph. The centers, which had 70,000 patients in the last fiscal year, are at 2456 N. Woodlawn, 2850 S. Seneca and 8615 Frazier.

For primary medical care, however, the best course is to see a family physician.

People who do not have a physician, or have minimal or no insurance, can receive primary care at a number of low-cost clinics in Wichita. However, the demand can be overwhelming.

For example, Hunter Health Clinic chairman Bart Steeves says he hired a second dentist at the clinic three months ago because the waiting period was six weeks. The waiting period for the new dentist is already four weeks.

Steeves says the National Association of Community Health Centers is considering opening two more clinics, one in the Garden City area and one in the Kansas City area. But he believes three or four more are needed just in Wichita.

And one final note: Two relatively new programs concentrate on the primary medical care needs of children.

The first is a free insurance plan called "The Caring Program for Children." Call 269-1670 for more information. The second is a children's clinic at the Wichita-Sedgwick County Department of Community Health. Call 268-8441 for more information.

Low-cost clinics

Each low-cost clinic in Wichita offers different services, so it's advisable to call ahead for details about times, physician availability and payment requirements. The clinics are:

- Good Samaritan Clinic, 3701 E. 13th, **688-5020.**
- Guadalupe Clinic/Catholic Social Service, 940 S. St. Francis, **264-8974.**
- Hunter Health Clinic, 2318 E. Central, **262-2415.**
- St. Francis Family Practice Center, 925 N. Emporia, **265-2876.**
- St. Joseph Family Practice Center, 1131 S. Clifton, **689-5500.**
- United Methodist Urban Ministry Clinic, 1611 N. Mosley, **263-7455.**
- Wesley Clinic, 3243 E. Murdock, **688-3100.**
- Wesley Family Practice Center, 3340 E. Central, **688-3070.**
- Wichita-Sedgwick County Department of Community Health (and affiliated health stations), 1900 E. Ninth, **268-8441.**

THE LEAGUE OF KANSAS MUNICIPALITIES

AN INSTRUMENTALITY OF KANSAS CITIES 112 W. 7TH TOPEKA, KS 66603 (913) 354-9565 FAX (913) 354-4186

Municipal Legislative Testimony

TO: Senate Committee on Ways and Means
FROM: Chris McKenzie, Executive Director, League of Kansas Municipalities
RE: Opposition to Senate Bill 770
DATE: May 4, 1992

I appear today in opposition to SB 770. This legislation is contrary to the League's convention-adopted policy statement opposing changes in the present method of distributing the 10% private club drink tax. SB 770 would direct $1.73 million of the present $10.4 million available from parks and recreation to alcohol and drug abuse treatment. It also would significantly narrow the purposes for which funds could be spent from the special alcohol and drug program fund of a city. Under current law such moneys may be spent "only for the purchase, establishment, maintenance or expansion of services or programs whose principal purpose is alcoholism and drug abuse prevention and education, alcohol and drug detoxification, intervention in alcohol and drug abuse or treatment of persons who are alcoholics or drug abusers or are in danger of becoming alcoholics or drug abusers." SB 770 would narrow this field to eliminate expenditures for prevention, education or detoxification and allow such moneys only to be supplied to **alcohol and drug abuse treatment programs licensed, certified or funded by the department of social and rehabilitation services.**

Our objections are as follows:

(1) It would reduce funding available for local parks and recreation programs by $1.7 million.

(2) Such limitations on the discretion of city governing bodies removes local flexibility in determining which organizations can best meet the objectives currently in K.S.A. 1991 Supp. 79-41a04;

(3) Alcohol and drug abuse prevention and education, and alcohol and drug detoxification, are valid objects of expenditure from such funds;

(4) The bill would limit the distribution of funds to only those centers that are **licensed, certified or funded** by SRS. In some communities this would limit to funding to at most one organization--possibly to an organization outside the community. This wording would still allow funding of a center that is only funded by SRS but not certified or licensed. The League submits that city governing bodies are capable judges of which organizations can best meet the objectives specified in existing law and the needs of individual communities.

