Approved: 2-22-00
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on February 18, 2000 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
Lisa Montgomery, Revisor of Statutes
Hank Avila, Legislative Research Department
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:
Michael H. Fox, Asso. Chair, Health Policy and Management, University of Kansas
Elizabeth W. Saadi, Ph.D., Center for Health and Environmental Statistics and Health Care Data Governing Board Staff
Robert St. Peter, MD, Kansas Health Institute
Charles Hunt, Epidemiologist, Bureau of Health Promotion, KDHE
Jerry Slaughter, Executive Director, Kansas Medical Society
Melissa Hungerford, Senior Vice President, Kansas Hospital Association
Sally Finney, Kansas Public Health Association
Robert Day, Director, Medical Policy/Medicaid, Health Care Policy, SRS
Chip Wheelan, Kansas Osteopathic Medicine

Others attending: See attached list

Hearing on: SB 554 - Collection of health service utilization data

Michael H. Fox, Department of Health Policy and Management, University of Kansas, addressed the Committee and expressed his support for **SB 554** which would authorize the Kansas Health Care Data Governing Board to receive patient-level health services data from all health providers in the state. Mr. Fox stressed the importance of adequate data, and noted that this legislation would allow Kansas to minimize the expense and inconvenience to providers while maximizing the usefulness of having this great resource. He felt the greatest usefulness of this legislation would be to the providers who can participate, and the data would have great importance for policy makers also. (Attachment 1)

The Chair briefed the Committee on proposed amendments to **SB 554** that would clarify existing statutes. (Attachment 2) The Revisor noted that a substitute bill for **SB 554** would be advisable. Senator Steineger made a motion that language in the proposed amendments create a **substitute bill** for **SB 554**, seconded by Senator Hardenburger. The motion carried.

Elizabeth W. Saadi, Ph.D., Center for Health and Environmental Statistics and Health Care Data Governing Board staff, expressed her support for **Sub SB 554** noting that language in the bill solidifies the provisions in the enabling legislation for the Health Care Data Governing Board to collect health services utilization data from health care providers, and the data would tell what kinds of health problems occur in Kansas communities. (Attachment 3)

Robert St. Peter, MD, Kansas Health Institute, also expressed his support for the bill. Dr. St. Peter emphasized four points to consider regarding collection of data: (1) To think about the burden and cost of collecting data from providers, (2) a need to proceed in the data collection in a realistic manner, (3) resources needed to be available within state agencies getting data, and (4) safeguard issues needed to be addressed. He also felt it would be beneficial to bring in technical experts from other states who have gone through the data collection process.

Charles Hunt, Epidemiologist, Bureau of Health Promotion, KDHE, expressed his support for the bill and briefed the Committee on statistics relating to Recurrent Assaultive Injury in Missouri: A Retrospective Cohort Study Examining Assault as a Risk Factor for Assault. (Attachment 4)

Jerry Slaughter, Executive Director, Kansas Medical Society, stated that KMS is not opposed to the state beginning an effort to collect patient level data from individual providers so long as the following conditions are present: data collected for a specific purpose which is communicated to the providers who will be asked to supply the data; data collected in a manner that does not involve a significant amount of cost, intrusion and administrative hassle for the providers; and data collected in a manner that assures confidentiality of patient and provider information. (Attachment 5)

Melissa Hungerford, Senior Vice President, Kansas Hospital Association, expressed her support for **Sub SB 554** and the conditions expressed by Mr. Slaughter, KMS. Ms. Hungerford's written testimony refers to the original bill. (Attachment 6)

Sally Finney, Kansas Public Health Association, expressed her support for the bill, (Attachment 7) and the Chair noted support was also received from representatives of the Kansas Association of Osteopathic Medicine and the Kansas State Nurses Association.

Action on Sub SB 554
Senator Steineger made a motion the Committee recommend **Sub SB 554** favorably for passage, seconded by Senator Hardenburger. The motion carried.

Hearing on SB 555 - Voting status of governmental members of the health care data governing board
Elizabeth Saadi, KDHE, expressed her support for **SB 555** which would expand the voting membership of the Health Care Data Governing Board from nine to 12 members (Attachment 8) and Robert Day, Director, Medical Policy/Medicaid, Health Care Policy, SRS, also expressed his support for the bill.

