Approved: February 16, 2000
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 February 9, 2000 in Room 423-S of the Capitol.

All members were present except: Representative Brenda Landwehr, Excused
Representative Bill Light, Excused
Representative Dale Swenson, Excused

Committee staff present: Emalene Correll, Kansas Legislative Research Department
Dr. Bill Wolff, Kansas Legislative Research Department
Norman Furse, Revisor of Statute's Office
June Evans, Secretary

Conferees appearing before the committee: Representative Melvin Neufeld
Joyce Volmut, KS Assn for the Medically Underserved

Others attending: See Attached Sheet

The Chairperson opened the hearing and said we would be taking possible final action on **HB 2586 - Dental Practice Act Amendments.**

Staff gave a briefing on **HB 2586**, stated the bill was drafted and introduced by the Transition Oversight Committee and as a result of that committee's studies on dental services, or the lack thereof, as related to the Medicaid program and problems with getting dental care providers in sufficient numbers for the child health insurance program. The Health Care Reform Oversight committee also looked at these issues and reviewed materials that had been presented both to the Transition Oversight Committee and the Childrens Issues Committee relating to dental services under Medicaid in the Chip Program and they too adopted a position supporting amendment of the law to authorize dentists to practice in these settings without the restrictions that currently exist. This piece of legislation is necessary because there is a provision in another statute, the Medical Practices Act, which prohibits dentists from being employed by a corporation or under contract with another entity. The legislature, not that many years ago, adopted a statute that says those 4 types of providers of care may employ dentists and that dentists are not operating in violation of the Dental Practices Act if they contract with or are employed by one of those 4 entities. However, if the dentists who are employed in those situations were to contract and provide services in those settings can only serve people who are a member of a family earning at or below 200% of the federal poverty level. The restrictions have caused some problems for federally qualified health centers. As the bill was drafted the whole restriction of those that can be served by dentists employed by the clinic or not-for-profit would be stricken as would the language on page 2 which authorized the Kansas Dental Board to adopt rules and regulations necessary and carry out provisions of this section. The net result of that would be to allow dentists who are employed by anyone of the 4 entities listed in section 1 (a) to serve anyone who is eligible for services through those entities.

Representative Neufeld offered a balloon to **HB 2586** and stated the Transition Oversight Committee had some concerns as they looked at the issue of dental access and there are a lot of issues that aren't addressed. It was found there was a conflict the way the law is written. The federal law requires the FQHCs provide dental services to anybody that walks through their door and the state law says if you are over 200% of poverty and have any kind of health insurance, whether dental or not, you can't get services. The balloon exempts the FQHCs from portions of the bill in sub section 1 (b). Earlier it was felt this balloon would resolve the problem but not sure this is what is needed. Need to make sure that the federally qualified health care centers can provide the services required by federal law and keep the rest of the clinics under state law and that was the intent of the SRS Transition Oversight Committee (See Attachment #1).

Representative Geringer questioned what would happen if we don't match the federal laws for the federally qualified health clinics?

Representative Neufeld replied, the dentists that volunteer in the FQHCs risk their license and the state could end up in an audit and would risk FQHC money, either putting the dentists that volunteer at risk or the federal money at risk.

The Chairperson stated there are 11 proponents and asked each to summarize their testimony to speed the process. The Chairman stated that the bill as it was originally introduced was not the intent of the SRS Oversight Committee and most of the testimony will be based on the way the bill was written, so need to take that into consideration, but at the end of the testimony will have to determine whether or not to accept the balloon which is the charge from the SRS Oversight Committee.

Joyce Volmut, Kansas Association for the Medically Underserved, testified as a proponent to **HB 2586**, stating dental care remains one of the most critical problems in Kansas. Lack of access to dental care is not just an issue of the poor - although they are most at risk, the problem is widespread across the state - and no one group is to blame. Of the 105 counties in Kansas, 22 have been designated federal dental health professional shortage areas. This means in these counties there is a ratio of 1 dentist to over 5000 population. A workable ratio should be about 1:2000 (See Attachments 2&3).

Representative Storm stated we are working **HB2586** which is in the book and the Neufeld amendment and would like to know what any of it does.

Representative Geringer asked if the clinics see everybody regardless of ability to pay?

Ms. Volmut responded, yes.

Representative Geringer asked if a person earning $100,000 a year could go in and be treated free, true or false?

Ms. Volmut responded, false, you would have to pay the full fee which would depend on regular services for that particular area as determined by that clinic. Proof of income has to be shown, the rule is a community rule, there is no common rule.

Representative Geringer stated every community may establish their own rules.

Representative Haley asked if there was a sliding scale or do you pay or not pay if above or below the 200% of poverty so you don't have to show your W-2.

Ms. Volmut stated there is a sliding scale. When a patient enters the clinic there is a form they fill out and they are asked for verification of income. Different clinics use different proof; some requests pay stubs and some W-2 forms. Some people may be paid in cash and do not have any proof. If people are under 100% of poverty, they usually aren't charged at all, but it is dependent upon the policy by the clinic.

The Chairperson stated what we are working is the bill because we just found out two days ago that there was a difference between the bill that is in the bill book and what the bill was supposed to look like that was passed out by SRS Oversight Committee and consequently that is the reason that we have the balloon. After we hear this testimony we will go back to the balloon and vote on either accepting or rejecting the balloon. The bill that we are going to have to work then is going to be that bill, not the one we are hearing the testimony on right now that is in the book. I am sorry for that but we did not have time to tell all of these people that the bill is not the right bill.

Representative Storm stated they are testifying on the bill that is in the bill book and think everyone is confused.

The Chairperson closed the hearing on **HB 2586**. A new bill will be drafted, based on the balloon, and when that is received will see if there is time to hold hearings.

The Chairperson opened the hearing on **HB 2759 - Relating to Pharmacy Act of the State of Kansas.**

Staff gave a briefing stating the bill was requested for introduction by the Pharmaceutical Association that would authorize pharmacists to administer vaccine in certain circumstances.

Gianfranco Pezzino, MD, MPH, State Epidemiologist, Director, Bureau of Epidemiology and Disease Prevention, testified that **HB 2759** has the potential to expand adult immunization by making vaccines more easily accessible which can be a serious barrier, particularly in rural settings. According to information from the American Pharmaceutical Association, at least 22 states allow pharmacists to administer vaccines (See Attachment #4).

Sally Finney, Executive Director, Kansas Public Health Association, Inc., testified in support of **HB 2759**, stating it makes sense. Public health has learned over time that for disease prevention outreach to succeed, we must reach the target audience by bringing interventions to them (See Attachment #5).

Bob Williams, Executive Director of the Kansas Pharmacists Association, testified in support of **HB 2759**, stating this would allow pharmacists to administer adult vaccinations (eighteen years and over). The bill requires pharmacists to obtain a "vaccination protocol" with a physician and successfully complete a course of study and training approved by the American Council on Pharmaceutical Education (ACPE) or the State Board of Pharmacy that includes vaccination storage, protocols, injection technique, emergency procedures and record keeping. The bill also states that the pharmacist "may not delegate to any person the authority granted under this Act to administer a vaccine" (See Attachment #6).

Chris Collins, Director of Government Affairs, Kansas Medical Society, testified in opposition to **HB 2759**. It is believed Kansans have adequate access to vaccinations. If this change is made then propose amendment to protect the patient by ensuring that pharmacists are working under a protocol with a physician, after receiving training. However, the bill does not limit the types of vaccinations that pharmacists would be authorized to provide. A number of our members feel that if it is the intention of the pharmacists to provide only flu and pneumonia vaccinations, then the bill should be specific on that point. The bill also raises the questions of future scope of practice concerns (See Attachment #7).

The Chairperson closed the hearing on **HB 2759.**

The Chairperson stated regarding **HB 2586**, would ask for a new bill to be drafted and introduced in Appropriations and have assigned back to Health and Human Services Committee and the testimony would be on the bill.

The meeting adjourned at 3:05 p.m. and the next meeting will be February 10.

HEALTH AND HUMAN SERVICES

DATE February 9, 2000

NAME	REPRESENTING
Brad Hubin	Kansas Pharmacists Assoc.
BOB WILLIAMS	" " "
BOB ALDERSON	" " "
Dr. B. Lemon	Douglas County Dental Clinic Inc
Judy Everly	KS Assn. for Medically Underserved
Michelle Strong	Konza Prairie Community Health Center
Suzanne Gierloch	KS Assoc. for the Medically Underserved
Carolyn Middendorf	Ks St Ns Assn
Rich Gottuso	Health Midwest
Thelma Bowhay	SRS - Health Care Policy Division
Tim Wood	VCHS
Jeri Freed	KS Dental Bd
Mary Blubaugh	KSBN
William T. DONIGAN JR DDS	SELF
DEVIN ROBERTSON	KS. DENTAL ASSN
[illegible]	KS. Dental Hygienist Assn
[illegible]	KDHE - Primary Care
Maria Q. Espinoza	Federico Consulting
Cathy Harding	Flint Hills Community Health Center
Vern Razone	Heinlweir Chrtd.
Carrie Ann Lower	KAHP

HHS 2-9-2000 Att #1

HOUSE BILL No. 2586

By SRS Transition Oversight Committee

11-19-99

AN ACT relating to the dental practices act; concerning services for indigent persons; amending K.S.A. 65-1466 [1999 Supp.] and repealing the existing section.