Thank you for your consideration of our concerns.

SWAM
May 4, 1992
Attachment 4

KANSAS RECREATION AND PARK ASSOCIATION

700 JACKSON, SUITE 705
TOPEKA, KANSAS 66603

(913) 235-6533
Laura J. Kelly, Executive Director

Testimony before the
Senate Ways and Means Committee
May 2, 1992

Opposing SB 770

Chairman Bogina, members of the Committee, I am Laura Kelly, Executive Director of the Kansas Recreation and Park Association. I appear before you today on behalf of the 600 members of KRPA representing 175 governmental entities that provide recreation services and maintain park facilities for use by all Kansans.

As you might expect, KRPA strongly opposes SB 770 which would shift one half of the liquor excise tax money dedicated to the special local parks and recreation fund established by the Legislature 10 years ago to drug and alcohol programs approved by the Department of Social and Rehabilitation Services.

KRPA is not unaware of the magnitude of the substance abuse problem and all of its ramifications in our state. Just yesterday, I spent the entire day in Salina with 21 other members of the Implementation Planning Committee of the Kansas Family Initiative whose specific mission is to empower Kansas families to deal with substance abuse and prevention among our children. Every day park and recreation professionals deal with these issues in their programs. Park and recreation programs are open to the entire public and every segment of the population makes use of their services. Community centers and public parks are often headquarters for our high risk youth; day camps and swimming pools have become summer day care for many families at risk. Through this exposure, parks and recreation professionals are acutely aware of the problems brought on by substance abuse and have for years been providing programs, services and facilities to deal directly with the problem and, in a broader sense, to contribute to the prevention of additional problems. While substance abuse and prevention is a very complex topic and many factors contribute, I believe it is safe to say that people, young and old, who make productive use of their leisure time are less likely to be involved in substance abuse.

SWAM
May 4, 1992
Attachment 5

SB 770 is intended to add more money the the SRS budget to wage the war on drugs through treatment programs. This money is said to be necessary as the number of people needing treatment increases every day.

The number of people needing treatment is likely to increase even more if you dessimate the budgets of those agencies that are in the best position to provide the types of services that contribute to prevention. Already local parks and recreation departments are struggling to finance routine maintenance programs to keep facilities open and safe. Many of the public facilities in Kansas were built 35-40 years ago and need replacement. Federal funding for such projects has dwindled over the last ten years from a high of over $2 million to the 1991 allocation of just $230,000 for the entire state. SB 770 would take away an additional $1.7 million and further erode the ability of our park and recreation agencies to keep facilities up and running. Lawrence, KS uses its portion of the funds to operate its swimming pools each summer. In some cases, it is the money that finances some of the programs most used by our high risk families. In Wichita,for example, nearly $350,000.00 of operating funds would disappear. With it would go much of the summer programming which provides full day services to over 2,000 children. If our local units of government lose this funding, cities will be forced to curtail essential maintenance, capital improvements and programs or increase the tax burden on their citizens to continue to provide these services.

The Kansas Recreation and Park Association urges this committee to vote against SB 770 at this time as it does nothing in the long run to deal effectively with the substance abuse problem. We would encourage the Legislature to use its resources to study the issue of substance abuse prevention and treatment in depth and to develop a thoughtful, long range comprehensive plan to decrease the negative impact substance abuse has upon the people of Kansas.

Thank you.

TABLE II

1991 Gross Operation & Maintenance Expenditures
From Park and Recreation Survey
Percentage Breakdown of Financing Sources

	Number of Local Units Reporting	Gross 1991 O & M Expenditures	% Source of Financing			
			Local Tax	Fees	Liquor Tax	Other
Local Units with Separate Mill Levy for Parks & Recreation	10	$ 2,788,133	52%	24%	2%	22%
Local Units not having Separate Mill Levy for Parks & Recreation	19	20,851,783	70%	21%	6%	3%
TOTALS	29	23,339,916	68%	22%	5%	5%

TABLE III
1991 Gross Capital Improvement Expenditures
From Parks and Recreation Survey
Percentage Breakdown of Financing Sources