Action on SB 555
Senator Steineger made a motion the Committee recommend **SB 555** favorably for passage, seconded by Senator Salmans. The motion carried.

Action on SB 512 - Controlled substances scheduled under the uniform controlled substances act
The Revisor noted that the bill needed to be amended that would change the effective date from publication in the statute book to Kansas register. Senator Steineger made a motion to adopt the amendment that would change the effective date to "Kansas register", seconded by Senator Langworthy. The motion carried.

Senator Steineger made a motion that the Committee recommend **SB 512 as amended** favorably for passage, seconded by Senator Langworthy. The motion carried.

Action on SB 541 - Non-human institutional drug rooms
Senator Steineger made a motion to rename reference to "non-human institutional drug rooms" to "Veterinary Medical Teaching Hospital Pharmacy", seconded by Senator Hardenburger. The motion carried.

The Revisor pointed out that a typo needed to be corrected on page 6, line 6. Senator Steineger made a motion to remove the parentheses on page 6, line 6, and add the word "or" between on and administration to, seconded by Senator Hardenburger. Further discussion concluded that the words "or experimentation on" should be deleted too. Senator Steineger withdrew his original motion. Senator Steineger made a motion to delete the parentheses on page 6, line 6, and the words, "or experimentation on", insert the word "or"before the word "administration", seconded by Senator Hardenburger. The motion carried. Senator Steineger made a motion the Committee recommend **SB 541 as amended** favorably for passage, seconded by Senator Langworthy. The motion carried.

Conclusion of Hearing on: SB 599 - Physician Assistant licensure
Chip Wheelan, Kansas Osteopathic Medicine, offered an amendment to **SB 599**. (See Attachment 9)

Adjournment
The meeting was adjourned at 11:00 a.m.
The next meeting is scheduled for February 21, 2000.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-18-00

NAME	REPRESENTING
Bill Sneed	KFDA
Larry W Pitman	KFMC
Kevin Brown	Merlin Chtd.
Robert Day	SRS
Chip Wheelen	Osteopathic Assoc.
Chris Collins	Kansas Medical Society
Carolyn Middendorf	KSNA
Sally Finney	Ks. Public Health Assn.
Lorna K. Hayes	KDHE

The University of Kansas

Department of Health Policy and Management

Honorable Senator Sandy Praeger, Chair
Senate Committee on Public Health and Welfare
Kansas Legislature

February 17, 2000

Dear Senator Praeger:

I would like to offer my support for Senate Bill 554 authorizing the Kansas Health Care Data Governing Board to receive patient-level health services data from all health providers in the state. This is important legislation that would place Kansas in a position to better understand the ways in which medical services are practiced in the state, to the overall benefit of not just citizens receiving these services, but providers as well.

As I know you are aware, there are precedents for this legislation in a number of other states concerned about the cost and quality of their health care. Taking the knowledge learned from these examples would allow Kansas to ***minimize the expense and inconvenience to providers***, while ***maximizing the usefulness of having this great resource***. Some of these lessons that the Committee should be aware of, include:

1. encouraging public input into how the data will be used;
2. performing an initial inventory of the capacity of providers to comply with this request; and
3. **only** requesting data from those providers who are electronically prepared to contribute data without hardship or significant expense, and who have sufficiently large volume to warrant participating;
4. maintaining rigid confidentiality standards towards patients, and sharing provider information only in the aggregate.

I believe the greatest usefulness of this legislation will be to the providers who can participate. The effects of changes in supply, reimbursement rates, new programs, or managed care are largely unknown to providers. These data will allow physicians and clinics, for example, to identify how effectively they treat patients with specific diseases, such as heart disease or diabetes. They will allow hospitals to determine if their patients receiving hip replacements receive adequate outpatient care so that their patients' mobility can be restored. What works best and for whom? And perhaps equally important, what does not seem to work, and how can practice change to improve outcomes? This use of information is sorely lacking for most providers, who have little knowledge of the entire picture of medical care provided to patients they may see for only a short time.