1999 Supp.

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

Section 1. K.S.A. 1999 Supp. 65-1466 is hereby amended to read as follows: 65-1466. (a) (1) Notwithstanding any other provision of the dental practices act, a not-for-profit corporation having the status of an organization under 26 United States Code Annotated 501(c)(3) which is also a facility qualified under subsection (b) of K.S.A. 65-431 and amendments thereto to select and employ professional personnel an indigent health care clinic as defined by the rules and regulations of the secretary of health and environment, [a federally qualified health center] or a local health department may employ or otherwise contract with a person licensed under the dental practices act to provide dental services ~~to dentally indigent persons~~.

~~(b) Dentally indigent persons are those persons who are: (1) Determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of "poverty income guidelines" published in the federal register by the United States department of health and human services and are not indemnified against costs arising from medical and hospital care or dental care by a policy of accident and sickness insurance or an employee health benefits plan; or (2) eligible for medicaid; or (3) qualified for Indian health services. This subsection shall not be construed to prohibit an entity under subsection (a) which enters into an arrangement with a licensee under the dental practices act for purposes of providing services to dentally indigent persons pursuant to subsection (a) from defining "dentally indigent persons" more restrictively than such term is defined under this subsection.~~

~~(c)~~ [(b)] A licensee under the dental practices act who enters into an arrangement with an entity under subsection (a) to provide dental services pursuant to subsection (a): (1) Shall not be subject to having the licensee's license certificate suspended or revoked by the board solely as a result of such arrangement; and (2) may not permit another person who is not licensed in Kansas as a dentist, and is not otherwise competent to engage

(1)

to dentally indigent persons.

(2) Notwithstanding any other provision of the dental practices act, a not-for-profit corporation having the status of an organization under 26 United States Code Annotated 501(c)(3) which is also a facility qualified under subsection (b) of K.S.A. 65-431 and amendments thereto to select and employ a federally qualified health center may employ or otherwise contract with a person licensed under the dental practices act to provide dental services to any person

(b) Dentally indigent persons are those persons who are: (1) Determined to be a member of a family unit earning at or below 200% of poverty income guidelines based on the annual update of "poverty income guidelines" published in the federal register by the United States department of health and human services and are not indemnified against costs arising from medical and hospital care or dental care by a policy of accident and sickness insurance or an employee health benefits plan; or (2) eligible for medicaid; or (3) qualified for Indian health services. This subsection shall not be construed to prohibit an entity under subsection (a) which enters into an arrangement with a licensee under the dental practices act for purposes of providing services to dentally indigent persons pursuant to subsection (a) from defining "dentally indigent persons" more restrictively than such term is defined under this subsection.

in the clinical practice of dentistry. No entity under subsection (a) or any other person may direct or interfere or attempt to direct or interfere with a licensed dentist's professional judgment and competent practice of dentistry.

~~(d)~~ [(c)] A dentist who is classified as "retired" by the Kansas dental board is not required to pay the annual renewal fee or comply with the dental continuing education requirements if the dentist elects to provide dental services to the indigent through one of the entities specified in subsection (a). A "retired" dentist providing such services shall be required to comply with the annual renewal requirements of the Kansas dental board.

~~(e) The Kansas dental board may adopt rules and regulations as necessary to carry out the provisions of this section.~~

~~(f)~~ [(d)] This section shall be part of and supplemental to the dental practices act.

Sec. 2. K.S.A. 1999 Supp. 65-1466 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

(e) The Kansas dental board may adopt rules and regulations as necessary to carry out then provisions of this section, except that no such rule and regulation shall alter or affect the intent of paragraph (2) of subsection (a).

KAMU

Kansas Association
for the
Medically Underserved
The State Primary Care Association

112 SW 6th Ave., Suite 201 Topeka, KS 66603 785-233-8483 Fax 785-233-8403 www.ink.org/public/kamu

February 9, 2000
Health and Human Services Committee
HB 2586 -
Representative Boston, Vice chair Rep. Geringer, Ranking Minority Rep. Henry and members of the Health and Human Services Committee:

My name is Joyce Volmut. I am the executive director of the Kansas Association for the Medically Underserved here to testify in support of HB2586.

Access to dental care remains one of the most critical problems in Kansas. And although current studies tend to focus primarily on children, Medicaid children, it is a problem for all age groups- the elderly, young adults who are just entering the work force or starting new families, middle aged persons, between 45-65, who have lost jobs, changed jobs or are newly widowed and without health coverage, all suffer from lack of access to dental care.

Lack of access to dental care is not just an issue of the poor - although they are most at risk, the problem is widespread across the state - and no one group is to blame. Of the 105 counties in Kansas, 22 have been designated federal dental health professional shortage areas. This means in these counties there is a ratio of 1 dentist to over 5000 population. A workable ratio should be about 1:2000.

Passage of House Bill 2586 is one step in correcting the problem. It removes the restrictive language that has created barriers to care and restricts dental practice in Federally Qualified Health Centers (FQHC's) and other non-profit dental clinics in Kansas.

FQHC's and the non-profit primary care clinics are comprehensive primary care clinics who provide services in Kansas. Operating very much like the Kansas Community Mental Health Centers, these clinics make up the primary care safety net for underserved populations across the state.

- Like the Community Mental Health Centers, they are governed by a community board- in the case of FQHC's, this board must be composed of 51% user.
- They must have a medical director or in the case of a dental clinic, a dental director.
- They must provide comprehensive services. They must have the ability to diagnose, treat and follow up client care - in other words serve as a medical home for the client and charge for these services on a sliding fee.

Primary Care Clinics and FQHC's are generally funded by state and or federal primary care dollars. A few also receive funding from foundations, such as the United

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Methodist Health Ministry Fund. Sixteen of these clinics receive a portion of their funds through KDHE. Generally referred to as the Community Based Primary Care Program or State Funded Primary Care Clinics, these clinics were created by the 1991 Kansas legislature. The FQHC's were created by federal legislation in the late 60's as part of the public health law and are sometimes referred to as Public Health Section 330 Clinics.

It is somewhat of a misnomer to refer to these clinics as medically indigent clinics. When enacted by Kansas legislature, the intent was never to restrict access. The only purpose for defining the indigent patient was for purposes of the Kansas Tort Claim Act in order to determine eligibility for coverage. In the original RFP, state funded clinics were strongly encouraged to see all patients with access problems, regardless of their ability to pay. By the state grant regulation and by federal regulation, clinics must charge according to a sliding fee scale. By federal law, FQHC's are required to see anyone who resides within their catchment area, regardless of their ability to pay and regardless of payor type. Priority is given to patients under 200% of poverty.

Who does the restrictive language hurt?
Although the majority of individuals served meet the definition of dentally indigent as outlined in the Dental Practice act, there are those in need of service who do not. People choose to go to primary care clinics or FQHCs for many reasons- most having to do with access:

- They cannot meet current insurance deductibles.
- They have other catastrophic illnesses, such as AIDS. (Federal Ryan White legislation allows eligibility for clients with incomes below 300% of the federal poverty level. Yet these clients cannot access dental care.
- They are unable to access care in the private sector for other reasons.
- They are long standing users of primary care clinics or FQHC's.
- They have incomes that fluctuate around 200% of the federal poverty level.
- They require a great deal of support, including case management and other support services, in order to be compliant with care.
- They have only recently begun to have higher incomes or just entered the job market and struggle to rise above the poverty level.
- They have a right to choose the provider of choice.

Of the 30 clinics who make up our member organizations, 7 are currently providing dental services on site. These include the Flint Hills Community Health Center in Emporia, Hunter Health Clinic, Good Samaritan, United Methodist Clinics of Wichita and the Wichita-Sedgwick co. Health Department, all in Wichita, the Martin de Porres dental clinic in Topeka, and United Methodist of Harvey County in Newton. Several more are in the process of assessing need or of implementing care. These include Salina Cares in Salina, The Lawrence Dental Coalition, Konza Prairie Community Health Center in Junction City. The Douglas Community Health Center in Kansas City Kansas has also identified dental need as one of the highest needs for their community but have been hesitant to initiate a dental clinic until changes are made within the dental practice act that allows FQHC's to fully meet their federal mandate. In 1999, 7000 individuals received dental services in non-profit dental clinics and FQHC's.

KAMU agrees with the Kansas Dental Association and other state health officials and legislators, that the need for dental care is one of the most critical unmet needs. In a recent study of 2000 clients enrolled in Kansas primary care clinics and FQHC's , 60% told us they were in need of dental care. Adults over age 18 made up 53% of the group in need.

We believe that dental care is an essential component of primary care. Yet while sensitive to the Kansas Dental Associations quest to preserve the independent practice of dentistry, we believe current language in the Dental Practice Act is, in itself, a barrier to access and to recruitment and retention of qualified dentists in primary care clinic and FQHC practices. HB2586 removes these barrier. In view of this we emphatically support this legislation as written and will oppose any amendments that barriers.

Family Dental Care

John H. Hay, D.D.S.
10 East 9th Street, Suite C/D
Lawrence, KS 66044
(785) 749-2525

Representative Gary Boston
Chairman: Health and Human Service Committee
February 8, 2000

Dear Representative Boston:

I am writing to you to voice my support of HB2586. As a licensed, practicing dentist for nearly 13 years in the State of Kansas, I have seen firsthand the need for increased access to dental care in our state for lower income individuals. I have witnessed the reduction in numbers of Medicaid providers for our children as well as the bare bones attempts to treat adult urgent care needs through volunteer efforts.

