Approved: 3-10-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on February 23, 1995 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:
Adam A. Richardson, D.P.M.
John Lynch, M.D.
Senator Sandy Praeger
Tom Bell, Kansas Hospital Association
Robert Schulte, Lawrence City Commissioner
Steven Potsic, M.D., Director of Health, KDHE
John Leifer, Senior Vice President, KC, Columbia/HCA
Jerry Slaughter, KMS
Harold E. Riehm, Kansas Association of Osteopathic Medicine

Others attending: See attached list

Hearing on: SB 55 - Scope of practice of podiatry

Dr. Adam Richardson, Hutchinson podiatrist and podiatric surgeon, testified before the Committee in support of **SB 55** as noted in his written testimony. (Attachment 1) During Committee discussion a member suggested a list showing the comparison of educational training between an M.D. and D.P.M. would be helpful to the Committee.

Chip Wheelen, KMS, submitted written testimony (Attachment 2) in which he noted that **SB 55** would significantly expand the statutory scope of podiatry in Kansas by allowing podiatrists to perform extremely dangerous surgical and medical procedures. It was noted that even thought podiatrists are licensed and regulated by the same agency that licenses and regulates physicians and chiropractors, the laws are separate and podiatrists are not licensed to engage in the healing arts.

Written testimony was submitted by Larry Buening, KBHA, and in his testimony Mr. Buening noted that concern was raised by the Board as to the deletion of existing language in **SB 55** regarding the current prohibitions against amputating the foot and administering anesthesia other than local. The Board was of the opinion this may allow total foot amputations and the administration of general anesthesia by podiatrists, and since they did not have adequate information of such action, no recommendation was given. (Attachment 3)

John Lynch, M.D., testified in opposition to **SB 55** and expressed his concern with the language "functional foot" in the bill because, as he noted, functional foot can be described as anywhere from the knee down or include the knee itself and is entirely different than the interpretation of anatomical foot. Dr. Lynch also expressed concern regarding what is not stated in the bill, and that is the ability to do amputations and the deletion of the limitation of anesthesia.

The Chair noted that further discussion and hearing on **SB 55** would continue at a later date.

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 526-S Statehouse, at 10:00 a.m. on February 23, 1995.

Hearing on: SB 321 - Community health cooperation act

The hearing was opened by Vice Chair Langworthy.

Senator Sandy Praeger addressed the Committee and submitted written testimony in support of **SB 321**. Senator Praeger noted that the legislation would provide for a community negotiating process when a purchase or lease of an existing city, county or district hospital is proposed or when a new hospital is being considered in a community with a city, county or district hospital. A summary of the programs offered at Lawrence Memorial Hospital was also submitted. (Attachment 4)

During Committee discussion Senator Praeger pointed out that there are approximately 145 hospitals in Kansas, three are for-profit run by Columbia/HCA, 80 hospitals are city, county or district hospitals and the remainder are not-for-profit under private ownership which are tax exempt and provide community benefits such as educational programs and indigent care. Three city hospitals from Cities of the First Class in Kansas have the same type of licensure, and they are Stormont-Vail in Topeka, Coffeyville and Lawrence Memorial. It was noted that district hospitals would come under county governance as well as county hospitals.

Tom Bell, KHA, addressed the Committee and noted that while KHA endorses the cooperative process of **SB 321**, adding another governmental council or unit into the mix could confuse the process and invite conflict, and secondly, they question the amount of authority given to the new government entity as noted in his written testimony. It was suggested that these councils could be the advisory body and the ultimate decision made by the governing body. (Attachment 5)

It was noted by the Chair that language in the bill is permissive, and councils could only be established if the community felt it was in their best interest to have this dialogue and discussion.

Robert Schulte, City Commissioner of Lawrence, appeared before the Committee in support of **SB 321** and noted that the city owned hospital in Lawrence represents a tremendous public investment and public resource, and that it is appropriate its mission be protected with this proposed legislation. (Attachment 6)

Dr. Steve Potsic, KDHE, addressed the Committee in support of the basic concepts of **SB 321**, outlined specific impacts of the program if the bill were enacted and submitted proposed amendments as noted in his written testimony. (Attachment 7)

John Leifer, Columbia/HCA, appeared in opposition to **SB 321**. Mr. Leifer gave a brief background of Columbia's history as the world's largest healthcare provider and their involvement in communities across Kansas as noted in his written testimony. (Attachment 8)

Because of the lack of time to conclude the hearing on **SB 321**, the Chair announced that the hearing on **SB 321** would continue at 12:00 p.m.

The Committee recessed until 12:00 p.m.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 526-S Statehouse, at 12:00 p.m., February 23, 1995.

Continued hearing on: SB 321 - Community health cooperation act

Kevin Hicks, Overland Park Regional Medical Center, gave an overview of Columbia/HCA facilities in Kansas and in particular the Overland Park Regional Medical Center. He noted OPRMC provides the services of a Trauma Center, Level Three Neonatal Intensive Care Unit, two community rural health clinics, community education programs as well as care to patients regardless of their ability to pay.

During Committee discussion a question was asked if there would be assurances that hospital benefits would continue once Columbia located in a community and assumed the responsibility of health care services, and Mr. Hicks commented that in order for them to be successful in competitive markets, essential services and community needs would be met. He pointed out that in a Columbia partnership, Columbia would own equally the assets of the new company and the control would rest with the governing board of that new partnership -- 50% appointed by the city and 50% by Columbia. He noted Columbia ventures into a community only after researching if there is a need. He also felt that **SB 321** was anti-competitive.

John Leifer noted that Columbia would be happy to provide information to whatever community council might be formed, and that they are not afraid of the scrutiny with this piece of legislation, but is concerned with licensure. He felt that in terms of disclosing information with communities so that communities can make an informed decision as to whether they are supportive of Columbia's presence is not an issue, but that it's simply an issue of how you cower that local community.

Kevin Hicks commented that Columbia cannot buy or lease a facility from a city or county owned hospital without their agreement, and that such an agreement would have to be made with a public body. In regard to new facilities, he noted that construction of those facilities would eliminate the not-for-profit hospital providing all community services. That scenario was questioned and if those essential community services would be shared jointly, such as taking care of the indigent. Mr. Hicks suggested they could accept language in the bill that would require they enter into certain agreements regarding services provided.

During Committee discussion a member expressed concern that barriers might be set up and an inflexible situation occur in the community if decisions were left up to county commissioners who appoint a board or council. Another member expressed concern that reducing health care costs is not always a number one priority with for-profit hospitals.

