Approved: 3/3/99
Date

MINUTES OF THE SENATE WAYS AND MEANS.

The meeting was called to order by Chairperson Dave Kerr at 11:00 a.m. on February 19, 1999 in Room 123-S of the Capitol.

All members were present except:

Committee staff present: Alan Conroy, Legislative Research Department
Debra Hollon, Legislative Research Department
Rae Anne Davis, Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Revisor of Statutes
Judy Bromich, Administrative Assistant
Ann Deitcher, Committee Secretary

Conferees appearing before the committee: Roger Lambson, Vice-Chancellor of Administration KU Medical Center
Lorene Valentine, Director of Rural Health Education And Services
Arneatha Martin, Center for Health & Wellness - Wichita
Pat Hurley, representing KS Academy of Family Physicians - Topeka
Joyce Volmut, KS Association for Medically Underserved
Marlin Rein, Office of the Chancellor - Kansas University
Dr. Dennis Tietze - Kansas Academy of Family Physicians

Others attending: See attached list.

SB 248 **Concerning the university of Kansas medical center; construction, repair, remodeling and renovating buildings from private moneys; exemptions from certain statutory requirements**

Paul West of the Legislative Research Department explained **SB 248.**

Roger Lambson, Vice-Chancellor of Administration for the University of Kansas spoke as a proponent for **SB 248.** (Attachment 1).

Senator Kerr asked that the Committee give consideration to the bill and they would vote on it at the conclusion of the discussion of other bills.

SB 249 **Medical student loan act; establishing an urban underserved bridging program.**

Paul West explained **SB 249.**

Lorene Valentine, Director of Rural Health Education and Services spoke next in favor of **SB 249.** (Attachment 2). + 3)

Next to testify as a proponent for **SB 249**, was Arneatha Martin, CEO & Co-President of Center for Health and Wellness, Wichita. (Attachment 4)

Pat Hurley, representing Kansas Academy of Family Physicians, spoke in support of **SB 249**. He said the organization's support was conditioned upon one factor. If there are state funds that go into such a program if this bill were passed, that they not be taken from the rural bridging program. There are a

number of counties that are critically underserved and the rural program helps to ameliorate the problem so they would not want to see any funding going to that program. (SEE ATTACHMENT 5)

Joyce Volmut of the Kansas Association for Medically Underserved, a state primary care association urged favorable passage of **SB 249** with the addition of an amendment in section 1(d) (2) lines 41-43, to include the County of Shawnee. She said in regard to recruiting, there are those who want to work in underserved areas, but there isn't an incentive to go there. And then there are those facilities where there are training programs for medical students or residents to go through the program. But if they would choose to continue to work there, there is no incentive. The salaries paid at these facilities can't begin to compete with the salaries that someone could make elsewhere. (SEE ATTACHMENT 6)

Senator Salisbury asked what other states were doing regarding this problem.

Senator Kerr said that at this point they would not vote on **SB 249** and it would not be his intention to vote on it at the end. He told the proponents that for it to be brought up for a vote, it had to have some significant changes made to it, and Senator Salisbury's question as to what other states were doing would have to be looked at. He said his impression was that if they were to give it serious consideration one necessary change would be that they have to have a local partnership component.

Senator Ranson said she was interested in what other kinds of scholarships the state is providing for doctors. And does the American Medical Society or the Kansas Medical Society provide any incentive in this area.

Senator Salisbury said that she would follow up on what other states were doing in regard to this.

SB 266 **Medical student loan act; satisfaction of loan recipients service obligation.**

Paul West gave a brief explanation on **SB 266.**

Marlin Rein of the Office of the Vice-Chancellor of Kansas University, spoke as a proponent for **SB 266.** (Attachment 7).

Testifying as an opponent for **SB 266** was Dr. Dennis Tietze of the Kansas Academy of Family Physicians. (Attachments 8 and 9). He said they hadn't paid very much attention to the emergency medicine provision in the student loan but, medical student loans were one of his organization's suggestions years ago when they began to look at ways to move family physicians into rural communities. They are very strongly in support of putting primary care physicians into the community and they would oppose any measure that would dilute that opportunity as they feel **SB 266** does. Dr. Tietz said he believes the problem in this country is not a physician shortage but a mal-distribution, both geographically and by specialties, of physicians.

The Chairman said that he was not prepared to vote on **SB 249 or SB 266** and asked the Committee to return to **SB 248**. He reminded them that this was in regard to the removal of the cap and the sunset on construction projects where funding comes from private moneys.

It was moved by Senator Ranson and seconded by Senator Salisbury that **SB 248** be amended to reestablish the private moneys definition on line 19. The motion to amend passed on a voice vote.

It was moved by Senator Salisbury and seconded by Senator Gilstrap to adopt **SB 248** as amended. The motion carried on a roll-call vote.

The meeting was adjourned at 12:30 p.m. The next meeting is scheduled for Monday, February 22.

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.

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: 2/19/99

NAME	REPRESENTING
Ken Baker	Ks. Governmental Consulting
Marlin Rein	KU
Lorene Valentine	KU
Roger Lambson	KUMC
Jack Hawn	KPERS
Armeatha Masler	Center for Health & Wellness
Bill Sneed	UKHA
Dennis Tietze	KAFP
Jon Josserand	KU
Joyce Volmut	KAMU.

SENATE BILL 248
TESTIMONY TO SENATE WAYS AND MEANS COMMITTEE
February 19, 1999

My name is Roger Lambson and I appear on behalf of the University of Kansas Medical Center in support of Senate Bill 248.

Senate Bill 248 amends K.S.A. 76-833 pertaining to construction projects at the University of Kansas Medical Center financed from private monies. This legislation was initially enacted in 1993 and revived in the 1996 session. The original intent of the legislation was to provide the institution a degree of freedom from typical State processes in construction and remodeling projects financed from private monies.

Senate Bill 248 amends the current law in two respects--1) it removes the cap of $500,000 on the cost of a project subject to this act, and 2) strikes the sunset clause which would cause this authority to expire on June 30, 2001.

The original legislative authority was sought to remove delays that were often associated with these small projects financed from private monies. Contributors of the funds became very impatient with the bureaucratic controls that tended to delay these projects. Examples of such projects have included two Cancer Center Modifications, Radiation Oncology Shielding, Cray Diabetes Center and the History of Medicine. These projects range in cost from $20,247 to $343,000. Future projects in the range of $100,000 to $300,000 might include: Skilled Nursing Unit, Pneumatic Tube System Modification, Adult Psychiatry Clinic, and Clinical Trial Data Center.