While I am a general practicioner in a private setting and not a public health specialist, the facts are plain and simple. There is a significant portion of our population that does not have access to basic services within their budget.

I am a member of the Kansas Dental Association and previously served on their executive council but I am in disagreement with their premise that the relaxed guidelines proposed by HB2586 is a threat to independent practice. Patients who would benefit from and frequent "sliding fee" or "indigent" care clinics do not make up private practice "fee for service" client bases. These patients are turned away or receive emergency care only due to their inability to pay.

While I am very much in favor of dental practices being owned only by licensed dentists and would vigorously oppose the "for profit" ownership by 3rd party entities (ie: national retailers, insurance companies), anyone who thinks that these indigent clinics threaten their private practice is suffering from either delusions or paranoia.

I would welcome a place to refer people in my community to where a reduced fee setting allowed them to obtain basic preventive and therapeutic care. As a Kansan and dentist I would be proud to see our state and profession do the right thing in increasing access to care. Thank you for your time in considering my point of view. While I was not able to testify in person, I would welcome you sharing my viewpoint with the rest of your committee.

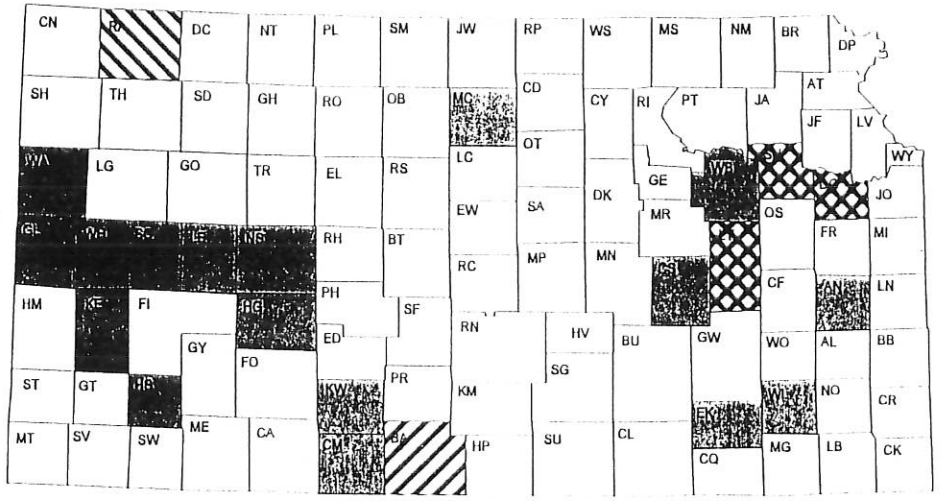
Respectfully,

John H. Hay D.D.S.

2-5

Federally Designated

Dental Health Professional Shortage Areas



As of September, 1999, 20 counties were wholly or partially designated as Dental Health Professional Shortage areas.

- ☐ Not Designated
- ☐ Whole County Designated
- ☒ Indigent Population Only
- ▨ In Process

NCEMCH Policy Brief

May 1998

Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care

Burton L. Edelstein, D.D.S., M.P.H.

"...80 percent of the tooth decay occurs in only 25 percent of U.S. children and adolescents."

For millions of America's children, the reality of their dental pain and dysfunction contradicts claims that modern dental care has conquered dental disease in children. The tremendous improvement in children's oral health witnessed over the last generation has not been extended to all of our children. Fifty years of fluoridation, the advent of pit and fissure sealants, advancements in dental science, and growing public awareness about healthy behaviors have made beautiful smiles commonplace. Despite these improvements, tooth decay in children has held on stubbornly and oral disease remains pervasive among millions of children, especially those from families with low incomes and from minority groups.

What Are the Hidden Facts?

- More than one-half of all children ages 6–8 and two-thirds of all 15-year-old adolescents continue to experience dental decay.[1]
- Among parents reporting their children's unmet health care needs, 57 percent reported unmet dental needs—nearly five times the number reporting the need for eyeglasses.[2] Twice as many parents claimed unmet desires for their children's dental treatment as for their medical care.[3]
- Nearly one-third of the cavities in children ages 6–8 have not been repaired—a higher percentage today than 10 years ago.[1]
- Fewer children visit a dentist before entering kindergarten today than 10

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A Research Center of Georgetown University's Public Policy Institute

years ago, despite widespread understanding that tooth decay starts before 2 years of age.[1]

The National Institute of Dental Research reports that 80 percent of the tooth decay occurs in only 25 percent of U.S. children and adolescents.[4] Low income is a significant risk factor for childhood caries,[5] and the greatest unmet treatment needs are seen in children from families with low incomes[6]—those children who are eligible for dental coverage under the Medicaid program and the new State Children's Health Insurance Program (CHIP).

Why Is Tooth Decay Still an Important Policy Problem?

Policymakers and dentists who are concerned about the health of children are regularly confronted by the reality of children with extensive cavities. These children suffer daily the distraction of chronic toothaches, acute and searing pain of dental abscesses, disfigured smiles, dysfunctional speech, and difficulty in eating—all of which result from a disease many thought had been conquered. Often viewed as an innocuous and trivial disease, tooth decay and its consequences cause harm far beyond the mouth. Chronically poor oral health is associated with diminished growth in toddlers,[7] compromised nutrition in children,[8] and cardiac and obstetric dysfunction in adults.[9] Affected children suffer through meals, are distracted from learning and playing, and live with the embarrassment and diminished self-esteem resulting from an unattractive appearance. Observing these children, Jonathan Kozol noted, "Although dental problems don't command the instant fears associated with low birth weight, fetal death, or cholera, they do have the consequence of wearing down the stamina of children and defeating their ambitions."[10]

Who Owns This Problem?

Parents, dentists who treat children from low-income families, child advocates, and health care program officials—from case workers to senior administrators—know the reality of this problem. Parents in communities know this reality: when given the opportunity to rank their own health problems, they rank dental disease as a top issue.[11] Hospitals also know this reality: emergency room and operating room staffs regularly see large numbers of children presenting with unrelenting toothaches and caries beyond dental office management.[12,13] Yet the public, their elected representatives, and many in the broader health community do not see or feel this problem.

What Is Medicaid's Role?

For more than 30 years, Medicaid dental programs for children have offered more promise than performance. All children enrolled in Medicaid are entitled to comprehensive dental services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program; yet the U.S. Department of Health and Human Services' Office of the Inspector General reported in 1996 that only 18 percent of Medicaid-eligible children received even a single preventive dental service.[14] Despite the inclusion of dental benefits, state Medicaid programs face a myriad of difficulties, from low levels of participation by dentists to difficulties in teaching beneficiaries how to negotiate the dental care system. Nevertheless, both access to and the delivery of dental services can benefit from a number of improvements made during this decade, including advances in risk identification and disease management, changes in health care organization and financing, and the growing interest of policymakers in children's oral health.

However, dental care is far more expensive than Medicaid officials previously recognized. The National Association of Children's Hospitals and the National Academy of Social Insurance both note that nearly 30 percent of all child health expenditures (public and private, insured and out-of-pocket, inpatient and outpatient) are devoted to children's dental care[15, 16]—a spending rate over 10 times the 2.3 percent expended by Medicaid for children's dental care.[17] Although funding is neither the sole problem nor the simple solution, it is clear that dental care for children enrolled in the Medicaid program is grossly underfunded.

What Action Needs to Be Taken?

Millions of children, their parents, their dentists, and health care officials entrusted with their health care know that the dental problems are real and that Medicaid is not working for them. Medicaid and CHIP can work for children if concerted and cooperative efforts are made through honest negotiation, appropriate funding, generation of political will, and thoughtful program reform. Shared ownership of the problem and

strong partnerships among families, health providers, and Medicaid/CHIP officials are essential.

One such initiative is the national conference "Building Partnerships to Improve Children's Access to Medicaid Oral Health Services" (June 1998), sponsored by the Health Care Financing Administration, the Health Resources and Services Administration, and the National Center for Education in Maternal and Child Health. Such partnerships are the starting point for developing lasting solutions to the crisis in care resulting from children's lack of access to Medicaid oral health services. ■

Burton L. Edelstein, D.D.S., M.P.H., is Director of the Children's Dental Health Project, a policy and advocacy effort supported by the American Association of Dental Schools and the National Center for Education in Maternal and Child Health, in cooperation with the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.

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KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

February 9, 2000

Testimony on HB 2759 presented by:

Gianfranco Pezzino, MD, MPH
State Epidemiologist, Director
Bureau of Epidemiology and Disease Prevention

The Kansas Department of Health and Environment looks with interest at any initiative aimed at improving the immunization coverage of adults in our state. While great progress in our state and in the country as a whole has been achieved in improving immunization coverage among children, too many adults still do not receive the immunizations they need. For example, a survey carried out by our agency in 1997 revealed that only less than 35% of adults interviewed had received a flu vaccine. In addition to influenza vaccine, other vaccines highly recommended for all adults or for some high risk groups are pneumococcal (to protect against invasive pneumonia), diphtheria, and tetanus.

HB 2759 has the potential to expand adult immunization by making vaccines more easily accessible, which can be a serious barrier particularly in rural settings. According to information from the American Pharmaceutical Association, at least 22 states allow pharmacists to administer vaccines. We have personally verified that pharmacists can administer immunizations in Nebraska and Oklahoma. In Colorado, immunizations are administered in drugstores by nurses. No information was available from Missouri in time for this hearing. My conversations with colleagues in states where pharmacists have been allowed to administer immunizations revealed that overall no major problems were encountered and people seem satisfied that such projects have made vaccines more easily available to the public.