	Number of Local Units Reporting	Gross 1991 C.I. Expenditures	% Source of Financing			
			Local Tax	Fees	Liquor Tax	Bond
Local Units with Separate Mill Levy for Parks & Recreation	10	$ 132,624	76%	6%	0%	18%
Local Units not having Separate Mill Levy for Parks & Recreation	19	2,964,513	34%	6%	23%	37%
TOTALS	29	3,097,137	35%	6%	22%	37%

As Amended by House Committee

Session of 1992

HOUSE BILL No. 3198

By Committee on Appropriations

3-30

AN ACT concerning the state fire marshal; relating to certain certification and registration programs under the Kansas fire prevention code; prescribing the adoption of rules and regulations and fees therefore; ~~establishing a fire marshal fee fund; amending K.S.A. 1991 Supp. 75-3170a and repealing the existing section~~.

Be it enacted by the Legislature of the State of Kansas:

New Section.1. (a) The state fire marshal shall assess annual fees for the registration and certification programs authorized under the Kansas fire prevention code and specified in subsection (b). The fees charged shall be used to administer and operate the respective registration and certification programs.

(b) The state fire marshal shall adopt rules and regulations for the following specified certification or registration programs. The rules and regulations adopted by the state fire marshal shall establish fees for the following programs, except that such fees shall not exceed the following amounts:

(1) Explosive blaster permits, an amount of not more than $500;

(2) explosive user permit, an amount of not more than $500;

(3) explosive site permit, an amount of not more than $100;

(4) bottle rocket manufacture permits, an amount of not more than $1,000;

(5) fireworks manufacture permit, an amount of not more than $1,000;

(6) public fireworks display operator permit, an amount of not more than $250;

(7) fire detector system installation and repair, maintenance or company registration, an amount of not more than $500; and

(8) fire sprinkler system installation and repair company registration, an amount of not more than $500;.

~~(9) LP gas bottle fill site registration, an amount of not more than $250;~~

~~(10) LP gas checklist certificate, an amount of not more than $250; and~~

~~(11) private liquid fuel transport inspector permit, an~~

Fire Marshall Fee Fund already created in H 2611 passed over the governor's veto.

SWAM
May 4, 1992
Attachment 6

~~mount of not more than $500.~~

(c) ~~There is hereby created the fire marshal fee fund in the state treasury. All expenditures from the fire marshal fee fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the state fire marshal or a person or persons designated by the state fire marshal.~~ The state fire marshal shall remit all moneys received for fees under this section to the state treasurer at least monthly. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury. The state treasurer shall credit 20% of each such deposit to the state general fund and shall credit the remainder of each such deposit to the fire marshal fee fund.

Sec. 2. K.S.A. 1991 Supp. 75-3170a is hereby amended to read as follows: 75-3170a. (a) The 20% credit to the state general fund required by K.S.A. 1-204, 2-2609, 2-3008, 9-1703, 16-609, 16a-2-302, 17-1271, 17-2236, 17-5609, 17-5610, 17-5612, 17-5701, 20-1a02, 20-1a03, 34-102b, 44-324, 44-926, 47-820, 49-420, 55-155, 55-609, 55-711, 55-901, 58-2011, 58-3074, 65-6b10, 65-1718, 65-1817a, 65-2011, 65-2855, 65-2911, 65-4610, 66-1,155, 66-1503, 74-715, 74-1108, 74-1405, 74-1503, 74-1609, 74-2704, 74-3903, 74-5805, 74-7009, 74-7506, 75-1119b and 75-1308 and K.S.A. 1990 Supp. 55-176, 58-4107, 65-5413, 65-5513, 84-9-411, 84-9-413 and section ~~5 of 1991 Senate Bill No. 77~~ *1 of this act* and K.S.A. 1991 Supp. 2-3013, and acts amendatory of any of the foregoing including amendments by other sections of this act is to reimburse the state general fund for accounting, auditing, budgeting, legal, payroll, personnel and purchasing services, and any and all other state governmental services, which are performed on behalf of the state agency involved by other state agencies which receive appropriations from the state general fund to provide such services.

