Approved: 3-11-99
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on March 9 in Room 423-S of the Capitol.

All members were present except: Representative David Haley, Excused

Committee staff present: Emalene Correll, Kansas Legislative Research
Norman Furse, Revisor of Statutes
June Evans, Secretary

Conferees appearing before the committee: John Pepperdine, American Cancer Society
Jerry Slaughter, Executive Director, Kansas Medical Society
Bob Alderson, Kansas Pharmacists
Marcene Grimes, Executive Director, Topeka Chapter, Alzheimers Association
Debra Zehr, Kansas Association of Homes and Services for the Aging

Others attending: See Attached

The Chairperson opened the hearing on **SB 108 - Off-label drugs.**

Staff reviewed the bill stating the bill was requested by the Health Care Reform Legislative Oversight Committee. **SB 108**, as amended, enacts new law related to "off label" use of drugs. The term "off label" is defined as prescribing prescription drugs for treatments other than those stated in the labeling approved by the federal food and Drug Administration (FDA).

The bill would prohibit insurance companies and health maintenance organizations that provide coverage for prescription drugs from excluding coverage of a prescription drug for cancer treatment on the grounds the prescription drug has not been approved by the FDA for that covered indication. The drug being prescribed for off-label use must be recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. If requested by the insurer, the prescribing provider must submit documentation supporting the off-label use. Staff stated there were some problems with New Sections 2 and 4 and needed to be amended. New Section 1, line 22 (a) needs to delete "prescription drug" and where specifically want to reference the antineoplastic agent approved by the FDA just insert that. There might be a simpler way and staff would have to determine that. Section 8 shows this act shall take effect and be in force from and after its publication in the Kansas register. If it were to become effective after July 1 it would have to be tested through the Kansas Insurance Plan.

John Pepperdine, Manager of Government Relations, American Cancer Society, testified in support of **SB 108**, stating after a drug is approved for one purpose, physicians legally may prescribe the drug for other purposes or diseases. This is called "off-label" use of drugs or use for "unlabeled indications." The US General Accounting Office estimates that about 56 percent of cancer patients received an off-label drug. (See Attachment #1)

Jerry Slaughter, Executive Director, Kansas Medical Society, testified as a proponent to **SB 108**, stating the KMS supports the practice of allowing physicians to prescribe drugs for purposes other than those indicated on the label, according to their medical judgment and consistent with credible medical studies. Most insurance companies in Kansas currently cover off-label prescribing by physicians and do not want to restrict a physician from prescribing according to his or her best medical judgment. However, this bill covers only off-label drugs used in the treatment of cancer. There is concern that by not specifically requiring coverage for other off-label prescribing, the bill could inadvertently send a message to insurance companies that other conditions do not merit coverage. The KMS recommends an amendment on page 2, New Section 4, line 20, to insert after act "shall not be construed to limit, restrict or prohibit the prescribing and coverage of off-label use of drugs for any condition not specified in new section2, nor

does this act (See Attachment #2).

Bob Alderson representing the Kansas Pharmacists Association, testified as a proponent to **SB 108**, stating that KphA does not have a policy specifically addressing the mandated coverage of off-label drug uses. However, the American Pharmacy Association advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist and physician, those products are for medically acceptable, off-label uses (See Attachment #3).

Written testimony supporting **SB 108** was provided by Sally Finney, Executive Director, Kansas Public Health (See attachment #4).

The Chairperson closed the hearing on **SB 108** and stated this could not be worked unless it were amended as suggested by staff.

Representative Morrison requested clarification of language by staff, then work with a clear bill.

The Chairperson stated **SB 108** would be brought up on March 16 after receiving a clear bill.

The Chairperson opened the hearing on **SCR 1606 - Long-term care staff training funds.**

Staff gave a briefing on **SCR 1606,** requesting the governor of the state of Kansas to identify funds available for training and retraining long-term care staff.