One issue we would like to bring to your attention is that accurate record keeping to show what vaccines each individual has received is essential to assure that the proper individuals are vaccinated and to prevent the administration of unnecessary vaccinations to individuals already immunized. This bill puts a limit of two years on the record-keeping requirement for pharmacists. Given that some vaccines in adults are administered every five or ten years (or sometimes even only once or twice in the lifetime) the two-year limitation may be too loose. To help you put this issue in perspective, most medical practices will retain immunization records for at least ten years, and some will do that indefinitely. Other issues to consider related to record keeping are whether pharmacists will forward a notice regarding the vaccination to the "medical home" of each individual they immunize and whether a pharmacist would be able to access medical records containing information on previous immunizations received by an individual.

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H.H.S
2-9-2000
Atch #4

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Testimony presented to
House Committee on Health and Human Services by
Sally Finney, Executive Director
February 9, 2000

Thank you, Mr. Chairman and members of the committee, for allowing me to appear before you today. I am here on behalf of the members of the Kansas Public Health Association to ask your support of House Bill 2759.

HB 2759 makes sense. Public health has learned over time that for disease prevention outreach to succeed, we must reach the target audience by bringing interventions to them.

Since vaccine technology first became available in the last century, immunizations have been an integral part of public health. A list of leading causes of death among Kansans in the year 1900 is attached to my testimony. That list shows that influenza/pneumonia, diphtheria, typhoid fever, measles, and whooping cough ranked second, seventh, eighth, ninth, and tenth, respectively. For comparison, the list on the reverse side shows causes of death for the year 1998. **In 1998, influenza/pneumonia ranked as the fifth leading cause of death among Kansans, and, in fact, ranks as the sixth leading cause of death in the United States.**

Although technology exists to prevent most cases of influenza and pneumonia, many adults fail to take advantage of it. Where immunization against influenza is concerned, we believe this is largely because, unlike other vaccine-preventable diseases, immunization against the flu is time-sensitive. That is, immunizations must occur just before the "flu season" begins in order for an individual's immune system to develop enough resistance when flu viruses begin to appear in the population. This requires many older Kansans to schedule a special appointment with their physician in order to receive vaccine. **Passage of HB 2759 would afford older Kansans the choice of accessing immunizations as part of regular visits to their local pharmacies**.

We believe that allowing pharmacists to administer immunizations is a positive step towards making sure that influenza/pneumonia will be absent from the list of causes of death for Kansans in the year 2100.

Again, I ask your support of HB 2759. Thank you for your time.

H & HS
2-9-2000
Atch# 5

Leading Causes of Death in Kansas

1900

1. Heart and kidney diseases
2. Influenza and pneumonia
3. Tuberculosis
4. Gastritis, duodenitis, enteritis, and colitis
5. All other causes
6. Cancer
7. Diphtheria
8. Typhoid fever
9. Measles
10. Whooping cough

Source: Kansas Department of Health and Environment, Office of Health Care Information

Leading Causes of Death in Kansas

1998

1. Heart disease
2. Cancer
3. Stroke
4. Chronic obstructive pulmonary disease
5. Influenza and pneumonia
6. Diabetes mellitus
7. Motor vehicle accidents
8. All other accidents
9. Suicide
10. Kidney disease

Source: Kansas Department of Health and Environment, Office of Health Care Information

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ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
HB 2759
House Health and Human Services Committee
February 9, 2000

My name is Bob Williams. I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee regarding HB 2759.

HB 2759 will allow pharmacists to administer adult vaccinations (eighteen years and over). The bill requires pharmacists to obtain a "vaccination protocol" with a physician and successfully complete a course of study and training approved by the American Council on Pharmaceutical Education (ACPE) or the State Board of Pharmacy that includes vaccination storage, protocols, injection technique, emergency procedures and record keeping. The bill also states that the pharmacist "may not delegate to any person the authority granted under this act to administer a vaccine."

As many of you know, influenza and pneumonia are the sixth leading cause of death in the United States. Influenza and its complications account for 10,000 to 40,000 excess deaths annually in the U.S., of which more than 80% occur in the elderly. According to the World Health Organization, more than half elderly Americans do not receive a flu vaccination. According to the Kansas Foundation for Medical Care, the influenza immunization rate for 1996 was 47.3% and 48.7% for 1997. I have been unable to obtain rates for 1998 and 1999. According to *Partnership for Prevention*, a national organization whose mission is to increase the priority for prevention, one of the six reasons listed for individuals not receiving

H&HS
2-9-2000
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immunizations is "Lack of patient-friendly, easily accessible immunization services in the community." What could be more convenient, friendly, and accessible than your local community pharmacy?

Attached to my testimony is a list of thirty states that currently permit pharmacists to administer vaccinations. Please note that all of the states surrounding Kansas permit their pharmacists to administer vaccinations. In February 1999, South Carolina reported the largest rate increase for influenza immunizations in the country for adults ages sixty-five and older. The increase occurred from 1995 to 1997 which corresponds to when pharmacists began administering vaccinations. In an article published in the *South Carolina Pharmacy Journal,* Dr. Blake Williams, South Carolina Medical Review Director of Operations, is quoted as saying: "We are fortunate that South Carolina is a state that permits pharmacists to immunize against influenza."

Tennessee allowed pharmacists to administer immunizations in 1998. In the fall of 1999 the Tennessee Pharmacists Association asked community pharmacists to participate in a survey of their patients to validate the pharmacist's value in the immunization process. *Seventy-seven percent* of the patients said receiving an immunization at a pharmacy was easier than at any other place; *eighty-eight percent* of the respondents said pharmacies administer immunizations at more convenient times; *sixty-four percent* said they trust their pharmacists about the same as other immunization providers and *ninety-five percent* of the survey population said they would receive their immunizations at a pharmacy again next year.

The Wisconsin Pharmacists Association began an immunization program in 1999. Less than 100 pharmacists participated the first year. In a survey of participating pharmacists, they reported administering 4949 flu vaccines and 591 pneumococcal vaccines. No serious adverse reactions were reported.

Pharmacists providing immunizations have become so prevalent, the American Pharmacists Association now provides a "list-serve" for pharmacists who are actively involved with the administering of immunizations. A sample of the January 21, 2000, Immunization List-Serve is attached.

I have also attached a letter from Dr. Jose F. Cordero, Deputy Director, National Immunization Program, Centers for Disease Control and Prevention that states: ". . . the CDC comprehensively reviewed the educational materials for *Pharmacist-Based Immunization Delivery: A National Certificate Program for Pharmacists*. The review showed the program adequately addresses CDC's national vaccine standards and appropriately prepares pharmacists to assist public health officials with vaccine delivery. Overall, the CDC felt the program was of high quality and was pleased to recognize the effort."

Lastly I have attached a sample "Immunization Protocol," "Protocol for Management of Severe Allergic/Anaphylactic Reactions," "Vaccine Administration Record" and "Screening Questionnaire for Adult Immunization" for your review.

In summary, HB 2759 will permit pharmacists to administer adult vaccines only. It clearly states the requirements, restrictions and certification necessary in order for a pharmacist to administer vaccinations. Kansas pharmacists have been participating for a number of years with the Kansas Partners in Wellness Coalition (managed by the Kansas Foundation for Medical Care) to increase the immunization rate in Kansas. As stated previously, access is one of the barriers to obtaining vaccinations. HB 2759 will be a step in the right direction to eliminating that barrier.

Thank you.

From: mcr@mail.aphanet.org <mcr@mail.aphanet.org>
To: apha-ssb@eGroups.com <apha-ssb@eGroups.com>
Date: Friday, January 21, 2000 9:27 AM
Subject: [apha-ssb] Immunization List serve January 21, 2000

APhA Immunization Update
A list-serve provided by the American Pharmaceutical Association
Janury 21, 2000

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IN THIS ISSUE:

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I. Recommended Childhood Immunization Schedule -- United States, 2000

Each year, CDC's Advisory Committee on Immunization Practices (ACIP) reviews the recommended childhood immunization schedule to ensure it remains current with changes in manufacturers' vaccine formulations, revisions in recommendations for the use of licensed vaccines, and recommendations for newly licensed vaccines. This report presents the recommended childhood immunization schedule for 2000 and explains the changes that have occurred since January 1999.

Since the publication of the immunization schedule in January 1999 (1), ACIP, the American Academy of Family Physicians, and the American Academy of Pediatrics have recommended removal of rotavirus vaccine from the schedule, endorsed an all-inactivated poliovirus vaccine (IPV) schedule for polio vaccination, recommended exclusive use of acellular pertussis vaccines for all doses of the pertussis vaccine series, and added hepatitis A vaccine (Hep A) to the schedule to reflect its recommended use in selected geographic areas (2). Detailed recommendations for using vaccines are available from the manufacturers' package inserts, ACIP statements on specific vaccines, and the 1997 Red Book (3). ACIP statements for each recommended childhood vaccine can be viewed, downloaded, and printed at CDC's National Immunization Program World-Wide Web site, http://www.cdc.gov/nip/publications/ acip-list.htm.