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Edwards Campus • (913) 897-8585 • Fax: (913) 897-8681 • http://kue

Senate Public Health & Welfare
Date: 2-18-00
Attachment No. 1

These data have great importance for policy makers also, who themselves are responsible for developing guidelines for Kansas Medicaid, HealthWave, and many public health programs. The effectiveness of Medicaid managed care and other waiver programs, the nature of health care being received by the uninsured, and the relationship of public health services to those paid for by insurance are just a few issues that can be analyzed using these data. It is my hope that the passage of Senate Bill 554 will lead to improved quality and access to health services for all Kansans, and greater understanding of resources by state policy makers. With this knowledge, we can develop strategies in our state that lead to the best possible care at the lowest possible cost, a goal that all of us share.

I strongly urge a favorable reading of this legislation in the weeks ahead.

Sincerely,

Michael H. Fox, Sc.D., Associate Chair
Department of Health Policy & Management
University of Kansas
Lawrence
Member, Health Care Data Governing Board

Sec. . K.S.A. 1999 Supp. 65-6801 is hereby amended to read as follows: 65-6801. (a) The legislature recognizes the urgent need to provide health care consumers, third-party payors, providers and health care planners with information regarding the trends in use and cost of health care services in this state for improved decision-making. This is to be accomplished by compiling a uniform set of data and establishing mechanisms through which the data will be disseminated.

(b) It is the intent of the legislature to require that the information necessary for a review and comparison of utilization patterns, cost, quality and quantity of health care services be supplied to the health care database by all providers of health care services and third-party payors to the extent required by K.S.A. 1999 Supp. 65-6805 and amendments thereto and this section and amendments thereto. The secretary of health and environment at the direction of the health care data governing board shall specify by rule and regulation the types of information which shall be submitted and the method of submission.

(c) The information is to be compiled and made available in a form prescribed by the governing board to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of health care services.

Sec. . K.S.A. 1999 Supp. 65-6804 is hereby amended to read as follows: 65-6804. (a) The secretary of health and environment shall administer the health care database. In administering the health care database, the secretary shall receive health care data from those entities identified in K.S.A. 1999 Supp. 65-6805 and amendments thereto and provide for the dissemination of such data as directed by the board.

(b) As directed by the board, the secretary of health and environment may contract with an organization experienced in health care data collection to collect the data from the health care facilities as described in subsection (h) of K.S.A. 65-425 and amendments thereto, build and maintain the database. The secretary of health and environment may accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to this section.

(c) The secretary of health and environment shall adopt rules and regulations approved by the board governing the acquisition, compilation and dissemination of all data collected pursuant to this act. The rules and regulations shall provide at a minimum that:

(1) Measures have been taken to provide system security for all data and information acquired under this act;

(2) data will be collected in the most efficient and cost-effective manner for both the department and providers of data;

(3) procedures will be developed to assure the confidentiality of patient records. Patient names, addresses and other personal identifiers will be omitted from the database;

(4) users may be charged for data preparation or information that is beyond the routine data disseminated and that the secretary shall establish by the adoption of such rules and regulations a system of fees for such data preparation or dissemination; and

(5) the secretary of health and environment will ensure that the health care database will be kept current, accurate and accessible as prescribed by rules and regulations.

(d) Data and other information collected

2-3

pursuant to this act shall be confidential, shall be disseminated only for statistical purposes pursuant to rules and regulations adopted by the secretary of health and environment and approved by the board and shall not be disclosed or made public in any manner which would identify individuals. A violation of this subsection (d) is a class C misdemeanor.

(e) In addition to such criminal penalty under subsection (d), any individual whose identity is revealed in violation of subsection (d) may bring a civil action against the responsible person or persons for any damages to such individual caused by such violation.

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

Testimony Presented to the
Senate Public Health and Welfare Committee

Senate Bill 554

by

Elizabeth W. Saadi, Ph.D.
Kansas Department of Health and Environment
Center for Health and Environmental Statistics and Health Care Data Governing Board staff

Madam Chair and members of the committee, thank you for the opportunity to provide testimony on behalf of Senate Bill 554. The language in this bill solidifies the provisions in the enabling legislation for the Health Care Data Governing Board to collect health services utilization data from health care providers. In other words, you as policy makers, and those who are health program managers, need to have basic data about health services being delivered in Kansas to understand how sick our population is. Kansas community health planners, providers, researchers and program managers need health services utilization data to assess health status, document needs, and plan for resources. These data provide information about specific health conditions that cause significant morbidity and mortality in Kansas.