Marcene Grimes, Executive Director, Alzheimer's Association-Topeka Chapter on behalf of the Kansas Coalition of Alzheimer's Association Chapters, testified in support of **SCR 1606.** The objective is to get all the nursing homes in Kansas and also the home health agencies to start utilizing consistent, standardized training programs so that CNAs, for example, trained in one facility would have the proper credentials when they transfer to another facility. Some of the facilities are going to need help paying for all this training and retraining, since continuing education is going to be part of the game plan. **SCR 1606** directs the governor to seek sources of this funding from within the administration. (See Attachment #5)

Debra Zehr, Vice President, Kansas Association of Homes and Services for the Aging, testified as a proponent to **SCR 1606**. Staff recruitment and retention is the foremost concern of KAHSA members. Nursing homes are in the midst of a staffing crisis that cuts across rural/urban and ownership lines, negatively impacting the quality of care for nursing home residents throughout the state. Average annual turnover among CNAs statewide is nearly 120% according to the Department of Social and Rehabilitation Services. Among not for profit nursing homes the figure is 90%. **SCR 1606** is good public policy because it directly addresses what is known as underlying cause of staff turnover in nursing homes. By helping to stabilize nursing home staffing, it would reduce costs to the state, and, most importantly, achieve and maintain high quality of care for frail elders residing in Kansas nursing homes. (See Attachment #6)

The Chairperson closed the hearing on **SCR 1606.**

Representative Wells moved and Representative Morrison seconded to pass **SCR 1606** out favorably and place on the consent calender.

There was discussion and Representative Landwehr moved a substitute motion to also report to the SRS Oversight Committee, the Appropriations Committee of the House and the Committee on Ways and Means of the Senate. The motion failed for lack of a second.

Representative Wells moved and Representative Swenson seconded a substitute motion to move **SCR 1606** out of committee favorably. The motion carried.

Representative Landwehr requested to be recorded as voting NO.

The meeting adjourned at 2:30 p.m. The next meeting will be March 10.

HUMAN AND HEALTH SERVICES

DATE March 9, 1999

NAME	REPRESENTING
Tim Wood	Via Christi Health System
Wesley Marshall	InterHab
Donald L. Banning	Independence
Kathy Tinsley	Ks. Public Health Assn.
Lee Gilliam	Health Midwest
Debra Zehr	KAHSA
Marcene Grimes	Alzheimer's Association
Bob Alderson	Kansas Pharmacists Assoc.
Nancy Daughtry	KAMU
Doug A. Blaylock	Intern for Bill Snyder
Keith R. Landis	Chiropractic Science Committee on Publication for Kansas
Steve Jack	KDOCH
Brad Smoot	DCBS/HLR
Stacy Seldon	Kleint + Klein Chtd
Greg Hill	Federico Consulting
Kathie Anderson	KAHP

AMERICAN CANCER SOCIETY® Hope. Progress. Answers.

March 9, 1999

Written testimony by John Pepperdine
Manager of Government Relations

SUPPORT OF SENATE BILL 108 UNDER REVIEW BY THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

Thank you for allowing me to speak. My name is John Pepperdine and I am Manager of Government Relations for the American Cancer Society. Representing over 270,000 volunteers and supporters in Kansas, I am here to support Senate Bill 108 in it's current form.

After a drug is approved for one purpose, physicians legally may prescribe the drug for other purposes or diseases. This is called "off-label" use of drugs or use for "unlabeled indications." The US General Accounting Office estimates that about 56 percent of cancer patients received an off-label drug.

It is important to note that cancer is unique and depends on novel approaches, even more so than most diseases. Such novel approaches often require access to novel treatments and drugs. Unfortunately, this may be blocked by insurers who only cover FDA approved use of the drug. For the cancer patient, the risk of side effect is far less than the risk of death from cancer.

In the words of Dr. Katie Rhoades, a American Cancer Society Board member and volunteer as well as President-elect of the Kansas Medical Society, **"unforeseen numbness in the foot is a lot better than cancer progressing to the rest of your body."**

Many health insurers limit access to "off-label" uses of approved drugs by refusing to provide financial reimbursement for them. This presents an undue financial and emotional strain on cancer patients and may result in unnecessary suffering and even death if the treatment is denied.