Written testimony in support of **SB 321** was received from Chris McKenzie, Executive Director, League of Kansas Municipalities. It was recommended by Mr. McKenzie that additional provisions be added to New Section 4 that would require final approval of any community benefit agreement by the local elected governing body before it can be used by the other party in making application to establish a medical facility under Section 6 of the bill. (Attachment 9)

Jerry Slaughter, KMS, submitted written testimony on **SB 321** and noted that a positive step would be taken if communities would establish planning and dialogue with residents and providers in the community, and that **SB 321** would make such a community dialogue possible. (Attachment 10)

Harold Riehm, KAOM, addressed the Committee and noted that **SB 321** has merit as noted in his written testimony. (Attachment 11)

Reconsider Action on: SB 286 - Cosmetologists licensure requirements and fees

The Chair called attention to page 2 of the bill that created a situation where a cosmetologist could not work in a barber shop and recommended that such language be stricken as shown in the attached section of the bill provided by staff. (Attachment 12) Senator Walker made a motion the Committee reconsider its action on **SB 286** and strike language referred to on page 2 of the bill as well as clean up of technical language suggested by staff, and recommended **SB 286 as amended** favorably for passage, seconded by Senator Hardenburger. The motion carried.

The meeting was adjourned at 1:00 p.m.

The next meeting is scheduled for February 24, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-23-95

NAME	REPRESENTING
Chip Wheelen	KS Medical Soc.
John Lynch, M.D.	" " "
W. Grosse	Shawnee Mission Med. Cntr.
Mary Ellen Conlee	ST Francis Reg. Med. Center
Ron Hein	Columbia/HCA
KEITH R LANDIS	CHRISTIAN SCIENCE COMM ON PUBLICATION FOR KS
JOHN LEIFER	COLUMBIA/HCA
Stacey Simpson	Columbia/HCA
[illegible]	
Joseph Kroll	KDHE
[illegible] Simons	St. Luke's Health system
GREG REESE	KDHE
Jon Newman	KS Governmental Consulting
Nicki Goodman	KSBN
Ezra Mraygon	KSBN
Pat Johnson	KSBN
[illegible]	KSBN
[illegible] Ryan	N.E.A. Rural Health
Kevin J. Hicks	Columbia/HCA

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-23-95

NAME	REPRESENTING
Denise Apt	Ks Podiatrist Assoc
Gary Howell	Children's Mercy Hospital
Rich Guthrie	Health Midwest
Joe Furjanic	KCA
Shelby Smith	KPMA
R.A. Bradbury, DPM	KPMA
Clarence G. Clayton, DPM	KPMA
Kenneth Dobbs Jr	KPMA
Adam Richardson DPM	KPMA
Ginger Richardson	
Don Maker	KPMA
Phyllis A. Taylor	KPMA
Jerry Slaughter	KMS
Steve Potter	KDHE
Larry Buening	Bd of Healing Arts

Kansas State Senate
Committee of Public Health and Welfare
Testimony of Adam A. Richardson, D.P.M.

Ladies and Gentlemen of the Committee:

My name is Dr. Adam Richardson. I am a 1992 graduate of the College of Podiatric Medicine and Surgery in Des Moines, IA. In May of 1994, I graduated from a two year podiatric surgical residency in La Crosse, WI. During this residency, I performed 11 months of medical rotations including internal medicine, infectious disease, orthopedics, emergency medicine and rheumatology (just to name a few). Throughout these rotations, I performed the exact same duties and carried the exact same responsibilities as the rotational, transitional and surgical residents within Gundersen Clinic. My remaining 13 months of residency were spent performing, in excess, of 500 podiatric surgical procedures. These often included digital and/or partial metatarsal amputations.

Currently, I am practicing with a 45 physician group at the Hutchinson Clinic, in Hutchinson, KS. Though I had serious reservations about practicing in a state with such limited statutes, the merits of Kansas life prevailed in my decision process. This decision has not been without regrets, however, as one of my first referral patients was from an internist from within the clinic. The patient had a nonhealing ulcer at the end of her toe due to deformity. The most rapid and safest route to recovery for the patient was to have the end of the toe amputated. By law, I was not allowed to do this procedure. Instead, I had to explain to the patient that she would have to wait an additional 1-2 months while I referred her to the clinic's orthopedic surgeon. Then she would be able to have the amputation. My next task was to explain to the clinic's internist why, despite being the clinic's "foot surgeon", I was unable to provide prompt service to this patient. Despite this setback, I still have full support from the clinic and would like to include this letter of support from the clinic within my testimony.

I know that my situation is not unique. While I was taking the state licensure examination, I conversed with six additional podiatrists. They too were residency trained in surgery - with one even certified in arthroscopy. This individual was practicing in Texas and stated that he would most likely not move to Kansas because he would lose his privilege to perform partial foot amputations as well as limiting his abilities to perform arthroscopy. Based upon this testimony, I respectfully request that the committee vote favorably on Senate Bill No. 55. Thank you for your time.

February 17, 1995

Senate Committee on Health and Welfare
Kansas State Senate
State Capitol Building
300 SW 10th Avenue
Topeka, KS 66612-1504

Ladies and Gentlemen of the Committee:

The Hutchinson Clinic, P.A. is a 45 physician, multispecialty clinic located in Hutchinson, KS. Since August 1, 1994, we have employed Adam A. Richardson, D.P.M., as a podiatrist and podiatric surgeon. Dr. Richardson was selected for the Hutchinson Clinic due to his education and his extensive surgical residency training. During his tenure with the clinic, he has adequately demonstrated the knowledge and abilities of a limited licensed physician - managing the podiatric medical and surgical needs of the clinic's population.

We do not presume to know all of the ramifications of Senate Bill Number 55; however, the Hutchinson Clinic, wholeheartedly, supports the continued efforts of Dr. Adam Richardson; and, we firmly believe that his training, knowledge and abilities have earned him the right to be deemed a "physician".

Sincerely,

Murray Holcomb, M.D.
Hutchinson Clinic, President

c: Adam Richardson, D.P.M.

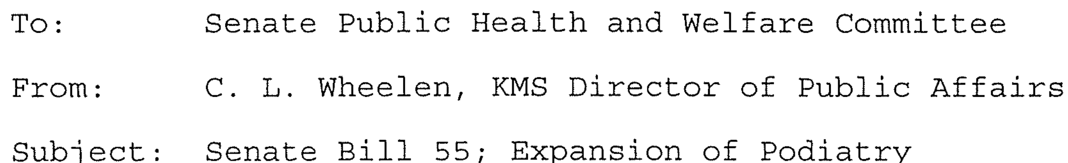
2101 N. Waldron Hutchinson, Kansas 67502 (316) 669-2500
TOLL FREE: 1-800-779-6979 FAX (316) 669-2501

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

February 23, 1995

To: Senate Public Health and Welfare Committee

From: C. L. Wheelen, KMS Director of Public Affairs



Subject: Senate Bill 55; Expansion of Podiatry

Thank you for the opportunity to testify in opposition to SB55. This bill would significantly expand the statutory scope of podiatry in Kansas by allowing podiatrists to perform extremely dangerous surgical and medical procedures.

First let me clarify a common misunderstanding that contributes to two very convoluted and misleading Attorney General opinions. There are only three branches of the healing arts under the Kansas Healing Arts Act; allopathic medicine (M.D.s), osteopathic medicine (D.O.s), and chiropractic (D.C.s). For an excellent description of how the Kansas Healing Arts Act evolved, please refer to the 1994 interim committee report by the Special Committee on Public Health and Welfare.

Perhaps the reason that some attorneys and others become confused about podiatry is because podiatrists are licensed and regulated by the same agency that licenses and regulates physicians and chiropractors; the State Board of Healing Arts. But the laws are separate and podiatrists are not licensed to engage in the healing arts.