The significant change requested in this bill is the removal of the $500,000 cap. Most projects for which we would utilize this authority are small remodeling and renovation projects. One obvious exception was the burn unit at the Medical Center which exceeded the $500,000 ceiling. Even though the cap would be removed, we wouldn't envision that this authority would be used for major new construction in that the Endowment Association has separate authority to do these projects. While the source of money for the projects with which this bill is concerned may be funded from the Endowment Association, the scope of the projects are generally so small that the Endowment Association does not wish to undertake managing them.

Thank you for your consideration. I would be pleased to try to answer any questions you may have.

Senate Ways and Means Committee
Date 2/19/99
Attachment # 1

SENATE BILL 249
TESTIMONY TO SENATE WAYS AND MEANS COMMITTEE
February 19, 1999

My name is Lorene Valentine and I appear on behalf of the University of Kansas Medical Center who requested introduction of Senate Bill 249.

SB 249 establishes an Urban Bridging Plan that is modeled after the Kansas Bridging Plan. I have attached to the written testimony background information on the Kansas Bridging Plan (Attachment A).

URBAN BRIDGING PLAN (SB 249)

Need

Based on being uninsured or having an income less than $10,000 per year, it is estimated that roughly 51,000 people in Sedgwick County should be called "vulnerable" either because they lack health insurance or have very low incomes. Most special clinics for the medically underserved feel that additional clinics are not needed. Existing services are underutilized and each of these clinics could accommodate more patients. One barrier to serving more people is the lack of physician providers.

According to the 1996 Community Health Assessment for Wyandotte County, access to and availability of health care is a major problem. Barriers to health care include lack of health insurance coverage, physician availability, cost of health services and transportation.

Medical students at the KU School of Medicine-Wichita have expressed concerns regarding the lack of role models or mentors in Wichita who care for the medically

Senate Ways and Means Committee
Date 2/19/99
Attachment #2

underserved. After residency training, there are few physician practices to join who serve the medically underserved.

Purpose and Goals

The purpose of the Urban Bridging Plan is to improve the availability and number of physicians in underserved areas of Sedgwick and Wyandotte Counties in order to increase access to health care. The goals of this program are:

1.) improve the availability of physicians in urban, underserved clinics,

2.) stimulate interest in urban, underserved health care by medical students and residents, and

3.) enhance the educational environment by providing physician mentors who serve the medically underserved.

The Plan

This plan provides incentives and opportunities for residents in general pediatrics, general internal medicine and family practice to locate their medical practice in medically underserved urban areas in Kansas upon completion of residency training.

After completing one year of post-graduate training, residents in family practice, general internal medicine and general pediatrics residency programs are eligible to enroll. A resident entering into a Loan Agreement can receive a payment of $10,000 for each of the last two years of residency training. The loan is forgiven when the loan requirements are met.

The Loan Agreement requires that the resident:

- Complete the primary care residency training program;
- Engage in the full-time practice of medicine for a period of three years in a medical care facility or institution approved for participation in Sedgwick or Wyandotte county which primarily serves indigent patients;
- Commence such full-time practice within 90 days after completing the residency training program.

Under this plan the medical care facility or institution will not be required to match the State funding. If the resident fails to satisfy the loan requirements, the loan must be repaid within 90 days. The resident must repay the amount equal to the amount of money received, less credits earned, plus interest at the annual rate of 15% from the date such money was received.

Funding

For FY 2000, it is proposed that $20,000 be appropriated to allow two residents at $10,000 each to participate in the program. In addition, $12,000 for operating support for part-time office assistance and operating supplies, postage, printed materials, etc., would be necessary. For FY 2001, an additional $20,000 would be necessary to allow two more residents to participate. This funding would allow for two residents in their second year of training and two residents in their third year of training. The total cost for loans in FY 2001 would be $40,000.

Summary

Based on the success of the Kansas Bridging Plan and the need for more physicians to practice in medically underserved urban areas in Kansas, the University of Kansas Medical Center encourages your favorable consideration of SB 249.

With those comments, I will conclude my testimony and be pleased to respond to questions.

2/17/99

Attachment A

KANSAS BRIDGING PLAN

Purpose

The purpose of the Kansas Bridging Plan is to encourage primary care physicians to practice in **rural** Kansas communities upon completion of residency training.

The Plan

After completing one year of post-graduate training, residents in family practice, general internal medicine and general pediatrics residency programs are eligible to enroll. A resident entering into a Loan Agreement can receive a payment of $5,000 for each year of residency training. The loan is forgiven when the loan requirements are met.

The Loan Agreement requires that the resident:

- Complete the primary care residency training program;
- Sign a Practice Commitment Agreement with an eligible community that indicates the resident will engage in the full-time practice of medicine for three years in the community. Any community outside Douglas, Johnson, Sedgwick, Shawnee and Wyandotte counties is eligible.
- Commence full-time practice of medicine within 90 days after completing residency

An appropriate entity or organization in the community matches the State funding – up to $10,000 per resident and also agrees to pay the resident $6,000 upon completion of the residency training program. The financial incentive for the resident is $10,000 from the State and $16,000 from the community for a total of $26,000.

If the resident fails to satisfy the loan requirements, the loan must be repaid within 90 days, less credits earned, plus interest at the annual rate of 15 percent from the date(s) the money was received.

Enrollment

Since the program started in January 1991, 111 residents have enrolled. Eleven have defaulted on their loans.

Community Selection

Of the 100 remaining Bridging Plan contracts issued, 76 residents have selected 49 communities as practice sites. 24 residents are currently looking for a practice site in Kansas.

Out of the 76 residents who have selected a community, 56 residents or 74%, have selected communities with populations less than 12,000 and 9 residents have selected communities with populations between 12,000 and 20,000. Eighty-six percent of Kansas Bridging Plan participants are or will be practicing medicine in communities with populations less than 20,000.

Evaluation

Thirty-eight residents have completed their service obligation. Seven physicians have left their communities after completing their service obligation. Five of the 38 physicians moved out of state and 2 remain in practice in Kansas. Eighty-seven percent of Kansas Bridging Plan physicians continue practice in Kansas.

Funding

The appropriation for the Kansas Bridging Plan loans is $110,000. This funding allows 11 new residents at $5,000 each to enroll in the plan.

2/17/99

Enrollment

Applications are accepted by Rural Health Education and Services, KU School of Medicine, from July 1 to December 31 of each year.