Requiring FDA approval for every new indication may take more than five years each and millions of dollars on behalf of the drug manufacturers. In addition, once the patent for a drug expires, there is little incentive for the drug company to seek FDA approval for a new indication because the company may not be able to recoup the investment in research without exclusive manufacturing and marketing capability.

The American Cancer Society concurs with the FDA position that "off-label" use of approved cancer drugs may be an appropriate treatment regimen for many patients, as determined by medical experts and prescribed in accepted medical compendia and journals.

Continued

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Again, the American Cancer Society supports legislative and regulatory initiatives to require health insurance companies, Medicaid, Medicare, and public employee benefits plans to provide reimbursement for off-label use of approved cancer drugs, provided that such drugs have been recognized for treatment of the specific types of cancer in established medical reference compendia.

On a final note, insurers who have testified in the past, point out that legislation of this type or mandates are a burden to them. While this may be true, I would hope the committee not only looks at the burden on these companies but considers the burden placed on the individual cancer patient. The insurance providers may be forced to raise their rates, however, the cancer patient may be forced to decide between medication that can save their life or food on the table.

As of July 1998, 31 states had laws for private insurers to cover off-label use of drugs, including Missouri and Oklahoma. Our organization sincerely hopes Kansas will be the next state to enact such legislation.

Thank you for your time.

KMS

KANSAS MEDICAL SOCIETY

March 9, 1999

To: House Health and Human Services Committee

From: Jerry Slaughter
Executive Director

Subject: **SB 108; relating to mandatory insurance coverage for off-label prescribing of drugs for cancer**

The Kansas Medical Society appreciates the opportunity to appear today in support of the SB 108, which relates to off-label use of prescription drugs for cancer treatment. KMS supports the practice of allowing physicians to prescribe drugs for purposes other than those indicated on the label, according to their medical judgment and consistent with credible medical studies.

Off-label prescribing is a common and widely accepted practice by physicians. The Food and Drug Administration (FDA) normally approves a specific therapeutic use for a particular drug, even though there may be other acceptable uses for the product. There are many examples of such uses, and the treatment of cancer is but one of the many legitimate applications of off-label prescribing.

We are aware that most insurance companies in Kansas currently cover off-label prescribing by physicians. We support this, and do not want to do anything to restrict a physician's freedom to prescribe according to his or her best medical judgment. However, this bill covers only off-label drugs used in the treatment of cancer. We are concerned that by not specifically requiring coverage for other off-label prescribing, the bill could inadvertently send a message to insurance companies that other conditions do not merit coverage. To that end, we would like to offer an amendment that does not mandate coverage, but makes it clear that the bill is not intended to limit off-label prescribing to cancer treatment. Our amendment is attached.

Thank you for considering our comments.

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Atch #2

investigation that has not been approved by the federal food and drug administration for the specific type of cancer it is being tested safe and effective in treating.

New Sec. 2. An insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation or health maintenance organization that provides coverage for prescription drugs may not issue, deliver, execute or renew any health insurance policy or health service contract on an individual, group, blanket, franchise or association basis which excludes coverage of a prescription drug for cancer treatment ~~and pain management~~ on the grounds the prescription drug has not been approved by the federal food and drug administration for that ***covered*** indication if the prescription drug is recognized for treatment of the indication in one of the standard reference compendia or ***in substantially accepted peer-reviewed*** medical literature. The prescribing physician shall submit to the insurer documentation supporting the proposed ~~off-limit~~ ***off-label*** use or uses if requested by the insurer.

New Sec. 3. The commissioner of insurance may direct an insurer or contractor regulated by this section to make payments as required by this act.

New Sec. 4. This act ~~does not~~ alter existing law regarding provisions limiting the coverage of prescription drugs that have not been approved by the federal food and drug administration; does not require coverage for any prescription drug when the federal food and drug administration has determined its use to be contraindicated; and does not require coverage for experimental drugs not otherwise approved for any indication by the federal food and drug administration.

shall not be construed to limit, restrict or prohibit the prescribing and coverage of off-label use of drugs for any condition not specified in new section 2, nor does this act

Sec. 5. K.S.A. 1998 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1998 Supp. 40-2,160 *and sections 1 through 4 of this act, and amendments thereto*, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 6. K.S.A. 1998 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-

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MEMORANDUM

TO : House Committee on Health and Human Services

FROM: Bob Alderson on Behalf of Kansas Pharmacists Association

RE : 1999 Senate Bill No. 108 (As Amended by Senate Committee)--
Off-Label Drug Use

DATE: March 9, 1999

My name is Bob Alderson, and I am appearing on behalf of the Kansas Pharmacists Association (KPhA) in support of Senate Bill No. 108. Thank you for this opportunity to address the Committee.