The data that will be required by SB 554 will tell us – in a non-identifiable manner – what kinds of health problems occur in Kansas communities. Subsequently, ways to alleviate the suffering from these conditions can be sought and implemented. Kansas has good information about the circumstances of birth and what causes us to die. However, when we look for information about illnesses endured by Kansans, public access to this information is almost non-existent. You will hear a presentation by Mr. Charlie Hunt about how health data could be used to raise awareness and solve problems. We cannot duplicate the work Mr. Hunt has done for Kansas because of the lack of accessibility to the appropriate data.

Utilization data is maintained within the private sector, hospitals, associations and doctor's offices. There is a great need for these data to be made available to the public – not to punish physicians and medical care facilities – but to understand how sick Kansans are and address the conditions that plague us. Most of the work that has been reported in the past has involved extrapolations from national data. **Kansas policy makers need Kansas-specific data upon which to make Kansas-specific decisions.**

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400 SW 8TH Street, Suite 200
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Senate Public Health & Welfare
Date: 2-18-00
Attachment No. 3

You created the Health Care Data Governing Board so that when health issues arise, as in 1993 with health care reform, you can make informed decisions based on Kansas-specific information. In creating the Governing Board, health care providers were made partners so the owners of these health data would be involved in the decision-making process. Providers will assist in making decisions on how to collect the data required by HB 554. Additionally, decisions for data collection will be made based on the following premises:

– Collect data in the least burdensome manner for data providers and

– seek the most cost effective method for data collection.

Much of the data sought with this bill is currently available in electronic format. This would minimize the reporting burden for providers.

I urge you to support HB 554 and encourage sharing of health information for policy decision-making and program planning needs.

Thank you for your time.

Recurrent Assaultive Injury in Missouri: A Retrospective Cohort Study Examining Assault as a Risk Factor for Assault

D. Charles Hunt, MPH
Epidemiologist
Kansas Department of Health & Environment
Bureau of Health Promotion

Introduction

Violence is a Leading Public Health Problem

- One-third of all injury deaths are intentional
  - 40% are homicides
  - 60% are suicides
- Homicide is the 2nd leading cause of death for persons 15 to 24 years of age
- >19,000 deaths annually from homicide
- >130,000 people hospitalized from interpersonal violence
- Minority populations carry greatest burden of violence
  - Homicide is the leading cause of death for African-American and Hispanic youth aged 15-24

Trauma is Not Random

- Trauma is a chronic condition with high rates of recurrence (particularly violent trauma)
- Mostly descriptive studies
- Few studies have examined violent trauma itself as an independent risk factor for subsequent assaultive injury

Limitations of Current Literature

- Urban trauma centers
- Most studies in the literature are descriptive
  - Lack of comparison populations
- Underestimation of risk due to single study site
- Small sample sizes
- Lack of control for confounding factors
- No population-based studies of problem in U.S.

Population-based Studies on Violence

What is Needed?

- Population-wide *patient* data system to capture violent events and pertinent information
- High sensitivity
- Comprehensive
- E-codes
  - Supplemental coding system to ICD-9
  - Specifies external cause *as well as intent* of injuries

Missouri Patient Abstract System

- Statewide hospital discharge database
- Maintained by Missouri Dept. of Health
- Supported by State statute and rules
- Includes inpatient and emergency department records
- MO residents hospitalized in certain IA, KS, & IL hospitals included
- Sensitivity ≥90%
- E-codes mandated

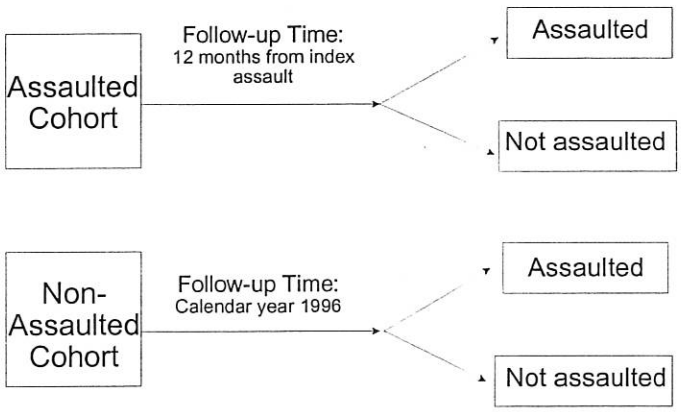
Research Questions

- What is the extent to which assaultive injury is a risk factor for subsequent assault?
- Does the severity of assaultive injury influence the risk of subsequent assaultive injury?
- What demographic factors, if any, are associated with the risk of recurrent assaultive injury?