Furthermore, although the podiatry act authorizes podiatrists to prescribe drugs and perform surgery on the human foot, this does not make them physicians. Any conclusion to the contrary is totally inconsistent with K.S.A. 65-2869 (a section of the Healing Arts Act) which describes persons licensed to practice medicine and surgery as "persons who attach to their name the title M.D., surgeon, physician, physician and surgeon." In other words, a physician is someone licensed to practice medicine and surgery under the Healing Arts Act. In contrast, one provision of K.S.A. 65-2001, the definitions section of the Podiatry Act, states succinctly that one who practices podiatry is a podiatrist.

The Podiatry Act (K.S.A 65-2001 *et seq*) absolutely prohibits amputation and strictly limits anesthesia to local anesthetic. This is because general anesthesia is extremely dangerous as is amputation. Such procedures should be performed by a physician who has had the benefit of a comprehensive medical education and the clinical training necessary to obtain a license to practice medicine and surgery. While the education and training of a podiatrist may be impressive, it is not the same as medical education and training.

Thank you for taking our concerns into account. We urge you to **defeat SB55**.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 2

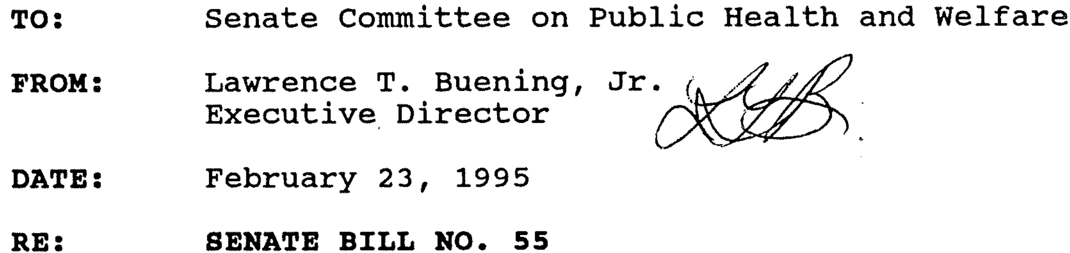
KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

LAWRENCE T. BUENING, JR.
Executive Director

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(913) 296-7413
FAX # (913) 296-0852

M E M O R A N D U M



TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 23, 1995

RE: **SENATE BILL NO. 55**

Thank you for the opportunity to provide information on this bill on behalf of the State Board of Healing Arts.

The Board reviewed Senate Bill No. 55 at its meeting on February 11, 1995. At that time support was expressed for licensed podiatrists to be allowed to amputate toes and to administer regional anesthetic under certain circumstances. However, concern was raised as to the deletion of the existing language in lines 26-28 by deleting the current prohibitions against amputating the foot and administering anesthesia other than local. The Board was of the opinion this may allow total foot amputations and the administration of general anesthesia by podiatrists. The Board did not believe it had adequate information regarding the training of podiatrists in these areas. Therefore, the Board believed it should take no position on this bill at this time. In order for the scope of podiatry to be expanded as allowed by Senate Bill No. 55, the Board felt further study should be undertaken and additional information received so a fully informed decision can be made. Should Senate Bill No. 268 be enacted, the issues presented by this bill could then be given detailed consideration and study and a report made to the Legislature.

Thank you for the opportunity to provide this information.

bj

MEMBERS OF BOARD
JOHN P. WHITE, D.O., PRESIDENT
PITTSBURG
RONALD J. ZOELLER, D.C., VICE-PRESIDENT
TOPEKA

DONALD B. BLETZ, M.D., OVERLAND PARK
C.J. CONRADY, JR., ANTHONY
SERGIO DELGADO, M.D., TOPEKA
JAMES D. EDWARDS, D.C., EMPORIA
HOWARD D. ELLIS, M.D., LEAWOOD
EDWARD J. FITZGERALD, M.D., WICHITA
JOHN P. GRAVINO, D.O., LAWRENCE

GRACIELA A. MARION, EUDORA
LAUREL H. RICKARD, MEDICINE LODGE

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 3

STATE OF KANSAS

SANDY PRAEGER
SENATOR, 2ND DISTRICT
3601 QUAIL CREEK COURT
LAWRENCE, KANSAS 66047
(913) 841-3554
STATE CAPITOL—128-S
TOPEKA, KS 66612-1504
(913) 296-7364

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIR: PUBLIC HEALTH AND WELFARE
JOINT COMMITTEE HEALTH CARE DECISIONS FOR THE 90'S
MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
CORPORATION FOR CHANGE
KANSAS HEALTHY KIDS CORPORATION
JOINT COMMITTEE ON CHILDREN AND FAMILIES

February 23, 1995

TESTIMONY

SB 321

Senate Public Health and Welfare
Senator Sandy Praeger

Thank you, Committee, for this opportunity to present this information to you in support of SB 321.

I asked for this legislation to be introduced not to try and block the market forces that are bringing about change in the way health care services are delivered in our state, but because I want to focus attention on the need for communities to remain in control of their health care system. I do believe that market reforms can work, but only if the needs of the individual communities are addressed in the reform process.

This legislation provides for a community negotiating process when a purchase or lease of an existing city, county or hospital district hospital is proposed or when a new hospital is being considered in a community with a city, county or hospital district hospital. Currently these hospitals operate in a tax-exempt environment and often are also tax-supported through a mill levy. In return for this tax free status, these community hospitals must provide community benefit to retain this status. These community hospitals provide many medical, educational and prevention services to benefit the community either free or at a very low cost to the consumer. These services range from smoking cessation classes to substance abuse education to wellness programs to indigent care. I've included a summary of some of the programs offered at our community hospital, Lawrence Memorial. You will note on the first two sheets that there are fees assessed for some of these programs, but the fees do not cover the actual costs. In the case of low income persons, they can ask for the fees to be waived.

I don't want to belabor this point, but I think it is important that communities understand the benefits that are currently being provided by their hospitals and the potential impact on those benefits should the ownership, management or competitive

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 4

Infant And Child CPR This class is a must for ALL parents and caregivers. It includes valuable information on basic safety issues for the infant and child. Participants will learn infant and child CPR and how to handle a choking emergency. It is offered two to three times per month in the evening from 7:00 to 9:00 p.m. and occasional Saturday mornings from 9:00 a.m. to 11:00 a.m. The **cost is $12/person or $20/couple.** Please call early to enroll as class size is limited to **20 couples (or 6 students per instructor)** and classes fill quickly.

Second Times Parents-A Prenatal Refresher Class Has it been awhile? Do you need a refresher prenatal course? The class is designed for experienced, expectant parents. This class includes a review of labor and delivery preparation skills and a tour of the LMH delivery unit. There are three sessions held on Monday evenings from 7-9 p.m. The **cost is $10/person or $20/couple.** Call for dates and to enroll -- **limited to 15 couples.**

Breastfeeding Your Baby Breastfeeding is the recommended method of infant feeding. Do you have questions about the how-to's of breastfeeding? This two hour class covers the benefits and techniques of breastfeeding as well as the special concerns of the working mother. The class is offered every six weeks on Tuesday evenings from 7:00 to 9:00 p.m. Both mothers and their partners are encouraged to attend. The **cost is $5/person.** This class is taught by a certified lactation consultant. Registration in advance is requested -- **10-15 participants** is the maximum enrollment.