Application is initiated by filling out a Resident Profile Form. Forms are available on the Rural Health World Wide Web site (http://ruralhealth.kumc.edu) and at the Kansas City and Wichita offices of Rural Health Education and Services.

The eligibility of each applicant is verified and all eligible applicants are placed in a pooled drawing. On the second Monday in January, a number is assigned to each applicant in the order the applicant is drawn from the pool. Applicants are enrolled in the Kansas Bridging Plan by numeric order until all loans are committed.

A resident does not need to have a practice location chosen to be eligible for participation in the drawing. A resident who has chosen a practice location does not have preference over residents who have not.

Applicants not selected for enrollment, but still interested in the program, must reactivate their application by responding to a form sent by Rural Health Education and Services.

For More Information

Rural Health Education and Services
The University of Kansas
Medical Center
3001 Murphy
3901 Rainbow Boulevard
Kansas City, Kansas 66160-7195
913-588-1228
FAX: 913-588-1420

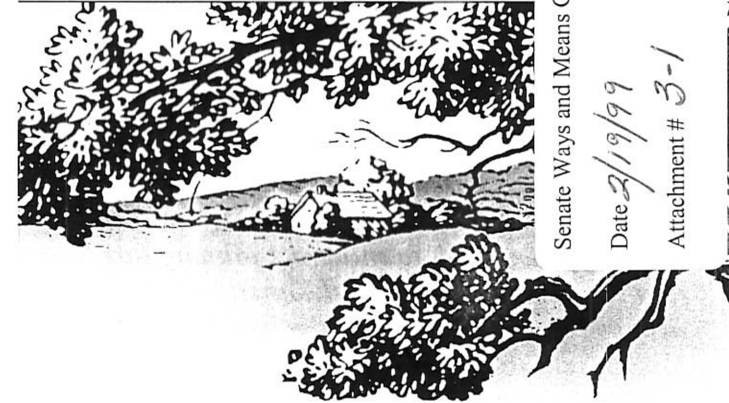
or

Rural Health Education and Services
The University of Kansas
School of Medicine-Wichita
1010 N. Kansas
Wichita, Kansas 67214-3199
316-293-2649
FAX: 316-293-2671

E-mail: rhealth@kumc.edu

Web site: http://ruralhealth.kumc.edu

The University of Kans
Medical Center
Rural Health Education and



Senate Ways and Means Committee
Date 2/19/99
Attachment # 3-1

KANSAS BRIDGING PLAN

A program designed to encourage physicians to practice in Kansas

KANSAS BRIDGING PLAN

The State of Kansas recognizes the need for additional primary care physicians in the state. In order to address this need, the state has funded the Kansas Bridging Plan - a loan program. The purpose of the plan is to encourage primary care physicians to practice in rural Kansas communities upon completion of residency training. Rural Health Education and Services directs the plan and assists communities and residents in meeting the need for primary care physicians in Kansas.

Eligibility

Residents in family practice, general internal medicine and general pediatrics residency programs operated in the State of Kansas and approved by the Kansas State Board of Healing Arts are eligible.

Requirements

Residents must have completed one year of post-graduate training in their primary care specialty; must complete a one-month rural rotation during their residency program; and must be eligible for an unrestricted Kansas license.

The Plan

A resident entering into a Kansas Bridging Plan Loan Agreement can receive a payment of $5,000 for e[illegible] year of residency training, or any part of a ye[illegible]uch training, after the date on which the loan agreement is completed. The loan is forgiven when the loan requirements are met.

The loan agreement requires that the resident:

- Complete the primary care residency training program;
- Commence full-time practice of medicine within 90 days after completing the residency training program; and
- Sign a practice commitment agreement with an entity in an eligible Kansas community. Any community outside Douglas, Johnson, Sedgwick, Shawnee and Wyandotte counties is eligible.

The Practice Commitment Agreement

The resident must sign a practice commitment agreement with an appropriate entity or organization, such as a hospital, physician group or community foundation. In this agreement, the organization agrees to provide the resident benefits that have an aggregate monetary value equal to or greater than the aggregate amount of payments under the provisions of the loan agreement. The organization also agrees to pay the resident $6,000 upon completion of the residency training program. The resident agrees to engage in the full-time practice of medicine for 36 months in the community.

Compliance

The loan is cancelled when the loan requirements are met. In November of each year, a "Request for Cancellation of Debt" form is sent to physicians who have completed their residency program. The loan is cancelled based on the number of months in practice during the calendar year. The physician will receive a Federal Miscellaneous Income Form 1099 for the amount of loan principal and interest forgiven for the calendar year.

Default

If the resident fails to satisfy the obligation to engage in the full-time practice of medicine in accordance with the provisions of the loan agreement, the resident must repay the loan within 90 days of such failure. The amount to be repaid is the amount equal to the amount of money received, less credits earned, plus interest at the annual rate of 15 percent from the date such money was received.

Kansas Medical Scholarship/Loan

Residents who have been a recipient of a Kansas Medical Scholarship and/or Kansas Medical Loan are eligible to receive a Kansas Bridging Plan Loan. Residents must select a practice location that meets the service obligation of the Kansas Medical Scholarship and/or Kansas Medical Student Loan. The service obligation for the Kansas Medical Scholarship Program and the Kansas Bridging Plan can be satisfied concurrently.

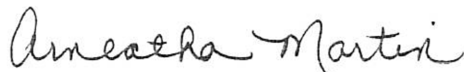
TESTIMONY submitted to the Senate Committee on Ways and Means Senate Bill No. 249.

Senator Kerr and members of the committee on Ways and Means. I am Arneatha Martin, CEO and Co-President of the Center for Health and Wellness in Wichita, Kansas. The Center for Health and Wellness is a state-of-the-art primary healthcare facility designed to meet the needs of the predominately Urban Community in Northeast Wichita, Kansas. Our mission is to provide family healthcare through improved access and a heightened and unrelenting focus on education and prevention.

I am testifying in **support** of the **Senate Bill No. 249** to establish the Kansas urban underserved Medical Residency Bridging Program to provide encouragement, opportunities and incentives for persons in primary care residency training programs. The urban community has similar issues attracting qualified physicians as you see in the rural areas of Kansas. Statistics validate that the mortality rate is higher for people living in urban underserved communities. In order to break this chain of events that cost lives in our communities, we need to provide incentives for physicians to practice in our urban communities.

I am in **support** of this bill. All Americans should have access to a basic set of high quality health services that includes access to physicians to manage their health care needs. Funding should be allocated to support the primary care residency training programs in order to deliver appropriate and effective services in a cost-effective manner to urban underserved communities.