Study Design

MO Patient Abstract System 1995-1996 Utilized

- Retrospective cohort study
- Cohort 1 (exposed group)
  - MO residents assaulted in 1995
  - Hospitalized or treated at ED for injury (subclassifications)
  - Discharged alive
- Cohort 2 (unexposed group)
  - Population of MO minus exposed group
  - Obtained from census data tables
- Outcome of interest
  - Assault within 12 months resulting in ED visit, hospitalization, or death



Descriptive Epidemiology

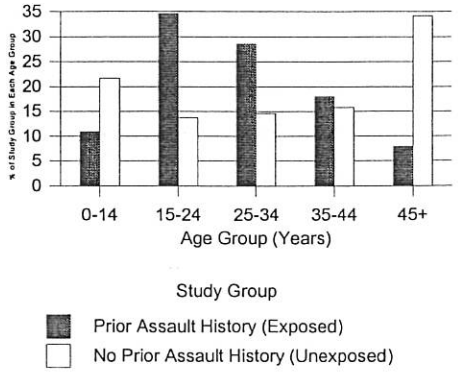
Assaulted Cohort (Exposed)

- n = 26,873
- 93.9% treated in emergency department and released
- 6.1% hospitalized

Causes of Initial Injuries Among Exposed Cohort

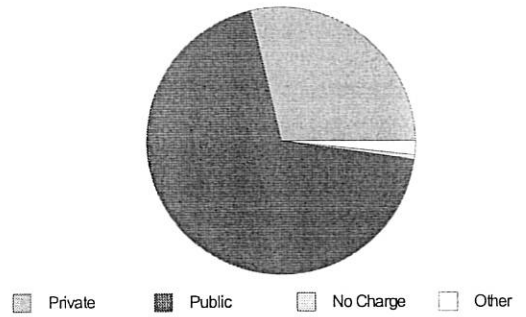
Unarmed fight/brawl	53.4%
Rape	2.9
Firearms	3.7
Cutting/piercing (stabbing)	6.9
Child battering (by parent)	1.2
Child battering (by other person)	1.4
Striking by blunt object	10.9
Bite of human being	7.9

Percentage of Patients in Age Groups, by Assault History (Exposed and Unexposed)



Distribution of Primary Payer Status

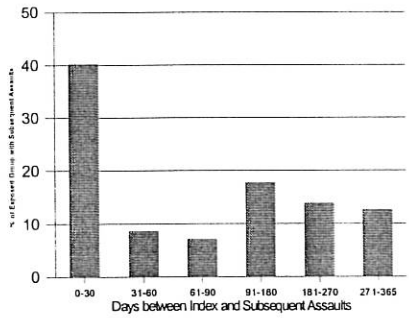
Assault Cohort



Risk of Subsequent Assault

- Relative risk (age- and gender-adjusted) of subsequent assault among patients with assault exposure compared to patients with no prior assault: 11.61 (95% CI = 11.17, 12.06)
- Risk not associated with severity
- Probability of subsequent assault within 1 year among patients with index assault = 0.0962
- Probability of subsequent assault similar between demographic groups

Percentage of Patients with Recurrent Assault Assaulted within Specific Time Intervals



Conclusion

Implications for Prevention

- Primary prevention
- Secondary prevention also important
  - Hospital-based interventions
- High public financial burden of assault
  - Public investment in prevention worthwhile

Conclusion

What Else Can We Learn?

- Are there differences in recurrent assault risk between urban and rural areas?
- Does type of assault injury influence the risk of recurrent assault?
- Linkage with other data systems
  - Are adolescents who suffer boxer's fractures at higher risk of criminal record later in life than other adolescents?
- Intervention program evaluation
  - Does hospital-based post-assault social work or counseling referral reduce the risk of subsequent assault?