Tyke Hyke This is a program for big brothers and sisters-to-be ages three and older. The children receive a tour of the LMH Mother-Baby Unit. They will also participate in a discussion and view a video about new babies. Each child will receive a take-home activity book. An adult must attend with the child. This class is offered twice a month on either Thursday afternoon or Saturday morning. There is **no charge** but you must register in advance -- **limited to 10 children and their parents.**

And Baby Makes Four (Or More) Are you expecting your second or third or more child? This class is for you! It will cover information about sibling adjustment and tips and timesavers for parenting more than one. Offered approximately every two months. The class is one hour in length and there is **no fee** but enrollment in advance is requested -- **25 maximum enrollment.**

Baby Talk Is there a new baby in the house? Do you have a lot of questions about caring for your baby or just need an opportunity to share experiences with other new parents? Then join our free bi-weekly discussion group for new parents. Sessions will include information about infant care, nutrition, safety, sleeping, crying, play, illness, development and adjusting to parenthood. New and experienced parents are invited. Babies under 6 months are also welcome! Sorry, there is no babysitting available for older children. Parents may join this discussion group at any time. The group meets the first and third Thursday morning of the month from 10:30 a.m. to 11:30 a.m. There is **no fee** for this program and no registration is required (**no limit on the number of participants**).

Baby Parade Join us at the Riverfront Mall every Wednesday morning from 9:00 a.m. to 10:00 a.m. for the Baby Parade! This is an opportunity for parents and their infants and toddlers two years of age and under to meet and play in an informal setting. There is a speaker each week on a topic of interest to parents. Snacks and a play area for the children are provided. There is **no fee** for this program and no registration is required -- **(no limit on the number of participants)**. Co-sponsored by the Lawrence Riverfront Plaza and Lawrence Memorial Hospital.

Think Light This is a 6 week weight control program. Healthy menus, recipes, and shopping lists are provided. Class meets weekly to learn about and discuss a variety of topics. **Cost is $75/person and** enrollment is limited to **20 people**.

FreshStart Want to quit smoking? This 4 week class will help you get in control of your smoking habit. A certified instructor will discuss various topics including how to chose a quit date, nutrition, weight control, and stress management. Sponsored by the American Cancer Society. There **is no cost** but class size is limited to **25 people**.

Safe Sitter Does your babysitter know how to stop a child from choking? This nationally known 3-day class is for babysitters ages 11-13. They will learn infant and toddler care, how to handle emergencies, and basic life saving skills. The **cost is $30** and is limited to **15 children**.

Growing Up Female
Growing Up Male These 2 classes present family-centered sexuality education. The female class is for girls ages 8-11; and the male class is for boys ages 9-12. The four session programs cover the normal physical and emotional changes of growing up. One parent must attend with the child. The **cost is $15** and enrollment is limited to **15 students per class**.

First Aid for Parents & Daycare Providers Accidents always happen. Come learn how to handle those emergency situations. Participants will learn the basics of first aid and basic life saving skills. This class is taught by a Registered Nurse. The **cost is $15/person** and is **limited to 25 people**.

Programs Related to Wellness (or other topics available on request)

Annual Health Fair. Held in the spring (April) and provides free health screenings (including hearing, vision, glaucoma, oral cancer, skin cancer, foot problems, and prostate cancer) to the public. Blood analysis is available for a nominal charge. We have had as many as 400 participants in previous years.

Free Monthly Programs: December 1994 -- *Menopause Seminar* and *Massage Away Holiday Stress*
January's program was canceled.
February 21st -- *Alzheimer's Seminar* (symptoms and current treatments)
March 2nd -- *Snoring: Not Funny, Not Hopeless* (treatments/symptoms)
April 5th -- *Counter Attactics* (a self-defense course for women)

Individuals can call *ConnectCare:* **749-5800 or 1-800-749-2226 (outside Lawrence)** if they want to enroll or have questions about a particular class.

I hope this information was helpful.

Sincerely,

Le-Thu Erazmus
KU Intern
LMH Health Education Department

Volunteers contribute 31,563 hours yearly to LMH. These hours, when computed at the average rate of pay, represent a cost saving factor for the hospital of $284,067.00.

Hospital Volunteer Services;

Baby Foto's - Every new born baby is photographed at the hospital for security reasons.

Clerical Services - Volunteers provide clerical support in Volunteer Services, Physical Therapy, Medical Records, Social Work, Laboratory, Accounting, Purchasing, Central Stores, Dietary.

Escort Services - Volunteers provide transport for patients being admitted, dismissed and going from place to place in the hospital daily from 8 a.m. to 4 p.m.

Gift Shop - The LMH Gift Shop is an entirely volunteer run shop. The profit from the shop goes to the hospital each year to purchase needed equipment. The Auxiliary last year finished a pledge for over $120,000.00 to purchase new beds for the mother/baby unit.

Information Desk - Provides patients, visitors, and staff with information and directions each day 7 a.m.. to 8 p.m.

Mail - Volunteers deliver both patient mail and mail to hospital departments on a daily basis.

Lifeline - A service provided by the Auxiliary. Lifeline is a personal response system that allows people to remain in their homes longer. We currently provide Lifeline for 85 people in the Douglas County area.

Patient Pride - Volunteers provide women patients with some pampering! Hand lotion, moisturizer, lip gloss and light makeup with a kind touch makes many women patient's hospital stay much brighter.

Patient Representative - Volunteers visit with newly admitted patients to see how we can improve their stay at the hospital.

Same Day Surgery - Volunteers assist in getting patients checked in and ready for their outpatient surgery each morning beginning at 6:30 a.m.

School Tours - Each Spring volunteers conduct tours for more than 600 area 2nd grade children to help them become more familiar with the hospital and the services here.

Surgery Waiting Room - Volunteers provide information and comfort to waiting families.

In addition to these areas, a hundred student volunteers contribute their time in the Emergency Room, Radiology, 2nd, 3rd and 4th floor nursing units, Physical Therapy, Return to Work, Occupational Therapy, Labor and Delivery and Pediatrics.

Memorandum

Donald A. Wilson
President

TO: Senate Public Health and Welfare Committee

FROM: Kansas Hospital Association

RE: Senate Bill 321

DATE: February 23, 1995

The Kansas Hospital Association appreciates the opportunity to testify regarding the provisions of SB 321. This bill creates a process whereby the community at large is able to play a formal role in decisions affecting community health care delivery. We think the development of such a process makes good sense.

Over the past two years there have been many discussions and debates concerning the health care delivery system. Those debates have taken place from coffee shops to state legislatures to Congress. They have resulted in numerous governmental measures designed to improve health care delivery. Even though such discussions continue today on the same levels, there is one uncontradicted fact that runs throughout -- our health care system is currently undergoing dramatic changes. Some of these changes are the result of government action, but in large part they stem from market forces. For example, every day we see signs that the system is becoming more integrated. In addition, no one denies that managed care is playing more and more of a role in all kinds of health care decisions.