Thank you for allowing me the opportunity to address this committee. If you have questions, I am prepared to answer your questions.



Arneatha Martin, RN, MN, ARNP
CEO & Co-President
Center for Health and Wellness
Wichita, Kansas

Senate Ways and Means Committee
Date 2/19/99
Attachment # 4

Kansas Academy of Family Physicians

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Jeff Atwood, MD
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Richard M. Glover, MD
Steve Grillot, DO
Verlin Janzen, MD
Mike Kennedy, MD
Thomas L. Koksal, MD
William R. Rooney, MD
Board of Directors

Mary Beth Miller, MD
Resident Representative

Graig Nickel
Student Representative

Carolyn N. Gaughan, CAE
Executive Director

Representing the largest medical specialty group in Kansas

Feb. 18, 1999

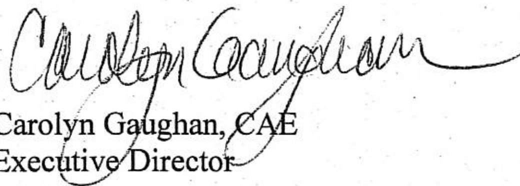
TO: Senate Ways & Means Committee
FROM: Carolyn Gaughan, CAE, Executive Director
RE: Position on SB 249

Dear Sen. Kerr, Sen. Salisbury, Sen. Petty, and Committee Members,

The Kansas Academy of Family Physicians supports SB 249 establishing an Urban Underserved Bridging Program. We believe that this program can be of service in recruiting and retaining physicians to serve in underserved urban areas. Our support for the measure is conditional upon the funding being separate and not reducing the funding for the current Kansas Bridging Program which pairs physicians with rural communities.

We commend the University and those who have developed the program, and look forward to working with them to place physicians in urban underserved areas. Please feel free to contact me if you have questions.

Sincerely,



Carolyn Gaughan, CAE
Executive Director

Senate Ways and Means Committee
Date 2/19/99
Attachment # 5

Kansas Association for the Medically Underserved

www.ink.org/public/kamu

The State Primary Care Association

February 19, 1999
Testimony - Senate Bill 249
Establishing the Kansas Urban Medical Residency Bridging Program

Presented by: Joyce Volmut
State Primary Care Association, Kansas Association for the Medically Underserved

Senate Ways and Means Committee:
Chair David Kerr

Chairman Kerr and members of the Committee:

My name is Joyce Volmut. I am executive director of the State Primary Care Association - an association of primary care clinics and health centers whose primary purpose is to assure access to primary care to Kansas medically Underserved populations. I am here to speak in support of Senate Bill 249 and to request an amendment that also includes the county of Shawnee.

Across the state there are 27 primary care clinics and health centers who provide primary care services to clients who would otherwise be without access to care. Today I will concentrate on just four of the Health Centers that are located in urban areas of the state that would benefit by passage of SB 249 and the amendment as proposed.

These include the Shawnee County Health Department in Topeka, the Douglas Community Health Center in Kansas City KS, the Hunter Health Clinic and United Methodist Health Center, both located in Wichita.

Together, in 1997, these four entities provided comprehensive primary care services, including prenatal care in three of the facilities, to over 30,000 clients. In total this amounted to approximately 67,000 physician encounters.

Each of these facilities are Federally Qualified Health Centers which means they meet the HCFA requirements for Medicaid and Medicare cost based reimbursement, which are similar to those established for Rural Health Clinics and the Department of Health and Human Service guidelines for Federally funded Public Health Section 330 Community Health Centers. Their mandate is to provide comprehensive community based primary care services to anyone within their catchment area who is in need of this service, regardless of ability to pay.

In each of the locations physician primary care services are long standing. Hunter

112 SW 6th Ave., Suite 201, Topeka, KS 66603 785-233-8483

Health Clinic has been a federally funded Community Health Center and Indian Health Center since 1985, Shawnee County Health Department has been providing physician primary care services since the early 1970's. Each of the centers play a major role in their communities in serving the uninsured and medicaid and will play a major role in delivery of services to children who qualify for the Kansas Children Insurance Program, Health Wave. They are also beginning to see increasing numbers of Medicare eligible clients, especially those clients who are dual Medicaid/Medicare eligible.

One of the biggest problems these centers face is recruitment of qualified physician staff. Currently one of the only avenues available for recruitment is through the National Health Service Corps and this is becoming more and more difficult to achieve in urban areas- first because the requirements for federal designation are not easily met in states like ours and secondly because Kansas urban areas cannot demonstrate the same level of need as some other states where priority of need is greater, such as Mississippi.

For the past three years, KAMU has become more actively involved in both the shortage designation process and recruitment process of health professional in Underserved parts of the state. We know from our limited experience that it pays off in the long run to recruit Kansas physicians, to begin training early, to provide information about what it means to work with vulnerable populations and to provide practice locations where the practitioner has an opportunity to work with different settings with different types of clientele. What has been missing in urban areas is an incentive for the practitioner to remain within that service. The bridging program provides that incentive.

We therefore urge favorable passage of SB 249 with addition of the following amendment:

> **Insert Section 1 (d) (2)** lines 41-43, "engage in the full-time practice of medicine and surgery for a period of three years in a medical care facility or institution, approved for participation pursuant to subsection (e) in Sedgwick, <u>Shawnee</u> or Wyandotte county which primarily serve indigent patients."

SENATE BILL 266
TESTIMONY TO SENATE WAYS AND MEANS COMMITTEE
February 19, 1999

My name is Marlin Rein and I appear on behalf of the University of Kansas Medical Center which had requested introduction of Senate Bill 266.

Senate Bill 266 amends that section of the Medical Loan Program Act which allows medical loan recipients the option of satisfying their service obligation as faculty members of the University of Kansas School of Medicine. The current statute permits former loan recipients to fulfill their service obligation by serving as faculty members in the School of Medicine in general internal medicine, general pediatrics, family medicine or family practice. Senate Bill 266 extends this option to physicians trained in emergency medicine.

In one sense, this bill was introduced in order to provide some consistency in the manner in which loan recipients are treated relative to their service options. One of the service options in the original 1992 legislation was to serve as a full-time faculty member in family medicine or family practice at the rate of two years of service for each one year of obligation.

In the 1995 session, Senate Bill 169 amended this provision to add general internal medicine and general pediatrics to the specialties in which faculty could satisfy the service obligation on a two-year for one-year basis. This legislation also imposed a new limitation that the number of full-time faculty members who were former loan participants could not exceed 25 percent of the total number of full-time faculty members in that specialty.