KMS

KANSAS MEDICAL SOCIETY

Date: February 18, 2000

To: Senate Public Health and Welfare Committee

From: Jerry Slaughter
Executive Director

Subject: **SB 554; concerning the collection of certain health data**

The Kansas Medical Society is pleased to have the opportunity to appear today as the committee considers SB 554, which deals with information collected by the Health Care Data Governing Board. We understand that Chairman Praeger has a draft of a substitute bill that reflects some of the issues raised by the Data Governing Board at its last meeting.

This legislation was developed by the Board to facilitate its efforts to begin collecting more comprehensive data on patient care issues across the state. Currently, the Data Governing Board does not require individual health care providers to report patient-level data. The data being collected and made available to those who request it is largely summary data from insurance claims and manpower data about various health professions.

We are not opposed to the state beginning an effort to collect patient level data from individual providers so long as the following conditions are present:

- the data are collected for a specific purpose which is communicated to the providers who will be asked to supply the data;
- the data are collected in a manner that does not involve a significant amount of cost, intrusion and administrative hassle for the providers; and
- the data are collected in a manner that assures confidentiality of patient and provider information.

We will work with the Health Care Data Governing Board to assure that adequate privacy protections and sensitivity to costs that will be imposed on providers are built into the process. Additionally, we will urge the Board to develop a written plan addressing these issues prior to implementing the data collection process. While we support efforts to make the state's database more comprehensive, we do not want to burden physicians' offices with costly requests to produce data, particularly if the need for that data has not been clearly communicated to the provider community in advance.

Thank you for the opportunity to offer these comments.

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Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 800.

Memorandum

Donald A. Wilson
President

February 18, 2000

To: Senate Public Health and Welfare Committee

From: Melissa Hungerford, Senior Vice President

Subject: Senate Bill 554

The Kansas Hospital Association has been and continues to be strong supporters of the Kansas Health Care Data Governing Board. We do believe that the authority outlined in SB 554 was provided in the enabling legislation, but we understand the desire to further clarify the intent of that legislation. KHA supports the principle of SB 554.

There are two sections in SB 554 that could be deleted and dealt with in rules and regulations or in departmental procedures. First, Section 2 (c) refers to a 90-day limit for developing an agreement with the state for providing data on behalf of providers. The start time and duration of that limitation are problematic. We feel everything after line 30 should be deleted. Second, section 2 (e) describes the data that will be returned to providers who submit data. We definitely support this approach, but are concerned that this section creates a distinction between data access for providers and others who would ultimately have access to the data. Again, we feel that this section could be eliminated and dealt with in rules and regulations or procedures.

We have reservations concerning the cost, both to the state and our members, of implementing new data collection requirements, and we feel that the purpose or use of the requested data should be articulated clearly.

We continue to encourage the Health Care Data Governing Board to 1) fully utilize existing databases prior to implementing new requirements on providers; and 2) if they need to create a new database, that it include information about the different settings from which health care is provided in today's environment. The existing databases currently available illustrate the types of data that will be requested from providers and provide a significant insight into the possibilities and limitations of the data. In addition, KHA believes only a database that crosses provider settings will provide the information necessary to accomplish the purposes laid out in the enabling legislation.

KHA thanks the committee for the opportunity to provide our comments and would be happy to work with staff on amendments.

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 7

Senate Public Health & Welfare
Date: 2-18-00
Attachment No. 6

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.
AFFILIATED WITH THE AMERICAN PUBLIC HEALTH ASSOCIATION
215 S.E. 8TH AVENUE
TOPEKA, KANSAS 66603-3906
PHONE: 785-233-3103 FAX: 785-233-3439
E-MAIL: kpha@networksplus.net

Testimony presented by
Sally Finney, Executive Director
on February 18, 2000

Chairman Praeger and members of the Senate Committee on Public Health and Welfare, I am here today on behalf of the Kansas Public Health Association asking you to support Senate Bill 554. The ability of the public health community of this state to plan appropriate public health interventions hinges on our ability to review data to determine what we should be doing and with whom. It also is critical to helping us evaluate what kind of progress we have made. Making health care utilization data available to the health care data governing board will go a long way towards assuring the public health community's ability to use most effectively the limited financial resources that support our efforts.