I have attached to my testimony a copy of the testimony which Bob Williams, KPhA's Executive Director, presented to the Health Care Reform Legislative Oversight Committee this summer regarding off-label drug use. In that testimony you will find a brief description of the drug approval process, accepted texts recognized as authoritative resources on off-label uses, definitions of "label" and "labeling" and examples of drugs and their off-label uses. I trust the Committee will find this information useful to its consideration of SB 108.

I would like to reiterate that KPhA does not have a policy specifically addressing the mandated coverage of off-label drug uses. However, the American Pharmacy Association advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist and physician, those products are for medically acceptable, off-label uses.

KPhA is in support of SB 108. It is a good first step. However, we trust that, based on the experience to be gained from the passage of SB 108, future legislatures will mandate the coverage of **all** off-label drug uses. We believe this would allow for better patient care and more positive outcomes.

We encourage your support of SB 108. Thank you.

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3-9-9
Atch #3

THE KANSAS PHARMACISTS ASSOCIATION
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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
Health Care Reform Legislative Oversight Committee
September 22, 1998

Off-Label Drug Mandate

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee.

While the Kansas Pharmacists Association does not have a policy specifically addressing the mandated coverage of off-label drug uses, the American Pharmacy Association advocates removal or restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist and physician, those products are for medically acceptable, off-label uses.

The Kansas Pharmacists Association has received member reports of difficulties and frustrations in seeking compensation for drugs dispensed for off-label but widely accepted indications and/or dosages.

A defined use for a drug approved by the Food and Drug Administration (FDA) can be included in a drug product's labeling only after the pharmaceutical manufacturer submits that use in a New Drug Application (NDA) or in a supplemental NDA, and gains approval for that use from the FDA.

The use of approved drugs for off-label uses is escalating. There are currently three accepted texts recognized as authoritative resources on off-label uses: the American Hospital Formulary Service Drug Information (AHFSDI); the American Medical Association Drug Evaluations (AMADE) and the United States Pharmacopeial Drug Information (USPDI). These texts establish and support the standards of practice for the use of FDA-approved drugs for off-label indications. These references are accepted by Blue Cross/Blue Shield and the Health Industry Association of America, however, there is substantial variation among these reference texts.

There is little incentive for manufacturers to supply FDA with studies or data on additional uses for new or established products. There are situations in which one company has pursued extensive indications when others who market the same drug under their own brand names have not. The decision to pursue additional indications for use often rests on financial rewards to be derived by the manufacturer. There was a piece related to off-label uses included in the Food and Drug Administration Modernization Act of 1997 (FDAMA). This provision allows pharmaceutical manufacturers to share information (i.e. medical journal articles) on off-label uses of FDA-approved products with certain health professionals or organizations such as physicians and PBMs. Although the FDA expresses no intent to influence payors in their decision as to whether a drug is covered for an off-label use, many payors respond by not paying for "unapproved uses."

The terminology linked to this subject contributes to some of the confusion that exists. The definitions of labeling and label are contained within the Food, Drug and Cosmetic Act (FDCA). Labeling refers to "all labels and other written, printed, or graphic matter upon any

articles or any of its containers or wrappers, or accompanying such article" (e.g. package inserts, advertisements). The term label refers to "a display of written, printed, or graphic matter upon the immediate container." When a product's label or labeling is false or misleading, the product is misbranded. Therefore, a pharmaceutical manufacturer or marketer that promotes or labels a product for an "unapproved" use is in violation of the FDCA because the product would be deemed "misbranded." The "package insert" often referred to as professional labeling, establishes the limits to be used by the company for promotion of the drug product. The FDCA does not, however, limit the manner in which a physician may use and approve drugs. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimes for patient populations that are not included in approved labeling. Such "unapproved," or more precisely "unlabeled" uses may be appropriate and rational in certain circumstances and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature. A more suitable term is "off-label" use because the specific indication is not found in the labeling.