As these changes occur, everyone is uncertain about what is in store. Patients wonder if they will be able to continue to choose their doctor. Physicians are concerned about their ability to make independent clinical decisions. Hospitals wonder if quality of care can be maintained. Even associations are forced to consider their continuing role. Recently the Kansas Hospital Association went through a process of attempting to determine the most important role it could play in the future. The conclusion was that KHA should strive to be an association of health care organizations "cooperating to improve health status in the state through community-based health and hospital services." In many ways, SB 321 is entirely consistent with the new mission of KHA because it establishes a structure to help decide what these community-based services should be. SB 321 is, in essence, based on the assumption that community-based services are best. We agree.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 5

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 2

One of the most important changes currently affecting the health care delivery system is the move toward integration. This integration is taking place not only vertically, where different types of providers come together to offer a continuum of care, but also horizontally, where competitors merge to become more efficient. As these "integrated delivery systems" are formed, it is becoming clear that the successful ones share numerous attributes, including an orientation toward health outcomes; a shift in focus from illness treatment to illness prevention; a balance between the health care needs of a community and economic development; and the promotion of community education. In other words, a community orientation will be important in the formation of integrated delivery systems. As SB 321 suggests, the first step should be a process where community representatives, providers and social service organizations come together in a search for common ground. This legislation provides such a mechanism.

While we endorse the cooperative process SB 321 puts in place, we think there are two other issues that need to be carefully considered. First, in addition to the construction of a new hospital, SB 321 applies to the "purchase or lease" of an existing facility. In order for an outside entity to purchase or lease a governmental hospital, already existing government entities such as the hospital board and the county commission would have to approve. For example, the county hospital laws provide that the "board may enter into written contracts for the lease of any hospital property to any person, corporation, society or association upon such terms and conditions as deemed necessary by the board." (K.S.A. 19-4611) Those same statutes contemplate that when the operation of a county hospital is proposed to be terminated, the issue must be submitted to the voters. (K.S.A. 19-4625) The point here is that current law provides a mechanism for part of the procedures contemplated by SB 321. We think that adding another governmental unit into the mix could confuse the process and invite conflict.

Secondly, we question the amount of authority given to the new government entity. Section 6 disallows the construction, purchase or lease unless an agreement is reached with the community cooperation council. We know that many will say this section is important because it provides the enforcement mechanism. Our questions, however, stem from the possibility that Section 6 could in some instances actually create more conflict. This section creates a new governmental entity with apparently absolute power to decide whether the purchase, lease or construction of the hospital should proceed. As we mentioned earlier, there may be two other local governmental units who feel they should be involved in the decision making process. If these different units of government disagree, the community will not benefit. We think that the importance of SB 321 lies in the creation of the community cooperation council, not in giving it the power to make a final decision.

Thank you for your consideration of our comments.

TLB2/SB321.tes/pc022295

City of Lawrence
KANSAS

CITY COMMISSION

MAYOR
JOLENE ANDERSEN

COMMISSIONERS
BOB MOODY
DOUG COMPTON
JOHN NALBANDIAN
ROBERT C. SCHULTE

MIKE WILDGEN, CITY MANAGER

CITY OFFICES 6 EAST 6th
BOX 708 66044-0708 913-832-3000
TDD 913-832-3205
FAX 913-832-3405

To: Honorable Senator Sandy Praeger, Chair,
Senate Committee on Public Health and Welfare
and Committee Members

From: Robert Schulte, City Commissioner
City of Lawrence
Date: February 23, 1995
Re: Senate Bill 321 - Community Health Cooperation Act

The City of Lawrence appears before the Committee today to urge its support of Senate Bill 321 - the Community Health Cooperation Act.

The intent and effect of this legislation is to require consultation, coordination, and cooperation among publicly owned hospitals, future hospital providers and locally elected officials. Communities have a tremendous investment in their publicly owned hospitals. A City owned and operated hospital represents taxpayer investments, years of community involvement and responsibility, and the trust that the community will seek the best health care for its citizens. A City owned hospital is a vital asset to the health care needs of a community. Such is certainly the case with Lawrence Memorial Hospital, which is owned by the City of Lawrence and governed by a Board of Trustees appointed by the City Commission.

In these times of changes in the health care industry, a community's asset in a City owned hospital should be protected from future hospitals which would not recognize their responsibilities to the community. Senate Bill 321 provides a mechanism for discussing these important issues with a potential hospital provider in a community. It is entirely appropriate to ask future hospitals -- in communities with a City hospital already in existence -- the manner in which they plan to meet the health care needs and burdens of a city. It is also in the public's interest that these new hospital providers be required to comply with the plans developed by the community health cooperation councils. In essence, this bill allows a social contract to be forged that the community's health care needs will be addressed by both a city hospital and any new private provider.

The City owned hospital in Lawrence represents a tremendous public investment and public resource. It is appropriate that its mission be protected with this proposed legislation.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 6

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

TESTIMONY PRESENTED TO THE

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Senate Bill 321

Thank you for the opportunity to provide testimony this morning related to Senate Bill 321. This bill establishes a mechanism by which local units of government may review construction of new hospitals or the purchase/lease of existing hospitals in communities which have city, county, or district hospitals. The bill also requires the Kansas Department of Health and Environment (KDHE) to enforce any "community benefit agreements" which might be developed resulting from enactment of Senate Bill 321.

Background

KDHE currently licenses approximately 165 medical care facilities (hospitals, ambulatory surgical centers, and recuperation centers) under the provisions of KSA 65-425 et seq. Of this number, there are an estimated 80 city, county, or district hospitals.

The expressed purpose of the medical care facility licensure act, as found at KSA 65-426, is:

> . . . to provide for the development, establishment and enforcement of standards: (1) For the care and treatment of individuals in medical care facilities; and (2) for the construction, maintenance and operation of medical care facilities.

KSA 65-430 provides authority to KDHE to take an action against a licensed facility if the facility:

- Is found to be out of substantial compliance with the provisions of the act;
- Fails to report acts committed by referenced practitioners, which may be grounds for disciplinary action by appropriate licensing boards; and
- Fails to maintain a risk management program.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 7

900 SW Jackson St, Suite 620, Topeka, KS 66612-1290

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Program Impact

It is difficult to measure the full impact of enactment of Senate Bill 321 since there is no way to predict how many city, county, or district hospitals may face the prospect of being purchased or leased by another owner or how many new hospitals may be built or purchased or leased in those counties having such facilities. The prospect of new hospitals is most likely limited. However, purchase/lease arrangements may be more significant.

KDHE has two significant responsibilities under the provisions of Senate Bill 321. These center around the enforcement of "community benefit agreements." The first appears in new Section 5 in which the Secretary's decision that "the new owners of the hospital have substantially failed to comply with a community benefit agreement" can have tax payment implications on the violator of the agreement. Previously tax-exempt personal or real property can be taxed if the new owners fail, as determined by the Secretary, to comply with the agreement. KDHE has not had this type of authority, and it raises some implementation issues.