Removal of Rotavirus Vaccine from the Schedule

On October 22, 1999, ACIP recommended that Rotashield[Registered]* (rhesus rotavirus vaccine-tetravalent [RRV-TV]) (Wyeth Laboratories, Inc., Marietta, Pennsylvania), the only U.S. licensed rotavirus

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vaccine, no
longer be used in the United States (4). The decision was based on the results
of an expedited review of scientific data presented to ACIP by CDC. Data from the review indicated a strong association between RRV-TV and intussusception among infants 1-2 weeks following vaccination. Vaccine use was
suspended in July pending the ACIP data review. Parents should be reassured that children who received the rotavirus vaccine before July are not at increased risk for intussusception now. The manufacturer withdrew the vaccine from the market in October.

Inactivated Poliovirus Vaccine for All Four Doses

As the global eradication of poliomyelitis continues, the risk for importation of wild-type poliovirus into the United States decreases dramatically. To eliminate the risk for vaccine-associated paralytic poliomyelitis (VAPP), an all-IPV schedule is recommended for routine childhood vaccination in the United States (5). All children should receive four doses of IPV: at age 2 months, age 4 months, between ages 6 and 18
months, and between ages 4 and 6 years. Oral poliovirus vaccine (OPV), if available, may be used only for the following special circumstances:

1. Mass vaccination campaigns to control outbreaks of paralytic polio.
2. Unvaccinated children who will be traveling within 4 weeks to areas where polio is endemic or epidemic.
3. Children of parents who do not accept the recommended number of vaccine injections; these children may receive OPV only for the third or fourth
dose or both. In this situation, health-care providers should administer OPV
only after discussing the risk for VAPP with parents or caregivers.

OPV supplies are expected to be very limited in the United States after inventories are depleted. ACIP reaffirms its support for the global eradication initiative and use of OPV as the vaccine of choice to eradicate polio where it is endemic.

Acellular Pertussis Vaccine

ACIP recommends exclusive use of acellular pertussis vaccines for all doses of the pertussis vaccine series. The fourth dose may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at 15-18 months.

Hepatitis A

Hepatitis A vaccine (Hep A) is listed on the schedule for the first time because it is recommended for routine use in some states and regions. Its appearance on the schedule alerts providers to consult with their
local public health authority to learn the current recommendations for hepatitis A vaccination in their community. Additional information on the use of Hep A can be found in recently published guidelines (2).

Hepatitis B

Special considerations apply in the selection of hepatitis B vaccine products for the dose administered at birth (6).

Vaccine Information Statements

The National Childhood Vaccine Injury Act requires that all health-care providers, whether public or private, give to parents or patients copies of Vaccine Information Statements before administering each dose of the
vaccines listed in this schedule (except Hep A). Vaccine Information Statements, developed by CDC, can be obtained from state health departments and CDC's World-Wide Web site, http://www.cdc.gov/ nip/publications/VIS.

Instructions on use of the Vaccine Information Statements are available from CDC's website or the December 17, 1999, Federal Register (64 FR 70914).

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* Use of trade names and commercial sources is for identification only and does not constitute or imply endorsement by CDC or the U.S. Department
of Health and Human Services.

- MMWR, January 21, 2000

II. FDA prescribes caution in use of flu fighter

The Food and Drug Administration, saying it has received reports of respiratory problems following use of the new inhaled flu medication Relenza, is advising doctors to use "special caution" when prescribing the drug to patients with asthma or chronic obstructive pulmonary disease. In a health advisory, the FDA said patients who have breathing problems should use Relenza only with careful supervision. The advisory also reminds doctors that flu vaccine is the first line of defense and that new anti-viral medications are not effective against bacterial infections.

- USA Today, January 13, 2000

III. Conference on Vaccine Research

The Third Annual Conference on Vaccine Research: Basic Science--Product Development--Clinical and Field Studies will be held April 30-May 2, 2000, in Washington, D.C. This conference is sponsored by the National Foundation for Infectious Diseases (NFID) in collaboration with CDC, the National Institute of Allergy and Infectious Diseases, the International Society for Vaccines, the Center for Biologics Evaluation and Research of the Food and Drug Administration, the World Health Organization, the Albert B. Sabin Vaccine Institute at Georgetown University, and the U.S. Department of Agriculture. The meeting covers scientific data and issues from the disciplines involved in the research and development of vaccines and associated technologies for the control of human and veterinary diseases through vaccination.

Program announcements and forms for abstract submission, registration, and hotel reservations are available from Kip Kantelo, NFID, Suite 750, 4733 Bethesda Ave., Bethesda, MD 20814-5228; telephone (301) 656-0003, ext. 19; fax (301) 907-0878; e-mail kkantel-@nfid.org; World-Wide Web site http://www.nfid.org/conferences/.*

IV. MMWR Summary of Notifiable Diseases, US 1998

The MMWR Summary of Notifiable Diseases, United States, 1998 contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases in the United States for 1998. These statistics are collected and compiled from reports to the National Notifiable Diseases Surveillance System (NNDSS), which is operated by CDC in collaboration with the Council of State and Territorial Epidemiologists (CSTE).

Because the dates of onset or diagnosis for notifiable diseases are not always reported, these surveillance data are presented by the week they were reported to CDC by public health officials in state and territorial health departments. These data are finalized and published each year in the MMWR Summary of Notifiable Diseases, United States for use by state and local health departments; schools of medicine and public health; communications media; local, state, and federal agencies; and other agencies or persons interested in following the trends of reportable diseases in the United States. This publication also documents which diseases are considered national priorities for notification and the annual number of cases of such diseases.

The Highlights section presents information on selected nationally notifiable and non-notifiable diseases to provide a context in which to interpret surveillance and disease-trend data and to provide further information on the epidemiology and prevention of selected diseases.

Background

As of January 1, 1998, a total of 52 infectious diseases were designated as notifiable at the national level. A notifiable disease is

one for which regular, frequent, and timely information regarding individual
cases is considered necessary for the prevention and control of the disease.

This section briefly summarizes the history of the reporting of nationally notifiable diseases in the United States.

Highlights for 1998

Diphtheria

One probable case of diphtheria was reported from Oregon in 1998. The case-patient had acute membranous pharyngitis. An oropharyngeal specimen was weakly positive for diphtheria toxin by polymerase chain reaction, but bacterial culture of the specimen was negative.

Outside the United States, more than 2,700 cases of diphtheria were reported in an epidemic in the Newly Independent States of the former Soviet Union (Dittmann S, Wharton M, Vitek C, et al. Successful control of
epidemic diphtheria in the Newly Independent States of the Former Soviet Union:
lessons learned in fighting public health emergencies. J Infect Dis 2000 [in press]). This epidemic has resulted in approximately 155,000 cases and
5,000 deaths since 1990. No importations into the United States were reported
in 1998.

Haemophilus influenzae, Invasive Disease

In 1998, a total of 255 cases of Haemophilus influenzae (Hi) invasive disease among children aged less than 5 years were reported (data were provided by the National Immunization Program and were based on date of onset, not MMWR week). Before a vaccine was introduced in 1987, approximately 20,000 cases of H. influenzae type b (Hib) invasive disease occurred among children annually (JAMA 1993;269:221-6). The sharp
decline in the number of Hib cases is attributed to the widespread use of the Hib vaccine among preschool-aged children. Of the 255 cases reported in
1998, a total of 197 (74%) Hi isolates were serotyped, and 61 (31%) of these
were type b. Among the 61 cases of Hib invasive disease reported in children
aged less than 5 years, 25 (41%) were among children aged less than 6 months,
which is too young to have completed a three-dose primary Hib vaccination.

However, 22 (61%) of the 36 children who were old enough (i.e., aged greater than or equal to 6 months) to have completed a three-dose primary series were incompletely vaccinated or their vaccination status was unknown.
These cases might have been prevented with age-appropriate vaccination.

Hepatitis A

In 1999, the Advisory Committee on Immunization Practices (ACIP) issued revised recommendations for the use of hepatitis A vaccine (HepA). Routine childhood HepA vaccination is recommended in states or counties/communities where the average annual hepatitis A virus (HAV) rate during 1987-1997 was approximately 20 cases 100,000 population (i.e., approximately twice the national average). In addition, routine childhood HepA vaccination can be considered in states or counties/communities where the average rate during 1987-1997 was at least 10 cases/100,000 population.

Of the 23,229 cases of HAV reported in 1998, approximately 60% originated from the 17 states affected by the ACIP recommendations. Eleven of these states had average rates of approximately 20 cases/100,000 persons during 1987-1997, and six states had average rates of approximately 10/100,000 during this period. However, these 17 states account for only 34% of the U.S. population.

Hepatitis B

The number of reported acute hepatitis B cases has decreased by more than 50% during the past decade, from 21,102 cases in 1990 to 10,258 cases in 1998. This downward trend is expected to continue as a national strategy for eliminating hepatitis B virus (HBV) transmission is implemented.
Components of this strategy include a) screening pregnant women for hepatitis B surface antigen (HBsAg) and providing postexposure immunoprophylaxis to infants of infected women; b) routinely vaccinating infants; c) providing catch-up vaccinations for children aged less than 19 years (particularly those aged 11-12 years); and d) targeting vaccinations to children, adolescents, and adults at increased risk for infection.

Draft Healthy People 2010 objectives emphasize the elimination of HBV transmission and include reducing the number of perinatal HBV infections to less than 400 and reducing the number of acute hepatitis B cases in persons aged 2-18 years to less than 10. Proposed age-specific target rates per 100,000
population for persons aged greater than 18 years are as follows: 3.2 cases/100,000 for persons aged 19-24 years, 11.1/100,000 for persons aged 25-39 years, and 1.0/100,000 for persons aged greater than or equal to
40 years.