Students who participate in the loan program must first enter into a qualifying residency program upon graduation. Qualifying specialties are internal medicine, pediatrics, family practice and emergency medicine. In order to provide loan recipients who select emergency medicine the same choice of options as available to students who select other qualifying residencies, it is requested that this section related to faculty service be amended to include emergency medicine.

The University of Kansas School of Medicine does not offer a residency program in emergency medicine. As a consequence, few students who participate in the loan program tend to select emergency medicine as their specialty because of the limited opportunities to satisfy the service obligation in Kansas. As you recall, loan recipients cannot fulfill their service obligation by practicing in Sedgwick, Shawnee, Douglas, Wyandotte or Johnson counties. Given the limited opportunities in emergency medicine in the State other than in those counties, students tend not to select the specialty. In fact, over the last three years a total of five students graduating from the University of Kansas School of Medicine who participated in the loan program chose emergency medicine as their specialty training. There is an emergency medicine residency program at the University of Missouri-Kansas City and programs are also available in Denver and Oklahoma.

The fiscal note on the bill reports that the only fiscal impact would be a potential decrease in revenues to the Medical Loan Repayment Fund assuming that former students who came back to serve as faculty members at the University would otherwise not be in compliance. The 25 percent limitation on the number of faculty who can be former loan recipients would limit the number of former students who could avail themselves of this opportunity. The size of our faculty is only six, which means that at any one time no more than one faculty member can be a former loan recipient.

With those comments, I will conclude my testimony and be pleased to respond to questions.

Kansas Academy of Family Physicians re opposition to SB 266

-Public policy behind the student loan program is to put primary care physicians in undeserved areas to care for citizens of Kansas

-Change would negate purpose of medical student loan which is to induce students to go to rural undeserved areas.

-Significant undeserved areas remain though program is working.

-Primary care - point of entrance, comprehensive, continuity of care. This is not accomplished in the emergency room.

-State trauma system - is importance for small community hospitals to stabilize patients - need primary care physicians to do this not trauma specialists both needs of community provided by family physicians

-SB 266 - no cost no extra money dilutes available positions for primary care in undeserved areas.

-related issues

-definition of primary care changes considered - loss of residency slots at Olathe
-no ER residency at KU
-recruitment and retention of teachers of primary care especially family practice

Dennis D. Tietze MD.
February 19, 1999

Kansas Academy of Family Physicians

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Wichita, KS 67212
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kafp@southwind.net

Family Physician Education in the State of Kansas:

A Challenge for Change

Senate Ways and Means Committee

Date 2/19/99

Attachment # 9-1

FAMILY PHYSICIAN EDUCATION IN THE STATE OF KANSAS

A CHALLENGE FOR CHANGE

I. INTRODUCTION

The Kansas Academy of Family Physicians (KAFP) is the representative organization for the specialty of family practice within the State of Kansas. Its 700-plus members represent the largest medical specialty group in the state, and they deliver the majority of primary care services to its citizens. Since the Academy's beginning in 1948, it has been dedicated to the task of insuring a constant supply of quality-trained family physicians for the state. To this end, the KAFP has continually worked with the University of Kansas School of Medicine (KUSM), the Legislature, the Kansas Medical Society, Kansas Hospital Association and others interested in medical education. The working relationship by these associations has proven beneficial in improving access to quality health care in Kansas.

In this report, we examine the changes that have occurred in the physician demographics of health care in our state. We also document the status of family physician education and the effect on health care of current trends, both now and in the future. We close with recommendations to help insure continued improvement in the quality and access to medical care for all Kansans.

II. HISTORY

The KAFP first became concerned about the supply of family physicians in Kansas because of changes in medical liability insurance expenses that occurred in the 1980's. Data indicated that because of increasing medical liability premium rates, that older physicians would retire more quickly than graduating family physicians could take their positions. At the same time, a "graying" of rural family physicians was taking place, which further compounded the shortage. Working with the KMS and the legislature, these issues were addressed through tort reform. A new liability insurance company was also formed. Soon thereafter, KAFP worked with

the KUSM to initiate a proposal that the Legislature adopted, to establish the Kansas Medical Scholarship Program and the Kansas Bridging Program. Thus, tort reform and competition within the medical liability market complemented the Bridging and Scholarship Programs to cooperatively create an environment within the state conducive to family physician retention and recruitment, even within rural areas.

Parallel to these efforts, changes in national health care economics occurred, with far-felt effects in Kansas. Because of market place demands, for the most part, and the threat of national health care reform, to a smaller degree, incremental changes in the financing of health care occurred. This placed the high quality, efficient family physician in high demand.

National family practice work force data had also predicted the decreasing family physician work force and subsequent increasing demand. More residency slots were created. The number of graduating family practice residents in Kansas has increased by 70 percent since 1992.

This growth in family medicine also translated into a need for more family practice medical student training. KUSM has seen a great expansion in the medical student experience in the last 10 years: student interest has never been higher. The result of this expansion poured out great rewards for the State of Kansas with more family physicians trained in *our* medical school staying in *our* state. This growth, however, comes with a price tag. Nowhere was this felt more than within the departments responsible for training residents and students: the Department of Family and Community Medicine on the Wichita campus, and the Department of Family Medicine on the Kansas City campus.

III. DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE & DEPARTMENT OF FAMILY MEDICINE

The Department of Family and Community Medicine and the Department of Family Medicine, under the KUSM banner are located in Kansas City and Wichita. These two campuses are distinct in administration, identity and budget.

The Kansas City department directly oversees the training of both resident and medical students. While the number of residents has increased by about 70 percent, the number of FTE family practice faculty at the KU campus has increased by only 35 percent, and inflation-adjusted state funding for their training has remained unchanged. This has resulted in a shortfall of roughly $200,000 to $400,000 within the department. While this situation is not unique to family practice, it makes it difficult to maintain the current level of training for students and residents.

The Wichita Campus is structured differently but shares a difficult economic picture. The Wichita department directly controls medical student education and shares supervision of residency training with three hospitals. The Wichita Department has seen a rise of 46 percent in the number of family practice clinical rotations and a 30 percent rise in residency graduates. The success of retaining these physicians is unparalleled, with 70 percent of these graduating family physicians practicing within the State of Kansas. The Department of Family and Community Medicine at Wichita has placed more than twice the number of primary care physicians in rural Kansas than all other primary care departments in Wichita or Kansas City combined. During the time in which all of this has occurred, however, the state funding to the department has not increased. Not only has it gone unchanged, it is at the level of *one-half* of the other medical school departments with comparable student contact.