As noted, the amendment to KSA 65-427 in Section 6 makes a "community benefit agreement" enforceable by KDHE as part of the facility's license. The following issues are raised by this amendment:

- KDHE would be responsible for enforcing provisions of an agreement in which it has had no input into the agreement's formation.

- Some of the items expected to be enforced could be less than specific, such as:

  > . . . the community expectations of availability of services to be provided, the coordination of services to be provided, the coordination of services with existing facilities, the opportunities for minimizing duplication of services, the care to be provided uninsured and underinsured persons, the benefits to the community which will result and other matters relating to community expectations which the parties to the community benefit agreement deem appropriate.

- KSA 65-430 provides KDHE the authority to "deny, suspend or revoke a license" if there is "substantial failure to comply with the requirements established" under KSA 65-425 et seq. If the expected benefits to the community are not met in accordance with the agreement or the amount of care to be provided uninsured persons is not fulfilled, does KDHE revoke the license? The bill does not contemplate any mechanism for revision or amendment to the community benefit agreement.

- KDHE will be in a position to enforce actions taken by a local council of five to 15 persons based upon information gathered in public hearings. Community benefit agreements may be established without benefit of established standards, objective data, or staff resources. The result could lead to broad cooperative agreements with questionable enforcement standards established.

Conclusion

KDHE supports the concepts within Senate Bill 321 which provide local communities and their publicly-owned hospitals with a mechanism for input into the delivery of health care at the city, county, and hospital district level. The following technical suggestions and clarifications are made for your consideration.

- In line 32 of new Section 2(b), the board of county commissioners or governing body of the city is required to decide whether or not a community health cooperation council will be appointed. Some consideration should be given to establishing further time frames for the conduct of public hearing or adoption of a final agreement. What if the 90 days pass, Section 2 (c), and the process is not completed? Can construction then occur? In addition, the county commissioners or governing body of the city should be able to extend the time period for good cause shown.

- Since KDHE is to have "enforcement" authority under Section 6, a copy of the agreement also should be filed with the Secretary. In addition, KDHE should receive a draft copy of the written agreement in order to comment (not for approval but for technical assistance) on the proposed provisions, e.g., are they measurable, quantifiable and enforceable?

- Some consideration might be given to include language allowing the community health cooperation council and a new "owner" to amend the "community benefit agreement" as necessary.

- Under Section 6 (b), KDHE suggests an amendment (see attached) which would clarify the application process.

- It is unknown at this time what resources may be necessary in the future in order for KDHE to fulfill the new statutory provisions since the number and/or complexity of the community agreement(s) is impossible to estimate. Thus, we ask that the Legislature be supportive for reasonable budgetary requests for any future, substantial statutory demands.

Thank you very much for this opportunity to speak with you this morning.

Presented by: Steven Potsic, M.D., M.P.H.
Director of Health
Kansas Department of Health and Environment
February 23, 1995

1 each such year during which such property was not taxed, and it shall be
2 designated on the appraisal roll as "added appraisal" for each such pre-
3 ceding year or years. The county clerk, upon receipt of the valuation for
4 such property shall place such property on the tax rolls and compute the
5 amount of tax due based upon the mill levy for the year or years in which
6 such tax would have been levied, and shall certify such amount to the
7 county treasurer as an added appraisal. The amount of such tax shall be
8 due immediately and payable within 45 days after the issuance of an
9 additional property tax bill by the county treasurer. No interest shall be
10 imposed unless the tax remains unpaid after such 45 day period. Taxes
11 levied pursuant to this section which remain unpaid after such 45 day
12 period shall be deemed delinquent and the county treasurer shall collect
13 and distribute such tax in the same manner as prescribed by law for the
14 collection and distribution of other taxes levied upon property which are
15 delinquent. If the owner of such property is deceased, taxes charged as
16 herein provided shall be levied against the estate of such deceased person
17 and shall be paid by the legal representative or representatives of such
18 estate.
19 (c) Any tax collected under this section shall be distributed as oth-
20 erwise provided by law except that with the agreement of the local taxing
21 districts eligible to receive such revenues the revenues which would have
22 been received by the local taxing districts may be placed in a community
23 fund, in accordance with such agreement, to support local health initia-
24 tives as provided in the agreement.
25 Sec. 6. K.S.A. 65-427 is hereby amended to read as follows: 65-427.
26 ~~After July 1, 1973,~~ *(a)* No person or governmental unit, acting severally
27 or jointly with any other person or governmental unit shall establish, con-
28 duct or maintain a medical care facility in this state without a license
29 under this law.
30 *(b) The agreement reached by the community health cooperation*
31 *council and by the person filing notice under subsection (a) of section 2*
32 *and amendments thereto to construct, develop or otherwise establish a*
33 *new hospital or to purchase or lease an existing hospital shall be a part*
34 *of any license issued for the hospital and shall be enforceable by the li-*
35 *censing agency as a condition on the license. If a community health co-*
36 *operation council is appointed under section 3 and amendments thereto,*
37 *no* [application from] ~~*license shall be granted to*~~ *any person who has filed a notice under*
38 *subsection (a) of section 2 and amendments thereto for the construction,*
39 *development or other establishment of a new hospital or for the purchase*
40 *or lease of an existing hospital* [shall be complete] ~~*unless*~~ *such person has cooperated with*
41 *the community health cooperation council under the community health*
42 *cooperation act and an agreement has been reached by the community*
43 *health cooperation council and such person under section 4 and amend-*

1 *ments thereto* , and such agreement is attached to the application.

2 Sec. 7. K.S.A. 65-427 is hereby repealed.

3 Sec. 8. This act shall take effect and be in force from and after its
4 publication in the Kansas register.

7-5

COLUMBIA/HCA

A New Commitment To Healthcare . . . Together

Healthcare Corporation

Two Brush Creek, Suite 401
Kansas City, Missouri 64112
Office 816/756-0566
Fax 816/756-5974

Testimony Regarding Proposed Senate Bill 321

--February 23, 1995--

John Leifer
Senior Vice President, Kansas City Division
Columbia/HCA

I appreciate the opportunity to speak to you on behalf of Columbia/HCA regarding Senate Bill 321. Before I begin my commentary on the merits of this Bill, please allow me to give you some brief background information on our company and its interest in this legislation.

Columbia/HCA is the world's largest healthcare provider. Upon the completion of our merger with HealthTrust next month, Columbia will operate in excess of 300 hospitals worldwide, and employ more than 170,000 people. Within the state of Kansas, we operate three hospitals: Wesley Medical Center in Wichita, Western Plains Regional Hospital in Dodge City, and Overland Park Regional Medical Center. These facilities are complemented by a number of outpatient facilities, rural health clinics, and other related services.