Hepatitis C

Hepatitis C virus (HCV) infection is the most common chronic bloodborne infection in the United States (MMWR 1998;47[RR-19]). Based on data from CDC's sentinel counties viral hepatitis surveillance system, approximately 242,000 new HCV infections occurred each year during the 1980s. Since 1989, the annual number of new infections identified in the sentenial
counties has declined by 80%. For reasons that are unclear, this dramatic decline correlates with a decrease in cases among injecting-drug users (MMWR
1998;47[RR-19]). But in 1996, data from the Third National Health and Nutrition Examination Survey (1988-1994) indicated that approximately 4 million Americans (1.8%) have been infected with HCV. Most are chronically infected, although the majority might be unaware of their infection

because they are not clinically ill. Chronically infected persons can transmit
the virus to others and are at risk for chronic liver disease, including cirrhosis and liver cancer.

CDC guidelines for prevention and control of HCV infection and HCV-related chronic disease were published in October 1998 (MMWR 1998;47[RR-19]). The U.S. Food and Drug Administration also issued guidance in 1998 requiring the notification of persons who received blood or
blood products before July 1992 from donors subsequently found to be infected
with HCV. In May 1999, a national campaign was initiated to educate the public about hepatitis C and the need for persons at increased risk to be
tested.

These recommendations and activities are expected to increase the number of HCV-infected persons identified and reported to state and local health departments.

Lyme Disease

In 1998, a total of 16,801 cases of Lyme disease were reported, the highest number ever reported. This increase could be caused by an increase in human contact with infected ticks and enhanced reporting of cases.
Lyme disease occurs primarily in the northeastern and northcentral United
States.

The following nine states had incidence rates higher than the annual national average of 6.39 cases/100,000 population and accounted for 93.0% of reported cases: Connecticut (105.0/100,000), Rhode Island (79.6), New
York (25.5), New Jersey (24.0), Pennsylvania (22.9), Maryland (13.1), Massachusetts (11.5), Wisconsin (12.8), and Delaware (10.7).

In December 1998, a new Lyme disease vaccine was approved by the U.S. Food and Drug Administration. The Advisory Committee on Immunization Practices issued recommendations for use of this vaccine in June 1999 (MMWR 1999;48 [No. RR-7]). These recommendations emphasize that the decision
to vaccinate should be based on both geographic risk and individual exposure to tick-infested habitats. Because the Lyme disease vaccine is not 100% effective and does not protect against transmission of other tickborne
diseases, vaccinated persons should continue to practice personal protective measures against ticks and seek early diagnosis and treatment of
suspected tickborne infections.

Pertussis

On July 29, 1998, the fourth diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) was licensed for use in children aged 6 weeks-6 years. This vaccine is called Certiva,TM and it is manufactured
by North American Vaccine, Inc. Other DTaP vaccines licensed since 1996

include Tripedia[Registered] (Connaught Laboratories, Inc.), ACEL-IMUNE[Registered] (Lederle Laboratories Division of American Cyanamid Company), and Infanrix[Registered] (SmithKline Beecham Pharmaceuticals). The Advisory Committee on Immunization Practices recommends DTaP vaccines for all five doses in the childhood vaccination schedule.

Since 1980, the number of reported cases of pertussis has increased in the United States. The reasons for this rise are unknown, but could include increased awareness of pertussis among health-care providers, increased use of more sensitive diagnostic tests, and better reporting of cases to health departments. In 1998, a total of 24% of 7,405 reported cases occurred among children aged less than 7 months, who were too young to have received the recommended three doses of pertussis vaccine. Thirteen percent of cases were among preschool-aged children (i.e., those aged 1-4 years). Since 1995, the coverage rate with at least three doses of pertussis vaccine has been 95% among U.S. children aged 19-35 months. Twenty-six percent of cases were reported among children aged 10-19 years. Because vaccine-induced immunity wanes approximately 5-10 years after pertussis vaccination, adolescents can become susceptible to disease. Since 1990, the incidence among preschool-aged children has not changed, but the incidence among adolescents has increased in some states (Clin Inf Dis 1999;28:1230-7).

Poliomyelitis, Paralytic

As of January 1999, the Advisory Committee on Immunization Practices recommends only inactivated polio vaccine (IPV) for the first two doses of the polio vaccination series. Distribution of IPV as a proportion of overall polio vaccine use has increased from 6% in 1996 to 29% in 1997 to 34% in 1998. All six cases of vaccine-associated polio reported in the United States since January 1997 (including the single case reported in 1998) were associated with receipt of trivalent oral polio vaccine (OPV) for the first or second dose in an all-OPV schedule. An all-IPV schedule is recommended for routine childhood vaccination beginning January 1, 2000.
St. Louis Encephalitis A summertime epidemic of St. Louis encephalitis in southern Louisiana accounted for 18 of the 24 cases reported nationally. No cases were fatal.

Culex pipiens quinquefasciatus was presumed to be the primary mosquito vector. The last major epidemic of St. Louis encephalitis in the United States (223 cases and 11 deaths) occurred in Florida in 1990. This disease occurs in portions of both the eastern and western United States.

Streptococcal Disease, Invasive, Group A

Nationally, approximately 10,200 cases of invasive group A streptococcal disease and 1,300 deaths occurred in 1998, according to reports from the Active Bacterial Core Surveillance (ABCS) project under

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CDC's Emerging Infectious Diseases Program, which operates in seven states (California, Connecticut, Georgia, Maryland, Minnesota, New York, and
Oregon). The incidence of this disease during 1998 was 3.8 cases/100,000 population. Rates were highest among children aged less than 1 year (7.5 cases/100,000) and adults aged greater than or equal to 65 years (10.0/100,000). Streptococcal toxic shock syndrome and necrotizing fasciitis each accounted for approximately 5.1% of invasive cases. The overall
case-fatality rate among patients with invasive group A streptococcal disease was 12.2%.

Streptococcus pneumoniae, Drug-Resistant

During 1998, the Active Bacterial Core Surveillance (ABCS) project of CDC's Emerging Infectious Diseases Program collected information on invasive pneumococcal disease, including drug-resistant Streptococcus pneumoniae, in eight states -- California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee. Of 3,335 S. pneumoniae isolates collected during 1998, a total of 10.2% exhibited intermediate penicillin
resistance (minimum inhibitory concentration [MIC] 0.1-1 ug/mL), and 13.6% were
resistant (MIC greater than or equal to 2 ug/mL). For cefotaxime, 7.7% of all isolates had intermediate resistance (MIC 1 ug/mL), and 6.1% were resistant (MIC greater than or equal to 2 ug/mL). The proportion of isolates resistant to erythromycin was 14.7% (MIC greater than or equal to 2
ug/mL).

The overall proportions of isolates that were not susceptible to these three drugs were not substantially different compared with 1997 data. However, the proportions that were resistant varied widely among surveillance sites in 1998, and an increase in the prevalence of resistant strains, compared
with earlier years, was reported from some states (data available at http://www.cdc.gov/ncidod/dbmd/abcs/survreports.htm).

Tetanus

The first case of neonatal tetanus reported in the United States since 1995 was reported from Montana in 1998. The case occurred in an infant born to a mother who was not immunized because of her philosophic beliefs
and who used a nonsterile bentonite clay recommended by a lay midwife for the
care of the baby's umbilical cord. The infant recovered after a 3-week hospitalization, including 12 days of mechanical ventilation. Of the 41 cases of tetanus that occurred in 1998, a total of 16 (39%) were among persons aged greater than or equal to 60 years, and 16 (39%) were among persons aged 20-59 years.

Varicella

Although varicella (chickenpox) deaths did not become nationally notifiable until January 1, 1999, some states began reporting varicella deaths to CDC during the second half of 1998. These data highlighted that both children and adults are continuing to die from a disease that is

now vaccine-preventable. During 1998, national coverage for varicella vaccine among children aged 19-35 months was 43%. Efforts to increase vaccination of susceptible children, adolescents, and adults should include educating health-care providers that deaths and severe morbidity from varicella
are preventable.

Surveillance for Potential Bioterrorism Agents

CDC established the Bioterrorism Preparedness and Response Program in January 1999 to improve the public health capability to detect and respond to biological and chemical terrorism. Members of this program are
working with the FBI and other federal agencies to develop an organized and
tiered response to suspect and confirmed biological events. The program focuses on state-level preparedness for early clinical and laboratory detection, which is essential to ensure a prompt response to a bioterrorist attack (e.g., providing prophylactic medicines or vaccines). Initial activities target critical agents that a) are associated with high case-fatality, b) can be disseminated to a large population, c) can cause social disruption because of public perception, and d) require special preparedness needs. These critical agents and their associated diseases include variola major (smallpox), Bacillus anthracis (anthrax), Yersinia pestis (plague), Francisella tularensis (tularemia), Clostridium botulinum (botulism), and the viral hemorrhagic fevers (e.g., arenaviruses and filoviruses).

Several other agents have been identified but require less broad-based preparedness efforts, including ones that cause foodborne and waterborne diseases. A critical element for preparedness is defining the natural epidemiology of diseases that can be caused by critical agents, including anthrax and plague, which are nationally notifiable diseases. The last case of naturally occurring anthrax in the United States was reported in
1992. In 1998, a total of 9 cases of plague among humans were reported in the
United States.