There are numerous examples of off-label uses of drugs that were well-established in the medical field long before the FDA officially approved their uses. For example, by 1969, the efficacy of propranolol in angina and hypertension were well-established. These uses were not approved by the FDA until 1973 for angina and 1976 for hypertension. Studies indicating amantadine's effectiveness in Parkinson's date back to 1969; the FDA did not approve its use in Parkinson's disease until 1976. The use of lidocaine for management of cardiac arrhythmias dates back to 1950 and was finally approved by the FDA for that use in 1969. Finally, diazepam

was being used for status epilepticus in the early 1960's, but approval by FDA for that use did not occur until 1967.

Numerous drugs are currently being used for off-label indications. Some common examples include fluoxetine for weight loss, clonidine for the pain of shingles lesions, propranolol for generalized anxiety disorders associated with "stage freight" or "stress," and tetracycline for non-specific mouth ulcerations. According to one study, one-third of all uses for commonly used antineoplastic drugs were for off-label indications. Many pediatric doses of drugs are considered to be off-label.

Current FDA regulations dictate that a drug cannot be manufactured, packaged, or labeled for pediatric use unless the drug manufacturer has completed extensive testing on pediatric patients. Moreover, without such testing, the drug's manufacturer is prohibited from including instructions pertaining to pediatric use in its official dosing guidelines. In fact, according to the FDA, the dosing information for more than 80% of drugs approved between 1984 and 1989 for adult use contain no information whatsoever relevant to the administration of those drugs to pediatric patients.

Coverage and reimbursement for off-label use has been recognized as an important issue by numerous private insurers, the Health Care Financing Administration (HCFA), and state Medicaid departments. Coverage and reimbursement for what is determined to be "medically reasonable and necessary" has been the general standard for government and private third party payors. Views about what constitutes "medically reasonable and necessary" are quite varied.

While insurance companies and other third party payors provide reimbursement for labeled uses in accepted standards of practice, each company's policy varies in regard to

compensation for off-label uses, evolving therapies, and investigational therapies. Some third party payors cover these drugs when established protocols have been followed and other medications have been tried beforehand without satisfactory outcomes. Some third party payors seem to view inclusion of an indication in the labeling as a prerequisite for coverage and reimbursement. An off-label use of a FDA-approved drug refers to a use which is not included in the approved labeling. An off-label use may be appropriate and rational in certain circumstances, and may reflect approaches to drug therapy that have been extensively reported. Because the FDA does not prefer comparative evaluations, and does not make an official determination about uses outside of the label that might affect a special population, such as those covered by Medicare, the FDA is comfortable with health professionals and third party payors making determinations on "medical necessity" beyond those based on the "safety and efficacy" standards that must be met for inclusion in the official label.

Thank you.

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KANSAS PUBLIC HEALTH ASSOCIATION, INC.

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Testimony on SB 108
Submitted by Sally Finney, Executive Director
on March 9, 1999

The Kansas Public Health Association supports SB 108, a bill to allow off-label use of prescription drugs. Once the U.S. Food and Drug Administration approves a drug for one use, physicians may, based on published findings showing that drug to be effective for other uses, prescribe it for purposes not specified in the FDA's original approval. Unfortunately, their patients typically must bear the cost of such treatment because insurers do not reimburse for this "off-label" usage. The process for a pharmaceutical manufacturer to gain FDA approval for each new indication for a drug sometimes takes more than five years at a cost the company is usually unable to recoup. Ultimately, patients may be forced to forego treatment with drugs showing promising new uses because they cannot bear the added cost of already expensive care.

Because SB 108 includes language required documentation supporting the proposed off-label use, we are confident the intentions of this legislation will be carried out in the best interest of patients without abuse by providers or insurers.

We ask your support of SB 108.