Neither department could realize this kind of success without dedicated faculty and a committed cadre of volunteer physician faculty. Yet, the paid faculty members are compensated at the 20th percentile of the AAMC average, and the volunteer physicians are stretched to the limit by the stresses of medicine at the end of the 90's.

IV. PRIMARY CARE PHYSICIAN EDUCATION GRANT

1995 brought a glimmer of hope to the financial problems within the Department of Family and Community Medicine and the Department of Family Medicine. The Kansas Health Foundation partnered with the University of Kansas School of Medicine to create the Primary Care Physician Education Project (PCPE). $15,000,000 was set aside in an attempt to change the emphasis of medical student training to one conducive to

the development of physicians in family practice, pediatrics and internal medicine. Family physicians were brought on board with the idea that these dollars would be a bridge that would help promote the re-allocation of dollars from the basic sciences and subspecialty training to the Departments of Family and Community Medicine for the training of family physicians.

Now beginning the 4th year of the grant, we have yet to see any reallocation. Instead, we have seen the development of a separate bureaucracy that has, in effect, drained resources from the already financially strapped family practice departments. The grant has been extended from 5 to 6 years, but the original intent has been lost to the philosophy of innovation over substance.

V. CONCLUSION

The Kansas Academy of Family Physicians has addressed this problem at all levels over the last 10 years. We have witnessed multiple changes in the departments of family practice. New chairs now chair both departments. We have seen many changes in the administration at the medical school, in the Dean and of Executive Vice Chancellor's offices. We have discussed the problem with the KUSM administration numerous times, and have been met with helpless resistance. While they realize a problem exists, they seem to be unwilling or unable to make changes necessary to correct the problem. With all of the changes and lost chances to put both departments on stable footing, we have only to see them even more precariously situated.

The State of Kansas has a great investment in the University of Kansas School of Medicine. Our medical school has enjoyed a larger proportion of state funds than have other like institutions. In the last session of the Kansas Legislature, the state paved the way for the University Hospital to be more competitive in the health care marketplace with the Hospital Authority bill, which KAFP supported vigorously. However, it would be a mistake to assume that the hospital or the medical school itself would succeed without healthy and growing departments of family medicine to drive the referral base.

In the end, the people of Kansas have the most to lose if the family medicine departments are not strengthened. The number of men, women and children of the state who receive their medical care from family physicians is larger than that for any other medical specialty. But the momentum in the health care system that

has brought family physicians to the forefront of care will eventually slacken, and the University of Kansas School of Medicine will not be able to sustain the current level. We will experience the loss of faculty and physicians to other states with better-funded family practice medical education infrastructure.

The need for increases in funding for the family practice departments has never been more obvious. The failure of the current system to reallocate those funds has never been more evident. The potential loss for the State of Kansas has never been so near.

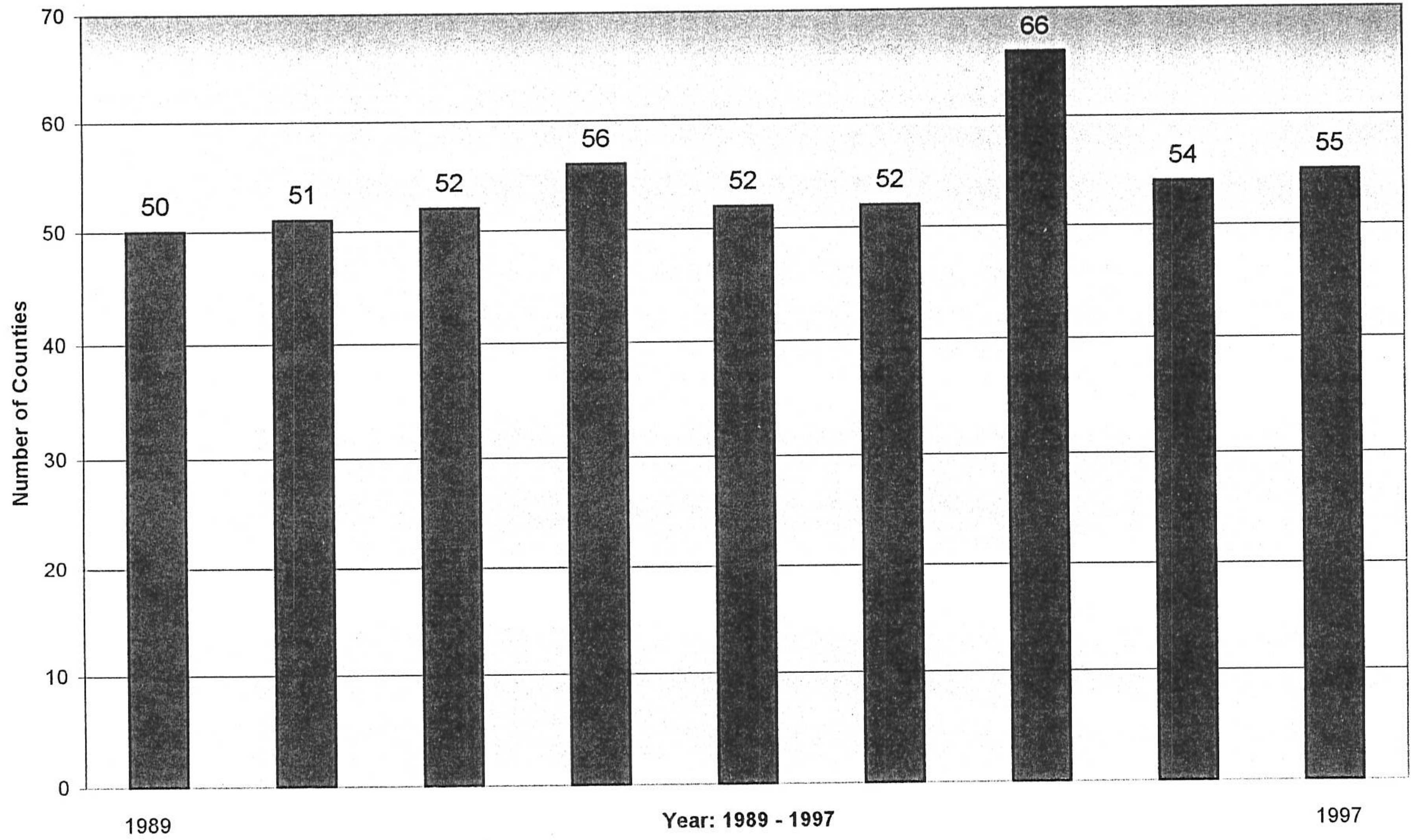
It is time for a legislative solution to the problem. Money needs to be earmarked by the State of Kansas specifically for the Department of Family Medicine at Kansas City and the Department of Family and Community Medicine in Wichita. This level of funding needs to be large enough to make them solvent and bring them to the level consistent with their peers. It is estimated that an increase of $500,000 per year, per campus, would bring them to that level. Without the leadership of the Governor and the Legislature in this work, a decline in access to family physicians and health care in our state is guaranteed.