Have such data on hand will help bring needed federal and private dollars to Kansas to address demonstrable needs. I can personally attest to the fact that not having such data has kept funds from flowing to the state. Last year, our organization applied for a $10,000 grant from the American Public Health Association to support education of pediatricians and family physicians about the complexities of proper use of child safety seats in passenger vehicles. Our application was denied because we could not provide Kansas-specific data showing the APHA that Kansas children are being injured in motor vehicle accidents and would also be unable to show a reduction in injuries. Two years ago, we had to abandon plans to pursue private foundation funds for a dog bite prevention project because we could provide only child death data. Because most children who are injured by dogs survive, this information is not reported to the child death review board and could not be gathered.

The Kansas Public Health Association believes passage of SB 554 will benefit all Kansans, and we ask your support.

Senate Public Health & Welfare
Date: 2-18-00
Attachment No. 7

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

Testimony presented to the
Senate Public Health and Welfare Committee

Senate Bill 555

by

Elizabeth W. Saadi, Ph.D.
Kansas Department of Health and Environment
Center for Health and Environmental Statistics and Health Care Data Governing Board Staff

Madam Chair and committee, I am presenting to you today on behalf of the Health Care Data Governing Board regarding Senate Bill 555.

Section 1 of this bill amends KSA 65-6803 which describes the membership of the Health Care Data Governing Board. When the original legislation establishing the Governing Board was drafted, there was a concern that this new entity would represent government dictating to the private sector. Governing Board members have been working together for seven years now and a level of trust has developed among the public and private members in which governmental representatives are viewed as major players in health purchasing and health information system development. It is the consensus of the non-governmental members that voting status should be granted to governmental representatives. Therefore, at the request of the voting members of the Health Care Data Governing Board, I am seeking Governing Board voting status for the representatives from the Kansas Department of Health and Environment, Social Rehabilitation Services, and the Kansas Insurance Department.

Thank you for your consideration of this statutory change.

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such temporary registration shall be permitted to any one person without the majority approval of the members of the board.

(b) A temporary license is valid (1) for one year from the date of issuance or (2) until the state board of healing arts makes a final determination on the applicant's request for licensure. The state board of healing arts may extend a temporary license, upon a majority vote of the members of the board, for a period not to exceed one year.

Sec. 6. K.S.A. 1999 Supp. 65-2896e is hereby amended to read as follows: 65-2896e. (a) *The practice of a physician assistant shall include medical services within the education, training and experience of the physician assistant that are delegated by the responsible physician. Physician assistants practice in a dependent role with a responsible physician, and may perform those duties and responsibilities through delegated authority or written protocol. Medical services rendered by physician assistants* ~~*may include but are not limited to: (1) Obtaining patient histories, performing physical examinations and health assessments; (2) ordering or performing diagnostic and therapeutic procedures, or both; (3) formulating diagnosis; (4) developing and implementing a treatment plan; (5) monitoring the effectiveness of therapeutic interventions; (6) assisting in surgery; (7) offering counseling and education to meet the patient needs; and (8) making appropriate referrals. These activities*~~ *may be performed in any setting authorized by the responsible physician, including but not limited to, clinics, hospitals, ambulatory surgical centers, patient homes, nursing homes and other medical institutions.*

(b) Physician assistants shall be considered the agents of their responsible physicians in the performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services.

(c) A person ~~whose name has been entered on the register of physicians' assistants~~ *licensed as a physician assistant* may perform, only under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the ~~physician's~~ *physician* assistant and only to the extent such acts are consistent with rules and regulations adopted by the board which relate to acts performed by a ~~physician's~~ *physician* assistant under the responsible physician's direction and supervision. A ~~physician's~~ *physician* assistant may prescribe drugs pursuant to a written protocol as authorized by the responsible physician.

(d) Before a ~~physician's~~ *physician* assistant shall perform under the direction and supervision of a physician, such ~~physician's~~ *physician* assistant shall be identified to the patient and others involved in providing the patient services as a ~~physician's~~ *physician* assistant to the responsible physician. *Physician assistants licensed under the provisions of this act shall*

Amendment suggested by Chip Wheelen

delete lines 15-20 and in line 21
delete all before "may"

Senate Public Health & Welfare
Date: 2-18-00
Attachment No. 9