- MMWR, January 21, 2000

****

> We are looking for immunization success stories to highlight in
> advocacy material. Please email Mitch Rothholz at
mc-@mail.aphanet.org
> with information.
>
> **********
> RESOURCES:
>
APhA2000 - APhA's Annual Meeting: March 10-14, 2000, Washington, DC

IMMUNIZATION RELATED- PROGRAMS

- HHS Secretary Donna Shalala: Monday, March 13, 9:30-11:00am,APhA Second General Session

- Pneumonia: The Uphill Battle with Resistance: Saturday, March 11,
8-10:00am

- Vaccinations for High Risk Populations: Saturday, March 11,1-3:00pm

- Extraordinary Infections: A Focus on Bioterrorism: Saturday,March 11,
3:30am-5:30pm

- Building a Year-Round Immunization Program: Saturday, March 11,
3:30-5:30pm

- Immunization Licensing Partners Briefing (invitation only):
Sunday, March 12, 11:30am-3:00pm

- Travel Vaccine Primer: Sunday, March 12, 3:00-5:00pm

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* Interested in Pediatric Immunization Delivery - contact John Bullock, RPh, PharmVac, Inc., pharmva-@aol.com

* Disposal System for Needles/ Syringes - easy to utilize - contact SCI - Sharps Compliance at 1-800-772-5657

* Immunization Action Coalition & the Hepatitis B Coalition
Web: http://www.immunize.org/

>
> Mitchel C. Rothholz, R.Ph.
> Deputy to the Executive Vice-President
> APhA
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> mc-@mail.aphanet.org
>

Prototype*

Immunization Protocol

Standing Vaccine Orders
Authority to Immunize
Authority to Initiate Immunization
Standing Prescription Order to Administer Immunizations

Addressee **Date**

(Name of Pharmacist), Pharmacy License #_____, acting as delegated agent for the undersigned physician, according to and in compliance with Article _____ of the _____ State Pharmacy Practice Act, may administer the medications listed below on the premises of the ABC Pharmacy [or elsewhere] and for a fee.

[If desired, the pharmacist's credentials and training for competence in immunization delivery can be described here.]

To protect people from preventable infectious diseases that cause needless death and disease, this pharmacist may administer the following immunizations to eligible infants, children, adolescents, and adult patients, according to indications and contraindications recommended in current guidelines from the Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control & Prevention (CDC) and other competent authorities:

- influenza vaccine
- pneumococcal vaccine
- hepatitis B vaccine
- hepatitis A vaccine
- tetanus-diphtheria toxoids (adult, Td)
- measles-mumps-rubella (MMR) vaccine
- varicella vaccine
- *Haemophilus influenza* type b (Hib) vaccine
- other vaccines licensed by the Food & Drug Administration, except:
- [list those exceptions]

Other vaccines may be added to or deleted from this list by written supplementary instruction from the undersigned.

In the course of treating adverse events following immunization, this pharmacist is authorized to administer epinephrine (at a dose of approximately 0.01 mg/kg body weight; maximum of 0.5 mg per dose) and diphenhydramine (at a dose of approximately 1 mg/kg; maximum of 50 or 100 mg per dose) by appropriate routes pending arrival of emergency medical services. The pharmacist will maintain current certification in cardiopulmonary resuscitation.

In the course of immunizing, this pharmacist must maintain perpetual records of all immunizations administered. Before immunization, all vaccine candidates will be questioned regarding previous adverse events after immunization, food or drug allergies, current health, immunosuppression, recent receipt of blood or antibody products, pregnancy, and underlying diseases. All vaccine candidates will be informed of the specific benefits and risks of the vaccine offered. All vaccinees will be observed for a suitable period of time after immunization for adverse events.

All vaccinees will be given a written immunization record. The immunization will be promptly reported to the patient's primary-care provider by FAX or mail. The immunization will also be reported to appropriate county or state immunization registries.

The pharmacist will endeavor not to disrupt existing patient-physician relationships. The pharmacist will refer patients needing medical consultation to a physician. The pharmacist will make special efforts to identify susceptible people who have not previously been offered immunizations.

[Add other specific instructions appropriate to this scenario].

As the authorizing physician, I will review, on a quarterly basis, the activities of the pharmacist administering vaccines under this protocol.

The authorization shall be valid until two years from the date indicated above, unless revoked in writing sooner or unless extended in writing.

Physician Name: _____

Physician Signature: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Medical License #: _____

* Adapt according to your state's laws and regulations before implementing.

Prototype*

Protocol for Management of Severe Allergic/Anaphylactic Reactions

If an allergic reaction to a medication occurs, the following standing orders will be used:

1. Procedures:
   - ✓ Be prepared to call 911.
   - ✓ Take a thorough history for allergies and prior adverse events before any immunization.
   - ✓ Allow adequate physical space for fainting or collapse without injury and to lay patient flat on a hard surface in the event cardiopulmonary resuscitation (CPR) is needed.
   - ✓ Maintain current competency in immunization; observe all vaccinees for a suitable period of time after immunization; remind vaccinees to report any adverse events to you.

2. Supplies to Stock:
   - ✓ Epinephrine USP, 1 mg/ml (1:1,000). May be in vials of solution, *Ana-Guard* syringes (in *Ana-Kits*), or in an *Epi-Pen*. If an *Epi-Pen* is to be used, at least two adult *Epi-Pens* and two *Epi-Pen Jrs.* will be available whenever immunizations are given.
   - ✓ Diphenhydramine liquid and injection
   - ✓ Blood-pressure cuff, pediatric and adult size, with stethoscope

3. Recognition of Anaphylactic Reaction:
   - ✓ Sudden onset of itching, redness, with or without hives, within several minutes of administering a medication. The symptoms may be localized or generalized.
   - ✓ Angioedema (swelling of the lips, face, throat)
   - ✓ Bronchospasm, shock

4. Emergency Treatment:
   - (a) If itching and swelling are confined to the extremity where the immunization was given, observe patient closely for a suitable period of time, watching for generalized symptoms. If none occur, go to paragraph 4(g).
   - (b) If symptoms are generalized, activate the emergency medical system (EMS), (e.g., call 911) and call the consulting physician for instructions. This should be done by another person, while the immunizer treats and observes the patient.
   - (c) Administer epinephrine according to the dose in the table below, subcutaneously or intramuscularly. Site of administration can be the anterior thigh or deltoid muscle.
   - (d) Administer diphenhydramine by IM injection according to the dose in the table below. Do **NOT** administer diphenhydramine or any other drug by mouth if the patient is not fully alert or if the patient has respiratory distress.
   - (e) Monitor the patient closely until EMS arrives. Perform CPR and maintain airway, if necessary. Keep patient in supine position unless they are having breathing difficulty. If breathing is difficult, patient's head may be elevated, provided blood pressure is adequate to prevent loss of consciousness. Monitor vital signs frequently.
   - (f) If EMS has not arrived and symptoms are still present, repeat dose of epinephrine every 5 to 20 minutes, depending on patient's response.
   - (g) Patient must be referred for medical evaluation, even if symptoms resolve completely. Symptoms may reoccur after epinephrine and diphenhydramine wear off, as much as 24 hours later. After the event is concluded, complete a VAERS form.

Epinephrine Dosing

(Dosing by body weight is preferred)

Age Group	Weight (kg)*	Weight (lbs.)*	Epinephrine Dose (1mg/ml=1:1,000 w/v)
1-6 months	4-7	9-15	0.05 mg / 0.05 ml
7-18 months	7-11	15-24	0.1 mg / 0.1 ml
19-36 months	11-14	24-31	0.13 mg / 0.13 ml
37-48 months	14-17	31-37	0.16 mg / 0.16 ml
49-59 months	17-19	37-42	0.18 mg / 0.18 ml
5-7 years	19-23	42-51	0.2 mg / 0.2 ml
8-10 years	23-35	51-77	0.3 mg / 0.3 ml
11-12 years	35-45	77-99	0.4 mg / 0.4 ml
> 12 years	>45	>99	0.5 mg / 0.5 ml

Diphenhydramine Dosing

(Dosing by body weight is preferred)

Age Group	Weight (kg)*	Weight (lbs.)*	Diphenhydramine Dose (1mg/ml=1:1,000 w/v)
1-6 months	4-7	9-15	5 mg
7-18 months	7-11	15-24	10 mg
19-48 months	11-17	24-37	15 mg
4-7 years	17-23	37-51	20 mg
8-10 years	23-35	51-77	30 mg
11-12 years	35-45	77-99	40 mg
> 12 years	>45	>99	50 to 100 mg

*Weights reflect 50th percentile for corresponding ages.

Pharmacist's signature _____ Physician's signature _____ Date _____

Reference: Thibodeau JL. Office management of childhood vaccine-related anaphylaxis. Can Fam Phys 1994; 40:1602-10.

6-18

VACCINE ADMINISTRATION RECORD

Your pharmacist will keep this record in your medical file. Please complete the top portion of this form.

"I have read or have had explained to me written information about the vaccine listed below. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named below for whom I am authorized to make this decision."