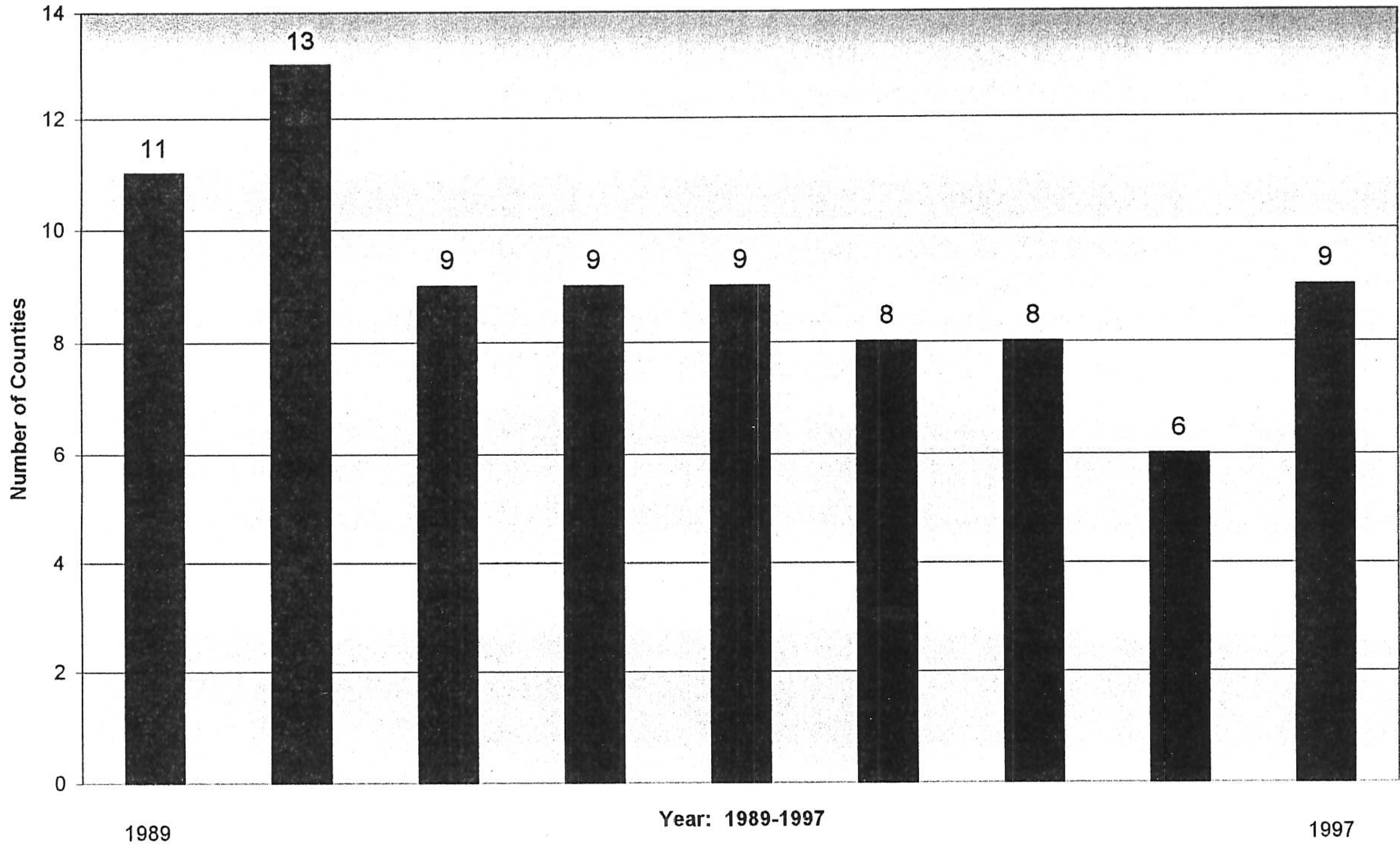
Year of Report	# of Counties Underserved	%	# Counties Critically Underserved	%	# of Counties Not Underserved	%
1989	11	10.5%	50	47.6%	44	41.9%
1990	13	12.4%	51	48.6%	41	39.0%
1991	9	8.6%	52	49.5%	44	41.9%
1992	9	8.6%	56	53.3%	40	38.1%
1993	9	8.6%	52	49.5%	44	41.9%
1994	8	7.6%	52	49.5%	45	42.9%
1995	8	7.6%	66	62.9%	31	29.5%
1996	6	5.7%	54	51.4%	45	42.9%
1997	9	8.6%	55	52.4%	41	39.0%

Definitions: Underserved = a county that is at or below 1 primary care physician per 2,695 population (2,695 : 1)
Critically Underserved = a county that is at or below 1 primary care physicians per 3,000 population (3000 : 1).

Source: Primary Care Underserved Areas Reports 1989 - 1997; KDHE Office of Local and Rural Health Services.
State Designated Medicall Underserved report map.