In 1993, our corporation provided $750 million in uncompensated care. This number does not represent medicare write-offs or discounts from charges -- it is uncompensated care. The same year, we paid $700 million in taxes. Within the state of Kansas that year, we provided $24.6 million in uncompensated care, and paid approximately $8.5 million in taxes. We honored our commitments to maintain costly yet vital medical education programs, while at the same time making major capital commitments to expand the capabilities of many of our facilities. In short, we acted as responsible members of the healthcare community.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 8

One of the characteristics used to describe our organization is that we are aggressive competitors. It's true -- we are, and we're proud of it. We see how competition is dramatically reshaping the healthcare landscape. A decade of double digit healthcare inflation is being replaced by ever so modest increases in the cost of care. This is not the result of regulation, but the result of marketplace competition. Given a chance, competition will work to the betterment of the system. Unfortunately, if Senate Bill 321 is enacted, in its present form, competition may well be stifled in many communities. There are certainly positive aspects to this legislation, but before I discuss them, allow me to share with you my concerns.

This bill may effectively eliminate competition in communities throughout Kansas by empowering these communities to exclude new entries into their markets. It is, in effect, certificate of need administered at the community level, and as such, a throwback to protectionist planning schemes of the 1960s and 70s.

Numerous authors have documented the ineffectiveness of certificate of need legislation as a regulatory device in healthcare:

Arnold J. Mendelson, writing in the Winter 1993 issue of Spectrum magazine stated:

> CON Programs have not been successful in holding down hospital costs. This conclusion is based on extensive empirical analyses of hospital costs between 1980 and 1989. Our findings concur with a number of studies conducted during the 1970s, concluding that the program did not decrease hospital costs during that time (Sloan, Steinwald 1980) (Policy Analysis, Inc., 1981), and two more recent studies that showed CON associated with modest increases in costs in the early 1980s (Ashby 1984 and Federal Trade Commission 1988).

Mendelson went on to say: "Legislators also are frequently interested in whether costs increased in states that repealed CON. We have found no evidence of increased costs in the 12 states that repealed their CON programs."

Rhode Island was one of the first states to create a CON process. Dr. Joseph Chazan, Clinical Associate Professor of Medicine at Brown University, described the efficacy of CON during the period from 1970-1979:

> The process had no effect on system-wide planning and did nothing to prevent duplication or encourage economy. [It] also acted as a virtual bar to the development of any comprehensive plan for health care growth. The process was reactive and lacked a planning framework.
>
> Rhode Island Medical Journal
> June, 1986

Dr. Chazan goes on to conclude that: "Efficiency and economy of scale, provision of unique services, and an innovate approach to the delivery of health care is mandated at all levels. In this setting, the certificate of need process represents a cumbersome, retrogressive approach to the reality of healthcare in the 1980s."

These authors may not be familiar with Lawrence, or Salina, or any other town in Kansas. But they are familiar with healthcare -- and they know that CON type legislation simply does not work.

Though we believe that the licensure clauses contained within this bill would have a deleterious effect on healthcare reform and cost containment, we do agree with select provisions of the bill. We believe that communities have a right to understand how the provision of healthcare may change when a new competitor enters the market, or when an existing facility is sold or leased to another provider. Representatives of Columbia/HCA are more than willing to participate in open hearings designed to educate residents of local communities about Columbia's plans and the ramifications of these plans. We believe that the better consumers understand their options, the more likely they are to welcome us into their backyards.

Thus, it is not scrutiny that we are afraid of here, but rather, that this bill provides for the formation of local committees that may have tremendous vested interests, yet are granted ultimate licensure authority within certain geographical boundaries. This will not result in an astute planning process at the community level, but rather an economically or politically driven committee whose motivation may have little to do with the ultimate healthcare needs of their community.

A final thought I'd like to share with you. I want to speak about a specific community -- Lawrence, Kansas, where we have a medical office building in operation and an outpatient facility under construction.

Prior to entering the Lawrence market, we did considerable research. We looked at the demand for certain medical services. We examined existing capabilities. And most importantly, we spoke directly with the people of Lawrence. We used an objective, third party research company to ascertain attitudes and opinions of local consumers, past patients, and employers regarding the need for a competing healthcare provider within their community. Though the vast majority of these respondents indicated a moderate to high level of satisfaction with the existing hospital, they told us that competition was welcomed -- and they believed that it would result in a better healthcare product and better value. We asked where this facility might best be located, and more than 75% of the respondents named our existing site as the best location. As you can see, we didn't enter Lawrence on a whim. We entered it based on an astute assessment of the demand for services and the desires of the marketplace. This is what should drive healthcare -- not more legislation.

Now, I'd like to introduce a representative from one of our hospitals -- Kevin Hicks, the Chief Executive Officer at Overland Park Regional Medical Center, who would like to make a few, brief remarks before we address your questions.

League of Kansas Municipalities

LEGISLATIVE TESTIMONY

PUBLISHERS OF KANSAS GOVERNMENT JOURNAL 112 S.W. 7TH TOPEKA, KS 66603-3896 (913) 354-9565 FAX (913) 354-4186

TO: **Senate Public Health and Welfare Committee**
FROM: Chris McKenzie, Executive Director
DATE: February 22, 1995
RE: Support for SB 321

I appreciate the opportunity to appear today in support of SB 321, enacting the community health cooperation act. I am appearing on behalf of the League of Kansas Municipalities, a public agency representing its 543 member cities of all sizes and stripes. Some of these cities (Arkansas City, Herington, Lawrence, Holton, Coffeyville, Sabetha, and Fredonia) have made direct investments in the construction of municipal hospitals. Still many other cities are located in counties that are served by county or district hospitals. In other words, the 543 League member cities have a big stake in the future of municipal, county and district hospitals and the substantial public investments they represent.

SB 321 simply provides an **optional** process through which a community could determine some of the terms under which a new hospital facility would be constructed or an existing hospital would be purchased or leased. This **optional** process calls for the appointment of a community health cooperation council by the governing body which would undertake the important and common sense process of conducting hearings and soliciting input on the nature of the proposed transaction and the likely impact on the community. It also puts in place a mandatory process through which an agreement could be negotiated to ensure the most feasible level of coordination occurs in the development, lease or purchase of a hospital facility in any community.

In addition to my perspective as the representative of cities across our state, I also bring to this task a recent experience chairing a somewhat similar council in Douglas County which led to the planning of new and remodeled facilities for a number of community health agencies in the county such as the health department, the community mental health center, and the home health agency. That process involved all three agencies in a planning process with the municipal hospital, and it led to a plan that was approved by the voters last November to finance the construction and remodeling of facilities on the existing municipal hospital campus to allow for the greatest level of coordination and cooperation among the health care agencies, including the hospital. That experience demonstrated to me the absolute importance of requiring close coordination before new health care facilities are constructed in a community.

While we do support this legislation, we would recommend that additional provisions be added to New Section 4, requiring final approval of any community benefit agreement by the local elected governing body before it can be used by the other party in making application to establish a medical facility under Section 6 of the bill. It also may be desirable to include some time deadline in Section 4 so negotiations must be completed by a date certain. A similar time schedule by which consideration and action by the appropriate governing body also would seem appropriate. I would suggest that action approving or disapproving the agreement should be required within 45 days of the date the agreement is filed with the governing body.