(b) Nothing in this act or in the sections amended by this act or referred to in subsection (a), shall be deemed to authorize remittances to be made less frequently than is authorized under K.S.A. 75-4215 and amendments thereto.

(c) Notwithstanding any provision of any statute referred to in or amended by this act or referred to in subsection (a), whenever in any fiscal year such 20% credit to the state general fund in relation to any particular fee fund is $200,000, in that fiscal year the 20% credit no longer shall apply to moneys received from sources applicable to such fee fund and for the remainder of such year the full 100% so received shall be credited to such fee fund, except as otherwise provided in subsection (d) or (f).

(b) Notwithstanding any provision of K.S.A. 2-2609 and 2-3008 and amendments thereto or any provision of any statute referred to in subsection (a), the 20% credit to the state general fund no longer shall apply to moneys received from sources applicable to the grain research and market development agencies funds, as specified for each such fund by this subsection, and for the remainder of a fiscal year the full 100% of the moneys so received shall be credited to the appropriate fund of such funds, whenever in any fiscal year:

(1) With respect to the Kansas wheat commission fund, such 20% credit to the state general fund in relation to such fund in that fiscal year is equal to that portion of $100,000 that bears the same proportion to $100,000 as the amount credited to the Kansas wheat commission fund during the preceding fiscal year bears to the total of the amounts credited to the Kansas wheat commission fund, the Kansas corn commission fund, the Kansas grain sorghum commission fund and the Kansas soybean commission fund during the preceding fiscal year;

(2) with respect to the Kansas corn commission fund, such 20% credit to the state general fund in relation to such fund in that fiscal year is equal to that portion of $100,000 that bears the same proportion to $100,000 as the amount credited to the Kansas corn commission fund during the preceding fiscal year bears to the total of the amounts credited to the Kansas wheat commission fund, the Kansas corn commission fund, the Kansas grain sorghum commission fund and the Kansas soybean commission fund during the preceding year;

(3) with respect to the Kansas grain sorghum commission fund, such 20% credit to the state general fund in relation to such fund in that fiscal year is equal to that portion of $100,000 that bears the same proportion to $100,000 as the amount credited to the Kansas grain sorghum commission fund during the preceding fiscal year bears to the total of the amounts credited to the Kansas wheat commission fund, the Kansas corn commission fund, the Kansas grain sorghum commission fund and the Kansas soybean commission fund during the preceding fiscal year; and

(4) with respect to the Kansas soybean commission fund, such 20% credit to the state general fund in relation to such fund in that fiscal year is equal to that portion of $100,000 that bears the same proportion to $100,000 as the amount credited to the Kansas soybean commission fund during the preceding fiscal year bears to the total of the amounts credited to the Kansas wheat commission fund, the Kansas corn commission fund, the Kansas grain sorghum commission fund and the Kansas soybean commission fund during the preceding

fiscal year.

(e) As used in this section, "grain research and market development agencies" means the Kansas wheat commission, the Kansas corn commission, the Kansas grain sorghum commission and the Kansas soybean commission. Such agencies have been created to fund appropriate research projects; to conduct campaigns of development, education and publicity; and to find new markets or maintain existing markets for commodities and products made from those commodities, among their other duties. Such grain research and market development agencies shall be funded by an assessment collected from the grower at the time of the sale of such commodity by the first purchaser. The assessment shall be sent to the proper grain research and market development agency.

~~(f) (1) Through June 30, 1993, notwithstanding any provision of any statute referred to in subsection (a), whenever in any fiscal year such 20% credit to the state general fund in relation to the Kansas sheep commission fund is $8,000, in that fiscal year the 20% credit no longer shall apply to moneys received from sources applicable to such fund and for the remainder of such year the full 100% so received shall be credited to such fund.~~

~~(2) On and after July 1, 1993, the provision of subsection (e) shall apply to the Kansas sheep commission fund.~~

~~Sec. 3. K.S.A. 1991 Supp. 75-3170a is hereby repealed.~~

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