Name: _____

Birthdate: _____ **Gender:** _____ **SS#:** _____

Allergies: _____

Doctor: _____

Medicare #: _____ **Medicaid #:** _____

Other Insurance: _____ **Policy #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____

Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

_____

For Clinic/Office Use:

Vaccine Name: _____ Manufacturer: _____

Lot Number: _____ Site of Injection: _____

Date Administered: _____

Vaccine Administrator: _____ Title: _____

Signature: _____

Clinic/Office Address: _____

City: _____ State: _____ Zip: _____

6-17

Adult Vaccine Administration Record

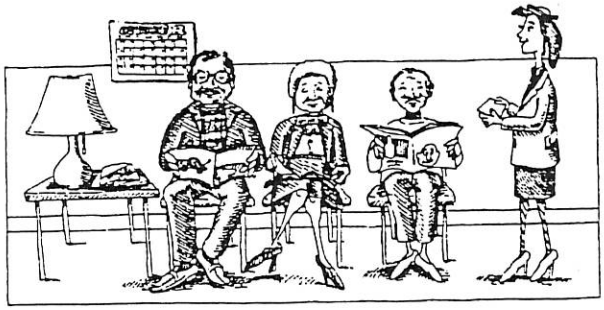
Patient name: _____

Birthdate: _____

Clinic chart number: _____

Vaccine administrator: Before administering any vaccines, make sure the person understands the risks and benefits of these vaccines and that their questions have been answered to their satisfaction. Make sure you give the patient an updated shot record card at every visit.

Vaccine and route	Date given mo/day/yr	Dose	Site given (RA, LA, RT, LT)	Vaccine lot number	Expiration date	Vaccine manufacturer	Signature or initials of vaccine administrator
DTP/DTaP/DT/Td - 1 (IM)							
DTP/DTaP/DT/Td - 2 (IM)							
DTP/DTaP/DT/Td - 3 (IM)							
DTP/DTaP/DT/Td - 4 (IM)							
DTP/DTaP/DT/Td - 5 (IM)							
Td booster (IM)							
Td booster (IM)							
Td booster (IM)							
Td booster (IM)							
Hepatitis B - 1 (IM)		mcg					
Hepatitis B - 2 (IM)		mcg					
Hepatitis B - 3 (IM)		mcg					
Hepatitis A - 1 (IM)							
Hepatitis A - 2 (IM)							
MMR - 1 (SQ)							
MMR - 2 (SQ)							
Varicella -1 (SQ)							
Varicella - 2 (SQ)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Influenza (IM)							
Pneumococcal (IM or SQ)							
Other							
Other							
Other							
Other							



Your name: _____

Date of birth: mo _____ day _____ year _____

Today's date: mo _____ day _____ year _____

Screening Questionnaire for Adult Immunization

The following questions will help us determine which vaccines may be given in clinic today. Please answer these questions by checking the boxes. If the question is not clear, please ask the nurse or doctor to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, eggs, any vaccine, or any vaccine component?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?	☐	☐	☐
6. During the past year have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐	☐	☐
7. For women: Is it possible that you are pregnant or may become pregnant in the next three months?	☐	☐	☐

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your shots. If you don't have a record card, ask your doctor or nurse to give you one! Bring this record with you to your clinic visits. Make sure your clinic records all your vaccinations on it.

Artwork courtesy of New York State Department of Health

Item #P4065 (2/97)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health S

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

October 30, 1998

John A. Gans, Pharm.D.
Executive Vice President
American Pharmaceutical Association
2215 Constitution Avenue, NW
Washington, D.C. 20037

Dear Dr. Gans:

Thank you for sharing with the Centers for Disease Control and Prevention (CDC) the training materials for your educational program, *Pharmacy-Based Immunization Delivery: A National Certificate Program for Pharmacists*. Also, the information you presented on the American Pharmaceutical Association's (APhA) efforts to actively involve pharmacists in national vaccine efforts is valuable to my colleagues and me.

At your request, the CDC comprehensively reviewed the educational materials for *Pharmacy-Based Immunization Delivery: A National Certificate Program for Pharmacists*. The review showed the program to adequately address CDC's national vaccine standards and to appropriately prepare pharmacists to assist public health officials with vaccine delivery. Overall, the program is of high quality and we are pleased to recognize your efforts.

The development of these training materials was supported in part by funds provided by the CDC's National Immunization Program (NIP) under Cooperative Agreement No. U66/CCU312177 *Enhancing Partnerships with Private Sector Health Care Providers* and with the contribution of CDC personnel and materials. However, its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

I look forward to your continued involvement with immunization advocacy. Our combined efforts will help to advance public health.

Sincerely,

José F. Cordero, M.D.
Deputy Director
National Immunization Program

Enclosure

6-22

IMMUNIZATION STATES FOR PHARMACISTS
(as of August 1999)

Alabama
Alaska
Arkansas
California
Colorado
Delaware
Georgia
Idaho
Illinois
Indiana
Iowa
Kentucky
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Mexico
North Carolina
Ohio
Oklahoma
Oregon
South Carolina
South Dakota
Tennessee
Texas
Utah
Virginia
Washington State
Wisconsin

WESLEY
Medical Center
550 North Hillside
Wichita, Kansas 67214-4976
Telephone 316/688-2468

February 4, 2000

Robert Haneke, PharmD, BCPS
President KPhA
Wesley Medical Center
Wichita, KS 67214

Dear Dr. Haneke,

Thank you for contacting me and allowing me to provide my input regarding the legislation pending for pharmacists working under protocol with physicians to provide immunizations. As Chairperson of the City Wide Immunization Task Force in Wichita, Kansas I feel that this is a worthwhile cause and am very excited about it.

This Task Force, which I Chair, is working on finding methods to improve our immunization rates, not only internally in our hospitals, but also outside our institutions in our communities. As you are well aware of, access to immunizations is a barrier to patients as well as a deterrent. I feel that this legislation will provide better access for all patients to acquire proper and timely immunizations. Over thirty other states, including those that surround Kansas, have similar legislation and have dramatically improved their individual state's immunization rates, with no reports of any adverse outcomes.

I work with pharmacists on a daily basis in my practice and feel that those properly trained, working with physician oversight, are well qualified to provide immunizations, as outlined in this legislation.

I fully support this legislation and am excited about the fact that the residents of the State of Kansas will have this opportunity available to them.

If I may be of any further assistance in this matter, please do not hesitate to contact me.

Thank you.

Respectfully,

Valerie C. Rohlman MD

Valerie C. Rohlman, MD
Board Certified Infectious Disease
Chair, Medical Performance Improvement Committee
President Elect, Medical Staff Executive Committee
Wesley Medical Center
Wichita, Kansas

6-24

February 4, 2000

Robert Haneke, PharmD, BCPS
President KPhA
Wesley Medical Center
Wichita, KS 67214

Dear Dr. Haneke,

Thank you for contacting me and allowing me to provide my input regarding the legislation pending for pharmacists working under protocol with physicians to provide immunizations. As a practicing Physician in the State of Kansas, I feel that this is a worthwhile cause and I am very excited about it.

Physicians in Kansas are constantly working on finding methods to improve our state's immunization rate, both urban and rural. As you are well aware of, access to immunizations is a barrier to patients as well as a deterrent. I feel that this legislation will provide better access for all patients to acquire proper and timely immunizations. Over thirty other states, including those that surround Kansas, have similar legislation and have dramatically improved their individual state's immunization rates, with no reports of any adverse outcomes.

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Thank you.

Respectfully,

Donna E. Sweet, MD
FACP
Professor of Medicine, University of Kansas School of Medicine

6-25

February 4, 2000

Robert Haneke, PharmD, BCPS
President KPhA
Wesley Medical Center
Wichita, KS 67214

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Thank you.

Respectfully,

Thomas A. Moore,, MD

THOMAS A. MOORE, M.D.
INFECTIOUS DISEASE SPECIALIST
IDC, PA
1100 N. ST. FRANCIS Suite 130
WICHITA KS 67214
316/264-3505

6-26

KMS

KANSAS MEDICAL SOCIETY

To: House Health and Human Services Committee

From: Chris Collins
Director of Government Affairs

Date: February 9, 2000

RE: HB 2759; Vaccinations by Pharmacists

The Kansas Medical Society appreciates the opportunity to testify today on HB 2759, which amends the Pharmacy Act to permit pharmacists to administer vaccine pursuant to a written protocol by a physician.

This bill presents a bit of a dilemma for us. KMS supports efforts to improve immunization rates across the population. It is well established that improved rates of vaccination will help prevent illness. However, we do have some concerns about this bill.

First, is there truly a need for this change? Do adult Kansans not already have adequate access to vaccinations? Physicians' offices, hospitals, and public health clinics all currently provide vaccinations at nominal cost. Will this change really improve vaccination rates, or will it just further fragment care?

Nonetheless, if this committee does feel this change is necessary, then the proposed amendment does protect the patient by ensuring that pharmacists are working under a protocol with a physician, after receiving training. However, the bill does not limit the types of vaccinations that pharmacists would be authorized to provide. A number of our members feel that if it is the intention of the pharmacists to provide only flu and pneumonia vaccinations, then the bill should be specific on that point. Our members have expressed reservations about pharmacists performing other vaccinations, such as for hepatitis, because they carry greater risk of adverse reactions.

This bill also raises the questions of future scope of practice concerns. Is this just the first step in pharmacist's wanting to expand pharmacy practice to include operating primary care clinics? What will be next?

In summary, KMS agrees that vaccines should be readily available to all Kansans. However, we are not convinced that an access problem exists in this state, nor that this bill will solve that problem. We appreciate the opportunity to testify today on this issue.

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Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 800.293.2363 • FAX 913.625.8234

H&HS
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Atch# 7