Thank you again for the opportunity to appear today.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 9

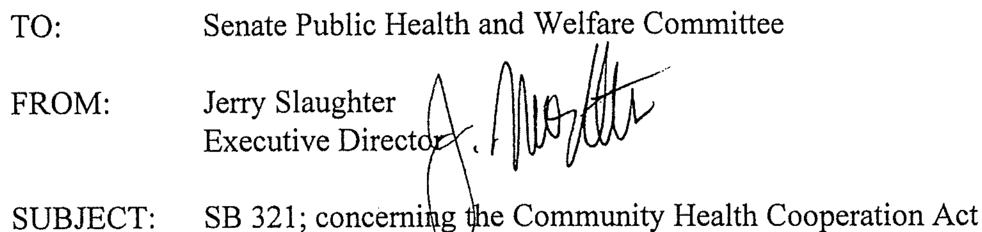
KANSAS MEDICAL SOCIETY

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

February 23, 1995

TO: Senate Public Health and Welfare Committee

FROM: Jerry Slaughter
Executive Director



SUBJECT: SB 321; concerning the Community Health Cooperation Act

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 321, which establishes the Community Health Cooperation Act. This bill is the first attempt we are aware of which encourages communities to take a more active role in the decisionmaking process which takes place when corporations or individuals express their intent to purchase or build a hospital which may duplicate existing facilities. While we are not directly affected by the bill, the decision to construct a new hospital has tremendous impact on local physicians, and the entire provider community.

It seems to us that the important element contained in this legislation is its attempt to give community leaders the opportunity to engage in a meaningful discussion about community health needs with potential hospital developers before additional bed capacity, and cost, is added. The bill doesn't appear to block someone from building or acquiring a hospital; it just requires them to go through this process, if the community wants to participate in the discussions.

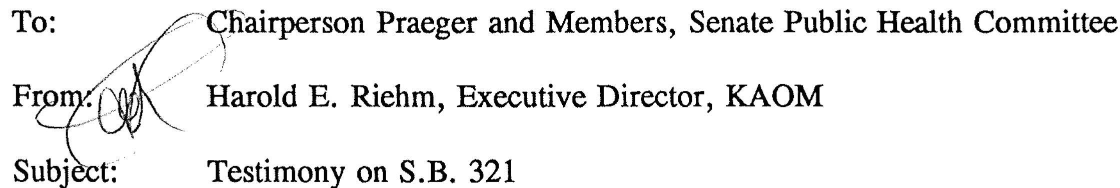
This bill gets at the heart of a trend which is reshaping the health care system. Until just recently, health care was for the most part controlled and delivered locally by not-for-profit entities, or by local providers; in other words it was community based. Lately, there has been rapid growth in the extent to which for-profit corporations have begun to take over the delivery of care, especially as it relates to hospitals and health plans. That is not to say that the trend is necessarily bad, but it does raise the issue of losing the "local" focus of health care. SB 321 will not stop the trend, but it will at least make a community dialogue possible, if the affected community wants to talk. We would encourage you to give the bill serious consideration. Thank you for the opportunity to offer these comments.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

February 23, 1995



To: Chairperson Praeger and Members, Senate Public Health Committee

From: Harold E. Riehm, Executive Director, KAOM

Subject: Testimony on S.B. 321

Thank you for this opportunity to express our views on S.B. 321. We appear to express our concerns on what is happening in the delivery of health care that no doubt parallels, in some respects, the concerns which prompted introduction of this Bill.

In past testimony, I have relayed to you concerns of physicians I represent on developments in both the horizontal and vertical integration of health care delivery in Kansas. In some respects, activities by hospitals to purchase physician practices, consolidate the referral base, and related activities, are a response to the reality or potential that there are new hospital players in the "game". We have stated before, that many of the consequences of these changes are unknown--they may ultimately be positive or, perhaps, detrimental to the health consuming public.

One thing we think is needed, though, and one not always present, is for the communities whose health care delivery systems will be impacted by these changes, to have opportunity for input into the decision making process. In some cases that occurs naturally; in others it is absent, or unilateral. This Bill would put in place a process for systematic consideration of the consequences of suggested changes in hospital related services.

There is another concern, one that is often intangible in its effect and difficult to describe. It is the extent to which a community hospital is often, in itself, an important "defining feature" of what constitutes a local community. True more in rural and small town areas more than in large urban areas, a community hospital often shares characteristics with a high school or other institution in which citizens take great pride and in which its very existence may have become a reality at great local citizen expense and involvement. To that extent, a hospital often "defines" a community. Its loss, or a decline in local identity, is a matter of considerable community importance.

To the extent that this Bill would institutionalize a process of meeting and considering and requires those proposing change to deal with the specifics of their plans, we think this Bill has merit. The extent to which such a process then actually determines the extent or process of change, we will leave to the deliberation of others.

I will be pleased to respond to questions.

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 11

~~(1) Manicuring, pedicuring or sculpturing nails;~~

~~(2) massaging the hands and arms;~~

~~(3) shampooing or applying temporary color rinse to the hair;~~

~~(4)~~ *(1)* Performing ~~scalp treatments,~~ facials, skin care and eyebrow and eyelash services; or

~~(5)~~ *(2)* removing superfluous hair from the face or body, using either the hands or mechanical or electrical appliances other than electric needles.

(f) "Manicurist" means any person who, for ~~profit~~ *compensation, whether direct or indirect*, practices the profession of cosmetology only to the extent of manicuring, pedicuring and sculpturing nails.

(g) ~~"Onychology"~~ *"Nail technology"* means the ~~practice of cosmetology only to the extent of~~ *information related to* manicuring, pedicuring and sculpturing nails.

(h) "Electrologist" means any person who, for ~~profit~~ *compensation, whether direct or indirect*, removes hair from, or destroys hair on, the human body for beautification by use of an electric needle only.

(i) "Person" means any individual, corporation, partnership, association or other entity.

Sec. 2. K.S.A. 65-1902 is hereby amended to read as follows: 65-1902. (a) Except as provided in subsection (b), no person shall:

(1) Engage in practice ~~as a cosmetologist, cosmetology technician or manicurist~~ *of cosmetology, esthetics, manicuring or electrology* unless the person holds a valid license, issued by the board, to engage in that practice;

(2) engage in practice ~~as an electrologist unless the person is a licensed cosmetologist or cosmetology technician and also holds a valid license, issued~~ *of cosmetology, esthetics, manicuring or electrology in any place other than a salon licensed* by the board, ~~to engage in that practice~~ *under K.S.A. 65-1904a and amendments thereto, a medical care facility licensed under K.S.A. 65-425 et seq. and amendments thereto, an adult care home licensed under the adult care home licensure act, a jail, correctional facility or other place established for the confinement of offenders or the home of a disabled person*;

(3) conduct a school for teaching cosmetology unless the person holds a valid license, issued by the board, to conduct the school;

(4) teach cosmetology in a licensed school unless the person holds a valid cosmetology instructor's ~~permit or~~ license issued by the board;

(5) conduct a school for teaching ~~onychology~~ *nail technology* unless the person holds a valid license, issued by the board, to conduct the school;

(6) teach ~~onychology~~ *nail technology* in a licensed school unless the person holds a valid cosmetology or ~~onychology~~ *manicuring* instructor's

Senate Public Health & Welfare
Date: 2-23-95
Attachment No. 12