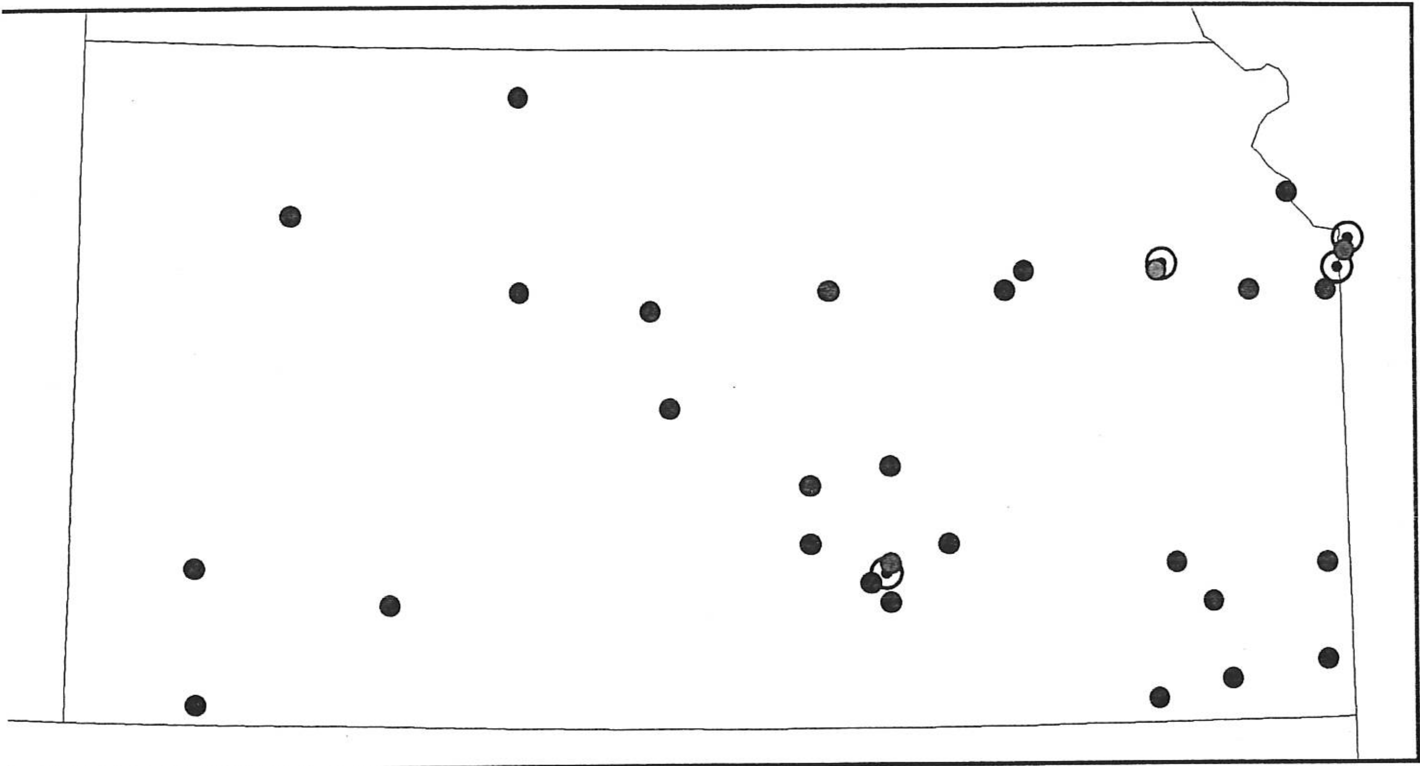
9-8





Number of Counties Underserved
14
12
10
8
6
4
2
0
Number of Counties
11
13
9
9
9
8
8
6
9
1989
Year: 1989-1997
1997

Pediatrician Distribution
1998



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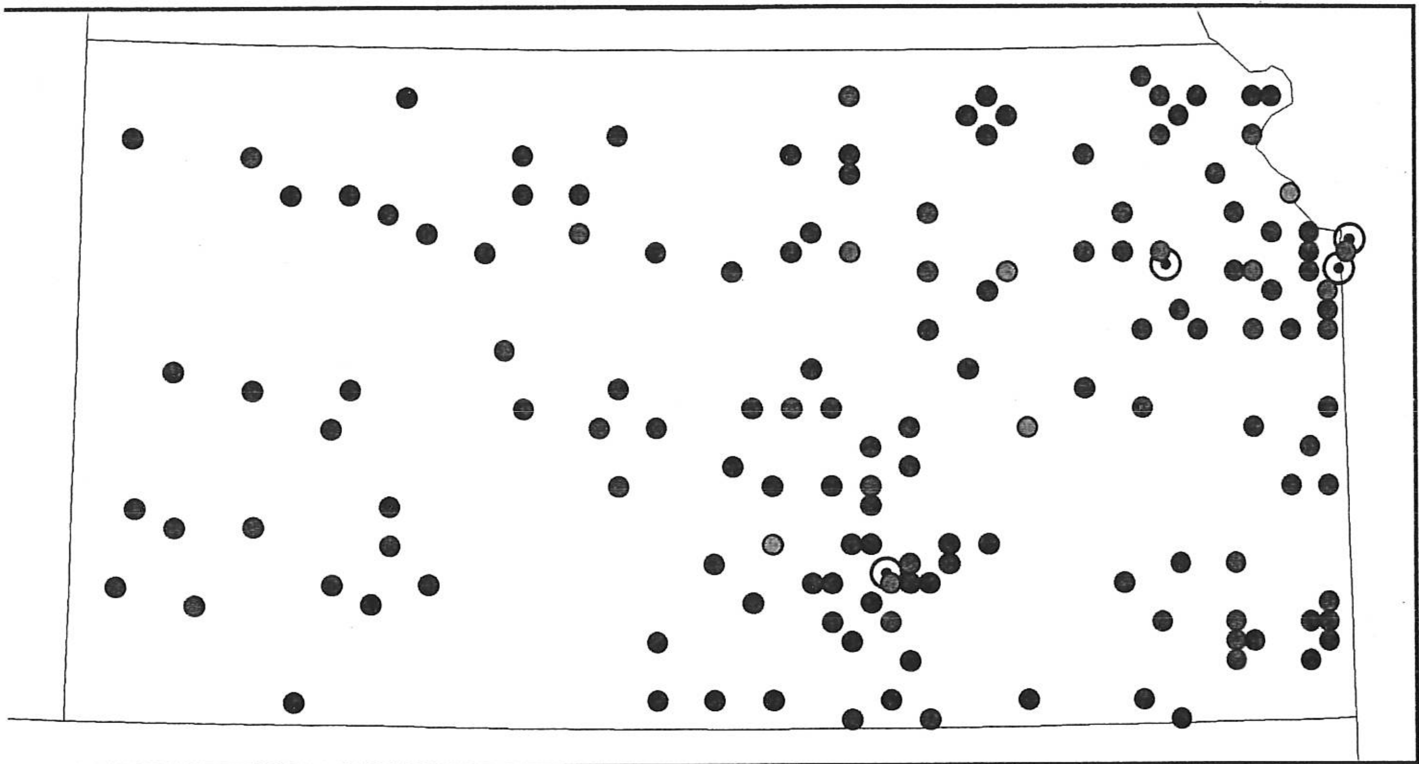
Family Physician Distribution
1998



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