HHS
3-9-99
Atch #4

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TESTIMONY IN FAVOR OF SCR 1606 March 9, 1999

Presented by Marcene Grimes, Executive Director, Alzheimer's Association-Topeka Chapter on behalf of the Kansas Coalition of Alzheimer's Association Chapters

Over 50% of nursing home residents in Kansas suffer from dementia. The Certified Nurse Aides (CNAs) who care for these residents, the front-line caregivers, need to be trained in the special care needs of dementia residents. They need to learn some special skills in working with dementia patients that are not necessary in working with residents who are just growing old naturally or who have specific physical ailments that are treatable.

The three Alzheimer Association chapters in Kansas are part of a new Dementia Training Initiative that has as its goal the development of dementia-specific training curricula for all staff in adult care homes and home health agencies. The CNAs are a vital part of this initiative and one of our first targets. Eight other organizations and state agencies are involved in this initiative. The curricula will be developed during this calendar year and will be offered to nursing homes and home health agencies to implement on a voluntary basis starting in 2000. A description of this Initiative was included in the packets we delivered to all legislators' offices on February 11.

Our objective is to get all the nursing homes in Kansas and also the home health agencies to start utilizing consistent, standardized training programs so that CNAs, for example, trained in one facility will have the proper credentials when they transfer to another facility.

Some of these facilities are going to need help paying for all this training and retraining, since continuing education is going to be part of the game plan. SCR 1606 directs the governor to seek sources of this funding from within the administration. Another bill in the hopper, S.B. 187, would create a long term care training fund for nursing home staff within the Department of Commerce and Housing. Although we are not sure why this particular agency was chosen to oversee such a program, the Coalition of Alzheimer's Association chapters strongly supports all efforts to fund training for dementia care staff in long term care settings.

We urge you to vote for SCR 1606.

HHS
3.9.99
Atch #5

KAHSA
KANSAS ASSOCIATION OF
HOMES AND SERVICES FOR THE AGING

TESTIMONY IN SUPPORT OF SCR 1606

To: Representative Garry Boston, Chair, and Members,
Senate Public Health and Welfare Committee
From: Debra Zehr, Vice President
Re: Senate Concurrent Resolution 1606
Date: Tuesday, March 9, 1999

Thank you Chairman Boston, and Members of the Committee.

The Kansas Association of Homes and Services for the Aging (KAHSA) represents 160 not-for-profit nursing homes, retirement communities and housing providers in Kansas.

On behalf of our members I ask your support for SCR 1606.

Staff recruitment and retention is the foremost concern of KAHSA members. Nursing homes are in the midst of a staffing crisis that cuts across rural/urban and ownership lines, negatively impacting the quality of care for nursing home residents throughout the state. Average annual turnover among Certified Nurse Aides (CNAs) statewide is nearly 120% according to the Department of Social and Rehabilitation Services. Among not-for-profit nursing homes the figure is 90%. (This does not mean that every position has new staff every year; in most nursing homes, a core group of dedicated staff have to deal with the constant disruption of positions that turn over frequently.) Nursing homes with less than 50% CNA turnover are envied by their peers, but even those homes consider their turnover levels unacceptable given their commitment to quality care.

KAHSA and its members helped sponsor a study in 1998 by Wichita State University on the underlying factors of staff retention and recruitment problems in Kansas nursing homes. Researchers found no quick fixes or easy answers to this long-standing problem. Instead, they discovered that there is a dynamic and often conflicting relationship between the underlying values, beliefs, and expectations of various types of employees and the realities of work life in a nursing home. This clash results in low job commitment and high turnover. Some of the study's most urgent recommendations are the need for ongoing education in interpersonal communication, self management, problem solving and empathy for all levels of nursing home staff. (See attachment.)

SCR 1606 is good public policy because it directly addresses what we now know is an underlying cause of staff turnover in nursing homes. By helping to stabilize nursing home staffing, it will reduce costs to the State, and, most importantly, achieve and maintain high quality of care for frail elders residing in Kansas' nursing homes.

Thank you for this opportunity to offer support for SCR 1606. I would be happy to answer any questions you may have.

HHS
3-9-99
Atch #6

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